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Stakeholder Perspectives on Therapeutic and Safe Building Design in Residential Care

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ABSTRACT

Residential care is a form of out-of-home care that plays a critical role in supporting vulnerable young people in Australia. However, there is an evidence gap regarding the built environment in this context. This research aimed to explore the perspectives of key stakeholders in residential care in Victoria, Australia, regarding design that can offer home-like and therapeutic environments, and safe workplaces. A qualitative research design was used, with semi-structured interviews ($n = 14$) and seven focus groups ($n = 30$) conducted with key programme and policy stakeholder groups. All data were audio-recorded, transcribed verbatim with pseudonyms applied at that time, and analysed using thematic analysis. Ten themes were identified from the data, focused on the importance of home-like and therapeutic environments, and the provision of a safe workplace. Residential care design was found to influence experiences of safety, comfort and therapeutic intent, with stakeholders emphasising the importance of personalisation, maintenance, occupancy levels and visibility in shaping these outcomes. Together the findings reveal significant opportunities to transform residential care environments through targeted design solutions and systematic redesign across regulatory and operational frameworks.

1 | Introduction

Out-of-home care (OOHC) in Australia includes foster care, kinship care, family group homes and residential care for children and young people unable to live with their families, most often due to substantiated maltreatment (Australian Institute of Health and Welfare 2024a). Residential care, specifically, involves placement in a residential building with paid staff providing 24-h care and supervision. In the Australian context, residential care is frequently positioned as a 'last resort' option for young people with complex needs, challenging behaviours and histories of placement breakdowns (Australian Institute of Health and Welfare 2024b); however, residential care remains a critical component of OOHC, providing accommodation for approximately 7% of young people in OOHC nationwide (Australian Institute of Health and Welfare 2024b).

Over the past decade, there has been a significant international policy shift away from traditional residential care models that focus on supervision and physical needs toward trauma-informed and therapeutic approaches (McNamara et al. 2022). This transformation reflects growing recognition that young people in residential care have typically experienced complex developmental trauma and maltreatment (McCrory and Viding 2015; Tarren-Sweeney 2016) requiring service models that actively facilitate 'healing and recovery' (McLean 2019, 2). Therapeutic residential care (TRC) aims to provide a safe and nurturing environment that fosters emotional healing, growth and the development of essential life skills and to provide young people with positive and safe experiences (McLean 2019). This approach has gained traction across Australia, with several states and territories implementing various TRC models. In Victoria, approximately 75% of residential

care placements are provided with therapeutic support, while the 2023–24 State Budget included funding to enable access to therapeutic supports for all young people in residential care by 2025–26 (Victorian State Government 2024b).

The shift to TRC in Australia has taken a distinct trajectory compared to international models. While Australian TRC approaches acknowledge the importance of therapeutic milieu and relational practices (McPherson et al. 2024, 2025), they have predominantly focused on facilitating individual therapeutic supports rather than cultivating a comprehensive therapeutic community or environment. The Victorian framework, for instance, incorporates therapeutic specialists who work alongside residential care staff but maintains a division between daily living and therapeutic intervention (Victorian State Government 2016). Similarly, a review of national key policy documents informing or related to the delivery of TRC in New South Wales (e.g., legislation, policies, strategies, programmes, practice guides, regulations and statements) found that while there was a policy emphasis on relational practices, the documents focused on monitoring and compliance rather than concrete practices (McPherson et al. 2024). Given the shared foundation in national policy and similar service structure, Victoria may face comparable challenges translating therapeutic principles into practice.

In addition to models of care, the built environment has been identified as a critical and modifiable factor in shaping the lived experience of young people in care (Ames and Loebach 2023). The built environment encompasses human-made physical surroundings, including architectural structures, spatial arrangements, interior design and landscaping, which influence functionality, social interaction and wellbeing (Portella 2023). In residential care, the built environment can enhance the therapeutic value of a space by promoting safety, reducing retraumatisation and facilitating the development of core competencies (Ames and Loebach 2023; Fleming and Goldhour 2023). Underscoring the importance of the physical environment, Whittaker et al. (2016) applied an expanded definition of TRC that includes the 'planful use of a purposefully constructed, multi-dimensional living environment' (p. 94). Despite this, the role of the built environment in TRC is often overlooked or overshadowed by the focus on psychosocial aspects (Ames and Loebach 2023). This is exacerbated in Australian TRC models, where a pragmatic response to existing service structures and funding is prioritised over holistic integration of therapeutic care.

This paper sought to examine stakeholder perspectives on the built environment in residential care settings in Victoria, Australia. It aims to explore how physical design elements are conceptualised and implemented and how these understandings inform policy and practice. The findings will contribute to developing more intentional approaches to residential care design that consider how therapeutic and design considerations can be reflected in the built environment and respond to the needs of both young people and care providers.

