

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

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Doctoral Thesis

“We’re here for these kids, but we’re here for each other as well”: Carers’ perspectives of supporting the needs of Looked-after-Children.

Steven Sulej

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Steven Sulej

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

[s.sulej@lancaster.ac.uk](mailto:s.sulej@lancaster.ac.uk)

## Word Count

	Main Text	Appendices (inc. tables, references, abstract, footnotes and title pages)	Total
Thesis Abstract	299		299
Literature Review	7985	6756	14744
Research Paper	7998	7621	15618
Critical Appraisal	3979	331	4310
Ethics Section	4338	9463	13801
Total	24599	24171	48770

## Thesis Abstract

This thesis consists of two parts focusing on carers of care-experienced young people and their experiences of providing support for this population group both generally and regarding the specific presentation of self-harm.

The systematic literature review was a meta-ethnography containing 12 qualitative papers related to carers experiences of providing support alongside professionals to meet the needs of the young person in their care. This review highlighted concerns for carers regarding communicating and understanding information professionals provided, experiences with professionals often left carers feeling inadequate, criticised, or not valued within their role. The review highlights specific perspectives of foster carers regarding developing their practical skills as carers. How carers of care-experienced/looked after young people valued support from their peers for both practical knowledge and emotional support was also identified. The reviews findings indicate further consideration is needed by professionals regarding how to better support carers in a manner meeting their needs while also empowering them within the support process.

The empirical paper explored the experiences of residential staff supporting care-experienced young people who self-harm. Interpretive Phenomenological Analysis was used, 9 residential staff took part in semi-structured interviews. Four themes were developed to represent how participants made sense of their experiences "Understanding as a road to preventing"; "The care within the control"; "A bond beyond the role"; "The conflict in the system", these themes related to staff members feelings around wanting to understand the self-harm as a way to reduce it, how self-harm impacted on the

relationships they had with the young person, fellow staff members and the systems around them.

The critical appraisal reflects on the researchers own journey through this research.

Considering their own role within this research and how their previous experiences may have influenced their reflections and how this project may influence future clinical practice.

## **Declaration**

This thesis documents research undertaken in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology. The work presented here is my own, except where due reference is made. This thesis has not been submitted for the award of a higher degree elsewhere.

Signature:

Print name: Steven Sulej

Date: 26/04/2023

## Acknowledgements

Firstly, I would like to thank all those who took part in this research, for sharing their stories and reflections, as well as for taking the time within their own busy schedules and roles to speak with me. It was a privilege to speak with you and I will always be grateful for the opportunity I have had to support your voice to be heard.

Thank you also to Clare, Suzanne, and Sue for your support during my time completing this project and while on the course. You have all supported me academically, clinically, and personally and I will always feel grateful and fortunate to have had you all alongside me on this project. I hope that in my professional career I can be as thoughtful, containing, and supportive to those I work with as you have been to me. Academic work, (especially this thesis project!) is something that I have always doubted myself about, however as a result of the guidance I have received from all of you I now feel much confident being in the academic world!

I want to also thank my colleagues on the course, who I am very proud to call some of my closest friends, your presence, knowledge, humour, and support is one of the key reasons I have been able to make it through the doctorate. You're all amazing psychologists and even better human beings, my memories of our quiz team (Up the UPJ!) will forever be some of my most cherished.

To my dad and Pat, thank you for all your support, guidance, love and care all through my own journey into clinical psychology, I couldn't have done it without you there with me. Thank you for your belief in me and willingness to guide me and help me whatever the circumstances. Also thank you for all the meals, cups of tea and other things that have got me through those long thesis days!

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**Section One: Systematic Review**

Steven Sulej

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Steven Sulej

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

[S.sulej@lancaster.ac.uk](mailto:S.sulej@lancaster.ac.uk)

Carers' experiences of working alongside professionals and services to support the needs of looked after children: A meta-ethnography of qualitative research.

### **Abstract**

This systematic literature review explored carers of "Looked-after-Children's" experiences of working alongside professionals to provide support for children in their care. The review explored how carers experience the support process, their role within this and barriers to providing effective care. This review also attempted to explore differences between carer groups to provide further insight into their unique contexts.

This review contained twelve studies synthesised using meta-ethnography. Four themes were developed highlighting key aspects of foster and residential carers' experiences of working alongside professionals. Including: "A need for understanding and communication with professionals", "Seeking to increase understanding and skills through support from professionals", "The impact of support on feelings of confidence or inadequacy" and "Not feeling like a valued part of the system."

Findings suggest further consideration of how professionals approach working alongside carers of looked-after-children is needed, as carers highlighted several challenges when working with professionals and systems.

This review makes recommendations around supporting carers to feel more connected to support being offered to children in their care while highlighting the importance of professionals considering carers' own needs in detail. It also recognises further research exploring multiple types of carers' experiences providing support to Looked-after-Children in more depth is required.

## Introduction

The care and support needs of young people are currently being focused upon both socially and politically, particularly those within the care system. This population includes those defined legally within the “1989 Children’s Act” as “Looked-after-children” (LAC). These young people receive care from foster carers or within residential settings, outside their family of origin, may remain in monitored placements with birth parents or live with kinship carers. Around 72% of LAC are within foster placements or kinship care and 14% are supported via residential settings (DfE, 2021).

When caring for those within the care system, there are several professionals, meetings, and requirements expected of carers. This may be due to the emotional, social, and mental health needs of the young person. Looked-after-children generally have a higher prevalence of identified mental health needs (49% - Bronsard et al., 2016) than those within the general population (16% - NHS England, 2020).

Carers of LAC also need to ensure they have, for example, annual health checks, that require communication between multiple professionals (Croft, 2014).

Some LAC have further difficulties regarding stability of placements with 10% needing to move between three or more homes in a twelve-month period (DfE, 2019). Previous reviews suggest higher placement stability may support better mental and physical health outcomes, with fewer placements being associated with less input from services and better outcomes when accessing services (Jones et al., 2011), as well as better behavioural outcomes (Rubin et al., 2007).

A key contributor to placement breakdown within foster and residential settings identified in a recent review regarding factors impacting placement stability among LAC, was carers feeling they lacked skills or resources to best support the young person, meet their needs, and manage any risky behaviour (NICE, 2021). However, this review did not explore how carers experienced support provided by professionals. Another review reported experiences of services and placement provision often leaves foster carers feeling “frustrated” or “let down” (Blythe et al., 2014). This highlights the importance of considering the support offered to carers from professionals, how they experience this, and how we can improve it, to help to buffer against some of the factors possibly leading to placements breaking down.

The overall professional support offered to LAC and their carers varies across services provided locally, nationally and internationally (O’Cillín, 2022). Some services work with carers and people around the young person, some work with the young person directly, and some combine both approaches. Some approaches may use a consultation model, some are solely training for foster carers, and some may involve direct mental health intervention with the young person. Several of these approaches are discussed by carers within this review.

Currently, there are reviews of LAC’s experience of support from mental health and social care professionals (Aslam, 2012; Curtis et al., 2018), and a review regarding LAC and carers’ experiences of seeking mental health support and the potential barriers to this (Powell et al., 2021).

However, there remains a paucity of reviews focusing on carers’ experiences of working alongside professionals to support the young person in their care. Approaches to

support for LAC often involve consultation, advice, guidance, and possible psychoeducation provided to carers by various professionals and services. There are also regular (at least six monthly) multi-agency meetings called 'LAC Reviews' in the UK where the young person (if appropriate), the carer, the social worker, and Independent Reviewing Officer (IRO), and other professionals involved in supporting the young person and carer, review the young person's health care, education, and emotional wellbeing, and ensure that actions are followed up.

Carers play a vital role in supporting and maintaining the wellbeing of LAC in their care, as well as acting as a "bridge" between health and social services, they provide regular updates on the young person's presentation, attend meetings, provide professionals with detailed insight into the young person and may support young people to interact with professionals.

There are key differences between those providing foster or kinship care and those providing residential care. Those providing foster care or kinship care do so within their own home compared to specialist facilities such as residential settings. Foster and kinship carers support LAC alongside their own family and daily routines. Foster and residential carers both receive payment for their roles whereas a kinship carer will not. However, a kinship carer will likely know the child prior to agreeing to support them.

Those working within residential settings are more likely to receive professional supervision, research suggests this is something foster carers feel they should also receive regularly, but have less regular access to (Donachy, 2017).

Key concerns of carers supporting LAC are risk-related behaviours, such as self-harm (Harkess-Murphy et al., 2013) or aggression/violence (Sempik et al., 2008). These

presentations may be difficult for carers to safely manage without direct support from professionals and may also impact the mental health and well-being of carers themselves (Khoo & Skoog, 2014).

As above, young people within the care system may struggle with their emotional, social, and mental health needs, have likely experienced significant trauma, and may engage in risk-related behaviours, often as a way of coping or seeking support. The impact of caring for a young person who has experienced significant trauma is well documented within the literature around trauma-informed care, such as vicarious traumatisation (Hannah & Woolgar, 2018), carer burnout (Hitchiner, 2021) and blocked care (Casswell et al., 2014). Regarding blocked care, this is important to consider in terms of carers' ability to continue to be emotionally available to the young person they are caring for. Previous research has suggested when carer emotional wellbeing is acknowledged and supported, it can lead to "positive working practice[s]" (Burbidge et al., 2020).

Literature reviews involving carers of LAC tend to focus on their views of outcomes of mental health support (Blythe et al., 2014), views on support needs of young parents leaving care (Gill et al., 2020) or potential impacts of stress and how this contributes to burnout for foster carers (Adams et al., 2018). The conclusions drawn from these reviews may support service planning and delivery for LAC, but do not focus on what aspects of this support were helpful. Nor did these reviews consider the other forms of support LAC and their carers regularly receive, and their experiences of working with professionals. To better consider how professionals and services should work with, and alongside, carers to support LAC, a systematic review of the qualitative literature available is required.

A key feature of this review currently absent from available literature is its focus on multiple carer groups who provide in-home care and residential care. This is important to consider as each of these groups has their own context and resources. Including foster and residential carers within this review allows for a better insight into the similarities and differences within these carer groups. This is valuable to professionals working within LAC population groups as they may work with both carer groups within their roles and findings of this review may support professionals to address the individual needs of each carer group.

Initially this review was to include kinship carers, foster carers, and residential carers, however due to the lack of research in this area around kinship care, the review will focus solely on foster carers and residential care workers (referred to as “carers” throughout the review).

This review will focus upon how carers experienced working with, and alongside professionals when providing support for the young person in their care.

Within this review “support” will be defined as input offered to LAC and their carer from professionals, aiming to improve overall psychological, emotional, and behavioural well-being of the young person. This will include direct interventions with LAC such as talking therapies, indirect interventions such as consultation meetings, review meetings, psychological formulations, care planning meetings, psychoeducation, or contributing to the information gathering process, through discussions or assessments carried out by professionals.

The term “professionals” will be defined in this review as those employed to provide health and social care support to the LAC, this will include social workers, services, psychologists, mental health workers or physical health workers.

This review will also consider how carers experienced working with professional services to support the needs of the LAC in their care, how they experienced this process, their role within it, what support they feel they needed to carry out this “support” and the barriers to this.

This review is relevant to clinical psychology as it may support development of deeper insights into support for carers of LAC, which may enable them to contribute more to and feel more confident regarding multi-agency working. Thus, this may support carers’ ability to continue their caring role and meet the needs of LAC long-term.

The primary research question of this review is:

- What are the experiences of carers of looked after children of working with, and alongside, professionals to provide support for the children in their care?

The question will be addressed using meta-ethnography to synthesise qualitative research identified using systematic search techniques (Noblit & Hare, 1988). Meta-ethnography allows for synthesis of qualitative data, enables interpretation of qualitative data across multiple studies and may support potential development of models of care better suiting the needs of this identified population group (Atkins et al., 2008).

## Method

To support reporting Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed (Page et al., 2021). In terms of presentation, guidance was sought from France et al 2019a, which highlighted methodological issues regarding transparency and accuracy of several reviews claiming to use meta-ethnographic approaches. It was felt these guidelines would support “completeness and clarity” of meta-ethnography reporting within this review (France et al., 2019a).

A literature search was conducted in April 2023 within the following databases: Psychinfo, Medline, The Cumulative Index to Nursing and Allied Health Literature (CINHAL), SOCindex and Child and Adolescent developmental studies. These databases were chosen as they contained articles from a range of disciplines involved in the review’s topic area. No restrictions were placed on publication date. Limiters were placed on searches within each database to ensure carers of young people aged under-18 were identified. Those aged over 18 are considered legally adults within the “Conventions on the rights of a child” (United Nations, 2002). Eighteen is also the upper age limit for a young person remaining in care of the state within the United Kingdom (UK).

Search terms were developed in a multi-step process. Currently, the often-preferred clinical term to identify this population group is “care-experienced young people”. However, the term “Looked after Child” was chosen as this is a frequent term used within research, so would better meet the review’s aims. The term LAC is also used throughout this review to better reflect the language choices of the included studies and support access to this review, by using prevalent language within this topic area. This term was tested via scoping searches within each database and via the “APA thesaurus of psychological terms index”. This

produced additional terms included in database searches, highlighted in Table 1. This process was repeated for the terms “carers”, “support and “experiences”.

Once search terms were developed, they were combined into a single search, in searches of titles and abstracts within each database using the search-combine feature. Boolean operators “And”, “OR” were used to add additional terms. This produced the search strategy presented in Table 1.

**Table 1. Search Terms produced for each database.**

Original term chosen	Search Query developed
Looked after children	(DE “Looked after children”) OR TI (“Foster care” OR “LAC” OR “Child in Care” OR “CIC” OR “out of home care”) OR AB (“Foster care” OR “LAC” OR “Child in Care” OR “CIC” OR “out of home care”)
Carer	(DE “carer* OR “Foster*” OR DE “Caregivers” OR DE “Home Care Personnel” OR TI (OR care worker* OR care-worker* OR kinship* OR Support* OR Staff* OR paid carer OR Home care* OR Residential* OR Support* OR counsellor* OR (foster N3 parent*) OR AB (care worker* OR care-worker* OR counsellor* OR (foster N3 parent*))
Support	(DE “Support*” OR TI (“multi-professional working” OR DE “Systemic” OR DE “System*” OR DE “Services” OR DE “Team” OR DE “Multi-agency*” OR DE “Multi-disciplinary*” OR DE “Professionals” OR DE “Clinicians” OR DE “Mental health” OR DE “Psychiatr*” OR DE “N3 Therapist” OR DE “Social services” OR DE “Psycholog*” OR DE “Counsell*” OR DE “Social work*” OR DE “Partnership Working” OR DE “Consultation” OR DE “Guidance” OR DE “Review*” OR DE “LAC Review” OR DE “Supervision” OR DE “Care planning*” OR DE “ Risk

assessment" OR DE "Formulation" OR DE "Help-seeking" OR DE "Training" OR DE "Brief Interventions" OR DE "Caregiving" OR DE N3 interven\* OR N3 treatment\* OR therap\* OR support\* ) OR AB ( "Support\*" OR DE "Systemic" OR DE "System\*" OR DE "Services" OR DE "Team" OR DE "Multi-agency\*" OR DE "Multi-disciplinary\*" OR DE "Professionals" OR DE "Clinicians" OR DE "Mental health" OR DE "N3 Therapist" OR DE "Psychiatr\*" OR DE "Social services" OR DE "Psycholog\*" OR DE "Counsell\*" OR DE "Social work\*" OR DE "Partnership Working" OR DE "Consultation" OR DE "Guidance" OR DE "Review\*" OR DE "LAC Review" OR DE "Supervision" OR DE "Care planning\*" OR DE " Risk assessment" OR DE "Formulation" OR DE "Help-seeking" OR DE "Training" OR DE "Brief Interventions" OR DE "Caregiving" OR DE N3 interven\* OR N3 treatment\* OR therap\*)

Experiences (DE "Qualitative Measures" OR DE "Qualitative Methods" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis") OR TI (experience\* OR opinion\* OR feeling\* OR view\* OR qualitative) OR AB (experience\* OR opinion\* OR feeling\* OR view\* Or qualitative)

Titles and abstracts of studies produced from searches were screened using inclusion and exclusion criteria, identified in Table 2.

