“You need to know [their] soul, what makes them tick”: residential support workers’ perceptions of their role in a therapeutic setting

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THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	**Professional Doctorate in Clinical Psychology**
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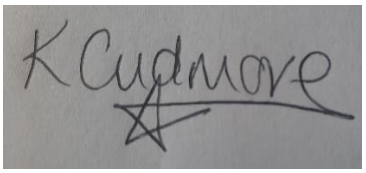
Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed:  Date: 24.05.2024

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Contents

Thesis abstract

As part of a Professional Doctorate in Clinical Psychology, the author of this thesis was particularly interested in exploring the experiences of support workers working in residential children's care-homes.

Paper 1 presents a literature review of nine published studies that investigate the outcomes for residential children's home staff after being trained in trauma-informed care (TIC). The studies were critically appraised using the Crowe Critical Appraisal Tool (CCAT) and a narrative synthesis was undertaken of the findings. The findings indicate that there are some trends in the effectiveness of training, including improved, attitudes towards TIC, TIC knowledge, understanding of children's behaviours and emotions, self-reflection skills, and understanding of relationships. Barriers to implementation of training into practice were identified including availability of resources. There is need for more research on the outcomes for staff after TIC training.

Paper 2 is an empirical study which used Reflexive Thematic Analysis (RTA) to explore residential children's home support workers' perceptions of their role in a therapeutic setting. Findings suggest that these support workers are skilled in their therapeutic work but may benefit from ongoing support from Clinical Psychologists to maintain their confidence and skills in this area. Difficulties with guarding their emotions in their work, and systemic conflicts were identified. These are protected by support from management, with shared debrief and reflection in teams. Suggestions are made for supporting these teams using the clinical consultation already offered by Clinical Psychologists. Future research should look at the understanding of what 'therapeutic work' means in care-homes.

Paper 3 is an executive summary written as an accessible account of the research for the participants who took part in this research, but can also be used to disseminate findings to those interested in the experiences of residential children's home support workers and their perceptions of their role in a therapeutic setting, including professionals working with these teams and developing these services.

Paper 1: Literature review

Outcomes for residential-children's-home-staff after being trained in trauma-informed care models: A literature review

Word count: 7998

This literature review is intended for publication in the journal 'Child and Family Social Work.' Author guidelines for the journal can be found in Appendix A. Further modifications will be made before submitting to the journal to meet these guidelines.

Abstract

Residential-children's-home-staff (hereafter referred to as "staff") work in difficult emotional environments with children with complex needs. It is essential that they are trained to understand the experiences and perceptions of the children they work with, and develop an understanding of their own responses to this complex work and working environments. Trauma-informed-care (TIC) training aims to improve understanding of how historical experiences of children influence their behaviours in their current life. There are limited models of TIC training developed for residential-children's-care-homes (hereafter referred to as "care-homes").

This review aimed to synthesise research investigating the outcomes for staff after being trained in TIC. A systemic search of ten electronic databases was conducted. Nine studies were selected that met inclusion criteria. These were critically appraised using the Crowe Critical Appraisal Tool (CCAT). A narrative synthesis was undertaken of the findings.

The findings indicate that there are some trends in the effectiveness of training, including improved attitudes towards TIC, knowledge, understanding of children's behaviours and emotions, self-reflection skills and understanding of relationships. Barriers to implementation of training into practice were identified including availability of resources.

This review identified the need for more research on the outcomes for staff after TIC training.

Keywords: trauma-informed, children in care, looked after children, substitute care, residential care homes.

Introduction

Care-homes offer substitute care where children have physical, emotional, and mental health needs that can't be met in other care arrangements, (e.g., foster care or adoption). Children living in residential-care have complex needs due to the developmental trauma they have often experienced (Felitti et al., 1998). Children living in residential-care may have limited or restricted access to the biological attachment figures in their life. As a result, staff can often be the most consistent presence and influence in a child's life, playing vital roles in helping to provide parenting for these children. The NICE guidelines for looked-after-children recommends that staff provide genuine, caring relationships to children in their care, and treat them as 'one of their own' (NICE, 2021). To do this, there is an expectation to maintain 'family' roles in the workplace, such as, adopting a parenting role. Consistent with evidence-based guidance (e.g., NICE, 2021), residential care teams in the UK are widely supported by clinical psychologists who offer clinical supervision and consultation, mainly focused on promoting TIC, and the forming and maintenance of attachment relationships between staff and children.

Although there is no requirement, some care-homes train in TIC approaches to understand the children they work with and adapt their working practices accordingly (UK Government, 2023). This differs between organisations, including the length of, regularity and quality of, training. There is a need to better understand the impact on staff and the children living in their care, however no review to date has examined this.

It is known that caring for traumatised children places staff at risk of vicarious trauma (indirect exposure to trauma through the first-hand account from others), burnout, and blocked-care (Ireland et al., 2022), where prolonged exposure to stress supresses staff capacity to sustain empathic feelings towards children. The potential implications of this are high turnover of staff and sickness. Lack of consistency in staff teams can perpetuate attachment difficulties for the children (Assouline & Attar-Schwartz, 2020) and add extra workload for the staff team. This can also result in the 'family roles' adopted becoming a secondary priority alongside practical duties in the workplace (Munro, 2011; Furnivall et al., 2012; Parry & Jay, 2022).

TIC approaches support understanding of the earlier traumatic experiences of the child and how these may lead to behaviours or difficulties later in life (Reeves, 2015). TIC models work on the principles of: realisation of the trauma, recognising

signs and symptoms, and preventing re-traumatisation (UK government, 2022). The TIC approach acknowledges that it may not be possible to replicate a full family unit for the child (e.g., due to staff working shift patterns or substitution of family hierarchies with management structures in homes, such as a homes manager or keyworker). The type of models and approaches which can be recommended are The Sanctuary Model (Bloom, 2013) and The Attachment, Regulation and Competency (ARC) Model (ARC Framework, 2024), although a variety of models exist, including more general models of therapeutic care and those developed by in-house clinician led teams, often underpinned by attachment and family models (Beeghly et al., 2016; Siegel, 2020; Fonagy & Target, 1996; Fenton, 2015) and developed using the assumptions of a 'usual family unit' (e.g., for foster families).

To evaluate the outcomes of TIC training for staff it is useful to assess TIC knowledge and attitudes, understanding of self and others, and culture and dynamics in the workplace. There is some research which looks at the effects of TIC training on the outcomes for children living in residential-care, (e.g., the child's perception of staff roles after training, and number of restraints) (Matte-Landry & Collin- Vézina, 2022). In 2018, Bailey et al., completed a review looking at the outcomes for children living in out-of-home care settings, after the staff working with them had completed TIC training. They found that TIC training had positive outcomes for children including, behaviour and wellbeing improvement and anxiety reduction. They suggested that future research should focus on evaluating the efficacy of training on outcomes for staff. Reviewing outcomes for staff is helpful to understand the components of TIC training which are useful in their work. In this review several different TIC models are used including approaches from an organisational and direct working level.

Rationale and Aims of the Review

Staff are sometimes trained in TIC, usually offered with aim to better understand and manage the needs of children with complex needs living in residential-care. There are few training models which are developed specifically for children's residential care workers (Brend et al., 2020), so there is need to better understand the outcomes of TIC training on staff, to develop, improve and better tailor training to these organisational contexts.

The aim of this review is to synthesise research looking at outcomes for staff after being trained in TIC. This review looks at outcomes which evaluate TIC

knowledge and attitudes, understanding of self and others, and culture and dynamics in the workplace.

The question addressed by this review is, 'what are the outcomes of training in TIC for residential-children's-home-staff?'

Method

Search Strategy

Scoping searches were completed on Google Scholar and Cochrane databases between 12th May and 20th May 2023 to establish if any previous reviews had been completed, to determine if the proposed review was viable and novel, and to refine search terms due to the diversity of terminology used by researchers.

Searches were conducted between 20th and 30th May 2023. Search terms were determined from scoping searches, search terms used in previous reviews, reading relevant literature and discussions with a supervisor and an academic librarian. A search strategy and inclusion criteria was developed (Booth et al., 2022; Cooke et al., 2012) (table 1).

Table 1 Eligibility criteria for inclusion in review

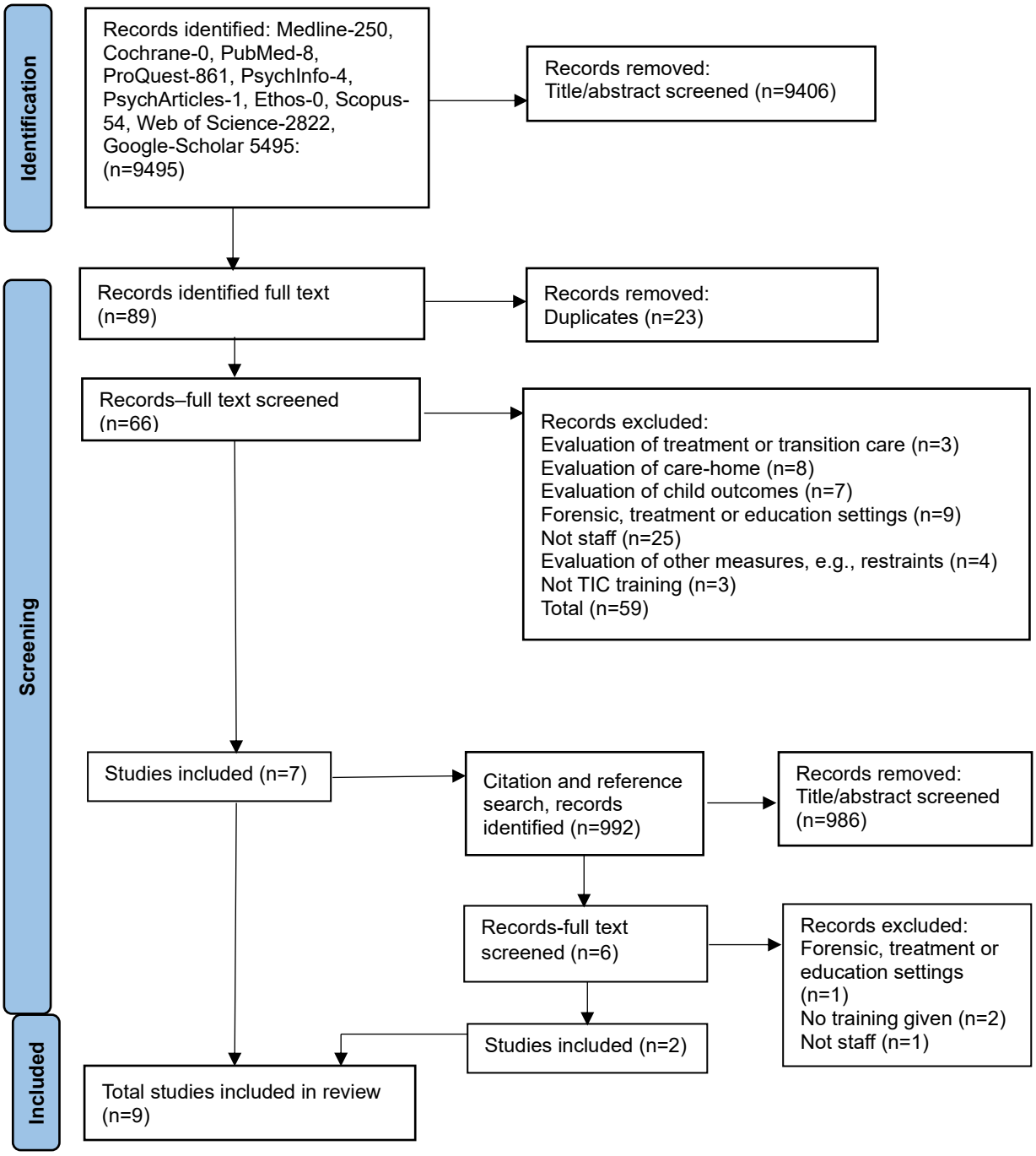
Criteria	Inclusion	Exclusion
Population	Staff – including direct and indirect staff (>50% direct staff)	Not staff – e.g., foster or kinship carers OR mixed staff with <50% direct staff Forensic/secure/YOT/education/treatment centre
Intervention	TIC training delivered to staff	
Publication type	Peer reviewed research articles and theses	Review, commentary, editorial, perspective/opinions piece, policy document
Language	English language (or translated)	Non-English
Objective	Looking at post TIC training effects on staff	Review or evaluation of training model
Outcomes	Staff completed TIC training and post-training outcome measures or interview	TIC training completed but no post-training outcome measures or interview completed Evaluation of children's outcomes

Systematic searches were completed using Medline, Cochrane, PubMed, PsychInfo, PsychArticles, Scopus, Web of Science and Google Scholar. The Google Scholar search resulted in 5490 papers, but only offered viewing of the first 2000, therefore these 2000 papers were reviewed. No limiters were used due to this review being novel. To minimise publication bias a search of grey literature was completed using ProQuest and Ethos. There were no theses identified that met inclusion criteria.

The following search terms were used: (“trauma informed” OR “trauma-informed”) AND (“residential care” OR “out of home care”) AND “child*” AND (“intervention” OR “outcome”). The terms “intervention” OR “outcome” were used in place of the term “training” based on scoping results. These search terms were altered for the Web of Science search to increase specificity of search results: “trauma informed” OR “trauma-informed” AND (“residential care” OR “out of home care”) AND “child*” AND (“intervention” OR “outcome”). The protocol for the review was not pre-registered

The search strategy is depicted in the PRISMA diagram (figure 1).

Figure 1 *PRISMA flow chart showing the search and selection process* (Moher et al., 2009)



After screening 9495 titles/abstracts, 9406 studies were removed. From the 89 studies remaining, 23 duplicates were removed. The full texts of 66 studies were reviewed against the selection criteria. Seven articles were included. Citation searches using Google Scholar and manual reference list searches were completed of these seven articles. This yielded an additional 6 articles which were reviewed against the

eligibility criteria. Two additional articles were included. Nine papers in total were included in this review.

Definitions used in review

Diversity of terminology was used across the studies. This is understood based on the different countries and terminology used in different working sectors, e.g., social care. For this review the following terms are used:

- Staff – staff working in residential-care. Widely categorised as 'direct' and 'indirect,' referring to different profession's interactions with children, e.g., 'direct' includes support workers and 'indirect' includes administration staff.
- Care-home – children's homes, sometimes referred to in the studies as 'out-of-home care.'
- TIC training (HM Government, 2022) – trauma-informed training offered to care workers to:
    - understand that trauma can impact a person's neurological, biological, physiological, and social development
    - recognise the signs, symptoms, and widespread impact of trauma
    - prevent re-traumatisation

Publication bias

Publication bias is where the outcome of a study or research biases the decision of whether this is published or not. This can result in bias towards significant effect findings and a lack of transparent understanding of the evidence around an area or issue (Song et al., 2013). For this review, Google Scholar and the British library database Ethos were used to check for publication bias by searching the grey literature. No relevant grey literature was identified from these searches. No non-English language papers were identified.

Data Extraction

The following data were extracted from each study: author, year, location, aim, sample, training, measures, data collected, analysis, key findings, limitations, and quality score. See table 2 (and appendix B).

Quality Assessment

The papers were critically appraised by the author using the Crowe Critical Appraisal Tool (CCAT) (appendix C) which can be used when considering a range of methodologies (Crowe et al., 2012). This is beneficial over using different appraisal tools for each different methodology and gives a useful overview of different papers using one appraisal tool, therefore giving comparative outcomes. The papers were a mix of qualitative, quantitative, and mixed-method designs so this was considered an appropriate appraisal tool. The CCAT user guide was used as Crowe (2015) recommends using this to inform use of the CCAT form to maintain validity and reliability of scores.

Consistent with the CCAT guidance each paper was read twice, one time for completing each side of the CCAT form. The CCAT has 22 items divided into eight categories: Preliminaries, Introduction, Design, Sampling, Data collection, Ethical matters, Results and Discussion. Each item has multiple descriptors to consider in appraising and scoring. Each category receives its own score on a six-point scale from 0-5, scored as a whole number. A total score from 0-40 and percentage score are offered, but the CCAT guidance states that this should be taken in context with the knowledge of the category scores. Given the limited research in this area, no study was excluded from this review based on its quality score. See appendix D for scores.

Data Synthesis

Using guidelines from Booth et al. (2022) a narrative synthesis was conducted. The intention is to integrate qualitative and quantitative evidence to create a breadth and depth of understanding that can confirm or dispute evidence, and ultimately answer a review question posed (Lizarondo et al., 2020). Narrative synthesis is useful when reviewing papers with different methodologies and quality as it can accommodate differences between the questions and research design of each individual study (Green et al., 2006). Narrative synthesis disguises such differences by weaving the studies together to find a common line of understanding (Booth et al., 2022; Green et al., 2006). The findings of each study were summarised and then

collated with other studies of similar results and effect. Idiographic and divergent findings were reviewed. These results were then compiled into narrative themes which were described to synthesise the summaries and understand the themes running through the studies.

Reflexivity

When compiling narrative themes, it is important for the reviewer to reflect on their own biases and experiences in relation to the review process. A reflexive diary was kept by the reviewer, who has experience of working in a residential-care setting, and therefore may hold some assumptions about how staff respond to TIC training, but not specifically to the models used in this review. Although biases like these cannot be removed, the reviewer checked the consistency of their theme interpretations and re-read texts before completing the synthesis to ensure rigor within the review process.

Results

Overview of the studies

Nine peer-reviewed articles were included in this review (see table 2). Studies were published between 2010 and 2023. Two qualitative (Gavin et al., 2022; Steinkopf et al., 2022), three quantitative (Brown et al., 2012; Crable et al., 2013; Galvin et al., 2020), and four mixed method (Holden et al., 2010; Brend et al., 2020; Baker et al., 2018; Bailey, 2017) studies were included. Articles were published worldwide but predominantly in North America: UK (Bailey, 2017), USA (Baker et al., 2018; Brown et al., 2012; Crable et al., 2013; Holden et al., 2010), Canada (Brend et al., 2020), Australia (Galvin et al., 2022; Galvin et al., 2020), and Norway (Steinkopf et al., 2022). Eight different TIC training models were focused on in research (see appendix E). Six standardised outcomes measures and five bespoke outcome measures were used to evaluate TIC training (see appendix F).

The main aim in most studies was to consider if the training model improved TIC attitudes post-intervention (Bailey, 2017; Baker et al., 2018; Brend et al., 2020; Brown et al., 2012; Crable et al., 2013; Galvin et al., 2020; Holden et al., 2010; Steinkopf et al., 2022). Half of these focused on evaluation of the model (Brend et al., 2020; Brown et al., 2012; Crable et al., 2013; Holden et al., 2010; Steinkopf et al., 2022). One aimed to replicate previous research findings showing improved TIC beliefs after Risking Connection (RC) and Restorative Approach (RA) training (Baker

et al., 2018). Three studies discussed considering TIC attitudes and future training to influence this (Bailey, 2017; Baker et al., 2018; Galvin et al., 2022). One study aimed to consider understanding of vicarious trauma, and impacts on work (Baker et al., 2018). One aimed to consider the barriers and enablers of implementing training (Galvin et al., 2022).

