Article

The Care Trajectories and Nature of Care Received by Children Aged 5–11 Who Are in Need of Therapeutic Residential Care

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Abstract: A total of 10% of children looked after in residential care in Scotland are aged 5–11. Although there has been a significant amount of information published about the care trajectories of adolescents in residential care, there is limited information about the experiences of younger children. In this paper, we explore the care trajectories and nature of care received by 5–11-year-olds identified as being in need of residential care. Our results show that younger children who enter residential care have significant trauma histories and experience significant levels of emotional and behavioural dysregulation that foster carers find challenging to manage, resulting in recurrent placement breakdowns. Residential care, particularly small-group-sized care that adopts social pedagogical and psychotherapeutic approaches, was considered beneficial for addressing the psychosocial and emotional needs of younger children. Despite these findings, there were concerns about the long-term use of residential care for younger children. Our results highlight that there is a need to improve access to paediatric mental health services for children in family-based placements. There is also a need to invest in better training and support for foster carers looking after children in severe distress. Community-based outreach services and in-home respite services provided by residential care teams are one way this could be achieved. Finally, in order to promote earlier and more timeous use of residential care, there is a need to shift societal views around residential care being a placement of last resort to rather being a place of recovery and healing that should sometimes be used as a placement of first resort.

Keywords: residential care; foster care; foster care strain; child and adolescent mental health; relationship-based practice; therapeutic practice; looked-after children; care-experienced children; younger children

1. Introduction

Residential care is a form of non-family-based group care, where children and young people are looked after by paid staff who work on a shift basis. There are four broad reasons why residential care is used. First, to provide therapeutic care and education for children with social, emotional and behavioural difficulties, complex long-term disabilities and/or histories of maltreatment, trafficking and sexual exploitation [1–5]. Second, to provide 'respite' care for families and caregivers [1]. Third, as a short-term solution while longer-term family-based placements are identified [2,6,7]. Fourth, as a long-term care placement when suitable family-based care is not available, cannot be sustained or is unable to fully meet the needs of the child [8,9].

There are two types of residential care described within the literature. These are institutional care and therapeutic residential care. Institutional care is characterized by the use of strict routines to provide depersonalized care [10]. It is typically provided within group-living settings such as orphanages, children's institutions, children's homes, infant homes, children's villages and similar residential settings [10]. Therapeutic residential care, on the other hand, has been described as "*the planful use of purposefully constructed, multi-dimensional living environments designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal*

and informal helping resources" [11]. It is typically delivered in community-based children's homes, community schools or through campus-based care environments that combine living and educational facilities [10].

In Scotland, approximately 1300 children are cared for in residential care placements each year [12]. These placements are most commonly used for the purposes of recovery, rehabilitation and treatment [13]. The general approach taken focusses on using relational practice to support the building of safe, secure and trusting relationships [14]. It also places trauma-informed, attachment-orientated and child-development-centred practices at the heart of this practice [14–17].

Although residential care is a significant part of the Scottish care continuum, it is often viewed as "*a placement of last resort*" [18]. There are two key reasons for this. First, proven episodes of historical child abuse have resulted in concerns about the safety of residential care [19,20]. Second, outcomes-based research indicating that children living in residential care experience poorer outcomes than children living in family-based placements has created concerns about the efficacy of residential care. [21–26]. Within Scotland, concerns about the safety and efficacy of residential care have resulted in practitioners adopting a preference for family-based placements [27]. This preference is most apparent for younger children due to local authorities having previously initiated policies that prevented the placement of children under the age of 12 in these settings [27].

Viewing residential care as a placement of last resort can "*significantly underestimate the contribution that they can make, the stability that they can deliver, and the high-quality care they can extend to children who have had terribly fractured lives*" [28]. This is because existing knowledge on residential care outcomes is likely to have been confounded by the conflation of institutional and residential care. For instance, while previous research has consistently highlighted the poorer mental health outcomes of children in residential care, there is evidence that therapeutic care can result in short-term improvements in the psychosocial, behavioural and educational functioning of children [29–31].

The potential benefits of therapeutic residential care are reflected in current guidance to practitioners. This argues that residential care should be considered earlier in the care trajectories of children with substantial histories of neglect, serious attachment problems, complex physical and mental health needs, and increasingly challenging behaviours that are difficult to manage within family-based placements [32]. In all cases, the decision to use residential care should be based on children's needs, rather than their age [32,33].

Children aged 5–11 account for 10% of the residential care population in Scotland [13]. The limited evidence that exists indicates that these children tend to be boys who require additional levels of care and support due to disability, attachment difficulties and engagement in risky and offence-type behaviours. There is also a tendency for these children to exhibit a range of behaviours that caregivers can find difficult to manage, including age-inappropriate sexualized behaviours; controlling, violent and aggressive behaviours; and dysregulated sleep patterns [29,34]. There is no published information on the nature of interventions used to address the needs of younger children in residential care.

In this paper, we aim to expand our knowledge of how and when residential care is used for younger children. We do this by qualitatively exploring four key issues. These are as follows: (1) the presenting difficulties of younger children requiring residential care; (2) the challenges that parents and caregivers experienced while caring for these children; (3) the range of interventions available to children both before and after entering residential care; and (4) perceptions around the continued use of residential care for younger children.

2. Materials and Methods

In-depth individual and paired interviews were conducted with 22 caregivers (12 residential carers and 10 foster carers) between March and December 2020. The foster carers interviewed included both first time foster carers and those with more experience, including intensive therapeutic foster carers. Intensive therapeutic foster carers are foster carers who have undertaken additional training to support them to use trauma-informed

approaches and therapeutic techniques to support the child's emotional well-being and help them develop healthy coping mechanisms and social skills. They usually have a proven record of responding to the attachment and trauma needs of children. The residential carers interviewed included those employed by local authority social work departments and independent providers of residential care.

The majority (n = 20) of the interviews were conducted by telephone or using video-conferencing software due to social distancing restrictions relating to the COVID-19 pandemic. The other 2 interviews were conducted in person prior to restrictions being enacted.