**Table 2. Inclusion and Exclusion criteria for studies screened.**

Inclusion Criteria	Exclusion criteria
Article is written in the English language.	Unpublished dissertations or book chapters
Article is Peer-reviewed	
Identified Qualitative approach and analysis method. Includes mixed-method studies with clearly identified qualitative aspect to support identification of first, second and third order constructs.	Used Quantitative methods only  No clear definition of qualitative approach taken, or analysis used. As this may have impacted the quality of the meta-ethnography of the review as a true qualitative approach may not have been used
Identified focus of the experience of carers receiving support offered to a young person with the aim of improving the overall psychological, emotional, and behavioural well-being. This includes direct work carried out with the young person, indirect work carried out with carers or a combination of these approaches via talking therapies, group work, psychoeducation, supervision, review meetings, consultations and support via meetings or updates regarding the young person from services and professionals.	How carers feel they are able to manage the support needs of the people they care for without the use of professionally recommended interventions. As this excludes the role of the professional in this care  How carers experience solely informal support, such as from fellow carers, family, or friends. As this does not included perspectives on professionals input on this support
Involved interviews, including those conducted one-to-one and those conducted within focus groups.	No form of interview used or opinions gathered through the use of closed question surveys. This would have impacted the quality of the meta-ethnography as it would have impacted the

quality of the synthesis. The use of surveys may have limited the responses of the participants meaning their true experience may not have been represented though data being collected in manner.

Participants included carers of "LAC" This included Foster carers, paid members of staff and kinship carers. To allow for identification of similarities and differences of experiences across both carer groups caring for the same population group (LAC).

Qualitative analysis did not differentiate the views of carers from participants of other groups e.g. mental health professionals' adoptive parents, birth parents, experiences of young person themselves or other professionals. As accurate synthesis of carers perspectives would not have been possible when developing third order constructs

Membership of carer group and number of participants belonging to this group not clearly identified i.e. foster carers = N, kinship carers = N and residential staff = N. As quality of the synthesis may have been impacted and prevented any differentiation between the perspectives of the two groups

Involved experiences, and views of how carers found working alongside mental or physical health professionals or social services, at some time to support the care needs of the young person. Either through contributing directly or indirectly to the

Experiences regarding an identified training package for care e.g. carers' experiences of physical restraint intervention. As this would have limited discussions to the specific context of the training

development and application of this care  
for the young person

Involved carers experiences of what aspects  
of professional support they feel is valuable  
to them in their role as a carer

Included young people not currently identified  
as "LAC". As these groups were not the focus of  
the review

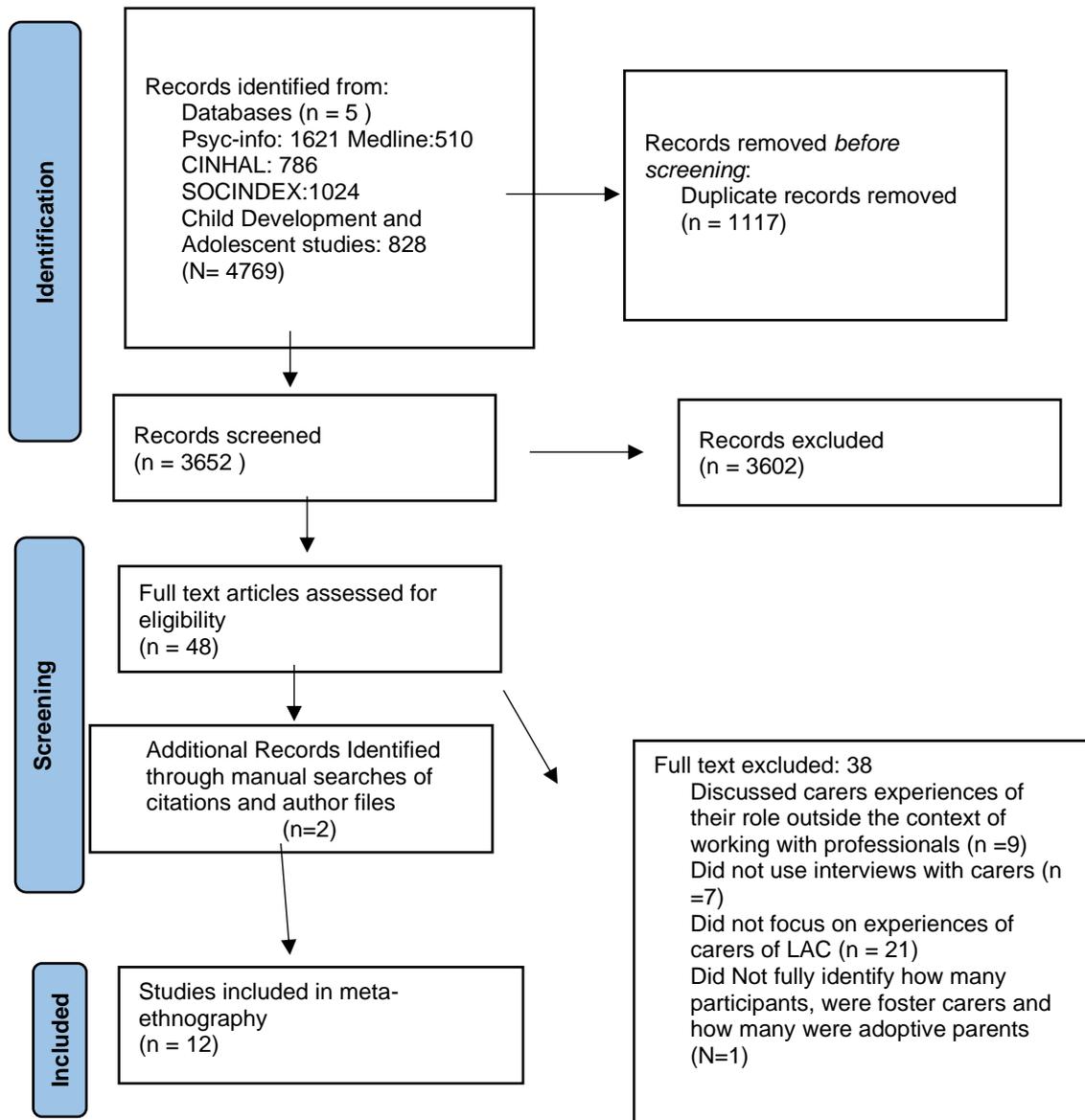
Experiences of the outcomes of interventions  
reported only. As this would not have included  
perspectives of working alongside professionals  
and would have instead focused on the specific  
intervention used

Experiences of measures of assessment tools  
used by professionals.

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The PRISMA procedural steps are represented in a PRISMA diagram (Figure 1).

Figure 1. PRISMA Diagram



Studies meeting inclusion criteria were screened via review of full text articles. After review of fifty articles meeting inclusion eligibility, twelve studies were identified as appropriate and included for analysis. A summary of these twelve papers is provided within Appendix 1-A. The studies included focused on views and experiences of foster and residential carers, no studies including kinship carers reached criteria for inclusion.

### **Data quality appraisal**

The Critical Appraisal Skills Programme (CASP) qualitative checklist (Critical Appraisal Skills Programme, 2018) was used to assess study quality. This checklist has been recommended for reviews using meta-ethnography within healthcare literature (Campbell et al., 2011; Sattar et al., 2021). This checklist contains ten questions answered “Yes”, “No” or “Can’t tell” and includes three categories: “Are the Results valid?” “What are the results?” and “Will the results help locally” (See Appendix 1-B).

A quantitative score was assigned to responses to the ten questions to support quality review (Yes-3, Can’t tell-2, No-1). This allowed a “Total score” from the CASP qualitative checklist. This approach was originally developed by Duggleby using the CASP to review literature quality for their systematic review (Duggleby et al., 2010). This allowed papers a total score out of 30, scores were split into “low quality” (papers scoring equal to or less than 15), “Moderate Quality” (papers scoring 16-23) and “High quality” (papers scoring 24-30). It was considered this approach may privilege methodological strength of studies rather than development and strength of conceptualisation of information. However, there is currently no empirical or recommended guidance for reviewing studies’ “conceptual strength”(France et al., 2019a), so it was felt that the chosen approach would still allow for the quality of chosen studies to be assessed. The CASP tool was also used to

identify if any papers needed to be removed from the review due to being rated as “low quality”. These studies would have been removed due to the possibility of impacting the overall quality of the review. Studies reaching “moderate quality” would be retained but methodological concerns would be considered as part of the review’s analysis process.

Critical evaluation of the twelve papers highlighted both strengths and potential weakness (See Appendix 1-C). The papers chosen highlighted their method of qualitative analysis, however in many, more detail into how the approach was carried out and why it was chosen over other possible qualitative approaches was lacking, for example consideration of Interpretive Phenomenological Analysis (Smith, Flowers & Larkin, 2021) as a potential approach could have been explored in more detail within the papers. Overall, each included study reached a rating of “Moderate” to “High” from the CASP. Meaning no further studies were removed at this stage.

The CASP tool identified potential issues regarding how rigorously the relationship between researcher and participants was considered in eleven out of twelve included papers. Within Evans’ (Evans et al., 2011) study however, this was highlighted and considered clearly, it was noted to participants that the researcher’s clinical supervisor was part of the research as well as having a key role in participants’ day-to-day work. As other studies involved external researchers the impact of this lack of consideration was reduced.

Overall, more detail regarding ethical considerations could have been made due to the sensitive nature of topics discussed. Evidence suggests these discussions can impact on carers of LAC’s wellbeing (Rock et al., 2013).

## Analysis

Once the twelve studies meeting inclusion criteria were identified and re-read in full, a document was created containing information for each study including, interview format, study aims, and key concepts developed. The use of a meta-ethnography approach (Noblit & Hare, 1988) remained the appropriate approach for this review due to the richness of the data in the chosen papers and their use of broadly similar interview based qualitative methods, rather than surveys or documentary analysis. Comparisons were made to determine “how the papers were related” both reciprocally and refutationally (Noblit & Hare, 1988). Initial thoughts regarding how papers related to the review’s aims were also noted.

Once this was completed, a further document was created containing initial concepts identified by the reviewer within each paper. To support this stage, Britten et al.’s (2002) approach to meta-ethnography, using first and second order constructs was applied to better identify different constructs within each paper. First order constructs are defined as participants’ direct quotes and second order constructs were defined as authors’ interpretations of data.

Both first and second order constructs were analysed together, as participant quotes are often used to support development of second order constructs (France et al., 2019b) it was thought that analysing these constructs together would enable a clearer description and understanding of their development, this is also a recommended approach for improving quality of meta-ethnography by France et al (2019a). This process aimed to support the stage of “translating the studies into one another”.

As recommended by France et al. (2019a), second order constructs were not just identified from listing concepts within results sections of each study, which may result in “primary study context being lost”. Instead, concepts developed within each section of the papers were noted to better articulate second order constructs. For example, within York’s (2017) study, second order constructs were identified within the context of information given regarding the research team and their reflexivity. In this section, York identified their prior working relationship with some participants, which helped to identify second order constructs related to the concept of “supervision”. York et al. noted this as a key aspect of their role outside of the research. This process also ensured this meta-ethnography followed the original guidance of Noblit and Hare regarding reading papers and noting “concepts and themes and what they tell us of the area of interest” (Noblit & Hare, 1988).

Once participant quotes and second order constructs were identified, they were reviewed to begin the process of synthesising translations. This involved creation of a list of first order constructs, second order constructs and alongside this, following Britten et al’s process, initial third order interpretations. Third order interpretations are concepts developed by the reviewer to represent the first and second order constructs of included studies. These third order interpretations were adjusted as each paper was reviewed to ensure that terminology used remained faithful to the original studies. For example, one initial third order interpretation was the idea of stigma of being a carer; however, it was felt this interpretation could be better represented as the concept of a “lack of respect”. The original quotes that resulted in the idea of “stigma” being developed were reviewed and it was felt that these quotes were reciprocal with the idea of “lack of respect”.

To support the aim of this review to provide insight into differences and similarities of experiences across both carer groups and support “translating the studies into one another” third order constructs were developed for residential carers and foster carers separately. These third order constructs were then compared to see which were shared across the groups and which were specific to a particular group. This allowed identification of which aspects of the newly developed third order constructs were of most relevance to each carer group.

This process resulted in development of four original themes, represented in Appendix 1-D. Overall, the relationship between the studies and the four original themes was a reciprocal one, even when a study did not contribute to the development of a particular theme.

To preserve the context and meaning of original themes within the studies, third order interpretations contained or considered language used across first and second order constructs. For example, within “Seeking to increase understanding and skills through support from professionals” each study contributing to the theme’s development contained first and second order constructs that mentioned “skill” or related to carers’ “understanding” as key constructs. Some studies also contained first order constructs relating to “direct training” however, this was not consistent, the terms “understanding”, and “skill” retained the original context and meaning more accurately.

During this process analysis was also supported through using the CASP tool. Due to the relevance of York et al (2017), this paper contributed a significant amount of first and second order data. However, because the CASP ratings highlighted the York paper’s issues regarding quality of data collection, relationships between participants and researchers and

ethical considerations, findings from this paper were not over prioritised when developing third order constructs.

## Results

### ***A need for understanding and communication with professionals.***

The theme of understanding and communication with professionals related to several aspects of carers' experiences of providing support. Carers across included studies felt one aspect of understanding related to how easily and regularly they were able to meet and communicate with the same professionals.

Foster carers highlighted their frustrations of wanting to seek support or advice from professionals but felt professionals were not contactable leading to foster carers not being able to access timely support. In Hiller et al. (2020), a participant described this as: "you have to wait and wait and wait" (Page 6). This was commented on in Murray et al.'s (2011) study: "You know, you ring the social worker, and it will take five weeks to get hold of her" (Page 153) and Samrai et al.'s (2011) study: "I was sort of having to sort of phone him to chase him for things." (Page 42).

Foster carers in Malette et al. (2020) felt when there was a lack of communication with professionals, it could lead to fear placements would break down: "It's hard to express your grievances, for fear they'll come take the kid" (Page 5). This could therefore lead to foster carers feeling unable to be open with professionals about their concerns, which may impact upon the carer-professional relationship and trust. This perhaps led to feelings of a power imbalance within their relationship with professionals, with foster carers feeling helpless or powerless when trying to access support. When discussing what would be

helpful to participants, York and Jones (2017)'s study identified professionals being available: "Someone who is always there for you, you know, at the end of the phone" (Page 18).