Table 2 Overview of studies included in the review (see appendix B for full table)

Author(s), year, location	Aim	Sample	Training	Measures Quantitative	Qualitative	Data collected	Analysis	Key findings	Limitations and quality score
Bailey, E, 2017 UK	Explore 'Fostering Attachments' training and staff views on use of the model	n=23 staff from 11 homes	Fostering Attachments Programme	In-house developed questionnaire	In-house developed feedback-form	Post intervention	Descriptive statistics	Participant's improved: • empathy towards children • understanding of children's behaviours and emotions Participants empowered to continue with their work strategies	Fostering Attachments was developed into Nurturing Attachments Training while this article was being published CCAT 38%
Baker, C, et al, 2018 USA	Replicate previous studies showing that RC and RA training improved TIC beliefs Evaluate whether TIC reduces staff experience of vicarious trauma	n=116 staff	Risking connection and Restorative approach	TIC belief measure Professional quality of life scale	8hr participant observations 10 in-depth interviews	Quantitative: pre, post, follow-up Qualitative: pre, post, follow-up	ANOVA *t*-Test Thematic analysis	Significantly improved TIC beliefs $F(2, 42)=19.02$, $p<.001$ pre- to post-test $F(1, 21)=20.33$, $p<.001$, $d=.94$ maintained at follow-up $F(1, 21)=26.07$, $p<.001$, $d=.1.02$ Rise in secondary traumatic stress over three time points $F(2, 44)=3.58$, $p=.04$ scores less favourable, pre- to post-test $F(1,22)=5.49$, $p=.03$, $d=.55$ maintained at follow-up $F(1, 22)=4.93$, $p=.04$, $d=.56$ Themes: Improved TIC attitudes	No control/comparison group Data collection over short timeframe CCAT 73%

								Increased awareness and understanding of vicarious trauma Organisational culture change of TIC as a steady process, driven by the training implemented	
Brend, D, et al, 2020 Canada	Present preliminary findings of Program Penguin, focusing on, development of TIC attitudes and practices, responsiveness to the well-being of workers, reduction of restraints and seclusions for school-age children	5 residential centres (n not specified)	Program Penguin	ARTIC-35 scale	Secure Base Interview	Quantitative: post intervention Qualitative: pre, mid and post intervention	Not included	Improved understanding of TIC Attitudes towards TIC impacted by: age of child worked with, and job role Reduction in restraints and seclusions after training Themes: Collegial support and adequate provision of resources are valuable to delivering TIC	Lacks generalisability Participant turnover caused difficulties with data collection CCAT 30%
Brown, S, et al, 2012 USA	Look at RC training and the effects on staff	n=261 Staff from 12 different companies	Risking Connection Trauma Training	Risk connection curriculum assessment TIC belief measure Staff behaviour in the milieu	n/a	Quantitative: Two measures post-intervention One measure at 5 months follow-up	*t*-Tests	Significantly improved TIC knowledge, pre- to post-intervention, all groups $t(29)=-7.79$, $p<.001$ Significantly improved favourable TIC beliefs, pre- to post-intervention, all groups $t(30)=-2.56$, $p<.05$ Significant favourable change in self-reported TIC behaviour, pre-intervention to follow-up	No follow-up looking at maintenance of outcomes CCAT 65%

								t(22)=-2.15, *p*=.04	
Crable, A, et al, 2013 USA	Evaluate the Gender-Specific-and-Trauma-Informed-training curriculum, looking at retention of on-the-job interventions, knowledge gained, and satisfaction with the training curriculum	n=40 female staff 20-intervention group 20-control group (no training offered)	Gender-specific-and-trauma-informed-training	Knowledge survey Satisfaction survey	n/a	Quantitative Pre-, post-, and 45 days follow-up post-intervention	*t*-Tests	Knowledge survey scores did not significantly increase from pre- to post-intervention Mean scores of surveys of knowledge were not significantly different between treatment and control group, post-intervention *t*(38), *p*=0.90 Satisfaction score decreased substantially (but not significantly), pre- to post-intervention, training group Basic literacy knowledge not retained at follow-up *z*=-0.25, *p*=0.79	Small sample taken from one residential facility, lacks generalisability Follow-up was done after a brief time-period Reliability/validity for outcomes used CCAT 63%
Galvin, E, et al, 2022 Australia	Explore the barriers and enablers of implementing The Sanctuary Model training, and impact on the organisation	n=38 staff from 7 homes	The Sanctuary Model	n/a	3 semi-structured interviews, in person or on the phone 6 focus groups during team meetings, on Zoom	Qualitative: Post intervention	Deductive coding	Themes: • Enablers influencing implementation - *Social support systems* - *Shared trauma-informed knowledge and understanding* - *Leadership and champions* • Organisational successes of implementation	Sample from one organisation, lacks generalisability CCAT 73%

								- *Sanctuary commitments* - *Safety, emotion, loss and future framework* - *Reflective practice and supervision* - *Trauma theory* • Barriers influencing implementation - *Informal practice* - *Lack of practice-based training* - *Poor introduction to young people* - *Resources* • Organisational challenges of implementation - *The Sanctuary toolkit* - *Young people's behaviour and engagement*	
Galvin, E, et al, 2020 Australia	Evaluate staff TIC attitudes	Staff from family	The Sanctuary Model	Pre-intervention:	n/a	Quantitative Pre-intervention	ANOVA	No significant difference in TIC attitudes, baseline to follow-up	Small sample size

		services agency Pre-intervention: n=55 Follow-up: n=31		ARTIC-35 Follow-up, 6 months: ARTIC-45		and follow-up		*p*=0.05 No significant difference between: • Pre-intervention and follow-up score • pre-intervention and follow-up, looking at job roles Subscales lower in youth workers and higher in case workers	No post-intervention data collection Measures for attitudes, but not functioning 'in-practice' CCAT 75%
Holden, M, et al, 2010 USA	Establish an evidence base regarding the impact of CARE training on staff practices, organisational functioning, and child wellbeing	n=74 staff	CARE training	CARE curriculum knowledge test	Post intervention: 'intent to change' collection of qualitative views	Quantitative: Pre- and post-intervention Qualitative: Post-intervention	ANOVA	Significantly improved knowledge of CARE curriculum $F(1,37)=118.6$, $p<.001$ 90% of participants reported intent to use CARE curriculum in their work	Limited information about measures used and analysis, interpretation of results difficult CCAT 30%
Steinkopf, H, et al, 2022 Norway	Evaluation of how staff transformed TIP into practice after training	n=19 staff	Trauma Informed Principles	n/a	Interviews	Qualitative Pre, post, follow-up	Phenomonological	Themes: • Self-awareness - *Self-reflection* - *Authenticity* - *Other-regulation* • Intended actions - *Actions to build strength* - *Actions to build mentalisation skills* - *Staff availability*	No demographic data Different participants used at each data collection stage due to staff turnover CCAT 73%

								- *Setting clear and safe boundaries* - *Collaboration* • Organisational and cultural practices - *A commonly shared mindset* - *Stability and routines* - *Cultural safety*	

List of acronyms used in the table:

CCAT – Crowe critical appraisal tool

TIC – trauma-informed care

ANOVA – analysis of variance

ARTIC – attitudes related to trauma-informed care

TIP – trauma-informed practice

CARE – children and residential experiences training

RA – restorative approach

RC – risking connection

Quality Appraisal

Quality appraisals of the studies rated them between 30% (Brend et al., 2020; Holden et al., 2010) and 75% (Galvin et al., 2020) (appendix D). Overall, studies scored highest in the 'introduction' section, and lowest in the 'ethical matters' section. Only two studies scored below '4' in the 'introduction' section (Brend et al., 2020; Holden et al., 2010). Other studies gave detailed information about aims, providing clear rationale for the study, with nearly half of the studies getting a full score in this area (Bailey, 2017; Baker, 2018; Brown et al., 2011; Galvin et al., 2022). In 'ethical matters,' studies generally discussed informed consent (Baker, 2018; Crable et al., 2013; Galvin et al., 2020; Galvin et al., 2022; Steinkopf et al., 2022) and ethical approval of the study (Baker, 2018; Galvin et al., 2022; Steinkopf et al., 2022). One study discussed ethical matters in depth, including, consent, withdrawal of data, anonymity, participant perspective of confidentiality and interim data analysis (Steinkopf et al., 2022). Two studies discussed with transparency, the issues of ethics, funding, and conflicts of interest (Galvin et al., 2022; Steinkopf et al., 2022). Galvin et al. (2020) was the only study to discuss debrief or aftercare for participants. It is noted that some of the studies may have constituted evaluations, which would not require formal ethical approval. The line between evaluations and research studies can sometimes be blurred, however it is still important to review ethics in these studies.

There was a lack of consistency of outcome measure result reporting. Although all studies reported an overall view and interpretation of analysis, only four studies gave detailed information about their analysis and results (Brown et al., 2011; Crable et al., 2013; Galvin et al., 2020; Steinkopf et al., 2022). Three studies gave limited data information, resulting in a lack of clarity for the conclusions made in these studies (Bailey, 2017; Brend et al., 2020; Holden et al., 2010).

Sampling and Recruitment

Across all studies, no inclusion/exclusion criteria or drop out-rates were discussed. Samples sizes ranged from 23 (Bailey, 2017) to 261 (Brown et al., 2012). No studies used a power calculation to determine sample size and that the data was suitably powered. No studies discussed the percentage of staff recruited from the overall staff teams available. Based on methods and aims of the studies, most appear to have recruited appropriate participant numbers (Baker et al., 2018; Crable et al., 2013; Brown et al., 2012; Galvin et al., 2022; Holden et al., 2010; Steinkopf et al.,

2022). The Bailey (2017) study identified aims to explore the helpfulness of training for staff but only invited two staff from each home to participate, which may limit the sample of participants and therefore restrict the depth of this data.

The qualitative studies used purposive sampling (Galvin et al., 2022; Steinkopf et al., 2022). Qualitative research aims to gain an enriched understanding of the experience under investigation, therefore, purposive sampling is often used to select participants who can provide substantial contributions to the understanding of the topic (Polkinghorne, 2005). None of the researchers discussed why the participants selected were deemed the most appropriate to provide information in this area which makes selection bias a difficult area to appraise. None of the qualitative studies discussed their methods for ending data collection. Considering information power or data saturation as a means of knowing when to stop collecting data in qualitative studies is useful in these analyses (Braun & Clarke, 2021; Mwita, 2022).

All other studies used convenience sampling, whereby they recruited by invitation to staff-teams and all who responded were included. Participants in all studies were recruited from within an organisation or agency providing staff to care-homes. This approach to sampling appears appropriate for the aims of these studies. The regular turnover of staff was discussed as an issue for data collection across time points by two studies (Brend et al., 2020; Galvin et al., 2020), and complications with outreach to staff due to the Covid-19 pandemic was discussed by one study (Galvin et al., 2022).

Design and methodology

The two qualitative studies used the methodologies: phenomenological (Steinkopf et al., 2022) and deductive coding (Galvin et al., 2022). Both these studies provided information about their approach and data collection, allowing for replication of these studies. Steinkopf et al. (2022) provided information on reflexivity, triangulation and checking of themes, which increases the rigour and trustworthiness of their findings. Although Galvin et al. (2022) provided enough information to replicate their study, they did not discuss their reflexive approach, and therefore their findings can be taken with reasonable caution around their bias and epistemological stance in approaching this research.

Crable et al. (2013) used a control design, offering training to the intervention group and no training to the control group. This design allows for comparison between

the groups, and evaluation of the outcomes of the training (Roberts & Priest, 2010). Where a control design is used in research, it is useful to include follow-up data collection to consider maintenance, or lack, of any effects. Crable et al. (2013) did this, which gave rich and useful data analysis for this study.

Most studies appeared to use designs which seemed suitable for the aims of the research, using outcomes measures related to the research aims (Baker et al., 2018; Brown et al., 2012; Galvin et al., 2020), and qualitative methods to explore and gain a richer understanding of effects (Galvin et al., 2022; Steinkopf et al., 2022). Brend et al. (2020) discussed exploring the reduction of restraints and seclusions but did this using interviews rather than data collection from incidents. This could result in a biased overview of this information rather than an understanding of the actual reduction in incidences (Roberts & Priest, 2010). Holden et al. (2010) described their aims to look at staff practices but collected data on staff knowledge.

Although information was included in all studies about the concept of the TIC model used, any information about the credentials or experience of who delivered the training is limited. Six studies gave no information (Baker et al., 2018; Brend et al., 2020; Crable et al., 2013; Galvin et al., 2022; Galvin et al., 2020; Holden et al., 2010), one identified that clinical psychologists facilitated training (Bailey, 2017), one identified that the author was a part of the training facilitation but offered no further detail (Steinkopf et al., 2022), one identified that RC faculty trainers were used initially then a train-the-trainer system offered (Brown et al., 2012). This lack of information makes it difficult to appraise the quality of training.

Measurement

11 different measures were used overall, looking at five areas, TIC attitudes, TIC behaviours, vicarious trauma, learned knowledge, and satisfaction. These were used in varying combinations, learned knowledge (Holden et al., 2010), TIC attitudes (Brend et al., 2020; Galvin et al., 2020), TIC attitudes and TIC behaviour (Brown et al., 2012), TIC attitudes and vicarious trauma (Baker et al., 2018), learned knowledge and satisfaction (Bailey, 2017; Crable et al., 2013). This means that there is minimal uniformity in the aims and outcomes being measured.

Four studies used outcome measures which were developed in-house specifically to evaluate knowledge of the specific training model used (Bailey, 2017; Brown et al., 2012; Crable et al., 2013; Holden et al., 2010). The subjectivity in informal

outcome measures used, and a lack of transparency in the detail of these makes it difficult to evaluate these results. All the studies used self-report measures which, while common, are also vulnerable to social desirability and subjectivity, which can reduce the validity of results (Rosenman et al., 2011). See appendix F for a full table of outcome measures.

Attitudes and beliefs towards TIC

Four studies used measures looking at attitudes towards TIC. The TIC belief measure is designed to look at attitudes towards TIC training (Brown et al., 2012). The TIC belief measure was used at pre-intervention, post-intervention and follow-up (Baker et al., 2018) and post-intervention and follow-up (Brown et al., 2018) to look at changes and sustained impact on attitudes. The attitudes-related-to-TIC scales (ARTIC-35 and ARTIC-45) were designed for organisations and programs that have implemented TIC (Baker et al., 2016). The ARTIC-35 is designed as a pre-measure, with the ARTIC-45 designed to be used at follow-up. Galvin et al. (2020) used these as designed. Brend et al. (2020) used the ARTIC-35 only at post-intervention.

Trauma-informed behaviours

One study used staff behaviour in the milieu scale at post-intervention and follow-up. This was designed as a self-report measure for participant behaviours thought to be indicative of TIC. Brown et al. (2012) used this in addition to the TIC belief measure, giving perspectives of internal and external understanding of this area.

Vicarious trauma

One study used the professional quality of life (ProQOL) scale to evaluate secondary trauma in participants (Baker et al., 2018). The ProQOL measures the positive construct of compassion satisfaction and the negative constructs of burnout and secondary traumatic stress and demonstrates strong internal reliability and construct validity (Geoffrion, 2019).

Learned knowledge

Four studies used a measure looking at learned knowledge. Brown et al. (2012) used the Risking connection curriculum assessment, designed to assess the knowledge and concepts taught in the risking connection 3-day basic training. Holden

et al. (2010) used a knowledge test described as a '25-item assessment of the core concepts of the CARE curriculum'. No further details are given around this so the validity may be questionable. Crable et al. (2013) used a 10-item knowledge survey aimed at assessing participants' understanding of the training (training group) and their awareness of the characteristics of trauma and knowledge retention from the gender-specific-and-trauma-informed-training. It was described as having 'no known reliability or validity' and without further detail may be questionable. Bailey et al. (2017) used an in-house developed skills and knowledge questionnaire, described to assess how participants feel training has helped in areas of their work.

Crable et al. (2013) assessed participant's 'knowledge germane to basic literacy skills' using a 10-item multiple choice survey. They provided no further detail around, or rationale for this and therefore it is difficult to review the purpose or use of this outcome measure.

Satisfaction

Training satisfaction was assessed by two studies. Bailey (2017) and Crable et al. (2013) both used in-house developed satisfaction surveys. There was no specific information given about the validity, so these may be taken in this context. These were the only outcome measures used in these two studies which brings further question to the rigour of this research. Bailey (2017) provided a table of results, but no discussion around the reliability or validity of the measure used. Both these measures are described as aiming to understand participant satisfaction with the training they had received. Due to a lack of detail, it is unclear if this is focused on participant satisfaction with the quality of teaching, or their understanding of the subject post-intervention.

Data analysis

Most of the studies gave information about their data collection and data analysis demonstrating rigour and reflexivity, and allowing for replication (Brown et al., 2012; Crable et al., 2013; Galvin et al., 2022; Galvin et al., 2020; Steinkopf et al., 2022). For quantitative data, significance levels were reported. Confidence levels are important as they provide a range in which the true value of the measured variable is in the population, with a certain level of confidence (usually 95%). These can provide the direction and strength of the effect, allowing conclusions regarding clinical relevance of the findings (du Prel et al., 2009).

The four mixed methods studies appeared to focus predominantly on the quantitative data collection and analysis, offering limited information around their qualitative data collection and analysis (Bailey, 2017; Baker et al., 2018; Brend et al., 2020; Holden et al., 2010). The descriptions provided were not sufficient for replication of studies and therefore make it difficult to assess the rigour in these studies.

Brend et al. (2020) did not provide any detail about their data analysis, and therefore it is difficult to fully assess the rigour of this study. Although they included the description of significant results in their study, there are no data tables or participant numbers. This means there are limitations to the assessment of this data and the overall understanding of this research study. Although Galvin et al. (2020) gave information about their data collection, this included different data collected at each stage of the study, and therefore a lack of continuity.

Synthesis of Findings

From a narrative synthesis of the findings five themes were identified; ‘changes in knowledge’, ‘understanding of self and others’, ‘organisational and work culture’, ‘TIC attitudes’, and ‘applying training to work’. These are discussed below.

Changes in knowledge

Improvements in learned knowledge were reported in three of four studies looking at: Fostering Attachments, RC and CARE (Bailey, 2017; Brown et al., 2012; Holden et al., 2010). After training in RC (Brown et al., 2012) and CARE (Holden et al., 2010) training participants showed statistically significant increases in knowledge from pre- to post-intervention. Looking at Fostering Attachments, participants reported improved knowledge of children’s emotions and behaviours, which they could integrate into their work (Bailey, 2017). Baker et al. (2016) reported increased understanding of vicarious trauma after RC and RA training. In the qualitative studies looking at The Sanctuary Model and TIP, participants considered their post-training knowledge increase as an enabler to their provision of TIC, in the context of improved understanding and positive effects to work (Steinkopf et al., 2022), and lack of training as a barrier to delivering TIC due to knowledge deficiencies (Galvin et al., 2022).

Crable et al. (2013) reported no significant increase in knowledge from pre- to post-intervention, or between intervention and control groups, looking at Gender-

Specific-Trauma-Informed-Training. They used an in-house knowledge survey described to consider 'the basic literacy skills of the participants' and therefore further exploration of this is needed.

Understanding of self and others

Both qualitative studies reported an increased understanding of self and others. Galvin et al. (2022) reported that The Sanctuary Model training enabled shared understandings of TIC, and gave shared language to use across the organisation. This facilitated positive changes in communication with the children worked with, and within teams.

After TIP training, self-reflection skills increased with positive effects (Steinkopf et al., 2022). Participants reported the recognition of their behaviour with the children they work with, and the need for them to be emotionally available for the children to be able to emotionally regulate. This included team intentions to work collaboratively moving forward, showing insight to self and how this relates to successful work with children.

Increased understanding of children's emotions (Bailey, 2017) and behaviours (Bailey, 2017; Brend et al., 2020) were reported after training in Fostering Attachments and Program Penguin. Bailey (2017) reported that four participants identified increased empathy towards children on feedback forms after training in Fostering Attachments. Brown et al (2012) reported statistically significant improved staff behaviours thought to be indicative of TIC, after RC training.

Organisational and work culture

There were improvements in use of team networks after completing RC Training (Brown et al., 2012), as reported using the Staff Behaviour in the Milieu Scale, pre-intervention to follow-up.

In qualitative interviews, cultural change was discussed as being led from 'top-down' (actions are initiated by management) after training in the Sanctuary Model (Galvin et al., 2022) and CARE (Holdon et al., 2010). This was also discussed after completion of RC training (Baker et al., 2018) and Project Penguin (Brend et al., 2020), and suggests a change in understanding of the staff-team as a 'family' network. Cultural change was discussed as a slow process driven by participant training (Baker et al., 2018), support from management (Brend et al., 2020) and appropriate resource

provision (Brend et al., 2020; Galvin et al., 2022). Cultural change is considered important within a TIC environment due to the need to be collaborative in understanding children's needs and aims of work (HM Government, 2022).

TIC attitudes

Four studies examined attitude changes towards TIC, three found improvements, (Baker et al., 2018; Brend et al., 2020; Brown et al., 2012). Two studies, both looking at RC training, used the TIC belief measure, reporting statistically significant improved attitudes towards TIC, pre- to post-intervention (Baker et al., 2018), maintained at follow-up (Baker et al., 2018; Brown et al., 2012). Two studies looking at Program Penguin (Brend et al., 2020) and The Sanctuary Model (Galvin et al., 2020) both used the ARTIC to measure attitudes towards TIC. Brend et al. (2020) did not report detailed information about their data analysis, but that "strong effects" were seen in their data analysis, impacted by: the age of the children being worked with and the professional role of the staff member. Due to a lack of information, further investigation into this may be useful. Galvin et al. (2020) provided a detailed description of their data analysis and utilised the ARTIC-35 and ARTIC-45 as designed for pre- and post-intervention evaluation. They reported a non-significant statistical difference, based on the professional role of the staff member and the amount of time having worked in their role, with direct workers having a more improved attitude towards TIC than indirect workers.

Applying training to work

After being trained in a Gender-Specific-Trauma-Informed-Training it was reported that satisfaction with the training curriculum decreased (Crable et al., 2013). Considering this in addition to their report of no change to participant knowledge, pre- to post-intervention, suggests there may be some correlation between knowledge and satisfaction. This is difficult to appraise due to a lack of information provided about the intervention.

Relationships with children was identified as a barrier to applying the Sanctuary Model training to work (Galvin et al., 2022). It was described in this qualitative study that despite there being a planned introduction agenda, there are a lack of formal introductions between staff and children when entering the home. This was described as having a negative impact on the start of relationships between staff and children. It

is widely understood that working with children on development of relationships with the significant people in their life (considering beginnings, endings, trust and communication) is key to their ability to engage in the development, and maintenance, of meaningful relationships throughout their life, resulting in more likelihood of home stability (Golding et al., 2006; Perry, 2014; Tronick & Perry, 2015; Golding, 2020; Beeghly et al., 2016; Bellis et al., 2017). This study also discussed relationships as an enabler to applying work, referring to the relationships between and within staff-teams, and the importance this has to understanding and embedding the Sanctuary Model training (Galvin et al., 2022). Where healthcare staff do not have a positive network of relationships within their team, this can affect the work they do, their understanding and compassion towards each other (Kelly, 2020), and therefore their ability to embed TIC into their work.

After training in TIP participants reported intent to work collaboratively as a team (Steinkopf et al., 2022). As previously discussed, some studies report this without significant detail (Bailey, 2017; Holden at el, 2010), however Steinkopf et al. (2022) provide the rich information of a qualitative study. They identified that staff discussed their intent to build skills, be available and present for the children they work with, and work collaboratively, to implement TIP.

Resources available was identified as a barrier to applying training to work (Galvin et al., 2022). Individually, it is understood that without the availability of resources, primary care staff will adapt and perform different actions, altering the aims in their work (Holmer et al., 2023), which has implications for working together as a team. Organisationally, staff discussed their difficulties with implementing safety plans due to the policy to wear these on a lanyard and staff feeling that this was unsafe. As a result, they would not wear, and consequently, forget about the safety plan.

Increased understanding of self and others after Fostering Attachments Training was correlated with participants feeling empowered to apply training to their work (Bailey, 2017). After being trained in CARE, 90% of participants reported their intent to apply changes to their practice (Holden et al., 2010).

