REVIJA ZA ELEMENTARNO IZOBRAŽEVANJE
JOURNAL OF ELEMENTARY EDUCATION
Vol. 14, Spec. Issue, pp. 35–61, August 2021

THE EXPERIENCE OF RESIDENTIAL CARE FROM THE PERSPECTIVE OF ADOLESCENTS AND CAREGIVERS

IVANA GAZILJ[1], IVANA BORIĆ[2] & ANDREA ĆOSIĆ[2]

[1] Residential Care Institution for Children and Youth Karlovac, Karlovac, Croatia
[2] Faculty od Education and Rehabilitation Sciences, University of Zagreb, Zagreb, Croatia

CORRESPONDING AUTHOR/KORESPONDENČNI AVTOR/
ivana.gazilj@gmail.com

Potrjeno/Accepted
26. 11. 2020

Objavljeno/Published
1. 8. 2021

Abstract/Izvleček

Aim of the study is to provide an insight into the experience of residential care from the perspective of beneficiaries and experts. The data was collected in two male residential units. The results show that adolescents and caregivers tend to have a negative attitude toward residential care. Adolescents are even more skeptical about the purpose of treatment since they experience shortcomings in the activities and the methods of treatment, as well as monotony and stigmatization by the local community. Caregivers highlight their disappointment regarding the inadequate intervention system and the complexity of working with children with multiple risks and problems.

Izkušnje stanovanjske oskrbe skozi perspektivo mladostnikov in vzgojiteljev

Cilj študije je zagotoviti vpogled v izkušnje obravnav v vzgojnih zavodih z vidika bivajočih otrok in mladostnikov ter strokovnjakov. Podatki so bili zbrani v dveh mladostniških vzgojnih zavodih. Rezultati kažejo, da so mladostniki in vzgojitelji negativno naravnani do obravnav v vzgojnih zavodih. Mladostniki so še bolj dvomljivi glede namena obravnav v vzgojnih zavodih, saj je v dejavnostih in poteku obravnave preveč monotonost, kakor tudi stigmatiziranje s strani lokalne skupnosti. Vzgojitelji poudarjajo svoje razočaranje zaradi neustreznega sistema intervenc in kompleksnosti dela z otroki z večplastnimi tveganji in težavami.

Keywords:
residential care, experience, adolescents, caregivers

Ključne besede:
vzgojne ustanove, izkušnje, mladostniki, vzgojitelj

UDK/UDC
376.018.3

DOI https://doi.org/10.18690/rei.14.Sp.Iss.35-61.2021

University of Maribor Press

Introduction

Separating a child from its family and placing it in institutional care is, in most cases, an intervention at the very end of the intervention spectrum, which happens only after various other opportunities and services in the community have been exhausted. Institutional placement over a specified period is designed to effect a reduction in behavioural problems, to provide care for everyday needs, and to encourage positive changes in the lives of children and adolescents (Harder, Knorth, 2014). Such a multidimensional therapeutic approach is intended for children and adolescents aged between 12 and 21 years who exhibit multiple emotional and behavioural problems, and have complex risks and needs, particularly regarding family, social relationships and personality (Attar-Schwartz, 2008; Žižak, Koller-Trbović, 2013; Harder, Knorth, Kalverboer, 2017; González-García et. al., 2017). The overlapping of life and the treatment context in residential institutions is a continuous challenge in terms of understanding its elements, quality, and efficiency. Each institution is a unique, dynamic social system, and institutional treatment should carefully integrate elements such as the theoretical foundation, respect for the psychological and social needs of children and adolescents, and creation of a supportive social and physical environment (Daly et. al. 2018). These elements are logically imposed in almost all therapeutic environments; however, research on the effectiveness of residential care is often expressed by the "black box" metaphor, as it is not yet entirely clear how positive outcomes for children and adolescents occur (Harder, Knorth, 2014; Leipoldt et. al. 2019). The quality and efficiency of residential care are a continuous challenge for researchers and practitioners (Leipoldt et. al. 2019; Wesenberg, et. al. 2020). It is therefore crucial to deepen the understanding of this form of care through different perspectives.

Previous research into the experiences of adolescents in residential care suggests that they have a generally positive experience of care, and primarily emphasize the quality of relationships with their caregivers and peers, as well as the feeling of purpose while staying in the institution. For example, Moore et. al. (2017) report that adolescents consider a good relationship with the caregiver to be the most important element of treatment. In other words, having an influential adult person to whom they can turn at any time while staying in the institution is of utmost importance to them.

Furthermore, adolescents consider residential care a safe place if it provides a sense of stability and predictability through consistent rules, routines and rituals, as well as a sense of control through involvement with the environment (Moore et. al., 2017). In a qualitative study conducted by Soenen, D'Oosterlinck and Broekaert (2013) regarding the quality elements of treatment, adolescents emphasized the availability and involvement of staff as key elements, as well as clearly defined rules and boundaries, and the existence of personal space and private time. Moreover, authors Palareti and Berti (2009) found that adolescents in residential care in Italy have a generally positive experience of care and treatment, show satisfaction with the opportunities that their institution provides and perceive it as a place to reflect on their own life goals. Research conducted by Lanctôt, Lemieux and Mathys (2016) on girls in institutional treatment, showed that the girls describe the quality of care by emphasizing the dimension of personal space during their stay, and the quality of relationships with the staff, which includes support and understanding of trauma, and active participation in the life of the institution. Furthermore, the research results suggest that emotionally involved, approachable and reliable experts who show interest in adolescents contribute to the general satisfaction of adolescents during institutional placement and their verbalization of the progress in understanding their own behaviour (Carter, 2011). Sellers (2020) obtained similar self-reported results from children and adolescents who pointed out a strong correlation between the sense of security and a good relationship with the caregiver. More specifically, the children and adolescents who had a greater perception of quality relationships also perceived the institution as a safer living space. A positive perception of institutional relationships encourages adolescents to feel involved in the treatment, to report greater support from the caregivers and other beneficiaries, and to describe at least one meaningful relationship with one of the caregivers (Leipoldt et. al., 2019). Johansson and Andresson (2006) interviewed adolescents and found that they consider their relationship with the caregiver as the crucial element in treatment, while the caregiver's sensitivity to their previous experiences is especially valued, as well as their sensitivity to how adolescents perceive the conditions, treatment and specific events at the institution (such as experiencing or perpetrating violence) and the hard work that the caregivers put into providing a sense of normalcy and belonging in the institution.