Included studies also highlighted carers' concerns about high turnover of professional staff, often leading to inconsistency for the child and carer and a lack of knowledge about the young person when making decisions about their care. Within Murray's (2011) study social worker turnover was highlighted, with foster carers stating the introduction of new social workers can lead to: "poor decision-making, based on insufficient knowledge of the children's histories" (Page 153). This was also highlighted in Tullberg et al., (2019) as a source of frustration for foster carers: "every time you turn around, they are changing caseworkers on them" (Page 5).

Foster carers in Jee et al. (2014) felt the consequences of a lack of communication with carers, or knowledge about the young person, meant social workers may suggest support LAC are not ready for and not consider the views of carers: "They made my foster kid go to therapy. I told them I didn't think it was a good idea" (page 549). Foster carers in Khoo et., al (2014) felt there was a lack of communication between services themselves: "Social services directed me to CYP [Child and Youth Psychiatry] and CYP directed to social services, and they can't work together" (Page 262).

Residential carers discussed understanding and communication as how professionals often placed pressure on them to be able to respond and meet the needs of LAC quickly, carers in Kor et al., (2021) noted: "they're asking us to match the placement within 24 hours and that's not giving enough time" (page 5). Some residential carers also gave examples of what can help professionals try to address some of the power imbalances that might be

present with the young people in their care, through the use of language and knowing the young person: “He can appreciate their talents and still understand that when he’s talking to them, he can’t just go off and up in the air professional talking” (Evans, 2011, page 212).

This theme highlights that lack of understanding and communication may be a barrier to what carers of LAC feel is effective care. Understanding for carers appears to relate to an adequate amount of accessible input occurring on a regular basis, with consistent professionals who know the child and listen to carers. It recognises the potential power imbalance that might play out within the carer-professional relationship, and how this might be felt by carers. It also highlights for foster carers there is often an understandable focus on frequency and availability of contact with professionals.

***Seeking to increase understanding and skills through support from professionals.***

This theme represented carers’ views regarding requests for more support from professionals to increase their level of understanding and skills to better meet the needs of young people in their care.

Foster carers highlighted feeling there is often a “step” missing when taking part in indirect interventions and professionals often give information on “how” to carry out interventions but not always on “why” that intervention is helpful, or the potential reasons behind the young person’s behaviour. Carers in Murray et al. (2011) directly requested the latter when discussing improvements professionals could make: “Training around how the behaviours occur so foster carers don’t think it’s all their fault” (page, 155). This was also requested by participants in McDonald’s (2003) study: “I needed someone to explain the behaviour” (page 828).

Participants in McDonald's study highlighted what can happen when support from professionals has increased carers' skills and understanding: "We tried new things I changed tactics explained what the behaviour was about we had more insight into psychological aspects of the child" (McDonald, 2003, page 829). This view was also expressed by foster carers in Hollett et al. (2022) in the context of increasing understanding: "I understand so much more now. I understand why these children behave like they do" (Page 425). Participants in Tullberg et al. (2019) felt that training and support around understanding should be continuous: "it's an ongoing thing. We're still learning" (Page 4).

Some foster carers felt that information was difficult to access from professionals because of their other commitments. For example, participants in Samrai et al. (2011) stated: "It's difficult for a carer, with young children, because it's not as easy to get the training that they offer." (Page 41). Some foster carers often sought out support from other foster carers: "That's where we get most of our ideas and training" (Hiller, 2020, page 7). Foster carers in Malette et al. (2020) noted a lack of training regarding unique contexts of foster carers such as adjustments in the foster carers' relationships: "there's definitely nothing in there about when you're bringing someone else into the relationship" (Page 4). Participants in Hiller's (2020) study highlighted how failure to explain why an approach has been taken can result in foster carers viewing the whole model negatively: "There's nothing wrong with them, it's attachment. They love to throw attachment absolutely everywhere." (Page 7).

This theme was a focus of discussion for foster carers and was not discussed by residential carers, which is important to consider when reviewing different needs of LAC carer groups. Residential staff may have more access to training, consultation, and

resources to increase their knowledge as this is often defined as part of their role. It appears foster carers must actively request support around increasing their understanding or skills, a source of frustration for foster carers “it shouldn’t be a system where you have to ask”

(McDonald, 2003, page 831)

It appears foster carers may have the greatest need for additional support regarding accessing information and further consideration is required from professionals regarding how information is presented to this group.

### ***The impact of support on feelings of confidence or inadequacy***

This theme represents carers’ perceptions of the emotional demands they face as carers and both professional and peer support can impact upon their feelings of confidence in caring for the child or can lead to them feeling deskilled and inadequate.

Many carers highlighted their overall wellbeing was connected to the LAC’s wellbeing. Participants in Kor et al., (2021) noted difficulties some residential staff had on coming away from the role: “you have to switch off. It’s so hard though” (Page 7). Foster carers in Hiller (2020) noted the impact of LAC’s experiences on carers, through hearing and being a part of their experiences: “You feel absolutely everything that [the child experienced], and that is horrible” (page 7). Foster carers in Jee et al., (2014) noted their concerns that people in their community would see them struggling to cope and think negatively of them: “they’re going to think I’m crazy and they live down the block from me” (Page 548).

Both carer groups highlighted the type of support they are offered is important, as if this is done in a way that they feel is unhelpful, it could lead them to feel deskilled, and that

other people do not feel that they are able to care for their child adequately. For example, participants in Evans (2011) study highlighted how suggestions made by professionals can impact carers' sense of their ability to cope: "but you actually come away and think oh my god, I feel so lacking in some skills ... it can make you feel a bit like that, that you personally haven't got what it takes" (Page 211). Foster carers in York and Jones (2017) highlighted if carers feel they lack required skills to manage a LAC's presentation this can impact how able they feel to manage situations: "when you have new situations that are right outside of the box, that you have no personal experience of and you think how on earth do I deal with that?" (Page 18). This suggests that feeling they lack the right skills or resources can negatively affect how able to cope, or look after the child, both foster and residential carers feel.

When professional support was unavailable foster carers highlighted how they may seek out peer support and felt this type of support could be beneficial, could build a sense of connection (reducing feelings of isolation), understanding with others going through similar experiences, and belonging (which was perhaps missing for them in theme 1). Multiple foster carers reported the value of other foster carers in supporting their needs as carers and their ability to cope with the demands of caring for LAC. Foster carers in Hollett et al. (2022) felt this was a "need" for foster carers: "Foster carers should be enabled to come together to support each other" (Page 428). Foster carers in Tullberg et al. (2019) also highlighted the value in connecting with other foster carers: "as foster parents we should all be together; we need to bond somewhere" (Page 5). In Mallette et al. (2020) participants felt this shared experience supported their ability to cope: "Having someone to understand what we're going through" (Page 4). When foster carers in Khoo et al. (2014) lacked this

peer support, they reported feeling isolated and less able to cope: “So, then I had no contact at all and I didn’t have anyone to talk to either.” (Page 262).

This theme highlights how both carer groups recognised support from professionals can sometimes act as barrier rather than enhancing carers confidence and sense of skill. This appears to lead to a feeling of inadequacy, judgment, or criticism. However, carers were able to have their emotional needs regarding belonging met by other carers with shared experience. Belonging and connection can be key factors in building resilience which is felt to be a key skill needed to support traumatised young people.

### ***Not feeling like a valued part of the system***

This theme identifies both carer groups did not feel like professionals valued their input or role within the care system. Foster carers, in Murray’s (2011) study described being made to feel: “part of the problem” (page 154). Within York and Jones’ (2017) study, foster carers described believing they have knowledge about the child due to their relationship that professionals need to hear: “They don’t really know that child but they’re not prepared to listen to what the carers have to say” (page 16). This was also discussed in Hollett et al (2022): “you don’t believe they are making the right decisions; you want something different for this child” (Page 425). Participants in Tullberg et al. (2019) highlighted this as potential value foster carers had in the care process: “we hold a very important part in this picture and that they have to respect us” (Page 3).

Foster carers in Hiller’s (2020) study commented on how their concerns were often downplayed or not listened to by professionals: “oh no no, everything’s fine...” and we’re like ‘No no no, I’m with this child 24/7, you have no idea” (page 8). This was also noted in Samrai et al. (2011), participants wanted to acknowledge the young person’s

difficulties and work on a solution together: “we just thought, no, this is the difficulties they’ve got – how are we going to overcome them?” (Page 43). Participants in Khoo et al. (2014) felt when foster placements came to an end, foster carers can feel powerless and that the ending has come abruptly: “I think that it’s bad on the social services because they went and did things this way and then they dump the foster family” (Page 265).

Residential carers emphasised feeling unable to have a role in developing or contributing to support provided for LAC. Residential carers in Kor et al. (2021) highlighted their views were not considered and professionals often prioritised their own opinions even when they did not see the young person regularly: “you don’t see the kids, so how can you really make an accurate assessment?” (Page 7). Residential carers in Evans et al. (2011) study felt they were often unable to speak because a sense of a power imbalance: “I’ve been involved in things, and you feel like you’re not able to say or give your opinion because you don’t know these people and you don’t feel comfortable with challenging what they’re saying” (page 212).

In contrast to other studies in the review, foster carers in McDonald (2003) provided examples of efforts made by professionals to acknowledge their contribution when supporting LAC’s needs: “the personal contacts were excellent, spoke to me as a fellow professional there’s no us and them” (page 829). Participants in this study highlighted when professionals made them feel like equals and prevent a sense of a divide between the two groups, they felt more confident in themselves and able to support the young person’s needs.

This theme represents a sense that residential and foster carers feel separated from the support process, that their knowledge is ignored or dismissed, and not valued or

respected, which they believe has a negative impact upon the overall care of, and decisions made around, the child.

### **Discussion**

Experiences of support for LAC have previously been researched from the perspectives of professionals providing mental health support and LAC receiving it (Newbold et al., 2013; Rye et al., 2019). Past systematic reviews regarding mental health support have also focused on perspectives of those delivering and developing this support (Chester et al., 2016; Shahmalak et al., 2019). However, this review is the first to consider carers experiences of working with, and alongside, professionals and services to support the child in their care, (Residential staff and Foster Carers specifically).

This review synthesised twelve studies, developing four themes representing carers of LAC's experiences of professionals and services when attempting to meet the needs of children in their care. The first theme highlighted a lack of understanding and often communication for carers. Foster carers emphasised this as frequency and availability of professionals, whereas residential carers related this to language and approaches used by professionals. For both groups understanding also represented how much involvement they had in the process of planning and developing support for LAC. This review highlighted similarities across experiences of these carer groups, while also identifying key differences regarding what aspects of these experiences the groups were more likely to identify.

Foster carers in the review highlighted a desire for support from professionals around increasing their understanding and skills to better meet their child's needs. They noted often looking to other carers for information rather than professionals. This may

support a sense of belonging for carers when this peer support is present that they are at times missing when working for professionals.

Foster carers may not always agree with the models or frameworks being discussed or implemented by professionals. This could lead to inconsistent care being provided across the adults caring for the child. Therefore, it is important that professionals work with foster carers to create a shared understanding and ensure consistency within the therapeutic approach taken.

That this theme was developed from perspectives of foster carers only and was not represented in residential carers experiences requires further exploration, particularly as previous research with LAC has directly identified a sense that some residential carers do not have a detailed awareness of LAC's mental health needs (Holland et al., 2020; Johnson et al., 2017; Rouski et al., 2020).

Both carer groups discussed how they attempt to cope with the complexities that arise, both emotionally and practically, while providing support for LAC's needs. Key similarities included when professionals made carers feel deskilled by discussing approaches, they had no awareness of carers felt less confident in their ability to provide care and to cope with the needs of their child.

A key experience for foster and residential carers with the review was "Not feeling like a valued part of the system", highlighting how both carer groups often feel their views and perspectives are not valued. Carers felt they had much to contribute via their own skills and relationships with the young person, that often was not respected or was felt to be ignored by professionals. Carers also spend large amounts of time with the child compared to professionals who then make large decisions around their care and treatment. Carers also

identified that professionals may sometimes approach working with carers in a manner that causes carers to feel unskilled and powerless, and therefore less able or willing to speak out in the future. It was also acknowledged by some carers that there was a fear of speaking out in case they were judged, or this would lead to decisions that could end the placement.

This review highlights both foster and residential carers at times feel disconnected from the support that is offered to the young person in their care, and feel it meets neither their nor the young person's needs. Considerations must be made regarding carer groups' current levels of knowledge, available support, and available resources, before recommending support.

What is highlighted within this review is carers currently have issues with how they are spoken to, in terms of the language used, how they are left feeling by working with professionals and the frequency with which they can speak with professionals. Previous research with LAC themselves has also highlighted their own requests for more regular and consistent dialogue with professionals (Quarshie et al., 2020). Overall, there is an identified need from both carers and LAC for detailed consideration regarding how professionals approach contact and communication when providing support.

A key experience for carers in this review was a feeling of a disconnect between carer and professionals regarding when support is required. This links to theme of "carers not feeling a valued part of the system" as carers feel their concerns are not being respected. It may be of benefit for services to aim to provide a shared sense of understanding, created jointly by carers and professionals, of the young person and their individual needs, this could be done through both consultation and formulation meetings which carers are already familiar with. In McDonald et al (2003) carers were considered as

part of the team and as a fellow professional on occasion, suggesting support around increasing carers sense of being part of a team of professionals is valuable. This could be achieved by asking carers opinions, considering their views, making sure that they are involved in decision making and are in agreement with the care plans/treatment suggested.

That the theme “not feeling like a valued part of the system” was prevalent for both carer groups across the studies requires further reflection and consideration by professionals. Currently carers feel their knowledge is not being valued by professionals or in some cases is being outrightly dismissed in favour of the models used by professionals. Professionals may approach this issue by considering information carers have regarding the LAC in more detail. Then, ensure their views are represented at each stage of the support process by inviting them to professional meetings or, if they are unable to attend, supporting them to provide statements regarding their views. This process may then provide carers with detailed, accessible outcomes and rationale for decisions made during these meetings.

This review has identified overall, carers of LAC often experience the support process negatively, and feel that they are not valued, respected, or given the right level of support at the right time by professionals. This is also reflected in the literature regarding LAC’s experiences of working with professionals for their mental health needs (McAndrew & Warne, 2014). However, both carer groups within this review highlighted which aspects of the support process had been helpful and, in some cases, left them with: “A sense of relief...what a difference” (McDonald, 2003, page 830).

## **Strengths and Limitations of the Review**

That this review contains perspectives of both foster and residential carers of LAC is a first within the literature and a strength of this review. Considering perspectives of both carer groups has allowed for key differences between these groups to be identified which may support professionals to be aware of the unique perspectives and needs of each group when supporting LAC in their care. However, this review contained several more studies regarding foster carer views than residential staff meaning perspectives of foster carers may be overrepresented. This is particularly relevant for the theme “seeking to increase understanding and skills through support from professionals” which was not discussed by residential carers in the included studies. This review also intended to include perspectives of kinship carers, however no studies including kinship carers met inclusion criteria meaning their perspectives were not represented.