2.1. Inclusion Criteria and Recruitment of Participants

To participate in the study, caregivers had to have experience of caring for a child who: was under the age of 12 and had been looked after in residential care; was under the age of 12 and considered to be in need of residential care by social work; had returned to living in a family-based placement after being in residential care prior to age 12.

The principal method of recruitment involved approaching all Chief Social Work Officers in Scotland and asking for information about the study to be cascaded to their residential and foster care teams. These requests were supplemented with formal approaches to independent providers of residential and foster care in Scotland. Information about the study was also circulated via the social media channels of the Scottish Children's Reporter Administration, the Centre for Excellence for Children's Care and Protection (CELCIS), Children's Hearings Scotland, the Association for Fostering, Kinship and Adoption Scotland (AFKAS), and the Fostering Network. Information about the study was also disseminated via the residential and foster care practice networks operated by CELCIS. Snowballing was used to bolster recruitment by asking participants in the study if they were aware of other carers in their network who met the inclusion criteria.

2.2. Consent Procedures

Information sheets about the study were emailed to all participants at least 24 h prior to being interviewed. The author (CN) reviewed the contents of the information sheet with the participants prior to consent for participation being sought. All participants were asked to give written consent for participation. Individuals who were interviewed in person completed their consent forms directly prior to being interviewed. Individuals who were interviewed remotely were asked to email their completed consent form to CN prior to the interview starting. When this was not possible (i.e., the interview was being undertaken by phone or the participant was experiencing difficulties with their email), oral consent for participation was obtained and the interview was undertaken. These participants were asked to retrospectively complete and submit their consent forms.

2.3. Data Collection and Analysis

All of the interviews were conducted by CN. The interviews focused on caregivers' experiences of providing care to younger children identified as needing residential care. The following topics were discussed: caregivers' understandings of children's backgrounds; the impact that children's backgrounds had upon their behaviour and development; how caregivers worked with children showing challenging behaviour; the support and training caregivers received; how the decision to use residential care for the child had been made; the support available to younger children in residential care; the perceived benefits and risks of using residential care for children's psychosocial and emotional wellbeing; and whether the use of residential care had been the right choice for the child. On average, the interviews lasted 45–60 min.

All interviews were digitally recorded and transcribed verbatim. Transcripts were anonymized prior to analysis by removing the names of any children and places mentioned. The transcripts were then compared with original recordings to ensure that narratives had been accurately captured, with any mistakes or missing segments updated by CN prior to coding being undertaken.

Thematic analysis was used to analyse the data. An initial coding framework was developed by CN. This framework was based on both predetermined research questions and themes identified through close and iterative reading of the interviews. The coding framework was applied to all interviews. Information about whether the coded data reflected a positive or negative representation of residential care was also captured. The initial coding framework was revised abductively. To do this, key messages from the wider literature on residential and foster care practices, as well as the lived experiences of children and caregivers, were used to provide an understanding of the behaviours and practices being described.

All of the transcripts were coded in Microsoft Word using electronic highlighting tools and making annotations within the reviewing pane. An Excel spreadsheet was used for the purpose of collating and consolidating the identified themes.

2.4. Ethical Approvals

Approval for the study and all study materials was provided by the Scottish Children's Reporter Administration's Research Ethics Committee. Consent was not sought to make the raw data publicly available. This decision was made for two reasons: (1) the small number of children cared for in these settings each year increases their risk of being identified; (2) the legal status of the children, many of whom remain subject to legal orders, makes it challenging to obtain fully informed consent for data sharing.

3. Results

3.1. The Presenting Difficulties of Younger Children Requiring Residential Care

Our results indicated that children who are looked after in residential care before the age of 12 have complex trauma histories that are often compounded by the additional health and social care needs of their parents: "*in terms of his experiences, there was drugs, alcohol, lots of domestic violence and lots of people in and out of the house*" (*intensive therapeutic foster carer*. Intergenerational transmission of abuse and violence were also common, as was exposure to poverty: "*their families often have a history of abuse or being in the care sector*" (*residential carer*).

Trauma and adversity were considered to have negatively impacted children's ability to form secure and trusting attachments with adults. These difficulties were often reflected in children's behaviour, with many of the caregivers describing the children they cared for as being overly self-reliant, pushing people away and being unable to seek comfort. For instance, "*when she (age 8) hurts herself, she'll just run off. She'll run to her room. She won't go to an adult*" (*foster carer*). Many of the children were also considered to be overly controlling of both people and their environments: "*He (age 11) cannot let go of the control. He has to keep that control*" (*foster carer*).

It was also common for trauma to manifest itself behaviourally, with many of the caregivers describing the "*challenging*" and "*distressed*" behaviours that the children they cared for had. These behaviours included "*screaming for hours*", "*tearing their hair out*" and "*scratching themselves*". Some of the children, particularly boys, were also engaging in risk- and offence-type behaviours that were alarming their parents and caregivers: "*his (age 11) behaviour in the community was just awful. He was setting fire to the neighbour's house and breaking into the neighbour's car*" (*residential carer*). Others were described as demonstrating age- and developmentally inappropriate sexual behaviours that caregivers had found difficult to manage: "*we have children (aged 5–11) who have quite extreme sexualized behaviours that foster carers struggle to cope with*" (*residential care manager*).

Caregivers reported frequently witnessing destructive and physically aggressive behaviour from the children: "*there was a lot of destruction of property. Televisions. Furniture. Just picking up anything and throwing it at people*" (*residential carer*). This behaviour was considered to stem from the children being hypervigilant and having easily triggered fight, flight or freeze responses: "*this kid (age 10) was constantly on alert and he would fight all the time because that was how he protected himself*" (*residential carer*). Several of the children were

described as having used weapons to threaten or harm their caregivers during periods when triggered. For instance: "*we were eating tea and something just set him off. It could have been something on the plate. Asmell. Some kind of trauma trigger. It just set him off. He became really quite dysregulated, kicking and punching, and before I knew it he had grabbed my steak knife and tried to stab me in the neck*" (*foster carer*). The physical aggression displayed by children during these periods was often directed at the primary caregiver who, in the majority of cases, was female.

