Differences and similarities in children's and caregivers' perspectives on the quality of residential care in Portugal

A first glance

Sónia Rodrigues

Department of Psychology, University of Porto, Portugal.

Jorge F. Del Valle

Department of Psychology, University of Oviedo, Spain.

Maria Barbosa-Ducharne

Department of Psychology, University of Porto, Portugal.

Correspondence should be addressed to: Sónia Rodrigues, Faculdade de Psicologia e Ciências da Educação da Universidade do Porto, Rua Alfredo Allen, 4200-132 Porto, Portugal. E-mail: pdpsi11008@fpce.up.pt.

Abstract

Residential care (RC) of children in Portugal has changed without an evaluation of its quality; the alterations were not based on sound criteria. Little research has been carried out in Portugal on residential child care, therefore emphasizing the relevance of a study on the quality assessment of the Portuguese RC system. The results of an exploratory study, as part of a nationwide evaluation of the RC system in Portugal, are hereby presented providing the perspectives of the main actors, i.e. children in care and their caregivers. Six RC centres were visited and 66 children and 62 caregivers were interviewed, using the ARQUA-P system for programme evaluation. Participants' opinions about the quality of the RC services were generally positive but significant intra- and inter-group differences were found. Children evaluated the dimensions 'respect for rights' and 'normalization and integration' in a less positive way than caregivers. Girls evaluated the quality of RC units' services lower than boys in almost every dimension, including 'overall quality'. There were no significant associations between children's age or time spent in care and their evaluation of the 'overall quality' of the

centre. However, time spent in care correlated positively with the children's perception of 'safety and protection'. Their age correlated negatively with perceived 'normalization and integration'. Neither caregivers' gender nor their training, was correlated with perception of 'overall quality'. Younger caregivers evaluated RC centres in a less positive way. The results underline the importance of more research that gives voice to all actors in the process of evaluating residential care, especially to the children and youngsters concerned.

Keywords: residential child care, institutional care, perceptions of children, perceptions of caregivers, quality evaluation, residential care system in Portugal

Introduction

Residential care (RC) of children and young people fulfils different needs in different countries and changes over time and place (Courtney & Iwaniec, 2009). The characteristics of residential care are socially and historically related and vary from country to country (Colton & Hellinckx, 1993; Sellick 1998). The residential care services are influenced by factors such as legislation, economy, political ideology, cultural and religious factors, natural disasters, staff qualifications and training, models of care, other community resources, the setting of the residential home, geographical surroundings, diseases or scandals about abuse, and the children's problems including those of the families (Courtney, Tolev, & Gilligan, 2009).

This complex interaction between many different factors and actors can be described in terms of Bronfenbrenner's *bioecological model* (Bronfenbrenner, 2001). The proximal developmental process operating in the residential care microsystem, as the child daily experiences person to person interactions, is therefore influenced by more distant processes operating at the meso, exo, macro and chrono systems' level.

Thus, the standards and the quality of residential care show different stages of development in different countries. Therefore, caution is needed in applying knowledge and practices from country to country (Kendrick, Steckley, & McPheat, 2009). Hence in a bioecological theoretical framework, collecting and comparing children's and caregivers' perspectives would provide a more comprehensive assessment of residential care quality.

In a total population of less than ten million inhabitants, more than 8,000 Portuguese children and youngsters are currently in residential care, representing more than 90% of all the children in out-of-home care (Instituto da Segurança Social [ISS], IP, 2014). In the last decade, the number of children placed in institutions has gradually but steadily decreased. However, since 2011 this number has started to grow again (Comissão Nacional de Proteção de Crianças e Jovens em Risco, 2014). Foster care placements have fallen continually over this period to a minimum of 4.4% of all out-of-home measures, as revealed by data from 2013 (ISS, IP, 2014).

Portuguese legislation still uses the term 'institutional care' to describe 'the placement of a child or young person in the care of an institution equipped with permanent facilities and qualified staff that ensures attention to his or her needs and provides the appropriate conditions for his or her upbringing, well-being and overall development' (art. 49 of the *Lei de Protecção de Crianças e Jovens em Perigo*, LPCJP, Lei n° 147/99; Law for the Protection of Children and Young People at Risk). This designation refers to the 'institutional model' that has been largely eliminated for decades in most developed countries (Bravo & Del Valle, 2009a, 2009b). Characterized by the predominance of a welfare type of care, these institutions housed large numbers of children and employed no, or very few, specially qualified members of staff with the sole purpose to meet the most basic needs (guardianship, essential care, food, hygiene and health) of the children and young people in care.