1.1 | The Delivery of Residential Care in Australia

Residential care in Australia is administered by state and territory governments, who hold statutory responsibility for child protection (Australian Institute of Health and Welfare 2021). In Victoria, there are approximately 500 children in residential care at any given time, and it is estimated that 30% of these children are Aboriginal or Torres Strait Islander People (Australian Institute of Health and Welfare 2024a). Typically, up to four children, usually aged 12 years and older, are placed in a suburban house and provided with 24/7 support by paid staff. Victorian residential care services are delivered by not-for-profit community service organisations (CSOs) and Aboriginal Community-Controlled Organisations (ACCOs) (Australian Institute of Health and Welfare 2021), commonly in dwellings that are purpose-built or retrofitted for purpose (Victorian State Government 2024a).

Victorian programme requirements for residential care acknowledge that 'the physical environment where a child resides and the material goods they are provided with have a significant impact on their physical, emotional and psychological development and wellbeing'. (Victorian State Government 2016, 31). This recognition, along with state government initiatives to improve young people's lived experiences by reducing the number of young people residing in dwellings (Victorian State Government 2020), aligns with research evidence on the importance of the built environment in care settings. While policy frameworks set broad expectations, they lack guidance on translating these to practice. For example, the current requirements emphasise 'home-like environments' that reflect community expectations of a 'home', where children feel safe and supported (Victorian State Government 2016) but offer limited direction on what this means in design terms or how to balance this aspiration with other competing needs such as occupational health and safety (OHS) and therapeutic functionality. Furthermore, in the context of residential care, where young people are placed in a home while being out of home, the concept of 'home' takes on a unique and complex meaning that requires consideration (Söderqvist et al. 2016).

'Home' in residential care encompasses both the physical space and the emotional environment (Attiwill 2023). For many young people in care, home has often been the site of trauma, compounding the complexity of what home feels like (McLoughlin and Gonzalez 2014). Accordingly, there are many interrelated and complex factors that contribute to the creation and impact of a home-like environment (Clark et al. 2015; Mitchell 2022). For example, a qualitative study exploring perspectives of young people with experience of OOHC in Melbourne (Monson et al. 2020) identified that providing a home-like environment was important for mental health, social connection and becoming an active citizen. More specifically, a home-like environment was associated with warmth, stability and self-worth. In terms of designing for a home-like environment, Docherty et al. (2006) explored opinions of care experienced young people and found that young people have strong opinions about the aesthetics, style and condition of houses, especially in rooms that are dedicated to them, such as bedrooms and bathrooms. Underscoring the critical role young people play in defining and designing home, the Commission for Children and Young People recommended that the Victorian Government, in consultation with young people with residential care experience, develop and apply guidelines to assess whether residential care environments

feel like a 'home' (Commission for Children and Young People 2019).

Safety is consistently identified as the most fundamental and universal aspect underpinning the concept of home, and therapeutic and trauma-informed care models (Johnson 2017; Whittaker et al. 2016). It is widely acknowledged as a basic human need, and in the context of survivors of complex trauma, safety provides a platform from which healing from trauma can begin (Pable and Ellis 2023). While safety has been identified as a priority for children and young people placed in residential care (Kor et al. 2020), research consistently shows the extent to which safety in residential care is achieved is questionable. Moore et al. (2017) interviewed 27 Australian children and young people about what they felt led to a safe environment in residential care. Participants distinguished between feeling safe and being safe; most reported that they were not safe and did not feel safe for most of the time living in residential care. Young people associated comfort, control over the space and personalisation with feeling safe in residential care (Moore et al. 2017). Further research by Kor et al. (2020) found that children placed in residential care linked staff supervision and surveillance with reduced peer victimisation and conflict. Accordingly, design that promotes passive and active surveillance, and comfort and control may contribute to young people feeling safe in residential care.

While trauma-informed and TRC has been recognised as essential, these settings operate simultaneously as a home for residents and a workplace for staff. Due to past trauma, children placed in residential care can display overt behaviours, including aggression and anti-social behaviour (Li et al. 2019; Purdy and Antle 2022). As a result, the care workforce in the child welfare sector is highly exposed to unsafe working conditions, especially occupational violence and aggression (OVA) (The Centre for Excellence in Child and Family Welfare [CFECFW] 2019; Parveen et al. 2023; Radey and Wilke 2021; Stanley et al. 2023). A recent evidence review highlights growing workforce demand alongside high levels of compassion fatigue and stress among OOHC workers (Benveniste et al. 2024). Residential care environments must therefore balance being home-like and therapeutic for young people while also ensuring a safe workplace that prevents OVA toward staff.

A systems analysis on OVA in residental care identified facility design as one of five interacting risk factors contributing to OVA (Aburumman et al. 2021). Poorly designed facilities were found to be both triggering (e.g., lack of trauma-informed facilities for clients) and enabling to OVA incidents (e.g., blind spots where staff may be cornered or attacked) (Aburumman et al. 2021). Further research on the management of OVA through building design in the residential care context is limited, however international studies focusing on design in juvenile facilities provide insight (Ulrich 2020). In the absence of reasoned architectural theory, Ulrich (2020) developed a conceptual design model for youth living units that links stress-reducing environments and effective staff observation and communication with reduced resident aggression, indicating the built environment impacts staff safety and work-related stress.

