Doctoral Thesis

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

Applying trauma-informed care within children's homes: An exploration of experiences, psychological formulation and implications for practice

Doctorate in Clinical Psychology

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Word Count

Section	Main text	Appendices, References and Tables	Total
Abstract	**299**	**0**	**299**
Literature Review	**8000**	**9954**	**17,954**
Empirical Paper	**7982**	**9420**	**17,402**
Critical Appraisal	**3929**	**718**	**4,647**
Ethics	**2673**	**6295**	**8,968**
Total	**22,883**	**26,387**	**49,270**

Applying Trauma-informed Care Within Children's Homes

Thesis Abstract

This thesis includes a qualitative exploration of applying trauma-informed care (TIC) within children's residential homes and consists of three sections, a systematic literature review (SLR), an empirical study and a critical appraisal of the overall thesis.

The SLR explored how TIC is implemented into children's residential homes (settings that provide care for children under local authority responsibility). A meta-ethnography approach was used to identify, analyse and synthesise qualitative studies, producing new insights into TIC. A synthesis of 11 papers produced seven third-order constructs within two overarching themes. The first theme highlighted three key factors influencing TIC implementation: utilising a TIC model/framework, practical barriers and cultural/organisational barriers. The second theme identified outcomes of effective TIC; including increased trauma awareness, relational safety, development of staff values and empowerment for young people. Implications for clinical psychology and the need for a theoretically driven TIC model are discussed, alongside recommendations for future research.

The empirical study explored the lived experiences of how residential staff in secure children's homes (settings with additional security for children who pose a risk to themselves or others) interpreted and used psychological formulation within their practice. It also considered whether psychological formulation impacted staff's working relationships with colleagues and YP, and identified what role formulation has for future TIC practice and policy. Nine participants were interviewed, and data were analysed using interpretative phenomenological analysis. Five themes emerged: 'Enhancing trauma-informed and holistic understandings', 'Promoting collaboration through multi-disciplinary team working', 'Strengthening connection and empowerment', 'Creating safety' and 'Flexibility, adaptation

and implementation'. The findings highlighted the critical role of psychological formulation in enhancing TIC, with implications for clinical psychology, practice, policy and future research discussed.

The critical appraisal identified the strengths, limitations, clinical implications, personal reflections, and recommendations for future research of both chapters.

Declaration

This thesis includes research carried out between September 2022 and March 2025 for the Doctorate in Clinical Psychology Programme at the Division of Health Research, Lancaster University. The work presented in the thesis is my own, unless reference is made. This thesis has not been submitted for the award of any higher degree elsewhere.

Name: Amy Toolis

Date: 21st March 2025

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Most importantly, I'd like to thank all the participants who took part in my research. I am so grateful for your time, dedication and openness whilst sharing your experiences with me and I hope that these findings reflect your stories that you kindly shared with me. I would also like to thank all the young people I have had the privilege of working with so far in my career, your strength and resilience is what inspired this research and I hope that this thesis helps to create change that is needed.

I would also like to thank my research tutor, Buket, for all your support throughout the research process, and my field supervisor Sarah P whose dedication to implementing trauma-informed care across children's homes is truly wonderful. I'd also like to thank my second field supervisor Sarah M, whose presence has been a source of containment and whose knowledge has inspired me since the day we met.

Finally, I'd like to thank my family and friends for being there for me through completing the doctorate and my thesis for the past three years. In particular, my Mum and Dad who have supported me throughout my whole life, and I wouldn't be the person I am today if it wasn't for you.

Contents

Section One: Systematic Literature Review

Trauma Informed Care Within Children's Homes: A Systematic Review and Meta-ethnography.

Word count (excluding references, tables and appendices): 8000

Abstract: 250 words

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SLR prepared for: Children and Youth Services Review (see Appendix 1-A)

Abstract

Background: Trauma-informed care (TIC) has increasingly informed healthcare policy in recent years globally. There is an over-representation of trauma and adversity experienced by children within the care system, particularly residential settings. Little empirical research exists within children's homes to understand how to implement TIC and the possible impact for children and staff.

Aim: This systematic review and meta-ethnography aimed to identify how TIC can be applied within children's residential homes, including identifying specific models, any commonalities and barriers to effective implementation, and the impact on staff and children.

Methods: Between November 2023 and January 2024, the PsychINFO, Medline, CINAHL and Scopus databases were systematically searched to identify research surrounding TIC being implemented into children's residential settings, resulting in 797 studies. Applying the inclusion and exclusion criteria, and following PRISMA guidance, 11 peer reviewed publications were selected to analyse using a meta-ethnography with reciprocal and line of argument analytical approach.

Results: Factors affecting implementation of TIC involved utilising a specific model, practical barriers, and cultural/organisational barriers. Effective implementation of TIC was found to lead to significant benefits for staff and children, such as enhanced trauma awareness, relational safety, consideration of values and empowerment.

Conclusions/Implications: The findings emphasise the importance of a comprehensive, theoretically based and attachment-informed TIC approach to help reduce the risk of re-traumatisation and vicarious trauma within children's homes. Future research should focus on prioritising children as participants and/or patient and public involvement. Implications for

clinical practice are highlighted and recommendations for policy and government backing for TIC.

Keywords: Trauma-informed Care, Children's Home, Attachment, Systematic Review, Meta-ethnography

Highlights:

- TIC requires a comprehensive, theoretical and attachment-informed approach.
- TIC can reduce the risk of re-traumatisation in children's homes.
- Utilising a TIC framework helps to support implementation of TIC.
- A meta-ethnography approach to analyse TIC within children's homes.
- Extra support is needed for transition from residential to community settings.

1. Introduction

The most recent reporting of care experienced children indicates there are 83,630 children in care in England (Department for Education, 2024), with approximately 19% being in homes for cared for children (NSPCC, 2024). Long term psychosocial outcomes for children in care are argued to be more concerning in comparison to non-care experienced children in a broad range of areas, such as education (Warburton et al., 2014), criminal justice involvement (Baidawi & Sheehan, 2020), and substance abuse (Kind et al., 2023). Therefore, these children are some of the most vulnerable within society, due to them being more likely to experience discrimination and exploitation (Brannstrom et al., 2017) as well as developmental challenges (Goemans et al., 2016). Consequently, it is important to understand their unique needs and what tailored support is needed to promote recovery from trauma.

Children in care, particularly in residential settings, have increased rates of adverse childhood experiences (ACEs; Felitti et al., 1998; Simkiss, 2019) and consequently need models of TIC to help reduce re-traumatisation. Furthermore, staff that work within organisations caring for traumatised individuals can be subject to vicarious trauma and burnout (Sweeney et al., 2018), which can subsequently impact the quality of care provided to children (Steinlin et al., 2018). Additionally, the Independent Review of Children's Social Care (MacAlister, 2022) argued that there are systemic pressures and financial strain within children's social care services.

There are some differences in terminology world-wide when describing children's homes. The UK's National Society for the Prevention of Cruelty to Children (NSPCC) defines a looked after child as a child in local authority care for over 24 hours. Whilst in the US and Australia, "Out of Home Care" refers to youth involved in child welfare through foster care, family group homes and residential care (Barth et al., 2011). Children who enter long-term residential care, for example children's homes and secure units, are argued to be the most vulnerable group of children within the care system and are likely to have experienced higher rates of trauma and

adversity (Fraser et al., 2014; Parry et al., 2021). Traumatic experiences can negatively impact children's psychosocial outcomes (Bloom, 2016), affecting their safety, self-regulation, and healthy relationship development (Wallace, 2020). Consequently, systems caring for children should use theoretically driven TIC approaches to minimise the risk of re-traumatisation in children who have experienced multiple traumas (Parry et al., 2021) and promote safety.

1.1.Trauma-informed Care

The United States Substance Abuse and Mental Health Services Administration (SAMHSA) define trauma as "An event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p.7). Felitti et al.'s (1998) study on ACEs highlighted that more traumatic childhood experiences increase the risk of adult health issues, like mental health difficulties, obesity, addiction etc. Therefore, this means that many children and adults accessing services would benefit from trauma-informed care (TIC). Critically, the original ACEs study, primarily involving white middle-class individuals, requires careful application across diverse socio-economic and cultural groups within society. Consequently, it is vital that TIC acknowledges childhood adversity and ensure that frameworks are responsive to meet the complex needs of children.

TIC is a model of service delivery that supports individuals in regaining control and empowerment following trauma (Hopper et al., 2010). The United Kingdom (UK – mainly Wales and Scotland) has increasingly incorporated TIC into policy and practice (Department for Levelling Up, Housing and Communities, 2023), aligning with SAMHSA's internationally established definition (SAMHSA, 2014). SAMHSA define TIC as a framework that recognises the widespread impact of trauma, identifies its signs and symptoms, and seeks to prevent re-traumatisation through six key principles: safety, trustworthiness, choice, collaboration,

empowerment and cultural consideration. This paper primarily draws on SAMHSA's concept of TIC due to it being a widely accepted definition, specifically within the UK and is referred to heavily within literature (Sweeney et al., 2018). Critically, whilst TIC is typically well defined, it's application and interpretation can vary across services. Furthermore, it's overlap with similar terms e.g. trauma-sensitive, trauma-informed approaches can lead to conceptual uncertainty. Trauma-informed approaches refer more broadly to strategies that raise awareness of trauma across systems (Hanson & Lang, 2016) whereas TIC is a framework focusing specifically on how services are designed and delivered to promote recognition of trauma and prevent re-traumatisation. Additionally, trauma-informed thinking can be used to describe a shift in mindset or organisational culture that reflects an awareness of trauma and its impact (Purtle, 2020). For example, the Power Threat Meaning framework acknowledges how past trauma and adversity are linked to power imbalance and threat, which shifts perspectives from "what is wrong with a person" to "what has happened to you" and "what did you have to do to survive" (Johnstone & Boyle, 2018). Consequently, this paper will refer to TIC to reflect the systemic and organisational frameworks that are used to embed trauma awareness, prevention of re-traumatisation and promotion of recovery and empowerment within services.

1.2.Models of Implementation

Trauma-informed services require systemic implementation through workforce and leadership development, trauma-focused training, and trauma-informed policy, procedures, and protocols (Bloom & Farragher, 2013; SAMHSA, 2014; Sweeney et al., 2018). As such, implementing TIC must have commitment from services to ensure there is systemic change. Several models have been developed to implement TIC, aiming to create organisational change. The Sanctuary Model (Bloom, 2010) is a comprehensive approach to create cultural change, aiming to reduce staff injuries, critical incidents, staff turnover and improve staff morale. The framework uses four pillars (see Figure 1); 1) trauma theory, 2) sanctuary commitments, 3) SELF conceptual

framework and 4) sanctuary toolkit. Australia has recently introduced a fifth pillar of cultural safety, aiming to provide quality care that aligns with individual cultural values and norms (Galvin et al., 2022). Therefore, this model begins to recognise the influence of cultural trauma and adversity on an individual's ability to engage with services.

****Insert Figure 1 here****

Additionally, the Attachment, Regulation and Competency (ARC) model supports children and their caregivers when working with children affected by trauma (Bartlett et al., 2016). ARC promotes healthy interpersonal relationships between staff and children, allowing children to regulate emotions, health from trauma, and enhance self-understanding through safe learning experiences. Critically, most studies on the ARC model's impact do not longitudinally examine its effects (Tabone et al., 2022), making it unclear whether it improves future positive outcomes for children. Nonetheless, attachment-focused approaches can mitigate the risk of re-traumatisation in children by utilising psychological theory that considers developmental trauma and adversity within care decisions.

1.3. Theoretical Underpinnings of TIC

There are several psychological theories that underpin TIC. For example, Attachment theory (Bowlby, 1969) highlights the importance of early caregiver relationships, which is crucial in children's homes where complex attachment histories are common (Taylor et al., 2018). Therefore, staff can act as professional attachment figures providing support and safety to help build healthy attachments (Parry & Jay, 2022; Utting & Woodall, 2022). Additionally, Polyvagal theory (Porges, 2011) explains how trauma can disrupt nervous system regulation, causing individuals/children to remain in fight/flight responses and struggle to self-soothe. As such, TIC recognises these difficulties and promotes environments that supports emotion regulation and safety.

1.4. Barriers to Implementation

TIC is increasingly recognised and integrated into policies and practices within the UK. Emsley et al. (2022) identified that TIC is established in various health policies at national, regional and local levels, however implementation remains inconsistent across different settings and regions. Therefore, it's crucial to identify existing barriers that hinder organisations from adopting TIC. Sweeney et al. (2016) identified various factors contributing to resistance to TIC, including austerity, underfunding, staff burnout, high turnover, organisational culture, lack of training and a reluctance to shift to a biopsychosocial model. Furthermore, senior staff's lack of commitment to trauma-informed models can delay implementation (Bartlett et al., 2016), emphasising the need for systemic change to support and influence TIC. Residential services for looked-after children often encounter challenges in implementing TIC due to the need to address the psychosocial needs of both children and staff (Robinson & Philpot, 2016). Additionally, Wall et al. (2016) argue that there is often a lack of definition for TIC and inconsistent application of models in services. Consequently, understanding and addressing barriers to implementing TIC is crucial, as failure to comprehend traumatised children can lead to distress and re-traumatisation (Murphy et al., 2017).

1.5. Rationale for Review

Although earlier sources suggested that empirical research on the implementation of TIC in residential settings for looked-after children was limited (e.g., Hanson & Lang, 2016), a more recent scoping of the literature indicated that sufficient number of relevant qualitative studies are now available to support a systematic literature review (SLR). A previous SLR researching effective strategies for implementing TIC in youth inpatient psychiatric and residential settings highlighted key factors, including senior leadership support, staff support and aligning policy with TIC (Bryson et al., 2017). However, the practical recommendations offered by this study is limited as it lacks specific concrete guidance and tools for practitioners and policymakers.

Furthermore, there is limited emphasis placed on direct TIC outcomes for children despite the target population being children. Additionally, it is not clear whether these findings apply specifically to children's homes, and research should explore children's homes' implementation of TIC principles, barriers faced and the impact on staff and children's well-being.

There is evidently an over-representation of trauma and adversity experienced by children within the care system. Ultimately, there is a need for a high-quality systematic review to understand how TIC is applied into children's residential settings and the following impact this can have on children and staff who work there. This meta-ethnography aims to address that gap by exploring how TIC is applied in these environments and its effects. It is hoped that the findings from this meta-ethnography and evidence-based research will inform future policy around TIC and attract further government support.

2. Method

A review protocol was prospectively registered on the 25th April 2023 in the Prospective Register of Systematic Reviews (PROSPERO): (CRD42023418920). This review utilised a meta-ethnography approach; a qualitative synthesis method that systematically reviews multiple qualitative studies on one specific topic to create new integrative insights (Erwin et al., 2011). This approach was suitable as the reviewer was interested in the theoretical understanding of the phenomena of trauma-informed care within children's residential homes. This review was guided by Sattar et al. (2021), who based their guidance on the seven phases of synthesis described by Noblit and Hare (1988). Whilst this guidance was useful for a novice meta-ethnography researcher, there could have been more clarity provided between phases four and six due to the complexity of these steps, and complex language could have been simplified to make the guidance more accessible to novice researchers. Nonetheless, the seven phases followed were 1) getting started, 2) deciding what is relevant to the initial interest, 3) reading

the studies, 4) determining how the studies are related, 5) translating the studies into one another, 6) synthesising the translations and 7) expressing the synthesis. The results of this meta-ethnography were reported according to the eMERGe guidelines (France et al., 2019).

2.1. Search Strategy

Heterogeneity in language use in relation to "trauma-informed care" and "children's homes" was captured within the search terms that were created (see Table 1) to accommodate for relevant studies worldwide, e.g. "child welfare, out of care home". Searches were conducted within four electronic databases in November 2023 (and repeated in January 2025): PsycINFO, Medline, CINAHL and Scopus. Studies published prior to 2013 were excluded to ensure the review focused on more recent literature aligned with more current understandings of trauma-informed care (TIC), particularly those influenced by SAMHSA's 2014 framework. Studies were screened according to the following inclusion criteria: a) included trauma-informed care outcomes within a children's home, b) children's home could include residential, forensic or secure care settings and c) children were defined as people who were aged under 18. To be eligible, studies had to have primary qualitative data, such as interviews, focus groups or observations with either staff working in children's residential care, or with children themselves. The decision was made to include mixed methods studies, but the author was careful about not extracting quantitative data, focusing solely on interpretations of the qualitative data. The author focused on the interpretations and themes developed by the original study authors in their qualitative analysis, using these as the primary data for meta-ethnography. Studies were excluded if they were a) not published in English language, b) not a primary research study, c) focused solely on trauma interventions and d) not empirical studies with qualitative data (see Table 2 for definitions of terms). Grey literature was excluded to maintain the methodological rigor and conceptual depth required for meta-ethnography, which relies on peer-reviewed qualitative data with theoretical and methodological grounding. Since grey

literature is not typically peer-reviewed, it can lack the depth, transparency, and structure needed (Benzies et al., 2006), making it less suitable for inclusion in a meta-ethnography review.

2.2. Critical Appraisal

The quality of the 11 studies were appraised using the Critical Appraisal Programme (CASP, 2018) tool for qualitative studies. The CASP was chosen based on guidance followed for meta-ethnography by Sattar et al., (2021) to help assess the rigour, credibility and relevance of the selected studies. For mixed methods studies, the CASP checklist was applied specifically to the qualitative components of the studies and quantitative data was excluded as per this review's exclusion criteria. As study quality informed the synthesis process (described below), the decision was made to introduce a scoring system to identify the study with the highest quality rating, which was then used as an index study in which concepts were translated across the remaining studies. No studies were excluded based on their scoring; however, caution was taken when interpreting and generalising findings from lower scoring studies. For this review, the selected studies were assessed and scored using a rating scale developed by Duggleby et al. (2010), where 1 = weak (little or no justification for the issue), 2 = moderate (addressed but did not fully elaborate), 3 = strong (a strong explanation or justification for the issue). Each paper received a total score, with a maximum of 24 and scores ranged between 19 and 24 (see Table 3). To increase reliability of the appraisal, a peer quality assessed 25% of the studies and results were compared. Disagreements were discussed and Table 3 indicates the final agreed scores between the two raters.

2.3. Data Extraction and Synthesis

Data extraction and analysis followed the guidance set out by Sattar et al. (2021) for conducting meta-ethnographies in healthcare research. Firstly, the first author read and familiarised

themselves with the studies that met inclusion criteria. Initial concepts were then considered based on how trauma-informed care principles were applied within children's residential homes. The first author then extracted the raw data (first-order construct; see Table 4) by identifying participant quotes in each results section and noting the primary author interpretations (second-order construct). The key themes from each paper were then placed into a table, (see Table 5) and were then analysed across all studies to look for commonality and relevant categories were created. Next, the studies were then translated into one another using reciprocal translation (Noblit & Hare, 1988) by comparing the themes from each paper to check for similarities and differences between the first and second order constructs. A translation table was produced to aid this process and ensure consistency (see Table 6). Refutational translation was not used as there were no findings that were contradictory in nature. The study with the highest CASP score (see Table 3) was used as an "index" study, meaning it provided a strong foundation for identifying key concepts. These concepts were then used as reference points to examine and translate similarities and differences across the other studies, thereby helping to guide and shape analysis (Atkins, 2008). This allowed the reviewer to develop higher third-order constructs (see Table 7), alongside a 'line of argument' (see Figure 3) to provide a fuller account of the phenomenon (Thorne et al., 2004) of trauma-informed care within children's residential homes. In this review, two studies (Burbidge et al., 2020; Parry et al., 2020) received equal highest scores on the CASP. Burbidge et al. (2020) was selected as the index study due to its purely qualitative design, which provided greater conceptual depth and interpretative richness within its themes compared to the mixed methods approach used in Parry et al. (2020). This made Burbidge et al. (2020) a more suitable foundation for starting the process of reciprocal translation within the meta-ethnography synthesis.

3. Findings

3.1 Study Selection

An overview of the study selection process is shown in a Preferred Reporting Items for Systematic Review and Meta-analyses (PRISMA; Page et al., 2021) flowchart (see Figure 2).

****Insert Figure 2 here****

The search returned 958 studies pre-screening which reduced to 797 after studies being marked as ineligible due to not being in the English language and not being a peer-reviewed journal article. Study screening and selection were conducted by the primary author due to time constraints and the project being an independent postgraduate thesis. Steps were taken to enhance consistency and transparency, e.g. a log was kept throughout the process to record decision-making and reviewed regularly (see Appendix B) and supervision was utilised regularly with the thesis supervisor. After duplicates were removed and studies were screened out based on their title and abstract, 79 were assessed for suitability. France et al. (2019) propose that deductive qualitative research is not suited to meta-ethnography. However, the decision was made to include Jacob et al. (2023) despite authors initially using a deductive framework analysis method as this was explicitly described as a preparatory step for managing large amounts of data. The study then used grounded theory (an inductive method) to derive themes for their analysis which aligns with the interpretive, inductive principles of meta-ethnography (Noblit & Hare, 1988; France et al., 2019). Following the screening process 11 studies were deemed suitable. A top up search was run in January 2025 however no additional publications were identified.

The selected studies' publication period ranged from 2016-2023 with four originating from the United Kingdom, two from Australia, two from Canada, one from Norway, one from the United States of America and one from Israel. Participants ranged from age 16-66, eight studies had a

participant sample of staff, and three studies had a small sample of children. Semi-structured interviews, focus groups and observations were utilised as qualitative methodology across the selected studies. Refer to Table 8 for further details. The selected studies demonstrated the presence of various TIC frameworks including the sanctuary model (Kramer, 2016; Galvin et al., 2022), restorative parenting recovery programme (Parry et al., 2021), 3 pillars model (Steinkopf et al., 2022) and The Framework for Integrated Care (SECURE STAIRS) (Taylor et al., 2018). Additionally, EDI considerations were included in Table 8 to reflect the importance of cultural safety, a key principle in TIC. EDI in this context is understood wider than culture alone, it includes other intersectionality such as gender, race, and neurodiversity that may influence how staff and children experience trauma and TIC. Highlighting EDI considerations helps reflect on cultural interpretations of implementing TIC within children's residential homes.

3.2 The Synthesis

This section provides an overview of the key third-order constructs identified through data translation and synthesis; utilising a TIC framework, practical barriers to implementation, cultural and organisational barriers, increased awareness and knowledge of trauma, relational safety, values and empowerment (see Table 7). These constructs relate to the first-order data and the second-order themes in Table 6. During the reciprocal process there was evidence of the constructs utilising a TIC framework, practical barriers to implementation and increased awareness and knowledge of trauma being repeated more across multiple studies, therefore having added weight in the findings.

3.2.1 Line of Argument: Factors Affecting Implementation of TIC and Key Outcomes.

The seven third-order constructs were merged into two higher-order themes, which interact to form an overall synthesis and line of argument (see Figure 3 and Figure 4). The contribution of this interpretive approach adds to the reciprocal synthesis by explaining complex associations between the key constructs/themes. The synthesis highlighted that having a TIC model can encourage key outcomes for TIC, such as awareness of trauma, increase positive relationships and promote safety, develop values amongst staff and provide empowerment for children. However, practical, cultural and organisational barriers negatively impacted staff and children, hindering the implementation of TIC.

****Insert Figures 3 and 4 here****

3.2.2 Factors Affecting TIC Implementation.

The review found that there are key factors that affect how well TIC is implemented into children's residential settings.

3.2.2.1 Utilising a TIC Framework/Model.

Authors across numerous studies reported the importance of using a framework and/or therapeutic model to help staff implement TIC more effectively. Having a TIC model provided staff with a structured framework and shared language to understand and respond to trauma, which helped develop a consistent approach to care (Steinkopf et al., 2020; Parry et al., 2021; Galvin et al., 2022). This encouraged staff to adopt a relational and strengths-based approach to working with traumatised children (Baker, 2018; Parry et al., 2021). Staff perceived that utilising a framework that reinforced theory and the development of therapeutic skills through training helped them recognise the theoretical underpinnings of their work and transfer this into practice (Steinkopf et al., 2020; Parry et al., 2021; Galvin et al., 2022). For example, training

supported staff to have *"a framework for… taking some of that theory and transcribing it into how to actually work on the floor with the youth"* (Baker, 2018, p. 670). This meant that undergoing training within a structured framework enabled staff to apply trauma theory and use practical, trauma-informed strategies within their work. Implementing the Sanctuary Model in an Australian residential care setting also aided staff to have a 'trauma lens' and become more attuned to their emotions to communicate with children; *"We come together and work out how do we implement this in practice… how do we communicate… best support this young person and keep them safe"* (Galvin et al., 2022, p. 659). Therefore, theoretical models or frameworks allowed staff to have structured guidelines that assisted them in applying TIC.

Authors highlighted that through using a framework, this encouraged a shift in language use and reiterated the importance of teamwork. For example, staff highlighted the need to *"move away from 'trying to control the behaviour' of youth"* (Baker, 2018, p. 670) and *"you need openness among your colleagues… to be able to express all issues"* (Steinkopf et al., 2020, p. 634). However, staff noticed that inconsistent use of language suggested a lack of shared understanding around TIC, which may reflect varying levels of engagement with the framework; *"I don't think we've got common language and a common understanding around what we call this"* (Collings et al., 2022, p. 1846). If staff were receptive to the model being implemented, this appeared to improve language use, communication and collaboration and increase an ongoing buy in to TIC. However, staff in a Canadian residential setting acknowledged that TIC is harder to implement in crisis situations when some colleagues have not bought into it (Baker, 2018), meaning that they felt unable to implement TIC principles when it is needed most. Consequently, it is vital that all staff feel confident in applying TIC to ensure its effectiveness in all scenarios.

3.2.2.2 Practical Barriers to Effective Implementation.

Practical barriers associated with the implementation of TIC was common across multiple studies, including staffing levels (Paterson-Young, 2022; Jacob et al., 2023), limited resources and irregularities amongst staff (Paterson-Young, 2022; Jacob et al., 2023) and the conflicting use of the word 'trauma-informed' leading to varying ways care was provided (Collings et al., 2022). Staff in a UK Secure Training Centre (STC) also felt that limited staffing numbers was a barrier to working with children in a meaningful way; *"If we had more people on the team then there would be a lot more we could do with the young people"* (Paterson-Young, 2022, p. 357). Authors across different studies reinforced that further policies were needed to create more consistency in applying TIC and drive sector-wide change (Collings et al., 2022; Paterson-Young, 2022). Therefore, logistical and practical barriers had an impact on staff's ability to provide effective therapeutic and TIC.

3.2.2.3 Cultural and Organisational Barriers.

It was common across studies that barriers to implementing effective TIC were often attributed to an organisational culture that hinders progress. It was highlighted that some services were not fit for purpose (Brend, 2020; Paterson-Young, 2022), reflecting deeper cultural issues such as rigid routines and punitive approaches towards children. Systemic difficulties also notably impacted the implementation of effective TIC, such as staff being afraid to discuss their emotions to senior staff (Galvin et al., 2022) and insufficient placement time for children (Brend, 2020). Many staff expressed concerns about the lack of effective processes in place to facilitate the transition of children into the community; *"I have watched kids leave here with nothing; we're sending them to live out on the streets"* (Brend, 2020, p. 5), *"You can come here and put all the interventions into the world… but if this isn't continued into the community then they haven't got a hope in hell"* (Paterson-Young, 2022, p. 360). These concerns relate to systems failing to provide TIC principles (such as safety and empowerment) at key times, such

as transition into the community, and may risk retraumatising children. Therefore, the impact of systemic difficulties was not only felt from staff but could also affect the children.

Interestingly, one study discussed how a positive organisational culture, characterised by a shared mindset and consistency amongst staff, can help to provide stability and routine for children and promote trust and confidence amongst staff (Steinkopf et al., 2020). However, in the absence of such a culture due to organisational and cultural barriers, this can undermine the effective implementation of TIC within children's residential services.

3.2.3 Key Outcomes of TIC.

This higher-order theme suggests that when TIC is applied effectively, this can positively impact children and staff within residential settings in the following ways.

3.2.3.1 Increased Awareness/Knowledge of Trauma

Authors across studies indicated that implementing TIC enhanced staff's understanding around the impact of trauma (Baker, 2018; Steinkopf et al., 2020; Collings et al., 2022; Gila, 2023), however recognised that this was a continuous process (Steinkopf et al., 2020; Collings et al., 2022). Staff who thought they had greater trauma awareness reported how they modified their approaches with children (Collings et al., 2022) to perceive complex behaviour as survival strategies, thereby reducing re-traumatisation; *"None of their conduct is trivial. Their souls are on fire and in pain, we must not forget this"* (Gila, 2023, p. 7). Whilst staff benefitted from having an increased awareness of trauma, some requested further specialised training to support children transitioning out of residential settings into the community (Parry et al., 2021). Transitions out of care can reactivate past trauma linked to loss, instability and abandonment and present through behavioural and emotional responses. Therefore, having a better understanding of trauma can enable staff to reframe behaviour during transition stages as

expressions of distress rather than intentional, supporting the application of TIC within this critical period.

Staff described how psychoeducation increased their awareness of trauma and their ability to recognise indicators of past traumatic experiences in children (Steinkopf et al., 2020; Collings et al., 2022), subsequently encouraging children to develop insight into their emotions; *"To understand that when they feel uncomfortable about smells… then there may be something about the smell that reminds them about past experiences"* (Steinkopf et al., 2020, p. 632). Additionally, training staff in trauma can help them acknowledge their own experiences (Collings et al., 2022), and feel more comfortable in labelling vicarious traumatisation (Baker, 2018). However, it was argued that vicarious traumatisation should be better integrated into contexts outside of trauma training, such as meetings, to promote professional and self-awareness (Baker, 2018). Consequently, it was vital that staff received training that helped them to notice any trauma responses within themselves and access appropriate support when necessary, which is essential for sustaining TIC and maintaining compassionate, person-centred care.

3.2.3.2 Relational Safety

Numerous studies highlighted that effective TIC approaches facilitated the development of therapeutic relationships, fostering a sense of safety amongst children and staff. It was acknowledged that an important mechanism of change within the children was through the development of positive therapeutic relationships (Parry et al., 2021; Jacob et al., 2023). For example, one child in a SCH stated *"Before I came here, I was nothing but horrible to people, now it's completely different. I respect people. The reason for that is the staff, they actually take their time in getting to know us"* (Jacob et al., 2023, p. 29). Similarly, one therapeutic parent in a residential setting discussed *"they* (children) *can talk to you, and they feel comfortable and*

safe with you" (Burbidge et al., 2020, p. 264), acknowledging the emotional impact of developing safe and therapeutic relationships.

Staff also felt that communication within the team was essential to their roles (Burbidge et al., 2020; Parry et al., 2021) to develop trusting relationships to support each other. It was argued that staff's psychological and emotional wellbeing can be enhanced by forming safe and mutually trusting relationships (Burbidge et al., 2020). For example, one residential setting in Australia identified that aboriginal staff were at increased risk of intergenerational trauma reactivation and introduced organisational processes to embed safety within its staff team (Collings et al., 2022), such as matching aboriginal caseworkers and families. However, some staff within residential settings felt that there was less support offered from managerial staff *"It's like you're in two different companies, you've got the home and then the head office"* (Burbidge et al., 2020, p. 267). Therefore, this perceived disconnect was seen as a risk factor for staff wellbeing, and as staff wellbeing and support is a key principle of TIC, a lack of this can undermine effective implementation of TIC.