Comparing the perspective of adolescents from residential care and other forms of care, Pérez-García et. al. (2019) found that adolescents from residential care report the lowest general satisfaction with treatment, which the authors link to the severity of problems within this group of adolescents. At the same time, the most positive aspects for adolescents are the resources, available activities (such as regular meals and workshops for skill development), positive relationships with caregivers, and the opportunities offered by the institution to bring about positive changes in their behaviour, while the negative experiences are associated with conflicts with peers, the inconsistency of caregivers and the closed nature of the institution. The research clearly points to certain difficulties and negative experiences that adolescents experience in institutional care. Studies show that adolescents are very competent and critical in reflecting on their life in the institution, and that their inclusion as partners is crucial in improving care and treatment. For example, in a study conducted by Moore et al. (2017), when asked about improving the treatment, the adolescents pointed out the need for better differentiation between programs based on the level of risk, better compliance of staff regarding discipline, and provision of a space for adolescents to contribute to life in the institution through active participation.

Experts, more specifically caregivers, are the key element in creating the treatment environment in residential care. Their task is primarily to provide security, to respond to a whole range of adolescent needs and to actively work on their resocialization and return to the family and the community (Silva, Gaspar, 2014). The caregiver profession is one of the most challenging and demanding professions in working with children and adolescents with behavioural problems (Knorth et. al., 2010). Therefore, the caregivers' experience of residential care, their relationships with adolescents and colleagues, the clarity of roles and job satisfaction must be understood, since these elements largely affect their daily work (Glisson, Hemmelgarn, 1998). A review of research on the role of caregivers in residential care shows that the most frequently explored topics are those related to the importance of their role in treatment (e.g., Knorth et. al., 2010), their relationship with the adolescents, as well as the interventions they provide (e.g., Bastiaanssen et. al., 2012; McLean, 2013), the organizational aspects of residential care (e.g., Minor, Wells, Jones, 2004), job satisfaction (e.g., Van der Ploeg, Scholte, 1998), and evaluation of the level of stress and burnout (e.g., Fernandez Del Valle, López López, Bravo Arteaga, 2007).

The results of certain studies indicate low job satisfaction among caregivers in residential care, which is associated with factors such as difficulty in establishing relationships with children with behavioural problems, a low level of support from the staff at the institution, a lack of organizational resources, emotional exhaustion and overload in terms of work and administration (Gibbs, Sinclair, 1998; Van der Ploeg, Scholte, 1998; Whitaker, Archer, Hicks, 1998). When it comes to the experience of treatment, a study conducted by Andersson and Johansson (2008) shows that caregivers in residential care use varied approaches in working with adolescents, pointing out good communication and good relationships as the most important elements, along with support from the system and colleagues at work.

Studies comparing the perspective of caregivers and adolescents regarding individual elements of care and treatment show certain differences in experiences. The studies on the perception of the treatment environment in residential care show that the staff has a more positive attitude than adolescents when it comes to the treatment environment (e. g. Langdon, Cosgrave, Tranah, 2004; Smith, Maume, Reiner, 1997). Unlike the staff, adolescents feel that the staff gives them insufficient encouragement regarding independence, learning practical skills, taking initiative, and openly expressing opinions (Langdon, Cosgrave, Tranah, 2004). A study conducted by Harder, Knorth and Kalverboer (2017) on the experience of elements that contribute to behavioural changes in care, shows that adolescents and experts have different views on therapeutic methods and goals. The authors also point out that adolescents associate the change in their behaviour exclusively with the treatment environment (security and good relationships in the institution), while caregivers attribute changes in behaviour to the treatment methods used (for example, individual conversation, structure and clarity of treatment). Furthermore, studies have shown differences in the perception of specific behaviours in the institution, for example bullying among peers in the institution. Caregivers report a rate of bullying among beneficiaries which is much lower than the rate experienced and reported by adolescents in care (Sekol, Farrington, 2020). When comparing the difference in the perception of caregivers and adolescents, it is important to state that there is a logic behind their differing perspectives, since these are two separate subcultures within an institution. Quality treatment, however, should be aimed at aligning the interests and perspectives of the beneficiaries and the staff, as it would increase the motivation of staff and contribute to the beneficiaries achieving their personal goals (Moos, Moon, 1998).

This paper focuses on the residential care experience of adolescents and caregivers in the Republic of Croatia. It is therefore important to refer specifically to the Croatian context. Children and young people with behavioural problems can be removed from the family when their behavioural problems are manifested intensely and are endangering the psychosocial functioning of the child, his/her family and surroundings over a longer period of time. After the removal, children can be placed in institutional care based on social-protective, family-legal, or educational measures. The aim of direction to an institution is to achieve positive and pro-social changes in the child, as well as to work with the family and the social surroundings. Across Croatia, there are currently ten residential care institutions of this type, that provide care and specialized intervention for children and young people with behaviour problems, aged 7 to 21. There are seven centre-based homes in Osijek, Karlovac, Rijeka, Pula, Zadar, Split and Zagreb. Besides those seven institutions there are three residential care homes located in Bedekovčina, Ivanec, and Mali Lošinj. All these institutions are open and, to an extent, differentiated by age and sex. At any point, there are around 350 children and young people in these homes (Annual Statistical Report of the Ministry of Demographics, Family, Youth and Social Policy, 2019). Apart from these institutions, institutional care for children and young people is also partly provided in two more establishments: Children's Home Zagreb (as part of small groups for intense treatment for boys up to 14 years of age), and the Educational Centre Lug, through the treatment measure for boys with intellectual difficulties.