Nowadays it is mandatory for residential child care to be based on a *family type model* in articulation with a specialized or therapeutic model, in opposition to the *institutional model* (Bravo & Del Valle, 2009a). This current model aims at normalization of care, respect for individual differences and personalized care, and strives for trained caregivers to be able to establish close relationships. A family type of care requires open facilities which are well integrated in the community, cater for small numbers of children (less than 12) per house, and staffed with a good ratio of caregivers to children (Del Valle, Bravo, Hernández, & Santos, 2012). The residential care staff should be sensitive and be able to respond effectively to problems and needs without being afraid of establishing attachment and significant relationships (Bravo & Del Valle, 2009b). Caregivers consistently acting as 'therapeutic parents' (Anglin, 2004; Shealy, 1996, 2002) are considered best for serving the children's interests. Therefore, caregivers must be approachable, respectful, culturally aware, fair, reliable, persistent, engaged, concerned, prepared to listen, and responsive (Shealy, 1996, 2002).

Latterly, there is consensus that residential care must answer each child's needs, and not vice versa (Calheiros, Lopes, & Patrício, 2011). It must be provided at the right time (Aldgate & Statham, 2001), and promote the youngster's development and well-being (Del Valle & Bravo, 2013).

In Portugal, most residential care centres are private but non-profit and have a social and solidarity role. These centres sign an agreement of cooperation with the state authorities and are supervised by district social welfare units, under the Department of Social Welfare (ISS, IP) in the Portuguese mainland or another similar official entity in the Azores and Madeira.

It must be noted that 48% of the Portuguese residential care institutions are gender specific, meaning that siblings are often separated in different centres. This figure rises considerably if we only take into account adolescents or older young people for whom separation by sex is still much more common (Rodrigues, Barbosa-Ducharne, & Del Valle, 2013). Beliefs about sexuality and fear of sexual abuse and teenage pregnancy justify this widespread segregation by gender. Many shelters are still run by priests and nuns, based on Catholic religious principles. Additionally, 99% of the babies and toddlers in out-of-home care (under the age of three) are placed in institutions, which goes against the international recommendations (Browne et al., 2006; Delap, 2011).

Foster care in Portugal plays a minor role as a result of the scarce number of families available for this task who can fulfil the requirements prescribed by the Law for the Protection of Children and Young People at Risk, when support and benefits are not considered compensatory (Delgado, 2010). Furthermore, some fears about this out-of-home type of placement are nurtured by a widespread negative view of foster carers, as a result of past cases of children's abuse and neglect.

Residential care of children and young people in Portugal has developed and changed without evaluation of quality (Rodrigues et al., 2013), despite the efforts made by Portuguese welfare services which included publishing of *Quality Manuals* (ISS, IP, 2007a; 2007b). According to the historical evolution and current context of residential care in Portugal, it is evident that a lack of knowledge still prevails regarding the functioning of these facilities and the quality of the services provided. Moreover, it is important to know if these services actually suit the identified needs of the children and youngsters, including the therapeutic strategies that are being used (Rodrigues et al., 2013).

The limited research in the area of residential child care, which is an international phenomenon (Bravo & Del Valle, 2009b), proves to be even more the reality in Portugal. Caregivers' practices are not empirically supported, and decisions made by directors or policymakers and determining the life of the children in care, are not evidence based.

Quality and assessment are closely linked (Martins, 2004); quality assessment requires a multiplicity of sources including the voices of all those involved in care, i.e. not only the caregivers but also the children in care (Calheiros et al., 2011; Dahlberg, Moss, & Pence, 1999; Delap, 2011; Palareti & Berti, 2009; Taylor, 2005). Up until now children and youngsters in care have not been sufficiently heard in discussions and studies on residential services (Delap, 2011; Kendrick, 2008), and no comparisons between children's and caregivers' perceptions about quality of services have been provided. This may mean that when caregivers' quality assessments are listened to, their opinions may not be coincident with those of the children in care. As a result, it is not evident that residential care services that have been transformed in accordance with professional evaluations actually correspond to the children's needs and preferences.

This paper presents the perceptions of children and caregivers on characteristics of residential care centres and the adequacy of the services provided according to international quality standards. By analysing and comparing the perspectives of the children and young people in care and those of their caregivers, this study intends to give an active voice to the main actors within these services.