3.2.3.3 Values

TIC helped to promote certain staff values and qualities that supported more effective engagement with children in residential settings. For example, the implementation of TIC was associated with increased self-awareness (Kramer, 2016; Steinkopf et al., 2020) and helping behaviours (Jacob et al., 2023). These developing values helped to facilitate relational connection, with one child reporting *"I'd talk to my case worker, I can sit down and talk to her about anything"* (Jacob et al., 2023, p. 29). Furthermore, staff described how engaging with trauma theory and practice enabled them to self-reflect and use their own emotional experiences as tools to connect with the children (Steinkopf et al., 2020). Therefore, illustrating how TIC principles can promote values within staff that help improve communication and build trusting relationships.

Additionally, engaging in TIC practices such as formulation meetings encouraged staff to humanise children rather than solely view them as "criminals" (Jacob et al., 2023), highlighting how effective TIC implementation helped to shape staff values, such as empathy and being non-judgemental which is essential for promoting positive outcomes for children in residential services.

3.2.3.4 Empowerment

Implementing TIC principles was found to empower children to make life changes and feel included in decisions made regarding their care (Kramer, 2016; Gila, 2023; Jacob et al., 2023). Building and modelling hope for the future can help children have more meaning and outlooks on their lives (Kramer, 2016), as well as giving them the ability to shape their futures; *"My behaviour and my mind are different. They altered my mindset, and I changed my conduct"* (Gila, 2023, p. 6). One study implementing the Sanctuary Model discussed how TIC principles being embedded into the service allowed children to feel empowered and develop trust in others, which can allow them to restore safety and influence change to decrease their future violence (Kramer, 2016). Removing social barriers through implementing and encouraging education and building interactions with the community was seen as vital as this can help children imagine an alternative future (Gila, 2023). Additionally, one study acknowledged that allowing children to be part of formulation conversations enabled them to feel listened to; *"Every professional in that room listened to me, they were interested in my feelings, rather than just telling me how I am or how I behave and how they want me to change it"* (Jacob et al., 2023, p. 30). Consequently, by creating an environment which empowers children aligns with key principes of TIC, such as collaboration and choice, which can have more positive future outcomes for children.

4. Discussion

This review aimed to understand the implementation of TIC principles into children's residential settings and the subsequent effects TIC has on staff and children. This was done through a meta-ethnographic synthesis of 11 qualitative studies, which generated two higher-order themes relating to participants' experiences; factors affecting TIC implementation and key outcomes of effective TIC. Key implications for clinical psychology research and practice are ensuring training around TIC and attachment theory and supervision is provided to staff, enhancing therapeutic relationships and attachment-informed care, addressing systemic and organisational barriers and improving transition support for children leaving residential care.

4.1. Summary of Findings

In this review, participants highly valued utilising a TIC framework that helped them to understand the rationale behind TIC and translate theory into practice. Whilst frameworks varied in how they implemented TIC into residential settings, agreeing with critiques by Wall et al. (2016) that there is inconsistent application of TIC into services, they all emphasised the importance of a holistic approach that created a therapeutic environment where staff and children felt psychologically and physically safe to develop meaningful relationships. This further highlights the value of attachment theory (Bowlby, 1969) within children's residential settings, so that staff can acknowledge the impact of developmental trauma on a child's internal working model and their capacity to develop trusting relationships. Overall adopting a TIC framework into children's residential homes is essential to create a safe and therapeutic environment where children can heal from difficult past experiences.

Trauma-informed services that increase knowledge about the impact of trauma on behaviour can help staff to formulate alternative understandings of complex behaviour, as shown in the findings of this review. This ability to formulate allows staff to consider a child's presentation

through a trauma perspective and implement more compassionate and person-centred care (Toolis & Parry, 2023). Furthermore, this supports previous research that suggests training staff to view behaviour through a trauma lens can enhance the capacity of services to provide support to individuals who have experienced trauma (Lambert & Gill-Emerson, 2017). Papers emphasised the importance of understanding a child's previous experiences rather than focusing solely on their presenting behaviour, aligning with the Power Threat Meaning Framework (Johnstone & Boyle, 2018) which argues that individuals develop threat responses based on perceived power and therefore services should respond in trauma-informed ways.

Of particular importance was the emphasis of developing therapeutic relationships within residential settings. Staff's sense of support and value, in addition to a well-resourced working environment and the ability to self-reflect, were crucial catalysts for increasing therapeutic relationships with children and their colleagues. Supportive relationships amongst staff are crucial in emotive settings like children's homes, as more rewarding relationships can impact positively on children's development and wellbeing (Garcia Quiroga & Hamilton-Giachritsis, 2016). The findings of this review evidence that developing healthy attachments between staff and children (e.g. developing trust, emotion regulation, maintaining professional boundaries) can improve communication and empower children by implementing more person-centred approaches. Building therapeutic relationships is critical and reinforces that staff should act as a professional attachment figure enabling children to regulate their emotions and feel supported and safe (Utting & Woodall, 2022). Furthermore, attachment-tuned working aligns with other attachment focused models for TIC such as ARC (Bartlett et al., 2016), whereby using an attachment theory lens can allow children to heal from trauma and reduce the risk of re-traumatisation. Therefore, prioritising the development of therapeutic relationships within residential settings could enhance emotional safety for children by creating a psychologically safe environment which is crucial to support the holistic recovery of trauma.

Additionally, participants highlighted the importance of minimising barriers to effectively implement TIC principles. It was agreed across papers that practical barriers, such as limited resources and low staffing levels, were identified as potential issues in applying TIC (Paterson-Young, 2022; Jacob et al., 2023). Critically, these findings around systemic and logistical barriers were extracted from papers with lower CASP scores, therefore requiring careful interpretation and application to other services. Nonetheless, this theme demonstrated similar outcomes to previous research reporting that underfunding and high turnover of staff can cause a reluctance to shift to a biopsychosocial model (Sweeney et al., 2016) and subsequently applying TIC. Furthermore, participants acknowledged systemic barriers, such as insufficient support from senior staff (Burbidge et al., 2020) that may contribute to a culture hesitant to adopt TIC approaches, leaving staff feeling undervalued and unable to discuss their feelings (Galvin et al., 2022). Consequently, the barriers shown within this review evidence the need for systemic, organisational change that will help to prevent re-traumatisation of staff and children (Murphy et al., 2017; Baker, 2018).

4.2. Clinical Implications

Children's residential settings should consider embedding a TIC model or framework into their services to provide consistency. Whilst many models have been referenced within this review, chosen models should be responsive to service need and create a cultural and organisational change that managers/staff will be receptive to. Importantly, implementing TIC models should focus on key features such as being valued, respected, safe, cared for, understood and trusted (SAMHSA, 2014). An essential part of this is training staff on trauma and attachment theory and integrating it into clinical practice, which is crucial for understanding the impact of trauma and promoting person-centred approaches. The National Institute for Clinical and Health Excellence (NICE) guidance for looked after children and young people (NICE, 2021) recommends that staff who work within caring settings for children should receive training that

develops their knowledge of trauma. Training could be provided by clinical psychologists (CPs) who are required to communicate psychological knowledge within their teams (Health and Care Professionals Council [HCPC], 2015). Furthermore, CPs could provide TIC based supervision to staff to help staff become more aware of their own emotional and attachment responses to children and put appropriate support in place, so staff feel more contained when working in complex environments. Supervision could include psychological models such as Compassion Focused Therapy (Gilbert, 2010) which could help staff acknowledge compassion in a complex system, reduce feelings of burnout and allow them to respond more empathically to children's trauma.

It was highlighted that there is further support needed to transition children into the community from residential settings (Brend, 2020; Parry et al., 2021; Paterson-Young, 2022). It is concerning that there are limited effective processes that help to facilitate transition, and that systemic cultures can prevent services from creating therapeutic transition plans. A systematic review (Haggman-Latila et al., 2019) researching children's preparedness for leaving care identified that some children were not involved in shaping their transition process. These findings along with those of this review reinforce the need that the care system needs to support and empower children to transition therapeutically into the community. Strategies to assist effective transitions could be to securely connect the child to their community through utilising their strengths and interests (Parry et al., 2021), which will help to empower children to take an active role in transitioning out of residential settings whilst developing their resilience. CPs could offer indirect work such as consultations and formulation meetings to community staff to transfer psychological knowledge and enhance multi-agency working (Draper et al., 2021). These formulations could use attachment models such as ARC (Bartlett et al., 2016) to help staff understand the child's early trauma history, attachment needs and how this can influence the transition process, consequently improving transition processes.

Meta-ethnographies hold value as they can be used to develop evidence for policy within health and social care (Classen & Alvarez, 2015), therefore the barriers highlighted within the discussion section of this review need to be prioritised within future TIC policy making. Whilst health policies favour TIC implementation within the UK, they lack specific regulation, strategy or funding and are not supported by evidence-based research (Emsley et al., 2022), therefore it is key that TIC receives more government support to translate policy into practice. Furthermore, CPs could complete further research to inform policy through service-based research, co-design and testing of TIC protocols and evaluations.

4.3. Strengths and Limitations

This review offers the first synthesis of how TIC is implemented into children's residential services and the impact on staff and children. The range of countries and settings included in the selected studies shown commonalities between TIC approaches and their subsequent effect, suggesting that TIC is a diverse approach which can consider cultural differences and intersectionality when implemented effectively. Furthermore, the arguments align with a previous systematic review and scoping review (Bryson et al., 2017; Saunders et al., 2023), which found senior leadership commitment, sufficient staff support; amplifying the voices of patients and aligning policy with TIC principles were vital factors when implementing TIC, however time and financial resources must be prioritised to implement organisational change; evidencing the findings of the current review being supported by previous research.

Most participants in the reviewed studies were staff members and more research is needed with cared for children, as well as care leavers (McKeown et al., 2020). To truly advance research in this area, future research could also involve children as authors and agents (MacSweeney et al., 2019), so that they can lead advancements in the field (National Institute for Health Research, 2019).

The findings of this meta-ethnography were influenced by the final studies selected. The exclusion of studies prior to 2013 was intended to ensure the review reflected current understandings of TIC which have been shaped by SAMHSA's 2014 widely accepted definition within health and social care policy. Whilst this approach supported a focus on current definitions and applications of TIC, it may have excluded earlier work that contributed to the growth of TIC. Including earlier studies may have offered historical and theoretical insights into how TIC has developed over time. This limitation should be considered when interpreting the findings as the review may not have reflected the full development of applying TIC within children's homes. Additionally, the systematic search criteria excluded studies that were not published in the English language, therefore potentially omitted research from lower income countries where childhood trauma may be more prevalent due to low levels of socioeconomic success (Bauer et al., 2022) and increased risks of violence (de Ribera et al., 2019). Whilst one study (Gila, 2023) originated from Israel and the key themes were similar to other higher income countries (UK, USA, Australia), more research needs to be carried out in less privileged nations to enable a global-wide approach to TIC and examine its impact on staff and children in more deprived countries. Additionally, the study screening was carried out by a single reviewer which increases the potential for selection bias and errors in study inclusion. Although careful consideration was taken, future studies would benefit from inter-rater scoring surrounding screening processes to enhance rigor and reliability. Finally, five papers (Brend, 2020; Collings et al., 2022, Galvin et al., 2022; Jacob et al., 2023; Paterson-Young, 2022) received CASP scores ranging between 19-21 which were slightly lower in comparison to the six top ranking papers. Whilst all papers met an acceptable standard of quality, the CASP scores were used as a guide during the synthesis process. To enhance the rigour of the analysis, papers were ranked via CASP score and translated into one another from highest to lowest score during

the translation process, and primary quotes from participants were utilised when possible to evidence themes derived from the data.

4.4. Reflexivity

The first author's epistemological stance is critical realist (Sayer, 1992), arguing that reality exists beyond our knowledge, and knowledge can be subjective, relative, and constructed by people (Tikly, 2015). A realist approach can also help researchers explain social phenomena and suggest practical recommendations to address social issues (Fletcher, 2016). The first author considered the impact of prior knowledge of psychological theory and TIC when interpreting, translating and synthesising data from selected studies. They also remained mindful they had prior experiences within children's residential homes therefore this could have affected synthesis. Regular supervision was utilised with co-authors during the synthesis process to address any biases and maintain consistency in data analysis. This review offers the field of clinical psychology a synthesis of how TIC frameworks are implemented into children's residential settings for the first time.

5. Conclusion

In conclusion, the findings of this review indicate that effective implementation of TIC into services requires a comprehensive, theoretically based and attachment-informed approach that aligns with SAMHSA's (2014) principles of safety, trustworthiness, choice, collaboration, empowerment and cultural consideration. When implemented effectively, TIC can help staff to have an increased knowledge of trauma which is a crucial factor to developing safe therapeutic relationships with traumatised children, as well as their colleagues. Furthermore, TIC can enable children to feel empowered by implementing person-centred approaches that help to reduce the risk of re-traumatisation from residential services.

There must be a perspective shift at the organisational level including buy in from senior management, appropriate resource allocation and a change in culture as well as from the wider systems through additional government funding and support. Future research needs to prioritise using children as participants and/or as PPI to help design and plan the research strategy as this will help consider their lived experiences of TIC. Furthermore, research on the long-term impact of implementing TIC into children's residential services is needed for evidence-based policy development.

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Figure 1

The Five Principles of the Sanctuary Model.

Figure 2

PRISMA flowchart of study selection process.

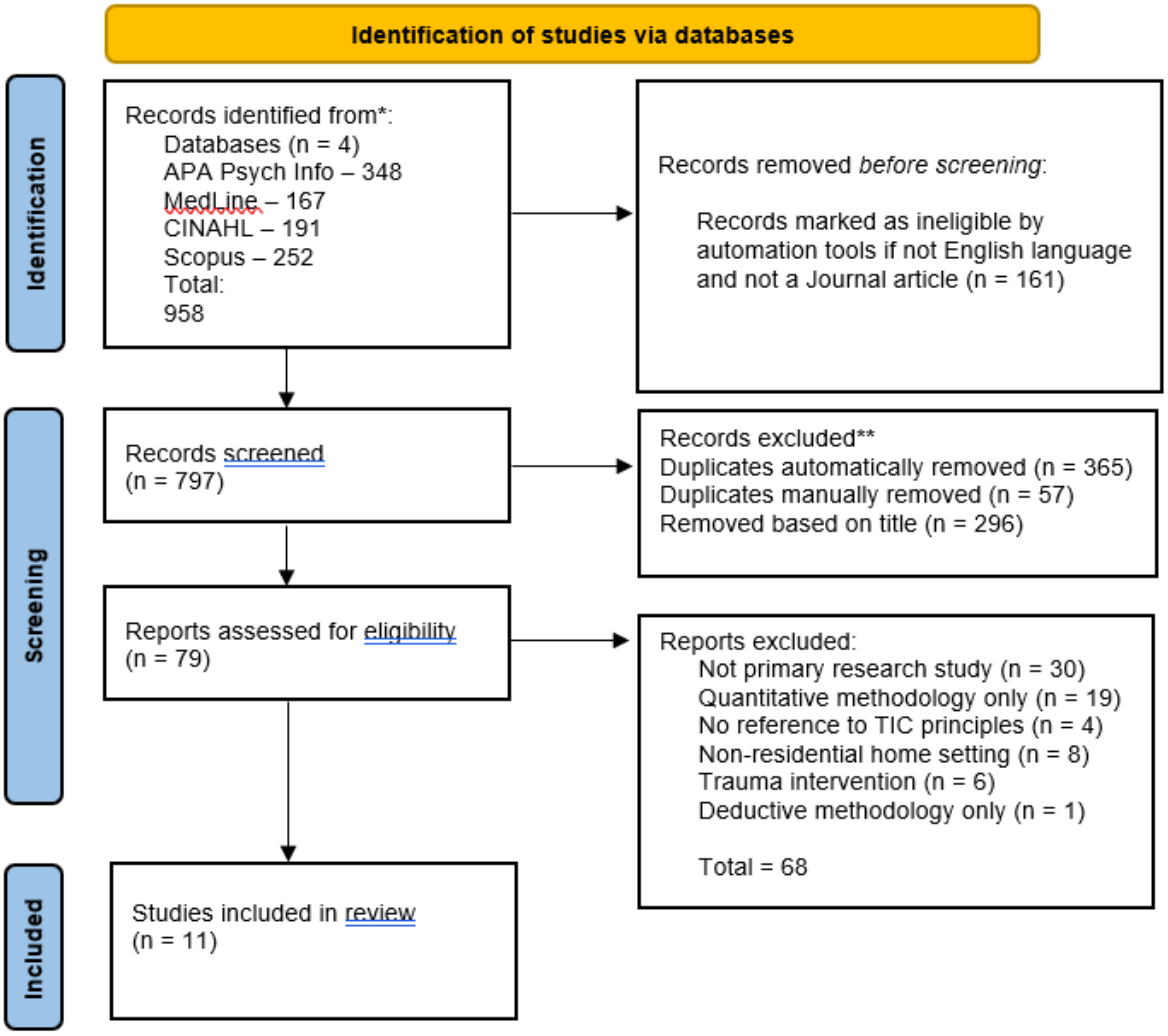


Figure 3

Visual Representation of Line of Argument Developed.

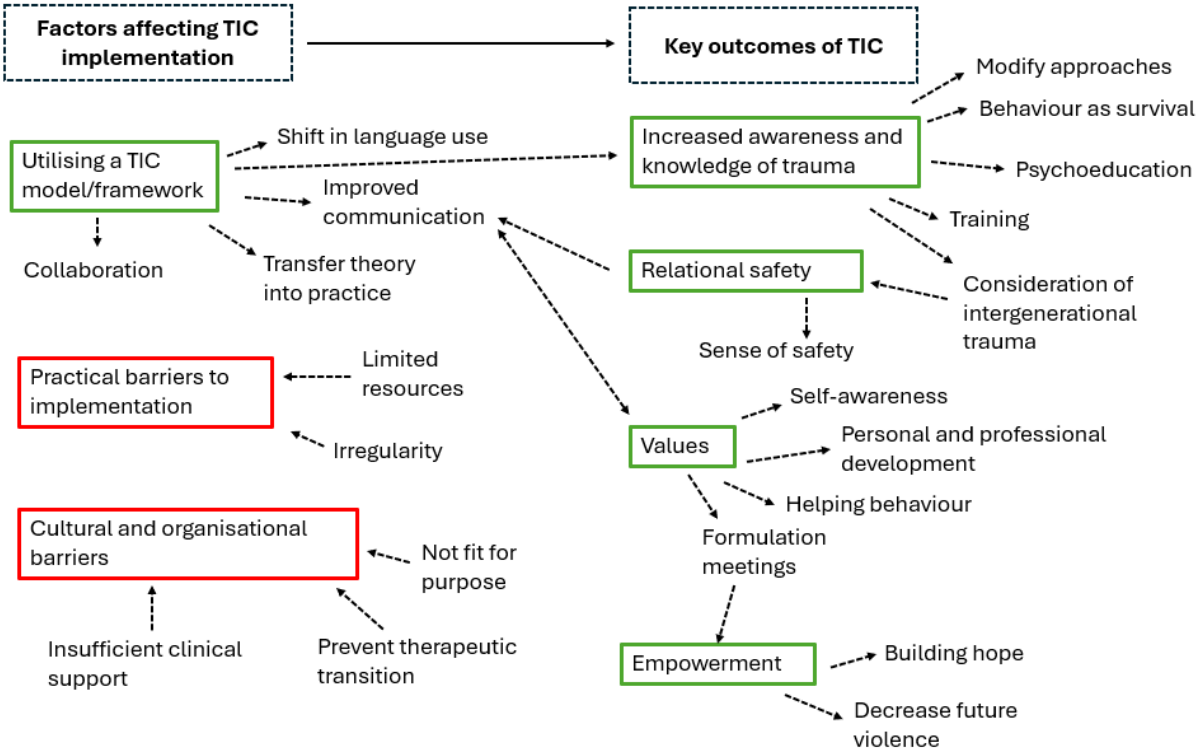
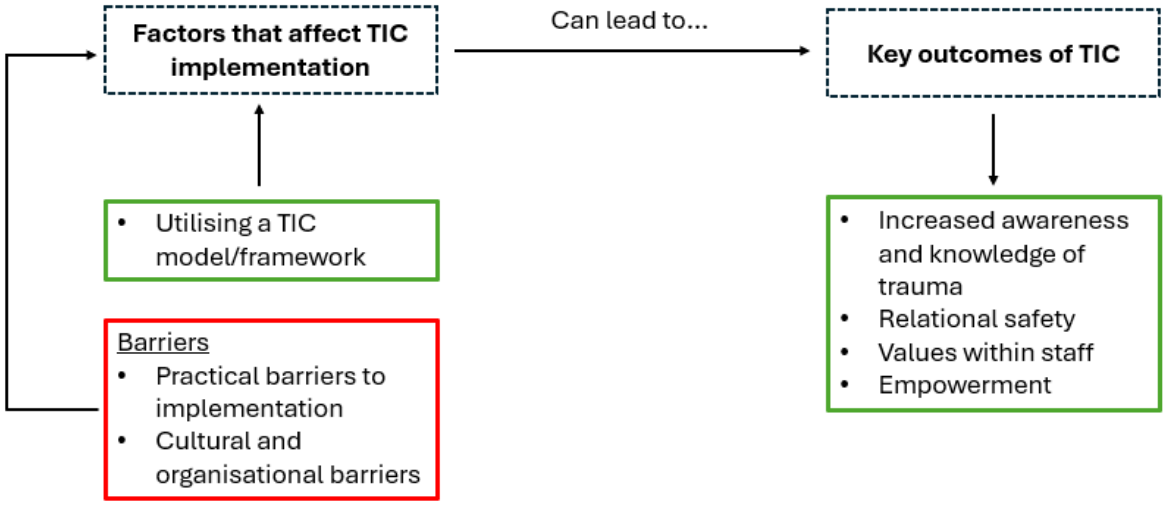


Figure 4

Synthesised Diagram for Staff in Homes.



7. Tables

Table 1

Search Terms

	Search strategy for PsychINFO, Medline and CINAHL.
Trauma-Informed Care	TI ((trauma-informed OR trauma-sensitive OR trauma-focus* OR trauma-reduct* OR trauma-awar* OR trauma-support*) N4 (care OR practi*e OR approach* OR program* OR support* OR service* OR system* OR intervention)) OR AB ((trauma-informed OR trauma-sensitive OR trauma-focus* OR trauma-reduct* OR trauma-awar* OR trauma-support*) N4 (care OR practi*e OR approach* OR program* OR support* OR service* OR system* OR intervention)) OR KW ((trauma-informed OR trauma-sensitive OR trauma-focus* OR trauma-reduct* OR trauma-awar* OR trauma-support*) N4 (care OR practi*e OR approach* OR program* OR support* OR service* OR system* OR intervention))
Children's Homes	TI (("child* home" OR "looked after child" OR "looked-after" OR "out of care home" OR "residential care" OR "child welfare system") OR (child* OR "young people" or adolescent) n3 home OR residential OR secure)) OR AB (("child* home" OR "looked after child" OR "looked-after" OR "out of care home" OR "residential care" OR "child welfare system") OR (child* OR "young people" or adolescent) n3 home OR residential OR secure))

	OR KW (("child* home" OR "looked after child" OR "looked-after" OR "out of care home" OR "residential care" OR “child welfare system”) OR (child* OR “young people” or adolescent) n3 home OR residential OR secure))
Search strategy for SCOPUS	((TITLE-ABS-KEY (“child* home” OR “looked after child” OR “looked-after” OR “out of care home” OR “residential care” OR “child welfare system”) OR TITLE-ABS-KEY (child* OR “young people” OR adolescent W/C home OR residential OR secure))) AND (TITLE-ABS-KEY (((trauma-informed OR trauma-sensitive OR trauma-focus* OR trauma-reduct* OR trauma-awar* OR trauma-support*) W/4 (care OR practi*e OR approach* OR program* OR support* OR service* OR system* OR intervention))))

Table 2

Table of Definitions

Term Used in Exclusion Criteria	Definition
Not a primary research study	Primary research studies refer to studies in which authors collect their own data, involving direct interaction with participants and specific settings, with the aim of answering specific research questions. Therefore, studies that weren't primary research, e.g. other literature reviews/SLRs, were excluded.
Studies focusing solely on trauma intervention	Trauma intervention refers to any structured intervention or programme designed to support recovery from trauma, e.g. EMDR (eye movement desensitisation reprocessing), trauma-focused CBT. Therefore, if study only focused on outcomes of these interventions and not the wider concept of TIC these were excluded.
Not empirical study with qualitative data	E.g. an empirical study only using quantitative data. Mixed-methods studies were included but only qualitative data were extracted for analysis.

Table 3

CASP Scoring Tool

Study	Research design*	Sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value of research	Total score
Baker	3	3	3	2	2	3	3	3	22
Brend	3	3	2	2	2	3	3	2	20
Burbidge	3	3	3	3	3	3	3	3	24
Collings	3	3	3	1	2	2	2	3	19
Galvin	3	2	3	1	2	3	3	3	20
Gila	3	3	3	3	3	3	2	3	23
Jacob	2	2	2	3	3	3	3	3	21
Kramer	3	3	3	3	2	3	2	3	22
Parry	3	3	3	3	3	3	3	3	24
Paterson-Young.	2	3	3	1	3	2	3	3	20
Steinkopf	3	2	3	3	3	3	3	2	22

*Items in column 2-9 here correspond in the same order to items 3-10 on the CASP tool. Scoring system: 1 = weak, 2 = moderate, 3 = strong.

Table 4

Example of First Order/second-order Data Extraction.

Themes	Participant quotes (first-order constructs)	Primary author interpretations (second-order constructs)
Reciprocal Restorative Relationships 1.1 Experiencing therapeutic relationship	"They do trust you finally… that's rewarding" "I think the biggest thing for me is… the staff and child relationship" "can talk to you and they feel comfortable and safe with you". "They really do respond well to us, I love sitting with them, talking with them, playing games with them".	Highlights the restorative and rewarding nature of these relationships. Participants emphasised the importance of the close relationships they develop to facilitate children's developmental progress.
	"You see they're happy, I do enjoy seeing the kids move on to new placements it's a nice feeling seeing them progress when they have had a difficult beginning".	The emotional impact of developing safe and therapeutic relationships, for staff and children.
	"An extension of our own family… we go the extra mile for them. Just being a parent, being a mum to them, treating them the same as I would my own, like living in two lives when I'm here I'm a parent to these children… and when I go home, I'm a parent to my son". "You kind of do what you would with your own children, you give them hugs… I do think it really helps".	Participants place importance on establishing affectional bonds with the children and experience these relationships as reciprocal. Relationships were referred to in familial terms. Participants experiences involved internalising work-based parental roles as they spoke about their daily responsibilities and commitments. Practitioners also place importance on the supportive relationships they have with their colleagues to create such environments.

1.2 Collegial support and safety	“It’s like you’re in two different companies, you’ve got the home and then the head office”. “I love the staff team, I think we’re really close knit, we always try be on the same page, we’re able to be open with each other”. “I think we’ve got a really close team and there’s a good balance”. “Everyone works well together, respects each other and listens to each other”. “Everyone’s opinion is listened to, there’s nobody here who doesn’t get on”. “we all support each other and, if somebody needs help then you help them, if you need a bit of support then you can get it”. “I love the staff team they’re just the best, every body there supports you”. “There is someone here I feel like I can go to… and if you didn’t you wouldn’t be very happy… I think for people’s mental health and emotional state it’s not great”. “I’m in a lucky position here because I do feel like the staff are behind me… I feel confident in my ability to move forward”. “Supervisions are really good… you can just approach them it’s really supportive”. “Managers always have our backs”.	Differences between two working environments – in the homes and main organisational office. Participants reflected on collegial support positively within home, which acted as protective factor for their wellbeing. Whilst from head office seems to be absent and acts as a risk factor towards practitioner’s wellbeing. Participants spoke positively of restorative nature within staff teams. They felt understood by their staff team through shared experience, beliefs, interests and opinions which aided team dynamics. They felt supported, appreciated, understood and respected by the staff team. Safe and mutually trusting relationships were of key importance. As a result this support may have been beneficial for psychological and emotional wellbeing and without it, the impact could be detrimental. Participants experiences of support had a positive impact where they felt secure and confident in their own abilities. They felt supported by managers and senior therapeutic parents. This led to participants feeling understood and accepted by management.

	"There are always going to be some people in teams you don't get on with and aren't so lovely". "There's been disagreements… or issues with staff". "Management and then the staff team are getting all upset, there's a bit of the relationship going offish". "Feeling that value… I think that would make me want to stay longer. It's the value coming from head office". "We've got people at head office that are separate, so a separate person to us". "I don't think that the head office fully understands what the homes are doing… they've never been to the homes and worked with the children".	There can be tension and difficulties between members of the teams. Relational challenges arose when there was an absence of shared experience and understanding amongst people with different roles. The homes need to be constantly staffed, although disparities in terms of how this is fairly shared amongst employees holding different roles caused tensions. Relationships between staff and those in head office felt relationally fractured. Head office had a lack of appreciation for their commitment and sometimes sacrifices (e.g. work-life balance, sleep as a result of long hours). A lack of perceived understanding and contact time in the homes from staff in head office led to a relationship of indifference, leading to staff feeling unsupported and undervalued from the overarching organisation they worked within, resulting in staff seeking comfort by becoming increasingly reliant on one another within the homes, and more distant from staff in head office.
The self within the system 2.1 The perceived efficacy and value of the professional self.	"I can be more effective, cause I don't think I'm as effective as I could be at the moment". "It was absolutely amazing". "It does help". "children do learn from it… and it does help them to relax and to calm down, to be more settled".	This subtheme highlights risk factors for perceived efficacy and value that could impact practitioner wellbeing. Participants had mixed experiences of working within the service.