## **Cultural Considerations**

The way in which services for LAC operate differs across countries, particularly across the Global North and Eastern European countries. Within Eastern Europe there is often less formalised support for children in care. Eastern European countries are more likely to provide support using kinship carers, who were not represented in the review, or residential homes. Within some countries LAC may be supported within “orphanages” or “baby homes” during their entire childhood (Garcia Quiroga & Hamilton-Giachritsis, 2017; Vashchenko et al., 2010). Also, those studies that were chosen for review were carried out in the Global North meaning this review did not contain perspectives from carers within African or Asian countries.

## **Implications and Future Research**

This review has highlighted several consistencies between the experiences of two LAC carer groups. When given opportunity to discuss their experiences regarding working with professionals and social services, carers of LAC within the review often felt the experience was a negative one that left them feeling frustrated, unheard, and unskilled.

The themes developed in this review may also be considered in the following pathway. Carers would like access to support that increases their understanding and skills, and when they feel they are not being heard, respected or that their views are not being considered it may impact negatively on carers' perceptions of their ability to "cope" with the needs of the LAC. With the result of this experience being that the carers do not feel like a "valued part of the system".

These findings can be implemented into professionals' practice by meeting regularly and consistently with carers as part of the support process and actively considering if carers are being consistently involved in the process, feel connected to those offering support and if efforts have been made to provide accessible information regarding the "How" and "Why" of support offered. Professionals need to maintain a sense of curiosity when working with carers in the sense that carers views are not just heard but explored in detail to obtain a better understanding. This may allow carers to feel they are not just being told what is going to happen which increases feelings regarding a power imbalance between themselves and professionals.

Practically, this could be achieved by holding regular and planned meetings, with carers during the support process, discussing if the carers feel their own needs are being met and if they feel the current support is accessible. This may provide carers with opportunities to discuss their needs, to ask questions, provide their own input, pass on information, and better understand the support recommended. Disagreements with carers can be considered in a compassionate manner by professionals spending time to explain why an approach has been chosen and respecting the views and opinions of the carer.

Training for professionals is required to support them to consider communication adaptations that can be made to ensure a joint understanding with carers. This may be further expanded upon by incorporating carer views into training for professionals, about what it can be like to work with the system/professionals, what helps and what does not.

For clinical psychologists specifically, this review highlights when working with carers of LAC clinical psychologists need to be more flexible within their own approach to interactions with carers and need to ensure they are not overly prioritising a single theoretical approach. A failure to do so may prevent carers from connecting to or buying into an approach, meaning the quality of care and support provided may be reduced.

Future research needs to consider perspectives of carers of LAC, regarding their experiences of both working alongside professionals and of supporting LAC, in more detail. This may be achieved through further qualitative research aiming to develop insight into how this experience impacts them, what they feel works when supporting LAC and what they feel are key skills. Also, it may be valuable to explore how carers build relationships with the LAC they support; it has been suggested previously that LAC accessing services find

the relationships they build with professionals a key part of the support process (Hassett & Isbister, 2017; Iyengar et al., 2018).

Overall, this review has highlighted that research regarding carers of LAC is currently limited and further exploration of experiences, needs and views of this group is required.

### **Conclusion**

This review highlights clear issues requiring consideration regarding carers of LAC's experiences working alongside professionals to provide support for LAC. It recognises how important carers are in terms of ongoing, daily support for LAC, and how they feel they are not always valued or respected within wider professional groups. The findings of this review may be valuable in considering how to build more positive relationships between carers and professionals, which may lead to better outcomes for the children in their care.

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**Appendix 1-A: Details of studies included for analysis.**

Study	Country	Study Aim	Sample	Data Collection Method	Type of Qualitative analysis used
(Evans et al., 2011)	UK	Evaluating care staffs' perceptions of their experience of psychological consultation within a mental health setting	6 participants, residential care staff	Semi structured interviews 6 individual interviews	Thematic Analysis
(Hiller et al., 2020)	UK	To understand how carers support the emotional needs of the young people in their care and their views on barriers and opportunities for support.	21 Foster carers	3 Qualitative focus groups	Thematic Analysis

(Hollett et al., 2022)	UK	Developing an explanatory theory and model of the processes involved in fostering looked after children and the relationship between the roles of parent and professional	10 Foster carers	Semi-structured interviews	Grounded Theory	1-45
(Jee et al., 2014)	USA	Perspectives on mental health treatment experiences and expectations for youth in foster care and their foster parents	33 participants 14 LAC 19 Foster carers	Semi-structured interviews	Thematic Framework approach	

(Khoo & Skoog, 2014)	Sweden	Foster parents' experiences of the events surrounding the unexpected ending of a child's placement in their care	8 foster parents	Semi-structured interviews	Interpretive phenomenology
(Kor et al., 2021)	Australia	Barriers experienced by residential care practitioners when implementing therapeutic care	26 Residential care practitioners	Semi-structured interviews	Framework Analysis

(Mallette et al., 2020)	USA	An exploration of the informal and formal support needs of foster caregivers	12 Foster carers	3 Focus groups	Thematic Analysis
(McDonald et al., 2003)	UK	To determine foster carers' experiences and perceptions of interventions carried out within a bespoke service	10 Foster carers	Semi structured interviews	Thematic Analysis

(Murray et al., 2011)	New Zealand	Foster carers' perceived need for support and training when working with professional services.	17 Foster carers	Semi structured interviews	Domain Analysis
(Samrai et al., 2011)	UK	Foster carers' experiences of placements and placement support, including their views of current services.	8 Foster carers	Semi structured interviews	Grounded Theory

(Tullberg et al., 2019)	USA	To explore different aspects of therapeutic foster carers experiences and identify ways in which they need support to carry out their role.	75 Foster carers	6 Focus groups	Thematic Analysis
(York & Jones, 2017)	UK	To elicit views of foster carers regarding the mental health needs of young people in their care and their experiences of accessing mental health services	10 Foster carers	Semi structured interviews	Grounded Theory

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**Appendix 1-B. Questions contained within the CASP qualitative checklist.**

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Question (Q)

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Q1: Was there a clear statement of the aims of the research?

Q2: Is a qualitative methodology appropriate?

Q3: Was the research design appropriate to address the aims of the research?

Q4: Was the recruitment strategy appropriate to the aims of the research?

Q5: Was the data collected in a way that addressed the research issue?

Q6: Has the relationship between researcher and participants been adequately considered?

Q7: Have ethical issues been taken into consideration?

Q8: Was the data analysis sufficiently rigorous?

Q9: Is there a clear statement of findings?

Q10: How valuable is the research?

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### Appendix 1-C. CASP Scores of Identified Papers

Study	CASP Score Question 1	CASP Score Question 2	CASP Score Question 3	CASP Score Question 4	CASP Score Question 5	CASP Score Question 6	CASP Score Question 7	CASP Score Question 8	CASP Score Question 9	CASP Score Question 10	Total Score on CASP
(Evans et al., 2011)	2	3	2	3	2	3	1	2	3	3	24
(Hiller et al., 2020)	3	3	2	2	2	1	1	3	3	3	23
(Hollett et al., 2022)	3	3	3	2	3	1	2	3	3	3	26
(Jee et al., 2014)	3	3	2	3	3	1	1	2	3	3	24
(Jennings & Evans, 2020)	3	3	2	2	2	1	1	2	3	3	22
(Kor et al., 2021)	2	2	3	2	2	1	2	2	3	3	22
(Malette et al., 2020)	3	3	2	2	3	1	1	1	3	3	22
(McDonald et al., 2003)	2	3	2	2	2	1	1	2	1	2	18
(Murray et al., 2011)	3	3	1	3	1	1	1	2	2	2	19
(Samrai et al., 2011)	3	3	2	2	2	1	2	3	3	3	24
(Tullberg et al., 2019)	2	2	2	2	2	1	1	2	3	3	20
(York & Jones, 2017)	3	3	3	2	2	1	2	2	3	3	24

**Appendix 1-D. Initial themes developed across original studies.**

Paper	A need for understanding and communication with professionals. (10 out of 12 papers)	Seeking to increase understanding and skills through support from professionals. (7 out of 12 papers)	The impact of support on feelings of confidence or inadequacy (10 out of 12 papers)	Not feeling like a valued part of the system (10 out of 12 papers)
<b>Evans, 2011</b>	X		X	X
<b>Hiller, 2020</b>	X	X	X	X
<b>(Hollett et al., 2022)</b>		X	X	X
<b>(Jee et al.,2014)</b>	X		X	
<b>(Khoo et al.,2014)</b>	X		X	X
<b>(Kor et al., 2021)</b>	X		X	X
<b>(Malette et al., 2020)</b>	X	X	X	
<b>Mc Donald, 2003</b>		X		X
<b>Murray, 2011</b>	X	X	X	X
<b>York and Jones, 2017</b>	X		X	X
<b>Samrai et al 2011</b>	X	X		X
<b>(Tullberg et al., 2019)</b>	X	X	X	X

**Appendix 1-E. Data Analysis Table Example (York and Jones, 2017)**

Concept	First Order Constructs	Second Order Constructs	Third Order Constructs
A need for connection and communication with professionals	<p>“At times of change there is a risk that children can fall through the net.....There should be a bridge between CAMHS services in different areas – a good handover –not struggling in this grey quagmire of nothingness”</p> <p>Having a good support worker – that’s brilliant. You know you’ve got someone who is always there for you, you know, at the end of the phone. Especially if you’ve got difficult children</p> <p>The foster carers also explained that sometimes the young people themselves disengage from the service and stop attending and as a consequence, they get lost in the system and are not followed up</p> <p>After the assessment there was a change in professional – the girl didn’t go back.....they lost her.....you can lose a teenager by turning him or her over to someone else.....For this girl her story was horrific to start with and she says she didn’t want to relive it with somebody else. It was bad enough doing it the first time</p> <p>“Straight forward process. [The] referral was made, appointment arrived followed by an interview and assessment”</p> <p>“[I] would use it for other children. Smooth and straightforward [referral process].... Did not have to wait long for appointment”</p>	<p>Times of transition were highlighted by the foster carers as being especially difficult, for example a move to a new CAMHS service in a new area, a new school, foster care back to biological family or foster care to independent or semi-independent living. Transitions are representative of yet another change for the child and are often anxiety provoking situations</p> <p>The foster carers discussed the different kinds of supports that they access, from more professional sources to that from their peers in formal settings such as an organised group or more informally. Everyone described their relationship with their social worker as fundamental, especially through the more difficult times</p>	<p>For the foster carers experience of long waiting times for specialist assessment and long term treatments, such as psychotherapy, generated real feelings of anxiety and powerlessness.</p> <p>The importance of support for the foster carers was a significant theme in this study and was directly related by the interviewees to the viability of the placement.</p>

Impact of experience on carers emotional and mental wellbeing

All foster carers need to be able to ask for help and not feel a failure if unable to manage a particular child, otherwise you can feel very isolated.” “Mentally it can really drain you. Especially when you have new situations that are right outside of the box, that you have no personal experience of and you think how on earth do I deal with that?”

All of the foster carers expressed that having support and to be able to ask for help from an accessible point of contact is imperative to their role, which can be emotionally and physically demanding.

This study highlights how their own mental health is noted as something that carers are aware of and feel that they need to be able to take care of their own mental health to do the best job possible for the LAC. Noted that having this support is invaluable to their role.

Not feeling like a valued part of the system

“As a Foster carer you have this child 24 hours a day – you know the child – they [social worker] come and see them once every six weeks. [...] They don’t really know that child but they’re not prepared to listen to what the carers have to say.”  
 “We’re everything to that child: we’re a mother, we’re a father, you know, we could be a nurse when they’re not well, you’re there looking after them, you know, you can also be a therapist to them but you’re also punch bag....and everything else, more than just a social worker, so you’d think they would listen.”

Not being listened to by professionals across the different agencies was another frustration reported by the foster carers. The foster carers expressed the view that they know the child better than most of the professionals involved, but that this is often not heard or valued. When communication is poor and professionals are perceived to be unresponsive and dismissive, then foster carers can feel frustrated, undervalued and not respected. Whereas when relationships are good, as some foster carers in our study reported, as well as in the wider literature then foster carers feel more valued and are involved in key decision-making. This perhaps in

A sense that carers own knowledge of the child is not valued by professionals. A sense that their views are not heard or listened to by professionals. A lack of appreciation for the relationship that carers have built with the LAC. At times responses from professionals can cause carers to feel that they are not valued or respected. A sense that carers feel they should be

turn promotes effective foster care with more positive outcomes for the child. included more in key decision making

The importance of support for the foster carers was a significant theme in this study and was directly related by the interviewees to the viability of the placement.

Implications for practice suggested by this study included

The foremost priority is partnership working; to work in collaboration with foster carers, acknowledging their expertise, valuing and respecting their views, listening to their experiences and ensuring their knowledge of the child they are looking after is incorporated into the child's care and treatment plan.

## Appendix 1-F . Search Strategy- Child Development and Adolescent studies database

□	S5  s1 and s2 and s3 and s4	Search modes - Find all my search terms	 <a href="#">View Results</a> (828)  <a href="#">View Details</a>  <a href="#">Edit</a>
□	S4  ( DE "Qualitative Measures" OR DE "Qualitative Methods" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis" ) OR TI ( experience* OR opinion* OR feeling* OR view* OR qualitative ) OR AB ( experience* OR opinion* OR feeling* OR view* OR qualitative )	Search modes - Find all my search terms	 <a href="#">View Results</a> (79,646)  <a href="#">View Details</a>  <a href="#">Edit</a>
□	S3  ( DE "carer" OR "Foster" OR DE "Caregivers" OR DE "Home Care Personnel" ) OR TI ( OR care worker* OR care-worker* OR kinship* OR Support* OR Staff* OR paid carer OR Home care* OR Residential* OR Support* OR counsellor* OR (foster N3 parent*) ) OR AB ( OR care worker* OR care-worker* OR kinship* OR Support* OR Staff* OR paid carer OR Home care* OR Residential* OR Support* OR counsellor* OR (foster N3 parent*) )	Search modes - Find all my search terms	 <a href="#">View Results</a> (67,988)  <a href="#">View Details</a>  <a href="#">Edit</a>
□	S2  DE "Looked after children" OR TI ( "Foster care" OR "LAC" OR "Child in Care" OR "CIC" OR "out of home care" ) OR AB ( "Foster care" OR "LAC" OR "Child in Care" OR "CIC" OR "out of home care" )	Search modes - Find all my search terms	 <a href="#">View Results</a> (4,799)  <a href="#">View Details</a>  <a href="#">Edit</a>
□	S1  DE "multi-professional working" OR TI ( "Support*" OR DE "Systemic" OR DE "System*" OR DE "Services" OR DE "Team" OR DE "Multi-agency*" OR DE "Multi-disciplinary*" OR DE "Professionals" OR DE "Clinicians" OR DE "N3 Therapist" OR DE "Social services" OR DE "Psycholog*" OR DE "Social work*" OR DE "Partnership Working" OR DE "Consultation" OR DE "Guidance" OR DE "Review*" OR DE "LAC Review" OR DE "Supervision" OR DE "Care planning" OR DE "Risk assessment" OR DE "Formulation" OR DE "Help-seeking" OR DE "Training" OR DE "Brief Interventions" OR DE "Caregiving" OR DE N3 interven* OR N3 treatment* OR therap* OR support* ) OR AB ( "Support*" OR DE "Systemic" OR DE "System*" OR DE "Services" OR DE "Team" OR DE "Multi-agency*" OR DE "Multi-disciplinary*" OR DE "Professionals" OR DE "Clinicians" OR DE "N3 Therapist" OR DE "Social services" OR DE "Psycholog*" OR DE "Social work*" OR DE "Partnership Working" OR DE "Consultation" OR DE "Guidance" OR DE "Review*" OR DE "LAC Review" OR DE "Supervision" OR DE "Care planning*" OR DE "Risk assessment" OR DE "Formulation" OR DE "Help-seeking" OR DE "Training" OR DE "Brief Interventions" OR DE "Caregiving" OR DE N3 interven* OR N3 treatment* OR therap* OR support* ) <a href="#">Show Less</a>	Search modes - Find all my search terms	 <a href="#">View Results</a> (121,280)  <a href="#">View Details</a>  <a href="#">Edit</a>

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**Section Two: Research Paper**

Steven Sulej

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Steven Sulej

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

[S.sulej@lancaster.ac.uk](mailto:S.sulej@lancaster.ac.uk)

“We’re here for these kids, but we’re here for each other as well”: An interpretative phenomenological analysis of residential staff members’ experiences of managing self-harm with care-experienced young people.