Given the need to integrate physical design and therapeutic interventions within a safe workplace, an evidence gap exists to guide practice in residential care. To address this gap, the study aimed to explore the perspectives of key stakeholders in Victoria, Australia, regarding built design that can offer home-like and therapeutic environments for young people, and safe workplaces for support delivery. Three research questions were posed: (1) What are the barriers and enablers to offering a home-like setting for young people in residential OOHC? (2) What are the barriers and enablers to delivering a therapeutic environment to residents for trauma informed care? and (3) What are the barriers and enablers to provision of a safe workplace for support delivery?

2 | Method

Human Research Ethics Committee approval was received from Monash University Human Research Ethics Committee prior to the research commencing (HREC approval number: 38937).

2.1 | Participant Recruitment

A qualitative research design was used, with in-depth semi-structured interviews and focus groups conducted with key programme and policy stakeholders involved in residential care. Due to the absence of a comprehensive public register of residential care providers in Victoria, variability in the way that the TRC services are configured (McLean 2019) and funding and timeline limitations, purposive and snowball sampling was used for participant recruitment. CSOs and ACCOs were purposively recruited by the research team to ensure a diverse sample, reflecting variation in operational scale, geographic coverage (metropolitan, regional and rural), and areas of specialised service provision across the Victorian residential care sector. The state government department and the workplace safety regulator also identified key stakeholders who had relevant content knowledge.

The research team was provided with a key contact for each CSO, ACCOs or key organisation, who was contacted via email and phone. Key contacts received a research summary and were asked to nominatate staff who met the study inclusion criteria. The research team emphasised the need for care provider participants to represent diverse roles and experiences (e.g., geographical location of service, job description and specialisation). Teams or individuals identified for inclusion in the research were provided with a written explanatory statement highlighting the voluntary nature of participation, and an invitation to an online meeting. To support snowball sampling, focus group and interview participants were invited to inform other eligible professional contacts about the research opportunity.

2.2 | Participants

A total of five CSOs and two ACCOs were invited to participate in the study. Of the five CSOs, three agreed to support the research; of the two ACCOs, one expressed interest in participating but withdrew due to a lack of resourcing and one did not respond. The

participating CSOs represented diverse providers; two were large organisations that offered an array of services across metro, rural and regional Victoria and one was a smaller provider in metro and regional Victoria. Table 1 shows the characteristics of each CSO invited to participate in the research. The characteristics provided are high-level to ensure participant confidentiality.

A total of 44 programmes and policy stakeholders participated in the research; 14 participated in interviews and 30 participated in seven focus groups. These included: frontline staff with current experience in delivering residential care ($n = 29$); management representatives from CSOs ($n = 7$); representatives from the relevant Victorian government department's operational and housing services and/or the workplace health and safety regulator ($n = 7$); and one individual from a peak body/advocacy group in the child and family welfare sector. Participants had experience working across metropolitan, regional and rural locations in Victoria. To protect the identity of participants, only basic demographic data has been disclosed in Table 2.

Our qualitative design prioritised depth and diversity rather than statistical representativeness. Due to the absence of a publicly available comprehensive list of Victorian residential care provider, this study cannot specify the proportion of providers represented. A separate study was designed to explore the perspectives of young who had lived experience of residential care, as this allowed for ethical considerations and methodological approaches tailored specifically to this at risk population.

TABLE 1 | CSO and ACCO characteristics.

Provider	Description	Participation status
CSO 1	Large, statewide provider with an array of care models	✓
CSO 2	Large, statewide provider, with an array of care models	✓
CSO 3	Small/medium, metro and regional, provider, specialises in TRC models	✓
CSO 4	Small/medium, metro and regional provider, specialises in disability services	✗
CSO5	Small, regional and rural provider, with an array of care models	✗
ACCO 1	Large, statewide provider	✗
ACCO 2	Small, regional and rural provider	✗

2.3 | Data Collection

A semi-structured question schedule for both interviews and focus groups was developed through a collaborative and iterative process with the research team, key representatives from the Victorian government department who contracted the research, and the workplace safety regulator. This approach ensured alignment with both research objectives and regulatory considerations for residential care. The draft questions were then tested within the research team and finalised for use in data collection. Questions were designed to elicit in-depth feedback drawing on study participants' experiences and knowledge.

Data collection was conducted from January to April 2024.

2.4 | Data Analyses

Focus group and interview data were transcribed verbatim and analysed using inductive thematic analysis (Braun and Clarke 2021) to address the three research questions, using Nvivo 14. Names of study participants were removed at the time of transcription, with participant numbers applied to maintain confidentiality. All data analysis and interpretation were undertaken by Schroder and Crivari. The funding body did not influence the analysis, interpretation or reporting of the study findings. To aid rigour and trustworthiness in the qualitative research process, fieldnotes were taken during data collection and a reflective journal was also used after each interview or focus group (Liamputtong 2019). Following this, Schroder and Crivari conducted two analysis phases that aligned with the principles of thematic analysis (Braun and Clarke 2021). In the first phase, the second author familiarised themselves with the

TABLE 2 | Participants demographics.