The indicators of research in Croatia over the past decade show general dissatisfaction with educational-correctional institutions among both the adolescents and the experts. The adolescents mention the problem of numerous shortcomings related to the inconsistent behaviour of caregivers and the organization of life in the institution (Kusturin, 2002), a lack of activities and content of treatment (Kusturin, 2002; Oreb, Majdak, 2013), inadequate living conditions (Kovačićek 2017; Koller-Trbović, Jeđud Borić and Mirosavljević, 2015; Sklepić, 2011) and the feeling of futility and inefficiency of living in an institution (Kovačićek, 2017; Ratkajec Gašević, Maurović, 2015). The adolescents sometimes perceive their life in an educational-correctional institution as an additional risk factor, owing to stigmatization by the local population, but also because placement in such an institution can mean, for some adolescents, an introduction to even riskier behaviours practiced by their peers (Jeđud, 2011).

Inadequate, poor relationships with the experts, who often ignore the problem of violence and use it as a means of controlling and sanctioning beneficiaries, is another element of dissatisfaction among adolescents (Sekol, 2012). Furthermore, the research conducted by Ratkajec Gašević and Maurović (2015) regarding escapes from institutions shows that the most common reasons for escaping are poor living conditions and poor relationships in the institution, feelings of not belonging there, as well as antisocial aspirations among adolescents. The experts also report general dissatisfaction with treatment (Ajduković, Sladović Franz, Kamenov, 2005; Herceg Babić, 2014; Koller-Trbović, 1996; Žižak, Koller-Trbović 1999). They primarily mention their dissatisfaction with the quality of working conditions and organization, as well as the challenges of working with children who have complex emotional and behavioural problems (Herceg Babić, 2014; Ratkajec, Jeđud, 2009; Žižak-Koller Trbović, 1999). The experts argue that the care and treatment could be improved through increasing the quality of interpersonal relationships and expertise among caregivers, achieving good relationships with the children, and creating a comfortable physical space (Vejmelka, Sabolić, 2015). The current state of residential care for adolescents with behavioural problems clearly indicates the need for a deeper understanding and redefining of key conceptual and value elements of institutional care.

Methods

The Aim and Research Questions

This paper aims to gain a deeper insight into the experience of residential care from the perspective of beneficiaries (adolescents) and experts (caregivers). Therefore, the following research questions were explored:

- How do beneficiaries and experts experience and describe residential care?
- What is the relation between the perspective of beneficiaries and experts regarding the experience of residential care?

Participants and Data Collection Procedure

The sample was relevant and included adolescents and caregivers from two residential care units for adolescent males in Croatia. In that sense, the sample was gender-restricted only to male institutions, since the majority of beneficiaries of residential care in Croatia are males (approximately 70%).

There is a need to explore the perspective of adolescent females in residential care in further research, since their perspective on residential care is expected to be different, owing to specific needs related to their gender.

In order to get a broader perspective from both the adolescents and the caregivers, the principle of heterogeneity was applied in the sampling procedure. Therefore, the sample included adolescents of different age, level of risk and duration of placement. Ultimately, 14 adolescents participated in the study, eight of whom came from *Residential Care Unit 1* and six from *Residential Care Unit 2*. The average age of the adolescents was 16.6 (the youngest participant was 14 years old and the oldest was 19). The average duration of placement was a little over 12 months (from 6 months to more than 2 years of placement in the residential care unit). Eight participants had experienced multiple placements prior to the current one (other residential care units, foster care). All adolescent participants had complex etiologies of high-risk behaviour (truancy, behavioural disorders, criminal acts) and multiple problems in their families.

In the sample of caregivers, a total of seven experts participated in the research, of which four were males and three females. Most caregivers were experts educated to provide care to children and adolescents with behavioural problems (psychologists, social pedagogical workers and social workers), while two caregivers had a teaching degree. On average, the caregivers had 13 years of working experience in the residential care institution of their current employment, ranging from 2.5 years to more than 20 years of working experience.

The data was collected through focus groups in the residential care units (two focus groups in each unit). The focus groups were conducted by one of the authors of this paper following the protocol for focus groups (a set of questions and follow-up questions related to the aim of the research, recorded and transcribed). The transcripts from the focus groups were used as units in the analysis.

Ethical Issues

Participation in this research was voluntary. In accordance with the National Code of Ethics for Research with Children (Ajduković, Kolesarić, 2003), adolescent participants were able to independently decide if they wanted to participate in the study, as they were all 14 years of age or older. The principles of privacy and confidentiality were applied. The participants had the freedom to quit the research at any time.

One of the adolescent participants decided not to participate after the first set of questions in the focus group. His answers were later excluded from the analysis.

Data Analysis

The data collected in the focus groups was transcribed, anonymized, and analysed using qualitative analysis. The analysis included the following phases: careful reading and identification of code units; generation of initial codes; redefining initial codes and grouping codes into categories; clustering categories into major themes. The process of analysis was iterative. The data was analysed by two independent persons (two authors of this paper) and later validated and discussed within the team in order to reduce bias.

Initially, a separate analysis was applied for the groups of adolescents and caregivers in order to gain insight into the specifics of their perspectives. In later analysis, the two perspectives were compared, the similarities and the differences were extracted and later discussed in the interpretation of results.