### **Abstract**

**Background:** Self-harm behaviours have increased in recent years across adolescent populations. This is of particular concern for care-experienced/looked after young people within residential settings, who show higher rates of self-harm and higher exposure to circumstances thought to lead to self-harm than peers. Managing and reducing self-harm is of clinical relevance when supporting this group. Previous research has explored experiences of young people who self-harm living in residential care, but little research exists regarding experiences of staff providing daily care and support to young people who self-harm and how this impacts their relationships with the young person and fellow staff. The aim of this research was to develop deeper insight into perspectives of staff supporting care-experienced young people who self-harm and how they understand their own role in the context of self-harm.

**Participants:** Nine residential staff were interviewed; interviews were analysed using Interpretative Phenomenological Analysis.

**Results:** Four themes were developed: “Understanding as a road to preventing”; “The care within the control”; “A bond beyond the role”; “The conflict in the system”.

**Conclusions:** Staff supporting young people who self-harm face pressures from organisations to reduce self-harm, manage risk and maintain positive relationships with young people. Staff find the complexity of managing the duality of their roles difficult and will attempt to build meaningful relationships within their teams to support their needs. Clinical recommendations and future research are discussed.

## Introduction

Self-harm is a current and major concern for physical and mental health professionals across multiple countries. Evidence suggests self-harm may begin and be most frequent during adolescence (Nock et al., 2013), with recent reviews indicating lifetime prevalence of self-harm behaviours of between 10-20% within this population group (Gillies et al., 2018; McManus et al., 2019), with a rise of 6% world-wide indicated between 2010 and 2015 within Gillies et al.

Self-harm has been defined as: “An intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent” (RCP, 2010). This definition of self-harm was also adopted for the purpose of this study. Though self-harm takes many forms, such as cutting, head-banging, scratching, burning the body and overdoses of medication (K. Hawton et al., 2012), the most reported form for adolescents is “cutting of the arms” (Gurung, 2018; Morey et al., 2017).

Self-harm in adolescence may indicate psychosocial difficulties in later life (Borschmann et al., 2017) including issues with substance abuse and mental-health difficulties (Mars et al., 2014). Self-harm as a predictor for suicide and suicide attempts is currently unclear as research suggests self-harm in adolescents does not appear linked to suicide attempts in later life (Mars et al., 2019) but also that those who do attempt suicide are more likely to have displayed some form of self-harm initially (Duarte et al., 2020).

Research regarding functions of self-harm reports adolescents wanting a “release” from strong feelings (Gillies et al., 2018; Nock, 2009), to “regulate” thoughts and feelings (Holliday et al., 2020) or for increased sense of “control” (Stänicke et al., 2018). Some

report feeling “addicted” to self-harm (Pollock et al., 2019), some describe this as a “black hole of self-harm” (Rouski et al., 2020).

Adolescents who self-harm report several difficulties seeking support or care for self-harm, including negative experiences with professionals and services, feeling “looked down upon” and “judged” (Johnson et al., 2017). They do not feel there is focus on their needs, only the risk of self-harm (Klineberg et al., 2013). Some report feeling “intimidated and confused” by professionals and services (Bellairs-Walsh et al., 2020).

Support around self-harm is of particular concern to those defined legally and within the current research as Looked-after-Children (LAC). This is due to increased risk of both the act of self-harm (Harkess-Murphy et al., 2013) and childhood risk factors associated with self-harm (Cleare et al., 2018). These risk factors are often referred to as “adverse childhood experiences” (ACEs). Looked-after-children are thirteen times more likely to experience four or more ACEs than the general population (Martin et al., 2022). They also currently report difficulty in accessing services for self-harm and report negative experiences when they do (Owens et al., 2016).

Looked-after-children are defined in the 1989 Children’s Act as young people within the care of their Local Authority for at least 24 hours either voluntarily or as the result of a court order. The term LAC will be used within this paper to reflect the current terms used within the literature and within the UK legal system. However, the term care-experienced is preferred within this population.

As of November 2022, there are 82,170 LAC in England (UK GOV, 2022), most recent data available suggests around 14% of LAC are currently placed within residential settings (DfE, 2021). Looked-after-children within residential settings are more likely to have

emotional, behavioural and social difficulties than peers (Steels & Simpson, 2017) and may have experienced multiple placement breakdowns, which are linked to increased likelihood of mental health difficulties and self-harm (Jones et al., 2011).

Due to identified increased needs, guidance states LAC in residential settings must be supported by staff who are trained, supervised, and offered support from outside professionals (NICE, 2021). Further guidance states staff should “foster positive relationships and encourage strong bonds between children and staff in the home” as well as “meeting the emotional and behavioural needs” of the LAC they support (DfE, 2015).

However, given the complexity of supporting LAC within residential settings, alongside expectations of completing a “Level 3 Diploma in Children and Young People’s Workforce” (DfE, 2015), there are several risks to carers’ wellbeing to consider. For example, staff report expectations of the role lead to “emotional exhaustion and depersonalisation” (Brouwers & Tomic, 2016) and a “lack of personal achievement” (Barford & Whelton, 2010). Such experiences may lead to high staff turnover, which is likely to impact on LAC as they may lose those “strong bonds” these settings are aiming to provide. Length of relationship and time spent together are important factors in how LAC rate their relationships with staff (Pineiro et al., 2022).

There is also a sense of difficulty in regards to presenting as “professional” as many staff feel this term lacks consistency and may be at odds with what they feel supports a meaningful connection with young people (Levrouw et al., 2020). Staff also report difficulty in trying to manage a balance between professional and genuine care (McLean, 2015).

Supporting young people who self-harm in residential settings may add another layer of complexity for staff, as research suggests working with young people who self-harm

increases feelings of “stress” (Toftthagen et al., 2014), staff often feel “criticised” by other professionals for their approach (Jennings & Evans, 2020), and increased risk may lead staff to carry out physical restraints which may impact their relationship with the young person (Slaatto et al., 2021). There may also be an increased pressure on staff from their organisations or from their own expectations, to increase the level of care and support they offer a young person after incidents of self-harm. This can cause conflicting feelings for young people who self-harm as some appreciate this additional care, however for others this increases a sense of “guilt” (Johnson et al., 2017).

If clinical psychologists and other professionals are to effectively support LAC within residential settings who self-harm, then a deeper understanding of contexts and experiences of those who support them is needed.

Research has explored experiences of LAC supported outside of residential settings (Wadman et al., 2017) and LAC within residential settings (Rouski et al., 2020) regarding their self-harm and how they make sense of this experience. However, research on perspectives of carers of LAC who self-harm is limited, especially residential staff. The current research available has explored residential staff’s experiences of professionals offering support to LAC who self-harm (Jennings & Evans, 2020), and how they experience direct management of self-harm behaviours (Brown et al., 2019).

However, this research aims to explore experiences of residential staff supporting LAC who self-harm in the context of how staff manage expectations of organisations to provide care that accounts for risk management, while meeting emotional and developmental needs of the young person. The impact of staff trying to find this “balance” on their relationships with young people, fellow staff, and the systems around them will also

be explored. Interpretive Phenomenological Analysis (IPA) was used to support development of in-depth understanding of the sense staff make of supporting LAC who self-harm.

## **Method**

### **Design**

This research project applied a qualitative design using IPA as its analysis method. This research aimed to explore the meaning staff make of their experiences balancing potentially conflicting demands. It was felt IPA was best placed to meet these aims due to its double hermeneutic, where the researcher attempts to make sense of participants sense making of their experiences (Smith, Flowers and Larkin, 2021). Semi-structured interviews were used, enabling each interview to have a similar structure while still allowing flexibility for participants to discuss, expand upon and engage in topics relevant to their experience.

### **Participants**

Participants were staff working within residential settings supporting LAC who self-harm. See Table 1 for inclusion and exclusion criteria.

**Table 1. Participant inclusion and Exclusion Criteria**

Inclusion Criteria	Exclusion Criteria
<p>Staff currently working within residential settings to support LAC. To enable participants to discuss live relationships and recent experiences.</p> <p>Have supported LAC who self-harm within the last year. To ensure the experiences of supporting those who self-harm was not impacted by memory recall.</p> <p>Supported LAC between ages of 10-18 years.</p> <p>Chosen as residential homes supporting children younger than 10 are often short-term placements and may focus of specific individual health needs.</p> <p>Staff have worked within their role for at least six months. To ensure staff have had training in their role and an opportunity to develop relationships with fellow staff and young people.</p>	<p>Staff working in inpatient mental health services.</p> <p>As these services may also include non-care-experienced young people.</p> <p>Staff whose roles did not involve direct care duties.</p> <p>As interactions with the young people may have been limited.</p>

A total of nine residential staff, five males and four females, were recruited from seven residential settings located across the UK. These included Local Authority residential care provision, and homes within the charitable sector.

## **Recruitment**

Recruitment was supported through contact with a child and family service providing psychological consultation across the UK. The researcher and field supervisor initially contacted two area managers overseeing two geographical localities. This allowed consideration of how best to approach residential care staff to make them aware of the project. Information regarding the project was shared with these area managers, as well as discussing which homes may be most suitable for recruitment.

These area managers provided details of various team managers who wished to be contacted regarding the project and may support recruitment. Information regarding the project and what taking part would involve was sent to these managers who disseminated this via staff email and in team meetings. Staff had the option to take part with other staff from their home in group interviews, or individual interviews these could be carried out face-to-face or virtually using Microsoft Teams. The researcher's university email address was included so those interested in taking part could contact the researcher. Participants emailed the researcher discussing a time and preference of format for interview. Prior to interviews taking place each participant signed a written consent form and gave verbal consent.

## **Ethics**

Ethical approval was gained from Lancaster University Faculty of Health and Medicine Research Ethics Committee. See ethics section for further details regarding ethical considerations.

## **Data Collection**

All participants chose 1-1 interviews and took part via Microsoft Teams. Interviews ranged from 50 to 70 minutes. Interviews were recorded using the “record meeting” function and transcribed using the “Transcription” tool on Microsoft Teams.

At the beginning of each interview, participants were asked to explain their role and were given opportunity to ask any initial questions. They were also reminded should they experience any emotional distress; the interview would be stopped either for a period or stopped completely depending on their preference.

An interview schedule was used (Appendix 2-A) to support participants to consider multiple contexts of their experience. To further explore their experiences, follow up questions were asked. Interview questions were developed through engaging in current literature regarding residential staff’s experiences of working with LAC and the systems around them as well as through attending residential staff meetings of multiple services. This was done to try and structure the questions in a way that staff may feel familiar with and use language they would find accessible. This allowed several questions around their experiences of the organisations in which they worked to be expanded and added to the interview. Initially a single question on staff’s experiences of their organisational systems was to be asked to prevent staff feeling led into discussing certain topics, however

consultation with staff and the literature suggested this may have led staff to discussing overly negative aspects of their organisations and other contexts may have been missed if this single question was retained.

Pseudonyms were used to represent each participant.

### **Data analysis**

Data analysis followed the second edition IPA approach by Smith et al. (2021). This allowed an idiographic focus and exploration of individual meaning each participant gave their experiences of supporting LAC who self-harm, using a two-stage process of interpretation.

Analysis involved reading and re-reading interview transcripts, which were developed by re-listening to interviews and correcting original transcripts created by Microsoft Teams. This supported “active engagement” with data. The next step involved “initial noting” using a table within a word document (Appendix 2-B) which examined content and use of language on an exploratory level through notes on the right-hand side of the table next to the original content of each interview. At this stage, experiential statements were developed through review of initial annotations and interpretations of blocks of text which were added to a separate Word document. Experiential statements were then grouped together based on similarity of context and focus allowing personal experiential themes to be developed for each individual participant.

Once personal experiential themes were developed, themes were grouped together again to create group experiential themes representing the data collected (Appendix 2-C). To support the validity of the analysis, regular supervision was held with the researcher’s

academic and field supervisors. The researcher also kept a reflective diary to allow reflections on the impact this may have had on the interpretive thread. The use of this diary allowed the researcher to consider their own positioning within the research, e.g. during the interviews participants often made comments around issues that the researcher thought of solutions for, by noting this in the reflective diary it ensured that the analysis of the data was not influenced by the researcher's interests in developing solutions and prevented follow up questions in future interviews from being influenced by these ideas.

## **Results**

Analysis of participant interviews led to the development of four themes representing experiences of participants: "Understanding as a road to preventing", "The care within the control", "A bond beyond the role" and "The conflict in the system".

### **Understanding as a road to preventing**

This theme captured the challenges and journey staff take in trying to find ways to intervene quickly, to prevent self-harm, and the emotional responses that may cause this to feel a priority. Participants highlighted prevention of self-harm to be their primary role when working with LAC who self-harm.

Participants discussed their role was to better understand young people's self-harm then manage this safely. They discussed a "need" to understand the reasons for each individual's self-harm to provide them with insight into "warning signs" or "triggers" they could react to. Alongside this were individual emotional responses staff experienced while witnessing and attempting to respond to self-harm, and how this influenced the priority they placed on preventing self-harm within their role.

The result of this emotional response appeared to develop into a “need” staff felt, to understand the “why” of each person’s self-harm, to be better able to prepare for and prevent this: “Our direct work is based on to try and kind of get to that underlying...the underlying issue” (Bruce); “The reasons, the background of that young person, what's triggered something?” (Natasha); “You've got to try...trying to understand the reasoning behind” (Diana). Some participants directly highlighted how understanding self-harm could prevent it, either through their interactions with the young person or through interventions. Barbara discussed this as though she had received training regarding how self-harm may help a young person meet their needs, the desire to make self-harm “stop” remained: “you still kinda carry the I want to stop it, I want to reduce it I want to delay it” (Barbara).

Wade discussed the importance that training for staff provides insight into approaches to stop self-harm: “Then just trying to work out strategies and how we can help her manage those” (Wade). Scott felt understanding “why” would reduce risk and increase safety which he felt was the biggest priority for staff in his role, even at the cost of developing a deeper relationship with the young person: “The main purpose of my role is to minimise risk to the young people or to others,” (Scott), a view shared by Barbara: “I’ve got a plan but my mission is to keep you safe and safeguarding trumps everything I’m afraid” (Barbara).