Method

Data were collected during an exploratory study within a nationwide and cross-sectional research project focusing on the quality of residential services for children and young people in Portugal.

Participants

Six residential care centres from various regions of Portugal voluntarily participated in this study. 114 children and young people, aged from 2 months to 20 years, were living in these centres. Of these, 66 children or young people were interviewed, representing all the children over six years of age who were at the centres at the time of the visit. They were on average 15.1 years old (*SD*=2.9), ranging from 7 to 20 years; 42 of them (63.6%) were boys.

Almost half of the group of children (43.9%) were placed in care because they had been neglected by their family, whereas 19.7% were placed in care because of behaviour problems, and 10.6% had suffered physical abuses. A smaller group of children, 4.5%, was in care because of economic reasons; 4.5% had witnessed parental violence; 4.5% had experienced a disrupted adoption; 3% had been abandoned; 3% were placed following a family breakdown; 3% had gone to the centre to be geographically closer to their family; 1.5% had been sexually abused; and 1.5% had been rejected by the foster family. When the data were collected the children had been living in the centre on average for 2.5 years (*SD*=2.1), ranging from a minimum of two months to a maximum of nine years; 72.2% were in care for one year or more. Almost all the children and youths (89.4%) lived at a gender specific centre. A majority (65.2%) lived in a large or medium sized institution (34.9% and 30.3%, respectively).

All the caregivers in the six care centres (*N*=62) participated in the study. The greater part consisted of females (75.8%). The participants were on average 38.4 years old (*SD*=8.3), ranging from 23 to 62 years of age. Caregivers had been working at the centre on average for 6 years and 8 months (*SD*=77.1 months), and had professional experience of 7 years and 9 months on average (*M*=93.5 months; *SD*=75.4). Of the staff, 36 (58,1%) were direct caregivers, 19 (30,6%) belonged to specialized staff, and 7 (11,3%) had other support roles such as cooking or cleaning. Regarding qualifications, 47,3% of the staff had no specialized training whatsoever; 29% had less than 12 years of school, whereas 45.2% were graduated.

Instruments

Data were collected using the ARQUA-P: Portuguese Comprehensive Evaluation System for Residential Care (Rodrigues, Barbosa-Ducharne, & Del Valle, 2014). ARQUA-P is a translated and adapted extended version of ARQUA's methodology of research. The latter is a Spanish system developed by Del Valle (1997) with decades of proven experience in residential care quality assessment. It is an ecological evaluation system that uses mixed methods and multiple sources of information, aiming to assess on the one hand the needs and psychological adjustment of children in care and on the other hand the quality of services provided by institutions, and then to understand the relation between these variables.

The process of adaptation of the original Spanish ARQUA involved a complementary incorporation of parameters relating to quality criteria detailed in Portuguese Quality Manuals (ISS, IP, 2007a; 2007b). The updating process included the revision of all the interview items according to the latest version of Quality Standards for residential child care (Del Valle et al., 2012),

thus guaranteeing a complete adaptation of the instrument to the latest international quality requirements in this sector.

In accordance with the overall ARQUA-P system, the data presented here were collected using the *Previous Information Survey* and three structured interviews: the *Quality Interview for Children 6 to 11 years old*, the *Quality Interview for Adolescents and Young People 12 years or older* and the *Quality Interview for Direct Caregivers*. In all the interviews each item was evaluated using a 5-point Likert scale.

The interviews with children and adolescents provide 12 quality dimension scores (the mean of the corresponding items) and one overall quality score (the mean of all evaluated dimensions). In the *Appendix* the different dimensions are further clarified. Cronbach's alpha coefficients were computed for every dimension. Dimensions with alpha coefficients under.70 were not used in further analyses. Therefore alpha coefficients ranged from .76 ('studies and training') to .90 ('safety and protection'), resulting in a value of .93 for the overall score.

The interview with caregivers provides 20 quality dimension scores and one overall quality score. The extra eight quality dimensions – in addition to the 12 that were also used in the interviews with children and adolescents – are caregiver-specific and are intended to assess: models of intervention; the plan of activities; case files; registers; coordination; human resources; organization; and leadership. Again, dimensions with alpha coefficients under .70 were not used in further analyses. Therefore alpha coefficients ranged from .71 ('studies and training') to .83 ('respect of rights'), resulting in a value of .95 for the overall score.