Results

The results and the major themes for each group of participants (Figure 1) will be presented, including by comparing the two perspectives. The results will be illustrated by providing original quotations *(All transcripts were anonymized. The quotations will be presented in the following way: FGAX- stands for the focus group with adolescents; X stands for the code number of a particular participant; FGCX- stands for the focus group with the caregivers; and X stands for the code number of a particular participant.)* from the participants.

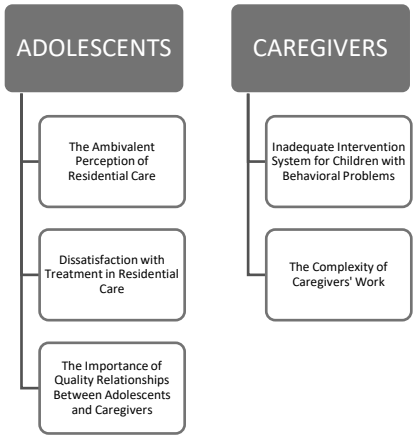

Figure 1 - Major themes for the two groups of participants

Adolescents

The Ambivalent Perception of Residential Care

Even though adolescents point out certain benefits of residential care, a negative perception of care is more evident. The adolescents, when asked to describe the institution of their residence, provide mostly negative metaphors such as *"psychiatric ward"* and *"juvenile correctional institution"*. They also state that placement in open-type educational-correctional institutions is a *"lesser sanction"*, i. e., in their own words, *"I think all of this...in parenthesis...is one big joke... You do whatever you want here, nobody can stop you"* (FGA6). The adolescents are also sceptical about the purpose and effectiveness of institutional placement, and often return to this subject in focus group discussions. In that sense, the adolescents had a very lively discussion on the advantages and disadvantages of living in an educational-correctional institution, while some mentioned the generally insufficient quality of institutional care. What seems to be a current advantage for them (e. g., freedom, an undemanding school environment and educational programs) is also perceived as negative in the future context. Another negative aspect of residential care for the adolescents is the inflexibility of institutions in adapting to the beneficiaries, as well as non-involvement of beneficiaries in treatment planning, where adolescents have the feeling that the caregivers have the power to make decisions about their lives. The adolescents express a fatalistic attitude toward the system of care, as they believe that *"all institutions are the same"* and that institutional placement does not benefit adolescents. In terms of behavioural change, the adolescents argue that institutions have a minor (or no) influence and that they themselves have sole responsibility for and control over positive changes.

The adolescents also mention the problem regarding the lack of differentiation between institutions based on the level of risk, and the fact that the same institution houses adolescents with very different characteristics, which leads to a higher incidence of bullying among peers. The adolescent research participants pointed out that *"some people don't belong here"*, and even mentioned *"intentional violence"* of the system toward the adolescents: *"This is intentional violence* (FGA6); *Well yes, this is inciting intentional violence. So, this guy is paired up with such a fool, it's like pairing up a mobster and a nerd, literally"* (FGA2).

Education is seen as the biggest advantage of institutional placement, with the adolescents verbalizing that the institution provides them with stability and security of education: *"I am glad I ended up in a juvenile facility as a child, because if I hadn't, I might be with my mom or dad, or anywhere, and I wouldn't have gotten any education, I just wouldn't know basic things"* (FGA4). Furthermore, the participants point out other benefits of institutional placement, such as developing independence, meeting new people, experiencing new things, and having the support of their peers. The element of peer support is particularly important for adolescents, and they point out that despite their disagreements, all beneficiaries *"stick together"*. The presence of peers who have had similar lives, who can be trusted and consulted for advice, is seen as a great advantage of institutional placement: *"There are a couple of guys I'm friends with, sort of. I give them a cigarette out of respect, we talk, umm…just like now. Some also give me advice and things like that. They tell me a hundred times not to do certain things. They are more experienced than I am and tell me how things are supposed to be done and how they're not supposed to be done"* (FGA8).

Dissatisfaction with Treatment in Residential Care

There are many aspects of dissatisfaction among adolescents when it comes to treatment and care: inadequate living conditions, strict rules and sanctions, unstructured time, monotony, inadequate behaviour by caregivers and stigmatization in the local community of educational-correctional institutions.

When describing their placement in educational-correctional institutions, the adolescents clearly point out the lack of treatment orientation in everyday work. The participants describe the daily routine of treatment, which includes school, meals and chores: *"I wake up in the morning, eat something before I leave, then go to school, eat lunch, wait for the teacher to come into his office, we talk sometimes and then I ask him, you know, to buy me some cigarettes. I sit down, light a cigarette, check my phone, and watch something on YouTube, Instagram etc., I call my sister. Then I watch TV, go for a walk and then I come back, and I'm bored in my room again. You know, I go for a walk again and come back and that's it, I go to sleep"* (FGA4), or *"We get up, we eat, we go to school, I come back and we clean, take our phones and eat* (FGA12)*"*. The adolescents also mention the monotony of everyday life when describing their daily routine. The following passage describes it well: *"So, each day here is like a TV show, and each day is a rerun of an episode. One episode is repeated throughout the year"* (FGA6). The adolescents point out that they lack professionally guided leisure activities and feel that they are left to themselves.

