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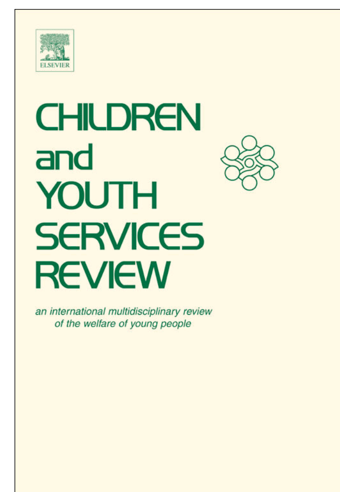

Toward coherent practice in shared residential care: Program methods, tools, and intervention models

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Title:

Toward Coherent Practice in Shared Residential Care: Program Methods, Tools, and Intervention Models

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Highlights:

- First study to conceptualize SRC practice models across programs
- SRC services focus mainly on mothers as primary intervention targets
- Some programs do not work directly with children, despite their protection mandate
- Educational and psychological tools are frequently combined in SRC
- Programs vary across five practice dimensions shaping family support

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Toward Coherent Practice in Shared Residential Care: Program Methods, Tools, and Intervention Models

Original Research Article for Children & Youth Services Review

Abstract

Objective

Within child protection, Shared Residential Care (SRC) allows parents and children to co-reside in supervised settings where staff support the enhancement of parenting capacities while safeguarding children and fostering their development. Despite being implemented in some countries, these programs remain little known and scarcely studied. This article examines how they operate in terms of methods and tools.

Method

As part of a national study on SRC in Italy, based on online surveys conducted in 2023–2024, we analyzed a dataset of written responses from 31 program managers to three survey questions: 1) What tools/methods are used with children? 2) With mothers? 3) With the mother-child relationship? Responses were examined through Qualitative and Quantitative Content Analysis and Thematic Analysis.

Results

Managers provided 106 responses, identifying 478 tools, mainly educational-support tools and most often targeting mothers. Thematic Analysis revealed five overarching dimensions - Approach, Care Settings, Community Orientation, Participation, and Process- each representing a methodological continuum. A subsequent program-level analysis mapped how respondents positioned their services along these dimensions.

Conclusions

Programs differed widely across the identified continuums, reflecting varied understandings and practices of SRC. The absence of a shared methodological framework highlights the need for more theoretically grounded and coherent approaches. This study sheds light on how professionals conceptualize intervention and offers a basis for improving practice with highly vulnerable families.

Keywords: Shared Family Care; Parenting Support; Program Implementation; Content Analysis; Thematic Analysis; Vulnerable Families; Child Protection

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Shared Family Care (SFC) is an umbrella term for child welfare residential services that accommodate children together with their parents. These services target highly vulnerable families – often affected by instability, psychological distress, and challenges in fulfilling parental roles – and aim to prevent family disruption due to child placement in foster care or residential settings. As Barth and colleagues (2024) have recently demonstrated, SFC encompasses three distinct models: (1) Shared Family Foster Care (SFFC), where host families provide shared caregiving and intensive modeling of effective parenting; (2) Shared Residential Care (SRC), in which professionals fulfill a similar role; and (3) Family Residential Treatment (FRT), which offers intensive treatment for families but does not involve shared caregiving or explicit role modeling for children. The authors have highlighted both the broad scope and potential of SFC as a promising child welfare intervention model that can address a range of challenges, including family instability, trauma, abuse, and neglect. However, their analysis has also highlighted a persistent gap: the limited availability of detailed information on the methodological approaches adopted by programs and the family processes they support. This lack of specificity makes it difficult to compare practices or assess their effectiveness in supporting vulnerable families. While the overall literature on SFC remains limited, emerging data suggest that SRC is the most commonly implemented form of SFC in practice (Barth et al., 2024; Ganne, 2017).

To address these gaps, this article examines Shared Residential Care (SRC) in Italy with the following objectives: (1) to identify the tools commonly employed in SRC settings when working with children, their parents, and the parent-child relationship; and (2) to investigate variations in methodological approaches. Additionally, the study aims to contribute to the broader discourse on interventions for vulnerable families within residential care.