	"Cohesive in the way that things work" "how it's structured and… it's got purpose" "I cant really fault it at all it's the best service I could think of because all the professionals work together to provide the best care and the kids get a say in their care, it's very child-centred".	An interesting phenomenon that emerged was how practitioners experienced themselves within the service and their working relationships. Some TPs liked how the service was structured, practically and within its ethos and the importance of child-centred care.
	"They know what's expected from them, everyone sings from the same hymn sheet, it works well". "We as a staff team deliver it, I think it's spot on".	Participants attributed the effectiveness of the service to individuals working together and understanding the role. Holding a secure sense of professional expectations, personal standards and values, alongside witnessing colleagues with the same, facilitated participants to assess the quality of their work. When organisational expectations were met, this positively impacted practitioners' perceptions of their own capabilities within the system.
	"I just think it's difficult when the resources aren't there and the money". "We shouldn't feel like we're scrimping on food in the house".	When resourced were lacking and limited, participants experience of being able to deliver an effective service seemed to be compromised. Financial constraints made practitioners felt as though their ability to perform were directly affected. Organisational restrictions reduces their work-related satisfaction and sense of value upon themselves as practitioners.
	"I think we do a pretty good job… I think all the staff here are pretty good at what they	Practitioners coping strategy in response to limited resources was to focus on their

	do". "It's just the satisfaction in thinking I've made that little bit of difference to this child and they're going to benefit from it". "a really significant fuzzy, happy feeling from seeing the children happy and seeing them achieve things in their lives, that's always been… quite fulfilling about work".	impact in the long-term, e.g. the effectiveness of the service delivered to the children. These positive feelings of satisfaction, happiness, reward and fulfilment shows that the perceived effectiveness of the service can impact the wellbeing of practitioners.
	"Our children have gone into fostering families but then a couple of the placements have broken down". "Clearly somethings not working, whether we're not delivering the programme properly or the programme isn't right for the kids… or the programme just doesn't work".	If participants perceive the service to be ineffective this can have a lasting impact on staff wellbeing as they doubted their own abilities and that of the service. Participants expressed an element of self-blame, perhaps highlighting how accountable and responsible they felt for the children. This had a negative impact on self-perception.
2.2 Practical strains upon professional practice and personal lives	"I think sometimes they can forget that we do have our own lives and our own families". "A lot of the staff were working sixty, seventy hours a week which is bonkers". "When you look at two hundred and fifty hours, it's a ridiculous number of hours to be working… it means you're drained so my days off are spent just sleeping, I don't get time to spend with my family". "It can be emotionally draining".	Practical strains experienced by participants such as long hours, demanding shift patterns and low staffing levels which could impact wellbeing. Long hours and varied shifts they worked resulted in tiredness, stress and work-related fatigure. Highlights the emotional labour of the work, particularly when staffing levels could be improved.

	"From staff's opinions, our wages don't reflect what we do". "Just random shifts, you don't know what days you're in, you don't know what times you're in, you can't really plan your own life".	Discrepancy between long unsociable working hours and financial remunerations. Shifts often appeared unpredictable.
	"We're trying to staff the home and when you've not got staff it's hard… we can't manage and we're not safeguarding the children".	Emotional availability is a key requirement for TPs in their role, organisations must support their emotional wellbeing to support the children in their care. A common outcome of burnout in residential childcare settings is frequent staff turnover.
2.3 The developing self	"I've learnt a lot by just being here".	Participants were developing as a result of the work they undertook and as part of their job role.
	"I think the training we get for positive behaviour management is really good, it does help you to understand… I think every training session I've been in, I've learnt something". "You put it in place and you go 'ahh it works', its good, learning and knowing you've got that information if you need it".	Participants found training useful and as a result were able to transfer the skills gained in training to their own practice.
	"I've been here just over three months and I've learnt more, done more training than I did in nine years".	Participants felt more capable to deliver the service. They felt prepared and confident which appeared to reduce stress and vulnerability.

Table 5

Table of Themes

Paper	Themes
Baker et al. (2018) – residential staff	1. Evidence of successful TIC implementation (relational/strengths-based, shift in language, collaborative teams, buy-in for TIC, training, challenges – role differences, become stricter, harder in crisis). 2. Vicarious traumatisation. 3. Parallel process in the context of TIC implementation (improvement in interactions/communication).
Brend (2020) – residential staff	1. Barriers to care
Burbidge et al. (2020) – therapeutic parents (staff)	1. Reciprocal restorative relationships (experiencing therapeutic relationships, collegial support and safety). 2. The self within the system (perceived efficacy and value of the professional self, practice strains upon professional practice and personal lives, the developing self).
Collings et al. (2021) – senior executive managers	1. Lack of consensus on terminology. 2. Building trauma awareness. 3. Dimensions of safety. 4. Signs of culture change.
Galvin et al. (2022) – Residential staff	1. Enablers influencing implementation (social support systems and resources, shared trauma-informed knowledge and understanding, leadership and champions).

	2. Organisational successes of implementation (sanctuary commitments, safety emotion loss and future (SELF) framework, reflective practice and supervision, trauma theory). 3. Barriers influencing implementation (informal practice, lack of practice-based training, poor introduction to young people, resources). 4. Organisational challenges of implementation (sanctuary toolkit, young people's behaviour and engagement).
Gila (2023) – staff members & children (young females)	1. Relationships. 2. Safety. 3. Empowerment, voice and choice. 4. Trustworthiness and transparency. 5. Perceiving maladaptive behaviours as useful survival skills. 6. Peer support and mutual self-help. 7. Removing social barriers. 8. Reduce re-traumatisation and empowering through introspection and visibility.
Jacob et al. (2023) – children in children and young person secure estate (CYPSE)	1. Helping behaviour. 2. Inconsistencies/instability within the setting. 3. Building facilitative relationships. 4. Sense that staff cannot help. 5. Communication. 6. Staff's capacity to understand children and/or express empathy. 7. Staff are caring. 8. Relationships work on a quid pro quo basis. 9. Being central to formulation conversations. 10. "Good" staff. 11. Trust. 12. Treat them like criminals. 13. Sense of fair treatment.
Kramer (2016) – staff and children	1. Commitment to a culture of nonviolence. 2. Commitment to a culture of emotional intelligence.

	3. Commitment to a culture of democracy, shared governance and open communication. 4. Commitment to a culture of growth and hope for the future. 5. Healing within the communal context of relationships and safety.
Parry et al. (2021) – residential staff	1. Learning and implementing trauma-informed practice and caring. 2. Therapeutic practices and relationships. 3. Reconciling the ethos with the reality.
Paterson-Young (2022) – Secure training centre (STC) staff	1. Uncertainty regarding the purpose of STCs. 2. Delivering the right support to children. 3. Limited resources and interventions.
Steinkopf et al. (2020) – residential staff	1. Self-awareness (self-reflection, authenticity, other regulation). 2. Intended actions (actions to build strength, actions to build mentalisation skills, staff availability, setting clear and safe boundaries, collaboration). 3. Organisational and cultural practices (a commonly shared mindset, stability and routines, cultural safety).

Table 6

Translations Table

Descriptor (groups of similar concepts clustered together)	First order data (primary quotes from studies)	Second order themes (themes developed by primary authors of studies)
Therapeutic relationships and safety	"There is someone here I feel like I can go to… and if you didn't you wouldn't be very happy… I think for people's mental health and emotional state it's not great". Burbidge "I think the biggest thing for me is… the staff and child relationship" "can talk to you and they feel comfortable and safe with you". Burbidge. "You just think wow this is really working and seeing that difference and seeing them… little children who can cope a bit better, it's just amazing". "It's just really rewarding knowing that you've made some sort of difference… the relationships the children have with everyone so like the staff and child relationship is just really, it's a really positive thing most of the time and I think having that they create a positive relationship where they can like talk to you and they feel comfortable with you and they feel safe with you to be able to talk to you	Reciprocal and restorative relationships (Burbidge et al, 2020). Therapeutic practices and relationships (Parry et al., 2021).

	just gives them that safe place and I think that's the most important thing". Parry	
	"Discipline comes out of respect and mutual relationships, first the girls must feel that you are there and you see them". Gila	Relationships,
	"I write about her strengths, what she brings to her self-work, where she was, where she is today". Gila	trustworthiness and transparency,
	"We fight but we also defend each other". Gila "Everything you need, the girls can also help you". Gila	peer support and mutual self-help (Gila, 2023)
	"at the beginning, when everyone is saying okay [my co-workers] aren't committed to the job or they are lazy or they seem to be avoiding these things, and then all the sudden we are talking about VT and maybe this is really hard for them and maybe this is something that they need help with… co—workers started to really provide support to each other". Baker	Parallel process in the context of TIC implementation (Baker, 2018)
	Residents stated they "come back to love". "We call this a family, not a unit". "Getting into fights is a waste of time, it's useless". Kramer Keeping feelings "in check", "keeling it real".	Commitment to a culture of nonviolence Culture of emotional intelligence (Kramer, 2016)

	"Expressing feelings gets a pound off my heart". Kramer	
	"Chill with staff, play a bit of pool with staff". "Before I came here, I was nothing but horrible to people, now it's completely different. I respect people. The reason for that is the staff. They actually take their time in getting to know the young people in here now". "Building up that trusting relationship. To the point where the first people they want to talk to is the staff because of the relationship they have. If there's no trust, then the young people can't get any help for any of their behaviours". Jacob	Building facilitative relationships, staff's capacity to understand children and/or express empathy, relationships work on a quid pro quo basis, trust (Jacob et al, 2023).
	"The more natural you can make it, the more children are going to feel like this is just a normal part of life". Collings	Dimensions of safety (Collings et al, 2022)
	"Children need contact with their families and if carers aren't able to support that, they're going to get all these mixed messages". Collings	
	"We've really tried to create a more child friendly environment for contact" Collings	
Barriers to TIC	"I just think it's difficult when the resources aren't there and the money". "We shouldn't feel like we're scrimping on food in the house". Burbidge	The self within the system (Burbidge et al, 2020).
	"I really like the therapeutic home… but then I think sometimes it wraps the children in cotton	Reconciling the ethos with the reality (Parry et al, 2021).

	wool and doesn't give them real insight into what the world is like". Parry	
	"You will have other staff you just don't want to be around". "Don't know how they passed interviews, just do it to get their pay cheques". "Some staff de-escalate a situation, but others can make it worse". Jacob	Inconsistencies and instability within the setting (Jacob et al, 2023)
	You are all doing an activity and then you have this child in complete crisis, being exposed to that has a very intense impact". "I want to make a difference but then judges give us less than a year… social workers are burned out after nine months". "It makes me absolutely freak out… I have watched kids leave here with nothing; we're sending them to live out on the streets". Brend	Barriers to care (Brend, 2020).
	"Being able to understand it in theory but can't explain it in practice". Galvin "It would be good to have a more formal process of introducing it to our young people, because we just make it up as we go". Galvin "With a lot of the young people, I think it can be a bit more challenging sort of being like alright lets sit down and use these steps". Galvin	Organisational challenges of implementation, barriers influencing implementation (Galvin et al, 2022).
	"There aren't enough staff offering psychology interventions and I don't think there is enough time." PY	Limited resources and interventions (PY, 2022)

	"We are really tight on resources for psychology… if we had more people on the team then there would be a lot more we could do with the young people." PY "You can come here and put all the interventions into he world, and they could reap the most amounts, but if this isn't continued into the community then they haven't got a hope in hell." PY I have worked with young people on a one-to-one basis and at the end they will say 'I'm really sorry K, thanks for all your help, but I'm going back to what I know and where I have come from'" PY "Children in these places really need support and encouragement. I worked with a young man… he came from a difficult family, and they initially wanted to send him to a YOI, but we argued he needed a more supportive and caring environment." PY "I think some of the values need to change sometimes, especially with the older boys we have now." PY	Delivering the right support to children (PY, 2022) Uncertainty regarding the purpose of STCs (PY, 2022)
Utilising a TIC framework	"I really do like that therapeutic model… we're really encouraged to do that every day, more guidance on key work sessions… I don't think that we have any training in running those sorts of sessions with kids". Parry Move away from "trying to control the behaviour" of youth. Baker	Learning and implementing trauma-informed practice and caring (Parry et al, 2021). Successful TIC implementation (Baker, 2018).

	"A framework for… taking some of that theory and transcribing it into how to actually work on the floor with the youth". Baker	
	"The wrong person could turn the whole system upside down and destroy the good practices we have struggled to achieve". Steinkopf	Organisational and cultural practices (Steinkopf et al, 2020)
	"Especially since we need to have this openness, you need openness among your colleagues, to be able to express all issues, weaknesses, and strengths". Steinkopf	
	"You need to have it as part of continuous, everyday life, in change-overs, in conversations throughout the day". Steinkopf	
	"We come together and work out, how do we implement this in practice, how do we communicate this with the young person… how can we best support this young person and keep them safe". Galvin Provided them with "the framework for knowing what to do and how to intervene". Galvin	Organisational successes of implementation, Enablers influencing implementation (Galvin et al, 2022).
	"I don't think we've got common language and a common understanding around what we call this". Collings "It's a fairly amorphous concept that in an ideal world would manifest in a whole heap of different ways". Collings	Lack of consensus on terminology (Collings et al, 2022).

Staff qualities/values	"I can be more effective, cause I don't think I'm as effective as I could be at the moment". "It was absolutely amazing". "It does help". "children do learn from it… and it does help them to relax and to calm down, to be more settled". "because all the professionals work together to provide the best care and the kids get a say in their care, it's very child-centred". Burbidge	The self within the system (Burbidge et al, 2020).
	"Say what you mean and mean what you say" "to say what you mean and don't be mean about what you say". Kramer	Commitment to a culture of democracy, shared governance and open communication. (Kramer, 2016)
	"What the youths do to us is information… I must be conscious of myself and my vulnerabilities, even more, when I see my own reactions as a practical tool". Steinkopf	Self-awareness (Steinkopf et al, 2020)
	"I think that, in order to promote good health, you need to have some abilities that relate to… love and sincerity…" Steinkopf	
	"They chat to you whenever you need it… that member of staff went out of his way to sort that out". "I struggle to open up about my story, they were quite respectful, and they appreciated that it is always going to be difficult for a young person to share their story with people they don't know, they don't push it".	Helping behaviour, communication, staff are caring, sense that staff cannot help, treat them like criminals (Jacob et al, 2023).

	“We are all seen as prisoners, all in the same category”. Jacob “I don’t think we’ve got common language and a common understanding around what we call this” Collings	
Awareness of trauma/impact	“None of their conduct is trivial. Their souls are on fire and in pain, we must not forget this” “Maybe the good we want for her is not the good she is seeking. Maybe her family lives in poverty but she is accustomed to being the parent at home and she runs away to cook food for her family”. Gila “We ask them questions regarding gains and losses from relationships. Therapy enables them to perceive how they contribute to unhealthy relationships and how to better choose friends and maintain beneficent relationships”. Gila “Although the girl arrives here by legal order, she chooses whether to stay and her voice and choices are seen and heard. Following Herman’s works on trauma, we strive to restore the girl’s sense of control over her life”. Gila Felt “empowered and really positive by the end”. “Consistently hopeful and energised”. “It's hard to talk to a supervisor who has an open-door policy when there is no staffing support for a break”. Baker	Perceive maladaptive behaviours as useful survival skills, Reduce re-traumatisation and empower through introspection and visibility, Safety (Gila, 2023). Vicarious traumatisation (Baker, 2018)

	"It has worked for some kids to talk about the emotions they have in the present and what they can tell about the past. We have talked about memories that are hard to recall but are stored in the body. To understand that when they feel uncomfortable about smells when they are triggered by specific persons, then there may be something about the smell of the person that reminds you about some past experiences". Steinkopf "I think one of the mistakes we made initially in implementing TIPC, was that we became afraid of setting safe boundaries. We were afraid of triggering something, and we forgot to be safe grown-ups". Steinkopf "Probably the biggest challenge is skilling up our carers to understand trauma. They've raised their own children in a particular way and it's helping them understand that that's not necessarily the way to manage that child". Collings "I don't think we're experts. I think that we all have to continually learn about trauma informed practice, because there's always new research". Collings	Intended actions (Steinkopf et al, 2020) Signs of culture change (Collings et al, 2022) Building trauma awareness (Collings et al, 2022).
Empowerment of young people	"I'm happy I did it because there are people here that give me what I need, not what I want. My behaviour and my mind are different. They altered my mindset, and I changed my conduct. Otherwise, I would end up an addict	Empowerment, voice and choice, Gila

	on the street… things don't just happen, everything is a choice we make". Gila	
	"I treat her as a person who is as knowledgeable as I am. This approach has therapeutic significance". Gila	
	"The words staff choose can rebuild states of mind and even create new ones". Gila	Removing social barriers (Gila, 2023).
	"You are preparing for the world out there, not in here". Kramer	Commitment to a culture of growth and hope for the future (Kramer, 2016)
	"Every professional in that room listened to me, they were interested in my feelings, rather than just telling me how I am or how I behave and how they want me to change it". Jacob	Being central to formulation conversations, having a fair sense of treatment (Jacob et al, 2023).

Table 7

Third-order Constructs

Third order constructs	Second order constructs	Notes
Relational safety	Building facilitative relationships, staff's capacity to understand children and/or express empathy, relationships work on a quid pro quo basis, trust (Jacob et al, 2023). Reciprocal and restorative relationships (Burbidge et al, 2020). Therapeutic practices and relationships (Parry et al., 2021). Dimensions of safety (Collings et al, 2022)	Importance of therapeutic relationship between staff and young people to encourage safety and opportunity to develop, but also staff feeling supported/safe by others they work with.
Practical barriers to implementation	Inconsistencies and instability within the setting (Jacob et al, 2023) Limited resources and interventions (PY, 2022) Lack of consensus on terminology (Collings et al, 2022).	These barriers more centred around practical implementation of TIC e.g. staffing levels, limited resources, inconsistencies amongst staff and way they provide care etc.
Cultural and organisational barriers	Barriers to care (Brend, 2020). Organisational challenges of implementation, barriers influencing implementation (Galvin et al, 2022).	Whereas these barriers associated with cultural and organisational barriers to implementing TIC. Processes that aren't put in place/don't work and the impact this has on staff and young people.

	Delivering the right support to children (PY, 2022) Uncertainty regarding the purpose of STCs (PY, 2022)	
Utilising a TIC model/framework	Learning and implementing trauma-informed practice and caring (Parry et al, 2021). Successful TIC implementation (Baker, 2018). Organisational and cultural practices (Steinkopf et al, 2020) Enablers influencing implementation (Galvin et al, 2022).	Having a framework can help staff feel more confident in the way they are providing TIC within their settings.
Values	The self within the system (Burbidge et al, 2020). Commitment to a culture of democracy, shared governance and open communication. (Kramer, 2016) Self-awareness (Steinkopf et al, 2020) Helping behaviour, communication, staff are caring, sense that staff cannot help, treat them like criminals (Jacob et al, 2023).	Staff values/qualities that are encouraged/developed through implementing TIC but have a positive impact on their own wellbeing and also those of young people.
Increased awareness/knowledge of trauma	Perceive maladaptive behaviours as useful survival skills, reduce re-traumatisation and empower through introspection and visibility, safety (Gila, 2023).	Having an increased awareness and knowledge of trauma has positive effects on staff and young people in residential settings.

	Vicarious traumatisation (Baker, 2018) Intended actions (Steinkopf et al, 2020) Signs of culture change (Collings et al, 2022) Building trauma awareness (Collings et al, 2022).	
Empowerment	Empowerment, voice and choice, removing social barriers (Gila, 2023). Commitment to a culture of growth and hope for the future (Kramer, 2016) Being central to formulation conversations, having a fair sense of treatment (Jacob et al, 2023).	By implementing TIC practices, this can empower young people to make changes in their lives and feel included in decisions made about their care.

Table 8

Characteristics of Studies Table

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
Kramer	2016	USA	Residential treatment centre for adolescent males – forensic/court-committed.	Staff, residents (children) and support workers. No demographics reported.	Focus groups with staff and residents, and individual interviews with staff. Grounded theory & utilisation-focused evaluation methods used to analyse data from interviews and focus groups.	Research knowledge interpreted through lens of Sanctuary Model principles. No reference to epistemological stance.	Sanctuary model commitments increased skill sets of staff. Theory emerged - Sanctuary offers the framework that shapes a positive role-modelling and parental love-type caring relationship between residents and their staff, within a therapeutic community. Residents gain a sense of well-being, attachment, and hope for the future.	Most important factor in reducing impact of trauma is to develop an attuned relationship with someone who can regulate emotions. Bonding, trust and acceptance is key from youth workers to help impact of trauma. Sanctuary model is a theoretical, epistemological and research-based model that can transform lives of youths and organisations.	No reference to EDI.

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
Baker	2018	Canada	Canadian residential youth services.	Residential staff – 5 direct care staff, 5 other staff e.g. therapists: 68% female, aged 21-66 years.	Mixed methods study, quant evaluated impact of TIP implemented into Canadian residential youth services. Qual – observations of verbal/non-verbal behaviours, and 10 Semi-structured interviews. Descriptive coding methodology. First data reviewed, then coded in software. Analysis focused on	No reference to epistemological stance.	Used Risking Communities and Restorative Approach training amongst staff. Successful TIC implementation – relational and strengths-based approach, shift in language used to describe youth. Vicarious trauma increased following training - increased awareness of trauma.	TIC implementation is a complex process that must span all levels of an organization and that requires years to fully occur. TIC implementation may also benefit from booster training sessions for staff, embed TIC concepts into the organisation across staffing levels and attention to vicarious trauma amongst staff.	Reference to first Nation/Aboriginal families who were forced to attend residential schools and suffer systemic trauma.

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
					final list of two overarching a priori codes and one a posteriori code.				
Brend	2020	Canada	Institutional rehabilitation setting for young people in welfare system.	10 residential staff members (all female, no reference to age).	Qualitative analysis of 10 interview transcripts completed in a previous study, however analysed for the purpose of this current studies research aims. Theoretical thematic analysis from pre-determined criteria. Deductive coding based on analysis of child welfare	No reference to epistemological stance.	One inductively developed theme "barriers to care". Staff can experience systemic and organisational factors that can cause distress; e.g. lack of resources to help support young people, lack of time, other professionals who they believed would sabotage.	Psychological distress needs to be addressed by systems inducing it. TIC proposed to help address moral distress in residential workers but needs to achieve system level change. TIC needs to be in practice, policy and procedure.	No reference to EDI.

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
					literature and then made into themes, then one inductively developed theme.				
Burbridge	2020	United Kingdom	Trauma-informed residential children's homes (therapeutic community homes).	12 "therapeutic parents" working at four children's homes. Four male, 8 female; aged 18-55. All worked at home minimum of 3 months.	Qualitative semi-structured interviews. Thematic analysis used to analyse interview responses (Braun & Clarke).	A critical realist epistemological position – looks at deeper causal processes and relationships without needing to control variables. Interpretative analytical approach allowing for personal meaning making.	Two important themes: 1) reciprocal restorative relationships (developing and experiencing therapeutic relationships) and 2) the self within the system (personal and professional selves considering emotional duties). Risk factors affecting staff wellbeing; long working hours, inconsistent shift patterns, and lack of paid	Need to have a well-resourced therapeutic environment with training focusing on knowledge and transferable skills, feeling valued, supportive relationships and seeing young people progress. Management within LAC organisations provide their practitioners with external support from outside of the homes, e.g. counsellors.	No reference to EDI.

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
							compassionate or sick leave.		
Parry	2021	United Kingdom.	Four residential homes implementing the Restorative Parenting Recovery Programme.	12 residential care staff members. 8 females, 4 males (aged 18-55).	Mixed methods – data collection (20 young people) on the Restorative Parenting Recovery Index. Qualitative semi-structured interviews. Quant – one-way repeated measures ANOVA. Qual – deductive thematic analysis (Braun & Clarke)	Interviews were social interaction based on perspective. Critical realist conceptualisation of themes.	Restorative parenting recovery programme combines a range of theoretical frameworks and adapting these to provide specialist care. Key themes: (1) Learning and implementing trauma-informed practice and caring, (2), Therapeutic Practices and Relationships, and (3) Reconciling the ethos with the reality.	RPRP is an effective model of care for LAC, combines a range of theoretical frameworks – rewarding but complex to implement. Argument for further specialised training and support, developing a clear attachment-based and TIC plan for managing transitions. Models of TIC need to focus on potential of vicarious trauma within staff.	Children in care overrepresented in forensic and homelessness population.
Collings	2022	Australia	Eight organisations that provided	Qual participants – 15 senior	States mixed methods study	No reference to epistemological stance.	Four themes emerged: (1) lack of consensus on	Build more awareness of creating a sense of	Recognised that indigenous children and

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
			long term placement support for children.	executive managers (12 female, 3 male; no reference to age)	however appears to be quant and then qual, no merging of results or findings. Quant methodology - anonymous online survey. Qualitative – semi structured interviews. Thematic analysis (Braun & Clarke). Categories were created to organise codes into enablers or barriers of TIC.		terminology; (2) building trauma awareness; (3) dimensions of safety; and (4) signs of culture change.	safety in contact between young person and their caregiver. More co-operation between all systems in how to protect a child's emotional safety. Implement trauma screening to help identify trauma early and help build awareness of triggers and co-regulation.	overrepresented in child protection services. Makes reference to aboriginal staff/children and cultural safety.
Galvin	2022	Australia	Therapeutic residential care settings implementing	38 (25 female, 13 male; no reference to	Qualitative research – purposive sampling.	No reference to epistemological stance.	Four key themes relating to the implementation of The Sanctuary	Shared knowledge and understanding across all levels can provide deeper	No reference to EDI.

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
			the Sanctuary Model.	age) residential care staff across all levels of staffing.	Three semi-structured interviews with area manager, house supervisor and residential care co-ordinator. Six focus groups across 7 residential homes. Inductive and deductive analysis methods were used with thematic coding.		Model in residential OoHC: (1) Enablers influencing implementation; (2) Organisational successes of implementation; (3) Barriers influencing implementation; and (4) Organisational challenges of implementation.	understanding of young persons trauma. Need to embrace collaborative approaches incorporating reflection and systemic thinking. Important to connect trauma theory to their practice to implement and embed Sanctuary Model.	
Paterson-Young.	2022	United Kingdom.	UK secure training centre – forensic setting.	30 participants (4 resettlement, 3 intervention, 4 secure	Qualitative research – 30 semi-structured interviews.	No reference to epistemological stance.	A dual approach to embedding trauma-informed practices, with staff training (bottom-up) complemented	Increasing staff understanding of TIC whilst embedding TIC practices throughout the Secure Training	No reference to EDI.

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
				care officer, 1 management, 3 education). – 11 female, 4 male; no reference to age. 7 YO manager, 2 YO officer, 2 social worker, 1 CEO charity, 3 police. 6 female, 9 male.	Thematic analysis – Braun & Clarke 6 step approach.		by policy and practice (top-down). Embedding trauma-informed "Child First" approaches would enable staff to support children with a child-focused approach that helps children recognize traumatic experiences and empowers relationships.	System could reduce reliance on restraint. STC's require substantial resources (specifically, substance misuse and psychology services so staff have the right skills to deliver appropriate care. "Child First" approach allows for appropriate support for children that acknowledges their vulnerabilities.	
Steinkopf	2022	Norway	Child welfare residential facility.	19 staff members (11 social workers, 2 teachers, 2 occupational therapists, 1 nurse, 1 economist, 1 police officer, 1	Qualitative research study. 27 semi-structured interviews with 19 staff members. Systematic network	Qualitative phenomenological perspective to come as close as possible to the informants' subjective understanding of TIP.	3 pillars model by Bath implemented into practice. 3 themes how staff in residential setting translate TIC into practice – self-awareness, intended actions	Elements of TIP are easily recognized in other models. One operationalised TIC model may lose staffs ability to reflect on own emotions. May also lead to a higher	No reference to EDI.

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
				corrections officer). Age range 24-65; 12 women, 7 men.	analysis used to produce basic themes then global themes.		and organisational and cultural practices. Self-reflexivity and other regulation are both unique and essential elements of TIP.	level of personal commitment and a broader understanding of relational interactions with young people.	
Gila	2023	Israel	Deep-end placement facility in Israel – houses 39 teens in 3 houses.	30 staff members (across all staffing levels), 23 young people (all female; aged 14.5-17 years). Staff member demographics not reported to maintain anonymity.	Qualitative observations and semi-structured interviews. Thematic analysis utilised (Braun & Clark).	Feminist constructivism as the epistemological and methodological approach to data collection and analysis.	8 principles of gender-responsive and TIC: 1) relationship, 2) safety, 3) empowerment, 4) trustworthiness, 5) behaviour as survival skill, 6) peer support, 7) removing social barriers, 8) reducing re-traumatisation.	Importance of establishing close interpersonal relationships. Understanding the unique circumstances that gender and trauma create is a powerful basis for reflexivity, mutuality, and partnership between service providers and users. Maintaining gender-responsive and trauma-informed care means constantly	Discusses impact of gender-responsive services – e.g. acknowledges vulnerabilities of being a female young person and services recognising the role of race/ethnicity in Israel.

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
								reviewing and reinterpreting reality in partnership with young people.	
Jacob	2023	United Kingdom	Children and Young Person Secure Estate. 5 sites – Secure Children Home, Young Offender Institute and Secure Training Centre. Forensic services.	Young people in CYPSE (*N* = 28 children from 25 interviews and 1 focus group); 16-18 years. 9 from SCH 4 from STC 15 from YOI.	Qualitative semi-structured interviews and a focus group. Analysis: Step 1 - qualitative framework analysis Step 2 – grounded theory methodology. Step 3 – Constant comparative method.	Acknowledged that prior knowledge to TIC, psychological theory and secure estate can impact the analysis.	TIC and SECURE STAIRS framework vital to improve relationships between young people and staff. Importance of good communication, understanding, reciprocal respect, trust, and a sense of fairness and understanding difficulties leading to challenging behaviours through a developmental lens. Highlighted the need for knowledge sharing and staff	Future directions should involve the inclusion of children and their families/carers as relevant, in all elements of forensic youth care, implemented in policy, with cross-learning applied internationally. Need for staff to develop and maintain meaningful therapeutic relationship with young people in CYPSE.	"Future research should also consider demographic characteristics: race, ethnicity, gender and specific complexity factors discussed here. Of priority is an exploration of the disproportionate number of children of colour in youth justice settings".

First author	Date	Location	Setting	Participants	Method(s) /Analysis	Epistemology	Key findings	Key recommendations	EDI
							training in effective helping skills.		

8. Appendices

Appendix 1-A

Link to author guide for Children and Youth Services Review:

https://www.sciencedirect.com/journal/children-and-youth-services-review/publish/guide-for-authors

Appendix 1-B: Example Log of Decision Making

Decision made	Rationale
Include "child welfare" as a term to recognise USA studies.	TIC originated from USA, wasn't that many more studies when completing searching process and felt able to manage this when it came to screening.
Include mixed methods studies.	Will only analyse qualitative results, had important results around TIC that would have answered research question. Make sure note in results section if truly mixed methodology or quant/qual e.g. are the results merged?
Used CASP tool.	Used this for quality appraisal rather than a selection process. Decided not to eliminate studies if lower score but report this in results section.
Only decided to use CINAHL not AMED.	No relevant results came back from AMED search.
Decision to include Brent study.	Was unsure if primary research or not – analysed previous study interview transcripts but for a different purpose – was their supervisor's study. Had emailed in December 2023 however email bounced back.
Not doing peer checking of SLR studies	Time constraints and kept a reflective log of decision making to ensure I was sticking to criteria.