They also say that the organization of daily life is the job of the caregivers, and not solely the responsibility of the adolescents. They also make it clear that too much freedom and boredom contribute to the risk, while boredom goes along with unstructured free time: *"You don't know what to do, you do something stupid because you don't know what to do, you simply have nothing to do. All the caregivers, every single one of them, should try to give us as little free time as possible during the day"* (FGA11). Furthermore, the adolescent research participants mention the inadequate living conditions that create an inadequate treatment environment: *"The living conditions here are very bad. This living room is not a living room. But there's this couch and that's what makes it a living room… I say that only because I have seen other facilities as well, that is why. That facility looks different, everything is different, and here it's like, almost like a real prison"* (FGA11). The adolescents express intense dissatisfaction with strict rules, such as confiscation of their cell phones, being forbidden to go to the city, and the fact that there is no reward system. The adolescents give the impression that various forms of positive reinforcement are not applied, while there is an abundance of negative reinforcement. Furthermore, it is troubling that the adolescents perceive the treatment work of the caregivers mainly through sanctions, such as cleaning and various deprivations (e. g., confiscating their cell phones, the right to go out, or money). This is well reflected in the following statement: *"For example, when I came here, I lit a joint, and when the caregiver saw it, I was forbidden from going out, I had to do the cleaning up. And that happened many times until I reached some sort of normalcy. Their treatment"* (FGA2).

One of the negative aspects of staying in educational-correctional institutions, which also adversely affects the quality of treatment, is the stigmatization of the beneficiaries of such institutions in the local community. The adolescents state that the local population sees them as *"gangsters, mobsters or thieves"*. What is interesting is their impression that the caregivers do not protect them from the accusations of the local population and the negative image in the local community, partly because the caregivers live in the same community: *"Some (locals) cause trouble, steal something, they know that the beneficiaries will be blamed first. And for example, that kid comes to the caregiver and the caregiver knows his parents, and the caregiver blames the kid from the facility just to protect the other one"* (FGA6).

The Importance of Quality Relationships Between Adolescents and Caregivers

A good relationship with the caregivers is highly valued by the adolescents, as they argue it is the key to a successful treatment. The adolescents mention various aspects of quality relationships and clearly recognize a lack of such relationships in their educational-correctional institutions. Thus, the adolescents report various problems in their relationships with the caregivers. They state the distressing fact that some caregivers are often absent from work (both physically and metaphorically – *"as if they're not here"*), and that their private lives impact their work in a negative way. The adolescents have the impression that some caregivers are just doing their job to get paid, showing no interest in the beneficiaries: *"Well, I think the guys who come here really need to talk to the caregivers, but they come to an institution and the caregiver, for example, goes out for coffee and is gone all day, you can't make any progress with them. They can only end up in an even worse place"* (FGA3). Caregivers are important to these adolescents, who are bothered when they are not doing their job, i. e., when they are not available or interested in having a relationship with the adolescents. It is interesting that some adolescent participants prefer a more distant relationship with the caregivers and state that it is *"just a job"* that does not require a close relationship. However, such statements also point to a potential problem, i. e., it is questionable whether the treatment can be successful if there is no relationship between the caregivers and the adolescents as a key element in the treatment. For lack of a quality relationship, the success of the treatment falls entirely on the individual adolescents and their desire to change. As the adolescents describe, the ideal caregiver takes care of the beneficiaries, helps them, and makes an effort. The adolescents claim that quality relationships are directly related to the progress of the beneficiaries: *"If you are a caregiver, your job should be to observe the kids, see what's wrong and try to solve it. And to try and solve the bad things, and not just keep an eye on a certain kid"* (FGM4). One positive aspect is that adolescents verbalize that there is at least one caregiver in the institution with whom they are friends and to whom they can turn in difficult times. Some adolescents perceive the caregivers as surrogate parents: *"Yes, that's my other dad. We can agree on everything, he's always there when I need him. I can call him even after his shift is done, and he'll lend me money for cigarettes and stuff"* (FGA3). It is also interesting that adolescents prefer female caregivers. They say male caregivers can sometimes *"play tough"*, and that they are more likely to experience violent behaviour coming from male caregivers.

Caregivers

Inadequate Intervention System for Children with Behavioural Problems

The experts in focus groups expressed a wide range of criticisms regarding the social welfare system. The discussion focused on the uneven criteria for placement of adolescents into educational-correctional institutions, as well as on the lack of an adequate institution for adolescents with mental issues. The experts argue that poor quality of differentiation between treatments and inadequate recognition of various behavioural problems lead to institutional placement of persons who do not belong in such institutions: *"We see a child who shows no progress, and who doesn't benefit from being here, but here he is, today and tomorrow, for a month, for six months, even a year, and you have to deal with them somehow. And that's not what we're meant to do. It is as if a person came to a clinic that does knee surgery and comes across a doctor who has never performed heart surgery. It just cannot happen. The boys suffer in that group"* (FGC1). In some cases, the experts describe the reputation of the educational-correctional institution as *"a last step"* and complain about insufficient cooperation with other institutions in the system. They also find it problematic that the information obtained during the reception of beneficiaries is occasionally embellished, i. e. inaccurate: *"Sometimes the information provided isn't honest, sometimes it isn't detailed enough, sometimes it's difficult to read the situation. We are often surprised. Sometimes the information leads us to the assumption that a certain case will be difficult and cause multiple problems, and then bam, there are no problems and vice versa. The information doesn't always make it clear why a certain person is here in the first place, and finally the problem is found on a higher level, so it's really difficult"* (FGC1). One of the participants describes his experience at a previous job: *"For ten years I worked in a social welfare centre, and I know how it was, they gave us friendly advice to embellish the situation when making a written statement" (*FGC3).

In relation to residential care as a form of intervention for adolescents with behavioural problems, the experts also list advantages of the institutions of their employment, more specifically, in-house school and workshops for vocational training of adolescents: *"I think there is a big advantage here - the fact that there are an internal school and internal workshops. So that's a big deal, and the kids stay in the institution practically all day, which leads to better supervision and better communication between the school, the correctional department, and the workshop. We are all in the same place, all of us together, so it is much, much easier to work"* (FGC11).