Shared Residential Care

Family partnering – defined as “the constant strive to forge and maintain strong and vital family linkages” (Whittaker et al., 2016, p. 96) in the context of child protection – is a recurring theme and a key consideration across the entire alternative care sector. Rooted in the application of family therapy process within institutional settings and family-oriented services (Lewis, 2011; Elizur, 2012; Merritts, 2016), as well as in a human rights-based approach in social work (Martínez-Herrero et al., 2024), family partnering seeks to develop collaborative, family-based programs that “integrate the tenets of involvement, collaboration, and empowerment to establish a respectful working alliance with the child’s caregivers” (Elizur, 2012, p. 141). It has been recognized as one principle of therapeutic action of residential care (Whittaker et al., 2016) and a predictor of positive outcomes (Holmes et al., 2018; Tang et al., 2024), as it has been shown to help maintain the child’s sense of identity and self-esteem, mitigating feelings of isolation, and reducing potential anxiety (Moyers et al., 2006). When families are in fact actively involved, they are more likely to contribute to and support the care plan, facilitating a smoother transition and adaptation for the child while also improving intra-familial relationships (Anglin, 2004; Ross et al., 2017).

However, this literature also highlights that family partnering is difficult to implement when children are placed in out-of-home care, partly due to objective barriers that arise – such as the placement being at some distance from the family home – and professionals’ attitudes toward family engagement (Author1 et al., 2025). The separation between children and parents in out-of-home care extends beyond physical distance, as the lack of shared daily

experiences – such as routines, meals, and informal interactions – hinders efforts to support and strengthen their relationship. This disconnection can increase the challenges of family-focused interventions and heighten the risk of difficulties during reunification. To move beyond mere contact, family partnering must engage with three key areas (Geurts et al., 2012):

1. formal care processes, such as family involvement in treatment planning;
2. involvement in child's everyday life, including activities like shared meals together;
3. direct work with families in their everyday contexts, providing support and guidance.

In this framework, residential staff members act as systemic practitioners, engaging both the family as a whole and its individual members.

From this perspective, SRC appears theoretically to be a strong solution, and a way to bridge the gap between home-based family support and out-of-home placement (Barth, 1994; Simmel & Price, 2002; Price & Wictherman, 2003; Author4 et al., 2026). Within SRC, parents stay actively involved in their children's daily lives, sharing routines and the living environment, and the systematic observation of parent-child interactions by staff provides an opportunity to assess and strengthen parenting skills. Parents can therefore receive immediate feedback and support to engage with their children, manage the household, and address personal challenges. Meanwhile, the setting provides a safer, more stable alternative to the family's original environment, reducing risk factors for children.

Although these advantages are emphasized in the limited literature available, they may not always be reflected consistently in the practices adopted by different programs. As a result, SRC lacks access to established, evidence-based tools and specifically tailored methodologies, at least in Italy, which is the context of this investigation.

The Italian SRC System

Italy is considered a medium user of residential services in the field of alternative care (Whittaker et al., 2022). SRC programs are classified as residential care within the child welfare system, where they account for 21.5% of services (Istituto degli Innocenti, 2024), with approximately 670 facilities nationwide, including both 24-hour and less intensive programs.

Programs are publicly funded but mostly managed by non-profit organizations, often alongside traditional residential child care services, sometimes sharing infrastructure and personnel. Depending on regional regulations, facilities typically accommodate four to eight families, predominantly mothers with children; only a minority of programs can host entire family units or father-child dyads. Placements usually last from several months up to two years, with possible extensions. Admission, whether voluntary or court-ordered, is coordinated by local social services, with a caseworker overseeing the intervention. Staff presence varies according to the level of need, with 24/7 coverage ensured in more complex child protection cases. Staff are qualified professionals, mainly educators with a bachelor's degree, who receive ongoing training. Following an initial observation period, staff develop

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an individualized care plan in collaboration with families and local social services, which is formally reviewed every six months.

The present study focuses on SRC programs providing 24-hour residential support, which predominantly serve families referred through judicial measures. In such cases, placements are ordered as child protection interventions requiring the child to be placed in a protected setting, together with the mother when she consents to the intervention. The target population mainly includes families with young children, predominantly under six years of age, although older children may also be present, experiencing multiple and interacting challenges. Among the most frequent referral conditions are children's exposure to domestic violence and high levels of interparental conflict, alongside broader situations of parental vulnerability, such as socio-economic deprivation, mental health difficulties, social isolation, and migration-related stressors.

These programs ensure continuous staff presence and are primarily staffed by qualified educators, as required by national regulations, often complemented by additional professionals such as psychologists. In a significant proportion of cases, particularly in services managed by faith-based organizations, volunteers also contribute to daily activities. Staff receive ongoing training and benefit from structured external supervision, although the extent and formalization of these provisions vary depending on regional regulations governing the sector. Facilities are located in both urban and rural areas, ensuring adequate access to public services and transportation. A more detailed description of program models and target populations, based on the same sample examined in this study, as well as analyses of associations between program characteristics and outcomes, is provided elsewhere (Author, in press).