The behaviours being demonstrated by children often intensified in the evenings. This resulted in children developing disrupted and dysregulated sleep patterns. When this happened, children were described as "*refusing to sleep*" or "*not sleeping through the night at all*". Some caregivers suspected that the children they cared for were actively afraid of going to sleep: "*she (age 5) was screaming and she would actually urinate on the floor. At nighttime her level of violence would increase and it was just an absolute fear of going to sleep*" (*residential carer*). In these cases, the suspicion was that the children had been sexually abused. In some cases, it was believed that the children had trained themselves to stay awake in order to care for and protect their younger siblings: "*he (age 7) said 'I had to stay awake to look after the baby'*" (*foster carer*).

The trauma histories and the behaviours that stemmed from them were considered similar to those demonstrated by adolescents living in residential care. However, what caregivers frequently commented on was both the "*intensity*" and duration of the behaviours being displayed by really young children. For instance: "*It could be two, three hours sometimes of her (age 7) screaming, rolling around in the mud, tearing her hair out and scratching herself*" (*foster carer*). Similarly: "*she (age 5) was putting herself at significant harm [in foster care]. She was trying to headbutt glass and hanging over bannisters, and she was like that for hours and hours just struggling*".

3.2. The Challenges That Parents and Caregivers Experienced While Caring for Younger Children in Need of Residential Care

Breakdown of foster care placements was a common factor in the care histories of younger children in need of residential care: "*she (age 5) had three foster care placements in three months*" (*residential carer*). Placement breakdowns were usually attributed to foster carers being unable to cope with the intensity of the behaviours being demonstrated by the children in their care. Changing placements often created a vicious cycle, in which children's behaviours became increasingly dysregulated, further increasing the risk of placement breakdowns. For instance: "*the foster carers were just unable to manage so she (age 7) got moved on and her behaviours got worse. Every time she moved, her behaviours just got worse*" (*foster carer*).

Placement breakdowns were considered to happen because the allocation of children to foster families was often based upon availability rather than the careful matching of children's needs against the skills, training and experience of foster carers. This sometimes resulted in first time foster carers being asked to care for highly dysregulated children. Many of the caregivers we interviewed believed that placement breakdowns could have been prevented if the children they had cared for had been allocated to intensive therapeutic foster carers as "*singleton placements*". However, both the limited number of these placements and the intensity of the therapeutic parenting caregivers were already providing meant that these places were not always available. For instance, one intensive therapeutic foster carer told us: "*the social workers were asking for a more experienced foster carer to take her (age 7). Had we not had any additional children when that seven year old came [for respite care] it might have been a situation where I could have helped her, but it just wasn't possible when we already had one with us who as on the verge of becoming that challenging*".

Looking specifically at foster carers' experiences, we identified three main reasons why caregivers struggled to manage challenging behaviours. The first reason related to the "*exhausting*" nature of caring for children with dysregulated sleep patterns. Caregivers who were living with children who struggled with sleep specifically emphasised the toll

that lack of sleep took on their ability to effectively support and care for children during the day. For instance, one foster carer stated: "*we're not wanting him (age 11) to leave here [to go to a residential care placement], but right now he's an 'unloved child'. We're going through the motions. We're washing him, feeding him, putting him to school and giving him hugs and kisses when required. But it's all just going through the motions as we are just so tired*".

The second reason focused on the lack of practical support and interventions available for children in foster care placements. The foster carers we spoke to described being actively dismissed by social workers when trying to gain access to services for children. They also expressed frustration at being offered support that either did not meet the level of need being demonstrated by the child or was being provided by individuals without specialist training. For instance, one foster carer angrily described declining the offer of play therapy for a child who was demonstrating significantly challenging and aggressive behaviours: "*you can hike off with the council play therapist as she's a support worker who has no formal training in play therapy*" (*foster carer*).

Often, the main support offered to foster carers was respite care: "*if you're struggling we'll give you a bit of respite*" (*foster carer*). Planned respite care was not always taken up by the foster carers. This was because some carers believed that using strangers to provide care would be perceived as another form of rejection by the children and would worsen the behaviours being demonstrated. They also worried about the ability of respite carers to cope with the behaviours being demonstrated: "*I don't get a break if I need to go and get him (age 8) in the middle of the night because they can't cope with his behaviour*" (*foster carer*). The ability of respite carers to cope with behaviours was considered particularly important as some foster carers had experienced respite carers actively refusing to look after children they considered to be "*too difficult to manage*". For instance: "*they didn't want to take him (age 11) because he was too high maintenance. There are no carers who will take him so it ends up that we don't get any respite*" (*foster carer*).

The third reason related to the quality of training received by foster carers. Both residential and foster carers identified that foster carers were not trained to deal with complex behavioural and mental health difficulties. For instance: "*the training that foster carers are given is terrible. It doesn't go into any great detail in the training. It doesn't prepare you for the reality*" (*foster carer*). Some of the foster carers felt that there had been an expectation from social workers that caregivers' professional training would help prepare them for caring for children with complex needs: "*what we [retired police officer and manager of a mental health charity] were told was that we would be fine because of our backgrounds*" (*foster carer*). These backgrounds included being employed as police officers, residential care workers, mental health nurses and social workers.

Several of the foster carers revealed that they had tried to address their lack of knowledge by asking to be sent on specialist training courses and investing hours of their spare time researching potential interventions to support the child(ren) in their care. For instance: "*I must have spent hours and hours and hours researching, just trying to find something, anything, to help her (age 7)*" (*intensive therapeutic foster carer*). Two of the foster carers who had asked to be sent on specialist training expressed frustration that there was a lack of funding for foster carers to receive additional training. These foster carers self-funded their training: "*we asked social work for training, but we couldn't get it, so we paid [£600 each] to go on a course to find out more about attachment and trauma*" (*foster carer*).

3.3. The Range of Interventions Availale to Children before Entering Residential Care

Many of the caregivers identified that there were a number of underlying factors that explained the behaviours that they were witnessing. These included the following: the children having never learned how to emotionally regulate; the impact of learning difficulties and developmental delays upon children's ability to communicate; and the impact of suspected or confirmed mental health difficulties or neurodiversity on their behaviour. For instance: "*he (age 10) has been on medication for ADHD since he was in residential so he obviously had ADHD in foster care and it was unrecognized and unmedicated.*

Knowing what we see here, when he is medicated, I can see how his behaviours would have been really challenging to other foster carers" (*foster carer*).