The geographical location of the institutions, some of which are located in smaller, relatively isolated communities, is considered problematic by the experts in terms of poor availability of the services and experts on which adolescents rely, especially when it comes to psychiatric treatment. In addition, the location of institutions in smaller communities also contributes to the stigmatization of adolescents by the local population: *"The town would like to get rid of the facility, it's inconvenient when something gets stolen, there were times when the boys put on a real show... Basically, as far as I know, most people don't like having the facility nearby"* (FGC4).

It is interesting that the caregivers most often believe that the (lack of) success regarding treatment is someone else's responsibility (other institutions, such as courts, social welfare centres, the system as a whole), and speak of their own responsibility to a much lesser extent. The caregivers also mention the insufficient number of caregivers in the institution and inadequate organization of work, emphasizing how difficult it is to set aside time for treatment work. They argue that institutions should have a special team of experts dealing exclusively with treatment work, while the caregivers would focus on taking care of daily routines and obligations. In this context, the caregivers also mention a lack of male caregivers as a more appropriate model for adolescents, since these institutions accommodate only adolescent boys. However, it is also interesting that male caregivers are in the majority in both institutions included in this study, but this is obviously still a dominant perception.

The Complexity of Caregivers' Work

When describing their work, the experts point out multiple risks of the adolescents they work with, which include various forms of behavioural problems, especially inadequate attitudes towards addiction and violent behaviour. The adolescents often use addictive substances, and the caregivers state that it is difficult for them to discover and monitor the variety of intoxicating substances used by the adolescents. Furthermore, the adolescents come from families with multiple problems and generally do not trust adults because of their poor life experiences in the family, school and beyond: *"They don't trust adults. They've had no reason to trust adults from the beginning of their lives until now. When they come here, they don't see them as someone who wants to help them. Trust is earned. They are turned against the system, be it schools, be it social welfare, or it the educational-correctional institution. I mean, throughout their lives they've had no reason to trust adults, their family and beyond"* (FGC1).

Most of these adolescents have had traumatic early-life experiences and show a great need for emotional connection: *"These are very deprived children who come from at-risk families and have previously failed to create a relationship of trust with another person, and a relationship of quality communication with another person - an adult who sets boundaries and rules to abide by, on the one hand, and on the other hand, gives them enough freedom of expression and enough freedom to actually see that there are plenty of adults who truly hear them, see them and who may love them - but that must not happen in a way they find intrusive" (*FGC11). When it comes to establishing relationships with adolescents, the experts mention humour and mutual learning as important elements. They also state that caregivers must seek a balance between gaining authority and gaining trust among adolescents. In addition to multiple risks, the experts also mention the good sides of adolescents, such as creativity, good intellectual capacity, and motivation.

Given these risks, the experts describe their work with the adolescents through the wide range of areas and topics they cover in their daily work: *"Essentially, we work on all areas of their lives. From education, to hygiene, cultural habits - everything that is part of a normal life. Any forms of prevention, counselling. I mean, there is only one caregiver per shift, he or she also really needs to maintain order and be present as an authority, at the same time showing concern for all segments of life. That person is both a police officer, a counsellor and a parent – everything"* (FGC1). When asked about the theoretical foundation of their work, the experts do not provide a specific answer, but they mostly list risks and various aspects of their work, without linking these with specific theoretical approaches and principles. Working with adolescents is primarily based on an individual approach, especially given the great diversity of the beneficiaries. The experts prefer individual and informal conversations, as opposed to group forms of work, which are rarely represented (only when it comes to agreements or a crisis). The caregivers also state that adolescents show little interest in participating in various leisure activities (sections), so these are rarely held: *"Only a few sections take place because of very low interest… They have to be begged and persuaded to attend them. People come here to hold workshops, and they don't show up"* (FGC1).

Discussion

The results of this study regarding the perception of residential care and treatment among adolescents in educational-correctional institutions and their caregivers support the thesis presented by Moos and Moos (1998). Their perspectives differ, which makes sense given that they belong to different groups, i. e., subcultures within the institution. Their perceptions are aligned in many segments, but each group points out certain aspects and problems that the other group does not mention and may not be aware of. In other words, adolescents and caregivers talk about the same things, but often in different ways. At the same time, some of the aspects highlighted by the adolescents are problematic and troubling to such a degree that one must question how it is possible for the experts who act in such manner to still be employed in the residential care system. This especially refers to the statements by the adolescent participants in which they clearly and without hesitation state that certain caregivers do their job very poorly and are often absent from work. Comparing the two groups of participants, one gets the impression that adolescents are more critical, more direct and substantial than the caregivers in their criticism, as shown by previous research on the treatment climate in educational-correctional institutions (e. g., Langdon, Cosgrave, Tranah, 2004; Smith, Maume, Reiner, 1997), which showed that experts perceive the climate in a more positive light than adolescents. Furthermore, Pérez-García et. al. (2019) state that adolescents in educational-correctional institutions have the lowest satisfaction with the treatment, which also arises from the severity of their problems. It is possible that part of the dissatisfaction with the treatment in residential care can be accounted for by the fact that adolescents are placed there involuntarily and have to make certain changes to their behaviour, which is not an easy task. However, even with all these explanations, it is undeniable that adolescents are dissatisfied with the life and the treatment in educational-correctional institutions and doubt their effectiveness. Previous studies show a prevailing positive experience with residential care, despite the disadvantages (Moore et. al., 2017; Soenen, D'Oosterlinck and Broekaert, 2013; Palareti and Berti, 2009), while the results of this study show a more negative perception, despite the advantages. The adolescents clearly state the key shortcomings of residential care.