Methods

Procedure and Participants

This study is part of a national project on Italian SRC programs, led by the University of XXX (blinded for peer review) in collaboration with the XXX social cooperative (Author4 and Author2, in press), building on a previous pilot study (Author4 et al., 2026). The research was disseminated through the two main national networks of residential care facilities, VVV and ZZZ (blinded for review), via mailing lists and presentations, generating widespread interest.

Following an online meeting outlining the study's criteria, instruments, and requirements, 31 SRC programs from nine regions volunteered to participate, motivated by an interest in reflecting on practices and methodological approaches. Inclusion criteria ensured sample homogeneity: (a) 24/7 high-intensity support by rotating staff; (b) at least four years of operation; and (c) a focus on mothers with children and/or pregnant women. Programs primarily oriented toward the therapeutic treatment of the parent (e.g., residential services for mothers with substance use disorders), where children may be present but are not the direct target of intervention, were excluded. The study was approved by the University's Bioethics Committee (No. 0155296/2023).

The Questionnaire

As part of the broader project, a custom-designed questionnaire was administered to SRC managers via Qualtrics. The 88-item tool included both closed- and open-ended questions, tailored to explore various SRC dimensions. A pilot test involved two managers not included in the main study. The final version was distributed via personalized links, allowing participants two months and multiple logins to complete it.

Data Analysis

In this study, we analyzed SRC managers' responses to three open-ended questions:

QC) What tools/methods do you use to work with children?

QM) What tools/methods do you use to work with mothers?

QR) What tools/methods do you use to work on the mother-child relationship?

We also considered responses to an optional space where managers could share additional methodological approaches. Respondents could skip questions they deemed irrelevant to their program.

The analysis followed a three-step process conducted by three independent judges (the first three authors), supervised by the fourth author as principal investigator.

First, using pen-and-paper Quantitative Content Analysis (Morgan, 1993), we coded and counted the tools and working areas cited in QC, QM, QR, and the additional text.

Second, we made margin notes and initial categorizations, then re-analyzed the data through Qualitative Content Analysis (Kondracki et al., 2002; Hsieh & Shannon, 2005).

Finally, we used Reflexive Thematic Analysis (Braun & Clarke, 2006; 2022) to cluster recurring themes. All authors reviewed codes, discussing inconsistencies and refining key meanings into coherent themes. Themes were then revised based on internal homogeneity and external heterogeneity. Extracts were reread to ensure consistency; those fitting multiple themes were coded accordingly. Once coding agreement was reached, themes were named and defined. Lastly, each of the 31 SRC programs was positioned within the themes through inter-judge agreement among three authors.

Findings

The dataset consisted of 106 textual occurrences (i.e., responses to QC, QM and QR and additional responses). SRC managers responded in highly heterogeneous ways, ranging from brief itemized lists to detailed, explanatory descriptions of their overall interventions. Given this variability, we rated the quality of responses to the three main questions on a four-level scale. Overall, 9.7% of responses were classified as missing or not evaluable, 18.3% as scarcely illustrative, 36.6% as sufficiently illustrative, and 35.4% as rich. Inter-rater agreement was 83%. In some cases, respondents provided identical answers across all questions. For the purposes of this article, this section presents the results of our analysis of the SRC tools and the themes and subthemes we found in managers' responses, as well as their distribution across the national sample.

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SRC Tools

By means of Quantitative Content Analysis, we systematically identified all tools reported by managers and counted their occurrences, resulting in a total of 478 tools. A total of 197 tools were reported for working with mothers, 160 with children, and 124 for addressing their relationships. These include both concrete operational tools (e.g., observation grids) and, in some cases, the methods through which they are applied (e.g., group or individual activities). For brevity, we will refer to both instruments and methods as "tools" in the following sections. We then grouped the tools into three main categories: (1) educational tools and artefacts (physical or visual materials intentionally created or used by staff as mediating tools), (2) psychological tools, and (3) professionals involved. Table 1 displays the tools identified for each area of intervention and category and their distribution across the sample.