Discussion

This review aimed to synthesise and critically appraise the literature on the outcomes of TIC training for staff. Nine relevant peer-reviewed articles were identified. A synthesis of findings highlighted five prominent areas; ‘changes in knowledge’,

‘understanding of self and others’, ‘organisational and work culture’, ‘TIC attitudes’, and ‘applying training to work’. After TIC training, increases in compassion, empathy, self-reflection, understanding of effects on the staff-teams and young people being worked with, and understanding of vicarious trauma were identified. Relationships and resources were identified as key to effectively embedding TIC into work.

The findings must be treated with a degree of caution when considering this group of articles due to the difference in critical appraisal scores using the CCAT, ranging from 30% (Holden et al., 2010) to 75% (Galvin et al., 2020). It might be considered that some of this difference may be due to the restrictions of publication as some studies identified data analysis which was not reported (Brend et al., 2020; Holden et al., 2010).

It is important to recognise that there are limited training models available for staff. It may not be possible or reasonable to simply translate the training which is aimed at foster carers or parents to care-homes due to the systemic ramifications on this family-based environment. However, the importance of recognising and applying relationship-based approaches was identified (Brend et al., 2020; Crable et al., 2013; Steinkopf et al., 2022).

The differences in assessment of training may need further exploration. Although studies have shown positive results, some studies appear to be focused on the appraisal of a particular training model. More rigorous, non-biased, research-based approaches would be advisable when designing studies of this type. This might allow for a more robust and comprehensive analysis of the effectiveness of TIC training for staff.

Limitation of the review and future research directions

There are several different roles when working in residential care settings. This demographic information was not always available in the studies in this review.
There are several different training models, outcome measures and analyses used. It would be useful to consider repetition of research to enhance the reliability of research in this area.

There was no consistency of pre-, post- and follow-up intervention outcome measures. For example, the ARTIC-35 and ARTIC-45 were developed to evaluate TIC attitudes after being trained in this area, with a pre- and post-intervention design but these measures appear to have been used interchangeably and separately. One study

used these as designed reporting non-significant results (Galvin et al., 2020). Future studies' use of these measures as designed would offer a more comparable understanding of results.

Clinical implications

This review highlights the importance of TIC training. There are psychosocial implications for staff. Availability of resource at staff level, and organisationally, was identified as key to implementing training (Galvin et al., 2022; Steinkopf et al., 2022). The availability of regular supported self-reflective spaces for staff would benefit services (Jones et al., 2021). These can be widely supported through consultation with clinical psychologists. Staff would benefit from the availability of resources which can help them embed their training into practice, e.g., crib-sheets for the key elements of TIC.

Relationships between staff-teams and children were identified as key factors in applying training (Galvin et al., 2022; Steinkopf et al., 2022), therefore, attachment bonds between staff-teams and the children they work with should be encouraged. Staff can implement this by being given clear understanding around, and support to, nurture and encourage relationship forming with the children they work with. This could include, but is not limited to, understanding and support with therapeutic touch and connected time with children (Moore, 2021). A more robust training model than those aimed at the bonding of parents and children should be considered, so to understand the forming and maintaining of the changing and evolving attachment bonds between staff and the children they work with. These approaches could be supported through clinical consultation. In the UK, Clinical psychologists use attachment focused approaches to approach elements of TIC, e.g., Dyadic Developmental Psychotherapy, as an approach to helping foster and adopted families form and maintain attachment bonds (Becker-Weidman & Hughes, 2008; Golding, 2019; Hughes et al., 2015; Purrington et al., 2023). Elements of this approach, e.g., PACE (DDP network, 2024), are understood to be widely used in training in care-homes, but there is limited research into the outcomes for staff from this training.

In this review, studies showed that TIC training improved knowledge (Brown et al., 2012; Holden et al., 2010; Steinkopf et al., 2022), self-reflection (Steinkopf et al., 2022), attitudes towards TIC (Baker et al., 2018; Brend et al., 2020; Brown et al., 2012), and empathy of staff-teams (Bailey, 2017; Baker et al., 2018; Brend et al., 2020;

Brown et al., 2012; Galvin et al., 2022; Holden et al., 2010; Steinkopf et al., 2022). This can also be considered from an organisational perspective, e.g., facilitation of reflective practice to develop and maintain this skill and embed it into normal practice in care-homes.

Future research

When designing future research to look at training effectiveness for residential-children's-home-staff, the following should be considered:

- If the study aim is to appraise a training model, this should be clearly identified.
- Research design should consider recruitment and following through with data collection.
- Use outcome measures as they are designed, e.g., ARTIC-35 and ARTIC-45.
- Demographic data collection, e.g., participant's job role.

Conclusion

This review has identified some trends in the effectiveness of TIC training on staff: improvements in, attitudes towards TIC, understanding of self and others, and TIC knowledge. Barriers to implementation were identified: availability of resources at staff and organisational level, and understanding of relationships. The rigour and validity of some of this research must be considered within the context of the sample populations and aims of the research teams in relation to their organisational connections and bias.

There are limited TIC models specifically aimed at staff, and limited research into models and approaches which are already being widely used in care-homes. Offering a TIC approach has been shown in this review to improve staff understanding of children's behaviours and needs, and of their own responses and experiences of working in this difficult environment. Improving empathy towards children and developing a deeper understanding of self has been shown to give a more prolonged and settled approach to the development of longer-term relationships (Urdang, 2010).

Clinical psychologists already offering consultation to care-homes are well placed to offer the support identified as useful in this review: reflective practice, TIC knowledge training, support to form and maintain attachment bonds with children and maintain staff networks. More research is needed to understand which might be the

better choice of trauma-informed model to use as, in this review, this appears to be interchangeable and personal to the environment and staff team being worked with. However, models such as RC and The Sanctuary Model might offer a useful basis to start with when training staff in TIC.

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Appendices

Appendix A: Publication guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

In-house submissions, i.e. papers authored by Editors or Editorial Board members of the title, will be sent to Editors unaffiliated with the author or institution and monitored carefully to ensure there is no peer review bias.

New submissions should be made via the Research Exchange submission portal. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

Child & Family Social Work now offers **free format submission** for a simplified and streamlined submission process. For details see section 4 of the guidelines.

Data protection:
By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

Pre-Print Policy

Please find the Wiley preprint policy here.

Child & Family Social Work will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

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Wiley believes that no valuable research should go unshared. This journal participates in Wiley's Refer & Transfer program. If your manuscript is not accepted, you may receive a

recommendation to transfer your manuscript to another suitable Wiley journal, either through a referral from the journal's editor or through our Transfer Desk Assistant.

2. AIMS AND SCOPE

Child & Family Social Work provides a forum where researchers, practitioners, policy-makers and managers in the field exchange knowledge, increase understanding and develop notions of good practice. In its promotion of research and practice, which is both disciplined and articulate, the Journal is dedicated to advancing the wellbeing and welfare of children and their families throughout the world.

Child & Family Social Work publishes original and distinguished contributions on matters of research, theory, policy and practice in the field of social work with children and their families. The Journal gives international definition to the discipline and practice of child and family social work.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Original Articles should normally be a maximum of 7000 words, including the abstract and any appendices, although shorter papers will be welcomed. References are not included in the 7000 word limit. The abstract should not exceed 200 words and it should be followed by six keywords.

The Editors also welcome the following scholarly papers:

Review These will be actively encouraged. Prospective authors should initially discuss their proposals with the Editor.

Spotlight This section publishes brief contributions (around 1000 words) on policy debates in different countries or short policy articles. Contributions are welcomed.

Special Issues From time to time the Editor may commission a special issue of the Journal which will take the form of a number of papers devoted to a particular theme.

Book Review

(i) Book reviews should be headed with the reviewer's name, in capitals. Beneath the reviewer's name, and ranged to the right, should come the full publication information (i.e., title in full, author, place, publisher, date of publication, edition statement, pages, special features [maps, color plates, etc.], price, and ISBN), for example:

The Peasantries of Europe: From the Fourteenth to the Eighteenth Centuries, by Tom Scott (ed.). London and New York: Longman. 1998. pp. xi+416. £ 44 (hb); £19.99 (pb). ISBN 0-582-10132-8 and 0-582-10131-X

(ii) The reviewer's institutional affiliation should appear (ranged to the left) as an unnumbered footnote on the first page of the review. Acknowledgements, if any, should also be made there.

Structure the book review as follows:

- One paragraph identifying the thesis, and whether the author achieves the stated purpose of the book.
- One or two paragraphs summarizing the book.
- One paragraph on the book's strengths.
- One paragraph on the book's weaknesses.
- One paragraph on your assessment of the book's strengths and weaknesses.

The word limit is 1000 words.

4. PREPARING YOUR SUBMISSION: FREE FORMAT SUBMISSION

Child & Family Social Work now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including statements relating to our ethics and integrity policies:
- data availability statement
- funding statement
- conflict of interest disclosure
- ethics approval statement
- patient consent statement
- permission to reproduce material from other sources

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details.

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- An ORCID ID, freely available at https://orcid.org.

To submit, login at https://wiley.atyponrex.com/journal/CFS and create a new submission. Follow the submission steps as required and submit the manuscript.

5. FINAL SUBMISSION REQUIREMENTS

Parts of the Manuscript

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file should be submitted in Microsoft Word (.doc or .docx) format.

Title page

The Title page should be uploaded under the designation 'title page'.

The title page should contain:

i. A short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Acknowledgments.

Authorship

Please refer to the journal's authorship policy the Editorial Policies and Ethical Considerations section for details on eligibility for author listing.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the section 'Conflict of Interest' in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Main Text File

The Manuscript without title page should be uploaded under the designation 'main document'.

As papers are double-blind peer reviewed the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

i. Title, abstract and key words;
ii. Main text;
iii. References;
iv. Tables (each table complete with title and footnotes);
v. Figure legends;
vi. Appendices (if relevant).

Figures and supporting information should be supplied as separate files under the designation 'figures'

Abstract
Please provide an abstract of no more than 200 words.The abstract should be followed by up to six keywords.

References
References in published papers are formatted according to the Publication Manual of the American Psychological Association (6th edition). However, references may be submitted in any style or format, as long as it is consistent throughout the manuscript.

Tables
Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends
Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures
Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Color Figures. Figures submitted in color may be reproduced in color free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white.

Additional Files

Appendices
Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Supporting Information
Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

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Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

The following points provide general advice on formatting and style.

- **Language**: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses

Appendix B - Overview of studies included in the review

Author(s), year, location	Aim	Sample	Training	Measures Quantitative	Qualitative	Data collected	Analysis	Key findings	Implications	Limitations and quality score
Bailey, E, 2017 UK	Explore if Residential-children's-home-staff find the 'Fostering Attachments' training helpful, and are more empowered with existing or new skills	n=23 residential-children's-home-staff from 11 homes 16 homes invited for 1 manager and 1 care worker to participate	Fostering Attachments Programme	In-house developed skills and knowledge questionnaire	In-house developed feedback form	Post intervention	Descriptive statistics	Participants reported that training was helpful in improving: • their empathy towards the children they work with • their understanding of children's behaviours and emotions Participants empowered to continue with their work strategies	Participants confidence and feeling of empowerment makes it more likely that participants will manage difficulties themselves rather than referring for external specialist support	Fostering Attachments training was developed into Nurturing Attachments Training resource while this article was being published CCAT 38%
Baker, C, et al, 2018 USA	Replicate previous studies showing that RC and RA improve beliefs favourable of TIC Evaluate the hypothesis that TIC reduces staff experience of vicarious trauma	n=116 staff	Risking connection (RC) and Restorative approach (RA)	TIC belief measure Professional quality of life scale	8hr of participant observations 10 in-depth interviews with participants	Quantitative: pre, post, follow-up Qualitative: pre, post, follow-up	ANOVA *t*-Test Thematic analysis	Significantly improved participant beliefs in TIC $F(2, 42) = 19.02$, $p<.001$ from pre to post-test $F(1, 21) = 20.33$, $p<.001$, $d=.94$ and maintained at follow-up $F(1, 21) = 26.07$, $p<.001$, $d=.1.02$ Increase in secondary traumatic stress over the three time points $F(2, 44) = 3.58$, $p=.04$ scores became less favourable from pre to post-test $F(1,22) = 5.49$, $p=.03$, $d=.55$	RC and RA implementation is associated with improved participant attitudes towards TIC Participant understanding of vicarious trauma may result in them feeling worse in the short term, and therefore this must be taken into consideration	No control or comparison group Data collection over a short timeframe CCAT 73%

								and maintained at follow-up $F(1, 22) = 4.93$, $p=.04$, $d=.56$ Themes: Improvement in TIC attitudes after training Increase in awareness and understanding of vicarious trauma after training Participants viewed organisational culture change of TIC as a slow and steady process, driven in large part by the training implemented	Understanding that the culture of TIC may take years to implement, including sustained commitment over time. However, may also influence positive changes in participant relationships with each other	
Brend, D, et al, 2020 Canada	Present preliminary findings of Program Penguin which aimed to: -Help develop TIC attitudes and practices -Make the workplace more responsive to the well-being of workers -Reduce restraints and seclusions	5 residential centres (n not specified-author contacted and confirmed that each home had 12-14 staff but there was staff turnover during the study and no 'n' was reported)	Program Penguin	Attitudes related to TIC (ARTIC-35) scale	Secure Base Interview	Quantitative: post intervention Qualitative: pre, mid and post intervention	Not included (Author contacted for information about analysis but no information received.)	Improved understanding of TIC (reported only as 'strong effects') Attitudes towards TIC were impacted by: age of the child being worked with and job role (No further detail given) Reduction in use of restraints and seclusions after training Themes: Participants considered there to be value in collegial support and adequate provision of resources to deliver TIC	Delivering TIC through social innovation is a positive approach, helping to improve participant understanding of children and TIC, and reduce the use of restraints and seclusions	Lacks generalisability Participant turnover caused some difficulties with data collection CCAT 30%

	for school-age children									
Brown, S, et al, 2012 USA	Aims to look at RC training and the effects on staff.	n=261 staff Staff recruited from 12 different companies	Risking Connection Trauma Training	Risk connection curriculum assessment TIC belief measure Staff behaviour in the milieu	n/a	Quantitative: Two measures post intervention One measure at 5 months follow-up	*t*-Tests	Significantly improved knowledge of TIC from pre- to post-intervention, for all groups $t(29) = -7.79$, $p<.001$ Significantly improved favourable beliefs about TIC from pre- to post-intervention, for all groups $t(30) = -2.56$, $p<.05$ Significant favourable change in self-reported participant behaviour indicative of TIC from pre-intervention to follow-up $t(22) = -2.15$, $p=.04$	RC training shows promise as a strategy for implementing TIC in childcare settings	No follow-up looking at maintenance of outcomes CCAT 65%
Crable, A, et al, 2013 USA	Evaluate the Gender Specific and Trauma Informed training curriculum, looking at retention of on-the-job interventions, knowledge gained, and satisfaction with the training curriculum	n=40 female staff 20 in intervention group 20 in control group (no training offered)	Gender specific and trauma-informed training	Knowledge survey Satisfaction survey	n/a	Quantitative Pre, post, and 45 days follow-up post intervention	t-Tests	Knowledge survey scores did not significantly increase from pre- to post-intervention. Mean scores of Knowledge survey were not significantly different between treatment and control group at post-intervention $t(38)$, $p=0.90$ Satisfaction score decreased substantially (but not significantly) from pre- to post-intervention in the training group	Gender Specific TIC Training was not useful in improving basic literacy knowledge, or improving participant satisfaction scores	Small sample which was taken from one residential facility, results are not generalisable Follow-up was done after a brief time-period Reliability or validity for the

								Basic literacy knowledge was not retained at follow-up *z*=-0.25, *p*=0.79		measures used CCAT 63%
Galvin, E, et al, 2022 Australia	Explore and understand the barriers and enablers of implementing The Sanctuary Model training, and impact on the organisational success and challenges	n=38 staff recruited from 7 homes	The Sanctuary Model	n/a	3 semi-structured interviews, in person or on the phone 6 focus groups during team meetings, on Zoom (Covid-19 lockdown affected data collection)	Qualitative: Post intervention	Deductive coding	Themes: • Enablers influencing implementation - *Social support systems* are useful to embed the model - *Shared trauma-informed knowledge and understanding* increases ability to know what to do - *Leadership and champions* guide and support staff in implementing the model • Organisational successes of implementation - *Sanctuary commitments* and key principles to embed	Focus on relationship, knowledge and leadership can promote TIC work when using The Sanctuary Model of training	Sample from a single organisation, therefore results are not generalisable CCAT 73%

								values into the work - *Safety, emotion, loss and future framework* offers a framework to have open and honest discussions with children - *Reflective practice and supervision* are tools for staff to feel supported in having honest conversations about their work - *Trauma theory* is successful in embedding in focusing on staff safety and wellbeing, as well as the children in care • Barriers influencing implementation		

								- *Informal practice* means that the Sanctuary model is embedded in practice but not explicit - *Lack of practice-based training* hinders staff from implementing the model - *Poor introduction to young people* affects staff building relationships with the children - *Resources* being limited to availability on the intranet is a major barrier to staff accessing and implementing training • Organisational challenges of implementation		

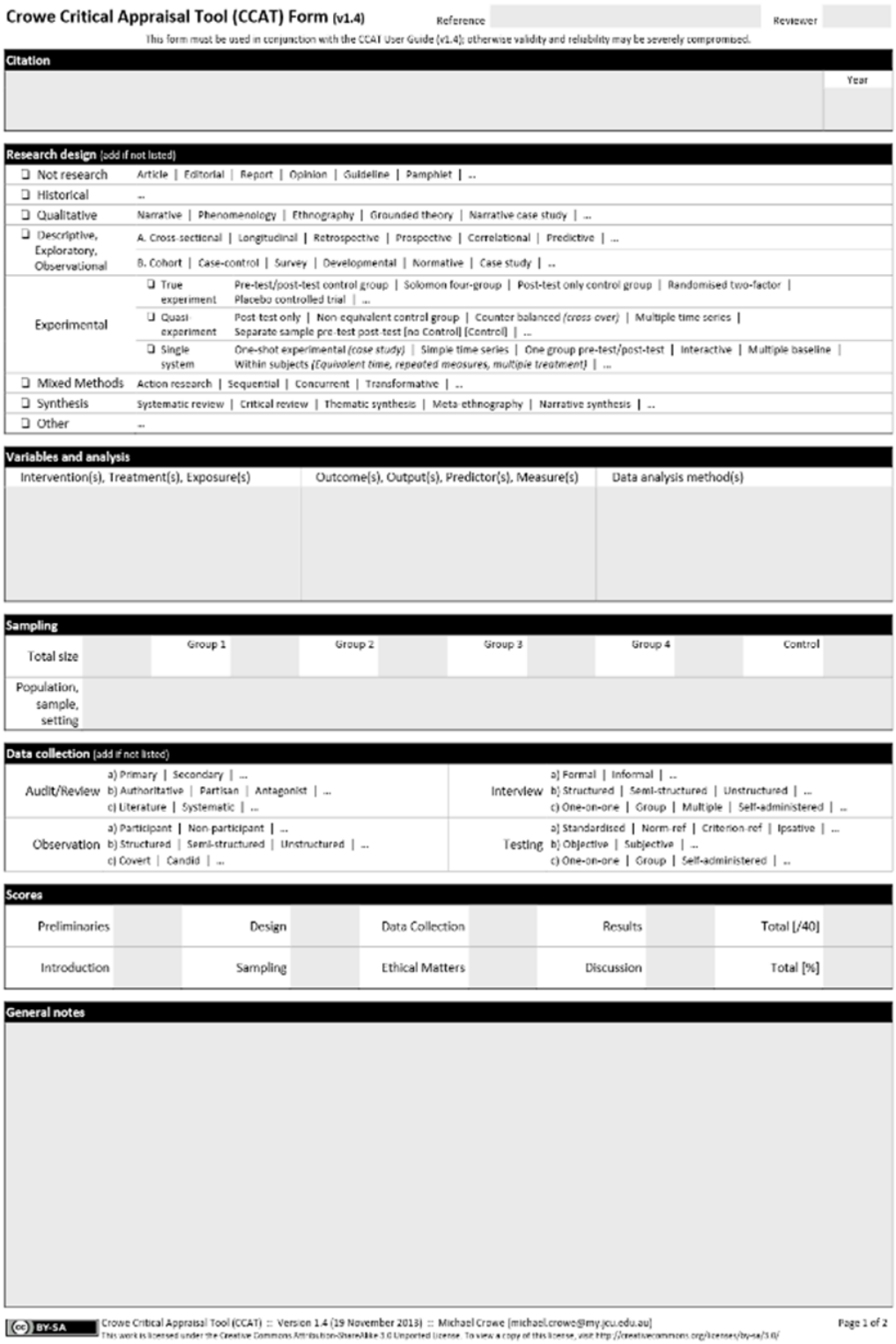
								- *The Sanctuary toolkit* feels too 'clinical' and affects access to this resource when working - *Young people's behaviour and engagement* shapes the dynamics of the home, and therefore implementation of the model		
Galvin, E, et al, 2020 Australia	Evaluate staff attitudes towards TIC	Pre-intervention: n=55 staff Follow-up: n=31 staff Staff recruited from Family services agency	The Sanctuary Model	Pre-intervention: ARTIC-35 Follow-up at 6 months: ARTIC-45	n/a	Quantitative Pre-intervention and follow up	ANOVA	No significant difference in attitudes towards TIC from baseline to 6-month follow-up *p*=0.05 (Summary findings not included in data) No significant difference between: • Pre-intervention and follow-up score • pre-intervention and follow-up when looking at job roles	Training may not have effect to staff attitudes towards children	Small sample size No post-intervention data collection Measures for attitudes, but not functioning 'in-practice' CCAT 75%

								Subscales were lower in youth workers and higher in case workers		
Holden, M, et al, 2010 USA	Establish a base of evidence regarding the impact of the CARE training on staff practices, organisational functioning, and child wellbeing	n=74 staff	Children And Residential Experiences (CARE) training	CARE curriculum knowledge test	Post intervention: 'intent to change' collection of qualitative views	Quantitative: Pre and post intervention Qualitative: Post-intervention	ANOVA	Significantly improved knowledge on the CARE curriculum $F(1,37) = 118.6$, $p<.001$ 90% of participants reported intent to use their new knowledge in the CARE curriculum in their work	After CARE training, staff have intent to use their new knowledge in their work	Limited information about measures used and analysis, which makes interpretation of results difficult CCAT 30%
Steinkopf, H, et al, 2022 Norway	Evaluation of how staff transformed TIP principles into practice after receiving competence building based on Howard Bath's 'three pillars' approach	n=19 staff 9 of these participants were employed for the entirety of the study	Trauma Informed Principles	n/a	Interviews	Qualitative Pre, post, follow-up	Phenomonological	Themes: • Self-awareness - *Self-reflection* as a prerequisite for responding adequately to the psychological needs of the children - *Authenticity* in work inspires safety and trust for staff and children - *Other-regulation* for staff inspires safety, e.g., being able	Improved participant self-awareness improves the recognition of ways to improve the emotional regulation in children	Demographic data not collected Different participants were used at each stage of data collection due to staff turnover during data collection CCAT 73%

								to say you are wrong • Intended actions - *Actions to build strength* and mastery for the children are important - *Actions to build mentalisation skills* for the children is useful - *Staff availability* as an essential TIP component - *Setting clear and safe boundaries* should be an essential part of TIP - *Collaboration* includes respecting the children's opinions, initiatives, and judgements • Organisational and cultural practices		

								- *A commonly shared mindset* is necessary for the practical implementation of TIP - *Stability and routines* help to secure a stable workforce - *Cultural safety* results in a trusting work environment		

Appendix C: CCAT



Crowe Critical Appraisal Tool (CCAT) Form (v1.4) Reference Reviewer

This form must be used in conjunction with the CCAT User Guide (v1.4); otherwise validity and reliability may be severely compromised.