The results of this research, therefore, build upon previous research in the Croatian context: there is a prevailing feeling that institutional placement is pointless, and the operation of the institution is an additional risk factor (Kovačićek, 2017; Ratkajec Gašević, Maurović, 2015; Jeđud, 2011), there is a lack of treatment activities (Kusturin, 2002; Oreb, Majdak, 2013) and living conditions are poor (Kovačićek 2017; Koller-Trbović, Jeđud Borić and Mirosavljević, 2015; Sklepić, 2011). The adolescents also mention various deprivations and sanctions in the institutions, for example confiscation of objects, the right to go out and money, all of which have been identified in previous research as factors contributing to escapes from the institutions (Ratkajec Gašević, Maurović, 2015).

Despite the above, the adolescents also point out certain positive aspects of their placement, such as the opportunity to change, make positive changes in their behaviour, and the opportunity to finish school. Carter's (2011) research with adolescents yields similar results, where they perceive the success of the treatment through positive changes in their own personality or the development of the capacity for empathizing.

Both the adolescents and the caregivers identify the problem of insufficient differentiation between treatment programs, and even between the institutions themselves. Excessive diversity of beneficiaries in educational-correctional institutions complicates the caregivers' work and negatively affects the experience of treatment among adolescents. In this regard, Huško (2010) argues that placing adolescents with different characteristics and treatment needs in the same space leads to many conflicts, threats, and unacceptable forms of behaviour.

The experts explicitly mention adolescents with mental issues who rarely have access to psychiatric treatment in the local community, since these educational-correctional institutions are located in relatively small, isolated communities. The institutions, which are described by both the experts and the adolescents as the *"last step"* in the intervention spectrum, most often do not offer appropriate treatment and can thus become a new (additional) risk for adolescents, as mentioned by Jeđud (2011).

When discussing the treatment work, the adolescents express a fair amount of dissatisfaction with the monotony, the inadequate range of activities and the (overly) routinised everyday life. Experts, on the other hand, are also dissatisfied because they feel they have the obligation to simultaneously provide various activities to adolescents and often have to start *"from scratch"*.

However, the adolescents and the experts agree in their description of everyday life, claiming that the prevailing activities are those related to care and accommodation, i.e., the functions of residential care that are aimed at meeting the basic needs (hygiene, food, accommodation and school), while other treatment needs are discussed to a lesser extent, even though the experts are aware of these (trauma, multiple risks, etc.). Specifically, the caregivers mention a lack of additional teams of experts or external associates to take over this part of their educational tasks. Based on the results of this study, it seems that several elements are lacking in what is called therapeutic residential (Whittaker, del Valle, Holmes, 2015), more specifically, the strategic use of a purposefully constructed multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support and protection.

The experts tend to link the responsibility for the quality of care and treatment to other, external stakeholders, at the same time not mentioning their own role and responsibility, which is consistent with conclusions of the study conducted by Herceg Babić (2014). This research also showed that caregivers neglect or insufficiently use certain elements of treatment in their work, such as conducting group work or practicing alternative techniques, which was also confirmed in this research. The caregivers prefer an individual and more informal approach, which suits certain adolescents, even though some also perceive it as a lack of interest from the caregivers.

The perspective of the adolescents and experts on education is also interesting. The experts are pleased that there are in-house schools and school workshops in the institutions, and they additionally point out the benefit of spatial confinement of beneficiaries, saying that *"everyone is in the same place, which makes work easier"*. The adolescents, however, find this form of schooling too undemanding. This leads to the conclusion that the caregivers prefer the static, closed nature of the institution, while the adolescents would prefer being more open to the local community and experiencing more involvement and normalization. Being more open would probably mean more work for the caregivers, but they seem to forget who is at the focus of their work and whose needs are primary.

Finally, it is important to reflect on possibly the most crucial aspect indicated by the results of this study: the relationship between adolescents and caregivers. Both groups of participants recognize and verbalize the importance of quality relationships as important determinants of treatment in educational-correctional institutions. The caregivers speak of relationships through examples of their own actions and the way they seek to establish a relationship with the beneficiaries. The adults clearly emphasize that establishing relationships is particularly important because the adolescents have previously had negative experiences in relationships with significant adults and perceive the caregivers as role models in this regard. That is why the results from the perspective of adolescents are especially disheartening, since they report the unavailability and absence of caregivers and their distant attitude towards the adolescents. Previous research also emphasizes the importance of the relationship between caregivers and beneficiaries, with some authors citing it as the most important element of treatment (e.g., Moore et al., 2017). D'Oosterlinck and Broekaert (2013) cite the availability and involvement of caregivers in this regard, while Johansson and Andresson (2006), as well as Lanctôt, Lemieux and Mathys (2016), emphasize the need for support and understanding of the trauma and past experiences of adolescents. Sellers (2020) argues that children and adolescents who reported better quality relationships also perceived the institution as a safer place, while Leipoldt et al. (2019) emphasizes that a positive perception of relationships within the institution contributes to greater involvement of adolescents in the treatment. Leloux-Opmeer, Kuiper, Swaab and Scholte (2016), as well as James, Roesch and Zhang (2011) argue that adolescents in residential care show a lack of trust in adults, which is often well-justified. This is confirmed by Bakić (2001), who argues that adolescents in residential care usually experience only rejection from adults, and that such experiences should be transformed in their relationships with caregivers. A positive relationship with the caregivers which contains elements of a warm, spontaneous, human relationship with clear boundaries and requirements contributes to greater success in treatment. However, when it comes to children and adolescents with behavioural problems, Brendtro (2010) points out the circular problem of building relationships, which can be very demanding for experts. The following dynamics takes place: the expert knows and believes that the relationship is key to the treatment work and tries to establish said relationship.