Table 1

Distribution of tools across SRC programs by area of intervention

	Area of intervention		
	Mothers (QM)	**Children** (QC)	**Mother-child relationship** (QR)
Tools	*n*	*n*	*n*
	Educational Tools		
Basic educational tools (individualized plan, talks, observation, support, relationship, assessment)	29	26	31
Artefacts: paper works, toolkits, maps, books, videos	8	5	5
Staff tools: meetings, minutes, observation grids, supervision[a]	8	7	4
Workshops	4	11	4

	Area of intervention		
	Mothers (QM)	**Children** (QC)	**Mother-child relationship** (QR)
Tools	*n*	*n*	*n*
Group activities and meetings	9	7	2
Play	-	12	3
Job Placement/Job Training	6	-	-
Dedicated mother-child experiences	-	-	8
PIPPI[1] toolkit for family engagement	4	2	1
Meetings with relatives and friends	3	-	-
Supervised family meetings[a]	-	6	-
External educational services	-	2	-
Subtotal	**30**	**26**	**31**
Psychological Tools			
Individual interviews/techniques	11	2	4

[1] Launched in 2011 to prevent out-of-home placements through home-based interventions, the PIPPI Program (Program of intervention for the prevention of institutionalization) is now a structured public social work program, developed in collaboration with the Italian Ministry of Labour and the University of Padua. Over the years, it has developed several tools to support family engagement (Ius, 2021).

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	Area of intervention		
	Mothers (QM)	**Children** (QC)	**Mother-child relationship** (QR)
Tools	*n*	*n*	*n*
Group Therapy	5	-	1
Subtotal	**13**	**2**	**4**
	Professionals		
Meetings with social services	5	-	4
Psychologist	5	3	-
Other specialists (e.g., obstetrician, pediatrician)	3	4	-
Key worker[b]	5	-	1
Pedagogist	2	3	1
Volunteers/supporting families	3	-	1
Manager's direct intervention	3	-	-
Subtotal	**17**	**7**	**7**
Mean tools per program	**6.8**	**6.0**	**4.0**
Total	**30**	**27**	**31**

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Note. N = 31 SRC programs; *n* = number of programs reporting at least one tool of this type.

Subtotals and totals are not arithmetic sums, as a single program may report multiple tools within the same category or area of intervention.

[a] Although staff supervision and supervised family meetings can be carried out by different professionals, including psychologists, in this study we classified them as educational tools, given their relevance to the educational aims and practices of SRC.

[b] Differently from other contexts, in Italy the keyworker is a dedicated educator that is the reference for the specific case at hand for the whole team.

All 31 programs reported using tools to support the mother-child relationship, followed by work with mothers (n=30) and children (n=27). Notably, the managers of the four programs that did not report tools for children explicitly stated that they do not work directly with children. In two of these cases, this appears to reflect a deliberate methodological choice to engage the mother as the primary agent of interaction with her child; for the remaining two, the available responses did not provide sufficient information to account for this approach.

Across all three areas of intervention, educational tools were the most widely reported and were used by nearly all programs. Psychological tools and the involvement of other professionals and volunteers were less frequently mentioned and more heavily concentrated in work with mothers. Indeed, intervention with mothers emerged as the most diversified area, characterized by the highest mean number of tools per program (M=6.8). Among the tools specific to this area, job-related support stood out as a distinctive feature, encompassing activities such as resume writing assistance and competency-based self-assessment.

For work with children, managers highlighted play-based approaches and the use of artefacts as central tools for fostering emotional expression, relational skills, and self-regulation. Workshops were frequently described as spaces for playful, creative, and emotionally oriented engagement, while group activities were primarily aimed at promoting socialization and providing enriching experiences.

Although addressed by all programs, work on the mother-child relationship appeared comparatively less varied in its approach, as reflected in the lower mean number of tools per program (M=4.0). This work was often embedded in everyday educational support, with a focus on nurturing positive interaction and communication between mother and child during shared daily routines. At times, this relational support was enriched through specific artefacts (such as drawings) or, with the mother's consent, through video-based tools that allowed for closer observation of relational dynamics during play. Dedicated dyadic experiences, including shared outings and joint activities, were also highlighted as meaningful opportunities to strengthen the emotional and relational bond.

SRC Themes

A pen-to-paper Reflexive Thematic Analysis led to the identification of five key themes, each capturing a core dimension of SRC practice. Written responses were coded accordingly, with an inter-judge agreement rate of 87%. Each theme is conceptualized as a continuum between two poles, highlighting variations in how SRC programs are organized and implemented. The themes are as follows:

1. *Approach* – educational vs integrated (psychological + educational);
2. *Care settings* – combination of group-based and individual interventions vs. one-on-one support only;
3. *Community orientation* – incorporation of external partnerships and community engagement vs. exclusive reliance on in-house activities;
4. *Participation* – mothers as active participants in decision-making and planning vs. passive recipients of predefined interventions;
5. *Process* – structured, phase-based intervention vs. undifferentiated, continuous approach.

In the following sections, each theme is illustrated with selected excerpts that exemplify distinct positions along the continuum, based on their representativeness within the dataset.