Citation

	Year

Research design (add if not listed)

❑ Not research	Article | Editorial | Report | Opinion | Guideline | Pamphlet | ..
❑ Historical	..
❑ Qualitative	Narrative | Phenomenology | Ethnography | Grounded theory | Narrative case study | ..
❑ Descriptive, Exploratory, Observational	A. Cross-sectional | Longitudinal | Retrospective | Prospective | Correlational | Predictive | ..
	B. Cohort | Case-control | Survey | Developmental | Normative | Case study | ..
Experimental	❑ True experiment: Pre-test/post-test control group | Solomon four-group | Post-test only control group | Randomised two-factor | Placebo controlled trial | ..
	❑ Quasi experiment: Post test only | Non-equivalent control group | Counter balanced *(cross over)* | Multiple time series | Separate sample pre-test post-test [no Control] [Control] | ..
	❑ Single system: One-shot experimental *(case study)* | Simple time series | One group pre-test/post-test | Interactive | Multiple baseline | Within subjects *(Equivalent time, repeated measures, multiple treatment)* | ..
❑ Mixed Methods	Action research | Sequential | Concurrent | Transformative | ..
❑ Synthesis	Systematic review | Critical review | Thematic synthesis | Meta-ethnography | Narrative synthesis | ..
❑ Other	..

Variables and analysis

Intervention(s), Treatment(s), Exposure(s)	Outcome(s), Output(s), Predictor(s), Measure(s)	Data analysis method(s)

Sampling

Total size		Group 1		Group 2		Group 3		Group 4		Control	
Population, sample, setting											

Data collection (add if not listed)

Audit/Review	a) Primary | Secondary | ... b) Authoritative | Partisan | Antagonist | ... c) Literature | Systematic | ...	Interview	a) Formal | Informal | .. b) Structured | Semi-structured | Unstructured | ... c) One-on-one | Group | Multiple | Self-administered | ..
Observation	a) Participant | Non-participant | ... b) Structured | Semi-structured | Unstructured | ... c) Covert | Candid | ...	Testing	a) Standardised | Norm-ref | Criterion-ref | Ipsative | ... b) Objective | Subjective | ... c) One-on-one | Group | Self-administered | ..

Scores

Preliminaries		Design		Data Collection		Results		Total [/40]	
Introduction		Sampling		Ethical Matters		Discussion		Total [%]	

General notes

Appraise research on the merits of the research design used, not against other research designs.

Category Item	Item descriptors [☑ Present; ☒ Absent; ■ Not applicable]	Description [Important information for each item]	Score [0–5]
1. Preliminaries			
Title	1. Includes study aims ❑ and design ❑		
Abstract (assess last)	1. Key information ❑ 2. Balanced ❑ and informative ❑		
Text (assess last)	1. Sufficient detail others could reproduce ❑ 2. Clear/concise writing ❑, table(s) ❑, diagram(s) ❑, figure(s) ❑		
		Preliminaries [/5]	
2. Introduction			
Background	1. Summary of current knowledge ❑ 2. Specific problem(s) addressed ❑ and reason(s) for addressing ❑		
Objective	1. Primary objective(s), hypothesis(es), or aim(s) ❑ 2. Secondary question(s) ❑		
	Is it worth continuing?	**Introduction [/5]**	
3. Design			
Research design	1. Research design(s) chosen ❑ and why ❑ 2. Suitability of research design(s) ❑		
Intervention, Treatment, Exposure	1. Intervention(s)/treatment(s)/exposure(s) chosen ❑ and why ❑ 2. Precise details of the intervention(s)/treatment(s)/exposure(s) ❑ for each group ❑ 3. Intervention(s)/treatment(s)/exposure(s) valid ❑ and reliable ❑		
Outcome, Output, Predictor, Measure	1. Outcome[s]/output(s)/predictor(s)/measure[s] chosen ❑ and why ❑ 2. Clearly define outcome[s]/output(s)/predictor(s)/measure[s] ❑ 3. Outcome[s]/output(s)/predictor(s)/measure[s] valid ❑ and reliable ❑		
Bias, etc	1. Potential bias ❑, confounding variables ❑, effect modifiers ❑, interactions ❑ 2. Sequence generation ❑, group allocation ❑, group balance ❑, and by whom ❑ 3. Equivalent treatment of participants/cases/groups ❑		
	Is it worth continuing?	**Design [/5]**	
4. Sampling			
Sampling method	1. Sampling method(s) chosen ❑ and why ❑ 2. Suitability of sampling method ❑		
Sample size	1. Sample size ❑, how chosen ❑, and why ❑ 2. Suitability of sample size ❑		
Sampling protocol	1. Target/actual/sample population(s): description ❑ and suitability ❑ 2. Participants/cases/groups: inclusion ❑ and exclusion ❑ criteria 3. Recruitment of participants/cases/groups ❑		
	Is it worth continuing?	**Sampling [/5]**	
5. Data collection			
Collection method	1. Collection method(s) chosen ❑ and why ❑ 2. Suitability of collection method(s) ❑		
Collection protocol	1. Include date(s) ❑, location(s) ❑, setting[s] ❑, personnel ❑, materials ❑, processes ❑ 2. Method[s] to ensure/enhance quality of measurement/instrumentation ❑ 3. Manage non-participation ❑, withdrawal ❑, incomplete/lost data ❑		
	Is it worth continuing?	**Data collection [/5]**	
6. Ethical matters			
Participant ethics	1. Informed consent ❑, equity ❑ 2. Privacy ❑, confidentiality/anonymity ❑		
Researcher ethics	1. Ethical approval ❑, funding ❑, conflict(s) of interest ❑ 2. Subjectivities ❑, relationship[s] with participants/cases ❑		
	Is it worth continuing?	**Ethical matters [/5]**	
7. Results			
Analysis, Integration, Interpretation method	1. A.I.I. method(s) for primary outcome(s)/output[s]/predictor(s) chosen ❑ and why ❑ 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen ❑ and why ❑ 3. Suitability of analysis/integration/interpretation method(s) ❑		
Essential analysis	1. Flow of participants/cases/groups through each stage of research ❑ 2. Demographic and other characteristics of participants/cases/groups ❑ 3. Analyse raw data ❑, response rate ❑, non-participation/withdrawal/incomplete/lost data ❑		
Outcome, Output, Predictor analysis	1. Summary of results ❑ and precision ❑ for each outcome/output/predictor/measure 2. Consideration of benefits/harms ❑, unexpected results ❑, problems/failures ❑ 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) ❑		
		Results [/5]	
8. Discussion			
Interpretation	1. Interpretation of results in the context of current evidence ❑ and objectives ❑ 2. Draw inferences consistent with the strength of the data ❑ 3. Consideration of alternative explanations for observed results ❑ 4. Account for bias ❑, confounding/effect modifiers/interactions/imprecision ❑		
Generalisation	1. Consideration of overall practical usefulness of the study ❑ 2. Description of generalisability (external validity) of the study ❑		
Concluding remarks	1. Highlight study's particular strengths ❑ 2. Suggest steps that may improve future results (e.g. limitations) ❑ 3. Suggest further studies ❑		
		Discussion [/5]	
9. Total			
Total score	1. Add all scores for categories 1–8		
		Total [/40]	

Appendix D: Critical appraisal table

CCAT category (Crowe, 2013)	Bailey, E., 2017	Baker, C., 2018	Brend, D et al., 2020	Brown, S et al., 2011	Crable, A et al., 2013	Galvin, E et al., 2022	Galvin, E et al., 2020	Holden, M et al., 2010	Steinkopf, H., 2022
Preliminaries	2	4	2	4	4	5	4	1	3
Introduction	5	5	3	5	4	5	4	2	4
Design	2	4	1	4	3	3	4	2	4
Sampling	3	4	2	3	4	4	4	3	4
Data collection	2	2	1	2	2	3	5	2	3
Ethical matters	0	2	0	0	1	2	1	0	3
Results	0	4	1	5	4	3	5	1	4
Discussion	1	4	2	3	3	4	3	1	4
Total (/40)	15	29	12	26	25	29	30	12	29
Total (%)	38	73	30	65	63	73	75	30	73

Appendix E: Table of training models

Model of training	Overview
Trauma-Informed Principles (TIP) (Bath, 2008)	Uses lectures, workshops and supervision to establish an understanding of attachment theory and early interactions. Continues with sessions about development, the brain and nervous system with focus on the stress-response system. The aim is for participants to understand both the child's developmental needs and their emotional and behavioural challenges. In addition, sessions are included about organisational learning and management support.
Children and Residential Experiences training (CARE) (Holden et al., 2010)	Designed to facilitate and guide the process of improving child wellbeing by getting staff at all levels within an organisation to consciously and purposefully reorient practice to serve the best interests of children. The CARE training includes principles related to child development, attachment, trauma, family involvement, and human ecology. The CARE training aims to achieve a sense of 'cohesiveness' or 'wholeness' within the entire system of care in an organisation.
The Sanctuary Model (Bloom, 2013)	An overarching framework for creating or changing an organisational culture. The Sanctuary model aims to influence attitudes towards TIC, provide participants with the tools to communicate about trauma and its impacts, and create an organisational culture of safety and well-being.
Gender specific and Trauma-Informed training (Crable et al., 2013)	Provides an overview of sexual trauma within the context of culturally competent care. Focus is on understanding trauma, prevention, intervention, and treatment. Aim is for staff to feel confident in their knowledge in order to empower the children they work with.
Risking Connection (Brown et al., 2012)	Provides a philosophy and framework for working with traumatised clients, and is not aimed at working with individuals or families. Based on constructivist self-development theory, drawing on attachment theory, relational psychoanalytic theory, developmental psychopathology, theory of cognitive schemas, and social learning theory. Aims to move focus away from both the traditional medical models and more control-orientated models historically used in care settings. Risking connection training includes leadership consultation, foundational trauma trainings, and guidance about embedding TIC into the system. Special emphasis is put on staff well-being and managing vicarious trauma.

Program Penguin (Programme Pingouin) (Brend et al., 2020)	A TIC program developed specifically to respond to the needs of residential treatment centres serving children aged 6-12. Uses a social innovation approach, and is informed by the theories of complex trauma (National child traumatic stress network complex trauma task force, 2003), polyvictimization (Finkelhor et al., 2007), attachment, self-regulation and competency (ARC) (Blaustain & Kinniburgh, 2018), and Positive behavioural interventions and support (PBIS) (Sugai & Horner, 2002).
Restorative Approach (RA) (Wilcox, 2023)	A trauma-informed approach to treatment and behaviour management, based on restorative justice principles, often used in conjunction with Risking Connection. RA emphasises clients learning restorative tasks rather than receiving punitive consequences. The aim is to provide staff with tools they can use in their work with clients. Special emphasis is put on staff well-being and managing vicarious trauma.
Fostering Attachments (Golding, 2023)	Fostering attachments offers an attachment and trauma focused framework to understand the social and behavioural presentation of children. It aims to guide carers in building relationships with their children, as well as managing behaviour by developing security and trust through the caregiving relationship.

Appendix F: Table of outcome measures

Outcome measure used	Measuring	Category	Bailey, 2017	Baker, et al., 2018	Brend, et al., 2020	Brown, et al., 2012	Crable, et al., 2013	Galvin, et al., 2022	Galvin, et al., 2020	Holden, et al., 2010	Steinkopf, et al., 2022
Trauma-informed care belief measure (Brown et al., 2012)	Attitudes towards TIC training. 19-item measure Items rated on a 5-point Likert scale. Average score is created.	TIC attitudes		X		X					
Attitudes Related to Trauma Informed Care Scale (ARTIC-35) (Baker et al., 2016)	Attitudes towards TIC 35-item scale Items rated on a Likert scale.	TIC attitudes			X				X		
Attitudes Related to Trauma Informed Care Scale (ARTIC-45)	Follow-up of attitudes towards TIC, designed for organisations and programs that have implemented	TIC attitudes							X		

(Baker et al., 2016)	trauma-informed care. 45-item scale Items rated on a Likert scale.										
Staff behaviour in the milieu	Describes staff behaviours thought to be indicative of TIC. 12-item self-report Items rated on a Likert scale.	TIC behaviour				X					
Professional quality of life scale (ProQOL) (Geoffrion, 2019)	Positive construct of compassion satisfaction, and the negative constructs of burnout and secondary traumatic stress. 30-item measure Items rated on a 5-point Likert scale.	Vicarious trauma		X							
Knowledge test (no details)	25-item assessment of the core concepts of the CARE curriculum.	Learned knowledge								X	

Risking connection curriculum assessment (RCCA) (Brown et al., 2012)	Assesses knowledge of Risk Connection training concepts taught in the 3-day basic training. 11-item multiple choice measure.	Learned knowledge				X					
In-house knowledge survey (no details) (Bailey, 2017)	Participants knowledge of the Fostering Attachments training.	Learned knowledge	X								
Knowledge survey (no further information provided)	Participant knowledge germane to basic literacy skills. 10-item multiple choice.	Learned knowledge					X				
In-house satisfaction survey (no details provided)	The degree to which participants feel training has helped in certain areas of their work.	Satisfaction	X								

(Bailey, 2017)											
Satisfaction survey (GS&TI programme) (no further information provided)	10-item satisfaction survey. Items rated on a Likert scale.	Satisfaction					X				

Paper 2: Empirical paper

“You need to know [their] soul, what makes them tick”: Residential support-workers’ perceptions of their role in a therapeutic setting

Word count: 7955

This empirical paper is intended for publication in the journal ‘Child and family social work.’ Author guidelines for the journal can be found in Appendix G. Further modifications will be made before submitting to the journal to meet these guidelines.

Abstract

Children in care (CIC) are vulnerable to developmental trauma due to the adversity they have experienced in life. This can affect their ability to form and maintain relationships with those around them (Felitti et al., 1998; Hughes, 2017) due to them bringing the working models of caring experienced in early life to their current relationships. NICE guidelines (2021) suggest that carers treat the children they work with as 'one of their own' and are available and reliable. Many children's residential care-homes (hereafter referred to as 'care-homes') are marketed as 'therapeutic' so support-workers in residential care (hereafter referred to as 'support-workers') are expected to act as 'therapeutic parents' (NICE, 2021). Although support-workers are expected to provide therapeutic care there is no current regulation of this. They are offered consultation by Clinical Psychologists, but this input varies due to a lack of regulation.

There is no research looking into the experiences of support-workers working with CIC. This research explores support-workers perceptions of their role in a therapeutic setting.

Eight support-workers completed semi-structured interviews, which were analysed using Reflective Thematic Analysis. Three themes were identified: "Whatever the child needs, that's the priority", 'Being a therapeutic practitioner', 'The holding environment'. Themes looked at support-workers availability for children, considering them holistically and prioritising their needs. They are therapeutically skilled, considering connections with children, non-verbal communication, and playfulness and creativity in their therapeutic work. Support-workers feel confidently led by clinical consultation in their therapeutic work. Support within teams, and management relationships are protective factors to compassion fatigue.

Future research should look at different understandings of what 'therapeutic work' means, and how this is implemented in care-homes.

Key words

Children in care, looked after children, residential care, substitute care, therapeutic parenting, support-workers

Introduction

CIC are vulnerable to developmental trauma due to the adversity experienced in their life. Support-workers in care-homes act as ‘therapeutic parents’ for these children, with minimal training about what this means. There is no research looking into the experiences of support-workers in their therapeutic role.

There are 2880 care-homes available across the United Kingdom (UK Government, 2024), providing one accommodation option for CIC (UK Government, 2024). The majority of children (66%) are in care due to risk of abuse or neglect (UK Government, 2024). They are vulnerable to developmental trauma, which is experienced when a child is exposed to multiple traumatic events in relation to interpersonal relationships (The National Child Trauma Stress Network, 2024). Developmental trauma usually occurs with primary care givers, in relation to severe, pervasive events such as abuse or neglect early in life, disrupting the child’s development, formation of sense of self, and ability to form and maintain secure attachments into adulthood (Hambrick et al., 2019; Felitti et al., 1998).

Due to their adverse experiences CIC may develop blocked trust (Hughes, 2017), whereby their lack of trust in early relationships develops into a ‘blueprint’ of their understanding of all relationships. If not addressed, this can result in a general mistrust of others, particularly those offering care, resulting in a ‘self-survival’ approach to interpersonal relationships. Resilience to potential rupture of parent-child relationships is a factor in their ability to learn and develop through new relationships. CIC may bring these early working models of relationships into their relationships with support-workers. This complicated learning results in CIC having complex needs, especially when living outside of a ‘family unit’.

Working with children on developmental trauma and meaningful relationships can result in more likelihood of home stability (Golding et al., 2006; Perry, 2014; Tronick & Perry, 2015; Golding, 2020; Beeghly et al., 2016; Bellis et al., 2017). NICE guidelines (2021) recommend that supportive positive relationships are developed with CIC, including support-workers treating the children they work with as ‘one of their own’, being available and reliable, and offering relationship continuity. This is difficult to manage when support-workers work shifts and are not available to the child on a daily basis. While both support-workers and social workers are expected to function

as a corporate parent[1] for CIC, there is a move towards support-workers being expected to act as the 'therapeutic parent'. There are different definitions of what 'therapeutic parenting' looks like, including: "nurturing parenting style developed from consistent, empathic, insightful connected responses to a child's distress" (National Association of Therapeutic Parents, 2024). If support-workers act as a 'therapeutic parent' they need to understand developmental trauma and blocked trust to be able to form and maintain positive and supporting relationships with the children they work with, approaching parent-child relationships with sensitivity, responsiveness and availability. To accommodate the NICE guidelines (2021) care-homes often offer a 'key worker' system whereby a support-worker is allocated to a child in the more senior role of their close family figure.

Many care-homes are currently marketed as being therapeutic, staffed by support-workers trained in care specific to that home. There are currently no regulations for care-homes regarding the therapeutic care they may offer. Different models are used (usually adapted by in-house clinicians) from therapeutic approaches aimed at foster/adoptive families (Beeghly et al., 2016; Siegel, 2007; Parry et al., 2021). Several barriers are obvious when applying these to care-homes including: additional non-biologically related children living in the home, and large numbers of staff within the home environment. In line with NICE (2021) guidelines, many care-homes receive consultation from Clinical Psychologists who are well placed to offer the support recommended for support-workers including, training and reflective practice. Without specific guidelines on what this input should look like, it can be offered on a spectrum from clinical teams working onsite daily, to a monthly visit.

There is a lack of research on how support-workers understand and identify with their therapeutic role. Understanding their experiences will be useful in offering CIC the best opportunities to manage their developmental trauma by developing their skills in forming and maintaining relationships throughout their life.

Rationale for the study

[1] 'Corporate parent' is the name given to an organisation who has special parental responsibilities for CIC, e.g., a local authority who assumes the parental role for a CIC may be the 'corporate parent' for that child (UK Government, 2024).

There is a move towards support-workers being expected to provide therapeutic care (NICE, 2021), with no requirement for therapeutic qualifications in their role. The owner company includes what they think is significant and relevant for training and supervision. This complicated and emotionally charged work can naturally include the requirement to tailor the care offered to each child, resulting in therapeutically un-qualified support-workers being left to make therapeutic decisions.

There is some research looking at the needs of foster parents for a successful foster placement. This recommends that community support, links to other foster families, and self-care skills, can enhance these relationships (Brown, 2008). Although this research may be loosely transferable to the support-worker/child relationship, there is no research around understanding the experiences of support-workers who are expected to deliver therapeutic work in care-homes. We have little understanding of how support-workers perceive 'therapeutic parenting' and how they may connect, understand, or identify with this element of their role when supporting CIC.

Researcher positioning

Although during data collection and analysis the researcher was no longer working in care-homes, they had a history of working in these environments as an Assistant Psychologist. This involved clinical consultation, including teaching support-workers the basic theory of attachment, PACE[2], and developmental trauma, whilst being supervised by Clinical Psychologists trained in Dyadic Developmental Psychotherapy (DDP). The researcher is aware of the competing demands for support-workers, including services being marketed as therapeutic, but not always realistically delivered as therapeutic, creating some discrepancy between the aims of the company and the role of the support-worker.