For Bruce, understanding “why” may lead to developing alternatives to self-harm; he felt training could offer insight into interventions staff could offer, thereby increasing safety: “So we can try and support and kind of develop our young people to look at other different ways of...of coping and without having to resort to self-harm” (Bruce). Natasha and Barbara discussed how understanding self-harm could allow staff to plan and stay “ahead” of self-

harm and ensure they were prepared should self-harm occur: “Always try and be one step ahead of what’s going on” (Natasha); “being proactive, erm is really important, kinda planning ahead you know” (Barbara).

Several participants felt identifying “triggers” and “warning signs” prior to self-harm occurring were key to understanding then preventing self-harm: “trying to find out what's...what's the...the sort of trigger points” (Wade). Scott felt understanding triggers was key to reducing self-harm: “Knowledge of the young person, knowledge of what their triggers are.” (Scott). Clark discussed difficulty in supporting multiple young people who self-harm to provide safety and having to learn to differentiate warning signs between each young person: “So it's sort of recognising those warning signs for that individual cause it can differ between person to person.” (Clark). From Logan’s perspective knowing potential triggers could provide safety quickly: “trying to learn what, what...what trigger signs they show physically and try and nip it early doors” (Logan).

This theme highlights how staff’s own emotional responses to self-harm may result in a need to make the self-harm stop, which drives their desire to understand the person and self-harm in more detail. It may be that staff feel having this understanding can protect them and the young person.

### **The Care within the Control**

This theme represents participants’ attempts to build relationships with young people while balancing dual roles of providing meaningful care and having a sense of control over self-harm behaviours. As highlighted within the previous theme, staff felt a need to prevent self-harm from occurring. They expanded on this further and described a conflict

between providing care and controlling the self-harm, while identifying barriers to building relationships with LAC who self-harm.

Some participants felt LAC who self-harm are more difficult to form connections with initially, possibly due to mistrust for professionals or because of stigma attached to self-harm: “the barriers that we come across erm and how we kind of erm metaphorically, break them barriers down” (Bruce). Several participants acknowledged connecting with young people through something other than their self-harm was important, such as recognising their interests, or via creative means. Bruce discussed while developing a relationship with a young person, they connected through a shared interest of drawing, which perhaps enabled them to express their feelings and allowed him a way to offer care: “Her drawings are very integral to how she's feeling and you can see that” (Bruce).

Barbara described building connections through adjusting to the person, their communication style, or interests to enable them to feel valued as an individual: “So communicating on a level they communicate so it might be through music, it might be through play, erm, it might be through just literally just chilling” (Barbara). Barbara added trying to understand young people’s perspective was key to building a genuine relationship as it enabled connection after incidents of self-harm: “How she sees the world is really important, so you can show you understand” (Barbara).

Gwen discussed how accepting relationships she had with young people might have “ups and downs” due to self-harm and the complexities of providing care within a residential setting, but it was helpful for staff and the young person to see that this is similar to other relationships: “Relationships go up and down, don't there? They have peaks and troughs” (Gwen).

Staff also reported ways they try to respond to self-harm that can build relationships, they discussed showing young people they wouldn't reject them because of their self-harm, and would still continue to provide care and interact with them in the same way they had before and after incidents occurred: "I think the relationship builds a lot when they realize that, You're not...It's not something that puts you off. It's not gonna push you away" (Wade). Wade discussed achieving this through sitting with the person while they carried out first aid to provide care and prevent a sense of rejection: "Actually you don't have to stand there staring at it, but being alongside somebody helping actually really improves your relationship" (Wade).

Participants discussed how responses to self-harm often go beyond risk management and staff look to provide genuine care. Bruce discussed his first thoughts when self-harm occurs are about taking care of the young person: "I'm thinking I need to look after this young person who's done this" (Bruce). Bruce noted this feeling came from a deep connection to the young person: "She felt like one of my family" (Bruce). Clark felt that genuine care and trust came from "consistency", and staff had to show the same level of care and interest, by checking in and spending time together, during periods of self-harm and when self-harm reduces: "it's just about being consistent and showing that you do care and keeping that interest up really" (Clark).

Logan discussed experiencing incidents of self-harm alongside young people provided a sense of safety and trust in them as staff: "sometimes you have to go through a couple of instances with that young person before you can build that relationship where they think... think, Oh well that yeah, this person can keep me safe" (Logan). Logan felt one way he provided this care alongside safety, was by sitting with the person and providing first

aid together, while offering reassurance: “Just go in, make sure if they need any first aid, let them wipe up and just state like it... it... it's fine”.

Two participants described working with young people who displayed high frequency and high-risk self-harm, meaning their role involved physical interventions to actively stop self-harm or to attempt to remove self-harm implements to prevent serious physical harm. This was a regular part of these participant's roles, and something they felt had to be understood in detail by others involved: “when you do have to do it, everybody knows what we're doing, why we're doing it, and we do it safely” (Scott). Scott discussed his own journey taking part in these interventions and becoming better able to remain focused on the need for safety and care without feeling overwhelmed emotionally: “There was much more emotion in it initially, now, it's more automatic. It's still emotional still...adrenaline burst. But erm, I think touch wood, more professional about it. Without losing the care” (Scott). Barbara, discussed the role her emotions had played, noting they had impacted her response: “I was probably too emotionally involved in it” (Barbara). Both participants discussed interacting with young people after these incidents occurred. Barbara discussed trying to use humour to reduce the severity of the situation: “I say humour goes a long way, erm you were a bit slippery in that restraint” (Barbara), however Scott emphasised the emotional connections they have with the young people: “We say to the kids, we love them, and in a good way” (Scott).

This theme highlights staff value relationships they build with young people and will often look for ways to develop these relationships. Some participants highlighted the impact of restrictive practice when supporting LAC who self-harm and that carrying out these interventions also has an impacts their own emotions. Having care and safety in equal

balance is important to staff as it enables them to show genuine care to the young person while also building a meaningful connection. Participants discussed how understanding the self-harm enabled them to show young people they valued them as an individual, were alongside them and the relationship between them would be able to withstand the self-harm.

### **A bond beyond the role**

This theme considers relationships staff build with each other while supporting LAC who self-harm. Staff discussed managing complexities of self-harm as a team, using each other as emotional and practical resources.

Participants discussed how observing self-harm had an emotional impact on them that impacted their usual duties after incidents of self-harm: “It’s really hard to move on and so then it is about our open communication, having that safe space to come in and say that’s really upset me” (Gwen). For Diana, witnessing self-harm caused frustration, due to feeling she was unable to make it stop: “It could be, really frustrating at times. Because no matter what you do...They still gonna do it” (Diana)

Participants discussed the importance of emotional aspects of their relationship with other staff and how containing other staff members emotionally and looking to other staff for emotional containment were key to their role within the context of self-harm. Some participants defined this as having “trust” in other staff: “You put a lot of trust in your team” (Bruce). Natasha discussed the value of knowing the staff team and developing trust: “But it's about knowing the team that you work in, having a lot of trust within the team that you work in” (Natasha). Scott described the context that this trust occurs in, noting sometimes staff may try to support their colleagues to “come away” from incidents of self-harm, by

disengaging from the young person completely and allowing other staff to step-in and offer support, due to how they are responding emotionally: “So there is a reluctance to come away. But you have to trust your colleague and that they've got the bigger picture” (Scott). Scott noted that “coming away” was sometimes difficult due to wanting to help, but trust can support with understanding this.

Clark felt trust is developed over time and linked this to staff showing “respect” for each other and their role, often by listening to other staffs’ perspectives or seeking their opinions: “show that you sort of respect them as an individual and build that trust up” (Clark).

Participants also discussed how having a relationship with other staff meant being able to notice emotional changes in each other and support each other to notice this change. Barbara highlighted difficulty in noticing these emotional changes in herself and how her staff team played a valuable role informing her when they noticed this: “but we don’t always recognise the signs in ourselves, I rely on my team to recognise that as well” (Barbara).

Staff felt they can offer each other a different perspective of situations and may build close relationships with key people while going through the process of developing support plans and interventions. Staff may come to each other with ideas and develop these further with other staff: “when you've got that person that you can bounce what's going on off they can put things into perspective quite easy” (Wade). This was described as an active process for staff, in that they may not wait to see emotional changes but may recognise the difficulty of their shared experiences and try to offer emotional containment. Gwen felt this was a key part of the post self-harm incident process: “Just make sure everybody else is OK

and check in on each other” (Gwen). Other participants felt having this relationship allowed acknowledgment of the impact of self-harm incidents and enabled them to ask other staff for support, either by giving them space to talk or by helping them with daily duties: “You go to your colleague and just say I had a really rubbish one yesterday it's knocked me a bit. Can you take the lead today?” (Logan). Scott discussed how staff may aid each other before assistance is asked for: “It's being aware of how everybody is and that staff as well and stepping in and offering assistance” (Scott). Scott added that this can involve offering each other emotional affection: “We hug each other reasonably frequently” (Scott).

This sense of almost already knowing how other staff may respond emotionally, due to experiencing the situation alongside them was highlighted by Bruce: “You kind of know what each other are thinking” (Bruce).

Participants described developing their own language at times, using “codes” to tell other staff to take a break or to indicate to others they need a break: “using scripts, so staff if they hear oh is that your phone ringing?” (Gwen); “[Staff name] tells me that my phone is ringing. That's the code word of... no, you're in too deep. Get out” (Scott); “You’ve changed your colour” (Barbara).

For some participants the relationship felt like it went beyond the role and developed into something more meaningful, for Diana this was akin to family: “Sharing with staff members, your own frustrations and feelings because. I think when you're a team. You're more of a family” (Diana).

This theme highlights the importance and closeness of relationships staff build with each other when carrying out their role in the context of self-harm. Staff noted multiple ways they use relationships to support their emotional responses to self-harm and become

skilled at highlighting when colleagues' emotional limits may be reached as well as offering them support around this.

### **The conflict in the system**

This theme captured participants' experiences of systems around them, including organisations they work in, professional services supporting young people, and how this becomes an additional layer of complexity in the context of self-harm. Staff felt certain structures within their systems helped provide a better understanding of young people but also highlighted barriers and conflict within this.

Participants described how their interactions with mental-health professionals provided opportunities to learn, seek opinions and better understand the young persons context: "Just speaking just having like that open forum, utilizing professionals as best as possible and getting that expert opinion" (Logan). An "expert view" was also discussed by Gwen who didn't just want professionals to listen she wanted them to actively offer suggestions: "They can come and say this is why she may be doing it. Rather than just listening to us, I suppose" (Gwen). Participants also described seeking reassurance from professionals; "So just reach out and use that session to just go over or confirm that you're on the right track or get new ideas" (Barbara).

For Clark, regular meetings with professionals promoted consistency and collaborative working, enabling him and colleagues to feel heard and supported: "There is regular meetings with the medical professionals as well, that's supporting her. So, it's really that collaborative approach and consistency and reporting" (Clark).

However, participants also discussed how expectations of help were not always met, leaving them feeling they needed more support or different forms of support, to address their own feelings regarding a “need” to prevent and reduce self-harm: “Help us we need something and you’re in that position to do so” (Wade). Logan discussed a sense of pressure when interventions are put into place onto staff by professionals and the organisation, around reducing self-harm: “I think people think it's got to be a 0 and that it's only a win if it's at 0. And that's completely unrealistic sometimes” (Logan). This sense of pressure from professionals and organisations may link back to the theme of “understanding as a road to preventing” and provide explanation as to why staff may feel they need to prevent self-harm as the main priority in their care for the young person. Logan also highlighted a sense of being criticised when self-harm behaviours do not reduce: “They're [residential care staff] gonna get some of the blame for that incident happening” (Logan).

The additional pressure created by a need to follow certain procedures set out in documentation after instances of self-harm was also highlighted. Participants felt at times documentation didn't fit individuals needs and instead fit the organisation's needs: “It's not that they don't wanna do the debrief with the young person, but it's making sure that it fits to the young person that it's been used for” (Gwen). Some participants felt this took away from providing meaningful care or support, causing a sense of conflict between staff and organisations regarding their goals: “I think sometimes paperwork and...and evidencing can take over” (Natasha); “you have a lot more to record” (Barbara).

Participants also highlighted positive aspects of interactions with both professionals and their organisations that supported their understanding: “He's very good with his

language and how he uses it and focuses. You know, he won't start baffling you with... with big psychological words" (Clark).

This theme represented the complexities and pressures staff face from systems around them. These systems offer support through information, guidance and reassurance but also cause frustration for staff regarding perceived expectations and demands placed on them, that staff feel in some cases do not meet the individual needs of the young people they support.

### **Discussion**

Four themes were developed during data analysis: "Understanding as a road to preventing"; "The care within the control"; "A bond beyond the role" and "The conflict in the system". Participants wanted to develop their understanding of self-harm to respond quickly to prevent risk/harm; by developing a deeper insight they felt better able to do this. That participants viewed supporting self-harm as the number one priority is a finding not highlighted in previous research. This focus on risk, however, was often at odds with how staff wished to build relationships with young people; they understood a need to show young people they were cared for, and someone was interested in them as a person rather than their self-harm. Staff shared examples of developing a connection outside of self-harm and how they tried to maintain a relationship when this occurred, using these occasions to build the relationship they had with the young person through the care they provided preventing the young person feeling rejected. This is important in the context of LAC, within residential settings especially, as they have likely experienced multiple transitions and perceived rejections. So, for staff, there is an awareness, of trying to build trusting

relationships where the young person feels safe and cared for without fear of the relationship ending abruptly.

The complexities of balancing both risk and care meant staff often looked to each other for emotional support in their roles. They felt that due to shared experience they could rely on colleagues to offer guidance, reassurance, and emotional containment. This supported the development of meaningful relationships participants valued. Within this, participants also attempted to manage pressures from organisations and professionals they worked alongside; these pressures were to reduce self-harm occurrences quickly and to prioritise paperwork related to self-harm. This caused frustration and conflict between staff and “systems” as it contributed to an emphasis on reducing risk which they felt could prevent them from offering care that supported a deeper connection with the young person.

Overall, participants shared a sense of “pressure” to understand and respond to self-harm in a manner that provided safety. Within this study, staff spoke about how reducing or ‘stopping’ self-harm was seen as the primary aim of their role. Participants discussed how a failure to achieve this could lead to serious consequences, often highlighted by their organisations and other professionals. This experience has also been noted in previous studies with residential workers, in some cases leading to a “culture of fear” whereby staff feel unable to effectively carry out their role due to “fear” of getting it wrong (Brown et al., 2018). This could lead staff to prioritise this above overall care of the young person, however, within this study, staff clearly also focussed on how they could build a trusting relationship with young people aside from the self-harm and thinking about how they responded to the self-harm to aim to maintain a good therapeutic relationship.

Previous research has highlighted that residential staff are often able to identify multiple reasons behind self-harm (Bryant et al., 2021). This study has highlighted some participants' reasoning behind their "need" to understand self-harm is so they may respond and reduce risk quickly, as well as developing a greater understanding of the young person and their needs.