The awareness that there could be an underlying reason for children's behaviour resulted in some foster carers actively seeking support for assessment and treatment from other services, mainly Child and Adolescent Mental Health Service (CAMHS). There were a number of barriers identified to accessing CAMHS. These included complicated referral pathways and the length of time it took for children to be referred, assessed and treated: "*It was a bloomin' nightmare getting CAMHS involved. It took years. We didn't get her diagnosed until she was 13 and we got her at 10. Three years it took us*" (*foster carer*).

One caregiver expressed frustration that poorly worded referrals to CAMHS could result in children being rejected by the service. They could also result in children receiving the wrong assessments and having to go back on waiting lists to be correctly assessed: "*when we got there the mental health nurse said he (age 10) is here for a mental health assessment and I was like 'no... he needs a wider assessment around attachment'. 10 weeks later they said 'he doesn't have mental health difficulties' and we agreed. So off we go back to the doctor to get re-referred. Three months have passed and he goes back on the waiting list for another 6 months, only for it to be rejected*" (*foster carers*).

Challenges to accessing mental health support were compounded by CAMHS being unable to undertake diagnostic assessments or therapeutic work if the children were considered to be too young or "*not stable enough in their placements*" for assessment. Not being in a permanent placement was considered a particular barrier to accessing support: "*psychological services would normally be for a child in a permanent placement. If they are not in a permanent placement it will all need to end again when they move again*" (*intensive therapeutic foster carer*). There was also a perception among some foster carers that services did not want "*to label*" children in care and that this was acting as barrier to children receiving support. This was a particular source of frustration for foster carers as not having formal diagnoses acted as a barrier to caregivers accessing other support services for children: "*on the one hand I can see that you don't want to give children too many labels, but on the other hand a label can help you to push for services*" (*foster carer*).

Several of the caregivers perceived the children in their care to be "*at the end of the queue*" for community-based mental health support. This resulted in foster carers using informal networks and education services to try to understand and support children's mental wellbeing: "*I know the CAMHS team here quite well so it was good to be able to get some informal advice or a suggestion about alternative things that I hadn't been trying with her (age 7)*" (*intensive therapeutic foster carer*). Some caregivers also offered to pay to purchase therapeutic services themselves: "*I said I'll pay for counselling for him (age 10) myself*".

There was a general belief that moving children into residential care increased their likelihood of receiving the intensive therapeutic support that was needed: "*I think in residential care children get the help they need quicker, whether that be educationally, physically, mentally or psychologically*" (*intensive therapeutic foster carer*). One foster carer, when reflecting on the challenges they had experienced accessing mental health support for a 13-year-old who had been looked after in residential care between the ages of 5 and 10, stated: "*she shouldn't have had to go back into residential care (at age 13) to get the support she needed*".

3.4. The Range of Interventions Available to Children after Entering Residential Care

In the majority of cases, the transition to residential care was unplanned and related to a crisis point being reached within the foster care placement. For instance: "*it tends to be that when it's a placement breakdown something has happened after a gradual demise that requires emergency intervention. For the younger children it tends to be a really traumatic event that has happened*" (*residential carer*). There were a few examples within our data of foster carers finding themselves in the uncomfortable position of having to choose which foster child "*in crisis*" they could continue to support and which child would need to be looked after in residential care: "*we lost our girl (age 13, in residential care from 5–10 years old) at that time as*

she moved on to residential as we couldn't cope. We had to choose. It was going to be her or him (age 10). We couldn't do both".

The need for emergency placements resulted in some children being moved rapidly and without any of the preparatory or settling-in work that would usually be undertaken as part of a planned move. It also meant that the decision about which residential care facility to use was based largely upon bed availability rather than a careful consideration of children's needs: "*there were no foster care placements available. We didn't even have a bed available so he ended up sleeping on a day bed in the lounge*" (*residential carer*). In several cases, the need for specialist residential care had already been identified prior to the crisis point occurring; however, the purchasing of these placements had not been completed. This resulted in some children quickly experiencing a second planned move into a setting that was considered to better meet their needs.

The majority of the children described in the interviews were placed into independently provided residential schools and children's homes after an initial emergency move into a local authority children's home. These specialist facilities were considered to offer an opportunity to build a team around children who were demonstrating challenging behaviours. They also provided high staff-to-children ratios, i.e., "*we have 5 members of staff to 4 kids*" (*Residential Carer*). They were also considered to avoid the potential for younger children being placed into a local authority home that was structured around adolescents and where they could be exposed to a range of negative and risky behaviours.

The high staffing ratios, along with the shift patterns that caregivers worked, were considered to be beneficial as it allowed for children to be consistently supported. It also allowed caregivers to focus on building relationships with children. For instance: "*with the high staff ratio we are able to provide support and really get in-depth and speak to the kids and have reflective chats with them*" (*residential carer*). High staff-to-children ratios were also viewed as a means of minimizing burn out when working with traumatized children. For instance: "*I remember how intense it was in terms of the residential perspective, but the strength was that you had a team around the child. I can only imagine how difficult it would have been as a foster parent to try and support those behaviours on a day-to-day basis. It would very quickly wear you down*" (*residential carer*).

Being able to build a team around the child was also considered to be beneficial as it removed the pressure on children to form an attachment with one individual and instead allowed them to choose which adult(s) they wanted to develop relationships with. This was considered advantageous for children who really struggled in family settings, or whose trauma responses were triggered within the family setting. For instance, one residential caregiver described how an attempt to move a 5-year-old girl from residential care to foster care had failed as a result of the child really struggling to live in an environment that mirrored the mother–child dyadic: "*She was trying to kick holes in walls, trying to destroy the house, and just unable to settle. . . but I think it [living with a single female carer] was just too much of a mirror image of what she had had growing up and she just couldn't settle and trust that this person was able to keep her safe*".