The researcher's personal beliefs from working in care-homes was that support-workers have different levels of relationships in their role, with both staff teams and children. There was an expectation that support-workers may not recognise or acknowledge the work they do as therapeutic. This is individual to each support-worker, care-home and child being worked with.

[2] PACE is an element of DDP, an approach offered to help foster and adoptive parents to connect with children who have experienced complex trauma (DDP Network, 2024)

Aim

The aim of this study is to better understand how staff perceive therapeutic work and how they identify with this element of their role. By understanding this the research also aims to consider how clinical consultation is perceived by support-workers, to make recommendations for Clinical Psychologists working in care-homes. This may help to provide more useful consultation which can meet the needs of support-workers to maintain a stable and supportive placement for CIC.

Research question: How do residential support-workers perceive their role in a therapeutic setting?

Method

Ethics

This project was approved by Staffordshire University ethics committee (appendix H). Written consent was gained prior to arranging interviews (appendix I).

Potentially identifiable participant information was removed from transcripts and pseudonyms were assigned (table 1). After interview participants were sent a debrief form by email, which signposted them to further support if needed (appendix J).

Design

A qualitative methodology was used, incorporating semi-structured interviews and reflexive thematic analysis (RTA) (Braun & Clarke, 2022). Qualitative research allows for meaningful exploration of subject areas enabling deeper understanding of a phenomenon (Clarke & Braun, 2013; Smith, 2015). In this case support-workers' perceptions of their role in therapeutic care-homes.

Although considered, other methods of qualitative analysis were not used, e.g., interpretative phenomenological analysis, due to the idiographic focus (Smith, 2015). RTA allows the researcher to consider a nomothetic approach, looking at patterns and traits across a group of people. RTA allows the researcher to bring their own experiences into research to consider their own biases and perceptions. With the researcher holding beliefs of the residential care system due to previous work experience it was important for this to be considered in this data analysis. The aim

was to look at perceptions across a group of support-workers, and therefore a reflexive thematic approach met the aims of this research (Braun & Clarke, 2022).

Semi-structured interviews were used to gain a rich understanding of support-workers perceptions of their roles in therapeutic care-homes. This research is exploratory and therefore aims to gain initial understanding of the perspectives of those in these roles to obtain rich data which may guide future research. The appeal of this method is using an interview schedule from which deviation is permitted, allowing the interviewer to probe participant responses and explore unanticipated lines of enquiry (Rubin & Rubin, 2005). The interview schedule (appendix K) was developed in consultation with an academic supervisor and was flexible enough to explore aspects of what participants thought about their therapeutic role. Prompts were used, and modified in each interview, to help gain more depth from participant responses and encourage them to be more reflective when speaking about their experiences of working with CIC.

The researcher considered including support-worker/CIC views when developing the interview schedule but this was not completed due to time constraints.

Recruitment

Purposive sampling was used as this is a non-probabilistic sampling technique used in qualitative research to deliberately choose participants based on their characteristics which are relevant to the research (Rohleder & Lyons, 2017). This approach to recruitment has advantages of efficiency and effectiveness by advertising the inclusion criteria for research participation and asking participants to identify themselves to the researcher. Preference was given to recruiting people from a range of care providers, rather than targeting providers, with aim to reduce bias in recruitment. The study was advertised on Facebook, Twitter, LinkedIn (appendix L). It was posted in care worker support groups on Facebook, with administrator approval. Potential participants contacted the researcher by email.

During recruitment participants made comments that they were not aware if their support-worker role was a ‘therapeutic role’. It is possible that this lack of insight and clarity of role for some support-workers may have limited the recruitment due to mis-understanding.

When potential participants made contact, they received a copy of the research inclusion criteria and the participant information sheet (appendix M). Written consent was obtained before an interview was booked (appendix I).

Inclusion criteria:

- working as a support-worker in a therapeutic children's care-home in England or Wales
- over 21 years old (requirement of this work)
- be working or have worked as a residential children's home support-worker for at least one year (with aim to interview those with care work experience with a reasonably formed understanding of their job role)

Exclusion criteria included working in care-homes for learning disability, secondary mental health inpatients, or homes where children were detained by law, due to these services using different care models and possibly more restrictive practices due to risk.

Participants

Eight participants took part in this research. Recruitment was concluded as no further participants were identified within the time frame and information power was identified by the researcher noting a repetition of responses across interviews. Information power indicates that the more information the sample holds, relevant for the actual study, the lower number of participants is needed (Malterud et al., 2016). While quantitative methodology seeks to establish breadth of topic, qualitative research is concerned with depth, and a smaller sample allows for more in-depth inquiry (Crouch & McKenzie, 2006).

17 potential participants contacted the researcher. Six were care-home managers, not meeting inclusion criteria. One participant did not respond to communication, one was not a support-worker, one did not attend interview, or respond to further contact. Two participants identified being in their role less than 12 months, so consented to contact after the relevant time for them to meet this criteria, one completed an interview, there was no further response from the second. Non-attenders were followed up by email/phone, and where possible an alternative meeting arranged.

There were eight participants, with a mean age of 33. One identified as mixed Caribbean, one black African, one black Afro-Caribbean, five white British. Six identified as female, two male. They had differing levels of education and therapeutic training (appendix N).

Procedure

Once written consent was obtained an interview was booked on Microsoft Teams. Interviews took place between June and December 2023, and were recorded and transcribed using Microsoft Teams software. Demographic data was collected at the end of interview: age, gender, ethnicity, therapeutic training completed, other relevant qualifications, and level of education (appendix N). Interviews lasted in a range from 34-69 minutes, with the mean being 51 minutes. After interview, participants were sent an email debrief.

Data analysis

Each interview recording was played once to check and correct the transcription. Data was analysed using the RTA six-phases which allowed for systematic review of the data meeting the aims of this research question, and incorporating the subjective consideration of data interpretation (Braun & Clarke, 2021; Braun & Clarke, 2022).

Transcripts were read to familiarise with the data. Initial coding was completed by highlighting relevant sections of transcript text in a Microsoft Word document (appendix O), and assigning these with a code which was inputted in a Microsoft Excel spreadsheet (appendix P). Colour coding was used to structure and organise the data, allowing for easy referencing of codes within a large amount of data. There is no-one suggested way to organise data when coding in RTA, adding to the reflexive nature of this data analysis (Braun & Clarke, 2022; Trainor & Bundon, 2021). Codes were then printed and analysed manually by grouping the printed statements into subthemes and themes (appendix Q). At this point the researcher removed codes from the analysis due to there being a minimal depth of data. There is no agreed point at which coding data ends, or an ideal number of codes, it is suggested to use a set of codes that richly and thoroughly captures the analytically relevant aspects of the data set (Braun et al., 2022). Themes, subthemes, codes and extracts were inputted into an excel spreadsheet (appendix R) and reviewed and analysed by revisiting the extracts to

consider connection with the theme and the research question. During the writing up of themes, further considerations were made and discussed with researchers in workshops at Staffordshire University and with the academic supervisor. For example, the theme ‘My changing role’ (appendix Q) was removed due to the subthemes in this theme being focused on participants’ description of their duties rather their perception of their therapeutic role. Transcripts were read again and subthemes/themes revised using printed statements (appendix S) and an Excel spreadsheet (appendix T). Subthemes were then restructured and relabelled before being written up. This further analysis made useful connections between the overall sense of participant group perceptions and the themes, allowing the researcher to offer a reflexive approach to the data analysis (Braun & Clarke, 2022).

The analysis was inductive, grounded in sense-making, underpinned by a constructivist ontology and an interpretivist epistemology (Rohleder & Lyons, 2017). This approach was used as this allows the researcher to consider a bottom-up approach to acknowledging themes in the data, taking into account personal experience and understanding of the subject. Constructivism assumes a stance that there is no single reality or truth, reality is created by individuals in groups. A constructivist ontology allows for acknowledgement of difference in perceptions and personal meaning making, providing opportunities for participants to express their own interpretations of their experiences. Interpretivism is concerned with the need to discover the underlying meaning of events. In an interpretive epistemology, reality is interpreted from the data.

Consideration was taken to the reflexive nature of this data analysis by the researcher keeping a reflective diary (appendix U) to consider their stance and immersion in this data based on their own experiences, as is suggested best practice in RTA (Braun & Clarke, 2022). This ensured that they remained true to participant perceptions of their roles. The researcher brought rich knowledge of context to the project, including both positive and negative experiences of support-workers choosing priorities between paperwork and therapeutic work, recognition of the competing demands for support-workers, and their intermittent use of the clinical skills shared in training, reflective practice, and consultation.

Findings

Themes

Three themes were identified: “Whatever the child needs, that’s the priority”, ‘Being a therapeutic practitioner’, ‘The holding environment’ (table 2), with sub-themes derived from each. Themes are described below, supported by participant quotes.

Table 2: Themes and sub-themes

Theme	**Sub-theme**
1: “Whatever the child needs, that’s the priority”	1.1: Being consistently present and available
	1.2: The child’s emotional needs come first
2: Being a therapeutic practitioner	2.1: Making connections
	2.2: Playfulness and creativity
	2.3: Non-verbal communication
	2:4 Experiential learning
3: The holding environment	3.1: Resilience to manage emotional demands of the work
	3.2: Sources of protection in the workplace

Theme 1: “Whatever the child needs, that’s the priority”

All participants discussed focusing their work on children’s needs. They discussed being present and available for children in their therapeutic role, prioritising children over personal life, and thinking of children outside of working hours. Participants identified their need to guard children from their own emotional experiences at work. Two subthemes were identified, ‘Being consistently present and available’, ‘The child’s emotional needs come first’.

Subtheme 1.1: Being consistently present and available

Participants discussed their motivation to improve the lives of children: “*I just wanna make their lives better*” (Kate). There was a sense from all participants that

their job requires them to be present, available, and thinking of the children they work with daily. Christopher discussed being available for ad-hoc interactions: "*we check in with them whenever*". Jubilee discussed being readily prepared: "*we're here, we're ready, we can engage*". Sandra indicated this as a whole team approach: "*the ability to be able to change that child's life. To keep them safe and secure. I think that really motivates everyone I'd say, like our whole work force we really do just dedicate to the child*".

There was an overall sense of participants prioritising their availability for the children over their own needs. Christopher identified: "*I volunteered to work all weekend. You know, I'll put you first lads*". Yasmin described consuming her personal time outside of work: "*I'll remember she's got dentist appointment tomorrow (…) I'm like, oh I need to get school uniform for her as well. OK, like she's always in the back of your mind*". Louise described feeling guilty leaving her own children at home due to her dedication to her job: "*it makes you feel guilty, but then I feel so strongly about my job*".

Yasmin discussed having sought a job which required this purpose and meaning: "*I wanted a job where I could put my heart into it*". Jubilee compared their previous work in non-therapeutic care-homes, recalling different priorities in these roles: "*the institution's agenda subconsciously takes over the individual's needs (…) you don't spend quality time with the young people*".

Subtheme 1.2: The child's emotional needs come first

There was a sense from participants that they feel responsible for putting the child's emotional needs over their own, resulting in suppression of their emotions at work, and the their feelings being subordinate to those of the children. Mag said: "*you don't show them the emotional parts*", also discussed by Kate: "*[I'm] empathetic towards the situation, but I'm able to keep that inside*". Mag offered some understanding of this in their therapeutic role describing that children who struggle with emotional regulation may be attuned to the difficult emotions of their care giver: "*if the staff is stressed. You're going to indirectly or directly translate on the kids*", where Louise identified her compassion around not wanting the children to see her experiencing emotions: *"it's important to not let them see you upset (…) I just make sure that the child doesn't see it"*. Louise discussed not showing their conflict between feeling, and guarding children from, their emotions, as a strength: "*I'm quite good at*

separating that in the role in making sure that they don't see that". There was an overall sense that the longer participants worked in their role, the more they became accustomed to the suppression of emotions at work. Kate described: "*you don't become numb to it, but you sort of become used to that situation*".

Theme 2: Being a therapeutic practitioner

All participants described the therapeutic work they do, focusing on connection, relationships, playfulness, creativity, and understanding communication, as key skills. There was an overall sense of feeling 'backed up' by the consultation received from Clinical Psychologists. Four subthemes were identified: 'Making connections', 'Playfulness and creativity', 'Non-verbal communication', 'Experiential learning'.

Subtheme 2.1: Making connections

Intuitively building relationships and connecting with children was discussed by Christopher as key to their ability to do any therapeutic work: "i*f you haven't got a relationship with the children you shouldn't be here*". The basic elements of what a consistent and reassuring relationship would look like was described by Sandra: "*reliability, like they need someone they can rely on cause especially with trauma and their attachment issues, they've not had that consistent person in their life and I think being able to consistently, you know, attend your shifts and be there*". Christopher considered this beyond his interactions with children, suggesting that they have a responsibility to approach the children to reassure them each morning: "*I will make sure that I go up on the landings or whatever an say morning so they know they've got that friendly face*", also discussing nurturing relationships using observation and curiosity: "*When a new boy comes in. I'll observe. I'll just sit back for a couple of days thinking. (…) I'll find a way in there*".

Participants considered children holistically to connect with them, identified as a key factor to working progressively. Amber described: "*we are physical, mental, emotional and spiritual beings. Until we have connected with a child on each of those levels, there's no point trying to do anything*", while Christopher said: "*You need to know the boy's soul. What makes them tick*".

Subtheme 2.2: Playfulness and creativity

Playfulness and creativity were identified as well-used therapeutic skills which aid engagement. Jubilee described being creative and flexible in planning and preparing for key worker sessions: "*if I'm gonna do a [key worker] session, I will take him out to the park. I might do it in the park. I might do it after I've come back from the park or on the way back from the park*". Amber identified her playful approach extending to her own flexibility: *"he wanted to be Christian one day Muslim the next. Buddha the next and it's sort of just me not saying you don't know what you are sort of thing, it's me saying instead, OK, let's try that then (…) I've been a litter picker with him. I've been a tree climber*".

Jubilee discussed using movement to support emotional regulation: "*the activity it's absolutely crucial. You can't do the other stuff without the activity. That's your foundation. That's your scaffolding (…) If you don't do the regulation you've got no chance*".

Participants discussed taking a creative approach when supporting education. Christopher discussed helping teachers to connect with children to work better with them: "*they might need support down the school, lad's not engaging, makes a noise, having a bit of a strop (…) How can we make that lesson fun? More engaging*", while Jubilee discussed thinking adaptively when offering education provision themselves: "*we're trying to impart the knowledge without being in a classroom, so we'll take them for the day to [local stately home]. They do history*".

Subtheme 2.3: Non-verbal communication

All participants discussed understanding that the children they work with have difficulties communicating their needs. Louise said: "*it's about understanding the child and knowing their needs and then responding accordingly*". They discussed recognising, understanding, and interpreting communication differences. Yasmin said: "*when you look at the behaviour like a surface level, it's different to what it really means*". A sense that a non-judgemental stance benefits interpreting communication was described by Amber: "*accepting everyone for who they are and maybe what emotions and behaviours they bring, not focusing so much on the behaviour, but the cause of the behaviour*". Sandra described challenges in this area: "*communication, that can also be a barrier, you may not really think trauma can affect the way that they communicate. You obviously need to sort of understand what they're trying to say*". Mag discussed their self-awareness when communicating with children: "*The tone of*

your voice (…) once you harsh with the kids, you've spoilt their day, so I try to use the low tone and always smile".

Subtheme 2.4: Experiential learning

Experientially learning was discussed by participants observing their colleagues and clinicians at work. Experiencing the realities of children's difficulties in their work was described as useful and complementing to the participants' understanding of theory which had been learned in training: "*Trauma. Uh, I wasn't expecting certain things that they do (…) I feel like when it's on paper it never really truly reflects of what it actually is in person*" (Sandra), "*I think some of it does compliment the training, but then I think other times it's watching how people implement it (…) when you're actually in the moment, like how people deal with the situation like, I think that's missed off the training*" (Yasmin), "*I've learned a lot (…) I've done uni for like how long now? And I feel like I've learned more from the kids than I have like in my degree*" (Yasmin). It appeared that this way of learning helped participants to recognise their own parental development, and their identity as a therapeutic practitioner: "*I've become so more empathetic (…) I really know how they feel*" (Mag), *"it makes everything make sense a lot more when you can match your personal experiences and advice to what you're trained in*" (Louise). Christopher discussed feeling obligated to share knowledge gained over years of experience in the industry: "*now it's time for me to pass on my knowledge and my skills on to other people*". Imparting knowledge of their own care experience to support colleagues was discussed by Kate: "*some workers they've never been through any type of experience (…) I can sort of look under it and be like, there's probably something else there that they're struggling with and we need to try and get to the root of the problem*".

Participants appeared to reference the confidence they gain from the clinical consultation process by citing the varying levels of input experienced: "*We also have a psychologist that comes every two weeks*" (Sandra), "*we have a clinician that comes into the home once a month*" (Louise), "*we've got a fulltime psychologist, we get the additional knowledge about developmental trauma" (Jubilee).* The feeling of confidence in being led by clinicians was described by all participants, but there was some indication that the more ingrained the clinical team is within the home, the higher feeling of confidence in their therapeutic skills felt by the participant: "*I do feel empowered overall and I think what helps is because we've got a clinical director who*

is a psychologist who understands all that kind of stuff (…) She has real power" (Jubilee).

Theme 3: The holding environment

There was a sense that the therapeutic role of a support-worker is all-consuming and that staff need internal and external holding. Participants discussed internal holding using resilience. They discussed being held externally by management. Two subthemes were identified, 'Resilience to manage emotional demands of the work', 'Sources of protection in the workplace'.

Subtheme 3.1: Resilience to manage emotional demands of the work

Participants discussed experiencing emotions as an expectation of therapeutic work: "*one thing I find quite difficult (…) it's like you have to manage your own emotions well*" (Yasmin). Resilience was identified as important to managing emotional load: "*it's quite emotionally draining. I think you have to sort of be really resilient in that aspect*" (Sandra).

Louise described that teamwork helps to build collective resilience: "*I've got a great team and we all get on really well and we're able to channel those emotions together*". All participants discussed their skills and resilience to both receive, and give, emotional support to their colleagues. Sandra said this is embedded in their team approach to incidents: "*we have a debrief, we talk about what we did, what we could have done better, if we need any more training, if we need any sort of outside support*". This shared reflection and development was identified as important due to this need not being recognised by family and friends outside of their role: "*unless you're in that job I think it's hard to understand the more in depth challenges that residential care workers go through*" (Louise), *"they say, you just drop the kids off to school and then you've got the whole day to just do what you want (…) they don't really get it*" (Yasmin).

Subtheme 3.2: Sources of protection in the workplace

The need for protection from the conflict in aims between their work and the requirements of external agencies was described by Jubilee: "*Ofsted, can be very target driven. Very outcome driven, well, they haven't been to school for three days. Why not? Whereas we're saying, OK, yeah. but they've got developmental trauma. They've got attachment issues. School is a trigger (…) We have got a plan to work*

towards getting them into school. but we're doing it a different way". They elaborated on this, discussing their need for protection from the issues created by this work: "*do you know organisational trauma? (…) if these kids are traumatised, and we're working with this trauma and we hold on to this trauma*" (Jubilee). Amber reinforced this when discussing their experiences of management protection when struggling with feelings rooted in personal experience of the care system: *"they said [Amber], was you emotionally triggered by that? Because it seems as though you started not thinking about the young person, and you really actually started thinking about how angry the system makes you rather than, you know, looking at what the situation really is*". Jubilee discussed a need to protect their colleagues' by considering their motivation for therapeutic work: "*you have to accept that you get lots of staff who are wounded healers*[3] *(…) But we're open about that. We're explicitly looking at people from that point of view*", giving the implication that colleagues' mental health, and motivation is important to take into consideration in care-homes.

There was a sense that participants feel understood by their management, as a protective factor to the conflicts and systemic issues they experience in their work. Participants described receiving open and accessible support from their managers: "*we get a lot of support from the management (…) that make us competent enough to do the role*" (Louise) "she's always willing to talk" (Yasmin). Feeling this protection as part of the team work appeared to make it possible for them to deliver their therapeutic role: "*I said to my manager ohh well done, It's amazing, and she said Ohh it's a team effort, and I agree it is a team effort (…) you've gotta have a good manager to have a good team" (Louise)*.

Discussion

This research is considered to be the first looking at support-workers and their perceptions of their role working in a therapeutic setting, giving valuable insight to the understanding of this group of support-workers and their perceptions of their therapeutic role. The themes focused on, "Whatever the child needs, that's the priority", 'Being a therapeutic practitioner', 'The holding environment'.

[3] 'Wounded healer' is a term used for a person who is compelled to position themselves to treat/heal others due to they themselves feeling wounded (Jung, 1951)

“Whatever the child needs, that’s the priority”

There was an overall sense of participants expecting to ‘give-all’ to the children they work with. They discussed motivation to improve their lives, and responsibility to be available and prioritise the children’s needs. Providing the reliability and consistency the children may have missed from significant caregivers includes thinking about the children outside of worktime. This is in line with NICE guidelines (2021), suggesting that support-workers consider the children they work with as ‘their own’. This therapeutic approach is an example of where support-workers are well positioned to offer positive work based on attachment theory, which suggests that the presence of a caregiver, and nurturing of this secure-base relationship, can give children opportunities to expand their social repertoire with the confidence that their caregiver is available should they need them (Bowlby & Holmes, 2012). This exploration of the world in a secure-relationship has potential to help children develop skills to build positive relationships throughout their life (Hughes et al., 2015; Golding et al., 2006).