Section Two: Empirical Paper

Exploring Perspectives, Interpretations and Applications of Psychological Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis

Word count (excluding references, tables and appendices): 7982

Abstract: 180 words

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Exploring Perspectives, Interpretations and Applications of Psychological Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis

Abstract

Psychological formulation helps to develop an understanding of an individual's experiences and how they make sense of these. There is limited research around staff's perspectives of psychological formulation within the Children and Young People Secure Estate (CYPSE). The aim of this research was to explore residential staff's lived experiences of utilising and applying formulation into their practice, discover the impact on working relationships with young people (YP) and identify what role formulation has for future practice and policy. Nine qualitative semi-structured interviews were facilitated with residential staff in two Secure Children's Homes (SCH) in England. An interpretative phenomenological analysis approach was utilised, and five themes were developed. Psychological formulation enhanced trauma-informed understandings, promoted collaboration amongst professionals, helped to develop therapeutic relationships with YP, created psychological safety and promote empowerment. Additionally, formulation processes were flexible which helped staff to adapt their approaches to be more trauma-informed and person-centred. Future practice/policy should consider systemic challenges limiting engagement and prioritise YP's views on being involved in the formulation process. Implications for clinical practice are discussed as well as recommendations for future research.

Keywords: formulation, secure children's home, children and young person secure estate, trauma-informed care, SECURE STAIRS.

Practice Implications:

- Psychological formulation allows residential staff to build trauma-informed understanding of and deeper connections with YP.

- Strengthening therapeutic relationships between staff and YP can encourage empowerment and resilience in YP.
- Formulation meetings should ensure psychological safety, allowing staff to openly discuss emotional challenges of working with complex trauma.
- Systemic challenges must be prioritised by service managers to help promote engagement with formulation.
- There should be opportunities for YP that promote their active involvement with formulation, policy and research.

Introduction

The Secure Estate

Young people (YP) who commit criminal offences are placed within a variety of secure care systems which are led by different legal and welfare priorities (Transition to Adulthood [T2A], 2011). For example, in the United States, YP are typically housed in juvenile detention centres, with a primary aim of rehabilitation however it is argued that they are often centred around confinement and punishment (Ackerman et al., 2024). In contrast, Scandinavian countries such as Sweden and Denmark place YP in secure youth homes that emphasise the importance of treatment and rehabilitation (Nolbeck et al., 2024). Additionally, in Australia they have a mix of welfare and justice models across its states for YP who have offended, with some implementing more trauma-informed approaches than others (Day et al., 2023). Within England and Wales, the Children and Young People's Secure Estate (CYPSE) offers care and support to YP under the age of 18 who have carried out a criminal offence or are a risk to themselves/others. The CYPSE consists of Youth Offender Institutes (YOI), Secure Training Centres (STC) and Secure Children's Homes (SCH) that provide secure accommodation and support for YP's health, mental health and risk management needs. The main distinction between the settings is that STC's and SCH's prioritise education for YP, whereas YOI's accommodate large numbers of YP and is not an educational setting. SCHs are staffed by a multi-disciplinary team (MDT), which includes clinical staff (e.g. mental and physical health nurses, GPs, psychologists), education staff (to facilitate formal education), managerial (overseeing the non-clinical running of the home) and residential care staff. Residential staff work directly with children on the units where they live, providing a safe environment, managing daily routine and activities, responding to emotional and behavioural needs and building relationships. Their role is particularly important when considering how trauma-

informed care (TIC) is implemented and experienced within practice. SCH's are run by local councils and can accommodate YP for both criminal justice purposes and under a Secure Welfare Order for the protection of themselves and/or others (Children Act, 1989). It is important to recognise that not all children in SCHs have a criminal justice background and some are accommodated for welfare reasons and may present with different complexities and needs. Consequently, research based on justice samples may not always be directly applicable to children placed under welfare provisions and should be interpreted with caution. In March 2024, there were 156 YP reported to be in SCH's (Department for Education, 2024), therefore many YP with complex needs are housed within these residential settings.

Adverse Childhood Experiences

YP within the CYPSE have more complex needs, including greater rates of Adverse Childhood Experiences (ACEs; Baglivio et al., 2014; Martin et al., 2021), mental health difficulties (Souza et al., 2021) and neurodevelopmental difficulties (British Psychological Society [BPS], 2015). ACEs are highly stressful or traumatic events that occurs during childhood, such as abuse and witnessing domestic violence (Felitti et al., 1998). Additional ACEs have been established in recent years and can include community violence, racism and living in care (Cronholm et al., 2015). ACEs have been found to impact the likelihood of being a perpetrator of future violence (Fox et al., 2014), and YP in secure and custodial settings are more likely to experience attachment and relational difficulties (Taylor et al., 2018) because of adversity.

Trauma-informed Approaches

There is an increased recognition of the importance of trauma-informed approaches when working with children in the justice system who have a history of trauma and ACEs (Gray et al., 2021; Glendinning et al., 2021). TIC recognises the effect of trauma on individuals and helps services and systems identify the signs, symptoms and impact on service users. The

widely internationally accepted definition from the United States Substance Abuse and Mental Health Services Administration (SAMHSA) argues there are four key assumptions for TIC; realising the widespread impact of trauma, recognising the signs in clients, staff and systems, responding appropriately and actively resisting re-traumatisation (SAMHSA, 2014). Therefore, implementing TIC approaches within the children's justice system ensures that YP with complex needs and trauma backgrounds receive appropriate support.

Psychological Formulation

Psychological formulation can be defined as developing an understanding of a person's experiences and how they make sense of these (Johnstone, 2018). In the UK formulation is a core competency of clinical psychology (BPS, 2011) and is often encouraged as an alternative to psychiatric diagnoses (Johnstone & Dallos, 2013). Similar to the UK, counties like Australia and New Zealand have formulation emphasised within national guidelines and often consider culture and biopsychosocial (biological, psychological and social) aspects in formulating clients' difficulties (Royal Australian and New Zealand College of Psychiatrists, 2017; Pitama et al., 2017). However, this emphasis on formulation is not universal. For instance, in the United States, structured formulation is less widely adopted, as clinical practice tends to centre on diagnostic assessment guided by the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013).

The UK's National Health Service's (NHS) Five Year Forward View independent report (NHS, 2016) and Long-Term Plan (NHS, 2019) emphasise the necessity of psychological support for YP with complex needs. The Division of Clinical Psychology (DCP) argue that formulation should consider the role of trauma and abuse, the position of services in re-traumatising individuals and take a critical awareness of the wider context in which the formulation is occurring (DCP, 2011). Specifically in youth forensic services (YFS), formulation can create a trauma-informed insight of a young person's experiences and

behaviour (Dallos & Stedmon, 2013) by acknowledging the impact of trauma and developing a holistic understanding of a child's complexities (McKeown et al., 2022). It is recommended that formulations within YFS should incorporate psychological theory such as attachment theory (Bowlby, 1969) and therapeutic modalities to help increase compassionate and person-centred care for YP (Toolis & Parry, 2023). However, this paper is based on youth forensic settings, therefore may not be fully applicable to children also placed in the CYPSE based for welfare reasons only.

Team Formulation and The Framework for Integrated Care (SECURE STAIRS)

More recently, team formulation has been implemented within services to help staff develop a shared biopsychosocial understanding of a person, which can inform subsequent interventions and care plans (Johnstone, 2018). Within England and Wales, The Framework for Integrated Care (SECURE STAIRS) (Taylor et al., 2018) aims to support staff and children through formulation-driven and systemic TIC approaches. The framework places particular emphasis on formulation-driven intervention plans that are developed by an MDT, including frontline staff, healthcare staff, education, psychologists and psychiatrists. Notably, staff with less perceived power (e.g. residential staff) often have more to contribute to formulation meetings as they have more profound knowledge of the individual's life (Johnstone, 2018). An independent evaluation of the framework (Anna Freud Centre, 2022) found that its formulation-led, whole systems approach improved understanding of trauma, strengthened team cohesion and influenced positive shift in organisational culture. Additionally, staff felt more confident in supporting YP who consequently felt more heard and understood, highlighting how trauma-informed frameworks like the Framework for Integrated Care can embed principles of TIC into everyday practice.

A systematic literature review (SLR) analysing team formulation within MDT's found increased staff tolerance, reduced client blame, and more commitment to supporting and

understanding clients (Geach et al., 2018). This SLR indicates positive aspects for formulation, however none of the 11 studies included were set within the CYPSE, which must be considered when interpreting and applying results to the CYPSE. Furthermore, a study looking at YP's involvement within formulation processes in The Framework for Integrated Care (SECURE STAIRS) found that when young people attended a formulation meeting, staff's knowledge, motivation, confidence and satisfaction with intervention planning improved, which had a positive effect on therapeutic culture (McKeown et al., 2020). However, there is little qualitative research carried out with staff within the CYPSE, and McKeown et al. (2022) argue that more research is needed that explores how formulation can influence staff's perceptions of YP and how they adapt their approaches.

Rationale for Current Study

It is important to explore staff's perspectives, particularly residential staff, within the CYPSE as they can build attachments with YP that have experienced multi-type trauma and provide them with suitable support, safety and security (Parry & Jay, 2022), whilst reducing the risk of re-traumatisation. Further research is needed to understand staff's perceptions of psychological formulations within SCH and how they effectively implement their understanding of a young person into their therapeutic work.

The aims of this study were therefore to:

- Explore residential staff's interpretations and experiences of formulation within SCH's.
- Explore what processes formulation helps to support in terms of working relationships with other staff and YP.
- Explore if/what role trauma-informed formulation has for future practice and policy.

Materials and Methods

The standards for reporting qualitative research (SRQR) guidelines (O'Brien et al., 2014) were followed.

Design

The present study focussed on the lived experiences of residential staff members within SCH's who had attended formulation meetings, therefore a qualitative analysis was deemed most suitable. The researcher's epistemological position was critical realist, therefore to gather participants' lived experiences, semi-structured interviews were carried out and the data were analysed using an interpretive phenomenological approach (IPA). This method of qualitative analysis felt appropriate as IPA is concerned with the detailed examination of personal lived experience, the meaning of experience to participants and how they make sense of it (Smith, 2011). Therefore, IPA allowed for participants making sense of their own experiences which was then interpreted by the main researcher to identify commonalities, differences and subsequent themes.

Sampling and Participants

Participants were recruited from two SCH's within the CYPSE in the Northwest of England. One home supports YP (aged 10-18) who have offended, focusing on risk management, mental and physical health and educational needs whilst in custody. The second home aims to provide care for vulnerable, traumatised YP (aged 10-18) who have been disadvantaged and require the safety of a secure setting, however there is no criminal justice requirement for a young person to be placed there. This difference has been considered when analysing and interpreting the research data as experiences of staff members may be different depending upon the context within which they work. For example, in a criminal justice setting there may be more emphasis

on behaviour and risk management compared to a welfare setting which may have a stronger focus on relational safety.

Purposive sampling was used to recruit participants between April 2024 and August 2024. Posters (see Section 4 Appendix B) were put up around staff areas and emails (see Section 4 Appendix C) were sent across both sites to residential staff advertising the research. Participants scanned a QR code and expressed interest through Qualtrics. They were able to ask any questions prior to interview, and a date/time was agreed that was mutually convenient.

All participants were residential staff members across both sites. They were eligible to participate if they worked directly with YP on their units, had worked on site for a minimum of 4 months and attended one formulation meeting, and had an NVQ Level 3 qualification for working with YP or were currently working towards at the time of interview. An NVQ level 3 is a qualification that prepares individuals for a specific profession, in this case caring for children. The four-month minimum was suggested during stakeholder involvement and was selected due to staff undergoing a three-month probationary period, therefore four months allowed staff enough time to settle into their role following probation and gain meaningful experience on the unit's they worked on. Additionally, attendance at only one meeting was deemed valuable enough to participate as Interpretative Phenomenological Analysis (IPA) emphasises the richness and depth of participant meaning making rather than frequency or duration of their experience. Therefore, even attending one meeting can provide valuable insight into how staff make sense of formulation within their work. Participants could take part if they had the ability to engage in conversational English. Nine participants (five male and four female) took part which adhered to IPA recommendations of having a sample between four and ten participants (Smith, 2009). It is argued that a limited number of participants in IPA studies allow for a richer depth of analysis that may be prevented with a large sample size. Participants' ages ranged from 25-54 and the time worked at site ranged from 1 to 10 + years.

Notably, only one participant did not consider themselves as white ethnicity, so the author ensured that ethnic and cultural differences were considered when synthesising the data. Full demographic characteristics of participants are shown in Table 1.

Data Collection and Analysis

Qualitative semi-structured interviews were carried out online (four participants) and in person (five participants) all within work time, recorded through Microsoft Teams and were stored securely on OneDrive. All interview questions (see Section 4 Appendix G) encouraged participants to talk about their experiences in using within their setting. The main researcher sought stakeholder engagement with senior managers and heads of homes when creating the interview schedule and recruitment materials. Stakeholder involvement within social science research has demonstrated theoretical benefits, such as increasing trust, organisational commitment and enhancing support for the research (Powell & Vagias, 2010). All interviews ranged from 22-62 minutes, with an average time of 41 minutes. The lowest timed interview was 22 minutes due to the recording not having started, therefore once realised the participant summarised their answers to previous questions meaning the total interview time was shorter. Please refer to Appendix B for reflection on relatively short duration of interviews. Following interviews, all participants were given the opportunity to ask questions and reminded of the debrief information.

Interviews were transcribed verbatim by the main researcher and analysed according to IPA. IPA is rooted in phenomenology, hermeneutics and idiography, therefore supports an in-depth analysis of lived experience whilst acknowledging the researcher making sense of the participant, who is making sense of their experience/world (double hermeneutic) (Smith et al., 2009). The participants in this study were a homogenous sample in that they all shared the key experience of using psychological formulation within SCHs which allowed for a rich exploration of their individual experiences within a shared context. Due to the main author

being a novice IPA researcher, guidance for conducting and writing up IPA research was followed (Murray & Wilde, 2020). The data were analysed to generate experiential themes, which involved an iterative and cyclic process. Firstly, each transcript was read several times to allow the main author to fully immerse into the data. The author then coded each transcript including descriptive, linguistic and conceptual comments to engage with language and meaning (see Appendix C). For each transcript, initial codes were grouped into interpretive themes (using sticky notes and looking for patterns in participant experience), and then narratively summarised to create an audit trail (see Appendix D). These steps were carried out for each transcript without taking into account interpretations from previous transcripts. Once completed for each participant, themes were compared across all participants to look for common experiences and meaningful differences that reflect the shared and individual aspects of participants experiences (see Appendix E). This then led to the emergence of final themes, which showed the main authors interpretation of the participants' experiences. Throughout analysis the research supervisor checked each step within supervision to ensure IPA quality and reduce researcher bias. For example, the supervisor provided critical feedback on emerging interpretations which helped to refine themes and theme titles which ensured that the themes remained grounded in the data.

Reflexivity

This research was underpinned by a critical realist epistemology, which is compatible with IPA. Critical realism acknowledges that knowledge can be shaped by individual interpretation and social context (Tikly, 2015). This aligns with IPA's emphasis on the lived experience of participants and the argument that meaning is co-created between the researcher and participants (Alase, 2017). Within this study, it was important to understand participants' experiences of their reality in using formulation with YP. A critical realist perspective supported this by enabling the exploration of participant's meaning making, whilst also acknowledging

that participants' accounts are interpretative and constructed through language. Critically, researchers' epistemological positions can shape research aims, methods and outcomes (Haigh et al., 2019), therefore the researcher acknowledged that their prior experience in SCHs could influence interpretation. Consequently, reflexivity was critical to enhance rigour. A key strategy utilised was bracketing where the researcher acknowledges and sets asides their prior assumptions/experiences to engage more authentically and make sense of the participants' experiences (Smith et al., 2009; Alase, 2017). Reflexivity was applied throughout the study via regular supervision to reduce potential bias, and through the use of a reflective diary (see Appendix B) to ensure any biases or feelings were considered which was shared with the research supervisor. For example, after one interview the main researcher noted in the reflective diary a strong emotional response to a participant's experiences regarding managerial support, which resonated with their own past experiences. During analysis, the diary was used within supervision to identify where interpretation may have been influenced by the researcher's prior experience and subsequently some initial themes of participants were re-named. Reflection and supervision helped to maintain the credibility of the analysis.

Ethics

Ethical approval was received from University of Lancaster Faculty for Health and Medicine Ethics Committee on 11th December 2023 (Reference: FHM-2023-3707-RECR-2). An amendment was approved on 29th February 2024 due to a change in research supervisor. Informed consent was gained from all participants. Due to the potential for emotive topics to be discussed within interview, sources of support were included within the participant information sheet. After the interview ended, participants were reminded of the time scales for withdrawing their data and signposted to the sources of support available. No participants requested to withdraw their data from the research.

Although the main researcher had previously worked within one of the settings, they did not know any participants prior to the interview. A member of the research team worked within one of the homes, therefore participant data remained anonymous to everyone other than the main author. Pseudonyms were used to maintain confidentiality.

Results

Analysis created five themes: 1) enhancing trauma-informed and holistic understandings, 2) promoting collaboration through MDT working, 3) strengthening connection and empowerment, 4) creating safety and 5) flexibility, adaptation and implementation. A sample of initial coding and audit trail are presented in Appendices C and D, respectively. Appendix E presents themes from each participant that contribute to individual overarching themes.

Theme One: Enhancing Trauma-informed and Holistic Understandings

Eight participants contributed to this theme, and participants reflected that formulations helped them develop a more trauma-informed and holistic understanding of the YP, enabling them to consider underlying causes to behaviour and how they would provide support: *"normally if you've got issues with a kid and you could just it as aw he's naughty, but there's always a background to it so I like knowing how they've come to that point and a bit more about what they've been through then it helps me think about how I can help their behaviour be better whilst they're here with us" (Phil, p3, 27).* Formulations were experienced as individualised to each YP, helping staff connect with their background and complexities. Daniel stated *"it helps my understanding because you're hearing examples and you're hearing about behaviours they're presenting with, and it helps us consider why they're doing it and what might have happened in the past to be driving it and how we can manage that behaviour" (p5, 31).* This illustrates how formulations supported him to consider the impact of earlier traumatic experiences rather than immediate behaviour a YP was presenting with. This is reinforced by

Patrick who shared that "*knowledge is power innit, if you know what they've been through it's easier to not take it personally or get wound up" (p18, 137).* For Patrick, gaining insight into the YP's background helped him reduce reactive responses and be more empathic, highlighting how formulations were crucial spaces to build trauma-informed perspectives of YP and increase compassionate care.

Formulations appear to help staff identify insights into a YP's triggers which can help them to respond in more trauma-informed ways. For example, Lee found formulations valuable as "*y'know there must always be a reason why they're doing the stuff they're doing, and then he wants to know why he is impulsive, why is he doing this and we can discuss it as a team and with the child because then we're all understanding what's going on and then help them" (p12, 102)*. Likewise, Alice reflected on an example of how a formulation helped them to think differently about a YP being distressed at night in their room *"I think on a night time when they're locked inside a room that's when some of the demons come out"* (p25, 273). This illustrates how formulation can help to reframe distressing behaviour from disruptive to a reaction shaped by previous traumatic experiences. By having a formulation and understanding the context and meaning behind behaviour, staff can reduce blame towards YP and provide more compassionate, tailored support.

This change in perspective also reflects the influence that psychological formulation can have in guiding staff towards more trauma-informed ways of understanding YP. Lucy highlighted that after formulation meetings "*them unhelpful comments have just slowly stopped, we stopped thinking they were being naughty out of choice but instead we would talk about what they've been through and how they have to act that way to survive, you know.." (p22, 137),* suggesting that developing formulations helped staff to reframe their language and views towards YP and could promote more reflection within the staff teams. Similarly, Phil echoed *"you look at them a bit different, you're more understanding into when they are*

displaying negative behaviours" (p4, 35), demonstrating how formulation helps staff to develop more trauma-informed understandings of a YP and promote resilience and healing.

Theme Two: Promoting Collaboration Through MDT Working

Eight participants contributed to the second theme and recounted experiences of formulation helping them collaborate with other professionals through an MDT approach. Formulations involved input from different professionals such as care workers, health care, psychology, education and psychiatry. For Carl, the value of joint working was captured in the metaphor *"to get the best results we need to work together and put into the same pot and make something beautiful out of that pot" (p14, 89)* emphasising the collaborative nature and the ability to learn from one another. Similarly, Daniel reflected that *"in the formulation you get to see their working out and it's a place where wider explanation comes out and the discussion around them, the staff are going to give you information first hand" (p13, 94).* These reflections demonstrate how formulations were experienced as collaborative spaces that allowed for mutual learning and consistency of care across teams.

Interestingly, some participants identified how formulation helped to reduce power imbalances between professionals. For example, Lee reflected on the hierarchy amongst professionals within the meeting and *"although I'm the lowest rank, it's absolutely fine I know the most about that kid overall" (p16, 155)* showing that residential staff felt valued within the meeting. Likewise, Alice highlighted *"letting staff become involved in things like this… I think it puts us all on an even playing field and it doesn't matter what you work as or what you do in that meeting we're all equal and work together" (p13, 133)* evidencing how formulations help staff value one another's insights regardless of perceived status.

Some participants felt frustrations over education staff not prioritising attending formulation meetings, for example: *"I don't think they take enough time to make sure they're*

there, if they do come you can talk things through and think about what triggers them in school time cos most of these kids aren't great in education and haven't stayed in school in their life" (Phil, p2, 18). Therefore, formulation could encourage discussions around a YP's struggles in education and help staff work together to support their educational needs.

Theme Three: Strengthening Connection and Empowerment

Eight participants contributed to the third theme describing how formulations aided staff to build therapeutic relationships with the YP, which staff believe helped the YP feel safe and empowered in their care. The role of formulation was highlighted as helping staff to build stronger connections with the YP by increasing empathy and enabling staff to understand the YP's complex needs *"it helps them understand why the kid is presenting that way and actually what they need is closeness and someone to connect with" (Lucy, p21, 131);"We had to make her feel like she was safe, she was cared for, she was looked after" (Courtney, p6, 56).* Daniel's reflections, who was employed in a different home to Lucy and Courtney, appeared to be more structured around risk and behaviour: *"Because if they know we're looking at behaviours, it's no secret, and we can sit down and say we've had a meeting about you and why you're being this way and we can think about it together to reduce that behaviour" (p9, 62).* Across participant experiences, formulation was viewed as a process that helped staff build stronger connections with YP and involve them in meaningful conversations about their care and/or help to reduce risk (dependent on the setting).

Participants discussed balancing the need to develop a therapeutic relationship whilst maintaining professional boundaries. Alice reflected on her own role as a parent outside of work, stating "*it's hard because if you're a parent yourself, you just want to mother these YP because you know they haven't had it but you can't do that to an extent" (p4, 45)*. Participants emphasised the importance of validation and ensuring a YP's voice is heard throughout the formulation which can promote trust and enhance engagement, particularly when considering

transitions into the community or next placements: *"they might say I'm unsure about next placement… so I'll bring them up I'm sort of an advocate on their behalf as well" (Lee, p3, 20)*.

Strengthening connections and relationships with YP was perceived by staff to support their sense of empowerment within their own care. Staff promoted YP's strengths and confidence by using strategies that helped build relationships and ensure a YP felt included within their care. Anne gave the example of a "fuel meter" strategy *"He'd be sometimes like my fuel is full today and we'd be like well we know then so better off spending some time on his own" (p20, 156)* which they felt allowed the YP to feel empowered to communicate their emotions. However, it was crucial for participants to consider the YP's emotional well-being when sharing information with them. Patrick discussed *"I didn't want to bring anything up and partly because I didn't want him to start reliving it in custody" (p18, 146)* showing his desire to want to protect the YP and keep them safe. As such, formulation can aid staff in developing therapeutic relationships that help encourage empowerment amongst YP in the homes.

Theme Four: Creating Safety

This theme highlights how formulation meetings help promote a supportive environment and emotional safety for staff working with YP with complex needs which five participants contributed to. Participants valued formulations as they helped to normalise difficult feelings that may come up within their work: *"It's normal to have difficult feelings but you need to be able to understand it and work through it because if not then it does become an issue" (Lucy, p8,113).* This suggests how formulations can help staff make sense of emotional responses and offer a space where they can be understood and discussed.

Furthermore, formulations had positive benefits for staff as it helped them to become more self-aware of their feelings and triggers. Alice highlighted *"as I explained to*

[psychologist] in the formulation these YP are vulnerable, but staff are vulnerable as well, especially at night. I don't think a lot of people show it but staff's anxieties on a nighttime are heightened because there is less staff and them kids are vulnerable, so we are vulnerable" (p25, 267). For Alice, this showed that formulation offered her a space to name the emotional demands of the role, particularly in increased moments of stress such as night shifts, and have her feelings validated.

The atmosphere of the meeting was found to influence staff's feelings around being supported within their role. When formulations were not facilitated well and they felt like a "tick box exercise", this could have adverse effects on staff e.g. *"It's helped me evolve when done well but when it's not been done well it's made me draw back from certain team members. Sometimes you can see it's just a tick box exercise and they want to get it done as as fast as possible (Carl p15, 103).* Notably, the role of the psychologist in the meeting was valued in creating a safe space where staff felt contained: *"[psychologist] always reminds us it is a safe space so if we say something like they're grinding on me it's okay to feel that way (Anne p7,43)".* This reflects how formulation can aid staff to feel safe enough to process their own emotional responses.

From a senior staff member perspective, Lucy spoke about the importance of managers showing vulnerability to encourage openness amongst staff: *"We talk about emotions and behaviours so much people feel more comfortable coming to us and we can talk about it properly rather than them keeping it in and struggling" (p18, 111).* This suggests how psychological safety can be promoted through leadership culture that models vulnerability and helps staff to share feelings without judgement, reinforcing a positive culture within the team.

Theme Five: Flexibility, Adaptation and Implementation

Finally, nine participants contributed to this theme which demonstrates the importance of flexibility and adaptation during the formulation process to ensure it is implemented effectively and meets the needs of YP and staff. Formulations were viewed as an iterative tool, which could be adapted to target new risks YP may display and support staff when difficulties occurred *"it might be like 6 weeks before you go and revisit them again but actually we're struggling with them now and we could do with updating it now so we understand better and can do stuff different to support that child" (Anne, p18, 138).*

Formulation enabled staff to develop individualised approaches to meet the needs of the YP: *"it teaches me what I need to know about this YP and ways I need to adapt, like it helps me think why they're reacting a certain way and how I can respond in a way that makes them feel safe and secure"* (Alice, p10, 98). Similarly, Courtney discussed the need to tailor their strategies to enhance YP's engagement and implement person-centred care: *"we done everything marvel because that's something he was interested in we adapted everything for his needs" (p12, 102)*. Participants within the welfare home reinforced the value of theoretical models and frameworks within psychological formulation to help them adapt their practice to meet the needs of YP. For example, the use of a Compassion Focused Therapy (CFT) model helped Lucy understand a YP's emotional triggers and respond in appropriate ways specific to them: *when you formulate with a model… you can put it into something that makes sense and understand why they've been threatened by something and how we can help them soothe again" (p19, 124)*. Similarly, Courtney's reference to The Framework for Integrated Care (SECURE STAIRS) highlights how models can support the flexible yet consistent implementation of individualised formulations for YP, allowing staff to tailor their approaches to meet specific needs; *"we've been using formulations quite a while it's part of the SECURE*

STAIRS model and what I've found is they give you a better approach of how to work with that specific young person" (p1, 5).

However, participants raised systemic issues that affected their ability to implement effective strategies. Lee emphasised staffing issues: *"I know we're understaffed… but we should be a little bit better so we've got more time with the kids and more time to do stuff with them, they can't just sit there because we're running round doing everything else except actually caring for them" (p15, 131).* Similarly, Anne described difficulties she faces as a night staff member due to scheduling: *"I was staying up for them and I was like I'm knackering myself out… no that's not happening, I can't be expected to do that and then come into work feeling okay again a few hours later when I've not slept properly" (p22, 241)*. Participants highlighted that flexibility in formatting of formulations could improve accessibility and meet staff's diverse needs, for example remote access, physical copies of formulation and recordings. In one home, formulation meetings only took place in person but despite this, they tried to schedule the formulation meetings at times staff could attend, such as when the YP were in education so there was less disruption: *"they try and do it when the lads are in education so their key worker, person doing the formulation and ressy staff can attend" (Patrick, p21, 170).* Consequently, formulations were emphasised as being adaptable and flexible so that strategies are implemented effectively.

Discussion

The aim of this study was to qualitatively explore residential staff members' lived experiences of utilising psychological formulation within SCH's. Through IPA, five themes emerged; enhancing trauma-informed and holistic understandings, promote collaboration through MDT working, strengthening connection and empowerment, creating safety and flexibility, adaptation and implementation.

Two SCH's participated in the study, and findings indicated that formulation enabled staff to develop a more holistic and trauma-informed understanding of the YP across both participating homes. This is consistent with research by McKeown et al. (2022) who emphasised the role of formulation in perceiving a YP's presentation through the lens of developmental trauma. Implementing trauma-informed understandings led to changes in language used to describe the YP, shifting away from blame. This aligns with Sweeney et al. (2018)'s argument that trauma-informed thinking can shift perspectives from "what is wrong with you" to "what has happened to you" as formulation can help staff become more aware of trauma and develop more compassion and empathy towards a YP. Consequently, the findings to the present study evidence the positive benefits of trauma-informed formulation to encourage more person-centred care.

Staff within the welfare home referred to theoretical frameworks that helped them to make sense of a YP, for example CFT. Participants described having a CFT model of care, aligning with Toolis and Parry's findings (2023), which emphasised the need for therapeutic modalities within formulation to increase compassionate and person-centred care for YP. Similarly, staff discussed CFT in the context of understanding a YP's threat system, consistent with Taylor and Hocken (2021)'s argument that a CFT approach to formulation can help develop understanding of a person's past trauma and heightened threat responses. Appendix F provides a CFT formulation, and practitioners could particularly focus on a YP's key threats/fears and their subsequent protective and safety strategies developed to help build trauma-informed understandings. Interestingly, participants within the criminal justice home did not refer to any models or therapeutic approaches that helped them make sense of YP's experiences, potentially reflecting that theoretical frameworks may not have been as embedded into their site. Nevertheless, in the criminal justice setting theoretical frameworks may still be used, however staff may lack knowledge and confidence to describe a theoretical model in

more detail, suggesting the need for further training and/or support to increase understanding and application. Critically, to implement additional training, it is important to consider the context of both homes, the capacity/number of staff employed and whether this would make a difference on the logistics, for example the frequency of training and if training would cover all staff (including domestic staff). Therefore, a structured plan to implement training that accounts for these factors would ensure training is effective and sustainable. Such training would have to incorporate flexible scheduling to accommodate for shifts, ensure an inclusive approach covering wide aspects of trauma and TIC (e.g. understanding trauma, ACEs, principles, psychological safety, therapeutic relationships) and be evaluated to analyse its effectiveness.

It is known that staff working with YP who have been affected by trauma and abuse are more susceptible to vicarious trauma and burnout (Molnar et al., 2020; Smith, 2022; Lane et al., 2023). Participants in this study described formulation meetings as a space that creates psychological safety to explore and express emotions and identify the need for further supervision. This is consistent with The Framework for Integrated Care (SECURE STAIRS) (Taylor et al., 2018) that recognises staff acting as caregivers within the CYPSE must be supported within their role through trauma-informed systems. Previous research by Abraham et al. (2022) found that residential care workers within children's homes struggled with the emotional demands required within their roles, which impacted on their ability to be emotionally available for YP. However, echoing the findings of the current study, a positive team environment and opportunities for reflection increased their resilience. Therefore, the current study highlights how formulation can play a pivotal role in helping staff to recognise their own needs and triggers which may reduce the risk of future adverse effects.