Procedure

A team of at least four researchers visited each residential care unit, between March and June 2013, during one or two days (depending on the size of the institution). Participation in the study was strictly voluntary for all participants (including the centres). The visit involved prior preparation; information about the study was provided; clear-cut identification codes for all participants were created (the key was only handled by the research team on the day of the visit and then destroyed); an informed consent was signed; and descriptive data about the centre, caregivers, and children and youngsters in care were collected by e-mail.

Data analysis

An exploratory analysis of data was conducted for verification of the assumptions of parametric statistical methods using Shapiro-Wilk and Levene's test, revealing that some variables did not follow a normal distribution. In these cases the strategy of computing both parametric (t-Student test; Pearson correlation) and equivalent nonparametric tests (Mann-Whitney test; Spearman correlation) was used. Results obtained from both sets of tests were the same concerning statistical significance of results. Therefore, as recommended in the research literature (Marôco, 2011; Martins, 2011), the parametric test results will be presented.

Independent samples t-tests were used to analyse differences between the groups of children/youngsters and caregivers. When repeated measures were used, Bonferroni's correction of α level was applied (Marôco, 2011).

In order to better understand the impact that some children's and caregivers' characteristics had regarding perceptions of care quality, some intra-group analyses were computed. A Pearson correlation was computed to assess the relationship between age of children (in years) or time spent in care (in months), and the different dimensions of ARQUA-P, including 'overall quality'. The analysis of caregivers' variables was made accordingly to the same statistical approach: Pearson correlations were computed to assess the relationship between the 'caregivers' age', 'length of time working in the care centre', 'total working experience', and the different dimensions of ARQUA-P. IBM SPSS Statistics software (v.21) was used to analyse the data

Results

Table 1 presents children's and caregivers' scores for the common ARQUA-P quality dimensions with alpha coefficients above .70 (measured with a 5-point Likert scale), as well as the results of the independent sample t-test for group comparisons. Intergroup differences were found in some dimensions but no difference was found in the 'overall quality'.

Children and caregivers gave a positive evaluation of the quality of their residential care units in all ARQUA-P dimensions, including the 'overall quality'. Children perceived the dimensions 'respect for rights' and 'normalization and integration' significantly less positively than the caregivers.

Table 2 shows that there were significant differences between girls and boys in all quality of care variables except for the dimension 'support to family reunification'. Girls evaluated the quality of residential care units' services significantly lower than boys on almost every dimension, including 'overall quality'.

Table 1. Children's and Caregivers' Perceptions of ARQUA-P Dimensions of Quality of Residential Care: Means, SDs and Differences between Children and Caregivers

ARQUA-P dimension	Children *n*=66		Caregivers *n*=62				
	M	SD	M	SD	t	df	Sig.
Place, infra-structure and resources	3.86	.81	3.79	.80	.47	126	.640
Support to family reunification	3.96	1.28	3.89	.81	.32	93	.745
Safety and protection	3.79	.85	4.00	.57	1.69	114	.094
Respect for rights	4.17	.75	4.47	.54	2.63*	118	.010
Studies and training	4.41	.83	4.34	.51	.58	105	.564
Normalization and integration	3.75	.81	4.15	.49	3.37*	107	.001
Overall quality of care	3.98	.64	3.97	.48	.09	120	.928

* $p < .025$ (after Bonferroni's correction = $\alpha / 2$).

Table 2. Children's Perceptions of ARQUA-P Dimensions of Quality of Residential Care: Means, SDs and Differences between Boys and Girls

ARQUA-P dimension	Boys			Girls					
	M	SD	n	M	SD	n	t	df	Sig.
Place, infra-structure and resources	4.15	.71	42	3.36	.76	24	4.26*	64	.001
Support to family reunification	4.25	1.24	34	3.52	1,23	23	2.18	55	.034
Safety and protection	4.12	.71	42	3.21	.77	24	4.91*	64	.001
Respect for rights	4.42	.66	42	3.73	.70	24	3.96*	64	.001
Basic and material needs	4.34	.63	42	3.47	.78	24	4.94*	64	.001
Studies and training	4.69	.63	41	3.91	.92	23	3.98*	62	.001
Normalization and integration	3.99	.80	42	3.34	.67	24	3.34*	64	.001
Overall quality	4.25	.53	42	3.51	.55	24	5.34*	64	.001

* $p < .007$ (after Bonferroni's correction = $\alpha / 7$).