Cohort	Role distribution	Organisation type
Frontline staff	Therapeutic specialist (9), House coordinator (8), Case manager (4), Team leader (1), Psychologist (1), Sleepover staff (1), HSRs (5)	Community service organisation
Management representatives	Management (2), Specialist services (1), Program manager (1), Practitioner (1), Senior management (2)	Community service organisation
Operations and regulation	Specialist services (4), Management representative (3)	State government and government organisations
Advocacy and peak bodies	Management representative (1)	Non-government organisation

FIGURE 1 | Themes identified from the data.

data and developed preliminary themes via codes. In the second phase, Schroder conducted a second analysis to define and name the preliminary themes. This process also comprised discussion between the two team members (including any differences in the analyses, including coding and themes) to reach consensus, and enabled the final set of themes identified in relation to the three research questions (Krefting 1991). These themes will be discussed below.

3 | Results

Ten themes were identified from the data in relation to the three research questions—four related to the design of home-like settings, three related to the therapeutic environment and three related to the provision of a safe workplace. See Figure 1.

Each of the themes in Figure 1 will now be detailed.

3.1 | Home-Like Environment

3.1.1 | The Pivotal Role of Personalisation in Fostering a Sense of 'Home'

Key stakeholders identified personalisation as a key strategy for fostering a home-like environment. Participants explained the aim of personalisation was to tailor the built environment to reflect individual young people's preferences, histories and identities so they develop a sense of ownership over the space. Personalisation was also associated with increased comfort. Participants reported personalisation was commonly applied via the use of soft furnishings (e.g., cushions, throws, beanbags etc.), ornaments and decorations (e.g., flowers, books, children's artwork and photos), blackboard walls, activity spaces (e.g., video games, music rooms etc.), colour schemes and wall stickers.

> Colours were really important. We had pink bedrooms and purple bedrooms and blue bedrooms. So a lot of thought went into the colours. And making those colours – very often what the young person – if the young person was there long term, but in a really fun and friendly and calming and bright and happy.
>
> Advocacy and peak bodies 1

Frontline staff reported that personalisation was typically guided by organisation-specific policy; however, findings indicated the application of personalisation varied according to the young person, care provider, home and organisation. Differences in the notional budget allocated, approach and style impacted the extent to which personalisation was achieved. Participants considered personalisation most effective when led by young people and applied throughout the house. Bedrooms were identified as the priority area for personalisation, given their importance to children and young people. Accordingly, ensuring bedrooms were an aqequate size to accommodate furniture preferences was highlighted as important. Frontline staff and management noted that when done with sufficient buy-in, personalisation resulted in less property damage.

> We found that because they had buy-in in the design of the home and they picked out all the posters and furnishings and all the lighting, all that kind of stuff, they were less inclined to destroy the home when they felt upset, they took it out on something else or just spoke about it.
>
> Management 6

3.1.2 | Institutional Aesthetics Are Inherent in the Design of Residential Care Homes

Participants reported that the institutional aesthetic of residential care homes limited the effectiveness of personalisation efforts and the ability of residential care homes to provide young people with a sense of home. Institutional aesthetics were described as directly contrasting with a sense of comfort and safety that was associated with feeling at home. Safety and regulatory

design features combined with design conventions made residential care homes inherently institutional. Participants commonly highlighted fire safety equipment (e.g., evacuation maps, fire extinguishers, sprinklers), surveillance equipment (e.g., viewing windows, observation mirror domes) and the extensive use of locks as institutional features associated with safety and regulation. Participants took particular issue with these features being among the first seen from the street view and when a person entered the home:

> There's a massive subset of fire regulations that sit over our out of homecare houses that they've got to have all this additional infrastructure, and it sticks out. Some of it's just in the corridor when you walk in, so the potential, and there has been, for destruction, they're constantly replacing those sorts of things too. So we need hidden infrastructure, really good safe storage.
>
> Frontline 2

Regarding common design conventions, participants described residential care homes as appearing 'commercially built'. Several participants suggested that the materials and colours used in the facade and the front garden should be consistent with the local area.

> I think in some regional areas, it would be a lot better if we were building in the same materials as every other house in the street. So, you've got a whole row of weatherboard houses and then you have our house...
>
> Operations and Regulations 1

In regards to layout, participants felt a common layout where bedrooms are lined along a wide hallway created an institutional feel. Similarly, the colour, material and fittings used in bathrooms, the lack of natural lighting and the tendency for (older) houses to be dark inside were all associated with institutional environments. The colour scheme throughout houses was associated with clinical settings and described as 'not up-to-date' – Frontline 3, 4 & 5.