Staff expressed the importance of ensuring a YP's strengths and voices are heard within the formulation to aid engagement and empowerment. The individualised nature of formulation

allowed staff to adapt their approaches to meet the needs and interests of the YP, for example incorporating characters from the Marvel comic into their work. Positive childhood experiences such as emotion regulation strategies and supportive social relationships can help to reduce re-offending (Cunha et al., 2024), reinforcing that strengths must be emphasised within formulations to encourage goals and better future outcomes. This can be achieved within the formulation process by focusing on the YP's positive traits, achievements and resilience and incorporating goals-focused planning.

Additionally, staff acknowledged that formulation increased collaboration amongst professionals, encouraged team cohesion and improved decision-making processes. This supports the evaluation for the Framework for Integrated Care (Anna Freud Centre, 2022) that found formulation-led approaches improve relationships and unity within teams in the CYPSE. Staff described themselves as having increased understandings of a YP due to spending more time with them, consistent with Johnstone (2018)'s argument that staff with less perceived power often have more knowledge of a client's life therefore can contribute in more depth to formulation meetings. Although previous research has argued that perceived hierarchies within MDT's can lead to power imbalances and lessen staff confidence (Haines et al., 2018), participants within this study felt like formulation meetings put them on an even playing field. Therefore, the results suggest that formulation may help to lessen power dynamics and increase working relationships, however this would need to be explored further using research investigating if staff perceptions of power changes over time with use of psychological formulation.

Formulation was found to strengthen connections between staff and YP. However, staff in the welfare home referred more to the development of therapeutic relationships with YP who have experienced extensive trauma, and thus helping them to provide more compassion to the YP. Whereas in the criminal justice setting, staff referred more to how the improvement in

relationship helped them to manage their risks/behaviour better. This may be due to the added layer of criminal justice risk and security which could be on the forefront of participants' minds in a criminal justice setting. Ultimately, by enabling staff to understand a YP's complexities through trauma-informed formulation, this helps provide an environment which allows the YP to feel safe and looked after. This can be understood through attachment theory (Bowlby, 1969), highlighting the role of caregivers (residential staff) in facilitating healthy attachments and a sense of trust and connection. Therefore, this study highlights the role of formulation in promoting deeper connections between staff and YP, aiding healing in YP.

Implications for Practice

The third aim for this research was to explore what role trauma-informed formulation has for future practice and policy. Within the UK, the findings of the current study highlight the critical role of psychological formulation in enhancing staff's awareness of trauma and embedding TIC within the CYPSE. Clinical psychologists (CPs) can do this through providing evidence-based recommendations and demonstrating how trauma-informed formulations can lead to improved outcomes for YP. Critically, there needs to be caution when applying the study's findings globally due to the sample being UK based. Nonetheless, clinical psychologists (CPs) can contribute to the enhancement of TIC across a range of services by advocating for policy and service change and embedding TIC principles into practice. Therefore, whilst implementation may differ based on locality, the underlying principles of TIC and formulation are relevant for psychological practice worldwide.

Importantly, participants were aware of their own emotional responses to working in a complex system and recognised the importance of clinical supervision. Staff across both homes emphasised the CPs role within the meeting in facilitating a compassionate and supportive environment. CPs are positioned within MDTs to provide supervision, consultation and share psychological knowledge (Health and Care Professionals Council, 2015; BPS, 2024).

Additionally, CPs could provide training around theoretical models, however this must be supported by senior management to ensure its effectiveness. Consequently, service leads and commissioners globally within children's homes should prioritise including CPs within their staffing teams not only to support clinical delivery and training, but also encourage psychological safety amongst staff enhancing a more supportive environment.

Participants raised systemic issues faced when working within highly demanding settings, including low staffing numbers, limited time to read formulations and night staff being unable to attend day formulations. Staff expressed frustrations towards education staff not attending, however it may be that they face similar systemic barriers restricting their participation. Children's homes should liaise with education staff to increase engagement to provide the best educational outcomes for YP. Furthermore, services should consider scheduling monthly night staff formulations, e.g. at the start or end of shift to accommodate night staff perspectives and ensure continuity in care for YP.

Lastly, it is crucial that YP's strengths and voices are heard within formulations to enhance collaborative care and empowerment. Whilst there may be issues limiting a YP being present, e.g. sensitive information being discussed, residential staff could allocate time within their keywork sessions to ensure they gain the YP's perspective and communicate any outcomes of formulation to them. Furthermore, involving YP within the formulation process promotes engagement and a whole system approach to integrated care within The Framework for Integrated Care (SECURE STAIRS) (McKeown et al., 2020). This aligns with the Office for Health Improvement and Disparities guidance that recommends YP should be involved in their care and in the design, delivery and evaluation of services (Office for Health Improvement and Disparities, 2023). Additionally, involving YP would align with the evaluation of The Framework for Integrated Care (SECURE STAIRS) (Anna Freud National Centre, 2022) which found that including YP in formulations, whether directly or indirectly, was empowering

and helped to have their needs and voice heard by professionals. Therefore, including YP's perspectives within service delivery can strengthen collaboration, promote empowerment and align with best practice guidelines.

Strengths, Limitations and Implications for Future Research

This study is the first to qualitatively examine residential staff's perspectives of psychological formulation within the CYPSE. It brings a unique contribution to existing research by exploring how staff utilise and apply formulation within their practice whilst considering its influence on working relationships with YP and colleagues.

Nonetheless, there are some methodical limitations to this study. Recruitment was limited at one home within the CJS due to security measures restricting emails with attachments, preventing staff from receiving the recruitment poster with the QR code. Additionally, staff faced difficulties organising interviews due to technological and security issues. To account for these challenges, posters were displayed in various staff rooms across the site and the main author attended in person to facilitate interviews face-to-face with staff who were available. Whilst this helped participation, this may have excluded those who were interested but were not available on the day chosen for interviews. Nonetheless, the findings gathered from staff who participated provided valuable insight into how psychological formulation is utilised within practice.

Furthermore, in relation to the participant sample, only one out of nine participants identified as being from the global majority. Therefore, this study is biased to white British views and cannot be generalised to staff from different ethnic backgrounds. Given that 24% of staff within children's homes in the UK are from a global majority background (Department for Education, 2024), it is important that services are sensitive to cultural humility within their workforce to remain consistent with SAMHSA (2014)'s key principle of cultural consideration.

Future research and service development opportunities should prioritise staff from different ethnic backgrounds to explore any differences in perspective and ensure services globally are culturally inclusive.

Lastly, due to the small scale of the study and ethical restrictions, this research did not include the views of YP. Including YP within the formulation process is an area in need of further research (McKeown et al., 2020), and YP are under-represented in all stages of the research process (Perowne et al., 2024). Internationally within YFS, involving YP is argued to be a key principle from research to policy making (Souverein et al., 2019). Therefore, future research could explore YP's experiences of being involved within the formulation process to assess whether similar perspectives to staff are reported.

Conclusion

This research provides a novel exploration of staff's experiences in utilising and applying psychological formulation within the CYPSE. The findings highlight how formulation enhances working relationships amongst staff, develops therapeutic relationships with YP whilst considering attachment, and enables staff to utilise and apply formulation in adaptable and varied ways to ensure trauma-informed and person-centred care. Services must address systemic and logistical barriers that may prevent engagement with formulation. Additionally, they should prioritise the role of CPs in facilitating a supportive and containing environment, including providing staff with additional support through clinical supervision and training on theoretical modalities when necessary. Future direction within YFS should be centred around embedding TIC and involvement of YP within formulation, policy and research.

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Table 1. Participant Demographics

Pseudonym	Age	Gender	Ethnicity	Education Level	Time working at site
Lucy	25-34	F	White – English, Welsh, Scottish, Northern Irish	Higher or secondary education (A-Levels, BTEC, etc)	4-9 years
Patrick	35-44	M	White – English, Welsh, Scottish, Northern Irish	Higher or secondary education (A-Levels, BTEC, etc)	4-9 years
Anne	25-34	F	White – English, Welsh, Scottish, Northern Irish	University undergraduate degree	1-3 years
Alice	35-44	F	White – English, Welsh, Scottish, Northern Irish	Higher or secondary education (A-Levels, BTEC, etc)	4-9 years
Carl	35-44	M	Any other ethnic or mixed background	Higher or secondary education (A-Levels, BTEC, etc)	4-9 years
Lee	45-54	M	White – English, Welsh, Scottish, Northern Irish	Secondary school up to 16 years	10 years +
Daniel	45-54	M	White – English, Welsh, Scottish, Northern Irish	University undergraduate degree	10 years +
Phil	35-44	M	White – English, Welsh, Scottish, Northern Irish	Higher or secondary education (A-Levels, BTEC, etc	1-3 years
Courtney	35-44	F	White – English, Welsh, Scottish, Northern Irish	Secondary school up to 16 years	10 years +

Appendix 2-A: Residential Treatment for Children and Youth Author Guidelines

https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=wrtc20#preparing-your-paper

Appendix 2-B: Extracts from Reflective Diary

Initial reflections about interview times and durations:

One home shorter due to F2F v over teams at other home?? I wondered if some staff felt they had longer availability on teams? Development day in one home when I went in to interview staff – staff might have been mindful of time and not spending longer than necessary in interview if needed elsewhere in unit.

Also due to model of care/CFT based formulations could have given one home's staff more to talk about during interview and thus longer interview times.

13/08/24

At first I felt like I'd be more drawn to [site name] responses/answers and be able to connect with them more due to previously working there however as interviews progressed I noticed myself being drawn more to other homes responses. This could have been due to them being more psychologically driven?? E.g. used a CFT model and a lot of responses reflected that when talking about how formulations are utilised within their work.

CFT is my preferred approach when working clinically – Something to be mindful of when analysing and interpreting the results through IPA due to my own biases.

Formulation appears to be more well established and staff all knew format/what benefits of formulation were for the young people.

04/09/24

During an interview today, I became very aware of cultural diversity evident between myself as a white female researcher and a male participant who was from a mixed ethnic background. At the time, I considered whether it would be appropriate to bring this up, however it did not appear to be a barrier as rapport was built and the information gathered from the participant was valuable. It made me think about my own clinical practice, and times when differences in culture/ethnicity/gender have come up in the past. I will ensure going forward that I raise these conversations with clients so that I can work in more culturally sensitive and trauma-informed ways.

05/09/24

Noticing within [site name] interviews that there seems to be a lot of discussion and reflection around medication specifically medication centred around ADHD – wondered if this could be because they don't have a CFT model of care in place like [site name]. Are they more medical model within the service? Things to consider when writing discussion.

There was a staff member whose language used was sometimes a bit more medical than compassionate – e.g. discussing medication a lot and this somewhat evoked some negative feelings in me. Need to be mindful of this when analysing their responses.

During the interviews, I often felt a sense of guilt that I couldn't relate to what staff described the YP's past experiences to be as I myself haven't experienced complex trauma like the YP. It almost made me feel a bit guilty. However, I often remembered the reason why I was doing this research to try and help improve services caring for YP and using my position/voice to do this.

Appendix 2-C: Example of Initial Coding – Extract from Courtney

1		P: So we weren't going to get into that cycle with this young person so she didn't have to self-harm or do anything bad in her room for staff to go in and speak to her so we were like… we put in bed support so we adapted her way of thinking so from a previous secure which wasn't [unit] erm her experience of how to get staffs attention was by displaying self-harming behaviours or smashing your room up or banging all night	Didn't want to engage in a cycle with YP Used bed support to adapt YP's way of thinking Understanding her experience how to get staff attention
2	**14:00**	P: Whereas we've adapted a way of… at 8 o'clock you will have bed support for half an hour so you've got that time to speak to a member of staff erm… and then it's time for bed (R: Yeah) you know so you don't have to go to extremes so you're just adapting our way of working really with each young person and not every young person on site has bed support (R: Yeah) I mean we've probably only got one or two… if we were to offer it to every kid they'd be like I don't need anyone to sit with me in my bedroom but some young people need that	Adapting way of working to each YP.
3		R: Yeah and do you think staff are quite good at adapting their approaches based on the formulation?	
4		P: Yeah… and staff really want to adapt their approaches.. what we find is that staff try and look for different ways to work but when it's part of a formulation staff sort of like grab hold of it and run with it	Staff want to adapt their approaches and look for different ways to work Grab hold of formulation and run with it
5		R: Aww okay	
6	**15:00**	P: Because they know that we've all discussed as a team that that's the best outcome for the child… it's not beneficial if I go and sit with the child for two hours	Staff know discussed as a team and it's the best outcome for YP.

		someone else says no and someone else says I'm not going in at all (R: Yeah) we have to just work all as one and that's what a formulation brings it brings the same structure	Staff have to work as one Formulations brings same structure.
7		R: Like consistency?	
8		P: Yeah… well consistency probably not because you're never going to get consistency right because everyone works in different ways but it's more structured it's more routine… it's more this is what we're going to do you know… the young people have their favourites all young people have their preferences you know I'd rather she done it or they done it erm but yeah… staff do find them very very informative because sometimes it's information that's missed that they find out that can help support them moving forward	Never going to get consistency as staff work in different ways More structure and routine through formulation. YP have their favourite staff members. Staff find formulations informative Information that's missed can help to support staff moving forward.
9		R: Yeah definitely it seems that way… so the next question	
10	**16:00**	R: You've probably kind of already answered it but I'll read it anyway just in case anything else comes to mind so how does the use of formulation inform your work with the young people… erm because you mentioned like adapting and different strategies and thinks like that but is there anything else that comes to mind?	
11		P: It's more… so formulation like we do adapted education timetables so we might have a child who hasn't been in education for a number of years but once they get back in education and from the formulation we know that they struggle you know getting up in a morning so we'll do like adapted education timetables… we'll do like reward charts as part of a formulation… erm we'll do different things so we'll do different	Adapted education timetables as know that a YP struggles. One YP who liked lego so as part of formulation needed the 1:1 time.

		structures of the day so you know we had one young person in particular who liked lego so at a certain part of the day as part of his formulation he needed the down time the 1:1 time being in a group setting was sometimes too much for him but he didn't need a solo placement	YP being in a group setting can be too much.
12		R: Yeah	
13	**17:00**	P: So he would spend after education until tea time and from 6-8 would be his time to go away have the 1:1 with staff do a bit of lego therapy erm sit and build lego and then he knew then that at 8 o'clock it was time for bed (R: Yeah) and he would just quite happy take himself off and what we know about formulations is living in a group setting can sometimes over stimulate the other children	Utlise lego therapy with Y. Living in a group setting can be over stimulating for YP.
14		R: Yeah	
15		P: So depending on the backgrounds they've come from depending on you know we take kids who've come from groomed backgrounds we take kids who come from a gang culture we take kids who have been drug running and then when you put all them kids together they don't always make a happy mix but it's about finding what works best for that child and using that… so we might have four kids at 8 o'clock who are all having 1:1 time with staff but we know that's part of their formulation and that's what helps them	YP who have been groomed, from gang culture, drug running. Putting YP together don't always made a happy mix. Find out what's best for that YP. We know that's part of their formulation and what helps them.
16		R: Yeah	
17	**18:00**	P: You know we had a kid who liked to go in his bedroom and listen to music (R: Yeah) so at a certain time of night he'd go into his bedroom and put his earphones in and he'd just have a little dance around his bedroom now that is what we found because he suffered with psychosis and he had voices in	Found out YP had psychosis so would listen to music to block out voices before bed.

		his head so to block out the voices before bed it was music in and he'd have a little dance	
18		R: Yeah	
19		P: Now we wouldn't have necessarily known all that information because we… have you ever seen a secure referral?	Wouldn't have known that information.
20		R: I've not seen a referral I have seen the templates that [unit] use for their formulation so I kind of know the different areas that they cover	
21		P: Yeah so a secure referral it can be a long winded document but it can also be not a very informative document because it doesn't give you the good about the child	
22		R: Okay	
23		P: So the referral… they need to say why this child needs to be in secure so it's not going to be Rosie likes to go sniffing around the park	
24	**19:00**	R: [laughs]	
25		P: It's going to be Rosie continues to run away erm so when we get a referral our first view of the child is quite… it can look quite negative erm but then obviously once the child is here and we formulate the child we see the good in the child so we see all the… all the good like the kindness and the wanting to help people and that doesn't always happen but we do find good in everyone (R: Yeah) there is always something that they're good at that we can talk about in formulation… in formulation we do talk about the negative stuff but then we also bounce onto the good stuff as well so what it is that they do well, what works for them, what can we do better is there	Formulations help to see the good in the child. Do talk about negative but also bounce onto good stuff. What does the YP do well, what works, what can staff do better. Identifying what staff are hoping to achieve with YP.

		anything we can do to change, what are we hoping to achieve?	
26		R: Yeah, and it seems like that strengths based stuff as well is just as important?	
27		P: It is and if there's anything that staff aren't trained	
28	**20:00**	P: To do we do get them trained up to do you know we had a kid who had PDA and staff didn't know anything about PDA (R: yeah) so we got a course run so that everyone was aware and everyone knew… we had another young person who had psychosis we're not a mental health establishment so we don't really know a lot about mental health we know about acute mental health so like anxiety depression (R: Yeah) but anything a little bit more down the line we don't really know erm… so then we got a bit of a whistlestop tour about psychosis not too much in depth but this is what to expect this is what you can see.. so whatever young person comes in and whatever training we need we get	Get staff trained up in different approaches/conditions. Learnt more about psychosis to help support YP better.

Appendix 2-D: Audit Trail of Transcript – Courtney

Theme title: "Sometimes it's information that's missed": Enhancing collaboration through formulation.

Initial codes	Summary	Illustrative Quotes
• Staff team develop strategies together (p5, 47) • YP know we've discussed as a team that's the best outcome for the YP (p8, 66) • Sometimes it's information that's missed and staff find out that can help support them moving forward (p8, 68) • Staff team have to work as one and formulation helps to bring the same structure (p8, 66) • Formulation has to be an all round thing (p23, 195) • Make sure outcomes are documented in the formulation so everybody knows what they are doing (p23, 195) • Range of staff that attend, night staff, care workers, deputy managers etc (p3, 19) • The formulation gets sent around to everybody (p7, 58) • Will formulate with the staff team (p2, 11) • No challenges faced with staff team because formulation is something we do pretty well here (p21, 176)	This theme reflects Courtney's views on how formulations help to strengthen collaboration amongst the staffing team she works within to help support the YP. Courtney highlights that formulations are an opportunity for the team to work as one, which helps them to become more aligned within their approaches with the YP. She discusses that formulation helps to bring the same structure, which can help her and the team to use more effective strategies that the YP can make sense of. She refers to the YP knowing the staff team have discussed what's the best outcome for them, showing that consistency helps to create a sense of collaboration and trust. Similarly, Courtney discusses developing strategies as a staff team, which helps them to be collaborative and think as an MDT on what approaches are going to best support the YP's needs. She talks about a wide range of staff attending the formulation meeting which can include night staff, care workers and managers. This means that a wide range of perspectives collaborate to create an understanding of the YP's needs and subsequent appropriate interventions. Courtney highlights the importance of ensuring that the documentation produced	"it's more structured it's more routine… it's more this is what we're going to do you know… the young people have their favourites all young people have their preferences you know I'd rather she done it or they done it erm but yeah… staff do find them very very informative because sometimes it's information that's missed that they find out that can help support them moving forward" (p8, 68) "I don't think there's been any challenges within the staff team because I think it's something that we do pretty well here at [unit]" (p21, 176) "Yeah absolutely, absolutely, you know we even get night staff to read them the formulations get sent around to everyone. The whole staff team and we ask the night staff to read them" (p7, 59)

	from the formulation is disseminated across the staffing team. She discusses that strategies are included in the document so that everybody knows what they are doing and that these are sent around, helping the team to have accountability and ensuring collaboration between staff members so that everyone can implement the approaches. Courtney refers to the formulation meeting being a space where staff can come together and find out information they may be missing, which helps to discover and fill in any gaps in their understanding. She appears to value formulations and she sees no challenges with the staff team using them, highlighting they have become embedded into their working practice and is a tool for collaboration and consistency amongst the care provided to the YP.	

Theme title: "We see the good in the child: Promoting positivity and strengths through formulation.

Initial codes	Summary	Illustrative Quotes
• Once the child is in the home staff can formulate and see the good in the child (p10, 85) • Always something the YP is good at staff can talk about in formulation, staff do talk about negatives but also bounce onto the good stuff as well (p10, 85)	This theme highlights Courtney's beliefs around formulation helping to promote the strengths of the YP and bring a positive outlook to their care/future. She talks about formulating and seeing the good in the YP, making sure that positive aspects of their identity are discussed alongside any challenges or difficulties. She reflects that the team talk about negatives but also bounce	"it can look quite negative erm but then obviously once the child is here and we formulate the child we see the good in the child so we see all the… all the good like the kindness and the wanting to help people" (p10, 85) "we were not only focusing on the negatives but we were also focusing on

- YP genuinely know we can make changes and people can have more positive outcomes (p18, 155)
- Staff do talk about the good things the kids can do (p6, 49)
- The home is quite a nurturing environment and want to see the best out of all the kids (p21, 176)
- Staff are good at highlighting strengths and difficulties from early years (p4, 35)
- Staff focus on the positives, she (YP) doing absolutely fantastic and it's down to the hard work and dedication staff put in (p6, 50)
- Staff always try and achieve the best outcomes for these kids that's what we always do and strive to do it (p12, 194)

onto the good stuff as well, which helps to create a balanced understanding of the YP and utilise strengths-based approaches to help them develop and feel supported whilst under their care. Courtney discusses how the home has a nurturing environment and this helps to bring out the best in the YP and have more positive outcomes. She gives an example of a YP and how she is doing fantastic due to the hard work and dedication that staff put in to support her, demonstrating how focusing on positive outcomes can help the YP to build confidence and do well. Courtney reflects that the team always try to focus on strengths within the formulations by identifying what the YP enjoy, what they are good at and how staff can use these to develop appropriate strengths-based strategies. She also refers to the formulations looking at strengths from the YP's early years, ensuring that staff understand their background and can help to create thorough understandings of the YP. Courtney values positivity as being a motivating factor to support their work with the YP, as she reflects that staff always try and achieve the best outcomes and that's what they strive to do. Formulations help to develop confidence and resilience in the YP by focusing on their strengths and ensuring that they feel supported within the home.

what positives we can bring so she's moved on from [unit], and she's doing absolutely fantastic you know and it's sort of it's the hard work" (p6, 50)

"I just think we always try and achieve the best outcomes for these kids that's what we always do and we strive to do it from the day we walk through the door" (p12, 194)

"So the formulation is really good at highlighting strengths (R: Yeah) and difficulties and that comes from the early years that comes from the information that we get from early years" (p4, 35)

Theme title: "Every young person is different": Making adaptations based on the individualised needs of the YP.

Initial codes	Summary	Illustrative Quotes
• Staff need to transform approach and work another way (p7, 59) • With formulation staff can look at what has not been successful previously (p3, 24) • Formulation gives a better approach of how to work with that YP (p1, 5) • We get kids in here who work in different ways (p15, 125) • You get a better understanding by knowing the formulation and knowing a way to work with the child (p16, 136) • Staff used the spoon/fuel theory and done everything marvel because that's something he was interested in, we adapted everything for his needs (p12, 102) • Children don't see formulation as they can be quite raw, if needed staff could do a child friendly one (p4, 27) • Might be strategies that have worked with a previous YP but every YP is different so we have to adapt (p3, 17) • Challenges I would say the adapting and acceptance from YP (p20, 170) • We adapted a way… when he was getting up there like "lad do you need a minute"… he'd go outside and he'd just shut the door and pace (p13, 110)	This theme encompasses Courtney's views on formulation enabling staff to make adaptations to their practice based on the individualised needs of the YP they care for. Formulations provide a space where staff can reflect on what has worked or not worked well previously with a YP, and they can then discuss these and refine their strategies to help support the YP. She discusses the importance of being flexible and how staff need to transform their approach and work another way if the current way isn't effective. Courtney highlights that every YP works in different ways, and that strategies which have worked with another YP might not be effective with another. Therefore, this helps staff to realise every YP is different and they have to adapt and suit the needs of each YP. She gives an example of using the spoon/fuel theory with a YP as they have an interest in Marvel, showing the individualisation within their approaches and utilising the YP's interests to promote engagement. Courtney reflects on formulation being able to tailor strategies to target particular difficulties a YP may be facing. For example, she talks about a YP who became agitated and staff would allow him to go outside and pace to be able to	"sometimes you could be thinking you're doing really really good by working one way but actually you just need to transform your approach and just work another way" (p7, 59) "we'd use the fuel theory with him we done everything marvel because that's something he was interested in you know we adapted everything for his needs" (p12, 102) "so it's about us adapting our way of working with them as well so how we change so there might be things we've done in the past that have worked with a previous young person but every young person is different so we have to adapt" (p3, 17) "It's more… so formulation like we do adapted education timetables so we might have a child who hasn't been in education for a number of years but once they get back in education and from the formulation we know that they struggle you know getting up in a morning so we'll do like adapted education timetables" (p9, 71)

• Adapting own way of working with each YP (p8, 62) • From formulation can do adapted timetable to get YP back into education as staff know they struggle (p9, 71) • The YP not wanting to let staff try certain things because of how it makes them look (p26, 174) • We've took positive risks depending on their behaviour and how they react to staff (p27, 188)	regulate himself. Courtney also discusses making adaptations to a YP's education timetable to help support them back into education and tailor their approaches. Contrastingly, she discusses that a challenge of formulation is YP accepting the new adapted strategies. She discusses the stigma the YP may be experiencing and now wanting the staff to try certain things as to how it will make them look, which can create some push back. Courtney highlights that staff will take positive risks to help support the YP which can build trust whilst also balancing their risk needs with opportunities for development. She identifies that staff are able to adapt their approaches due to knowing the formulation and knowing how to work with the child, which emphasises the importance of considering the YP's needs when developing strategies to ensure the YP feels understood.	"you know so you don't have to go to extremes so you're just adapting our way of working really with each young person" (p8, 62)

Theme title: "It's part of the SECURE STAIRS model": The importance of structured and evidence-based formulations.

Initial codes	Summary	Illustrative Quotes
• Formulation process has been very informative (p1, 2) • Do formulation every week so formulate a different YP every week (p2, 11) • YP had 2 weeks to embed in and by 2 weeks we know a little bit about them (p2, 11)	This theme reflects Courtney's views on the necessity for formulations to be structured and grounded in evidence to help support their practice and work with the YP. She reflects on formulations being very informative and getting solid evidence, which helps staff to understand the YP's needs and behaviours. Courtney refers to using a CFT model within	"we do formulation meetings every week so we formulate a different young person each week erm so that literally… we do it around the 2 weeks in placement so that they've had 2 weeks to embed in and then by 2 weeks we know a little bit about them… so

- Formulation informative and guide staff in the right way to work with the YP (p3, 27)
- Formulation far better than just pulling information from referrals (p2, 7)
- We use a model of care called CFT (p16, 29)
- You're actually getting solid evidence from a formulation (p2, 9)
- When its formulation staff grab hold of it and run with it (p8, 64)
- In the meeting talk about what hoping to achieve at the moment and how best to achieve it (p4, 29)
- What behaviour the YP might display, what we expect to see and not expect to see (p2, 11)
- A lot more advanced than other homes and embedded formulation a lot earlier (p1, 5)
- Been using formulation for a while it's part of the SECURE STAIRS model (p1, 5)
- A lot of digging and diving within the formulation (p2, 7)

their formulations, which helps ensure the formulations are theoretically based and can be individualised to each YP. She also highlights how formulations have developed over time within the home, discussing that the team are far better now than the way they were doing it before, evidencing that formulations are a tool that has the potential to improve practice. Courtney discusses the process of the formulation, and that they will do a lot of digging and diving into the YP's background and current needs, whilst also looking at what behaviours they are displaying. Consequently, this structured process helps the staff to develop a better understanding of the YP and have evidence for their interventions. She also talks about the frequency of formulations and staff will formulate a different YP weekly. Courtney highlights the importance of ensuring a YP isn't formulated until 2 weeks after arrival, as this helps the YP get settled and for staff to get to know them more. This critical time period enables staff to gather evidence and think of ways to best support the YP. Courtney discusses how formulations help the staff to think in a structured way about what they are hoping to achieve with a YP, helping them implement strategies and feel confident with their justification. She reflects on how formulations within the home she works in is a lot more advanced than other homes,

what behaviours they might display" (p2, 11)

"I suppose with formulations because there's a lot of digging and diving within formulations you know you go back to health professionals previous and sometimes that's missed off a referral so I think formulations are far more better than doing it the way we were before" (p2, 7)

"we've been using formulations for quite a while erm obviously it's part of the SECURE STAIRS model but when… I've been to quite a number of secure stairs meetings and we seem to be a lot more advanced than other homes we seem to have embedded formulations a lot earlier than other homes" (p1, 5)

"No so we use a model of care called compassion focused therapy" (p16, 129)

	describing it as becoming deeply embedded in their work. She also makes reference to the SECURE STAIRS model framework, placing value on formulation-led interventions and ensuring their approach to care is evidence based to support the complex needs of the YP in the secure setting.	

Theme title: "There is a traumatised child behind it who needs our support": Formulations being a tool to understand trauma and implement trauma-informed care.