Approach: Educational vs Integrated (psychological + educational)

SRC managers described different approaches to intervention, as reflected in the tools and methods they reported using. In some cases, responses showed an integrated approach, combining educational strategies (e.g., modeling, structured activities) with psychological techniques (e.g., clinical interviews). In others, the emphasis was placed solely on educational tools. For instance, one program manager wrote: “Observation, educational support in daily activities, parental help/support, individualized plan , interviews/conversations.” (SRC_20, QR). This excerpt highlights a focus on practical, educationally oriented tools, with no reference to psychological interventions. By contrast, several respondents described the inclusion of psychological support – particularly when addressing the mother–child relationship. One manager reported:

> Clinical interviews addressing specific issues related to the mother-child relationship (e.g., managing tantrums, integrating emotional and normative functions, etc.). Workshop activities involving both mother and child, conducted either within the facility or externally, through participation in specialized courses (e.g., art workshops, informational courses on potty training or infant massage, etc.). Supporting moments of both free and structured play. Providing new stimuli. Daily discussions on the resources and risks associated with certain behaviors. (SRC_01, QR)

This example illustrates a multidimensional approach that combines psychological tools (e.g., clinical interviews) with experiential and relational strategies (e.g., workshops, play). Clinical interviews were cited across responses as the core psychological tool used to explore relational dynamics, emotional challenges, and parenting strategies in a protected

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setting. In addition to direct psychological support, this example highlights the use of educational activities aimed at promoting reflection and emotional bonding, demonstrating how both domains can be meaningfully integrated in practice.

Care settings: Group + Individual Care vs. One-on-One Support Only

SRC programs vary in the way they combine individual sessions with collective activities. Some rely entirely on one-to-one support, while others add group workshops exclusively for children, and a third group extends those shared sessions to mothers as well. For the purposes of this section, we focus on the contrast between programs that integrate adult group-based care alongside individual support and those that offer only individualized interventions.

Group-based activities were typically described as spaces for peer support and the development of social and relational competencies. For example:

> The educational and psychological support interventions carried out within the facility are generally aimed at: (…) providing practical support and accompaniment in managing the home and domestic activities, both individually and in collaboration with other residents; (…) organizing weekly group sessions for adult residents, facilitated by a psychologist-psychotherapist, followed by individual sessions for the more complex cases. (SRC_29, QM)

In these cases, group interventions are implemented both *intra moenia* and *extra moenia*, with the aim of enhancing residents' adaptive functioning within shared living arrangements and fostering communicative and relational competencies that may be beneficial beyond the residential context, particularly after discharge from the facility. In contrast, other respondents reported a preference for individual-based approaches, sometimes explicitly rejecting group care, as one manager explained:

> Group recreational activities are not proposed precisely to allow for the development or maintenance of [mother-child] routines, which may include moments of boredom, and to encourage mothers to seek out appropriate activities for themselves and their children within the local community. (SRC_18, additional response)

Here, the individual focus is justified ideologically, emphasizing the importance of preserving daily family rhythms and fostering autonomous initiative. This model reflects a facilitative, non-substitutive stance, where the goal is to empower mothers to engage independently with external opportunities and develop self-directed parenting routines.

Community Orientation: External Integration vs. In-House Activities Only

In line with the deinstitutionalization process emphasizing community engagement, some managers reported incorporating external resources and partnerships in their programs.

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For example, one manager described the following supports: “Development of feasible job search and training projects. Assistance in finding Italian language courses. Meetings with services to tailor individual pathways. Group discussion sessions. Active citizenship projects” (SRC_10, QM). Here, several tools explicitly involve external stakeholders, such as social and healthcare services, highlighting an orientation toward community-level intervention. The emphasis on citizenship education frames care as a means of empowerment, fostering individuals’ capacity to act as engaged, responsible members of their communities. Conversely, other managers described activities confined to the facility’s internal setting, as in the following example: “Workshops within the facility aimed at promoting well-being (as well as that of the mothers) to foster the development of relational, playful, and creative skills” (SRC_08, QC). While the internal workshops emphasize socio-emotional skill development and well-being, they are limited to the in-house environment, suggesting a less community-integrated approach.

Participation: Mothers as Active Participants in Decision-Making and Planning vs. Passive Recipients

In addressing this theme, the Thematic Analysis was guided by the four-tier framework of participation proposed by O’Sullivan (2011), adapted to the specific context of SRC. The levels identified were:

1. *Mothers being in control* – where mothers make decisions concerning their own lives and those of their children;

2. *Mothers as partners* – where SRC staff and mothers engage in shared decision-making;

3. *Mothers being consulted* – where mothers’ views are considered, but final decisions are made by SRC staff;

4. *Mothers being told* – where mothers are simply informed of decisions already made by SRC staff.