No significant associations between children's age or time spent in care and their evaluation of the 'overall quality' of the RC centre where they lived were found. However, 'time spent in care' correlated positively with the perception of children about 'safety and protection', $r = .31$, $p = .01$. The longer the time spent in care, the stronger was the feeling of being secure and protected. On the other hand, the child's age correlated negatively with the dimension 'normalization and integration', $r = -.25$, $p = .04$, showing that the older the child was, the less positive was his/her perception of the quality of the residential unit on this criterion.

Caregivers' age revealed more associations with ARQUA-P dimensions, showing that older caregivers in comparison with younger staff more often perceived the institution where they worked as having good levels of quality. 'Total work experience' showed more significant positive correlations with ARQUA-P dimensions than 'length of time working in the care centre'. No statistically significant differences associated to gender and training (with or without specialized training) of caregivers were found in perceived quality of care (see Table 3).

Discussion and conclusions

In this exploratory study all participants evaluated the quality of their residential care units positively, which is consistent with results of other studies (e.g., Del Valle & Casas, 2002; Delfabbro, Barber, & Bentham, 2002).

When comparing the perspectives of youngsters and those of their caregivers, the former perceived the dimensions 'respect for rights' and 'normalization and integration' in a significantly less positive way. In accordance with the adopted concept of quality, this could mean that car-

Table 3. Caregivers' Perceptions of ARQUA-P Dimensions of Quality of Residential Care: Pearson Product-Moment Correlations with Caregivers' Age and Work Experience (in that same Centre and in Total)

ARQUA-P dimension	Caregivers' age		Length of time working in the care centre		Total work experience	
	r(p)	Sig.	r(p)	Sig.	r(p)	Sig.
Place, infra-structure and resources	.23	.071	.16	.203	.28*	.025
Safety and protection	.35**	.005	.19	.133	.23	.069
Studies and training	.40**	.001	.23	.069	.32*	.011
Health and safety	.26*	.045	.17	.179	.20	.127

* $p < .05$ (2-tailed); ** $p < .01$ (2-tailed)

egivers do not adequately recognize the children's needs and preferences. Therefore, they may not be able to provide services that respond to those needs and preferences, which would make the children less satisfied with the care centre. This underlines the importance of *listening to children's voices* in matters regarding their well-being when in residential care (Baker, 2007; Hallett & Prout, 2003).

Contrary to other studies where lower levels of satisfaction with the quality of residential care were observed in older children and youngsters (Bravo & Del Valle 2001), in our findings children's age seemed to have no correlation with the way they perceived the overall quality of the care centre where they lived. Nevertheless, there was a negative correlation between age and the 'integration and normalization' dimension, revealing that older youngsters felt less integrated in the community and, as time goes by, they started seeing their own life style as somewhat different from other people of the same age but not living in care.

As was also found by Bravo and Del Valle (2001), time spent in care correlated positively with the 'safety and protection' dimension; i.e., youngsters who were in care for a longer time felt safer and more protected than youngsters whose time spent in care was shorter. A plausible explanation supported in the literature (e.g., Cruz, 2011; Del Valle, 1997; Del Valle & Zurita, 2000; Rosen, 1999; Rutter, 2000) may be the fact that residential care was an important resource when youngsters were in danger before placement and needed to be protected from a risky family context. In these cases residential care appeared to have a potential *buffering effect* on the impact of adversity, with children feeling safer and more protected as time in care went by.

Gender differences were observed not only in 'overall quality' perceptions between girls and boys in care, but also in all other dimensions, except for 'support to family reunification'. This result may be associated with higher expectations in girls' assessments (Barros, 2010), and may reflect a mismatch between the residential care services and the particular needs of female children, highlighting the importance of being aware of the impact of gender on young people's quality of care experiences (O'Neill, 2008).

Older and more experienced caregivers had more positive opinions about the services provided by the centre where they worked than younger and less experienced caregivers. The older and more experienced caregivers believed more than their younger co-workers that children's needs concerning 'safety and protection', 'studies and training' and 'health and life style' were being met. A possible explanation for this is the evolution in the quality of life that has taken place in Portugal in the last decades (FFMS, 2014). Thus, the comparison between caregivers' own childhood and the conditions nowadays for children in care may have affected their judgment on the quality of services provided.

Limitations and recommendations

This is an exploratory study aiming at the preparation of a larger research project. Therefore, in spite of its innovative character, this study has some limitations. A convenience sampling procedure (Babbie, 2001) was used and consequently it lacks representativeness over the Portuguese residential care system. Hence, generalization of the results should not be made. A larger number of participants from a broader type of care units must be heard and additional data should be collected.