Initial codes	Summary	Illustrative Quotes
• Once staff have formulated everyone we might do a unit dynamic formulation so how all the different traumas can impact what behaviour we see as a whole (p2, 11) • Formulation informed us about the abuse so we wouldn't have known (p5, 41) • Sometimes formulation can be quite emotional (p2, 17) • You forget about all that underpinning and underlying stuff but that's part of the formulation (p15, 125) • Providing them with a stable and secure environment where they feel cared for (p23, 198) • Helped us work with YP on individualised basis (p1,2) • We take kids from groomed background, gang culture, drug running and when put all	This theme encompasses Courtney's views on formulation being a tool to help understand and address the impact of trauma on the YP they care for and subsequently implement trauma-informed care practices. She reflects on formulations helping staff understand the underlying stuff that can influence their presentation, which helps to recognise the vulnerable child underneath their behaviour. Courtney speaks about the individualised nature of formulations for recognising a YP's early trauma and things they may have experienced in childhood. She discusses that formulations help staff to see there is a traumatised child who needs their support, which emphasises the importance of trauma-informed care. Similarly, Courtney finds that formulation helps staff to not re-traumatise the YP as they learn about the YP's past	"then once we've done everyone we might do like a unit dynamic formulation.. So how the different traumas can all impact what behaviours we see as a whole" (p2, 11) "is about providing them with a stable secure environment where they feel cared for because that's what we want for every child" (p24, 198) "whatever you forget about the vulnerable children behind that but that's what the formulation brings out, the formulation brings out that behind all this I wanna knock your head off I want to kill you I want to do this… there is a traumatised child behind it who really needs our support" (p2, 17)

together they don't always make a happy mix and it's finding out what's best for that child (p9, 75)

- It's not about letting them suffer anymore they've already suffered enough (p21, 182)
- Because he suffered with psychosis and had voices in his head, so to block out the voices before bed music was on and he'd have a dance (p10, 77)
- You forget about the vulnerable children but that's what formulation brings out (p3, 17)
- What we know about formulation is living in a group setting can sometimes overstimulate the YP (p9, 73)
- What we developed in formulation was if placed in single segregation in bedroom, someone had to be outside the window to speak to him (p5, 43)
- There is a traumatised child behind it who needs our support (p3, 17)
- We weren't going to get into that cycle with the YP, so she didn't have to self-harm or do anything bad in her room so we adapted her way of thinking (p7, 61)
- Sometimes the kids breath a sigh of relief once they know that we know because then it's easier and nobody can use anything against them (p18, 148)
- It's about not retraumatising them as well (p7, 56)
- YP who's staff found formulation helpful, he had been abused by dad but we were

experiences. She gives an example of locking a YP in their bedroom which re-traumatised them due to the abuse they had experienced in early childhood. However, after learning about the past trauma they were able to adapt their risk strategies and ensure that if this happened due to safety reasons, they would ensure a person was outside the window to speak to them so they didn't feel alone. Similarly, she reflects on the function of a YP's self-harming behaviour, and how staff recognised her past trauma and refrained from getting into a cycle where she would have to self-harm in her bedroom which consequently adapted the YP's way of thinking. Courney also highlights the role of formulations in thinking about group dynamics of YP who have all experiences trauma and come from different backgrounds, for example gangs, drug running and exploitation. She speaks about formulation exploring the different traumas that may be present and how this can impact on their behaviour, which subsequently helps staff to think about suitable interventions that meet the needs of all the YP on the unit. Courtney discusses providing a safe environment where the YP can feel cared for, which helps to recognise their trauma and promote resilience and healing within their approaches. She also highlights how formulations help bring a sense of relief for the YP once they

"it's individualised to what that child's been through so it's their early traumas or you know things that they've experienced that might impact why they do things that they do on a daily basis" (p1, 3)

"you forget about all that underpinning and underlying stuff but that's all part of the formulation" (p16, 125)

"So we weren't going to get into that cycle with this young person so she didn't have to self-harm or do anything bad in her room for staff to go in and speak to her" (p8, 61)

retraumatising him by locking him in a bedroom (p5, 41) • Individual to what the child has been through, early traumas, things they've experienced that might impact why they do things they do on a daily basis (p1, 3)	understand that staff know about their past trauma and experiences, which can help to alleviate any shame they may be facing. Consequently, formulations help Courtney to understand underlying reasons of a YP's behaviour which helps to implement trauma-informed practice and create an environment of safety for the YP to thrive and feel supported.	

Theme title: "Hang on, these are really interested in me": Building relationships and trust through understanding

Initial codes	Summary	Illustrative Quotes
• We had to make her feel like she was safe, cared for and looked after (p6, 56) • When we try to do a different way of working we can get a lot of push back because YP don't want to let us in (p20, 172) • Staff know that's part of their formulation and what helps them (p9, 75) • YP understand meetings take place but not how deep into it we go (p4, 31) • Staff who have positive relationship can bring other staff in as a power of trust so the YP know they can trust them (p19, 162) • Part of formulation and what we know about some children is they've displayed a behaviour and people have walked away (p16, 137) • YP know we talk about their care and how best to support them (p4, 29)	This theme reflects Courtney's views on how formulations help her to build trust and therapeutic relationships with the YP through understanding their needs and behaviour. She highlights that an important factor in building relationships is ensuring trust and safety, which is essential when supporting YP who have previous trauma. Courtney reflects on a YP she supports and says that they had to make her feel like she was safe, cared for and looked after which emphasises protection and security within the therapeutic relationship. By adapting care to the YP's specific interests and needs, this helps to build a therapeutic relationship and connect with them on a deeper level. For example, she refers to specific activities with the YP like playing lego and spending 1:1 time together, which can help to develop meaningful relationships.	"she didn't want to be here so we had to make her feel like she was safe she was cared for, she was looked after" (p6, 56) "the staff member who has a positive relationship can bring them in as that power of trust you know life sort of I trust you… and I think the kids then feel like the staff are involved because the staff who can support them and know how to support them can bring in the staff who are a little bit unsure" (p19, 162) "we want to genuinely care you know… so it might be I'll go down and have dinner with them.. I'll ask them how their day has gone… they've

- Need to send this type of message to a YP that regardless as to how you behave there may be consequences but I'm still going to come back (p13, 139)
- What his experience was is that adults are going to hurt him so he had to hurt them before (p13, 105)
- I'll go down at dinner, ask how their day has gone, probably never gad nobody interested in how their day has gone, that's what we do here was ask them about them (p17, 142)
- What we know from the formulation is he struggles to retain information so he needs things written down (p3, 24)
- The YP all have their favourites and preferences (p8, 68)
- The YP do feel like we are more there for them, feel like we've been supporting them more (p18, 151)
- The YP in particular who liked lego so as part of his day as part of formulation he needed the down time and the 1:1 (p9, 71)
- The YP feels like you've invested in them (p16, 136)
- Once we get on their wave length they can go hang on these are interested in me it's not just a money making exercise (p16, 137)

Similarly, Courtney talks about showing a genuine interest in the YP's lives by asking how their day has gone, which they may have not previously experienced. This can help the YP feel valued and that staff are invested in them, which can help to build trust and change their perception of staff just being there to "make money" and because they care about their needs and are interested in them. She also highlights how if a YP has a better relationship with a certain staff member, this can help them develop relationships with other staff as they can also be present as a "power of trust". This can also help the YP feel like they have trusted adults who they can feel safe with, which can help them to feel more stable and cared for within the secure setting. However, Courtney acknowledges that there can also be challenges to building therapeutic relationships with traumatised YP, as they may not have been able to trust professionals in the past. She speaks about formulation allowing them to understand that with one YP, people have left them and walked away previously if they have displayed a certain behaviour. By learning this, staff were able to send a message to the YP that although there will be consequences to their behaviour, they will still come back. This allows YP to let staff in and develop a trusting therapeutic relationship through consistent care approaches.

probably never had that nobody's probably ever been in interested in how their day has gone but that's what we do here we ask them about them instead of it being about us" (p17, 142)

"So they do feel we're more there for them they feel like we're supporting them more positively" (p18, 151)

"but once we sort of get on their length or get on their wave and then they go hang on these are really interested in me this is not just a money making exercise" (p17, 137)

"because I need to send this type of message to the young person that regardless as to how you behave there may be consequences to your behaviour but I'm still going to come back" (p17, 139)

Appendix 2-E: Participant Themes Contributing to Each Overarching Theme

Pseudonym	Overarching Themes				
	Theme 1: Enhancing trauma-informed and holistic understandings	**Theme 2: Promoting collaboration through MDT working**	**Theme 3: Strengthening connection and empowerment**	**Theme 4: Creating safety**	**Theme 5: Flexibility, adaptation and implementation.**
Lucy	"It's not the child choosing to do what they're doing": A tool for understanding trauma.		"They were able to connect with her": Building therapeutic relationships and a sense of connection.	"Staff feel more safe to be vulnerable": Creating a place that encourages safety.	"You can naturally weave the formulation into conversation": A normal part of day-to-day practice.
	"You wouldn't understand why she presents in that way": Understanding the function of behaviour.			"The kids triggering something in the staff member": Enhancing confidence and self-awareness.	"What might be good for one child may be unhelpful for another": Informing subsequent planning and intervention.
	"Them comments have just slowly stopped": Promoting a shift in language.				"How it can guide and support them": The benefit of using a CFT model.
Daniel	"That's the stuff I want to know": The journey of learning about and supporting a YP through formulation.	"You're getting information you might not necessarily get": An opportunity to share and gather information.	"It's not a barrier, but let's be sympathetic": The presence of the YP.		"If it's in the formulation it's sent more places": The importance of sharing and communicating.

Pseudonym	Overarching Themes				
	Theme 1: Enhancing trauma-informed and holistic understandings	**Theme 2: Promoting collaboration through MDT working**	**Theme 3: Strengthening connection and empowerment**	**Theme 4: Creating safety**	**Theme 5: Flexibility, adaptation and implementation.**
		"You get to see their working out": A place of conversation and explanation. "It's helped build relationships with them": A space to strengthen collegial relationships.			
Alice	"Speaking, working and adapting to their past": Individual needs and responding to vulnerabilities.	"Don't put the blinders on": Collaboration and shared insights through MDT working.	"You could build up a bond": Developing trust and connection through relationships.	"YP are vulnerable but staff are as well": The emotional impact of vulnerability.	"It's trial and error": The adaptive process of formulations. "It gives me ways I need to adapt: Practical application of strategies. "You should attend them and put your voice across": Recognising night staff contributions

Pseudonym	Overarching Themes				
	Theme 1: Enhancing trauma-informed and holistic understandings	**Theme 2: Promoting collaboration through MDT working**	**Theme 3: Strengthening connection and empowerment**	**Theme 4: Creating safety**	**Theme 5: Flexibility, adaptation and implementation.**
					and challenges in formulation.
Lee	"We're just piecing them together": Using formulation to develop a holistic understanding.	"Although I'm the lowest rank I know more about that kid": Appreciating key workers contributions to the formulation. "It makes it stronger": Improving MDT working and relationships through formulation.	"I'm sort of an advocate on their behalf": Advocating for and building relationships with YP.		"We should be a little bit better": Identifying challenges in the formulation process. "This is what was discussed and this is what we need to do": Transforming knowledge and practice.
Phil	"It's an understanding of why they're like that": Developing a holistic understanding of the YP's needs.	"How they're going to transfer all the information": Efficient communication and sharing information. "I look at them a bit differently": Developing new perspectives through			"I think prioritising kids who are struggling": Getting the regularity right. "Then it helps the way you work with them": Adapting strategies and

	Overarching Themes				
Pseudonym	**Theme 1: Enhancing trauma-informed and holistic understandings**	**Theme 2: Promoting collaboration through MDT working**	**Theme 3: Strengthening connection and empowerment**	**Theme 4: Creating safety**	**Theme 5: Flexibility, adaptation and implementation.**
		formulation. "I don't think they take enough time to make sure they're there": The value of being physically present.			improving practice.
Anne	"She does this to see if people come back": Individualised trauma-informed understandings.	"Where everyone comes together": Team formulation being a collaborative process.	"It brings out the more nurturing side to me": Developing trust through therapeutic relationships. "My fuel is full today": Involving and empowering YP through formulation.	"I feel like I have a weight lifted off my shoulders": A reflective space for emotional support.	"But actually we're struggling with them now": The importance of timely and responsive formulations. "If that's how they respond better to taking information in": Accessibility and flexibility according to staff needs. "It gives us the tools to how best work with them": Refining different approaches

Pseudonym	Overarching Themes				
	Theme 1: Enhancing trauma-informed and holistic understandings	**Theme 2: Promoting collaboration through MDT working**	**Theme 3: Strengthening connection and empowerment**	**Theme 4: Creating safety**	**Theme 5: Flexibility, adaptation and implementation.**
					to support YP.
Courtney	"There is a traumatised child behind it who needs our support": Formulations being a tool to understand trauma and implement TIC.	"Sometimes it's information that's missed": Enhancing collaboration through formulation.	"Hang on, these are really interested in me": Building relationships and trust through understanding. "We see the good in the child": Promoting positivity and strengths through formulation.		"It's part of the SECURE STAIRS model": The importance of structured and evidence-based formulation. "Every YP is different": Making adaptations based on the individualised needs of the YP.
Patrick	"Knowledge is power innit": Exploring deeper insights through information gathering.	"Different professionals that can bring something to the table": Creating a holistic understanding through an MDT approach. "The more you converse the better your relationship":	"You want to look after them more": Formulations enabling empathy and stronger connections. "I didn't want him to start reliving it in custody": Navigating	"It's a pretty laid-back environment": Formulation meetings being a supportive space.	"I'm free then can you push it back": The practicality and adaptability of formulations. "It helps you work with them more": Transforming

Pseudonym	Overarching Themes				
	Theme 1: Enhancing trauma-informed and holistic understandings	**Theme 2: Promoting collaboration through MDT working**	**Theme 3: Strengthening connection and empowerment**	**Theme 4: Creating safety**	**Theme 5: Flexibility, adaptation and implementation.**
		Strengthening professional relationships through collaboration.	honest and emotional well-being when sharing with YP. "Getting the most positive outcome for that YP": Promoting strengths-based approaches through formulation.		knowledge into practice.
Carl		"To get the best results we all need to work together": Collaborating through teamwork and formulation. "Having different experiences and backgrounds": Varying interpretations of formulation.	"It's a beautiful tool to help a YP": Caring for and empowering YP through formulation.	"When it's not done well it's made me draw back"; The importance of how a formulation is delivered.	"It's been a blockage in the past": Barriers to engaging with formulation. "I've seen staff's behaviour change towards YP": Discovering meaning and the impact on practice.

Appendix 2-F: CFT formulation template

Key Historical Influences (What key historical experiences have influenced you?)	**Key Fears/Threats** (Given historical experiences, what key fears have you been left with?)	**Protective/Safety Strategies** (Given key fears, what safety strategies have you developed to protect yourself?)	**Unintended Consequences** (Have your safety strategies led to any unintended or unforeseen consequences?)
	External Internal	External Internal	External Internal ↓ Self-to-self relating ↓ Mood

Section Three: Critical Appraisal

Critical reflections on researching the application of trauma-informed care within children's homes.

Word count (excluding references): 3929

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Prepared in accordance with guidelines for authors for *Residential Treatment for Children and Youth* (See Appendix A for submission guidelines)

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This critical appraisal offers comprehensive reflections on both research papers. I provide a summary of each paper and then critically engage with the strengths and limitations. I highlight my own personal reflections and experiences of the research process, and explore the clinical implications of both papers including recommendations for future research.

Overview of Findings

The systematic literature review (SLR) explored how trauma-informed care (TIC) is implemented within children's residential homes, including identifying specific models utilised, any similarities and barriers to effective implementation, and the impact on staff and children. The SLR used a meta-ethnography analysis of 11 papers, following guidelines set out by Sattar et al. (2021). The results revealed seven third-order constructs within two higher-order themes. The first theme highlighted three key factors affecting implementing of TIC into children's homes; utilising a TIC model/framework, practical barriers and cultural/organisational barriers. The second theme identified key outcomes of TIC when applied effectively; including increased awareness and knowledge of trauma, relational safety, development of TIC values amongst staff and empowerment for young people (YP). These findings were discussed in relation to clinical psychology and recommendations were made for future research.

The empirical study explored the lived experiences of how residential staff in two secure children's homes (SCH) interpreted and used psychological formulation within their practice, if this impacted their relationships with staff and YP and identify what role formulation has for future TIC practice and policy. Semi-structured interviews were carried out with nine participants. Interpretative phenomenological analysis (IPA; Smith et al., 2009) identified five themes: 1) Enhancing trauma-informed and holistic understandings, 2) Promoting collaboration through multi-disciplinary team (MDT) working, 3) Strengthening

connection and empowerment, 4) Creating safety and 5) Flexibility, adaptation and implementation. The findings emphasised the role of psychological formulation in enhancing TIC, which were discussed in the context of clinical psychology, implications for practice/policy and recommendations for future research.

Strengths and Limitations

Strengths

This thesis offers a unique contribution to the literature on TIC by combining an SLR with an empirical study, both with a focus on children's residential settings. A key strength of the thesis is it's emphasis on implementation as the SLR offers the first meta-ethnography analysis researching how TIC is implemented into children's residential homes and its impact on staff and how they report its impact on children. Similarly, the empirical paper offers unique insights how psychological formulation is applied by residential staff working within SCH's. Therefore, both papers provide an understanding of the systemic and relational aspects of applying TIC, whilst highlighting the necessity of comprehensive, theoretical and attachment-informed approaches to improve outcomes for YP and staff.

Additionally, another strength across both studies is the exploration of systemic barriers and enablers to TIC. The SLR recognises organisational challenges that can prevent effective TIC implementation, whilst the empirical study explores the systemic and emotional demands on staff, including staffing difficulties and the psychological effect of working with YP with complex needs. This is crucial as it can allow organisational changes to be made within residential children homes to help enhance the application of TIC and help reduce the likelihood of staff burnout and vicarious trauma (Sweeney et al., 2018).

Another strength is empowering staff to have a voice within research, particularly within the empirical study where lived experiences of formulation are heard. IPA allowed a

rich exploration of participants' experiences of engaging with formulation and highlight the impact this had on themselves as practitioners and the YP they care for. The research allowed staff to discuss their lived experiences and give them a voice to partake in research with the potential to influence future organisational change. This analysis allowed the researcher to discuss the findings in relation to clinical implications and TIC policy/decision-making within the Children and Young People Secure Estate (CYPSE). Furthermore, the results reinforce The Framework for Integrated Care (SECURE STAIRS) (Taylor et al., 2018) by exploring how residential staff can interpret and apply psychological formulation, which is a key aspect. The research aligns with the goal of The Framework for Integrated Care (SECURE STAIRS) to embed reflective, psychologically informed and trauma-informed practice into the CYPSE. As TIC is increasing in popularity amongst services caring for YP who have experienced trauma (Gray et al., 2021; Glendinning et al., 2021), the findings of this thesis offer valuable clinical insights to influence the implementation of TIC into children's residential services.

Limitations

There are some methodological limitations of the thesis that should be raised. For example, the SLR only had one independent screener, therefore there is a risk of bias towards the studies selected. Steps were taken to mitigate this risk, e.g. revisiting my inclusion and exclusion criteria consistently and having multiple discussions with my supervisor. However, this remains a limitation and in the future, I endeavour to increase the reliability of my research by completing inter-rater screening. Additionally, within the SLR the author was aware that they excluded research that was not in the English language, resulting in a bias towards English-speaking countries. Therefore, the findings may not fully represent perspectives from non-English speaking western nations and less privileged regions, highlighting both linguistic and geographical limitations.

Notably, the duration of interview time was relatively short. Inclusion criteria specified participants had to have attended one formulation, therefore if they had attended more the data may have been different and/or potentially richer in nature with more detail. As such, future studies could explore the impact of attending multiple formulations on staff perspectives, or a longitudinal approach could investigate whether repeated attendance could lead to greater understanding and confidence amongst staff.

Furthermore, some papers had lower quality appraisal scores when using the Critical Appraisal Programme (CASP, 2018) tool. Whilst this was considered during the analytical and synthesis process, it is important to acknowledge the wider implications contributing to lower quality research. For example, funded research is found to be of higher quality across various professions, including health and social care (Thelwall et al., 2022). Thus, highlighting the need for further government backing into TIC policy design, research and evaluation to enhance the overall quality of health research within children's homes.

One limitation of the empirical paper was that it only involved staff perspectives of formulation within SCHs. I initially discussed wanting to interview YP with my field supervisor, however due to the scope of the thesis and extensive ethical procedures required to gain access to YP in SCH's, this was not feasible. Future service development/research exploring YP's perspectives could give a voice to those who are marginalised and have a voice in research within an environment that has control over them (e.g. being held in secure services).

Lastly, there were practical limitations in recruitment for the empirical paper. One home was a criminal justice site, meaning that emails with attachments (the research poster) were bouncing back due to encryption levels. As a result, staff could not initially be recruited. To account for this, my field supervisor printed posters and placed these in staff areas around the

home, however I was aware that not all staff may have seen the poster meaning some staff voices may not have been heard.

Personal Reflections

The Research Process

Data Collection/Participants

As the interviews progressed, I became more confident in my interviewing skills and ability to develop rapport with participants. If I could repeat the research, I would ensure that I transcribed each interview after carrying it out rather than leaving this to the end, as this was tiring and impacted my concentration. If I transcribed as I went, I could have learnt more about my questioning style and identify areas within certain questions that would be helpful to explore, which could have potentially increased the average time of interview.

Participants consisted of five males and four females, with one participant being from a mixed ethnic background. It was noticed that the interviews with male participants were shorter than those with females. Being a young, white, female researcher, I am aware that this could have impacted on participants' feeling comfortable to share their experiences in working with YP with complex trauma, especially if this was emotive in nature. Demographics of interviewers such as age, ethnicity and gender have been found to influence interviewees willingness to share information and can impact on the length and richness of the data (Knott et al., 2022). I felt more conscious that I was a white British woman when interviewing a male participant from the global majority, and I reflected on this during the interview process using a reflective journal:

> During today's interview, I became aware of cultural diversity evident between myself as a white female researcher and a male participant who was from a mixed ethnic background.

> At the time, I considered whether it would be appropriate to bring this up, however it did not appear to be a barrier as rapport was built and the information gathered was valuable. It made me think about my own clinical practice, and times when differences in culture/ethnicity/gender have come up. I will ensure that I raise these conversations with clients so that I can work in more culturally sensitive and trauma-informed ways.

I discussed this with my research supervisor after choosing pseudonyms. I highlighted wanting to make sure I reflected the ethnicity of the above participant within their pseudonym, however due to them being the only participant from the global majority I didn't want this to risk their anonymity. Therefore, I remained with neutral names across all participants and in future research I will ask participants to pick a pseudonym for themselves.

I considered that there may be gender differences evident in discussing emotive aspects of their role and how psychological formulation can be used to help support staff. For example, one male participant referred to the meeting as "laid-back", whereas female participants described them more as "containing and safe". This made me more aware of gender stereotypes (Ellemers, 2018) within my role as a researcher when critically assessing and engaging with research. Furthermore, it applies within my role as a clinician when working with people who identify as a male. Whilst these two roles are conceptually different, they still influence each other in meaningful ways, and I will ensure I pay attention this within my own clinical practice and future research by raising this with clients and participants in transparent ways when appropriate.

Data Analysis

Although I had previous research experience, I was new to IPA and meta-ethnography. As such, I followed Murray & Wilde (2020)'s guidance for novice researchers conducting and writing up IPA research. This guide enabled me to create a thorough audit trail throughout the IPA

process, which I could reflect on within supervision. For the meta-ethnography, I referred to guidance by Sattar et al. (2021) although found this lacked detail in the steps provided, especially during translation and synthesis. Therefore, I utilised this the best I could and relied on previous research that had been published using a meta-ethnography approach to help me make sense of the steps. I sometimes found the research process challenging, due to learning and applying a new methodology whilst taking an active role in leading the project. I sometimes doubted my ability if I wasn't sure on a certain aspect of the analysis (e.g. looking for patterns and themes across interview transcripts), however when this happened, I utilised supervision effectively which helped provide containment.

Dissemination

Despite personal challenges, I found the research process rewarding. I felt honoured that participants trusted me to talk about their experiences of working within such complex settings, and somewhat pressured to ensure I captured their views and voices accurately within the research. As part of the research process, I published a paper centred around how psychological formulation can increase compassionate and person-centred care within youth forensic services (Toolis & Parry, 2023). This allowed me to travel to London to a British Psychological Society conference and discuss my research with other professionals, which I thoroughly enjoyed. This opportunity has made me strive to share my research findings with other professionals by seeking out networking events. My future dissemination plans include sharing the results with participants and the recruitment sites, as well as submitting the thesis to journals for publication to ensure the findings are distributed amongst professionals so that the implications can be implemented into practice.

My Role as Researcher

I was interested in researching the area of TIC and psychological formulation within children's homes due to a previous role in one of the participating homes. During this time, I was struck by every YP having a formulation completed as an MDT as part of The Framework for Integrated Care (SECURE STAIRS) (Taylor et al., 2018) framework, however after doing some scoping searches it became evident that TIC/formulation was an under-researched area. As someone who is passionate about working with YP, this gave me motivation and highlighted the need for further research to better understand and enhance TIC.

IPA recognises that there may be multiple truths across different participants, which aligns with my own epistemological stance of critical realism where knowledge can be subjective (Tikly, 2015), and influenced by the researcher's social context (Cuthbertson et al., 2020). I was aware that having previously worked in the SCH environment could influence my interpretation of the interview data. As such I took a reflexive approach, actively acknowledging and reflecting on my own experiences to reduce potential bias, and engaged in discussions with my supervisor to ensure my interpretations were grounded in the participant data rather than my own presumptions.

I was aware of my role as a trainee clinical psychologist alongside researcher during the interview process, and I reflected on this:

> The interview today felt more intense than some of the others, because the participant talked about her own mental health in relation to working with complex YP. Whilst there were no risk issues raised, I felt like I had to balance being a researcher whilst also offering reassurance and validation without influencing the participants answers to subsequent questions. I felt like I could empathise with the participant as I was aware

how stressful working in these environments can be and the impact vicarious trauma can have on myself/staff. I will remain mindful of this during analysis.

As an IPA researcher, the above highlights the importance of self-awareness as well as the potential for vicarious trauma within research. Although I didn't anticipate being emotionally impacted, at times I had emotional responses to some of the stories told. Balancing the different competencies required throughout Clinical Psychology training alongside a thesis has been a demanding and emotive experience, and having the opportunity to carry out my own research has enhanced my resilience which I have been able to transfer into clinical work and personal life.

Notably, my named research supervisor changed in February 2024, therefore I submitted a substantial amendment to the ethics board (see section four). This did not negatively impact me as I appreciated the expertise and relational approach of my new supervisor and was able to build a rapport.

Clinical Implications and Future Research

The clinical implications of this research are important for enhancing services that support YP who have experienced complex trauma, and highlighting the positive impact TIC has on YP and staff in children's homes. The findings from the SLR and empirical paper reinforce the importance of implementing TIC in children's homes using theoretical models and attachment focused ways of working. This is critical for residential staff, as they must feel supported within their roles by the wider system and receive comprehensive training to develop their knowledge of trauma and attachment. CPs hold a unique position as they can support the implementation of TIC at a clinical level (psychological formulation, psychological intervention, staff support, reflective groups etc), but also from a systemic leadership level working alongside systems to promote trauma-informed ways of working from the "top" down. CPs must work alongside

SCH managers to ensure staff can access continuous professional development (CPD) funds and/or inhouse training to help strengthen their knowledge and confidence when working with YP who have experienced trauma and present with risk. Consequently, these recommendations can help to influence and transform organisational culture, which is only successful if there is systemic change driven by TIC principles (Emsley et al., 2022; Huo et al., 2023).

Residential staff in the welfare home referred to a compassion focused therapy (CFT) model of care, which guides their service, model of psychological formulation and working practice. Interestingly, there was some divergence shown through analysis as it was unclear whether the criminal justice home utilised a CFT model of care, and if they did, whether staff felt confident enough to articulate their knowledge around CFT and its applicability to working with trauma. Findings from the SLR also recommended that children's homes must utilise a TIC framework or model, and CFT can be a suitable TIC model as it addresses key difficulties associated with trauma like shame and self-criticism (Vidal & Soldevilla, 2023), helps to regulate YP's emotions through soothing a threat system (Lau-Zhu & Vella, 2023) and aligns with TIC principles by promoting a safe environment (Neuenschwander & von Gunten, 2024). Therefore, children's homes should consider implementing a CFT model of care within their system, however this must receive backing from senior leaders and manager. Notably, implementing a CFT model of care if staff retention and/or staff morale may be low due to burnout can be challenging. There must be an ongoing implementation plan so that new staff are trained in the model and for this to be rolled out on a continuous basis. For homes that already utilise a CFT model of care, booster training sessions should be provided to staff to strengthen their understanding of CFT and its connection with TIC.

Critically, having previously worked in SCH settings I was aware that the approach within welfare SCH's is quite different to that in justice SCH's. For example, whilst both aim to embed TIC, welfare settings appear to have TIC more well established (e.g. staff are more

familiar with and can discuss models that help them to implement TIC such as CFT) and adopt more relationally focused approaches. In contrast, justice settings can place more emphasis on risk/behaviour management given their custodial context. This was apparent within the empirical findings, as participants from both homes discussed building therapeutic relationships, however some participants in the justice home discussed this in the context of reducing risk. Furthermore, it is important to consider that some divergences between the two homes may have been lost during analysis, therefore the findings should be interpreted with caution whilst acknowledging the complexity and contextual nuances that influence how TIC is understood and embedded within different SCH settings.

With regards to psychological formulation, it is important to consider that when resources may be scarce and there are less psychologists present in services, other disciplines could lead formulations such as mental health nurses, with a psychologist having oversight and/or providing supervision. If so, selected staff would have to be trained in the CFT model and adherence to a model to ensure consistency and fidelity would be important.

The findings from both papers reaffirm SAMHSA's six principles of TIC: safety, trustworthiness, choice, collaboration, empowerment and cultural consideration. For children's homes, including SCH's, to successfully embed TIC into their systems it requires ongoing support of all six principles. Notably, the principle of safety was highlighted in both papers which is important for YP to feel safe to build therapeutic relationships with staff, but also in encouraging psychological safety amongst staff so they feel supported within their roles. Formulation meetings provided a space for staff to explore and discuss their feelings about working with YP facing complex difficulties. CPs can act in leadership roles within children's homes, and participants highlighted their crucial role in facilitating psychological safety within formulation meetings. This aligns with previous research where leadership visibility and face-to-face contact can encourage psychological safety by promoting familiarity (O'Donovan &

McAuliffe, 2020). If psychological safety is prioritised amongst staff, this is consistent with TIC (Sichel et al., 2019) and can lead to reduced burnout (De Lisser et al., 2024). Thus, embracing this principle can help to create a more supportive trauma-informed environment where staff and YP can flourish.

A clinical implication from both papers was centred around ensuring YP feel empowered within their care, and one way is through promoting their strengths within formulations. It is critical that these outcomes are communicated effectively amongst staff within the service, but also other agencies/professionals at critical periods such as transitions. The Alliance for Youth Justice (2023) argues that it is crucial during transition phases to understand how YP's experiences will differ due to intersecting experiences of discrimination and structural disadvantage. Therefore, it is vital that formulations are shared and that YP's voices and strengths are emphasised within these to help aid engagement and multi-agency working. Furthermore, future research could explore the transition phase and whether empowering YP through including them within formulations can lead to better future outcomes. Additionally, in terms of holistic care and future planning, it would be important to obtain family and carer input into formulations, and attendance from external professionals such as youth offending teams and social workers. This would be essential for aiding transition home as if the YP is still working with a social worker, their involvement would be helpful to understand what has worked or not worked during time in a SCH to try and prevent future admissions. I hope that this thesis helps services implement TIC to provide the best possible outcomes for YP.

Similarly, future research should aim to fill the gaps of my research, specifically the sample of participants chosen. Both the SLR and empirical paper mainly focused on staff's perspectives of TIC and experiences of working within children's homes. Therefore, it is crucial that more research needs to be carried out that involves YP to ensure their voices are

heard. Positively, a new study (Nurturing Environments for Shaping Trauma-informed care and recovery in homes for cared for children; NEST study, 2023) has been developed in the North-west of England aiming to develop a TIC toolkit for children's homes utilising the voices of YP, staff, carers and other experts. As part of this, I was asked to be a member of the stakeholder advisory group, therefore I can attempt to implement the findings of this thesis into future research and clinical practice, whilst also bringing a secure perspective and enhancing the voices of YP within secure settings. It would be interesting to research the views of psychologists who lead the formulation meetings to see what they find helpful or challenging when developing and implementing formulations in similar or different settings. As CPs are trained to have transferrable skills in assessment, formulation and intervention (Health and Care Professionals Council, 2023), this thesis can benefit other services that are implementing regular psychological formulations into their practice.