However, the adolescent person, owing to past negative experiences and their own risks, has difficulty in establishing the relationship and does not allow (cannot/does not know how) the establishment of the relationship. Experts sometimes tend to react to such rejection by and problematic behaviour of adolescents by giving up on the relationship, which confirms those previous negative experiences of the adolescents. Brendtro (2010) describes this group of adolescents as "relationship-resistant", which means that the experts must put a great deal of effort into developing a good relationship with these adolescents. It is imperative that the experts avoid trying to become "attractive" to adolescents by giving in or imitating their behaviour ("being one of them"), at the same time criticizing other adults in the environment, taking on parental roles, acting aggressively and succumbing to power struggles, thereby allowing adolescents to see themselves as the problematic ones in the relationship. Instead, the experts should trust the adolescents, so that the adolescents can trust them in return.

It is also interesting that adolescents prefer female caregivers because they are less violent, while the experts state the need for more male caregivers. The adolescents seem to want a gentler and more intimate and therapeutic approach, while the experts usually turn to more rigid and authoritative solutions. As stated by Koller-Trbović, Jeđud Borić and Mirosavljević (2015), this kind of approach and a traditional understanding of gender roles are not uncommon in treatment. Even male social pedagogy students, reflecting on their own choice of occupation, mention certain gender specifics, for example, the male gender as an advantage in direct work (Ćosić, 2018).

To reach conclusion about the relationship between adolescents and caregivers, it is important to make indirect observations from the focus group discussions when it comes to addressing the caregivers. More specifically, the adolescents address the caregivers as "*Professor*", which is very formal and reflects their occupation (i.e., title). In the context of a contemporary approach, new relationships and the positions of power and responsibility of children and adults (Juul, 2005), it is important to transform formal, distant relationships into cooperative, real-life relationships. The authority of adults should be based on consideration, responsibility and mutual respect.

Limitations

One of the major limitations of this research is that it was conducted in only two residential care units that accommodate only adolescent males. In that sense, the sample is gender-limited to a male perspective. Further research should explore the female perspective more broadly and include a greater variety of residential care forms. The conclusions of this research cannot be generalized, since it is a qualitative study. However, the research data is comparable to prior research and the results can be applied and transferred into practice.

Conclusion

Adolescents with behavioural problems who have been separated from their families are an especially vulnerable social group. Therefore, the interventions provided to this group of adolescents need to be carefully designed and aligned with their needs. This study sought to gain insight into the experience of institutional treatment from the perspective of adolescents and their caregivers, in order to formulate guidelines for practice and education of future experts, but also for further research. The specific contribution of this research is in uniting and comparing the perspectives of the beneficiaries and the experts. In the context of practice, the most important guidelines are consistent with the recommendations provided by Trieschman, Whittaker, and Brendtro (2010): that behavioural change (which is the main goal of interventions) must be affected through daily activities and relationships. At the same time, everyday life must be dynamic and meet the needs of children and the modern way of life. Monotony and boredom only add to the risk, which is why educational-correctional institutions for adolescent boys, in addition to providing accommodation, should also offer a wider range of therapeutic and treatment activities primarily aimed at processing traumatic experiences, addiction problems and violent behaviour. Caregivers should develop positive and respectful relationships with adolescents to a much greater extent, as well as be present, involved, and available for building a relationship. There is a significant danger that caregivers who are disappointed in and dissatisfied with the system, will choose undesirable behaviours (absence from work, disinterest, indifference) and distance themselves from the beneficiaries.

Therefore, it is important to invest in the professional and personal capacities of caregivers through regular supervision and education, but also through visible changes in the system that will encourage caregivers to be proactive. However, this research also emphasizes the need for a faster and more decisive reaction from the competent ministry and other institutions regarding the inadequate behaviour of some caregivers.

The study also indicates the necessity of changes in the system of educating future experts for employment in educational-correctional institutions. It is crucial to revise subjects, topics and learning outcomes, and to focus more strongly on the development of treatment relationships with those "relationship-resistant" adolescents (Brendtro, 2010), on the dynamic programming of treatment based on the needs of adolescents, and on the development of new activities and methods.

In terms of research, it would be interesting to explore both the female perspective and the girls' experience of care. Similarly, it would be worthwhile from the perspective of both research and practice, to investigate the role of caregivers in more depth, i.e. to identify how caregivers describe and perceive their role and how this view aligns with modern knowledge. Further research should certainly be more participatory and even more action-based, so that it contributes to change (for the better) the practice and the life in educational-correctional institutions, without having to wait a long time for the academic results to find their way into practice.

Finally, the experts should continuously monitor the beneficiaries and their needs, while actively reflecting on their own practice. Caregivers need to take responsibility for their work, follow current knowledge and research related to the population and the context in which they work, and use these as the basis for their actions. They should also advocate for adolescents who are beneficiaries of institutional treatments and who deserve better care than they are currently receiving.

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Authors

Ivana Gazilj, mag.paed.soc.,
Social pedagogue, M.A., Residential Care Institution for Children and Youth Karlovac, Croatia, e:mail: ivana.gazilj@gmail.com
Socialna pedagoginja, Dom za vzgoj otorkov in mladostnikov Karlovac, Hrvaška, e-pošta: ivana.gazilj@gmail.com

Dr. Ivana Borić
Associate Professor, University of Zagreb, Faculty of Education and Rehabilitation Sciences, Zagreb, Croatia, e-mail: ivana.boric@erf.hr.unizg.hr
Izredna profesorica, Univerza v Zagrebu, Edukacijsko-rehabilitacijska fakulteta, Zagreb, Hrvaška, e-pošta: ivana.boric@erf.hr.unizg.hr

Andrea Ćosić, mag. paed. soc.
Assistant, University of Zagreb, Faculty of Education and Rehabilitation Sciences, Zagreb, Croatia, e-mail: andrea.cosic@erf.hr.unizg.hr
Asistentka, Univerza v Zagrebu, Edukacijsko-rehabilitacijska fakulteta, Zagreb, Hrvaška, e-pošta: ivana.boric@erf.hr.unizg.hr