For brevity, this section illustrates only the two most contrasting positions: mothers being in control and mothers being told.

In the first scenario, mothers are described as actively involved decision-makers in both the educational and practical dimensions of their own and their children’s lives. One manager explained: “The individualized plan is used, which is divided into five areas of interest. Within these areas, the parent sets her own goals, supported, if necessary, by the designated educator” (SRC_02, QM). This excerpt highlights a parent-centered approach in which the mother exercises full control over her personal life project. By allowing her to set “her own goals,” the staff member positions the mother as an active agent, rather than a passive recipient of care.

Conversely, the mothers being told category describes mothers involved only after key decisions have already been made by staff: “The educational plan is defined in terms of objectives and strategies in collaboration with the related social services and specialized services involved. At a later stage, the parent and the child are involved, depending on their

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age" (SRC_26, additional response). Here, mothers' agency in decision-making is minimal. The educational plan is developed primarily through collaboration among professionals, excluding the family. When parents and children are involved, it is delayed and conditional, framed more as a procedural formality than a recognition of their right to participate meaningfully.

Process: Undifferentiated vs. Process-Oriented Intervention

Some SRC units described their work without outlining a structured intervention process. Instead, they listed a series of actions, with no reference to a defined sequence or articulation in phases, as the following example: "Individual interviews with the presentation and reading of relevant materials to provide knowledge and 'objective' information. Informal conversations, participation in activities promoted by local associations to support parenting and child care" (SRC_24, QR). The excerpt presents the SRC intervention as a list of activities without a clear temporal hierarchy or conditional relevance between actions. In contrast, when the intervention was described as structured into distinct and temporally defined phases, as in the following case, the process emerged as more comprehensible and methodologically grounded.

> Observation of the woman both as a mother and as an individual. If necessary, observation grids or tables are used; otherwise, daily observations of the family unit are recorded in the Daily Update Report. Weekly meetings are held with the designated educator, and if needed, with the coordinator. Gradually, the woman's needs and goals – both as a mother and as an individual – are identified and shared. All findings and decisions are then discussed within the team. (SRC_04, QM)

This response describes SRC work as a process that unfolds over time and includes progressive, structured steps. The use of temporal markers such as "daily observations" and "weekly meetings," as well as the gradual identification of goals and needs, highlights an ongoing and adaptive approach. Furthermore, the reference to various tools (e.g., observation grids, daily reports, team meetings) reinforces the idea of a phased intervention in which information is systematically collected, discussed, and shared over time.

Distribution Across the National Sample

To move beyond a response-level analysis and better explore how the programs were positioned along the five thematic dimensions, the dataset was reanalyzed on a program-by-program basis. SRC units were assessed across the five themes identified in the analysis; Table 2 summarizes the distribution.

Table 2

Distribution of themes across the participating programs

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SRC Themes	Identified Options	SRC programs n (%)
1) Approach	Integrated (Psychological + Educational)	13 (42%)
	Educational	16 (52%)
	NE	2 (6%)
2) Care modalities	Group and individual care	16 (52%)
	Group work limited to children	5 (16%)
	One-on-one support only	7 (23%)
	NE	3 (9%)
3) Community orientation	External integration	16 (52%)
	In-house activities only	13 (42%)
	NE	2 (6%)
4) Participation	Mothers being in control	3 (9%)
	Mothers being partners	14 (46%)
	Mothers being consulted	2 (6%)
	Mothers being told	2 (6%)
	NE	10 (33%)

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5) Processes	Process-oriented (phased) intervention	20 (65%)
	Undifferentiated approach	6 (19%)
	NE	5 (16%)

Note. Percentages calculated on the total of N=31 SRC programs. SRC: Shared Residential Care, NE: Not Evaluable.

The reanalysis revealed considerable variability across programs in how these dimensions were implemented. With regard to *Approach*, a slight majority of programs (52%) reported relying solely on educational strategies, while 42% described integrating psychological tools – such as clinical interviews or emotion-focused interventions – alongside educational practices in their routines.

As for *Care settings*, a slight majority of programs (52%) combined individual and group-based care, suggesting a multidimensional approach to relational support. By contrast, 23% relied exclusively on one-on-one interventions, with no evidence of group activities, indicating a preference for individualized support. An additional 16% described group activities limited to child-focused structured group settings, implying a restricted use of collective practices, without broader involvement of adult residents.The theme of *Community orientation* also showed notable differences. While 52% of programs included activities involving external actors – such as social services, community associations, or training institutions – 42% operated strictly within the confines of the facility, with no reported partnerships or outreach, suggesting varying levels of openness toward social integration.