Conclusion

This thesis explored the implementation of TIC into children's residential services, including how residential staff interpret and apply psychological formulation into their practice. In the critical appraisal I have discussed strengths and limitations of each paper, my personal reflections on carrying out the research and highlighted clinical implications and areas for future research. I hope that this research is useful for staff, YP, services and commissioners to consider how best to apply TIC into services that care for YP who have experienced complex trauma. Moreover, I hope the findings helped to give residential staff a voice in shaping future service delivery and design as well as government policy around TIC. I am proud of this thesis and my development as a researcher over the doctorate course.

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Section Four: Ethics Proposal

Ethics proposal for the empirical study: "Exploring Perspectives, Interpretations and Applications of Psychological Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis"

Word count (excluding references, tables and appendices): 2,673

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Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

March 2025

Substantial Amendment Form v1.9.2

Substantial Amendment Form v1.9.2 - 1 SA

Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis - Approved

Amendment Information

Please note:

This form is for making substantial amendments to applications previously approved in REAMS. All "Substantial Amendments" will go through the review process again. Please check the "Amendment Guidance" to see if you can use the "Minor Amendment" form.

Please number which amendment this is:

1

Amendment Summary

Please summarise your changes and the reasons why you are making them. Ensure that you indicate which parts of the form have been altered.

My research supervisor has changed to Dr Buket Kara, therefore I am updating the ethics application and also changing Dr Sarah Parry's name to Dr Buket Kara on all my thesis documents.

Dr Sarah Parry will remain a field supervisor.

Will your project require NHS REC approval? (If you are not sure please read the guidance in the information button)

○ Yes ◉ No

Do you need Health Research Authority (HRA) approval? (Please read the guidance in the information button)

○ Yes ◉ No

Have you already obtained, or will you be applying for ethical approval, from another institution outside of Lancaster University? (For example, an external institution such as: another University's Research Ethics Committee, the NHS or an institution abroad (eg an IRB in the USA)? Please select one of the following:

- (•) No, I do not need ethical approval from an external institution.
- ( ) Yes, I have already received ethical approval from an external institution.
- ( ) Yes, I will be applying for ethical approval from an external institution after I have received confirmation of ethical approval from my Faculty Research Ethics Committee (FREC) at Lancaster University, if the FREC grants approval.

Is this an amendment to a project previously approved by Lancaster University using the previous "paper-based" system (Pre-Jan 2022)?

( ) Yes (•) No

To note: please do not change your answer to this question, as you are completing the Substantial Amendment form therefore it is apparent that this is an amendment to a previously approved Lancaster University project .

Which Faculty are you in?

Faculty of Health and Medicine

Which department are you in?

Health Research

Are you undertaking this research as/are you filling this form out as:

- ( ) Academic/Research Staff
- ( ) Non Academic Staff
- ( ) Staff Undertaking a Programme of Study
- (•) PhD or DClinPsy student or MPhil
- ( ) Undergraduate, Masters, Master by Research or other taught postgraduate programme

Will your research involve any of the following? (Multiple selections are possible, please see i icon for details)

- [x] Human Participants
- [x] Data relating to humans (Secondary/Pre-existing data only)
- [ ] Data collection from online sources such as social media platforms, discussion forums, online chat-rooms
- [ ] Human Tissue
- [ ] None of the above

Project Information

Please confirm/amend the title of this project.

Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis

Estimated Project Start Date 01/01/2024

Amended Start Date - *If the start date hasn't changed please re-enter* 01/01/2024

Estimated End Date 21/03/2025

Is this a funded Project?

( ) Yes (•) No

Research Site(s) Information

Will you be recruiting participants from research sites outside of Lancaster University? *(E.g. Schools, workplaces, etc; please read the guidance in the information button for more information)*

(•) Yes ( ) No

Please provide the number, type and location of external research sites that you are using (please see help text for details).

[redacted]

Applicant Details

Are you the named Principal Investigator at Lancaster University?

(•) Yes ( ) No

Please check your contact details are correct. You can update these fields via the personal details section located in the top right of the screen. Click on your name and email address in the top right to access "Personal details". For more details on how to do this, please read the guidance in the information button.

First Name

Amy

Surname

Toolis

Department

Health Research

Faculty

Faculty of Health and Medicine

Email

a.toolis@lancaster.ac.uk

Please enter a phone number that can be used in order to reach you, should an emergency arise.

07930445759

Supervisor Details

Search for your supervisor's name. *If you cannot find your supervisor in the system please contact rso-systems@lancaster.ac.uk to have them added.*

First Name

Buket

Surname

Kara

Department

Health Research

Faculty

FHM

Email

b.kara@lancaster.ac.uk

Do you need to add a second supervisor to sign off on this project?

○ Yes ◉ No

Additional Team Members

Other then those already added, please select which type of team members will be working on this project:

- ☐ I am not working with any other team members.
- ☐ Staff
- ☐ Student
- ☑ External

Please list all external contacts here:

First Name

Sarah

Surname

Mack

Organisation

Greater Manchester Mental Health NHS Foundation Trust

Please list all external contacts here:

First Name

Sarah

Surname

Parry

Organisation

Manchester Metropolitan University

Details about the participants

As you are conducting research with Human Participants/Tissue you will need to answer the following questions before your application can be reviewed.

If you have any queries about this please contact your Ethics Officer before proceeding.

What's the minimum number of participants needed for this project?

6

What's the maximum number of expected participants?

12

Do you intend to recruit participants from online sources such as social media platforms, discussion forums, or online chat rooms?

○ Yes ◉ No

Will you get written consent and give a participant information sheet with a written description of your research to all potential participants?

◉ Yes ○ No ○ I don't know

Will any participants be asked to take part in the study without their consent or knowledge at the time or will deception of any sort be involved?

○ Yes ◉ No ○ I don't know

Is your research with any vulnerable groups?

(Vulnerable group as defined by Lancaster University Guidelines)

○ Yes ◉ No ○ I don't know

Is your research with any adults (aged 18 or older)?

◉ Yes ○ No

Is your research data collected with completely anonymous adult (aged 18 or older) participants, with no contact details or other uniquely identifying information (e.g. date of birth) being recorded?

○ Yes ◉ No

Is your research with any young people (under 18 years old)?

○ Yes ◉ No ○ I don't know

Does your research involve discussion of personally sensitive subjects which the participant might not be willing to otherwise talk about in public (e.g. medical conditions)?

○ Yes ○ No ◉ I don't know

Is there a risk that the nature of the research topic might lead to disclosures from the participant concerning either:

- Their own or others involvement in illegal activities
- Other activities that represent a threat to themselves or others (e.g. sexual activity, drug use, or professional misconduct)?

○ Yes ◉ No ○ I don't know

Does the study involve any of the following:

- Physically intrusive procedures including touching or attaching equipment to participants
- Administration of substances
- Ultrasound or sources of non-ionising radiation (e.g. lasers)
- Sources of ionising radiation, (e.g. X-rays)
- Collection or use of samples of Human Tissue (e.g. Saliva, skin cells, blood etc.)

○ Yes ◉ No ○ I don't know

Details about the relationships with participants

Do you have a current or prior relationship with potential participants? For example, teaching or assessing students or managing or influencing staff (this list is not exhaustive).

○ Yes ◉ No ○ I don't know

If you need written permission from a senior manager in an organisation where research will take place (e.g. school, business) will you gain this in advance of undertaking your research?

◉ Yes ○ No ○ I don't know ○ N/A

Will you be using a gatekeeper to access participants?

○ Yes ◉ No ○ I don't know if I will be using a gatekeeper

Will participants be subjected to any undue incentives to participate?

○ Yes ◉ No ○ I don't know

Will you ensure that there is no perceived pressure to participate?

◉ Yes ○ No ○ I don't know

Details about participant data

Will you be using video recording or photography as part of your research or publication of results?

- (•) Yes
- ( ) No

Will you be using audio recording as part of your research?

- (•) Yes
- ( ) No

Will you be using audio recordings in outputs (e.g. giving a presentation in a conference, using it for teaching)?

- ( ) Yes
- (•) No

Will you be using portable devices to record participants (e.g. audio, video recorders, mobile phone, etc)?

- ( ) No
- (•) Yes, and all portable devices will be encrypted as per the Lancaster University ISS standards, in particular where they are used for recording identifiable data
- ( ) Yes, but these cannot be encrypted because they do not have encryption functionality. Therefore I confirm that any identifiable data (including audio and video recordings of participants) will be deleted from the recording device(s) as quickly as possible (e.g. when it has been transferred to a secure medium, such as a password protected and encrypted laptop or stored in OneDrive) and that the device will be stored securely in the meantime

Will you be using other portable storage devices in particular for identifiable data (e.g. laptop, USB drive, etc)? (Please read the help text)

- ( ) No
- (•) Yes, and they will be encrypted as per the Lancaster University ISS standards in particular where they are used for recording identifiable data

Will anybody external to the research team be transcribing the research data?

- ( ) Yes
- (•) No

Data Origin

Is the data you will be using in the public domain or from data repositories?

○ Yes ◉ No

Has consent for the use/reuse of the data for research purposes been obtained?

◉ Yes ○ No ○ I don't know

Will you protect confidentiality and anonymity in your (re)analysis of the data?

◉ Yes ○ No ○ I don't know

Data Analysis

Do you intend to conduct a secondary analysis of existing research data?

○ Yes ◉ No

General Queries

Does the funder or any organisations involved in the research have a vested interest in specific research outcomes that would affect the independence of the research?

○ Yes ○ No ◉ I don't know

Does any member of the research team, or their families and friends, have any links to the funder or organisations involved in the research?

◉ Yes ○ No ○ I don't know

Can the research results be freely disseminated?

◉ Yes ○ No ○ I don't know

Will you use data from potentially illicit, illegal, or unethical sources (e.g. pornography, related to terrorism, dark web, leaked information)?

○ Yes ◉ No ○ I don't know

Will you be gathering/working with any special category personal data?

○ Yes ◉ No ○ I don't know

Are there any other ethical considerations which haven't been covered?

○ Yes ○ No ◉ I don't know

REC Review Details

Based on the answers you have given so far you will need to answer some additional questions to allow reviewers to assess your application.

It is recommended that you do not proceed until you have completed **all of the previous questions**.

Please confirm that you have finished answering the previous questions and are happy to proceed.

☑ I confirm that I have answered all of the previous questions, and am happy to proceed with the application.

Questions for REC Review

Summarise your research protocol in lay terms (indicative maximum length 150 words).

Note: The summary of the protocol should concisely but clearly tell the Ethics Committee (in simple terms and in a way which would be understandable to a general audience) what you are broadly planning to do in your study. Your study will be reviewed by colleagues from different disciplines who will not be familiar with your specific field of research and it may also be reviewed by the lay members of the Research Ethics Committee; therefore avoid jargon and use simple terms. A helpful format may include a sentence or two about the background/ "problem" the research is addressing, why it is important, followed by a description of the basic design and target population. Think of it as a snapshot of your study.

Youth Forensic Services (YFS) provide care to young people aged 18 and under within the youth justice system to help support their mental health and risk management needs. Young people within YFS have often experienced a range of adversities and traumas which can increase the likelihood of mental health challenges and impact future life outcomes.

Formulation is an approach employed in health and social care to form a shared understanding of a person's strengths, difficulties and how they make sense of these. Specifically, trauma-informed formulation can help practitioners understand a young person's difficulties in the context of their past experiences, recognising the influence of environment and the impact of trauma on their needs.

In this thesis, I will listen to residential staff's perspectives on the use of formulation by interviewing staff to gain an understanding of how they use formulation to develop an understanding of the children in their care.

State the Aims and Objectives of the project in Lay persons' language.

The aim of this project is to explore how residential staff in Secure Children's Homes interpret the use and application of formulation in this unique setting.

Objectives:
To identify/understand how practitioners perceive their role in the use of formulation to inform training and implementation in this setting.
To understand what processes formulation supports in terms of working relationships, in teams and with young people.
To recognise if there is a role for trauma-informed formulation in this setting.

Participant Information

Please explain the number of participants you intend to include in your study and explain your rationale in detail (eg who will be recruited, how, where from; and expected availability of participants). If your study contains multiple parts eg interviews, focus groups, online questionnaires) please clearly explain the numbers and recruitment details for each of these cohorts (see help text).

Residential staff, between 6-12 staff - this is deemed enough for an Interpretative Phenomenological Analysis (IPA) study within doctoral research. Smith et al. (2009) argue that a limited number of participants in IPA studies allow for a richer depth of analysis that may be prevented with a large sample size. IPA was chosen as the method of analysis as through conversations with my field supervisor it is apparent that future participants have a good grasp of formulation as a central phenomenon within their work.

Inclusion – staff are currently working in SCH, employed by council or charity e.g. residential staff, staff have been in post for at least 6 months and attended at least one formulation meeting, staff work on residential unit, staff have an NVQ Level 3 qualification for working with children and young people or currently working towards, staff have the ability to engage in conversational English to take part in an interview for research, 18+.

Exclusion – Not attended a formulation meeting yet, any directors and admin staff, those who don't work frontline with young people.

I will be recruiting from two SCH's in the Northwest of England – Barton Moss SCH and Marydale Lodge SCH. Opportunity sampling will be utilised using posters to advertise the research in the homes and sent via email by clinical leads with a QR code for participants to scan that will lead them to Qualtrics. The recruitment poster will also be advertised in the monthly staff newsletter that is sent round via email to salford/nugent email addresses. I have been in touch with managers and clinical leads at both sites and had permission to recruit. Although the healthcare provision is provided by an NHS trust, they are an in-reach team contracted to the homes. The homes themselves are ran by Salford City Council (Barton Moss) and Nugent Charity (Marydale Lodge). All residential staff employed by the children's homes are employed by the council (Salford City Council – Barton Moss) with Salford.gov email addresses or a charity (Nugent Charity – Marydale Lodge) with wearenugent.org email addresses and all recruitment emails will be sent to these email addresses.

I will also attend both sites in person to spread awareness about the project in their staff development days. This will include a 10-15 minute slot to talk about the rationale for the research, what the participant process will look like and how it will be helpful for staff in their job roles. My recruitment poster will also be put up in staff rooms/meeting rooms to advertise the study so that it is easily accessible and visible around staff areas.

Qualtrics will contain the participant information sheet, consent form and also questions around demographic data (see below) which participants will be asked to read through and sign. If there are participants who would like to engage but have IT difficulties, I will attend site to go through the process with them. At the end of the consent form I will put my email address so that participants can contact me if they have any questions. I will also include an extra box where participants can tick if they would like to receive a copy of the research findings when completed and an email address to contact them on.

Once participants have consented to the study, I will then contact them to arrange a suitable time/date for an interview which will be held via Microsoft Teams or face to face depending on preference. If interviews are f2f or on microsoft teams during work hours, they will take place in a private confidential room off the residential unit. These will be booked in advance and all interviews will be kept confidential. If the participant would rather the interview take place off site at a time convenient for them this can be arranged. If a member of staff would rather meet in a public place (e.g. coffee shop), can agree a mutually convenient quiet place to conduct interview.

Following completion of the interview, participants will be given a debrief form which will contain sign posting to resources such as PROCOL, Greater Manchester Resilience Hub (for Barton Moss staff) and the Cheshire and Merseyside Resilience Hub (Marydale staff) if anything comes up during the interview they found distressing. My field supervisor will also be on site to assist with any debriefs if necessary.

At the end of the interview I will let participants know the next steps with the research and an approximate date when they will receive a summary of the findings if they wish to.

I used the HRA Decision tool to confirm I did not need HRA ethical approval for this project (this is included in a separate document titled HRA decision tool)

You have selected that you do not know if the research may involve personal sensitive topics that participants may not be willing to otherwise talk about. Please indicate what discomfort, inconvenience or harm could be caused to the participant and what steps you will take to mitigate or manage these situations.

Due to the nature of setting (SCH), staff could potentially talk about trauma of children and personal experiences which may have the potential to be triggering. If any distress caused by interview participant information sheet will provide details and further signposting of services/resources to utilise. My field supervisor will also be available for debrief if any staff feel they need this. Participants will be advised on the realms of confidentiality at the start of each interview and when this may have to be broken, e.g. if there is a risk of harm to themselves or other people. If there are any safeguarding concerns I will raise these with my super

I will develop a distress protocol for staff. For example, if someone gets upset will pause interview, ask if they'd like to take a break or continue or if distressed if they would like to reschedule. Participants will be able to stop interview at any time and will offer signposting information to practitioners support as and when needed. The link to the following websites will also be included in the PIS https://proqol.org/self-care-tools-1, https://www.cheshiremerseyresiliencehub.nhs.uk and https://www.penninecare.nhs.uk/gmh-staff.

You have indicated that you will collect identifying information from the participants. Please describe all the personal information that you gather for your study which might be used to identify your participants.

I will be collecting demographic data on participants such as gender, age, ethnicity, length of time working at the SCH and their highest qualification.

Please describe how the data will be collected and stored.

The interview data will be collected via video recording through Microsoft Teams and/or on a Lancaster University laptop. The data collected for this study will be stored securely via University OneDrive, and only the researchers conducting this study will have access to this data. The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.

Please describe how long the data will be stored and who is responsible for the deletion of the data.

Video recordings will be destroyed and/or deleted once the project has been submitted for publication/examined. The primary researcher (myself) will be responsible for deletion of data once the project has been submitted for publication and examined by the university board.

You stated that the study could induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life. Please describe the question(s) and situation(s) that could lead to these outcomes and explain how you will mitigate this.

Due to the nature of setting (SCH), staff could potentially talk about trauma of children and personal experiences which may have the potential to be triggering. If any distress caused by interview participant information sheet will provide details and further signposting of services/resources to utilise. My field supervisor will also be available for debrief if any staff feel they need this.

I will develop a distress protocol for staff. For example, if someone gets upset will pause interview, ask if they'd like to take a break or continue or if distressed if they would like to reschedule. Participants will be able to stop interview at any time and will offer signposting information to practitioners support as and when needed. The link to the following websites will also be included in the PIS https://proqol.org/self-care-tools-1, https://www.cheshiremerseyresiliencehub.nhs.uk and https://www.penninecare.nhs.uk/gmh-staff.

Participant Data

Explain what you will video or photograph as part of your project, why it is appropriate and how it will be used.

I will be video recording the interviews as part of my project as this enables me to re-watch the interviews to transcribe the data collected.

How will you gain consent for the use of video/photography?

In my consent form I will include the following statement "I understand that my interview will be audio recorded and then made into an anonymised written transcript stored securely at Lancaster University" where participants will have to tick yes to consent.

State your video/photography storage, retention and deletion plans and the reasons why.

The interview data will be collected via video recording through Microsoft Teams or in person on a Lancaster University laptop. The data collected for this study will be stored securely via University OneDrive, and only the researchers conducting this study will have access to this data. The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.

What would you do if a participant chose to make use of their GDPR right "of being forgotten" or "right to erasure"? Could you remove their data/video/picture from publication? (please see help text).

As detailed in participant information sheet:

"You are free to withdraw from the study without giving any reason for this for up to 10 working days after you have signed the consent form. After completing the interview, you will have one week to withdraw. After one week analysis may have begun therefore withdrawal will not be possible."

Will you take all reasonable steps to protect the anonymity of the participants involved in this project?

(•) Yes ( ) No

Explain what steps you will take to protect anonymity.

Video recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.

The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.

The typed version of the interview will be made anonymous by removing any identifying information including participants name. A pseudonym will be used during the write up, however if participants wish to choose one, I will give them the option at the interview.

Anonymised direct quotations from the interview may be used in the reports or publications from the study, and the findings and some anonymised direct quotes may be used in the thesis and in a range of publications and dissemination platforms. All reasonable steps will be taken to protect the anonymity of the participants involved in this project and participants names will not be attached to any dissemination platforms.

All personal data will be confidential and will be kept separately from the interview responses.

Additional Information

Will you be sharing your data with any other organisation?

○ Yes ◉ No

What are your dissemination plans? E.g publishing in PhD thesis, publishing in academic journal, presenting in a conference (talk or poster).

I plan to publish in academic journal such as International Journal of Forensic Mental Health and Mental Health Review Journal.

I aim to complete an article for Children and Young People Now with the outcomes and recommendations of thesis.

One-page summaries will be created for participants, posters within SCH's to promote trauma informed psychological formulation and the implications/recommendations from the project. Recommendations will be provided to site managers/clinical leads following on from outcomes of project.

I hope to be able to present my findings in a research conference in the future for example in the BPS Children, Young People and Families annual conference.

Data Origin

You have indicated that the data you will be using is not in the public domain. Please explain how the records will be obtained and indicate the original purpose for which the data was collected.

I will be interviewing participants, transcribing this data and then analysing using IPA. Therefore, the data is not in the public domain and will be retrieved only during the data collection process.

General Queries

You have stated that you don't know if the funder or any other organisation involved in the research has a vested interest in the research outcome. Please explain the steps you have taken to mitigate and manage this conflict of interest.

The organisations that I will be recruiting participants from - Barton Moss SCH and Marydale Lodge SCH may have a vested interest in the research outcome due to the research having the potential to improve service provision and enhance outcomes for young people and staff. Whilst I have met with site managers as part of stakeholder involvement, I will ensure that they do not participate in the research and are not interviewed throughout the process.

You have stated that at least one member of the research team has links to the funder or organisations involved in this project. Please explain the relationship and how you will mitigate or manage this conflict of interest.

My field supervisor currently works and I have worked within the service that I will be recruiting participants from. Due to my experience within the service, I am passionate in conducting the thesis around this topic.

To manage this conflict of interest, as I am analysing my data using Interpretative Phenomenological Analysis this involves looking at the lived experience of participants involved. I will read up on the interpretative approach, adopt a critical realist position and explore the hermeneutic cycle through supervision. The 6 steps of IPA will be followed which include 1. reading and re-reading 2. initial noting 3. developing emergent themes 4. searching for connections across emergent themes 5. moving to the next case 6. looking for patterns across cases (Smith et al., 2009, pp. 82-107).

Participation is completed in a confidential process therefore only main researcher will know who is participating in the study. If participants want to meet privately away from the working site at a time that is convenient for them, then that is also okay. If people want to take part on teams, can also do this from home at a time convenient for them. Field supervisor will not be aware of any participants as these will be anonymised. The only exception to this would be if a participant became distressed and would like to access a debrief which they will be made aware of prior to the interview beginning.

You have stated that you do not know if there are other ethical considerations that may affect your research project. Please explain the situation and how it may affect your research project.

There is a potential issue of time constraints of service and if staff going to be given time during the workday if required. All recruitment plans have been agreed with house managers that if completed in work time, participants will have protected time to complete. If participants want to meet off site at a time convenient with them then they are able to. From the conversations had so far and because of nature of research there appears to be no concerns about management knowing who will be interviewed/involved with the research. This will all be planned in advance of interview scheduling.

Additional Information for REC Review

How long will you retain the research data?

Research data (video recordings of interviews) will be destroyed and/or deleted once the project has been submitted for publication and examined by the Lancaster DClinPsy board.

How long and where will you store any personal and/or sensitive data?

The interview data will be collected via video recording through Microsoft Teams and/or on a Lancaster University laptop. The data collected for this study will be stored securely via University OneDrive, and only the researchers conducting this study will have access to this data. The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.

Please explain when and how you will anonymise data and delete any identifiable record?

Video recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.

The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.

The typed version of the interview will be made anonymous by removing any identifying information including participants name. A pseudonym will be used during the write up, however if participants wish to choose one, I will give them the option at the interview. Anonymised direct quotations from the interview may be used in the reports or publications from the study, but participants names will not be attached to them.

All reasonable steps will be taken to protect the anonymity of the participants involved in this project.

All personal data will be confidential and will be kept separately from the interview responses. Any personal data (email addresses) collected for the purposes of sharing the results with participants will be stored on university OneDrive on a password protected computer.

Document Upload

Important Notice about uploaded documents:

When your application has been reviewed if you are asked to make any changes to your uploaded documents please highlight the changes on the updated document(s) using the highlighter so that they are easy to see.

Please confirm that you have read and applied, where appropriate, the guidance on completing the Participant Information Sheet, Consent Form, and other related documents and that you followed the guidance in the help button for a quality check of these documents. For information and guidance, please use the relevant link below:

FST Ethics Webpage

FHM Ethics Webpage

FASS-LUMS Ethics Webpage

REAMS Webpage

☑ I confirm that I have followed the guidance.

In addition to completing this form you must submit all supporting materials.

Please indicate which of the following documents are appropriate for your project:

- ☐ I have no updated documents and confirm that all relevant documents were included in previous submissions.
- ☑ Advertising materials (posters, emails)
- ☑ Research Proposal (DClinPsy)
- ☑ Letters/emails of invitation to participate
- ☑ Consent forms
- ☑ Participant information sheet(s)
- ☑ Interview question guides
- ☐ Focus group scripts
- ☑ Questionnaires, surveys, demographic sheets
- ☐ Workshop guide(s)
- ☑ Debrief sheet(s)
- ☑ Transcription (confidentiality) agreement
- ☑ Other
- ☐ None of the above.

Please upload the documents in the correct sections below:

Please ensure these are the latest version of the documents to prevent the application being returned for corrections you have already made.

Please upload a copy of all of the consent forms that you will be using:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Consent Form	Consent form	Consent form.docx	22/02/2024	amendment	28.6 KB

Please upload a copy of all of the Participant Information Sheets that you will be using in this study.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Participant Information Sheet	Participant Info Sheet finished	Participant Info Sheet finished.docx	22/02/2024	amendment	322.2 KB

Please upload all of the advertising materials relevant for this project:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Advertising materials	Recruitment poster 2.0	Recruitment poster 2.0.png	22/02/2024	amendment	522.9 KB

Please upload all letters/emails of invitation used in this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Letters/emails of invitation to Particpate	Recruitment Email	Recruitment Email.docx	22/02/2024	amendment	68.8 KB

Please upload all of the question interview guides used in this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Interview question guide	Interview questions	Interview questions.docx	22/02/2024	1	14.0 KB

Please upload all questionnaire, surveys, demographic sheet templates used in this project:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Questionnaires, surveys, demographic sheets	Demographics questionnaire	Demographics questionnaire.docx	22/02/2024	original	92.9 KB

Please upload all debrief sheets used for this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Debrief sheet	Debrief Sheet	Debrief Sheet.docx	22/02/2024	amendment	180.2 KB

Please upload all transcription (confidentiality) agreement(s) used for this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Transcription (confidentiality) agreement	LancasterUniversityDataManagement Template	LancasterUniversityDataManagementTemplate.docx	22/02/2024	original	17.7 KB

Please upload any other documents relevant to this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Other	HRA decision tool	HRA decision tool.docx	22/02/2024	original	117.2 KB

Declarations and Sign off

Please Note

Research Services monitors projects entered into the online system, and may select projects for quality control.

All research at Lancaster university must comply with the LU data storage and governance guidance as well as the General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. (Data Protection Guidance webpage)

☑ I confirm that I have read and will comply with the LU Data Storage and Governance guidance and that my data use and storage plans comply with the General data Protection Regulation (GDPR) and the UK Data Protection Act 2018.

Have you that you have undertaken a health and safety risk assessment for your project through your departmental process? (Health and Safety Guidance)

☑ I have undertaken a health and safety assesment for your project through my departmental process, and where required will follow the appropriate guidance for the control and management of any foreseeable risks.

When you are satisfied that this application has been completed please click "Request" below to send this application to your supervisor for approval.

Signed: This form was signed by Dr Buket Kara (b.kara@lancaster.ac.uk) on 22/02/2024 17:18

Please read the terms and conditions below:

- You have read and will abide by Lancaster University's Code of Practice and will ensure that all staff and students involved in the project will also abide by it.
- If appropriate a confidentiality agreement will be used
- You will complete a data management plan with the Library if appropriate. Guidance from Library.
- You will provide your contact details, as well as those of either your supervisor (for students) or an appropriate person for complaints (such as HoD) to any participants with whom you interact, so they know whom to contact in case of questions or complaints?
- That University policy will be followed for secure storage of identifiable data on all portable devices and if necessary you will seek guidance from ISS
- That you have completed the ISS Information Security training and passed the assessment
- That you will abide by Lancaster University's lone working policy for field work if appropriate
- On behalf of the institution you accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- To the best of your knowledge the information you have provided is correct at the time of submission
- If anything changes in your research project you will submit an amendment

To complete and submit this application please click "Sign" below:

Signed: This form was signed by Amy Toolis (a.toolis@lancaster.ac.uk) on 22/02/2024 17:07

Appendix 4-A: Research Protocol

2.a. Protocol

(2,500-word limit, 10-15 references)

Trainee name	**Trainee number**
Amy Toolis	2267
Research Supervisor	**Field Supervisor**
Dr Buket Kara	Dr Sarah Mack, Dr Sarah Parry

Title of the primary research study
Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis

1. Background

What is known?

Formulation

Formulation, sometimes referred to as psychological formulation, can be defined as a working hypothesis developed through a shared understanding of a person's strengths and difficulties in the context of their historical and current circumstances, and how they make sense of these (Johnstone, 2018). Formulation is an essential competency for clinical psychologists due to psychologists combining psychological theory and practice with clinical judgement, to create a compassionate sense of an individual's experience from which to work from (Division of Clinical Psychology [DCP], 2011; Association of Clinical Psychologists [ACP], 2022).

Youth Forensic Services

Youth Forensic Services (YFS) in the United Kingdom, including the Children and Young People's Secure Estate (CYPSE), provide care to young people aged 18 and under within the youth justice system (YJS) who have committed a criminal offence, and help to support their risk management and mental health needs. Staff employed within YFS can consist of education, youth offending teams, and healthcare staff including psychology provision (Taylor, 2016). Young people within YFS are argued to have more complex needs than those in the general population, such as a higher prevalence of mental health difficulties, which can impact on future life outcomes (Souza et al., 2021) and higher rates of Adverse Childhood Experiences (ACEs; Baglivio et al., 2014). ACEs can be defined as highly stressful or traumatic experiences that a young person experiences within their childhood, for example abuse and neglect (Felitti et al., 1998). ACEs are highly relevant in the CYPSE population because these young people are likely to have complex histories of attachment and relational difficulties (Taylor et al., 2018), and high exposure to ACEs is linked to increased risk of emotional and physical health challenges over the life-course.

Policy and Frameworks

The National Health Service's (NHS) Five Year Forward View independent report (NHS, 2016), and subsequently the Long-Term Plan (NHS, 2019), highlighted the need to implement psychological support for young people who have complex needs. Across the UK, a range of frameworks support the use of trauma-informed formulation to support the needs of young people. For example, SECURE STAIRS (Taylor et al., 2018) in the CYPSE aims to help young people and staff through formulation-driven and systemic trauma-informed approaches.