The residential carers we spoke with were highly trained individuals who were constantly seeking and receiving support to develop their knowledge of child development and how trauma impacted upon this. This was reflected in caregivers' discussions around the applicability of attachment theory, social learning theory, social pedagogy, the impact of adverse childhood events (ACEs) on childhood development and the early years curriculum to their practice. The training residential carers had received was considered to be beneficial as it helped to contextualize the behaviours they observed from children. For instance, one residential carer reflected that "*we are much more immersed in theory and understanding of theory and why children behave in the way they do. So rather than just dealing with behaviours you are seeing them as symptoms of what's deeper and the trauma that is really there*". The amount of training that the residential carers we spoke to had received contrasted starkly with the training received by foster carers.

Although residential carers emphasised that the use of residential care removed the pressures on children to form secure attachments with their caregivers, they often described the residential care setting as being a "*secure base*" for children. In particular, residential carers spoke about the importance of nurturing the development of secure, trusting and consistent relationships between children and staff. Looking first at the issue of consistency, the majority of the residential carers spoke of the need to provide children with consistency, stability, routine and boundaries. This was considered particularly important given that many of the children were entering residential care with dysregulated sleep patterns and found it difficult to relinquish control to adults: "*we support them in terms of regulating their emotions, regulating their sleep patterns, their eating and all of these things that would have been quite chaotic prior to coming to us*".

Many of the residential caregivers spoke about how their organisations had drawn upon Dyadic Developmental Psychotherapy (DDP) to develop an attachment-promoting service. For caregivers, this meant embedding PACE/PLACE within their practice: "*you have to practice with PACE. That is you have to be playful, accepting, curious and empathic. But recently they've added an L into its. So it's PLACE and it's Love. You bring your whole self to work, and you have to have a glint in your eye, and be curious, and just be alongside the young people*". Playfulness and play-based learning were common themes raised in relation to undertaking emotions work with children. For instance: "*we use lots of visual things that we can use to discuss thoughts and feelings, and we do lots of imaginary conversations through teddies or puppets*" (residential carer). These approaches often reflected the nurture-based play approaches that some of the foster carers had tried to use to help younger children make sense of their worlds: "*At home we were doing the nurturing work. I had a big box of bandages and I would bandage him up like a mummy every night and we'd give him magic creams and magic sprays and magic fingers, and we had all the magic teddies. There was nurse teddy, doctor teddy and mummy teddy. And they all went around his bed on a night time*" (*foster carer*).

Relationships and relational practice were identified as the foundation of residential care: "*a lot of the time it is just the relationships that we use as the intervention. They're the intervention as relationships are the most powerful thing*". In fact, many of the residential caregivers we spoke with described themselves as being social pedagogues, i.e., practitioners who value relationship-centred approaches which aim to holistically support well-being, learning and social inclusion. This holistic approach could be seen in two key ways. First, several residential carers described how the physical environment of the residential care settings they worked in had been carefully designed to try and help children emotionally regulate. This included using space, physical activities, sensory experiences and chillout zones to provide a range of different options that could be tailored to the needs of children and their personalities. For instance: "*we've got bits that go on doors so that kids can hang and stretch and try to regulate their emotions. We've got giant beanbags in place so kids can just jump into them and disappear. We've got kind of hanging baskets that they can just climb into. We've got dark places that they can just go into to cut all of their sensory input. Outdoors we've got lots of big basket swings and trampolines that take account of the idea of regulating emotion through motion*" (*residential carer*).

Second, residential carers talked about the ways in which elements of forest school practices had been incorporated into their relational and nurturing practices with children: "*we've got a huge focus on learning through the outdoor environment*". This included allowing children to develop relationships with animals and introducing elements of monitored risk-taking into play. In many cases, there was a recognition that naturalistic learning practices served as an alternative form of education for children who were not able to engage with more formal education. For instance, one residential carer explained how their setting had taken "*a more pedagogical view that is less driven by league tables and more about encouraging the kids to learn by whatever means there is*". These approaches also recognised that maltreatment and trauma often resulted in children operating at a different development stage to their chronological age: "*we're very clear that we respond to our kids at their developmental stage as*

many of them are much younger developmentally and respond a lot of the time as 2 and 3 year olds" (residential carer).

Placing younger children into specialist residential care was also identified as a means of accessing mental health support that were not available in the community. While local authority care homes tended to rely upon the involvement of looked-after children's nurses to seek advice and support around children's mental health, independently provided residential care placements were often able to purchase psychotherapeutic support for children in the absence of CAMHS services. It was common for children living in these settings to have psychologists and psychotherapists involved in their care: *"we work really closely with the child psychotherapist and the child psychologist and they're very much involved with the therapeutic meetings that we have"* (*residential carer*).

Residential carers described three key ways that clinical staff worked with residential teams to support the care of younger children. First, clinical teams worked with residential caregivers to develop and revise care plans for children. For instance: *"they would support the team in terms of where the child was at just now and the different interventions and strategies that were included within the support plan or the care plan that we had"* (*residential carer*). These plans were described as being regularly reviewed, with the clinical team offering pastoral support and guided reflections with staff members.

Second, they supported residential carers to reflect upon and understand the context of the behaviours that they were observing. This was undertaken through a mix of training, reflective discussion and developing tools that could be used by practitioners to help identify developmentally appropriate behaviour. For instance, one residential carer described how they had asked their in-house clinical psychologist to help develop a tool that could help caregivers to identify whether children were reaching developmental milestones: *"I was thinking how do we help our adults understand where that child might be emotionally and socially? So I had a conversation with the psychologist and she helped develop a template that carers can use to match [the behaviour] against a list of milestones that children should be able to do between the ages of 0–2, 2–5 etc."*.

Finally, in-house or purchased clinical resources were commonly used for the purpose of conducting therapeutic conversations with children or supporting caregivers to have conversations with children around their behaviours and needs. For instance, one caregiver reflected on the role that the clinical team played in supporting conversations with children about their involvement in risky behaviours: *"sometimes they would get involved in that conversation with the young person and the staff member, and other times they would just give advice to the staff member who was going to have that conversation about different ways of approaching it"*. One aspect of the support that residential carers particularly valued was the space that psychologists provided for them to reflect on their practice. This was considered particularly useful if there had been an incident within the residential care setting, as it allowed carers an opportunity to reflect on all of the factors that might have contributed to the incident, including their own reactions to children's behaviour and how these could be better managed. For instance: *"we create a lot of space for staff members to reflect and talk. . . and think about what their triggers are and how to understand the kids triggers as well"* (*Residential care manager*).