In terms of *Participation*, 46% of programs described mothers as active partners in decision-making. However, only a small fraction (9%) positioned mothers as fully autonomous in setting goals and directing their own life projects. More hierarchical models of interaction also emerged: in 6% of cases, mothers were only consulted, and in another 6%, they were merely informed about pre-determined decisions. Notably, 33% of the programs did not provide sufficient information to assess this dimension, possibly reflecting either a lack of focus on participatory approaches or limited articulation of these processes in the responses.

Finally, regarding the *Process* dimension, a significant majority of programs (65%) described their interventions using temporally sequenced or phase-based models, suggesting an intentional structuring of the care pathway (e.g., assessment, planning, follow-up). In contrast, other programs presented their activities as undifferentiated lists, lacking a clear sense of temporal or methodological progression, thus offering less insight into the operational logic underpinning their work.

Discussion

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Describing the methodological approach and intervention strategies used in Shared Residential Care (SRC) settings is a complex task – made even more so by the absence of standardized models or references in the literature. In many cases, the approach evolves through daily practice, shaped by the specific needs and resources of a highly heterogeneous user population, constrained by institutional and organizational factors, and influenced by the professional background and turnover of staff. This article sought to address the lack of structured knowledge surrounding SRC methodologies by analyzing data from 31 Italian programs. To our knowledge, it represents the first systematic effort to map and interpret how SRC professionals define the tools and methods employed in their work with children, mothers, and parental relationships. Importantly, participation in the study was often driven by a desire among practitioners and managers to reflect on their own practices, compare them with those of similar programs, and explore new solutions to persistent challenges. However, the variability in the quality and depth of responses – even among motivated respondents – points to the difficulty many professionals face in articulating their own models of care. This may reflect not only differences in how SRC programs are conceived and managed, but also a broader need for professional development, shared frameworks, and reflective spaces within the sector (on this issue, see Author4 et al., 2012; 2020; 2026). The five themes identified offer a conceptual framework to support practitioners in articulating and reflecting on their work. In parallel, the detailed inventory of tools contributes to capturing the diversity of practices adopted in SRC, providing a shared reference point for comparison, training, and program development.

Entering into the substance of the findings, two key points emerge. First, there is a marked emphasis on working primarily with mothers, reflected in the broader range of tools used – particularly psychological ones – and the involvement of multiple professional figures. This suggests recognition of the complexity of mothers' needs and their dual subjectivity as women and caregivers, calling for diversified and multidisciplinary support. In parallel, it is notable that in some programs children were not consistently identified as a separate target of intervention. While this may reflect a deliberate choice to avoid weakening the mother–child bond or assuming parental functions, it raises important questions for child protection practice. This pattern appears linked to evolving interpretations of SRC as family-support settings or therapeutic developmental environments rather than only child-protection placements. At the same time, within the Italian legal and policy framework, SRC remains a child-centered and protective intervention, underscoring the need to balance parental support with direct attention to children's developmental and safeguarding needs.

Second, regardless of their intended target groups, SRC programs in our sample could be categorized along five thematic axes: (1) the use of educational and psychological approaches; (2) the combination of group-based and individual interventions; (3) the integration of in-house and external activities; (4) varying levels of mothers' participation; and (5) the presence (or absence) of a phased methodology. Regarding the first theme, half of the programs in our sample reported relying solely on educational tools, which may run counter to the tradition of integrating family psychotherapy into family-based services (Lebow, 1997; Liddle, 2016). This preference for pedagogical approaches – while understandable given the educational orientation of these services – raises important questions about the extent to which emotional processing and relational repair are prioritized within the shared living environment.

Regarding the use of group and individual interventions, nearly a quarter of programs focused exclusively on individualized support, overlooking the intrinsically social nature of

SRC. Cohabitation dynamics - such as negotiating shared spaces, managing conflict, and participating in common routines - represent meaningful relational experiences that, when addressed in group settings, can offer valuable opportunities for reflection and social learning. Group work in this context may serve as a form of relational training, supporting residents in experimenting with new interactional patterns and enhancing their social competence. Group-based settings appear more commonly used with children, although the specific goals of these activities - whether recreational, educational, or therapeutic - are not always made explicit.