This study has permitted instrument testing and researchers' training as preparation for a nationwide evaluation of the quality of the residential care system in Portugal. Further research with a larger, random and proportional sample will enable additional psychometric analyses of instruments and multivariate statistical analysis of data that should allow for a better understanding of the levels of quality in the Portuguese residential care system. It creates an opportunity to study associations between the quality and characteristics of care (e.g., quality dimensions, client-staff ratio, type of centre, segregation by gender) and children and youngster's needs, including developmental adjustment indicators and other descriptive variables (e.g., referral reasons, siblings in care, school level).

Conclusion

The similarities and differences in perceptions of the quality of residential care observed between caregivers and children/adolescents and also between older and younger caregivers, older and younger children, males and females, and between those with a longer versus shorter time in care, underline the importance of a system of quality assessment in residential care. Further research is needed to listen to and amplify the voices of caregivers and children in care, making them active agents (Van Nijnatten, 2013) in the process of matching care services to the real needs of vulnerable children in Portugal.

References

Aldgate, J., & Statham, J. (2001). *The Children Act now: Messages from research*. London: The Stationery Office.

Anglin, J. P. (2004). Creating 'well-functioning' residential care and defining its place in a system of care. *Child and Youth Care Forum*, *33*(3), 175-192.

Babbie, E. (2001). *The practice of social research.* Belmont, CA: Wadsworth Thomson (9th edition).

Baker, A. J. L. (2007). Client feedback in child welfare programs: Current trends and future directions. *Children and Youth Services Review, 29,* 1189-1200.

Barros, J. (2010). *Psicologia positiva - uma nova psicologia [Positive psychology - a new psychology]*. Porto: LivPsic.

Bravo, A., & Del Valle, J. F. (2001). Evaluación de la integración social en acogimiento residencial [Assessment of social integration in residential care]. *Psicothema*, *13*(2), 197-204.

Bravo, A., & Del Valle, J. F. (2009a). *Intervención socioeducativa en acogimiento residencial [Socio-educational intervention in residential care]*. Santander: Gobierno de Cantabria (Colección Documentos Técnicos). Available at: http://www.gifi.es/administrador/publicaciones/archives/65706_Int_soc_acores.pdf.

Bravo, A., & Del Valle, J. F. (2009b). Crisis y revisión del acogimento residencial. Su papel en la protección infantil [Crisis and revision of residential care. Its role in child protection]. *Papeles del Psicólogo, 30*(1), 42-52.

Bronfenbrenner, U. (2001). The bioecological theory of human development. In N. J. Smelser & P. B. Baltes (eds.), *International Encyclopedia of the Social and Behavioral Sciences, Volume 10* (pp. 6963-6970). New York: Elsevier.

Browne, K., Hamilton-Giachritsis, C., Johnson, R., & Ostergren, M. (2006). Overuse of institutional care for children in Europe. *British Medical Journal, 332*, 485-487.

Calheiros, M., Lopes, D., & Patrício, J. N. (2011). Assessment of the needs of youth in residential care: Development and validation of an instrument *Children and Youth Services Review, 33*, 1930-1938, doi: 10.1016/j.childyouth.2011.05.020.

Colton, M. J., & Hellinckx, W. (eds.) (1993). *Child care in the EC: A country-specific guide to foster and residential care*. Aldershot, UK: Arena.

Comissão Nacional de Proteção de Crianças e Jovens em Risco (2014). *Relatório de atividades de 2013 [Report on activities in 2013]*. Lisboa: Instituto para o Desenvolvimento Social. Available at: http://www.cnpcjr.pt/preview_documentos.asp?r=3453&m=PDF.

Courtney, M. E., Dolev, T., & Gilligan, R. (2009). Looking backwards to see forwards clearly: A cross-national perspective on residential care. In M. E Courtney, & D. Iwaniec (eds.), *Residential care of children: Comparative perspectives* (pp. 191-208). Oxford/New York: Oxford University Press.

Courtney, M. E., & Iwaniec, D. (eds.) (2009). *Residential care of children: Comparative perspectives*. Oxford/New York: Oxford University Press.

Cruz, L. (2011). Sobre el acogimiento residencial y las condiciones socioeducativas en las que se debe desarrollar la medida [On residential care and the implementation of socio-educational conditions of child protection measures]. *Pedadogia i Treball Social. Revista de Ciències Socials Aplicades*, *2*, 66-88.