3.5. Perceptions on the Future Use of Residential Care for Younger Children

Many of the residential carers that we interviewed felt that residential care, particularly therapeutic residential care, was not used early enough within the care trajectories of children who were demonstrating challenging behaviours within family-based placements: *"the research and the evidence is overwhelming that the earlier the intervention is the better the outcomes are. I think there are potential benefits of using residential care earlier"*. Some residential carers felt that using residential care earlier in children's trajectories could minimize some of the drift and delay that children experienced as a result of placement breakdowns. For instance, *"it would probably be most successful if local authorities didn't see residential as a last*

resort and actually used it as a first resort in some occasions so that there hadn't been such significant breakdowns in foster care".

It was identified that one of the main barriers to residential care being used earlier in children's care trajectories was the costs of commissioning these services. This was particularly identified in relation to specialist therapeutic providers of residential care: "*because of the cost of a service like ours local authorities are reluctant to place children unless they feel it has gotten to that last resort*". Another barrier to earlier use of residential care services for younger children was the perception that these settings were "*loveless*" "*institutions*" that could not replicate the emotional security that could be provided by living in a family-based placement. For instance, one foster carer told us: "*when she was in residential nobody touched her. They didn't touch her. She was six and had learning difficulties and she hadn't had a hug in all those years*".

Concerns about institutionalisation were particularly common among foster carers, many of whom described the impact this had on caring for children returned to family-based placements. For instance: "*she (age 10, lived in residential care from age 5–10) was completely institutionalised. It was awful. She would ask which one of us is going to be staying up overnight. 'Who is on duty?' 'Who is going to be awake?' And she would expect to be able to get up and just talk to the staff in the middle of the night*". To minimize the risk of institutionalisation, it was identified that the main use of residential care for younger children should be to provide short-term rehabilitative and therapeutic interventions for younger children: "*it should be an intervention and not a destination. It should be used as a period of calming and settling before matching and moving onto foster care or kinship care, or if the work is being done with the family then you go back to the family*".

Although this was the aspiration, it was not uncommon for caregivers to describe younger children who had been living in residential care for 3–5 years. This was particularly common for children who had both complex trauma histories and complex health needs and who needed significantly more preparation and support to be able to live in a family-based placement. For instance: "*she (age 9) has been here since she was 6 and they are looking for permanency. Social work are in agreement about her remaining here until we can get the autism assessment done. It's not writing off foster care completely. We just have to take it at a slower pace*".

The longer-term nature of placements meant that several of the residential carers spoke of caring for children who were at risk of "*ageing out*" of their residential care placements. This was because their registrations did not permit the establishment to care for older children. Two of the residential care providers we spoke with told us that their organisations had specifically changed their registration status to allow children to remain in their homes beyond 13 or 14 years of age. For instance: "*it didn't feel right for a kid at 14 years old to have to leave behind what had become their family and what had become their support network so about 2 years ago we changed our registration to allow us to keep the kids right up until their 18th birthday*". Addressing the continuity of care for younger children in need of longer-term residential care was considered an issue that needed to be addressed.

When asked how residential care could be improved for younger children, several of the residential carers highlighted how their skills could be used to provide earlier support for families and caregivers with children on the edge of residential care. For instance: "*I think the role of residential care should be to get in and around the family and support that family with their wee person. I'd like to see residential units becoming more like a family support service that services their locality or neighbourhood*". This was an approach that some residential providers were trying in order to promote the sharing of knowledge around children's behaviour: "*that was the beauty of being hand in hand with the fostering team. . . there was that seamless link where we (residential carers) are able to share our knowledge, insight and understanding of the children with the foster team*".

Some of the residential carers identified that using residential care to provide support in this way could reduce the number of emergency admissions to residential care for younger children. It was also considered to support better transitions between residential and family-based living. For instance, one residential carer recalled how the children's

home she had worked in had provided support for parents: *"we had a brother (age 4) and a sister (age 8) with us for about a year and we did extensive parenting work with their parents and they went home. They would come into the unit at bedtime and alongside staff they would learn how to do a bed time routine and things like that. And our staff would go into their home at crucial times and just watch what was going on and give praise and support"*. Another recalled a similar offering that had been in place for foster carers: *"we used to do a thing in this area where each of the residential care homes knew the foster carers that were in the locality and they could phone for support from the residential care officers, particularly at night"*.

One independent provider of residential care was piloting a service which would provide additional training and support to foster carers looking after 5–11-year-olds who had previously been in residential care. The children involved in the pilot had all had difficulty settling within family-based placements and were living in small group care settings with high staff-to-child ratios. All of the children had received psychotherapeutic support, and the residential carers were working with the children to prepare them for living in a family-based environment.

Prior to entering foster care, children were carefully matched with the foster carers, and a residential care worker was allocated to the family to provide in-home support and respite care. The level of support allocated was based on the assessed needs of the child. For instance, one foster carer who was looking after a 12-year-old boy who had been in residential care since he was 9 described how they had *"had keyworkers coming in from [the residential care centre] to support us twice a week for about four hours and then another day for about six or seven hours"*. Another told us that they had been allocated *"37 hours a week of keyworker support"*. Regular reviews of the support provided were undertaken to allow it to be both increased and decreased as required.

This type of partnership working was considered particularly beneficial as it allowed for the residential care ethos of building a team around the child to be extended into family-based placements. It also allowed the child's place within the residential care setting to be maintained while it was ascertained whether a family-based placement could be sustained. The importance of this was emphasised in the case of one child, who became *"highly distressed"* as a result of the move and returned to living in residential care. Her residential carer told us: *"we'd managed to get her (age 6) to a point where she was calm and we found an intensive foster care placement for her, and within six weeks that broke down and she returned to us. There was a package of support fit around her needs. She was initially getting 37 hours a week of support, but towards the end it was near enough around the clock…. with people having to be sent down to provide additional support. It wasn't feasible for anybody to sustain"*.