Regarding the integration of in-house and external activities, many managers appeared to embrace a vision of these programs as embedded within broader community networks, echoing Whittaker et al.'s (2016, p. 97) call for services that are "fully anchored in the communities, cultures, and web of social relationships that define and inform the children and families we serve." Nevertheless, the relevant proportion of programs (42%) that remain inwardly oriented raises concerns about the potential for social isolation or segregation, and the risk of SRC becoming self-referential systems rather than transitional platforms. Working toward social inclusion is all the more essential given that the families served often have limited social and familial networks, making the establishment of external connections a key condition for long-term autonomy (Author4 & Author2, in press). Turning to mothers' participation, fewer than half of the programs (46%) positioned mothers as active partners in decision-making processes, but not in control. Only in a minority of programs were mothers explicitly framed as autonomous actors, while staff assumed a scaffolding role (Wood et al., 1976), supporting decision-making without replacing it. Conversely, top-down approaches – where mothers were merely informed or superficially consulted (12%) – may undermine agency and reduce long-term engagement. Finally, the fifth theme concerns how SRC processes were structured and described. Most programs (65%) provided a step-by-step account of their interventions, indicating the presence of at least some formalized methodology or step. This suggests that many practitioners possessed an articulated understanding of the intervention phases, which may enhance both internal coherence and the evaluability of services.

Taken together, these findings call for deeper reflection on how SRC models are described, conceptualized, and implemented in practice and, by extension, how they are theoretically grounded and linked to broader theories of change.

Practical and Policy Implications

Despite its limitations, this study highlights several implications for SRC practice and policy. The marked variability across programs raises concerns about methodological coherence, suggesting that, in the absence of shared frameworks, the nature and quality of support may differ significantly across services and depend more on local organizational cultures than on a consistently defined system of care. While national guidelines for residential care have recently been updated (Ministero del Lavoro e delle Politiche Sociali, 2024) and address some of these dimensions, the findings point to the need for more specific and shared frameworks tailored to SRC to ensure minimum evidence-based standards across services.

For practitioners, the findings underscore the importance of structured reflective spaces and specialized training, as well as the need to make implicit models of care more explicit. Integrating the five thematic axes identified in this study into supervision and self-evaluation could support the development of more coherent theories of change. The risk of

inward orientation observed in many programs further highlights the importance of positioning staff as facilitators of community connections, rather than solely as internal caregivers.

At the governance level, funding models should promote inter-institutional collaboration and the active involvement of mothers, supporting SRC as a transitional pathway toward autonomy rather than a self-contained system.

Limitations and Future Research

This study represents a first attempt to explore SRC practices in Italy. However, the findings are based on self-reported data, which may not fully reflect actual practices, but rather what managers perceive as most relevant. As highlighted in organizational literature, discrepancies often exist between "espoused theories" and "theories-in-use" (Argyris & Schön, 1974). Accordingly, the positioning of programs along specific polarities should be interpreted as an analytical tool to explore variation in methodological approaches, rather than as a direct representation of practice.

A further limitation concerns potential selection bias, as participating programs may be more reflective about their work, thus offering a more favorable picture than the broader national landscape. The broader research project includes additional survey data collected from staff across the 31 programs, which will allow further exploration of these contexts. However, as these are also self-reported data, future research should adopt multi-perspective and longitudinal designs, incorporating families' perspectives and observational or ethnographic approaches. These would allow a deeper understanding of how identified tools and practices are enacted in everyday interactions and whether methodological variability is associated with different outcomes for families.

Challenges and Conclusions

Despite child protection being the primary reason for placement in SRC, and family partnering one of the main therapeutic principle and predictors of good outcomes in alternative care, we have illustrated that the wide variety of reported tools and methods of intervention themselves vary significantly and are not always child-centered nor family-partnered. Implementation of the programs often results in contradictory practices and could even rely on the personal judgment and sensitivity of individual caregivers (Seekamp et al., 2023) rather than on assumed theoretical and methodological reflection. By lacking dedicated literature, SRC tends in fact toward a hybrid "borderland" identity – a blend of methodological elements borrowed from different programs, such as child residential care, therapeutic residential programs for adults, and wraparound initiatives toward parent education. While this hybridity is inevitable due to the multi-systemic nature of SRC – serving two generations with limited legal and methodological frameworks, at least in Italy, country of the study – it also presents significant challenges. As we have illustrated, SRC programs encompass a broad range of activities that address the needs of the child, the mother, and their relationship simultaneously. However, respondents often struggle to clearly define and articulate their interventions. In this respect, our findings could serve as a starting point for practitioners to reflect on their current practices and move toward a more structured

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and intentional framework. To achieve this, organizations should rely on adequately trained staff to engage with families. At the same time, this study has broader implications for therapists working with vulnerable families, offering insights into how systemic and integrated interventions can be better designed to support vulnerable children and families.

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Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work the authors used *ChatGPT (GPT-5)* in order to assist with language editing and improving clarity of expression. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

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