> But I guess probably the bathrooms are the big one that's always raised with us, that with no matter what home gets built, they always put in the department style clinical bathroom, and the kids hate it...
>
> Management 6

Incorporating warm colours, natural elements and varied lighting, texture and building materials were suggestions to counteract institutional aesthetics.

3.1.3 | The Importance of Quality and Timely Maintenance and Repairs

Participants explained that given the trauma commonly experienced by young people placed in residential care, and resulting behaviours that may exist, damage to properties was to be expected. However, frontline staff and select stakeholders highlighted there was a need for a repairs and maintenance system that is responsive and effective as there could be a significant wait for repairs to be carried out.

> We don't have necessarily the issue of holes in the walls though, which is helpful but we do have difficulty with our maintenance as well, like half paint jobs all the time... Any damage we have isn't getting fixed for months...
>
> Frontline 5

Once completed, participants felt some repairs were of poor quality and were made without understanding the context. Common examples included mismatched fixtures, fittings, materials and colour schemes. Participants reported that delayed or poor-quality repairs and maintenance impacted living conditions that affected young people's experiences. For example, participants associated the condition of homes with a lack of respect or care. Moreover, delayed repairs served as a reminder of stressful and traumatic incidents, potentially re-traumatising young people. The living conditions were particularly impactful when young people transitioned into the home:

> ... And then we're bringing new kids into a place that has been destroyed, and so the message that we're sending them is, 'It's okay to have this destruction' when really what we're trying to do is give them pride in the place that they are living in...
>
> Frontline 2

Some stakeholders also suggested more data on repairs and maintenance was needed to inform building design.

3.1.4 | The Problem With Emphasising 'Home-Like' in Residential Care

Participants discussed that the policy and practice emphasis on providing a home-like environment was problematic. In regards to personalisation, while input from children and young people was considered paramount, participants indicated care providers tended to benevolently personalise communal spaces to their own expectations of home-like rather than that of the child or young person. Similarly, some participants flagged that understanding what constitutes a home-like environment for young people placed in care would be complicated. These participants explained that a young person's frame of reference for what is home-like would vary considerably based on their experiences and path into care:

> I've had kids sort of say to me, "Gee, this feels like a school." And I said, "Why do you say that?" And they said, "Well, it feels like a school because look at the size of the corridor." Or, if you like, that's where they're getting their cue from as to what sort of a space it is. The house they came from, I don't know if it was one of the old public housing places. There

> would have been small corridors, and it would have been the living and dining, the lounge would have been jammed in together, et cetera.
>
> Operations and Regulations 1

Compounding the problem with emphasising home-like design is the dual purpose of residential care homes as a home and a workplace. The infrastructure associated with work environments, regulation and legislation (e.g., offices, locks, wide corridors and safety and regulatory features described prior) and the work that care providers undertake in homes, was noted as incongruent with a home environment:

> By the same token, though, they know full well that they're not living in a typical family home and staff walking in and out of the house, they know it's not actually a home.
>
> Frontline 1

3.2 | Therapeutic Environment

3.2.1 | The Current Approach to Therapeutic Environmental Design

The majority of participants felt that the design of a therapeutic support environment was not adequately considered or planned for when planning homes and care services:

> Everyone goes, "We're therapeutically trained" but are you really working therapeutically? You might talk to the kids therapeutically and you do this, but is the space therapeutic? So yeah, I think that's a really wide-open difference of perspective.
>
> Frontline 11

Design improvements were noted in 'new builds' in relation to the kitchen/dining area. Participants described this area as feeling 'safer', more 'functional' for multiple users, and 'less institutional' due to the low reliance on locks and an open-plan design. The increase in safety and improved layout provided more opportunities for social connection and domestic routines, such as communal eating. What constitutes a newer build varied according to the participant, and only select participants had knowledge of newer builds.

Indoor and outdoor areas for recreation and connection were highlighted as critical for creating therapeutic environments but were largely overlooked in planning and funding. This included zoned outdoor areas to facilitate participation in therapeutic, social and physical activities e.g., sheltered seating, gardens, physical activity areas and tailored indoor areas.

3.2.2 | Worker Safety May Be Prioritised Over Therapeutic Outcomes

When discussing therapeutic design with participants, the duality of residential care homes as workplaces and home alternatives came to the fore. While safety for all was particiants' preferred objective, select participants felt that design solutions relating to OHS were prioritised over therapeutic outcomes. Participants attributed this to OHS legislation and the effectiveness of the workplace safety regulator in enforcing legislation. The prioritisation of OHS legislation resulted in culture that was 'risk averse' and 'rigid' and limited the application of design solutions that were child centred.