One of the key benefits of residential carers working with foster carers to provide this additional support was that it provided both children and caregivers with a larger support network: *"we've ended up doing more things with the keyworker rather than them coming in to give us a break. It's like he's the uncle of the family, and it's not about us getting a break from [the child] or us getting a break from him. It's about being together as a family"*. Although this continuation of relationships was viewed as important, it was highlighted that this type of collaborative working could not be implemented without additional resources. In order to minimize the time that younger children with complex trauma needs spent in residential care, it was identified that there was a need to invest in the following: the provision of mental health services for children; additional support for foster carers caring for children whose placements were at risk; and both upskilling and supporting foster carers to better recognise and respond to the mental health needs of younger children. The latter of these was considered particularly important as *"there is a lot of focus on getting children into CAMHS and external therapies, but if we could upskill and train the adults that are around the children they would have the confidence to approach and respond to these situations"*.

4. Discussion

Our results highlight that 5–11-year-olds who are looked after in residential care often grow up in households characterized by parental mental ill-health and substance misuse,

poor parenting skills and exposure to interpersonal violence and abuse. These findings, while providing insight into the lived experiences of younger children entering residential care, are not novel. Instead, they replicate findings from previous studies highlighting the presence of parental mental ill-health, substance dependency, interpersonal violence, poor parenting and maltreatment in the backgrounds of adolescents entering residential care [35,36].

Younger children in need of residential care had complex trauma histories that manifested in a range of dysregulated and developmentally abnormal behaviours that parents and foster carers found difficult to manage. These behaviours included age-inappropriate sexualized behaviour, violent and aggressive behaviours and being overly controlling of their environment and people. Many of the children also experienced dysregulated sleep and had significant difficulties regulating their emotions. The range of behavioural difficulties described builds upon existing knowledge of the characteristics of 5–11-year-olds, particularly boys, in residential care [27,29,34]. It also reflects the finding that adolescents in the care system are more likely than their peers to experience mental health difficulties, display harmful and age-inappropriate sexual behaviours, demonstrate offence-type behaviours, have insecure and disorganized attachment styles, and be overly controlling of situations and people [36–38].

Many of the children discussed within the study had experienced multiple changes in caregivers prior to entering residential care. The range of difficulties experienced by children and the challenges caregivers experienced in managing these were frequently cited as a reason for the breakdown of family-based placements. Our findings suggest that the experiences of caring for children who have trauma-driven emotional and behavioural difficulties extends beyond normative parenting experiences and places significant strain on foster parents. Fostering strain has been shown to reduce the parenting capacity of foster carers, resulting in carers becoming less attuned and responsive to children's needs [39]. This was something that was discussed in this study, particularly in relation to the effect that sleep deprivation had upon caregivers' ability to sustain the level of support needed by the children in their care.

Lack of support, conflict with social workers and poor access to services can compound fostering strain [40]. These were all issues that foster carers in this study raised, with many of those we spoke to seeking out informal support networks to try and address these gaps. The reliance on informal networks by foster carers is not a new phenomenon. In fact, previous research has indicated that the use of informal support networks by foster carers is associated with their ability to sustain fostering [41].

Although informal support may offer some benefits to foster carers, there is a danger that these individuals, through lack of understanding and training, could provide advice that exacerbates the difficulties being experienced. The use of informal support also raises questions about the extent to which seeking advice from others, even if they could be viewed as 'in trust' due to the role they occupy, would breach children's right to privacy. To minimize these risks, there is a need to ensure that foster carers are provided with support by individuals who have a detailed understanding of the impact of trauma on child development. Our findings indicate that using trained residential carers to provide in-home support and respite for children with complex support needs could be one way of addressing this.

Ensuring that foster carers, particularly those who are not registered to provide intensive therapeutic foster care, are not placed in the position of caring for multiple children exhibiting the levels of distress reported in this study is also important. No caregiver should be placed in the position of having to actively choose which child they have the capacity to support. This is particularly important given the difficulties that foster carers in this study encountered around accessing mental health assessments and therapeutic support for the children in their care.

Concerns around accessing mental health support for children, particularly those in care, are not new. In the UK, less than 1% of health funding is currently spent on mental

health service provision. In the light of the COVID-19 pandemic, calls have been made for significant investment in CAMHS provision. This includes a recognition that there needs to be increased investment in mental health service provision for children under the age of 5 [42,43]. The current lack of investment in mental health provision for children and young people can be seen in the fact that just one in four children identified as requiring mental health treatment go on to receive it. It is likely that this figure is lower for children in care, as a survey conducted in 2010 revealed that one in two children in foster care with identified mental health difficulties were not receiving CAMHS [44].

Limited resources within CAMHS means that access to services is now often prioritized for children who are actively suicidal, anorexic, severely depressed or demonstrating actively dangerous behaviours [43]. Lengthy waiting lists also mean that one in five children who require treatment wait four or more weeks to receive it [42]. While the targeting of limited resources at those children most at risk is understandable, the limits on CAMHS provision does not help caregivers who are struggling to manage challenging and developmentally abnormal behaviours.

In the absence of increased funding for CAMHS, our results highlight the need for foster carers to be adequately supported to better understand the emotional and behavioural problems that children in their care are exhibiting. Providing psychotherapeutic parenting support for foster carers may be one way of doing this. Promising examples of work in this area include the evaluations of the following: (1) the Reflective Fostering Programme, a trauma-informed group-based psycho-educational programme that is designed to help foster carers reflect upon how they experience, respond to and manage challenging behaviour [45,46]; and (2) Dyadic Developmental Psychotherapy provision for foster carers [47,48].

The formation of close and committed relationships between staff and children in residential care has been identified as a form of therapeutic intervention in its own right. This is because it can provide children with a secure base [14–17]. The residential carers interviewed in this study situated relational practice at the heart of their work with children. Descriptions of their practice largely reflected the models of place-based and relationship-focused care that have been identified as exemplars of best practice within residential care [49]. It was also clear that the residential care workers we interviewed were drawing heavily on social pedagogy and were trying to create a holistic and child-development-focused approach to identifying and addressing the needs of children. The extent to which this was delivered accordingly cannot, however, be assessed.