Participants described responsibility to protect children by subordinating their emotional experiences for the child’s. This appears to show their understanding of developmental trauma and how this may affect the child’s ability to cope with the complicated emotions of those around them (National child trauma stress network, 2024). This consideration for the child’s experiences shows that support-workers consider them with ‘mind mindedness’, suggesting that the caregiver considers the child as an individual with their own experiences, rather than merely an entity which needs to be satisfied (Meins, 1997). Although this prioritisation may be considered gallant for the children, support-workers appear to sacrifice their personal experiences, and this is not recognised by friends and family outside of work. This dedication to work can result in an individual struggling emotionally, physically, and psychologically, with helping others who have experienced prolonged stress or trauma, known as ‘compassion fatigue’ (Keeping well, 2024). Research has shown that compassion fatigue is present in support-workers (Benveniste et al., 2024) and can also be present for families of CIC where repeated stress impacts a caregiver’s ability to sustain meaningful connections and empathy towards their child (Fletcher et al., 2023).

Being a therapeutic practitioner

Making connections was discussed as a focus of the therapeutic role, mainly, building relationships with children. This is more formalised for those who take on a 'key worker' role and have focused responsibilities for one child. The association between exposure to childhood adversity and mental health problems in adulthood is reduced in effect when individuals report having at least one consistently available adult throughout their childhood (Bellis et al., 2017). This research shows that this key area is a natural consideration by this group of support-workers, suggesting that their intuition may play an important part in the work that they do around rupture and repair of relationships. Research has also shown that the therapeutic relationship can be more significant to the success of therapeutic work than the intervention itself (Ardito & Rabellino, 2011), and relationship depth is a predictor of subjective wellbeing in close relationships in the community (Di Malta et al., 2024). This research uniquely shows that support-workers are well positioned in their role to nurture these therapeutic relationships due to their ability to consider children more holistically than clinicians who might have limited contact time. It must be considered that the changing role and responsibilities for support-workers could create barriers to the consistency and reliability required to nurture these relationships and is therefore vital that support-workers are supported when building relationships with children to avoid placement breakdown (Golding et al., 2006).

This research helps us to understand that support-workers recognise their skills in their work, focusing on integrating therapy into life. Enriching a child's entire relational world outside of therapy sessions can be an important factor in buffering the effects of adverse early life experiences (Hambrick et al., 2019) and this research shows that support-workers are well placed to do this with CIC. Participants identified playfulness, creativity, and understanding communication as key to their therapeutic work. Playfulness and creativity were described as helping to meet the child in their own world, with movement and activity also used when making connections with children. This mirrors the work offered by clinical psychologists and therapists using activity-based approaches working with children (Beacon House, 2024; CalmBrain Approach, 2024). Therefore this research helps us to understand the level of therapeutic input being offered by support-workers in their role, and their ability to deliver this with confidence.

The skills in this theme, recognised together are a description of the playfulness, acceptance, curiosity and empathy offered as part of a DDP approach (DDP Network, 2024), aimed to aid formation and maintenance of attachment bonds (Golding, 2019; Hughes et al., 2015; Purrington et al., 2023). Participants in this research discussed their need to connect with children before considering intervention. This 'connect before you correct' approach is also embedded in the thinking of those trained in DDP. Although this is positive, it may be important to consider the long-term training required for this therapy (DDP Network, 2024), and the support available to qualified practitioners to maintain their competency to deliver this therapy. Although DDP can be considered a useful attachment-based approach, it must be considered from a family-therapy/systemic perspective as the one-to-one therapeutic relationship is not fully replicable in the residential care-home environment where no-one staff member is able to dedicate themselves to one child throughout their day.

This research offers us a unique understanding of how participants learn in their therapeutic role, they discussed learning best in experiential environments where they can observe colleagues at work. This was identified as key to understanding the theoretical base of therapeutic work. Participants discussed learning in this way, but also disseminating their knowledge and experience to colleagues. This 'train-the-trainer' approach to learning is already used in social care, and has been shown as effective in community-based family interventions (Lai et al., 2017). This research suggests that this kind of approach to learning may be useful in the care-home environment, where support-workers are open and willing to share and learn from each other, using team work as a positive learning tool. Participants described being led by clinical psychologists in consultation which appears to give them confidence in their work.

The holding environment

This novel research shows that support-workers experience a high emotional load, and therefore have need for emotional resilience to deliver the therapeutic work they do. Participants identified that the more work they do, the less they engage with their emotions at work. This was discussed as positive development, but this disconnection with this work could also be considered as an indicator of compassion

fatigue (Keeping well, 2024). Participants also identified that friends and family do not recognise the difficulties of their work. Therefore, teamwork and togetherness must be considered as protective factors for emotional load at work, with reflective practice and team debriefs identified as useful by participants. This has been shown to reduce the effects of difficult experiences for healthcare workers' (Rabin et al., 2023). This research shows that this can translate to support-workers in residential care-homes. In a review of literature, it was considered that having a higher level of job satisfaction is associated with lower levels of compassion fatigue in support-workers (Beneviste et al., 2024), and therefore should be considered with staff support and wellbeing.

Participants discussed experiencing conflict between the systemic requirements of their job role and the therapeutic work they do. It has been discussed that the decision makers within residential care settings appear to be disconnected from the realities of the demands of support-workers (Fenton, 2015), and that this discrepancy can lead to the focus of expected work for key workers to shift from relationship building to bureaucratic tasks to satisfy management requirements, the relationship with care givers becoming a second focus, being left behind when faced with a busy work environment (Munro, 2011; Furnivall et al., 2012). This can also result in a conflict of aims for the support-worker, who may be torn between their need to offer more hands-on support as a priority over paperwork, but may also add the protective layer of paperwork as a distracted work task when compassion fatigue is being experienced. Participants in this research identified that they feel protected from conflicting demands by their managers, but due to the novel nature of this research, and this conflicting with some of the researchers' personal experiences of work in care-homes, this may need further exploration.

This novel research identifies praise and validation as helpful factors in building support-worker confidence. Developing this compassion-focused approach could be useful when considering staff and team wellbeing (Gilbert & Simos, 2022), and has been shown to make healthcare workers better able to maintain or improve their level of compassion for the people they work with (Henshall et al., 2017).

Clinical Implications

This research offers a unique understanding of support-workers and their perception of their therapeutic role. Participants described their feelings of

expectations to ‘give all’ to others, and consider their own emotions subordinate to those of the children they work with. Although this approach to their job role is in line with the NICE guidance (2021), it appears that this guidance does not take into consideration the repercussions of this kind of ‘all-encompassing’ dedication to work. The sample of support-workers in this research appear to work in nurturing environments, with supportive colleagues. They appear to have autonomy and psychological flexibility in their work, feeling protected and cared for by their management. Without these protective factors they could be vulnerable to compassion fatigue (Beneviste et al., 2024; Holding et al., 2024). Systemically rooted compassion-focused approaches understand the need to balance drive and motivation as part of team identity, whilst also considering the need to soothe and offer self-compassion (Gilbert & Simos, 2022), and may be useful when considering the potential for compassion fatigue for support-workers in care-homes.

It is obvious from this research that it is not possible for support-workers to recreate the parental relationship one child may have with one consistent parental figure in care-homes due to support-workers working shifts and not being available to the child on a daily basis. Although as an individual therapy DDP is not perfect for the residential care-home environment it offers a two-phase attachment-focused approach (Hughes, 2017). The first is working with the carer around their motivation and ability to relate with the child in their environment (Fletcher et al., 2023). Using this phase to support staff teams to understand the child and the ways they can facilitate attachment security and parenting principles aligns with the participants’ descriptions of intuitively connecting approaches (Hughes & Simos, 2017). Using this kind of approach in Edge of Care and residential teams has been shown to reduce feelings of rejection or mistrust, and in turn nurture relationships within support systems between professionals and families (Fletcher et al., 2023), which could be replicated in care-homes.

This novel research shows that support-workers offer highly skilled therapeutic work in care-homes. They are aware of their responsibilities in their therapeutic work, including communication styles, and assessing and formulating a child’s needs. Support-workers are well placed to use their intuition and relationships with children to offer appropriate playful and creative interventions which can be formally planned or offered on an ad-hoc basis. Regular interactions with Clinical Psychologists offering

consultation gives support-workers confidence in their role. Clinical Psychologists must acknowledge that they are offering consultation to a population of support-workers who, although invested in their work, are not formally therapeutically trained, and therefore need repetitive and nurturing training and supervision.

Future research

Future research could explore the understanding of what constitutes 'therapeutic input' in a care-home, with exploration into where, when and how this is implemented, and by whom. This research could consider the perceptions of the professionals who market, plan and oversee this input, including the perceptions of managers, commissioners and marketeers of these services.

Strengths and limitations

To the researcher's knowledge, this is the first qualitative study exploring the experiences of residential support-workers in their therapeutic role. Using RTA offered an understanding of their perceptions of the therapeutic work they do, and how this can be supported by those offering clinical consultation.

Although demographic data was collected there was no difference based on demographics. The information about participants' length of experience working as a support-worker, any personal care experience, and the regularity and input of clinical consultation, was not collected. This information might be useful for future research in this area.

The researcher did take some consideration to service user involvement in this research, including potential input into development of the semi-structured interview schedule. Due to time constraints this was not completed. Beresford (2013) discussed that service user involvement in research can help to challenge the 'them' and 'us' created by the research process. The participants in this research were sent a copy of the executive summary, and alterations were made based on their feedback. No comments were made on the themes but this feedback included their requests for description of terminology, which was included in the summary as 'bitesize' visual elements explaining terms, e.g., "what is compassion fatigue".

The sample may be biased in some ways. Recruitment was completed using social media. This is reliant on the dissemination of a recruitment advert to care-home

support-workers. The researcher was contacted by managers of care-homes who were not eligible to participate but asked for information about the research. This appeared to be a decision point whether to disseminate the advert to their staff teams or not. Therefore, it is possible that participants in this research come from a pool of support-workers who are supported to participate by their managers approval rather than them finding this autonomously. In the proposed research, direct contact with children's homes was not used, with aim to reduce the direct targeting of particular care-homes and limiting the pool of participants.

Conclusion

This study offers a novel insight into the perceptions of residential support-workers of their role in a therapeutic setting. Support-workers are invested in the work they do, considering the children they work with as 'their own'. They are skilled in their therapeutic approaches, including, playfulness and creativity, awareness, and flexibility of communications, and connecting and building relationships with children.

Support-workers recognise their need for support, and to support other colleagues in their work, to protect them from compassion fatigue. Positive relationships with management also offer some protection for this. Clinical Psychologists offering consultation to children's homes must be mindful of their responsibility in training, nurturing, and supporting this workforce in the therapeutic work that they do.

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Appendices

Appendix G: Publication guidelines

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

In-house submissions, i.e. papers authored by Editors or Editorial Board members of the title, will be sent to Editors unaffiliated with the author or institution and monitored carefully to ensure there is no peer review bias.

New submissions should be made via the Research Exchange submission portal. Should your manuscript proceed to the revision stage, you will be directed to make your revisions via the same submission portal. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

Child & Family Social Work now offers **free format submission** for a simplified and streamlined submission process. For details see section 4 of the guidelines.

Data protection:
By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

Pre-Print Policy

Please find the Wiley preprint policy here.

Child & Family Social Work will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

Refer and Transfer Program

Wiley believes that no valuable research should go unshared. This journal participates in Wiley's Refer & Transfer program. If your manuscript is not accepted, you may receive a

recommendation to transfer your manuscript to another suitable Wiley journal, either through a referral from the journal's editor or through our Transfer Desk Assistant.

2. AIMS AND SCOPE

Child & Family Social Work provides a forum where researchers, practitioners, policy-makers and managers in the field exchange knowledge, increase understanding and develop notions of good practice. In its promotion of research and practice, which is both disciplined and articulate, the Journal is dedicated to advancing the wellbeing and welfare of children and their families throughout the world.

Child & Family Social Work publishes original and distinguished contributions on matters of research, theory, policy and practice in the field of social work with children and their families. The Journal gives international definition to the discipline and practice of child and family social work.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Original Articles should normally be a maximum of 7000 words, including the abstract and any appendices, although shorter papers will be welcomed. References are not included in the 7000 word limit. The abstract should not exceed 200 words and it should be followed by six keywords.

The Editors also welcome the following scholarly papers:

Review These will be actively encouraged. Prospective authors should initially discuss their proposals with the Editor.

Spotlight This section publishes brief contributions (around 1000 words) on policy debates in different countries or short policy articles. Contributions are welcomed.

Special Issues From time to time the Editor may commission a special issue of the Journal which will take the form of a number of papers devoted to a particular theme.

Book Review

(i) Book reviews should be headed with the reviewer's name, in capitals. Beneath the reviewer's name, and ranged to the right, should come the full publication information (i.e., title in full, author, place, publisher, date of publication, edition statement, pages, special features [maps, color plates, etc.], price, and ISBN), for example:

The Peasantries of Europe: From the Fourteenth to the Eighteenth Centuries, by Tom Scott (ed.). London and New York: Longman. 1998. pp. xi+416. £ 44 (hb); £19.99 (pb). ISBN 0-582-10132-8 and 0-582-10131-X

(ii) The reviewer's institutional affiliation should appear (ranged to the left) as an unnumbered footnote on the first page of the review. Acknowledgements, if any, should also be made there.

Structure the book review as follows:

- One paragraph identifying the thesis, and whether the author achieves the stated purpose of the book.
- One or two paragraphs summarizing the book.
- One paragraph on the book's strengths.
- One paragraph on the book's weaknesses.
- One paragraph on your assessment of the book's strengths and weaknesses.

The word limit is 1000 words.

4. PREPARING YOUR SUBMISSION: FREE FORMAT SUBMISSION

Child & Family Social Work now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including statements relating to our ethics and integrity policies:
- data availability statement
- funding statement
- conflict of interest disclosure
- ethics approval statement
- patient consent statement
- permission to reproduce material from other sources

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details.

- Your co-author details, including affiliation and email address.
- An ORCID ID, freely available at https://orcid.org.

To submit, login at https://wiley.atyponrex.com/journal/CFS and create a new submission. Follow the submission steps as required and submit the manuscript.

5. FINAL SUBMISSION REQUIREMENTS

Parts of the Manuscript

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file should be submitted in Microsoft Word (.doc or .docx) format.

Title page

The Title page should be uploaded under the designation 'title page'.

The title page should contain:

i. A short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Acknowledgments.

Authorship

Please refer to the journal's authorship policy the Editorial Policies and Ethical Considerations section for details on eligibility for author listing.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the section 'Conflict of Interest' in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Main Text File

The Manuscript without title page should be uploaded under the designation 'main document'.

As papers are double-blind peer reviewed the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

i. Title, abstract and key words;
ii. Main text;
iii. References;
iv. Tables (each table complete with title and footnotes);
v. Figure legends;
vi. Appendices (if relevant).

Figures and supporting information should be supplied as separate files under the designation 'figures'

Abstract
Please provide an abstract of no more than 200 words.The abstract should be followed by up to six keywords.

References
References in published papers are formatted according to the Publication Manual of the American Psychological Association (6th edition). However, references may be submitted in any style or format, as long as it is consistent throughout the manuscript.

Tables
Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends
Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures
Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Color Figures. Figures submitted in color may be reproduced in color free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white.

Additional Files

Appendices
Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Supporting Information
Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

The following points provide general advice on formatting and style.

- **Language**: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses

Appendix H: Ethics approval letter

School of Health, Science and Wellbeing

ETHICAL APPROVAL FEEDBACK

Researcher name:	Kate Cudmore
Title of Study:	SU_22_104 Residential children's home support workers: perceptions of their role within a therapeutic care setting
Award Pathway:	PGR
Status of approval:	Approved

Your project ***proposal has been approved*** by the Ethics Panel and you may commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site.

The Ethics Committee wish you well with your research.

Signed: 

Date: 23.02.23

Dr Jade Elliott

Ethics Co-ordinator
Psychology
School of Health, Science and Wellbeing

Appendix I: Consent form

RESEARCH PROJECT CONSENT FORM

Title of Project: Residential children's home support workers: perceptions of their role within a therapeutic care setting

Researcher: Kate Cudmore – Trainee Clinical Psychologist

I have read and understood the information sheet.	Yes ☐	No ☐
I have been given the opportunity to ask questions, and I have had any questions answered satisfactorily.	Yes ☐	No ☐
I understand that my participation in this study is entirely voluntary and that I can withdraw my data within two weeks from the interview date, without having to give an explanation.	Yes ☐	No ☐
I understand that the interview will be video recorded for the purposes of transcription, and that I can turn my camera off for the interview if I prefer.	Yes ☐	No ☐
I consent that data collected could be used for publication in scientific journals, or could be presented in scientific forums (conferences, seminars, workshops), or can be used for teaching purposes. I understand that all data will be presented anonymously. I understand that data used may include quotes from interviews.	Yes ☐	No ☐
I agree that data will only be used for this project 'Residential children's home support workers: perceptions of their role within a therapeutic care setting', although the data may also be audited for quality control purposes	Yes ☐	No ☐
All data will be sorted safely on a password protected computer (electronic data), or locked away securely (hard copies of data) for 10 years before being destroyed	Yes ☐	No ☐
I hereby give consent to take part in this study	Yes ☐	No ☐

_____	_____	_____
Name Participant (print)	Date	Signature
_____	_____	_____
Name Researcher (print)	Date	Signature

.

Appendix J: Debrief sheet

DEBRIEF SHEET FOR PARTICIPANTS

Project Reference Number: SU_22_104

Title of study
Residential children's home support workers: perceptions of their role within a therapeutic care setting

Thank you for participating in this research project which forms part of my Professional Doctorate in Clinical Psychology Thesis research. Your time and input is much appreciated.
Agreeing to share your experiences with me will help us understand more about residential support workers perspectives of their role working in therapeutic care homes. I hope that this will inform future practice, employment and training within residential children's homes.

What happens now?

Your participation is complete. You may withdraw your data from this project up to two weeks from your interview date. To do this please contact the researcher on c027894b@student.staffs.ac.uk.
All data will be stored securely on a password protected computer (electronic data), or locked away securely (hard copies of data) for 10 years before being destroyed.
Data collected in this project could be used for publication in scientific journals, or could be presented in scientific forums (conferences, seminars, workshops), or can be used for teaching purposes. All data will be presented anonymously.

Sometimes participants can find talking about their experiences can have an emotional impact. If you feel you would value speaking about your experiences more you can contact:

- Your residential care home supervisor/ manager, or clinical team, if available
- Occupational health provision in your workplace
- National Association of Care and Support Workers – well-being hub
  https://nacas.co.uk/
- Samaritans
  https://www.samaritans.org/
  116123
- MIND
  https://www.mind.org.uk/
  0300 1233393

If you would like to receive a copy of this research study once completed please give a contact email address: ……...

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Dr Tim Horne
Director of Research
Research, Innovation, and Impact Services
Staffordshire University
Leek Road Campus
32 Leek Road
Stoke-on-Trent
ST4 2RU
Tim.horne@staffs.ac.uk

Dr Yvonne Melia
Principal Lecturer in Clinical Psychology - Academic Director
Professional Doctorate in Clinical Psychology
School of Health, Science and Well Being (HSW)
Staffordshire University
Leek Road Campus
32 Leek Road
Stoke-on-Trent
ST4 2RU
Email: Yvonne.melia@staffs.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix K: Interview schedule

Interview schedule

Project title –
Residential children's home support workers: perceptions of their role within a therapeutic care setting

You have been invited to this interview as you work in a residential care home offering a therapeutic model of care. I am interested in children's residential care home staff and their perception of their job role within a therapeutic working environment. I am interested in your experience of working in this care setting.

During this interview, if the internet connection is lost I will try and reconnect with you to reschedule, or meet to complete the interview face-to-face.

1. **General**

Please choose a pseudonym for the purposes of anonymity.
All information from this interview will be used anonymously. You may be able to recognise your own experiences but these will only be used by referring to the pseudonym you have chosen.

Do you work in a residential children's home as a support worker? (check not management)
How long for?
What kind of children's home?

Thinking about your role as a support worker in a therapeutic residential care home I am going to ask firstly about your work as a support worker, then about your therapeutic work.

2. **Residential care work**

What are your daily responsibilities?
What are the priorities in your role?

- Do you make decisions about these?
- How do you manage these in your day?

Are there any unsaid expectations?

What are your values in your role as a residential care support worker

- What motivates you?

What do you value in your role in residential therapeutic setting?

3. **Therapeutic work**

You work in a therapeutic setting, what does this look like in terms of your role?

- Daily responsibilities/ activities
- Priorities

What does working in a therapeutic setting mean to you?
What values underpin the approach you take in your role?
What motivates you in your role?
What are the challenges/ barriers in your role?
Are there things expected of you which you find difficult to do?

- Maintaining boundaries with children?
- Discipline?

1. Managing risk?
2. Managing distress?

Are there things expected of you which you find straight forward to do?

What were your expectations when you first started?

3. Are there things about this which were unexpected?
4. Are there things you have had to do which you weren't anticipating in that role?

Do you feel able and empowered to do your role?

5. What affects this?

Are there strong emotions which come up in your role?

6. How does this affect your work?
7. How do you manage this?

What do you think other people's perceptions are of a therapeutic care role?
What do you think the children you work with perceptions are of a therapeutic care role?

How do you find balancing your residential and therapeutic duties?

8. What do you prioritise?
9. How do you prioritise?
10. Anything left out
11. Anything repetitive
12. Feelings/emotions

To what extent does your experience of your role fit with what you expected this to be like?
To what extent does your experience differ to what you expected this to be like?

13. Personal experience

Do you draw on your personal experiences in order to manage your role working in a therapeutic setting?

14. Parenting/ being parented
15. How do you manage this?
16. Do you feel this compliments/ benefits/ challenges your training?

What personal challenges have you experienced in your role?
What personal benefits have you seen from your role?