> If there's a choice, safety [for workers] comes first. That's even true, for instance, in the fact that [the regulator] can come in at any stage and decide that a practice or element of the house is unsafe and give us an order that we have to comply with.
>
> Operations and Regulations 1

Participants questioned why therapeutic outcomes, predominantly safety for young people, were not afforded the same systematic protections and accountabilities as safety for workers. Further, participants expressed concern that the context—particularly the trauma experiences of young people—was not adequately considered when planning for or responding to hazards. As a result, participants felt safety measures implemented to minimise risk for workers could hinder the provision of therapeutic environments and care. Common examples included viewing windows and extensive use of locks throughout houses that signified containment and supervision rather than care and comfort. The division of staff in locked offices and children 'on the floor' further created a power imbalance that was not conducive to the development of a therapeutic milieu. This approach limited the ability of care providers to tailor the built environment to meet the therapeutic needs of young people:

> I still have found though, the biggest constraint to flexibility is perceptions around OHS and risk. That is the constraint that I have stuck with at times, which I don't agree with. Not all of it.
>
> Frontline 24

3.2.3 | Designing for Safety

Therapeutic safety, in the context of residential care, was viewed to consider the physical and psychological safety of young people placed in care:

> Because we often say for kids, when we're establishing therapeutic safety, we're actually talking about what we need to establish first is safety. Because the kid can't engage with people until they feel safe, until they feel that the threat to them, either physically or psychologically, has been minimised.
>
> Frontline 7

While participants identified a wealth of safety measures within homes, they largely felt the measures had a greater

focus on the physical safety than psychological safety. For example, safety features targeted to children and young people predominantly focused on reducing self-harm or anti-social and violent behaviour through the use of anti-ligature fittings and fixtures, surveillance (e.g., surveillance windows and open plan design) and control (via extensive use of locks). However, participants expressed concern that the use of surveillance and locks negatively impacted psychological safety. These participants explained that bedrooms were often a place—and at times the only place—of sanctuary and privacy within residential care homes. Locks on bedroom doors prevented young people from using bedrooms as a quick place of retreat when they felt unsafe or threatened. The emphasis on control as a safety measure was also associated with perpetuating a power dynamic between care providers and young people. Similarly, some participants argued surveillance windows were stigmatising, disempowering and perpetuated a lack of trust.

The use of locks, especially on bedroom doors, and surveillance windows was highly contentious, with little consensus among participants as to the best approach. Many participants advocated for the flexible use of locks throughout areas of the house, based on need. Some participants considered surveillance windows essential to staff safety, while others argued for their immediate removal:

> There's multiple exits in offices. If you're that concerned about being around the young people, use another door... I don't see why there needs to be a [surveillance] window.
>
> Frontline 12

Design solutions for safety included ensuring privacy through the use of ensuites and soundproofing bedrooms and offices, sound dampening spaces, spacing out bedrooms to allow young people to enter and exit bedrooms and homes without confrontation, and clear visibility that promotes passive surveillance and easy exit in the case of behavioural escalation.

3.3 | Safe Workplace

3.3.1 | Building Design to Prevent OVA for Both Residents and Support Staff

Participants felt building design predominantly contributed to the risk of OVA by creating an environment that was triggering for young people. Participants explained that given the prior trauma many children and young people placed in residential care have experienced, their trauma can be easily triggered. The living conditions, institutional aesthetics and risk-averse culture created an environment that could be re-traumatising and escalate aggression. Accordingly, participants advocated for the need to rethink the approach to OHS in homes. They proposed prioritising therapeutic design to eliminate triggers and sources of conflict, to reduce the risk of OVA:

> It's the tension between, is it a safe work environment and is it a conducive family environment for the kids? And we constantly have conversations as if they're two different answers. And it should be the same answer to both of those. The environment that works as a safe environment for the kids should be one in which the behaviour is such that it is also a safe environment for the staff.
>
> Operations and Regulations 1

OVA was also linked to the number of young people residing in a home. Participants widely agreed reducing the number of bedrooms in homes to two or three bedrooms would improve staff ratios and improve client matching, thereby reduce sources of conflict. Participants proposed these outcomes would result in less severe OVA, reduced reliance on control measures that trigger young people and reduce work-related stress.

> I've found it's been more settled as a two bedder. My stress levels for the past couple of months have been very low compared to working in a three bedder to a four bedroom, but we've only ever had three clients at the moment. So even staff burnout, I found in the other house, like the two-bedroom house is a lot lower.
>
> Frontline 12

Some participants stressed that, given the levels of trauma experienced among young people placed in residential care, the risk of OVA would always be present and was escalating over time. As such, it was important for building design to consider how to reduce the risk of, and protect staff from OVA.

3.3.2 | The Roles of the OOHC System and Models of Care Influence Safe Support Delivery

The OOHC system and models of care (e.g., temporary vs. permanent care; care for young children or those with disability vs. older children) can also influence safe support delivery. For example, one focus group noted that young people in more permanent placements may have different needs than young people in temporary care and could benefit from pathways to independent living within the home. Designing placements and care models to reflect these needs may support more appropriate placement and greater stability in residential care.