Social pedagogy embeds the idea of working alongside children and young people to foster well-being, learning and social change through both formal and informal learning activities. For children in care, the adoption of social pedagogical approaches by caregivers has been associated with reductions in daily conflict, lower levels of running away from placement, increased engagement in education and caregivers being increasingly perceived as being emotionally warm. It has also been identified as a tool through which to promote greater staff cohesion in residential care by providing a shared language, ethos and culture [50]. In the UK, the evaluation of "head, hearts, hands", in which social pedagogical approaches were adopted into foster care, found early signs of placement stability during the latter stages of delivery [51].

It is this stability that the use of residential care for younger children appears to bring. For instance, a previous study conducted by Nixon and Henderson [29], which explored the case files of 135 children aged 5–11 in residential care, concluded that residential care can act as a stabilizing environment for younger children with challenging behaviours. In particular, the study concluded that within two years of entering residential care, there had been significant reductions in the number of behavioural difficulties displayed by children and an improvement in their mental wellbeing. Much of this improvement was attributed to the fact that three-quarters of the children had experienced either no placement moves or just a single move to a planned specialist therapeutic placement within that period.

While none of the caregivers we spoke to in this study wanted to see younger children living in long-term residential care placements, it was not uncommon for the 5–11-years-olds that the caregivers spoke of to have been living in residential care for 2–5 years. This echoes our previous finding that 82% of 5–11-year-olds who enter residential care remain living in these settings two years later [29]. The likely explanation for the length of these placements is that the severity of distress and emotional dysregulation that the children were experiencing upon their admission into care, along with the stability that was then created, resulted in decisions being made to maintain these placements. This raises the question as to whether earlier entry to residential care for younger children could have resulted in an increased likelihood of the children being rehabilitated into family-based care or indeed whether the use of shared care or the provision of edge of care services by residential care providers could have resulted in younger children's places within foster families being maintained. Future research should explore these issues.

Residential care, particularly when delivered therapeutically, has the potential to improve outcomes for some of the most emotionally vulnerable children in society, which highlights the need to significantly reframe how residential care is viewed. Within this study, we continued to hear residential care being framed as "*a last resort*" for children and young people, rather than being actively considered as a potential "*first resort*" for those children who were clearly struggling to develop the safe, secure base that is needed for healthy development within family-based placements.

Many of the foster carers considered the use of residential care to be potentially harmful for younger children. What we heard instead were multiple examples of child-centred and trauma-informed relational practice being undertaken to support the recovery and rehabilitation of children with significant and complex needs. The most prominent concern among foster carers related to younger children becoming institutionalized. Within this study, the use of this term very much focused on the entrenchment of children in systems, language and routines that seemed foreign within the context of the family home. Most importantly, it did not reflect concerns among foster carers that the children in their care would be placed into large group homes offering depersonalized care. These findings raise questions as to whether residential care is being commonly conflated with institutional care and whether this would act as a barrier to the use of residential care at an earlier point in children's care trajectories.

In order to alleviate any potential concerns about the impacts of therapeutic residential care, there is a need to explore whether the conflation of institutionalized care and residential care has had an impact upon the findings of outcomes-based research. For instance, it is widely known that the use of large-scale institutional care results in particularly poor outcomes for children [52]. However, the same may not be true of residential care that offers psychotherapeutic and pedagogical parenting practices within the context of "*homely*" care with high staff-to-child ratios [53–59]. Combining these types of care could therefore result in any measurable benefits of therapeutic residential care being effectively cancelled out. Future research should therefore aim to fully explore the extent to which the effects of residential care can be disaggregated by the nature of the care that children are receiving.

Our results also highlight that there is a need to better inform individuals about the role that residential care can play to support children with complex trauma and behavioural histories. Moving the discourse away from placement type to placement purpose [60] would be one way of addressing these concerns, as our data suggest that negative attitudes towards residential care can act as a barrier to the use of earlier and more timeous interventions for children in crisis within family-based placements.

One particular barrier that needs to be addressed relates to the potential role that perceived differences in parenting practices between residential and foster care might be playing in perpetuating the view of residential care as a last resort. This observation is based upon our findings that foster carers who rehabilitated children from residential care settings were often frustrated by the parenting practices within these settings, many of

which they described in ways that suggested they found the parenting styles used to be too permissive and lacking the structure that would normally be seen within a family home.

This finding is not new. For instance, an evaluation of the use of "head, heart, hands" with foster carers concluded that some foster carers considered the approach to be too permissive, while others felt that the principles did not fit with the existing practices for caring for children in foster care placements. If social-pedagogical approaches are to continue to form the approach to parenting that should be adopted for children in care, then there needs to be further research conducted to understand how differences in existing local practices, culture and attitudes towards different parenting approaches across the care continuum affect the adoption and implementation of social pedagogy [61].

5. Conclusions

The care trajectories of younger children who enter residential care are complex and reflect the effect of trauma, placement instability and lack of community-based support to address the psychosocial and mental health needs of this population. It is clear from our findings that there continues to be a need for increased investment in support for foster carers, with psychotherapeutic support identified as something that could be particularly beneficial. There is also a need to address the crisis that exists in mental health funding for children and young people in both Scotland and the wider United Kingdom, and more consideration needs to be given as to how the mental health of children in care is addressed given the challenges that placement instability place upon accessing assessment and treatment. Finally, there needs to be greater recognition that residential care, in particular small-group-sized, therapeutic and relational care for children, can promote stability and have beneficial effects on their psychosocial well-being. To address this, there is a clear need to continue shifting the view of residential care as a placement of last resort and instead work towards creating an ethos within social services wherein therapeutic residential care is viewed as a resource that can be used earlier in children's care trajectories for the purpose of rehabilitation and recovery.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Ethics Committee of the Scottish Children's Reporter Administration (17 December 2019).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study cannot be shared as informed consent for data sharing was not obtained from the participants.

Conflicts of Interest: The author declares no conflicts of interest.

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