The complexity of balancing a need for meaningful care with providing boundaries and structure needed to support LAC, discussed by all participants, has also been highlighted in research with residential staff (Abraham et al., 2022) and described as having to manage a "dual role" (McLean, 2015). Abraham's study (2022) highlighted how staff often find the responsibilities of their role can act as a barrier to forming emotional connections with young people they are supporting.

Participants in this study also highlighted pressures from their organisations to complete paperwork or certain interventions, such as debriefs, prevented them from providing the care aspect of their role consistently. This feeling has been discussed by other residential care workers (Burbidge et al., 2020) as not being as "effective" in their roles as they could be. Young people who self-harm have also highlighted a need for "care that is genuine" and recognised that organisational requirements can prevent this (Rouski et al., 2020). However, when participants in this study were able to provide care that went beyond risk, they spoke of meaningful connections with the young person and described this as something that was important to them on a personal level.

Previous research findings have highlighted that having space to form emotional connections outside of times of emotional difficulty is important to staff members (Garcia Quiroga & Hamilton-Giachritsis, 2017). Past research has also indicated that developing

meaningful relationships is of value to the young people themselves, with some young people feeling this can be a factor in reducing their self-harm (Epstein & Ougrin, 2020).

One way to contextualise the response staff had regarding seeing preventing self-harm as their key role, is to consider Karpman's drama triangle (Karpman, 1968), in this context staff members may be seeing themselves pulled into the role of "rescuer" and feel they need to hold this position to keep the "victim", in this case the young person, safe. The organisations around them may play the role of the "persecutor" as staff felt pressure was placed on them by their organisations regarding the self-harm when what they wanted was to keep the young person "safe".

All participants discussed their relationships with fellow staff members; for many participants these were key in supporting their overall resilience and emotional containment. Previous research has also highlighted how without these relationships can feel less confident and able to carry out their role (Moore et al., 2018).

Participants discussed a sense their roles are often not valued by those working outside their setting, feeling their views and experience were often ignored in preference for professionals' "knowledge", a view shared by other residential staff in previous research (Evans et al., 2011; Jennings & Evans, 2020). This experience may explain why staff feel they need to rely on each other, as participants in this study highlighted a sense of being "criticised" by organisations or other professionals and, by having a shared space where staff can be open and honest with those who share their experiences, staff can increase their own confidence around providing support for those who self-harm. This experience is similar to the concept of "psychological safety" defined as: "A shared belief that the team is safe for interpersonal risk taking" (Edmondson, 1999, p.354). An increased sense of

psychological safety may increase feelings around self-efficacy for healthcare staff and allow them to feel better able voice opinions during meetings with other professionals (Roussin et al., 2018). Previous research regarding residential staff and LAC has highlighted a shared sense of psychological safety can support relationship development between staff and young people (Sellers et al., 2020).

This study adds new information to understanding staff's experiences of supporting LAC who self-harm as it informs us of the awareness staff have of the need to develop meaningful relationships not just with the young person but also each other. The value they place on these relationships is also a novel finding as it has provided further insight into how staff appear aware of the need for relational aspects of care and of providing meaningful care to those who self-harm but feel organisational pressures around them may prevent this, which in turn impacts on staff on an emotional level.

### **Clinical Implications**

These findings highlight the value of different relationships staff working with LAC who self-harm seek to develop and how they go about trying to maintain and manage these relationships. For staff members to provide meaningful care for young people who self-harm that enables them to develop a better understanding of individuals, they must attempt to maintain different relationships each with different needs and expectations.

One of these relationships is between themselves and the young person, a relationship that requires a focus on the individual and their unique experience. Staff members feel they need to find "creative" ways to do this with LAC who self-harm as this can often be a difficult process due to past experiences. Staff often use self-harm itself to build this relationship, as it provides opportunities to provide practical care, demonstrate

acceptance, and show understanding of the young person as an individual. The care staff offer to the young person can act as a vehicle to develop meaningful relationships that allows effective support.

Then there is the relationship they develop between themselves and their fellow staff members, this relationship requires staff to develop an insight into the emotional presentation of other staff so they can better support them to carry out their role, something which is then reciprocated by other staff. Staff develop these relationships through a sense of respect and trust as well as bonding through sharing of experiences of supporting and witnessing self-harm.

The final relationship is between staff and the “systems” around them. These systems are often the organisations for which they work and the professionals they work alongside. The expectation in this relationship is that staff will understand risk, while also reducing self-harm and filling in documentation that provides evidence and information around self-harm.

To support development of meaningful relationships with young people, especially those who self-harm, staff need space to be able to do this and to make attempts to build these connections. Services may support this by ensuring staff have protected time, that is not interrupted by meetings or other duties, they are able to spend with the young people they are working with. By setting aside consistent times each day, which remains unconditional and should not be stopped if the young person self-harms, where staff and the young person can interact or do an activity together may support the development of this relationship in a way that allows the young person to feel staff care about them and their needs.

Support and training for staff around techniques that support engagement and communication, particularly around self-harm as a coping mechanism, may also be of benefit to staff members. This could be facilitated by clinical psychology directly to allow staff further insight into why particular models and approaches are relevant in the context of self-harm.

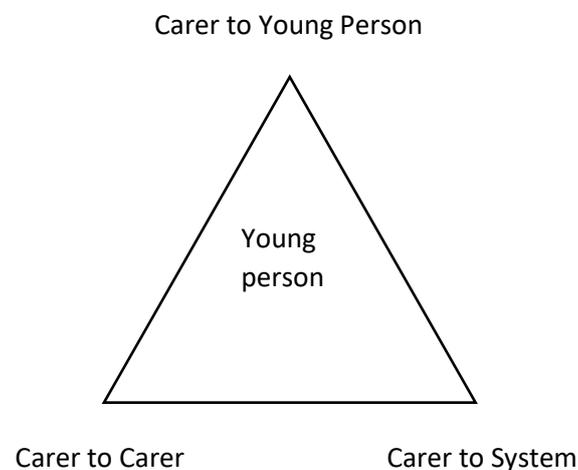
The relationship between staff may be supported using peer supervision, this would add to regular clinical supervision staff should be receiving. Staff could use this space to discuss their own experiences, emotional responses to self-harm, reflect on their roles and develop potential ideas for the service and the young people they support. This group could also support their skills in discussing distress which may also support conversations with the young person and staff particularly regarding self-harm.

To support the relationships between staff, the organisation, and other professionals, collaborative meetings led by clinical psychologists, aiming to produce psychological formulations could be carried out. This could involve the young person and staff developing an understanding of the self-harm and distress behind this, while being scaffolded by the professional using psychological models and approaches. An important part of this would be retaining a focus of the needs of the young person while including safety as an aspect of this. Finally, organisations could support a reduction in pressures on staff members by adjusting their focus to person specific goals set by the young person and staff than having the singular focus of reducing self-harm behaviour. This would allow work towards meaningful goals that are measurable and achievable.

Clinical psychologists specifically may adjust their approach to working with young people who self-harm by considering the needs of the person in context of the relationships

surrounding the staff providing their day-to-day care. By considering in detail the needs of the carer-to-carer relationships, the carer to young person relationship and the carer to organisation relationships while holding the young person at the centre (see figure 1.) then staff may be better supported to provide meaningful and effective care.

Figure 1.



It may also be valuable for staff working with LAC who self-harm to receive additional support when first starting their roles, this could take the form of identified peer support from more experienced members of staff. This could allow a space for new staff to discuss their early experiences of observing self-harm or their expectations of observing self-harm that validates any worries or difficult feelings they may have, without creating a feeling that this is something they must just “get on with” as part of their role.

### **Strengths and Limitations**

A key strength of this research is its novelty in seeking to understand how residential care staff experience self-harm in the context of their organisations and their relationships with young people and with other staff. Given the increasing prevalence of self-harm in young people, and within this population, the findings of this research are important in highlighting ways of supporting future service development and clinical practice.

There were aspects of the recruitment process that may have acted as a barrier as managers of services that were contacted had control of how information about the project was disseminated within their services. Information about the project was delayed in being sent to certain services due to difficulties currently occurring in those services as well as issues within the services regarding staffing levels. This may have prevented certain staff members from having an opportunity to take part in the research and privileged services that had higher staffing levels. Participants within this study were from different services in different areas and worked for both private organisations and local authorities meaning the perspectives of staff members working in different systems was gathered.

### **Future research**

Future qualitative research could build on these findings by exploring experiences of those managing staff teams in services providing support to LAC who self-harm. This would support previous research on experiences of self-harm from the perspective of the young person and this research in providing an “all round” view of the systems involved in supporting self-harm in LAC. By comparing all three groups we may be able to develop better frameworks around providing timely and effective care for LAC who self-harm. Future research could also explore young people’s and residential staff members’ experiences of

completing collaborative “safety plans” around self-harm and how this impacts self-harm behaviours and staff’s understanding of self-harm.

### **Conclusion**

This research aimed to develop an understanding of staff experiences of supporting LAC who self-harm. Findings showed the conflict staff experienced in trying to carry out their role in a way that allowed the development of a relationship with the young person while also managing pressures to keep the young person safe and reduce self-harm.

Understanding how staff manage this conflict and the importance of the relationships they develop with each other, the young person, and the systems around them supports our understanding of the contexts that exist when trying to offer support for LAC who self-harm within these settings as professionals.

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## Appendix 2-A. Interview Schedule

### Provisional Interview Schedule Draft One

#### Opening

Thank you for agreeing to take part in this project and share your experiences of working with adolescents who self-harm. As noted in the initial information sheets the questions today will look at your own experiences of working with this particular group both as an individual and as working as part of a wider team. Please feel free to contribute to the discussion today as openly as you feel comfortable with.

As we will be discussing working with vulnerable adolescents please try and maintain confidentiality and avoid directly naming adolescents where possible, however any real names used will be omitted from the transcripts of this interview.

Should anyone begin to feel distressed due to the nature of today's discussions please feel free to note this and we will try to take a break from the discussions or should anyone feel unable to continue in these discussions they can leave the interview. However, any comments made prior to leaving will still be included within the transcripts of this interview.

Also, just to confirm this interview is being recorded as both a video and an audio recording to support the transcription of the interview.

Are there any initial questions?

1. As a staff member how do you view your own role when providing support to those adolescents who self-harm
2. What kind of skills do you feel you needed to use to support this particular group?
3. How did that change compared to supporting adolescents who don't self-harm
4. Has working with adolescents who self-harm changed your own practice or views in any way?
5. How did you build working relationships with those adolescents (who self-harm)?
6. How did you manage incidents of self-harm that occurred with an adolescent you had a developed working relationship with?
7. How did this then impact on your working relationship with this person?
8. How were you able to manage your own reactions and feelings when this occurred?
9. How do you feel incidents of self-harm impact staff teams as a group?
10. What impact does working with adolescents who self-harm as a member of a team have on your relationship with other staff members, if any?
11. How did staff members manage a difference in views regarding self-harm behaviours?
12. How were the reporting of self-harm behaviours to other staff members managed?
13. How did the policies and guidelines within your organisation influence how you provided support to those adolescents who self-harm?
14. How did you support yourselves after witnessing incidents of self-harm behaviours?
15. How did your team members support you/ how did you support your team members after self-harm incidents.
16. As a staff member how did you find the balance between managing risk and developing a working relationship with those adolescents who self-harm
17. Is there anything you feel that is important to you that hasn't been covered during the questions asked today that you would like to discuss further?

## Appendix 2-B - Extract of coded transcript

Original Transcript	Exploratory comments
<p>P: Umm. And that a lot of the time you'll get or they're just doing it for attention, or they're just doing it for this. And I don't wanna give them that is try not to get them to understand how hard it is to actually cut yourself. Erm...You can't you... very rare to just be able to do it for attention, Because I certainly couldn't cut myself in any way for attention, Erm and just trying to dispel some of those myths almost helps the staff team, I think.</p>	<p>Descriptive comments</p> <p><i>Linguistic comments</i></p> <p><u>Conceptual comments</u></p> <p><u>The value of trying to “dispel myths” around SH and better understand this as a staff team together.</u></p> <p><u>The importance of the challenging of narratives</u></p>
<p>I: OK. And I guess So what impact does sort of working with self harm quite frequently have on the relationship between team members, do you think?</p>	
<p>P: I think it, I think out of, All of them. It probably fractures the team the most cause. It's just so hard for staff to deal with. Erm That's my experience anyway. I mean, we will at the time where it was worse, we were dealing with high leveled trauma, so aggression was quite high. So we could sort of deal with that. It was sort of in your face and knew it was coming and you could manage it.</p>	<p>An alternative view that SH can be divisive for staff teams, in that it can be emotionally draining for staff teams due to the complexities of managing SH.</p> <p><u>The complexity of SH can cause fractures in some staff teams</u></p>
<p>P: Aggression is hard to deal with as well for teams, but I think self harm just because you feel so helpless while it's happening. It can just really drive the team down and they can just they just want real quick fixes and real quick answers to it when they just isn't An overnight fix. If there was it, it'd be great.</p>	<p><u>SH can cause a sense of helplessness which impacts on the mood of the team and a desire for “quick fixes” or “answers” which is not a simple process</u></p>

I:

Yeah, definitely. And I guess sort of do you find that staff often sort of rely on each other, rely on yourself when these incidents might be occurring more frequently.

P:

Yeah I think staff definitely at that point you recognise more of a sort of hierarchy in that people on the ground essentially look up and say what are you going to put in place to help us because we can't manage. Where generally, when you're working in care you're all there to help the young people, it's all a common goal, but when things get really tough you do, you sort of get this...look up of help us we need something and your in that position to do so. But yeah, erm, But I think if you've got a good, there's always gonna be people within teams that that are hard, more hard work can have their opinions and things. But generally.

P:

Erm, all the teams I've been in, The The thing is to work towards helping the young person. It does get to a point sometimes. If it's really regular where It is a bit self-centered. The meetings like they want help themselves like I can't. I can't deal with this everyday and things like that, erm, But then. Yeah, it's just trying to get people to understand that it's you. Just between a rock and a hard place. If you don't put the effort in, it's gonna get worse. And then you have to deal with it more. So it. Yeah, it's just explaining it calmly. And yeah, trying to help the team all work as one united front.

I:

Yeah. And I guess, do you have any sort of particular skills that you think are helpful in sort of developing that and to getting that team to that position?

P:

Erm, I think story telling obviously like sort of doing with you now and just. Relaying to people that not, you know, like some people can go on about themselves all the time, not like that. But just I've we've had experience with people, share their experiences and this is how we got through, although it looks bleak now if if we do stay consistent, it's it's always worked. Erm, and then, yeah, just just leaning

The development of difficulties in the wider system as staff begin to ask for support from managers, perhaps at a time when their own emotional resources are reduced

*"help us we need something and your in that position to do so" staff feeling like they need management to be able to implement change due to their positions of power*

Staff requests for support can be to help themselves at times, when they reach a point of feeling at capacity or feel stuck with trying to manage and support the SH

Trying to support understanding of the situation and the available resources to support staff to come together

The value of success stories and reassurance that SH can be reduced and things can improve for the YP

*"just leaning on the help of others erm, that aren't part of the home. I think it's always good." The value of outside support for staff members*

The difficulty of supporting each other to remain "consistent" at times when it feels SH is more difficult or more frequent, staff supporting each other to "stick to it"

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on the help of others erm, that aren't part of the home. I think it's always good. So if you can get someone I don't know, like yourself or someone that's dealt... like learnt about self harm and stuff to come in and sort of if it relays what you're saying that gives people understanding that actually this guy knows what he's talking about. Let's stay with it, And stick to it.