Anything else about your role that we have not talked about and you think it would be important to mention?

Demographics

- age
- gender
- ethnicity
- therapeutic training completed in this role, or outside of this role?
- relevant qualifications
- level of education

Appendix L: Recruitment advert

Are you a residential support worker in a therapeutic children's home?

STAFFORDSHIRE UNIVERSITY

Participants wanted for a doctoral research project.....

You can take part if you are:

- **A residential children's home support worker with at least one years experience working in England or Wales in a therapeutic care home**
- **21 years old+**

Residential children's home support workers: perceptions of their role within a therapeutic care setting

What is involved?

- This study is being conducted to gain insight to the perceptions of residential children's home support workers of their role in a therapeutic care setting

What would I need to do?

- Participate in an interview, this will last around 1 hour and can be offered on Microsoft Teams or face-to-face at Staffordshire University, Stoke on Trent

If you have any questions or would like to participate in this research, please contact

Researcher: Kate Cudmore
c027894b@student.staffs.ac.uk
Research supervisor: Dr Yvonne Melia Yvonne.melia@staffs.ac.uk

Appendix M: Participant information sheet

INFORMATION SHEET FOR PARTICIPANTS

Project Reference Number: SU_22_104

Title of study
Residential children's home support workers: perceptions of their role within a therapeutic care setting

Invitation Paragraph

I would like to invite you to participate in this research project which forms part of my Professional Doctorate in Clinical Psychology thesis research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

There is little research that has investigated the experiences of residential children's home support workers, including the staff perception's of their role in supporting children who have experienced attachment trauma.
Support workers in children's residential care homes support the needs of looked after children who have often experienced high levels of adversity including abuse and neglect in their relationships with their primary caregivers, resulting in attachment insecurity. Many children's residential care homes now offer therapeutic models of care but we know very little about the experiences of support workers who undertake these therapeutic parenting roles working with children.
The aim of this study is to understand more about your perception of this role and your experiences working in a therapeutic care setting.

Why have I been invited to take part?

You have been invited to take part in this research if you:

- Are currently working, and have worked for at least one year or more as being a residential children's home support worker in a home that offers a therapeutic model of care
- Have this experience from working in children's homes which are NOT specifically for people with learning disabilities, secure or inpatient units, detention by law for forensic purposes
- Are 21 years or older.

What will happen if I take part?

You are invited to take part in a semi-structured interview asking about your perceptions of your role as a residential children's home support worker. Your interview is expected to last around one hour.

Your interview will take place online using Microsoft Teams. This will be recorded with your consent, for the purposes of transcription. If you do not have access to the internet, or you would prefer, your interview can be completed face to face at Staffordshire University, Leek Road Campus.

Your interview is aimed to gain some understanding of your perceptions of your work role within a therapeutic care setting. You will be asked about your perceptions and understanding, and not any specific detail of the people you work with.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

It is not expected that you will experience distress from this research. However, you will be signposted to potential sources of support if you have been emotionally impacted and feel you need to speak to someone further.
You will be able to take breaks as appropriate and required during the interview. If required the interview can be suspended or rescheduled.

What are the possible benefits of taking part?

There are unlikely to be any direct benefits to you personally, but in agreeing to share your experiences with me, you will be helping to improve understanding of the perceptions of residential children's home support workers and their understanding of their role within a therapeutic care setting. I hope that this will inform future practice, employment and training within residential children's homes which will improve the therapeutic care provision for looked after children living in residential care homes.

Data handling and confidentiality

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

1. You will be asked to provide a pseudonym for your interview in order to ensure your anonymity and confidentiality throughout this research.

2. Data will be stored electronically on the Staffordshire University OneDrive for 10 years, and then destroyed.

3. Anonymised data will only be shared with the research team, thesis examiners, or as a part of routine university research audits. This may occur via email through the Staffordshire University email system or by secure email to Midlands Partnership Foundation Trust.

Data Protection Statement

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free to withdraw without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until two weeks from your interview date, after which withdrawal of your data will no longer be possible due to data analysis having started.

If you choose to withdraw from the study we will not retain any information that you have provided us as a part of this study. If you would like to withdraw from this project please email c027894b@student.staffs.ac.uk.

What will happen to the results of the study?

The results of this research will be disseminated as a Doctoral Thesis for the purposes of qualification. This research is aimed to be put forward for publication in peer reviewed journals, and may be disseminated to the Midlands Partnership Foundation Trust, for the purposes of training. This research may be disseminated in other settings for training and conferences.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Principal Investigator: Kate Cudmore, Trainee Clinical Psychologist
Email: c027894b@student.staffs.ac.uk

Research Supervisor: Dr Yvonne Melia, Academic Director
Email: yvonne.melia@staffs.ac.uk

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Dr Tim Horne
Director of Research
Research, Innovation, and Impact Services
Staffordshire University
Leek Road Campus
32 Leek Road
Stoke-on-Trent
ST4 2RU
Tim.horne@staffs.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix N: Table of education level, training and qualifications

Pseudonym	Education level	Therapeutic training completed at work	Other relevant qualifications
Christopher	O levels	Good lives model Sexual harmful behaviour	Level 5
Jubilee	Level 5	CBT basics	Self-led learning on attachment theory
Mag	Undergraduate degree	Autism Challenging behaviour	Therapeutic communication (completed in Nigeria)
Louise	Undergraduate degree	PACE House model of parenting	Psychology and child development undergraduate Level 3 in early years and education Play work qualification Currently doing level 3 in residential
Yasmin	A Levels	Therapeutic parenting PACE Trauma-informed care	Currently doing a psychology degree Level 3 nvq in residential childcare
Amber	Level 4	Social pedagogy	Level 4 children, young people and family practitioner Level 2 in children and young people Level 4 in mentoring Self-led reading on PACE and other mental health issues Self-led learning in creativity from friend who is an art teacher
Sandra *	A Levels	Care certificate	Level 3 in health and social care
Kate	GCSEs	Attachment trauma Restraints (CPI) Level 4 diploma in children, young people and families practitioner apprenticeship	Personal meditation

*pseudonym allocated by researcher due to lack of name given

Appendix O: Interview transcript analysis – sample

0:6:24.310 --> 0:6:30.540
CUDMORE Kate E
If we think about, you know, describe such a lot of experiences, you know, responsibilities in the day. If you had to kind of tell me what the priorities are in your role, if you could sum up what do you prioritise? What do you need to prioritise and how do you decide this in your day.

0:6:46.900 --> 0:6:59.910
[redacted]
We have a very structured system here how we prioritise, but obviously basically in simple terms it's whatever the child needs that's the priority cause you know a lot of times the institutions agenda subconsciously takes over the individual's needs and you spend a lot of time doing this form and that form, you know what I mean and you don't spend quality time with the young people. So what we do is we we have a systematic handover. It's very detailed and then we come up with a plan and it's explicit like the amount of office time you have and why you need the office time. So we'll look at all the things that need to do. We'll prioritise them and then we'll divvy them out. Then, like, we'll check the diaries to see if the kids have got relationship days. So if the kid's got a relationship day with you, that means you're going out all day to to Barmouth or whatever. So you can't do various, you know, laborious tasks that has to be done by other people or done by another on another day. So. So it's just that balancing act because what happens when you don't do that is you just get subsumed, you know, you get swamped by all the paperwork and the procedural stuff and chasing social workers and nurses and doctors. That's why I've been flustered today because that's what I've been doing. And then you don't spend any quality time with the young people. So if you look at it in that way, we can build in the quality time everyday. That this quality time significant amount of quality time with the young people. So we try to front load the work so we do the work early in the morning or when they've gone to school. So that as soon as they come back, we're here. We're ready, we can engage.

0:8:31.690 --> 0:8:44.540
CUDMORE Kate E
What you described there as well is that it seems to be that structure within those priorities helps and where you're working, that structure seems to be fairly clear.

0:8:44.840 --> 0:8:45.260
[redacted]
Yeah.

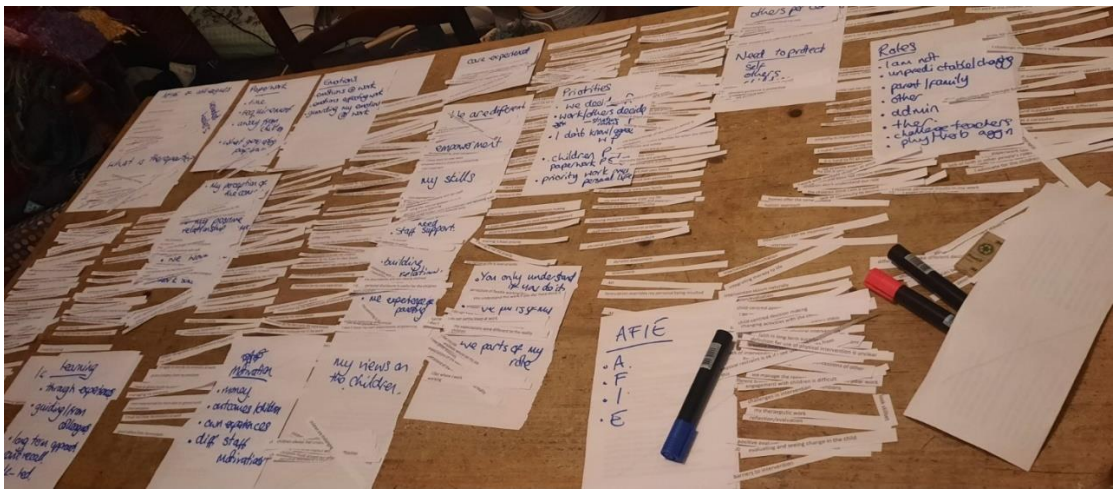
0:8:45.330 --> 0:8:55.570
CUDMORE Kate E
Where you've worked in previous settings has that always been the case or would you say you prefer a structured approach to that? You know what's your experience of that?

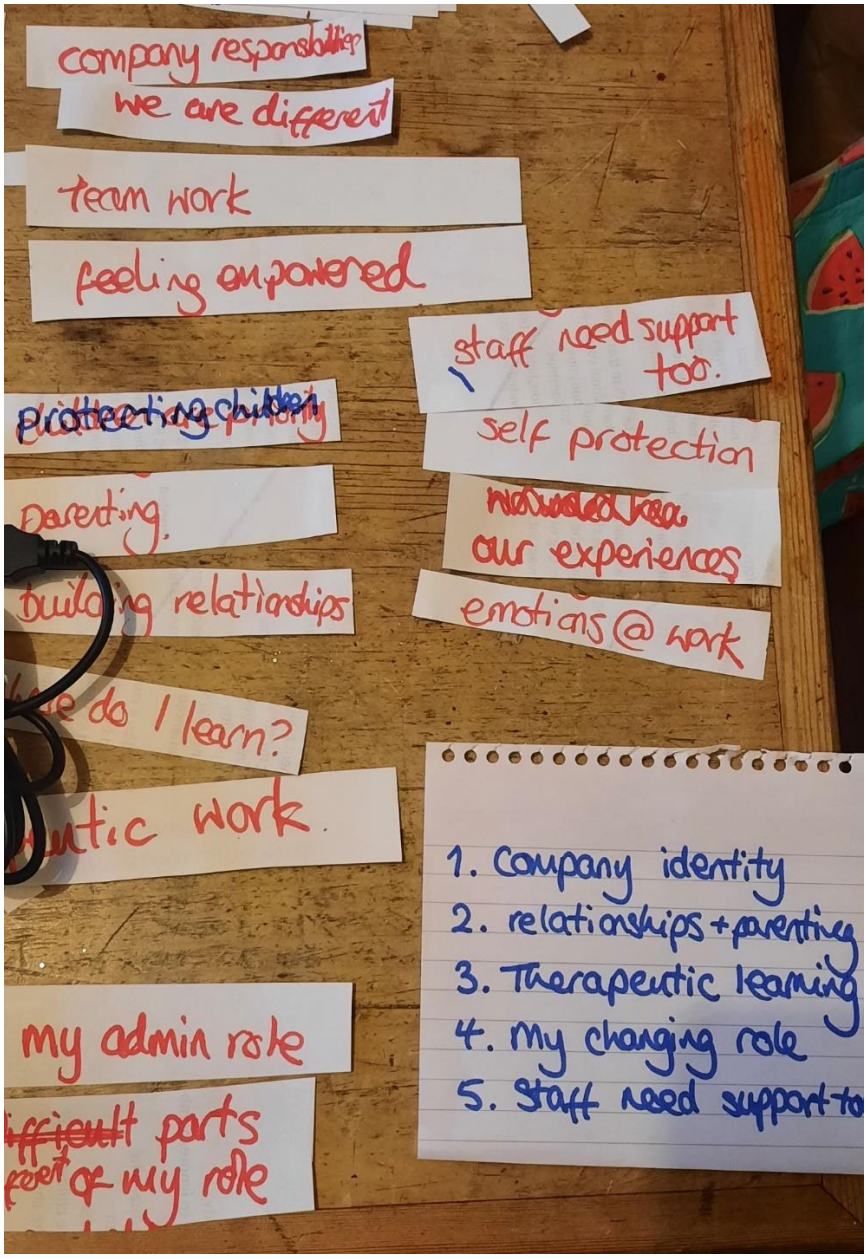
0:8:54.910 --> 0:9:2.670
[redacted]
I think this should have worse because you can then create freedom because if you a lot of the works that like you know if we have 4 members of the staff on. If I have to do certain kinds of work, then I can swap the work with somebody else or the paperwork, the procedural stuff, the functional stuff, and then I can spend the quality time with young people. Obviously, the smaller the staff team, like if it's a 2 bedded home, 2 on 2 off, it's much harder simply because there's only two of you, unless it's a 2 to one child.

Appendix P - Codes in Excel spreadsheet - sample

support the young people to achieve their goals	responsibilities are achieving goals	coaching role	
basically getting them ready to go back in general society	we are separate to society	we are separate to usual society	
we're actually tied to the local authority, they pay the money for them, young children to be here	responsibilities for placements	we are offering a service to the local authority	
So, you know, basically we want to return them to everyday life and make them good citizens	we are separate to society	we are separate to usual society	
if you work with me, there'll be a plan, but I'll change the plan. It It's always changing	autonomy over the day	lack of regularity in the day	
My thing is we got 16 boys in ours. You gotta 16 tools in a kit where you can bring them out	the children are part of the team	the children are art of the team	
But it's the same everyday, but it's not the same everyday	lack of clear aims in the day	lack of regularity in the days	
prioritise would be the boys straight away. Make sure make sure that they're OK if they're struggling to have a chat with him on Blah. Blah	being a therapist in the moment	my role as a therapist	
we got therapy on site. We got plenty of people on site here	we have everything we need	we are self-contained	
boys always come first, and you know your your your everyday tasks come second, even though the everyday tasks might be important	prioritise the children over other tasks	children are a priority	
so the priority is make sure the boys are OK and it's their duty of care is health, health, health, health, health and wellbeing. So it's appointments CAMHS appointments, doctor appointments, optician and dentist whatsoever and all the rest is secondary. So if the boy's are settled. *thumbs up*	prioritise the children over other tasks	children are a priority	
It's a nice house	affectionate comment about the house	I like where I work	
if you're sending the paperwork, even though there's something going on, I'll make time and space for you because it's pointing us right in a rubbish report	need to fulfill paperwork to save reputation	reputation depends on the quality of paperwork	
I can step in, step out, even though I've stepped back recently, I picked up another key child, but team leads aren't supposed to have them	confusion around role responsibilities/ lack of ability to maintain boundaries	my role is not cearly defined	
you're gonna get certain staff who are saved by the boys. So the ones who want to go out all the time	ability to avoid paperwork?	staff use activities to avoid paperwork	
if you're behind now with your paperwork and you don't work with me, I'll make time for you. To catch up, but then I can step in	if staff need relief, team leader steps in	dedicated paperwork time is needed	
So your original question, Am I manager? No, but I manage	role responsibilities/ lack of ability to maintain boundaries	my role is not cearly defined	
I also liaise with the managers here..... I can step in and step out anytime and it it's that learned that learned skill where others need to speed up, slow down..... So you know I like most things. You know, I keep telling you	lack of clarity of job role	my role changes in the day	
, if I can do it, anybody can	lack of confidence in own skills	anybody would do my job	

Appendix Q: Manual analysis of codes, themes and subthemes-1

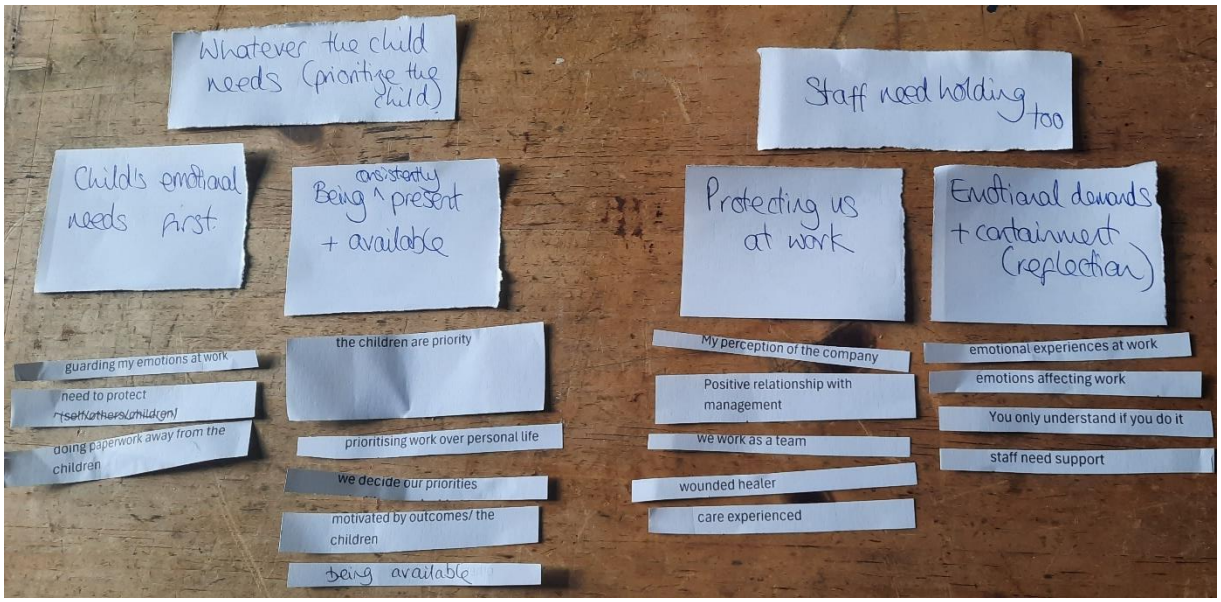


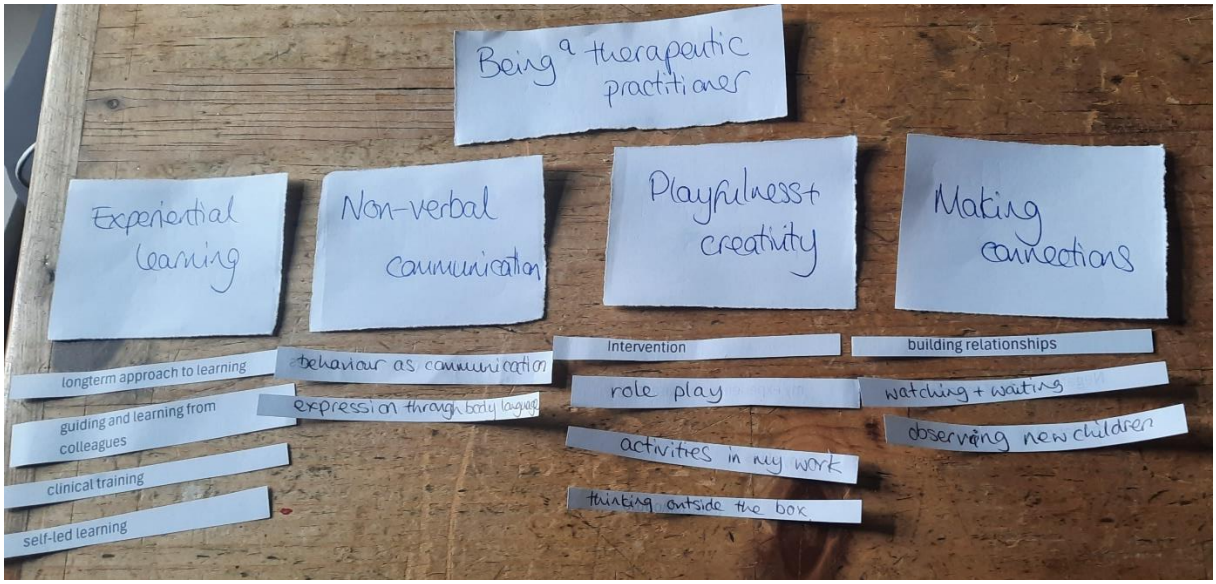


Appendix R: Themes, subthemes and codes discussed in workshop and supervision - sample

others decide priorities	What is expected of me by the company	Company identity
My perception of the company	What is expected of me by the company	Company identity
paperwork requirements	What is expected of me by the company	Company identity
others perceptions	we are different	Company identity
we are different	we are different	Company identity
You only understand if you do it	we are different	Company identity
we decide our priorities	team work	Company identity
we work as a team	team work	Company identity
Positive relationship with management	building relationships	Relationships and parenting
building relationships	building relationships	Relationships and parenting
my experiences of parenting	parenting	Relationships and parenting
parent/family role	parenting	Relationships and parenting
motivated by outcomes/ the children	protecting children	Relationships and parenting
need to protect children	protecting children	Relationships and parenting
the children are priority	protecting children	Relationships and parenting
doing paperwork away from the children	protecting children	Relationships and parenting
therapeutic role	therapeutic work	therapeutic learning
what is therapeutic?	therapeutic work	therapeutic learning
Assessment	therapeutic work	therapeutic learning
Formulation	therapeutic work	therapeutic learning
Intervention	therapeutic work	therapeutic learning
Evaluation	therapeutic work	therapeutic learning
experiential learning	where/how do I learn?	therapeutic learning
can't recall training	where/how do I learn?	therapeutic learning
clinical training	where/how do I learn?	therapeutic learning
self-led learning	where/how do I learn?	therapeutic learning
my skills	where/how do I learn?	therapeutic learning
longterm approach to learning	where/how do I learn?	therapeutic learning