Dahlberg, G., Moss, P., & Pence, A. (1999). *Beyond quality in early childhood education and care: Postmodern perspectives*. London, UK: Falmer Press.

Delap, E. (2011). *Scaling down: Reducing, reshaping and improving residential care around the world*. London: EveryChild.

Delfabbro, P. H., Barber, J. G., & Bentham, Y. (2002). Children's satisfaction with out-of- home care in South Australia. *Journal of Adolescence*, *25*, 523-533, doi: 10.1006/jado.2002.0497.

Delgado, P. (2010). O acolhimento familiar em Portugal: Conceitos, práticas e desafios. [Foster care in Portugal: Concepts, practices and challenges). *Psicologia & Sociedade, 22*(2), 336-344.

Del Valle, J. F. (1997). Evaluación de programas de acogimiento residencial [Evaluation of residential care programmes]. *Bienestar y Protección Infantil, 3*, 48-76.

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*, 251-257.

Del Valle, J. F., Bravo, A., Hernández, M., & Santos, I. (2012). *Equar: Estándares de calidad en acogimiento residencial [Equar:Quality standards in residential care]*. Madrid: Ministerio de Sanidad, Servicios Sociales e Igualdad.

Del Valle, J. F., & Casas, F. (2002). Child residential care in the Spanish social protection system. *International Journal of Child and Family Welfare*, *5*(3), 112-128.

Del Valle, J. F., & Zurita, J. F. (2000). *El acogimiento residencial en la protección a la infancia [Residential care in child protection]*. Madrid: Pirámide.

FFMS (2014). Figures of Portugal: Summary table. PORDATA - Portaits. Retrieved August 4, 2014, from http://www.pordata.pt/ebooks/PT2011v201306111700/RETRATODEPORTUGAL2011.pdf.

Hallett, C., & Prout, A. (eds.) (2003). *Hearing the voices of children*. London / New York: RoutledgeFalmer.

Instituto da Segurança Social (ISS), IP (2007a). *Manual de Gestão da Qualidade das Respostas Sociais: Lar de Infância e Juventude [Quality Management Handbook of Social Responses: The Home for Children and Youth]*. Lisboa: ISS, IP. Available at: http://www2.seg-social.pt/preview_documentos.asp?r=21429&m=PDF.

Instituto da Segurança Social (ISS), IP (2007b). *Manual de Gestão da Qualidade das Respostas Sociais: Centro de Acolhimento Temporário [Quality Management Handbook of Social Responses: The Temporary Care Centre]*. Lisboa: ISS, IP. Available at: http://www2.seg-social.pt/preview_documentos.asp?r=21644&m=PDF.

Instituto da Segurança Social (ISS), IP (2014). *CASA-2013. Relatório de Caracterização Anual da Situação do Acolhimento das Crianças e Jovens [CASA-2013. Annual Assessment Report on the State of Residential Care of Children and Youngsters]*. Lisboa: ISS, IP.

Kendrick, A. J. (ed.) (2008). *Residential child care: Prospects and challenges*. London/Philadelphia: Jessica Kingsley Publishers.

Kendrick, A., Steckley, L., & McPheat, G. (2009). *Residential child care: Learning from international comparisons*. Glasgow: Scottish Institute for Residential Child Care.

Lei nº 147/99, de 9 de Setembro – Lei de Protecção de Crianças e Jovens em Perigo [Law on Protection of Children and Young People in Danger]. Lisboa: Diário da República.

Marôco, J. (2011). *Análise estatística com o SPSS Statistics [Statistical analysis with SPSS]*. Pêro Pinheiro: r Editora.

Martins, C. (2011). *Manual de análises de dados quantitativos com recurso ao IBM SPSS: Saber decidir, fazer, interpretar e redigir [Handbook of quantitative analysis of data using IBM SPSS : Be able to decide, do, interpret and write]*. Braga: Psiquilíbrios Edições.

Martins, P. C. (2004). *Protecção de crianças e jovens em itinerários de risco: Representações sociais, modos e espaços [Protection of children and young people in at risk itineraries: Social representations, modes and spaces]*. PhD thesis. Braga: University of Minho, Departement of Child Studies. Available at: http://repositorium.sdum.uminho.pt/handle/1822/3238.