Many participants felt protection from OVA was already embedded in the current design of buildings, leaving limited scope for further modifications to improve worker safety. Instead, some participants suggested there was too much emphasis on the role of the building and discussed a number of systematic factors that could contribute to or reduce the risk of OVA. Primary among these was training of care providers and how information is shared:

> Our training and orientation, it's about staff knowing where to place themselves because that's often a big contributor with OVAs knowing, okay, keep yourself in a safe space and address things and approach

> things in a safe way, not putting yourself in those situations.
>
> Management 6

In addition, frontline staff highlighted that more information about the individual experiences and preferences of young people would assist in tailoring care and building design to their needs through the identification and management or removal of risks and triggers.

3.3.3 | Staff Spaces and Hazards Other Than OVA

A number of potential hazards related to building design, additional to incidents of OVA, were noted. These included the threat of unwanted visitors and intruders, and risks in the built environment such as trip hazards and non-ergonomic office design. To counteract the hazards associated with uninvited visitors, participants suggested adequate fencing, 'crim safe' on external doors, an intercom at the front door and cameras at entrances. The requisite caging of gas and water pipes and taps was noted as a trip hazard on the sites, on pathways, and in gardens. These cages attracted young people to climb on them, which was also noted as hazardous.

Inside, staff highlighted the design of offices is important to the health and wellbeing of staff, and the need for flexibility in design;

> Our staff offices, in particular at new builds, are not built appropriately. They are too small. They build in desks. You can't have built-in desks. I have someone who is six foot seven.
>
> Frontline 12

Participants identified a need for dedicated staff spaces in residential care, including private shower facilities and safe, comfortable break areas, particularly following incidents involving OVA. Others argued staff should remain primarily on the floor and that shared living spaces should suffice for breaks, with some suggesting smaller offices to encourage engagement. Overall, there was no clear consensus on optimal staff space design however the connection between improving the work environment for care providers and enhancing the quality of care for young people was a recurring theme throughout the discussions:

> 'We need to offer (safety) to carers as well, because carers can't give their best care; they can't offer what the young people need if they are feeling apprehensive or unsafe'
>
> Frontline 7

4 | Discussion

The national and international policy and service shift toward TRC models (McNamara et al. 2022; Victorian State Government 2020, 2016) combined with the growing recognition of the built environment as a critical and modifiable factor in therapeutic and residential contexts (Ames and Loebach 2023; Whittaker et al. 2016), presents an opportunity to reconceptualise residential care. However, this study reveals the complexity inherent in translating therapeutic care principles into spaces that function as both a home and workplace. Overarchingly, the tension between an ambition to provide personalised and therapeutic home-like environments for young people with complex needs, and the need to provide a safe workplace for staff delivering support to them, was apparent. Further, stakeholder perspectives demonstrate how regulatory frameworks, design paradigms and operating models can inadvertently perpetuate institutional characteristics and practices, creating environments that, despite good intentions, can compound rather than ameliorate the trauma experienced by young people in care and the risk of OVA for workers.

Our study found providing a home-like environment was a priority for stakeholders and personalisation was the preferred method for fostering a sense of 'home' and comfort for young people in residential care. This finding builds on previous research underscoring the importance of home-like environments (Monson et al. 2020), linking personalisation and comfort with safety (Moore et al. 2017) and the perspectives of young people with lived experience of residential care (Docherty et al. 2006). While such findings indicate a programme of personalisation is essential for creating home-like spaces that support identity development and attachment, particularly in transient environments like residential care, our findings demonstrate that this seemingly straightforward principle becomes complicated within the residential care context. As participants and prior research highlights, young people in care may have associations with previous 'homes'; given their often-traumatic path to residential care, this makes traditional home-like aesthetics potentially triggering rather than comforting (McCrory and Viding 2015; Tarren-Sweeney 2016; McLoughlin and Gonzalez 2014). Compounding this effect, is the tendency for communal spaces to be personalised according to care providers expectations of home-like rather than child-led (Söderqvist et al. 2016). This is despite participants reporting that when young people are actively involved in personalising their environment, it not only strengthens their connection to the space but also leads to reduced property damage, as they are less likely to express frustration destructively when they feel invested in their surroundings. The imperative to personalise spaces also conflicts with the poor approach to maintenance and repairs and the tendency to apply institutional design conventions reported in the current study. The result is an environment that may achieve surface level home-like appearances while failing to provide young people with the connection and comfort personalisation intends to provide. Collectively, the findings on personalisation highlight the need to develop of a programme of personalisation that employs a collaborative design approach so young people can meaningfully contribute to how their own space is personalised.

Underlying the tension between home-like, therapeutic and work environments in residential care is our finding on the regulatory capture of design decisions, where workplace safety regulation tends to override therapeutic considerations. The design

examples provided by participants (e.g., fire safety equipment, surveillance equipment and extensive use of locks), combined with participants descriptions of the effective enforcement of OHS standards, portray a system that inadvertently contributes to the creation of institutional and surveillance-orientated environment that detracts from the policy aim of providing TRC (Victorian State Government 2024b). Such findings are consistent with research from New South Wales that highlights the challenge with translating TRC policy into applied practice and outcomes for young people (McPherson et al. 2024) and point to the need for concrete design guidelines and practice that balance therapeutic and home-like design goals. Furthermore, the research underscores a need for a regulatory approach that establishes enforceable environmental standards that balance child safety standards and the rights of the child with workplace safety requirements.