What is needed?

Psychological formulation within YFS can encourage a holistic understanding of a young person and their complex needs (McKeown et al., 2022), so that staff can acknowledge the impact of trauma on a young person's presentation. However, there is a lack of research exploring the use of formulation within YFS or how practitioners perceive it's use and implementation; highlighting the necessity for this service-level research. McKeown et al. also (2022) state the need for further qualitative research within the CYPSE to explore how formulation processes within the SECURE STAIRS framework can impact on staff's attitudes towards young people and their approach to care.

What is the connection to clinical psychology?

ACP (2022) highlight that further research is needed that explores the impact of team formulation on MDT decisions and their collaborative understanding of a client's difficulties. Formulation is an essential competency for clinical psychologists, which is why this project is both relevant for clinical psychology research and how clinical psychologists can influence service development through the use of formulation. Finally, it is crucial that formulations within SCH are researched further using qualitative methods to gain a richer understanding into staff's perceptions of psychological formulation and explore the impact this can have on staff and young people they care for to drive positive change and collaboration across SCHs

2. Aim and objectives

2.1 Aim

To explore how residential staff in SCH interpret the use and application of formulation in this unique setting.

2.2 Objectives

To identify/understand how practitioners perceive their role in the use of formulation to inform training and implementation in this setting.

To understand what processes formulation supports in terms of working relationships, in teams and with young people.

To recognise if there is a role for trauma-informed formulation in this setting?

2.3 Research Question(s)

How do residential staff in SCH perceive, interpret and apply psychological formulation within Secure Children's Homes?

3. Method

3.1. Participants

Residential staff, between 6-12 staff - this is deemed enough for an Interpretative Phenomenological Analysis (IPA) study within doctoral research. Smith et al. (2009) argue that a limited number of participants in IPA studies allow for a richer depth of analysis that may be prevented with a large sample size.

Inclusion – staff are currently working in SCH, employed by council or charity e.g. residential staff, staff have been in post for at least 6 months and attended at least one formulation meeting, staff work on residential unit, staff have an NVQ Level 3 qualification for working with children and young people or currently working towards, staff have the ability to engage in conversational English to take part in an interview for research, 18+.

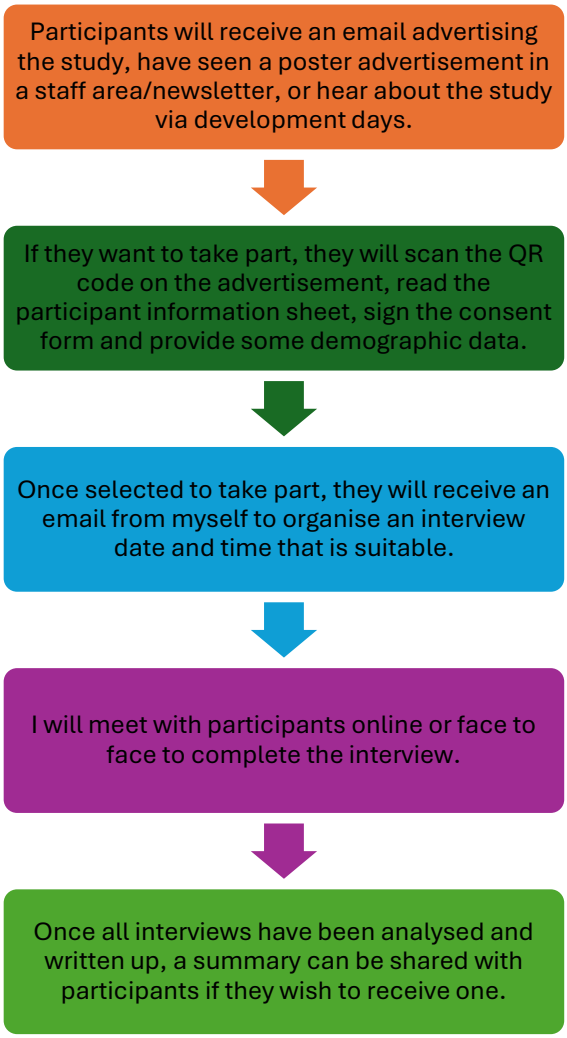
Exclusion – Not attended a formulation meeting yet, any directors and admin staff, those who don't work frontline with young people.

I will be recruiting from 2 Secure Children's Homes in the North West – *** and ***. Opportunity sampling will be utilised using posters to advertise the research in the homes and sent via email by clinical leads with a QR code for participants to scan that will lead them to Qualtrics. I will also attend both sites in person to spread awareness about the project in their staff development days. This will include a 10-15 minute slot to talk about the rationale for the research, what the participant process will look like and how it will be helpful for staff in their job roles. My recruitment poster will also be put up in staff rooms/meeting rooms to advertise the study so that it is easily accessible and visible around staff areas.

3.2. Design

To explore practitioners' interpretations on the use of formulation, I will employ IPA to explore the unique phenomena of psychological formulation in the context of SCHs. There has been previous quantitative research, but this is also very limited. There is no qualitative research into the use of psychological formulation within SCH's. IPA was chosen as method of analysis due to future participants having a good grasp of formulation as a central phenomenon within their work.

3.3. Procedure and materials



Participants will scan a QR code on the study advertisement that will lead them to Qualtrics. Qualtrics will contain the participant information sheet, consent form and also questions around demographic data (see below) which participants will be asked to read through and sign. If there are participants who would like to engage but have IT difficulties, I will attend site to go through the process with them. At the end of the consent form, I will put my email address so that participants can contact me if they have any questions. I will also include an extra box where participants can tick if they would like to receive a copy of the research findings when completed and an email address to contact them on.

Once participants have consented to the study, I will then contact them to arrange a suitable time/date for an interview which will be held via Microsoft Teams or face to face depending on preference. Following completion of the interview, participants will be given a debrief form which will contain sign posting to resources such as PROQOL, Greater Manchester Resilience Hub (for Barton Moss staff) and the Cheshire and Merseyside Resilience Hub (Marydale staff) if anything comes up during the interview

they found distressing. My field supervisor will also be on site to assist with any debriefs if necessary.

At the end of the interview I will let participants know the next steps with the research and an approximate date when they will receive a summary of the findings if they wish to.

Interviews were deemed to be the best fit for this study to capture participants lived experiences and engage in conversation around the use of formulation within SCH's. A semi-structured interview schedule will be utilised to help guide conversation so that all participants are given the opportunity to discuss the same themes/topic.

Materials:

Advertisement poster

Participant information sheet

Consent form

Data management procedure

Interview questions

Distress protocol

Recruitment email

3.4. Proposed analysis

I will be using an IPA method of analysis. IPA is concerned with the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience (Smith, 2011). IPA studies can enable researchers to understand the 'lived experiences' of research participants whilst also building a rapport (Alase, 2017). There is no qualitative research at present into use of psychological formulation within SCH, therefore using an IPA approach allows for a deeper and nuanced insight (Tuffour, 2017) into staff's experiences. It is important that this is researched qualitatively to provide the best possible care for traumatised young people in SCH. I have chosen to utilise IPA rather than thematic analysis as the participants will have a prior understanding of the phenomena of formulation due to them attending formulation meetings as part of their job role. Therefore, I will be able to explore their lived experience of how they utilise formulation within the care they provide to the young people.

I will read up on the interpretative approach, adopt a critical realist position and explore the hermeneutic cycle through supervision. The 6 steps of IPA will be followed which include 1. reading and re-reading 2. initial noting 3. developing emergent themes 4. searching for connections across emergent themes 5. moving to the next case 6. looking for patterns across cases (Smith et al., 2009, pp. 82-107).

I will also create audit trails that will evidence where my themes have emerged from. This is to provide a thoughtful and reflexive analysis.

3.5. Practical issues

There will be no additional research costs required. Technology will be required to scan the QR code to bring the participants to Qualtrics. All potential participants will have access to email, however if they are struggling to fill the online form in but still want to participate I will attend site in person to assist with this.

Interviews will also be offered face-to-face as well as on Microsoft teams in case any participants would prefer to be interviewed in person. If the interview is face-to-face, this can take place in a confidential room off the residential unit away from the staff members working area. This room will be away from busy areas and will be booked in advance. If participants would prefer to have the interview at a time/place better convenient for them, this will be offered. For example, Microsoft teams at home or in a coffee shop away from the site.

There was the potential issue of time constraints of service and if staff were going to be given time during the workday. I have had meetings with site managers and clinical leads regarding the outcomes of this project aiming to help inform service delivery and increase staff well-being. Site managers and clinical leads have agreed for time to be given to staff during their working hours if they would prefer to have the interview during working hours. If taking part in the interview via teams or f2f on site, this will be in a confidential room where participants will not be disturbed.

There is also a low level of risk to participants however they may begin to discuss potentially triggering topics associated with the young people's trauma or if they have had any difficult experiences in work. I have developed a distress protocol to follow if this was to occur.

3.6. Ethics and Governance

Due to the nature of setting (SCH), staff could potentially talk about trauma of children and personal experiences which may have the potential to be triggering. If any distress caused by interview participant information sheet will provide details and further signposting of services/resources to utilise. My field supervisor will also be available for debrief if any staff feel they need this. Participants will be advised on the realms of

confidentiality at the start of each interview and when this may have to be broken, e.g. if there is a risk of harm to themselves or other people. If there are any safeguarding concerns I will raise these with my supervisor.

I will develop a distress protocol for staff. For example, if someone gets upset will pause interview, ask if they'd like to take a break or continue or if distressed if they would like to reschedule. Participants will be able to stop interview at any time and will offer signposting information to practitioners support as and when needed. The link to the following website will also be included in the PIS https://proqol.org/self-care-tools-1.

Due to residential staff being employed by the council or charity and not NHS, the study will not need HRA ethics approval. HRA tool utilised to aid this decision. Only university ethics and sponsorship will be needed. I have completed the HRA decision tool and spoken with both supervisors. Academic supervisor sought additional advice and will go through university review and sponsorship process.

Although the healthcare provision is provided by an NHS trust, they are an in-reach team contracted to the homes. The homes themselves are ran by Salford City Council (Barton Moss) and Nugent Charity (Marydale Lodge). All residential staff employed by the children's homes are employed by the council (Salford City Council – Barton Moss) with Salford.gov email addresses or a charity (Nugent Charity – Marydale Lodge) with wearenugent.org email addresses and all recruitment emails will be sent to these email addresses.

3.7. Patient and public involvement

I have already had meetings with another SCH in Leeds that completed a service evaluation around their use of formulation. There were detailed discussions around questions/issues that arisen from that evaluation, such as dissemination of findings, who formulation is specifically for, what makes it a formulation and how would staff know. These were all considered when I was creating my interview schedule.

Further meetings are to be planned with site managers to discuss their ideal outcomes and how they would like the findings of the project to be disseminated within the SCH, e.g. one page summary, posters, questions to be included within formulation.

I plan to present the research proposal in national SCH meetings to gain feedback from commissioners and senior staff.

I have had meetings with site managers to distinguish what they would like in terms of outcomes from the project. I have also shared the recruitment poster and interview questions with both site managers to gather feedback. This was a helpful process and everything has been compliant with their advice.

4. Dissemination Plans

I plan to publish in academic journal such as International Journal of Forensic Mental Health and Mental Health Review Journal.

I aim to complete an article for Children and Young People Now with the outcomes and recommendations of thesis.

One-page summaries will be created for participants, posters within SCH's to promote trauma informed psychological formulation and the implications/recommendations from the project. Recommendations will be provided to site managers/clinical leads following on from outcomes of project.

5. Plain English Summary

What is the problem?

Youth Forensic Services (YFS) provide care to young people aged 18 and under within the youth justice system to help support their mental health and risk management needs. In January 2023, there were 516 young people recorded as residing in the Children's and Young Person's Secure Estate, which includes Secure Children's Homes (SCH), Secure Training Centres (STC) and Youth Offender Institutes (YOI). Young people within YFS have often experienced a range of adversities and traumas, such as neglect and witnessing abuse, which can increase the likelihood of mental health challenges and impact future life outcomes.

What can be done?

Formulation is an approach often employed in health and social care to form a shared understanding of a person's strengths, difficulties and how they make sense of these. Specifically, trauma-informed formulation can help practitioners understand a young person's current difficulties in the context of their past experiences, recognising the influence of environment and the impact of trauma on their needs.

What will I do?

In this thesis, I will listen to residential staff's perspectives on the use of formulation. I will interview residential staff to seek to gain an understanding of how they use formulation to develop an understanding of the children in their care. This thesis has the potential to improve service provision and enhance outcomes for young people and staff.

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Appendix 4-B: Advertisement poster

Appendix 4-C: Recruitment Email

Hello,

I am writing to let you know about a study that you may be interested in taking part in. The study is my thesis project for the University of Lancaster Doctorate in Clinical Psychology, which is titled "Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis". My supervisors for this project are Dr Buket Kara (Lancaster University), Dr Sarah Mack (Barton Moss Secure Children's Home) and Dr Sarah Parry (Manchester Metropolitan University). Ethical approval has been granted by the University of Lancaster.

Please view the attached recruitment flyer for more details on this research, including criteria you must meet to take part. The flyer contains a QR code to scan that will lead you to a participant information sheet, consent form and a demographics data section. Please fill these in if you would like to take part.

Participants will be recruited between February and July 2024. I would very much appreciate your participation in the study.

If you would like any further information about the study, please feel free to contact me on a.toolis@lancaster.ac.uk.

Thank you in advance.

Best wishes,

Amy Toolis

Amy Toolis | Trainee Clinical Psychologist

Clinical Psychology – Division of Health Research

Health Innovation One | Sir John Fisher Drive | Lancaster University | Lancaster | LA1 4AT

Participant Information Sheet

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis

Invitation to research

Hello, my name is Amy Toolis and I am a Trainee Clinical Psychologist at Lancaster University.

Through this research I hope to learn about how formulations are used within Secure Children's Homes to develop an understanding of the young people that reside there. I hope that by gaining a better understanding of how formulations are used within Secure Children's Homes, I can make recommendations to improve service provision and enhance outcomes for young people and staff.

Am I eligible to take part?

I am hoping to speak with around 12 staff to talk about your experiences of using formulation, and how these may impact on your way of working with the young people you look after.

You are welcome to take part if you:

- Are a member of residential staff currently working in a Secure Children's Home.
- Have been in post for at least 4 months and attended at least one formulation meeting.
- Work on a residential unit within the home.
- Have an NVQ Level 3 qualification for working with children and young people or are currently working towards.
- Have the ability to engage in conversational English to take part in an interview.
- Are aged 18+.

Do I have to take part?

No. It's completely up to you to decide whether you take part or not. We can go through this participant information sheet and answer any questions that may arise. You will then be asked to sign a consent form which will show you have consented to take part. You are free to withdraw from the study without giving any reason for this for up to 10 working days after you have signed the consent form. After completing the interview, you will have one week to withdraw. After one week analysis may have begun therefore withdrawal will not be possible.

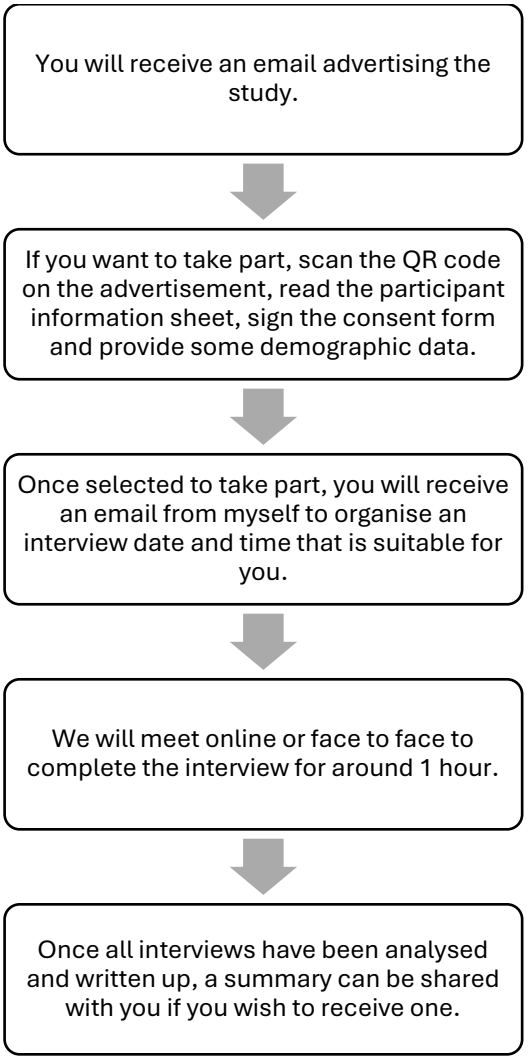
If you do decide to withdraw your consent, please contact myself at a.toolis@lancaster.ac.uk. Any personal information taken will be destroyed.

What will I be asked to do if I take part?

If you decide you would like to take part, you will be contacted via email to organise an interview date and time. The format of interview can be in person or via an online platform Microsoft Teams, whatever you would prefer. During the interview, you will be asked some questions about your experiences of attending a formulation meeting, and how that has been useful in helping you to support the young people on the residential unit you work on. Whilst there are no adverse risks anticipated with this study, after the interview has finished you will be provided with a debrief sheet with some resources in the event of any distress. These are also included at the bottom of this information sheet.

After all the interviews have been completed, I will then analyse everyone's experiences to look at how staff interpret and apply formulations within Secure Children's Homes.

Below is a guideline of your journey through the research process:



Will my data be Identifiable?

The data collected for this study will be stored securely via University OneDrive, and only the researchers conducting this study will have access to this data.

- Audio recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. A pseudonym will be used during the write up, however if you wish to choose one, please inform me at the interview. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

What will happen to the results?
At the end of this research study, the results will be summarised and reported in a thesis project as part of my university course. The results may be submitted for publication in an academic or professional journal. The findings and some anonymised direct quotes may be used in the thesis and in a range of publications and dissemination platforms. You will not be identifiable as your real name will not be used, and all information will be anonymised.

Are there any risks?
There are no risks anticipated with participating in this study. However, it can sometimes be difficult to talk about our personal experiences. If you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits in taking part. However, by sharing your experience you will be helping me to understand more about how using formulations within Secure Children's Homes can help to support young people and staff. This research has the potential to change and improve services for young people and staff in the future.

Who has reviewed the project?
This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact the main researcher:

Amy Toolis: a.toolis@lancaster.ac.uk

Alternatively, if you have any concerns and you do not wish to speak to the researcher, you can contact my research supervisor and/or field supervisor:

Dr Buket Kara:
Department of Health Research
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW
b.kara@lancaster.ac.uk

Dr Sarah Mack:
Barton Moss Secure Children's Home
Chat Moss
Barton Moss Road
Eccles, Manchester
M30 7RL
Sarah.mack@gmmh.nhs.uk

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Ian Smith
Research director
Department of Clinical Psychology
Health Innovation One
Sir John Fisher Drive
Lancaster University
Lancaster
LA1 4YW
Tel: +44 1524 592282 +44 75 078 570 69
Email: i.smith@lancaster.ac.uk

If you wish to speak to someone outside of the University of Lancaster Doctorate Programme, you may also contact:

Dr Laura Machin
Tel: +44 (0)1524 594973
Chair of FHM REC
Email: l.machin@lancaster.ac.uk
Faculty of Health and Medicine
(Lancaster Medical School)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

ProQOL – ProQOL have lots of self-care resources on their website about how staff can look after their well-being. These include topics around burnout, compassion fatigue, moral distress and secondary traumatic stress.
https://proqol.org/self-care-tools-1

Samaritans – Provide a free support line to talk about any distressing concerns and feelings.
Tel: 116 123

GMRH – Greater Manchester Resilience Hub offer support to staff who are working within the greater Manchester area. They can provide 1:1 emotional telephone support but also have great self-care resources on their website.
https://www.penninecare.nhs.uk/gmrh-staff

CMRH – Cheshire and Merseyside Resilience Hub have an extensive selection of self-care resources on their website for different wellbeing topics.
https://www.cheshiremerseyresiliencehub.nhs.uk/

Appendix 4-E: Consent form

(This information will be collected via Qualtrics however this is a physical hard copy of the research consent form)

Lancaster University

Title of research project: Exploring the Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes.

Participant Name:

Signature:

Date:

Please tick at the bottom if you agree to all the statements:

1. I confirm that I have read and understand the Participant Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. Please tick _____

2. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study and within two weeks of my participation without giving any reason. If I withdraw within two weeks of completing the interview my data will be removed. I will not be able to withdraw my data after two weeks of completing the interview.
Please tick _____

3. I understand that my participation is voluntary and whether or not I decide to take part will have no effect on my relationship with my workplace. Please tick _____

4. I understand that my interview will be audio recorded and then made into an anonymised written transcript stored securely at Lancaster University. According to terms and conditions of Lancaster University this will be stored for up to 10 years. Please tick _____

5. I understand any personal information I give will remain confidential and research data will be anonymous unless it is thought that there is a risk of harm to myself or others, in which case the researchers may need to share this information with the research supervisor (Dr Buket Kara, b.kara@lancaster.ac.uk)
Please tick _____

6. I understand some anonymised quotes from the study may be used in reports and academic papers and other dissemination outputs, but your identity will remain protected.

Please tick _____

7. I agree to take part in the above study. Please tick _____

If you would like a summary of the research please leave an email address below:

_____

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Signature of Researcher /person taking the consent_____

Date _____ Day/month/year

One copy of this form will be given to the participant and the original kept in the files of the researcher at Lancaster University.

Appendix 4-F: Data management procedure

Lancaster University Data Management Plan

Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis

1. Data Collection

- The interview data will be collected via video recording through Microsoft Teams or in person on a Lancaster University laptop. I will be interviewing participants, transcribing this data and then analysing using Interpretative Phenomenological Analysis (IPA). Therefore, the data is not in the public domain and will be retrieved only during the data collection process.
- I will collect personal data and consent via Qualtrics as this is a secure platform and provides a user-friendly access point for participants, although support and paper copies will be available if needed.

2. Documentation and Metadata

- The interview data will be recorded through a Lancaster University laptop and stored on OneDrive. The interview will then be transcribed, and the transcription will be analysed using (IPA) where themes will be included in the write up of the thesis based on the interview data.

3. Storage, Backup and Security

- The data collected for this study will be stored securely via University OneDrive, and only the researchers conducting this study will have access to this data.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.
- If a participant wishes to sign a physical copy of a consent form, then this paper will be scanned and the file placed onto OneDrive, and the original copy destroyed.

4. Ethics and Legal Compliance

- The typed version of the interview will be made anonymous by removing any identifying information including participant names. A pseudonym will be used during the write up so no participant will be identifiable.
- All personal data will be confidential and will be kept separately from interview responses.

5. Selection and Preservation

- Audio recordings will be destroyed and/or deleted once the project has been submitted for publication/examined.
- The thesis will be kept in Lancaster University files for 10 years.

6. Data Sharing

- Anonymised direct quotations from the interview may be used in the reports or publications from the study, and the findings and some anonymised direct quotes may be used in the thesis and in a range of publications and dissemination platforms. All reasonable steps will be taken to protect the anonymity of the participants involved in this project and participants names will not be attached to any dissemination platforms.

7. Responsibilities and Resources

- The lead researcher is responsible for the data management of this project. The resources required to deliver the plan will be a Lancaster University Laptop with a University OneDrive account.

Appendix 4-G: Interview questions

Introduction: Introduce self, role and research study again.

Ensure participant read participant info sheet and allow time for questions.

Remind participant of confidentiality / risk procedures.

Ensure happy to go ahead with interview.

1. Intro question - What has been your experience of the formulation process within this service?
2. How can formulation help you develop your knowledge and understanding of a young person's strengths and difficulties?
3. How does the use of formulation inform your work with the young people you care for?
4. How do you use and apply the information you learn in a formulation within your work with young people on the unit?
5. How does engaging with a formulation impact on your relationship with the young people you care for?
6. Have you noticed any changes in colleague relationships through the use of formulation?
7. Have there been any challenges with using formulations and how has this affected your work?
8. Anything else you would like to add that we have not already covered?

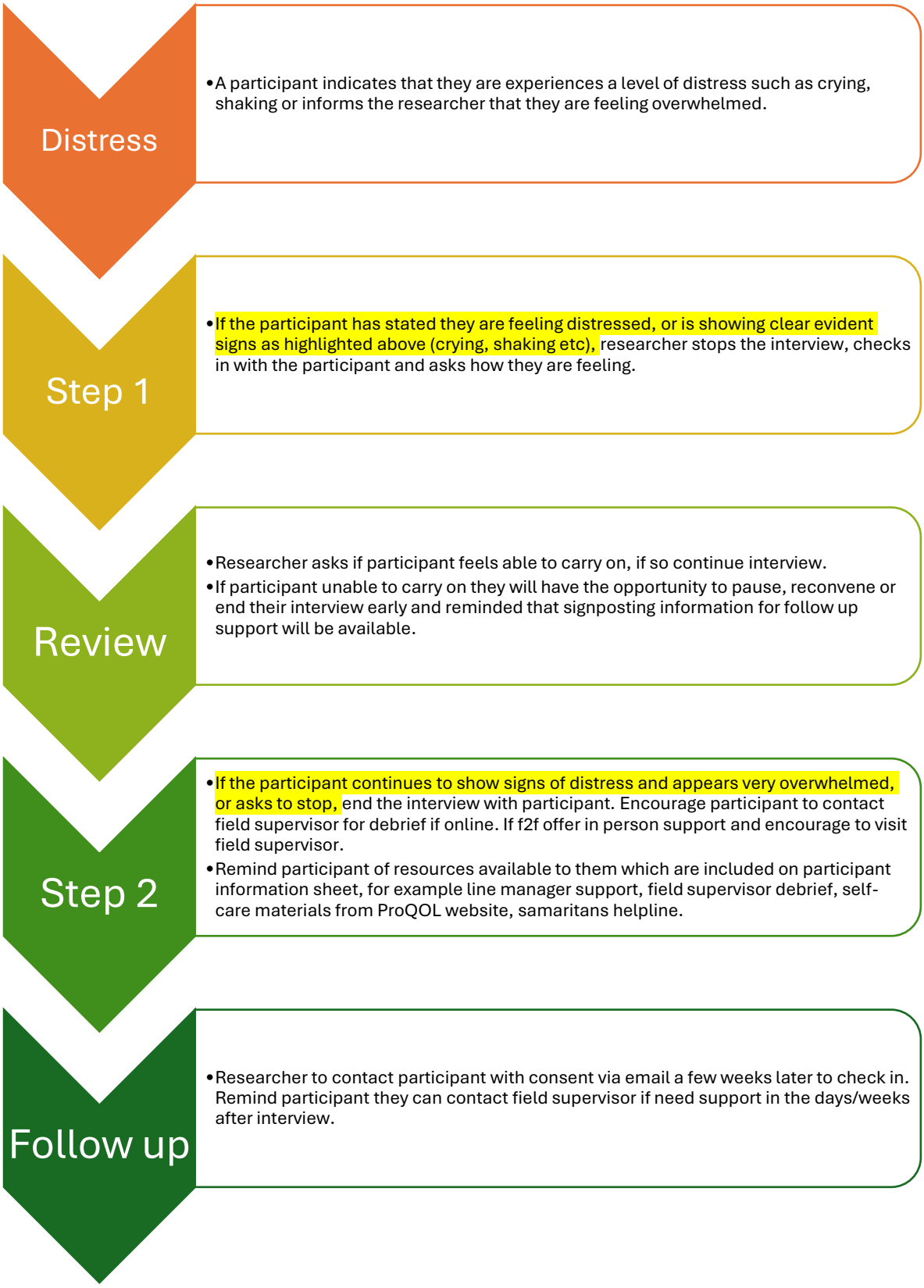
Prompt Questions:

- Can you tell me a bit more about that?
- What impact did that have?
- How did that affect your working style/practice?
- Did that help you feel any different towards staff/YP?

Debrief:

- Ask how they are feeling/how they found the interview. Debrief sheet is referred to and can email a copy to participant if they wish.

Appendix 4-H: Distress protocol



Appendix 4-I: Recruitment email

Hello,

I am writing to let you know about a study that you may be interested in taking part in. The study is my thesis project for the University of Lancaster Doctorate in Clinical Psychology, which is titled "Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis". My supervisors for this project are Dr Buket Kara (Lancaster University), Dr Sarah Mack (Barton Moss Secure Children's Home) and Dr Sarah Parry (Manchester Metropolitan University). Ethical approval has been granted by the University of Lancaster.

Please view the attached recruitment flyer for more details on this research, including criteria you must meet to take part. The flyer contains a QR code to scan that will lead you to a participant information sheet, consent form and a demographics data section. Please fill these in if you would like to take part.

Participants will be recruited between February and July 2024. I would very much appreciate your participation in the study.

If you would like any further information about the study, please feel free to contact me on a.toolis@lancaster.ac.uk.

Thank you in advance.

Best wishes,

Amy Toolis

Amy Toolis | Trainee Clinical Psychologist

Clinical Psychology – Division of Health Research

Health Innovation One | Sir John Fisher Drive | Lancaster University | Lancaster | LA1 4AT

Appendix 4-J: Approval email for ethics

Date Sent: 11 December 2023 13:56
From: ERM
To: <a.toolis@lancaster.ac.uk>
CC: <s.l.parry@lancaster.ac.uk>
Subject: **REAMS (Applicant Action) Ethics Approval from Faculty Research Ethics Committee FHM-2023-3707-RECR-2**

Dear Amy Toolis,

Please note that this is an automated e-mail (Please do not reply to this e-mail).

Name: Amy Toolis

Supervisor: Sarah Parry

Department: Health Research

FHM **REC Reference:** FHM-2023-3707-RECR-2

Title: Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis

Thank you for submitting your ethics application in REAMS. The application was recommended for approval by the FHM Research Ethics Committee, and on behalf of the Committee, I can confirm that approval has been granted for this application.

As Principal Investigator/Co-Investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licences and approvals have been obtained.

- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress).

- submitting any changes to your application, including in your participant facing materials (see attached amendment guidance).

Please keep a copy of this email for your records. Please contact me if you have any queries or require further information.

If you are experiencing any problems please contact your Research Ethics Officer.

Yours sincerely,

Professor Laura Machin
Chair of the Faculty of Health and Medicine Research Ethics Committee
fhmresearchsupport@lancaster.ac.uk

Lancaster University

Appendix 4-K: Approval email for amendment

This email originated outside the University. Check before clicking links or attachments.

FHM-2024-3707-SA-1 Exploring Perspectives, Interpretations and Applications of Formulation within Secure Children's Homes: An Interpretative Phenomenological Analysis

Dear Amy Toolis,

Please note that this is an automated e-mail (Please do not reply to this e-mail).

Thank you for submitting your ethics amendment application in REAMS. The amendment has been approved by the FHM.

As Principal Investigator/Co-Investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licences and approvals have been obtained.

- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress).

- submitting any further changes to your application, including in your participant facing materials (see attached amendment guidance).

Please keep a copy of this email for your records. Please contact me if you have any queries or require further information.

Yours sincerely,

Research Ethics Officer on behalf of FHM

Lancaster University