O'Neill, T. (2008). Gender matters in residential child care. In A. J. Kendrick (ed.), *Residential child care: Prospects and challenges* (pp. 93-106). London/Philadelphia: Jessica Kingsley Publishers.

Palareti, L., & Berti, C. (2009). Different ecological perspectives for evaluating residential care outcomes: Which window for the black box? *Children and Youth Services Review, 31*, 1080-1085, doi:10.1016/j.childyouth.2009.07.011.

Rodrigues, S., Barbosa-Ducharne, M., & Del Valle, J. F. (2013). La calidad del acogimiento residencial en Portugal y el ejemplo de la evolución Española [The quality of residential child care in Portugal and the example of its development in Spain]. *Papeles del Psicólogo, 34*(1), 11-22.

Rodrigues, S., Barbosa-Ducharne, M., & Del Valle, J. F. (2014). Quality of residential care system of children in Portugal: Preliminary results from a comprehensive assessment. In C. Pracana (ed.), *InPact International Psychological Applications Conference and Trends 2014 Proceedings* (pp. 36-40). Porto: InPact.

Rosen, M. (1999). Treating child welfare children in residential settings. *Children and Youth Services Review*, *21*(8), 657-676.

Rutter, M. (2000). Children in substitute care: Some conceptual considerations and research implications. *Children and Youth Services Review*, *22*, 685-703, doi: http://dx.doi.org/10.1016/S0190-7409(00)00116-X.

Sellick, C. (1998). The use of institutional care for children across Europe. *European Journal of Social Work*, *1*(3), 301-310.

Shealy, C. N. (1996). From Boys Town to Oliver Twist. *Child and Youth Care Forum*, *25*(4), 211-271.

Shealy, C. N. (2002). Knowing a way toward professional child and youth care: The therapeutic home parent model. In E. J. Knorth, P. M. van den Bergh, & F. Verheij (eds.), *Professionalization and participation in child and youth care: Challenging understandings in theory and practice* (pp. 87-106). Aldershot, UK / Burlington, VT: Ashgate.

Taylor, K. (2005). Understanding communities today: Using matching needs and services to assess community needs and design community-based services. *Child Welfare League of America, 84*, 251-264. INIST: 20612, 35400012934916.0090.

Van Nijnatten, C. (2013). *Children's agency, children's welfare. A dialogical approach to child development, policy and practice.* Bristol/Chicago: The Policy Press.

Appendix: Expanation of ARQUA-P dimensions

The first dimension 'place, infra-structure and resources' evaluates the location; available community resources (health, education, recreation); proximity of natural life contexts; comfortable facilities; and family-oriented environment. 'Placement and admission' aims to assess the intake preparation and the process/protocol of hosting and properly integrating the new child or young person. 'Support to family reunification' refers to the support and work done with the family when the goal is the child's return to his/her home. 'Safety and protection' items evaluate if the environment promotes a peaceful coexistence, affective connections, attachment relationships, and support from caregivers and peers (including ways of preventing and controlling situations of abuse). 'Respect for rights' intends to assess if children's monitoring and care is based on respect for all their rights, identity and individual differences or beliefs (and those of their families), how privacy and confidentiality are preserved, and how children's suggestions are heard. In the dimension 'basic and material needs' is valued the way that satisfaction of basic and material needs such as food, clothes and pocket money is accomplish and normalized. The 'studies and training' dimension intends to appraise resources and support for school integration, academic achievement, individualized study, and for overcoming specific difficulties in a normalized educational context. 'Health and life style' assesses the adequacy of health care and health records; detection, evaluation and treatment of conduct, emotional and developmental problems; and opportunities for a healthy lifestyle and affective-sexual education. 'Normalization and integration' values the normalization criterion regarding spaces, rhythms, and routines of life similar to any home environment; the integration in activities and resources of the community; visits, friendships and leisure materials (including internet and other recreational technologies); flexible hours; and no segregation by gender. 'Development and autonomy' estimates if the centre is an educational context that enhances the growth and development of children or young people through activities, experiences, routines, focusing on opportunities to acquire various skills including autonomy, with work to remediate difficulties that may be an obstacle to development. The dimension 'participation' assesses respect for the right and promotion of children's participation in decisions that concern their own life planning and gauges their satisfaction with quality of RC services provided. Finally, the 'use of consequences' dimension measures if the educational model is based on positive reinforcement of appropriate behaviour, and, when necessary, resorts to constructive, proportionate penalties as laid down in advance with the participation of children, including that only appropriate use of physical restraint is done.