Appendix S: Manual analysis of subthemes and themes-2





Appendix T: Themes, subthemes and quotes final - sample

I just wanna make their lives better, essentially, and that's what I draw on	Being consistently present and available	"Whatever the child needs, that's the priority"
we check in with them whenever	Being consistently present and available	"Whatever the child needs, that's the priority"
we're here, we're ready, we can engage	Being consistently present and available	"Whatever the child needs, that's the priority"
the ability to be able to change that child's life. To keep them safe and secure. I think that really motivates everyone I'd say, like our whole work force we really do just dedicate to the child	Being consistently present and available	"Whatever the child needs, that's the priority"
I volunteered to work all weekend. You know, I'll put you first lads	Being consistently present and available	"Whatever the child needs, that's the priority"
I'll remember she's got dentist appointment tomorrow (…) I'm like, oh I need to get school uniform for her as well. OK, like she's always in the back of your mind type of thing	Being consistently present and available	"Whatever the child needs, that's the priority"
it makes you feel guilty, but then I feel so strongly about my job as well	Being consistently present and available	"Whatever the child needs, that's the priority"
I wanted a job where I could put my heart into it	Being consistently present and available	"Whatever the child needs, that's the priority"
the institution's agenda subconsciously takes over the individual's needs (…) you don't spend quality time with the young people	Being consistently present and available	"Whatever the child needs, that's the priority"
you don't become numb to it, but you sort of become used to that situation	The child's emotional needs come first	"Whatever the child needs, that's the priority"
you don't show them the emotional parts	The child's emotional needs come first	"Whatever the child needs, that's the priority"
"[I'm] empathetic towards the situation, but I'm able to keep that inside	The child's emotional needs come first	"Whatever the child needs, that's the priority"
if the staff is stressed. You're going to indirectly or directly translate on the kids	The child's emotional needs come first	"Whatever the child needs, that's the priority"
it's important to not let them see you upset (…) I just make sure that the child doesn't see It	The child's emotional needs come first	"Whatever the child needs, that's the priority"
I'm quite good at separating that in the role in making sure that they don't see that	The child's emotional needs come first	"Whatever the child needs, that's the priority"
"[I'll] wait till it's quiet and then do my paperwork side because they don't need to see you filling up a file. It's really horrible I think	The child's emotional needs come first	"Whatever the child needs, that's the priority"
at the end of the day you can forget your practise. If you haven't got a relationship with the children you shouldn't be here	Making connections	Being a therapeutic practitioner
reliability, like they need someone they can rely on cause especially with trauma and their attachment issues, they've not had that consistent person in their life and I think being able to consistently, you know, attend your shifts and be there	Making connections	Being a therapeutic practitioner
I will make sure that I go up on the landings or whatever an say morning so they know they've got that friendly face	Making connections	Being a therapeutic practitioner
When a new boy comes in. I'll observe. I'll just sit back for a couple of days thinking. (…) I'll find a way in there	Making connections	Being a therapeutic practitioner
we are physical, mental, emotional and spiritual beings. Until we have connected with a child on each of those levels, there's no point trying to do anything	Making connections	Being a therapeutic practitioner
You need to know the boy's soul. What makes them tick	Making connections	Being a therapeutic practitioner
the facial expression, the odd dance move. It makes them want to do some activities even when they don't have interest initially	Playfulness and creativity	Being a therapeutic practitioner
if I'm gonna do a [key worker] session, I will take him out to the park. I might do it in the park. I might do it after I've come back from the park or on the way back from the park	Playfulness and creativity	Being a therapeutic practitioner
I was working with a young lad and he wanted to be Christian one day Muslim the next. Buddha the next and it's sort of just me not saying you don't know what you are sort of thing, it's me saying instead, OK, let's try that then (…) I've been a litter picker with him. I've been to farm with him. I've been a tree climber	Playfulness and creativity	Being a therapeutic practitioner
the activity it's absolutely crucial. You can't do the other stuff without the activity. That's your foundation. That's your scaffolding (…) If you don't do the regulation you've got no chance	Playfulness and creativity	Being a therapeutic practitioner
there's a lot of research around the relationship between walking and nature and calming you down and making you feel better	Playfulness and creativity	Being a therapeutic practitioner
they might need support down the school, lad's not engaging, makes a noise, having a bit of a strop (…) How can we make that lesson fun? More engaging	Playfulness and creativity	Being a therapeutic practitioner
we're trying to impart the knowledge without being in a classroom, so we'll take them to the day for [local stately home]. They do history	Playfulness and creativity	Being a therapeutic practitioner

Appendix U: Reflective diary extract

17.05.023
Started recruitment. I am getting lots of interest from home managers who want to talk about my research and give their suggestions. This is time consuming and already feels like some kind of gate keeping to accessing staff teams, ie, if they buy into the idea they may be enthusiastic but if not they may not. One manager offered to put this on a noticeboard at work. Others are asking for lots of information about research proposal etc. This feels useful in the moment as it is good that managers are showing interest, but as mentioned also feels a bit uncomfortable.
I have also altered my ethics in order to advertise on my personal social media. I hope that this reaches support workers more directly.
The Facebook groups pages are currently refusing to publish my advert. I plan to contact the administrators to discuss this further if needed.
I may need to alter my social media to note that no details are taken about where people work.

20.05.2023
I have spoken to a number of managers who would like to participate themselves. I have explained that I am looking at support workers, and feel a shift in the communications when I say this. Almost some annoyance that they aren't getting a voice in this. I have reflected on the repercussions of this, as it feels that the 'buy in' of managers is key to the advert being shared, and therefore them being annoyed may have an effect on this. However, I have tried to balance this and hopefully they will still send this out to their staff.

I have also spoken to a number of clinicians and managers, and there is definitely something about access to support workers which is about the manager/clinician 'buy in' to the thesis. For example, I have had conversations of an hour with clinicians and managers which has resulted in them saying that they are invested in the research and therefore can offer me large numbers of staff, or specifically experienced staff in order to get useful and rich data. However, this appears to be based on the 'buy in' from the conversation. This also results in me having to explain my need for a breadth of perceptions, and probably one or two people from each place only. Obviously I will not be aware of this as I am not taking this information.

- I might start to add an informal end to the interview where I take this information – will speak to Yvonne about this.

I have also been approached by some managers/clinicians whereby they have offered to share my research. This is great, but when I investigate further, this also appears it may potentially reinforce the hypothesis that people who 'buy in' to the research are people who have positive therapeutic models or plans. It would be useful to get the perceptions of a breadth of places.
I might need to go and sales pitch to some homes and see if they are interested for me to attend a staff meeting or something in order to share the advert. As an example of this, [redacted] have been less coming forward, and [redacted] has simply shared the advert to a staff noticeboard, whereas other people are telling me they will send it out and promote it. Their motivation will be present in the interviews I expect.

In reflection some of this also conflicts with my epistemological stance in that I have seen some very difficult perspectives of support workers in homes where therapeutic models are not used or fully understood. My expectation is that I would get a breadth of perceptions, but these may be dominated by a lack of therapeutic understanding and support, possibly some frustrations about responsibilities. However, if the data is saturated due to bias of positive therapeutic homes this may affect the themes. I feel I am an experienced enough practitioner to be able to interview and analyse the data reasonably but it is useful to take into account.

Paper 3: Executive summary

“You need to know [their] soul, what makes them tick”: Residential support-workers’ perceptions of their role in a therapeutic setting

Word count: 2484

With thanks to the participant consultants for reviewing a draft of this paper and providing valuable feedback

Executive summary

"You need to know the boy's soul, what makes them tick"

Residential support workers' perceptions of their role in a therapeutic setting

Kate Cudmore – Trainee Clinical Psychologist

May 2024

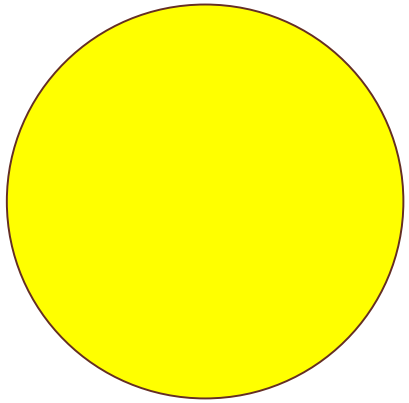
This summary has been read by support worker consultants. Their feedback has been used to improve the accessibility of this paper

images used in this executive summary are stock images

This summary has been read by support worker consultants. Their feedback has been used to improve the accessibility of this paper.

Feedback from support worker consultants included asking for clarification of terminology, which has been added in bitesize information in circular imagery on the slides where this terminology is used.

images used in this executive summary are stock images



Background

There are 2880 children's residential care homes in the UK (UK Government, 2024). The majority of children (66%) are in care due to abuse and neglect (UK Government, 2024), and have experienced **developmental trauma.** This can affect their ability to form and maintain relationships with those around them due to them bringing the working models of caring experiences in early life, to their current relationships.

Working with children in care on their **developmental trauma** can be key to the development and maintenance of meaningful relationships throughout their life. There are guidelines which recommend that carers treat children 'as one of their own' (NICE, 2021) but there are different definitions of what this 'therapeutic parenting' should look like (National Association of Therapeutic Parents,2024).

Some children's homes use a 'key worker' system to help with this, where a support worker holds a more senior role and is allocated to the child in the role of their close family figure, with support workers facing the systemic challenges of shift work and staff turnover in this work.

What is developmental trauma?

When children experience difficult situations in their childhood it can affect their development (The National Child Trauma Stress Network, 2024). This can affect their ability to recognise, understand, and manage their emotions, and their ability to form and maintain positive relationships throughout their life (Hambrick et al., 2019; Felitti et al., 1998)

Therefore, support workers are expected to 'carry' the workload as a 'therapeutic parent'. This therapeutic work is not regulated which means that there is no guideline as to how this therapeutic work might look.

Different models of training are used (usually adapted by in house clinicians) from therapeutic approaches aimed at foster or adoptive families. Clinical Psychologists offer clinical consultation to some homes. There is no guideline so this can be offered anywhere from daily to monthly.

There is no research looking at how support workers understand and identify with their therapeutic role. It is important to understand how they perceive this therapeutic work, to better understand how they can be motivated, developed and supported.

Aim

To better understand how support workers perceive their role in a therapeutic setting.

Also to help Clinical Psychologists who offer consultation to residential children's care homes to better understand the needs of support workers in their therapeutic role.

Method

The study was advertised on the researcher's social media, and on care worker support groups on Facebook. People who were interested in taking part contacted the researcher by email.

The participants took part in online interviews which were recorded and transcribed, so their words were written as text. The transcripts were analysed using **Reflexive Thematic Analysis (RTA)** The researcher generated themes to reflect the common perceptions and experiences of support workers about their role in a therapeutic setting.

What is RTA?
RTA allows for meaningful exploration of subject areas to enable a deeper understanding of a phenomenon or issue. This allows consideration of shared and collective experiences, and the researcher to consider their own experiences, biases and perceptions

Ethics

This project was approved by the Staffordshire University ethics committee. Written consent was gained prior to arranging interviews.

Pseudonyms (fake names) were used to protect people's identity.

After interview participants were sent a debrief form by email, which signposted them to further support if needed.

Who could take part?

Support workers who:

- work in a therapeutic children's home in England or Wales
- are over 21 years old
- have worked in a residential children's home for at least one year

Who couldn't take part?

- Support workers who work in specific homes providing care for learning disability, mental health inpatients, or homes where children were detained by law for forensic purposes (due to different models of care and potentially more restrictive practice

Who did take part?

- 8 participants
- Age range: 21-58
- Six females, two males
- Five white British
- Differing levels of education and therapeutic training

What did the researcher find?
Looking for similarities, differences and patterns across the transcripts, three main themes and eight subthemes were identified which described the perceptions that people shared in their interviews. A description of these themes is provided below. Quotes are given as examples of the things that participants said about those themes

Theme 1: "Whatever the child needs, that's the priority"

- 1.1 Being consistently present and available
- 1.2: The child's emotional needs come first

Theme 2: Being a therapeutic practitioner

- 2.1: Making connections
- 2.2: Playfulness and creativity
- 2.3: Non-verbal communication
- 2.4: Experiential learning

Theme 3: The holding environment

- 3.1: Resilience needed to manage emotional demands of the work
- 3.2: Sources of protection in the workplace

Theme 1: “Whatever the child needs, that’s the priority”

Two subthemes looked at the need to prioritise the children (sometimes over personal life), and a need to protect children.

1.1 Being consistently present and available

Participants discussed their motivation to see change for the children. They shared responsibilities to remain present and available in their therapeutic work, taking a whole team approach to this.

Support workers think about the children they work with outside of work, and try to think of them as ‘one of their own’. Participants identified their desire to work in a job role which required this kind of dedication.

“the ability to be able to change that child's life. To keep them safe and secure. I think that really motivates everyone I’d say, like our whole work force we really do just dedicate to the child”
Sandra

“I wanted a job where I could put my heart into it”
Yasmin

"you don't show them the emotional parts"
Mag

"if the staff is stressed. You're going to indirectly or directly translate on the kids"
Mag

1.2: The child's emotional needs come first

Participants discussed the emotional experiences they have in their work. They discussed guarding the children they work with from their emotional experiences, using disconnection from their emotions to do this. They see this as personal development.

Participants also described protecting the children from the realities of the paperwork they complete in their day.

"it's important to not let them see you upset (…) I just make sure the child doesn't see it"
Louise

Theme 2: Being a therapeutic practitioner

Participants discussed the therapeutic skills they use in their work, and how they learn these, in four subthemes.

2.1: Making connections

They discussed the importance of making connections and forming relationships with children, and thinking of them each as a whole person when working therapeutically. They think about this in their work, including being consistent and reliable in order to achieve connections. They feel that they need to meet this half way in order to be successful.

"You need to know the boy's soul. What makes them tick"
Christopher

"we are physical, mental, emotional and spiritual beings. Until we have connected with a child on each of those levels, there's no point trying to do anything"
Amber

- 2.2: Playfulness and creativity

Participants described the highly skilled work they do, using playfulness and creativity to engage children in key working. They use role play and activities in this work.

Participants discussed their responsibility to help school with this approach, or use it when offering education to the children themselves.

"the activity it's absolutely crucial. You can't do the other stuff without the activity. That's your foundation. That's your scaffolding Yeah, everything's built on, If you don't do the regulation you've got no chance"
Jubilee

"I think it's about understanding the child and knowing their needs and then responding accordingly really"
Louise

2.3: Non-verbal communication

Participants discussed their need to understand the complicated communication of children who have experienced trauma. They discussed their need for self-awareness in this approach, including their awareness of how they communicate with children.

2.4: Experiential learning

Experiential learning is useful for learning these therapeutic skills. Participants appeared to feel confidence which is rooted in the clinical consultation received from Clinical Psychologists.

"I've learned a lot (…) I've done uni for like how long now? And I feel like I've learned more from the kids than I have, like in my degree"
Yasmin

Theme 3:
The holding environment

Participants discussed their job to be 'all consuming'. Two subthemes looked at the internal and external holding needed by support-workers to manage this.

3.1: Resilience needed to manage emotional demands of the work

Participants discussed the emotions they experience in their work, and their need to manage this internally using resilience.

"unless you're in that job I think it's hard to understand the sort of more in depth challenges that residential care workers go through really"
Louise

"it's quite emotionally draining. I think you have to sort of be really resilient in that aspect"
Sandra

3.2: Sources of protection in the workplace

Support workers experience some conflicts between their role and the systemic aims of the company they work for. This also extends to the difficulties experienced by staff with care experience, and their motivation to do their role.

Relationships with management was identified as a protective factor to the conflicts in this work, with praise and availability being key factors to this.

"do you know organisational trauma? (…) if these kids are traumatised, yeah, and we're working with this trauma and we hold on to this trauma"
Jubilee

"we get a lot of support from the management (…) that make us competent enough to do the role"
Louise

So what does this mean?

Residential children's home support work is an all-consuming role, not understood by those who do not do it. Support workers are well positioned to offer holistic approaches to children who have experienced developmental trauma. They must be supported when building new relationships with children to avoid placement breakdown (Golding et al., 2006).

Support workers are present, available, and think about the children they work with, sometimes outside of worktime. This kind of secure base approach to relationships has potential to help children develop the skills to build positive relationships throughout their lives (Hughes et al., 2015).

Support workers are skilled in therapeutic work. They prioritise making connections and building relationships, using playfulness and creativity These approaches are embedded in **Dyadic Developmental Psychotherapy (DDP)** (DDP Network, 2024). They consider non-verbal communication, and activity-based approaches, mirroring the work offered by clinicians working with children (Beacon House, 2024; CalmBrain Approach, 2024). DDP is a two-phase model. Focusing on phase one can help support-workers to understand the child and the ways they can facilitate attachment security and parenting principles, which aligns with the participants' descriptions of intuitively creative and connecting approaches.

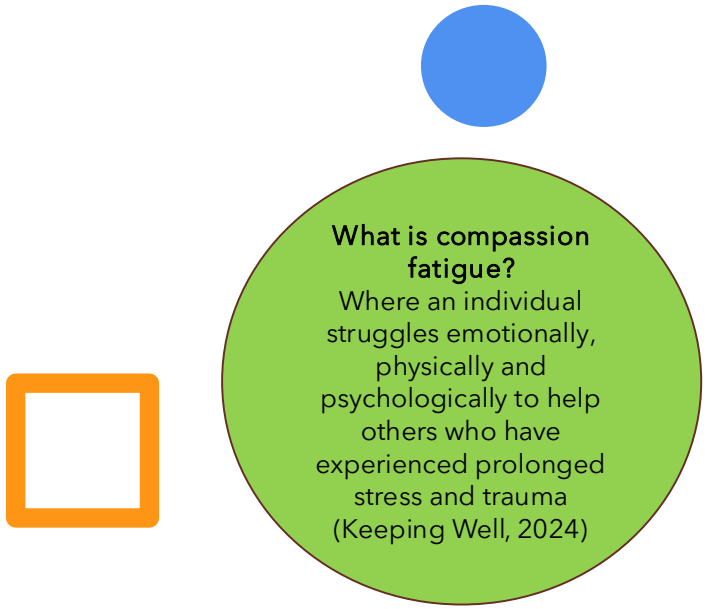
What is DDP?
A therapeutic model aimed as helping foster and adoptive parents build and maintain attachment bonds with their children (DDP Network, 2024)

Due to investment in their work, support workers experience emotional load, and therefore need their own support. This dedication to work can result in '**compassion fatigue**' (Keeping Well, 2024). Developing a compassion-focused approach could be useful when considering staff and team wellbeing (Gilbert & Simos, 2022), and has been shown to make healthcare workers better able to maintain or improve their level of compassion for the people they work with (Henshall et al., 2017).

Shared team debrief and reflection is useful, with more experienced team members passing on their knowledge. This 'train-the-trainer' approach to learning is used in social care, being shown as effective in community-based family interventions (Lai et al, 2017).

Support workers experience conflict between the systemic requirements of their role and therapeutic work. Relationships with management are helpful for support workers to feel protected.

Some confidence in this work appears to be rooted in being led by Clinical Psychologists.



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Suggestions for practice

Support workers are highly skilled, using intuition to guide their therapeutic work. Clinical Psychologists should offer training which aligns with support workers' intuitively playful, creative, and connecting approaches, e.g., DDP (DDP Network, 2024). It is key that Clinical Psychologists acknowledge that they are offering consultation to a population of support-workers who, although invested in their work, are not formally therapeutically trained, and therefore need repetitive and nurturing training and supervision.

The repercussions of the all-consuming nature of this work is high emotional load and personal investment which can dominate life. Clinical psychologists offering consultation are well placed to support management in building relationships with staff using attachment-focused models like **DDP**. Clinical Psychologists must consider staff needs to maintain consistency and stability for children. Therefore **compassion-focused approaches** should also be considered when offering clinical consultation to care-homes.

What is a compassion-focused approach?
Compassion-focused approaches consider staff as whole people, focusing on self-compassion in order to reduce shame and self-criticism in the workplace (Gilbert & Simos, 2022)

Future research
Future research could explore the understanding of what 'therapeutic work' means to those who manage, market and commission care-homes

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Strengths

To the researcher's knowledge, this is the first qualitative study exploring the experiences of residential support workers in their therapeutic role. This offers an understanding of their perceptions of the therapeutic work they do, and how this can be supported by those offering clinical consultation.

Limitations

Managers often acted as gatekeepers for signposting the research to their staff so this may have brought in some bias due to their choosing whether to support and distribute the research recruitment advert. This may have resulted in selection of participants outside of the researcher's control.

Consideration of service user involvement may have been useful for the planning and development of the semi-structured interview. This was not completed due to time constraints.

How will this research be used?

This research can be used by Clinical Psychologists who offer consultation to residential children's homes. It may be helpful for understanding the needs of the staff they support.

Those who design therapeutic residential children's services might use this research to inform their understanding of support workers and their roles in these therapeutic settings, including their skills, and need for experiential learning and consultation from Clinical Psychologists.

Managers might use this research to better understand their staff teams, and equip them with supportive working environments.

What happens now?

The full research paper will be included as part of the researcher's clinical psychology doctorate qualification and will be published in an academic journal.

This executive summary will be shared on the researcher's social media, and may be shown at conferences.

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