Addressing the design and regulatory imbalance requires rethinking how safety is conceptualised and applied in residential care. Consistent with therapeutic and trauma-informed models (Johnson 2017; Whittaker et al. 2016), participants identified safety as critical to home-like and therapeutic environments in residential care. Further, findings indicating a need for a more nuanced and intentional approach to safety that considers both physical and psychological safety align with reports from young people who identified a need to be safe and feel safe when living in residential care (Moore et al. 2017). While current and prior research reveal young people in residential care experience a lack of safety (both physical and psychological) (Moore et al. 2017; Kor et al. 2020), findings from the current study extend this work by linking the built environment with feelings of safety and design decisions regarding the built environment with regulatory frameworks. More specifically, stakeholder insights reveal that designing to prevent OVA benefits both young people and workers, but current approaches often focus narrowly on containment and surveillance, rather than addressing the underlying triggers in the built environment that contribute to distress and dysregulation. A comprehensive safety framework that considers the physical and psychological safety of young people, combined with more balanced regulation could work to move the drivers of design beyond risk-minimisation toward more proactive and therapeutic strategies.

Lastly, this study demonstrates the complex interplay between built environments and broader systemic factors such as model of care, the individual needs of young people and workforce development. Operational factors, such as the number of young people placed in each home, impact both the ability to deliver care safely, and the therapeutic potential of the support system and the built environment. For example, participants widely identified two young people as the ideal occupancy level, linking this capacity to improved outcomes for young people, reduced risk of OVA and decreased occupational stress. The state-wide move to reduce the number of young people residing in homes (Victorian State Government 2020) aligns with such an approach. The differing needs of young people in placements e.g., age, placement length and culture, further illustrate the need for environmental flexibility that can adapt to changing resident profile and care objectives. Similarly, staff training in the management of OVA emerged as an essential complement to OVA protections in the built environment.

5 | Study Limitations

The current study has some limitations. Whilst the research group was able to recruit a number of respondents across both interview and focus group activities, it is important to note that the current study only drew on the perspectives of particular groups of stakeholders being care providers, and the workplace safety regulator of OOHC. It is important to note that no ACCOs or Aboriginal or Torres Strait Islander Peoples were recruited, even though attempts were made to do so. Given the overrepresentation of Aboriginal and Torres Strait Islander children and young people placed in residential care, this poses a limitation which could be necessarily addressed through future targeted research focused on these communities, and design for cultural safety. Additionally, in the current study, all of these stakeholders were based in Victoria, Australia. Future research to understand national perspectives on residential care design and support delivery will be important. Similarly, understanding the perspectives of young people who access residential care is vital and—whilst the research group involved in the current study has some work underway—more is required to listen to and learn from the lived experience of young people. Finally, whilst the current research explored three key concepts guided by three research questions, a broader examination of the built environment in residential care, using mixed methods may be beneficial in future research.

6 | Conclusions

By examining stakeholder experiences in residential care, this study highlights a significant opportunity for reform. The sector's shift toward TRC, alongside increasing recognition of the built environment's role, creates the conditions to reconceptualise residential care not as a site of risk management, but as a deliberately designed therapeutic setting that supports the safety, wellbeing and development of young people and staff. However, findings reveal persistent tension between the multiple functions residential care must fulfil: home and workplace, personalised and therapeutic space and a regulated environment for managing complex needs and occupational safety.

While participants prioritised the creation of home-like environments, achieving this in practice was constrained by young people's prior experiences of home and care, organisational expectations, poor maintenance regimes and persistent institutional design. These constraints diluted therapeutic intent and, at times, compounded risks for young people and staff. Workplace safety requirements were frequently described as overriding therapeutic design goals, resulting in environments that prioritised risk avoidance over emotional safety, regulation and relational care. The findings suggest a need to move beyond surface-level domesticity toward supported approaches to personalisation, and to reconceptualise safety in residential care as encompassing both physical and psychological dimensions. Reducing environmental triggers for young people

emerged as a critical opportunity to shift from reactive risk-minimisation toward more proactive, therapeutic strategies that reduce OVA.

More broadly, the findings underscore the need to better align workplace safety regulation, policy, service design and workforce development with the realities of residential care, bridging the gap between policy intent and everyday practice to improve outcomes for children, young people and staff over time.

Author Contributions

Carmen Schroder: conceptualization, investigation, formal analysis, methodology, writing – original draft, writing – review and editing, project administration. **Olivia Crivari:** conceptualization, investigation, formal analysis, writing – original draft, writing – review and editing, project administration. **Phillippa Carnemolla:** conceptualization, methodology, writing – original draft, writing – review and editing. **Libby Callaway:** conceptualization, methodology, writing – original draft, writing – review and editing.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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