## Appendix 2-C. Experiential statements and Personal experiential themes for one Participant

Participant	Personal Experiential Themes and experiential statements examples	Example Quotes
Logan	<p><b><u>Developing a relationship with SH</u></b></p> <p><b>Understanding SH over time</b></p> <p><b>Responsibility of understanding</b></p> <p><b>Using the plans to understand</b></p> <p><b>The unique experience of SH-</b></p> <p><b>Lack of exposure to SH prior</b></p> <p><b>Sitting with uncertainty</b></p> <p><b>Experiencing SH for the first time</b></p> <p><b>Change of view over time</b></p> <p><b>Individuality of SH</b></p> <p><b>Learning triggers and responding</b></p> <p><b>Acceptance</b></p> <p><b>SH and doubt</b></p> <p><b>Spreading of doubt</b></p> <p><b>Emotional impact of SH</b></p> <p><b>Witnessing SH and its outcomes</b></p> <p><b>SH leading to burnout</b></p> <p><b>Individuality of SH</b></p> <p><b>Fluctuations in frequency of SH</b></p> <p><b>Understanding the purpose of SH</b></p>	<p>“which I didn't particularly have when I first started the role was as a Residential worker“</p> <p>“it's the around just the...the education of it, because I had, I had no no real information around it from. When uh before I started the job, I'd had no experience with any young people who done it or any adults who've done it or anything like that”</p> <p>“once you've got that kind of circulating...erm it's quite it's quite difficult to work in that environment”</p> <p>“Yeah, it's quite it's sometimes it can be quite shocking what watching it erm.. Or just seeing the aftermath, sometimes because sometimes I've I've been in in the room, a young person they're covered in blood, blood all over the floor, all over the walls, pools on the floor erm.. thinking this is like a horror film”</p> <p>“still learning now and cause none... No, no...Case with the young person has been the same since I've dealt with this. It's been different motives</p>

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		behind it, different methods of doing it”
	<b><u>The self-harm toolkit</u></b>	
Logan	<b>Controlling the self</b>	
	<b>Doing better next time</b>	
	<b>Going backwards to go forward</b>	“I've had times where it's at a bit of a negative impact and and we've we've gone back a couple of steps and I've got to do the repair work again and come forward”
	<b>Managing the incident and addressing later</b>	“You've got a buy in erm, when I've been in a residential work working with young people, I've been in teams where there's been no buy in and it's just not worked”
	<b>The bond in consistency</b>	
	<b>Getting a buy in</b>	
	<b>Maintaining a buy in</b>	
	<b>Show me you can</b>	“Got you've got almost. Use your team meetings and stuff and you hand overs you've gotta keep. You've gotta keep people upbeat and in a in a term not that laughing and joking and stuff, but you got to keep people in a positive manner”
	<b>Proving you can</b>	
	<b>Need for a direct approach</b>	
	<b>Seeing beyond the role</b>	
	<b>Understanding the individuals risks</b>	
	<b>Understanding the purpose of SH</b>	
	<b>A part of a system</b>	
	<b>Outside perspectives</b>	
	<b>Drawing on professionals</b>	“I always asked for their opinions erm if there's staff member on duty that day and it's an excep...and it's appropriate for them to attend I'll have them in the room with myself”
	<b>Sharing information</b>	
	<b>Collaboration and accountability</b>	
	<b>Involving staff in decisions</b>	
	<b>Modelling approaches</b>	
	<b>Providing a rationale</b>	“I'd challenge it in that situation saying, well, why do you think, and reflect on and why do you think it's always happens with that staff member, is there anything we
	<b>Seeking support from experienced staff</b>	
	<b>Looking for signs in colleagues</b>	

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Logan	<p><b>Trying to adjust narratives</b></p> <p><b>Considering alternatives</b></p>	<p>can do differently as a team to help”</p>
	<p><b><u>The responsibility in the role</u></b></p> <p><b>Understanding through training</b></p> <p><b>Meeting your needs through each other</b></p> <p><b>Support of the system</b></p> <p><b>Reflecting on next time-</b></p> <p><b>Getting others onboard-</b></p> <p><b>Separating the emotion</b></p> <p><b>Using resources in and out of work</b></p> <p><b>Receiving feedback</b></p> <p><b>Development of difficult Narratives</b></p> <p><b>Manging difficult narratives</b></p> <p><b>Becoming Blinkered</b></p> <p><b>Information leading to anxiety</b></p> <p><b>Accountability</b></p> <p><b>Creating a culture</b></p> <p><b>A reflection on us</b></p> <p><b>Noticing when things improve</b></p> <p><b>Unrealistic expectations</b></p> <p><b>Long term planning</b></p>	<p>“through the training stuff, you realize how how it's linked with different things like trauma... erm that release kind of stuff and that's how they cope with what's what's... something that might have happened to them”</p> <p>“Then I know I've I've learned where what, what it looks like when I'm. I'm in need of a bit bit help. Erm, but didn't always used to always think just bottle it up and keep going”</p> <p>“always take it, I always listen, I’m quite invested in it because sometimes you need. You can become quite blinkered when you're involved in the actual incident on the front line, so you need that outside objective perspective”</p> <p>“So it's just about trying to create that culture. Really, that...People aren't scared of of things happening. The confidence in the plans you got in place”</p> <p>“We're all doing this. We're all in it together. Kind of mentality. I think that's the best way.”</p> <p>“Erm I always try to make sure the following day. Give them</p>

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like, a little debrief after on the day. Saying are You OK? Erm, if they need anything, usually they're OK because they they're still in a little bit. I think it's usually the day after and I'll go into the home. Re...reassure them”

Logan

**Relational Symmetry**

**Engaging outside of crisis**

**Incidents supporting the relationship**

**The need for the bond**

**Together as a team**

**The value of team morale**

**Offering reassurance**

**Difficulties of communicating outside of work**

**Receiving feedback**

**Becoming a crutch**

**Reaching a limit**

**Finding a balance**

**A journey together**

**Negative impact of some staff**

**Needing to hide certain feelings**

**Hiding emotions to benefit others**

**Reflecting as a team**

**An open Approach**

**Reflection to develop an approach**

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“sometimes too supportive for people and then you become a crutch really for other people. That's when you really get burnt out”

“So you gotta get people to be willing to come on that journey with you.”

“I had to learn how to balance the support and also that challenge, that challenge back and push back as well.”

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Logan	<p><b><u>Providing and seeking emotional containment</u></b></p> <p><b>Colleagues individual needs</b></p> <p><b>Blame on staff for SH</b></p> <p><b>SH causing friction in the team</b></p> <p><b>Anxiety when YP leave</b></p> <p><b>Safety in Sabotage</b></p> <p><b>Blame from Professionals</b></p> <p><b>Separating from work</b></p> <p><b>Losing the sense of a home</b></p> <p><b>Conflict with restriction</b></p> <p><b>Managing difficult feelings</b></p> <p><b>Checking in after incidents of SH</b></p> <p><b>Two way street of support</b></p> <p><b>Wanting to protect</b></p>	<p>“So you need to give them the circuit Breakers. It's about knowing your staff team then”</p> <p>“They're gonna get some of the blame for that incident happening”</p> <p>“And yeah, sometimes because you can get to the point where you're you're locking stuff down. And and in the house. And then it it becomes less of a homely environment than and it can be quite a clinical place”</p>
Logan	<p><b><u>The battle with professionals</u></b></p> <p><b>Not valued</b></p> <p><b>Potential value</b></p> <p><b>In “combat” with professionals</b></p> <p><b>A need to meet the YP</b></p> <p><b>Solutions that don't fit</b></p> <p><b>Buying in to professional relationships</b></p>	<p>“used to... I used to feel as an RCW, sometimes it just like are you only you only a resi worker what do you know? I don't think you've views really taken”</p> <p>“that's been through different things really where the professionals have have give. Stuff that's not practical on boots to ground to do during the time”</p> <p>“So we were saying no, actually no they don't just display that behaviour or that or warning</p>

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sign and they were saying no  
they do. It was. It was quite  
combative”

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## Appendix 2-D. Group experiential themes within data

Group Experiential Theme	Personal Experiential Themes and participant
<b>Undertanding as a road to preventing</b>	<p><b><u>The many faces of Self-harm- Bruce</u></b></p> <p><b><u>Developing a “safety net”- Bruce</u></b></p> <p><b><u>Getting to the Root of Self-harm- Natasha</u></b></p> <p><b><u>An emotional ripple effect- Natasha</u></b></p> <p><b><u>The spectrum of Self-harm- Barbara</u></b></p> <p><b><u>Being contained to offer containment- Gwen</u></b></p> <p><b><u>Avoiding risk and providing safety- Scott</u></b></p> <p><b><u>Evolving of the role- Wade</u></b></p> <p><b><u>Developing a relationship with Self-harm- Logan</u></b></p> <p><b><u>Providing and seeking emotional containment- Logan</u></b></p> <p><b><u>Developing and using new tools- Clark</u></b></p> <p><b><u>Understanding why and watching out- Diana</u></b></p> <p><b><u>Giving everything I have- Diana</u></b></p>
<b><u>The Care within the Control</u></b>	<p><b><u>A journey to understanding- Bruce</u></b></p> <p><b><u>Balancing care and control- Bruce</u></b></p> <p><b><u>Building a deeper connection with the Young Person- Natasha</u></b></p> <p><b><u>Searching for Safety- Natasha</u></b></p> <p><b><u>The conflict in the care- Barbara</u></b></p> <p><b><u>Trying to care and control- Barbara</u></b></p> <p><b><u>Keeping you and me safe- Gwen</u></b></p> <p><b><u>The Pull and Push of Self-harm- Scott</u></b></p> <p><b><u>The multiple needs of care- Wade</u></b></p>

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	<u>The Self-harm toolkit- Logan</u>
	<u>Forging the connection – Clark</u>
	<u>The pulls and pushes in the relationship- Diana</u>
<u>A bond beyond the role</u>	<u>A shared Trauma- Bruce</u>
	<u>Connecting and Sharing together- Bruce</u>
	<u>Connecting through and beyond the role- Natasha</u>
	<u>Layers and responsibilities of Communication- Barbara</u>
	<u>Relying, supporting and being there for the team- Barbara</u>
	<u>Developing together- Gwen</u>
	<u>Building a bond with the team- Gwen</u>
	<u>Exploring the role of emotions- Scott</u>
	<u>Relying, supporting and being there for the team- Scott</u>
	<u>Going forwards as a team- Wade</u>
	<u>A part of a system- Logan</u>
	<u>The responsibility in the role- Logan</u>
	<u>Relational Symmetry- Logan</u>
	<u>A shared relationship through communication- Clark</u>
	<u>Receiving care to provide care- Diana</u>
<u>The Conflict in the System</u>	<u>A continued need to learn- Natasha</u>
	<u>The puzzle pieces of understanding Self-harm- Barbara</u>
	<u>Going beneath the surface of Self-harm- Gwen</u>
	<u>Relying on the system- Scott</u>

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The scaffolding of understanding Self-harm-  
Wade

Conflict created by the system- Wade

The battle with professionals- Logan

Systemic Barriers- Clark

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## Appendix 2-E: Guidance for Publication in the Clinical Child Psychology and Psychiatry Journal

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## 1. What do we publish?

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**Section Three: Critical Appraisal**

Steven Sulej

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Steven Sulej

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

[S.sulej@lancaster.ac.uk](mailto:S.sulej@lancaster.ac.uk)

## Introduction

The aim of this thesis project was to explore the experiences of carers of LAC, both in regard to their experiences of working alongside multiple professionals to provide support for the child in their care and to explore the sense residential carers made of their experience supporting LAC who self-harm.

The systematic review highlighted that the different carer groups of LAC may have some shared experiences regarding working alongside professionals that relates to them feeling there is a need for better communication and better attempts to increase the understanding of carers to better enable them to support the child in their care. A key finding of the review included that foster carers specifically felt they needed better support from professionals to increase their skills and access information. The review also identified that support from professionals can often have a negative impact on carers of LAC, in some cases this can leave carers feeling inadequate, low in confidence or that they are not a valued part of the process as they are not seen as a fellow professional. The outcomes of the review suggest that further consideration of carers of LAC needs are required and adjustments to the current support process must be made to better include carers perspectives.

The findings from the empirical paper highlight the complexities staff supporting LAC who self-harm face regarding how they attempt to develop and maintain relationships with the young person while also trying to manage the risk of self-harm and attempt to prevent this from occurring. Using Interpretative Phenomenological Analysis four themes were developed regarding the sense staff members made of their experience: "Understanding as

a road to preventing”; “The care within the control”; “A bond beyond the role”; “The conflict in the system”. Some participants felt that preventing self-harm was the key aspect of their role and often sought out many ways to try and achieve this, often through developing an understanding of the person, their triggers and potential warning signs.

Participants discussed how self-harm impacted their attempts to build relationships with the young person and how they attempted to maintain and further develop the relationships they had with the young people they supported, in a manner that they felt met the individuals needs while preventing a sense of rejection as a result of self-harm.

Participants shared the importance they placed on the relationships they developed with each other as staff and how they often looked to each other as a valuable resource for managing their own emotions in response to supporting self-harm. Participants also highlighted the impact of the pressures they faced from the organisations in which they worked, how often the aims of the organisations were often juxtaposed to the goals of both the staff member and the young person regarding self-harm.

This project has highlighted the need for further consideration regarding how to include and meet the needs of carers of LAC in more meaningful ways, that enables them to meet the pressures of their roles. It also highlights how opportunities that support joint working, and a shared understanding may support this.

This paper presents a critical review of the research process undertaken to complete both the systematic literature review and the empirical project. As well as presenting reflections of this process from the perspective of the researcher, there will be consideration of the implications of this research regarding future clinical practice, policies, and development of services. Alongside this will be considerations of my own journey

through the project, including why the project was chosen, the challenges faced during the project and emotional responses that arose during the research process.

### **Selection of Project Topic**

This thesis was clinically relevant as both the systematic review and the empirical project looked to gain a better understanding of the experiences of carers of LAC, a population group about whom research remains limited at this time. Also, there is currently a highlighted clinical need for additional forms of support from professionals for LAC population groups due to the increased likelihood of this group having to access a variety of physical and mental health services during their lives (Simkiss, 2019).

As a result, this project is of clinical value as it may provide insight into how to better support and enable carers within their roles of supporting the needs of the child in their care. Carers play a key role in supporting LAC and are the ones providing daily care to LAC and attempting to support interventions that professionals may wish to implement and evaluate for LAC. By understanding the experiences of LAC carer groups in more detail we can better consider how we develop and support both LAC and those providing their daily care in a manner that provides timely and effective care.

There is currently an expectation within current policies and recommendations that those supporting LAC, including foster carers, kinship carers and residential staff, should aim to support emotional wellbeing in LAC (Luke et al., 2018) while also attempting to meet individual mental health needs and carry out person centred interventions (Bazalgette et al., 2015) as part of this role. To support a better understanding of the experiences of carers of LAC, within the context of these expectations and the presentations of many LAC, it is of value that we explore the experiences of carers of LAC regarding specific presentations,

issues or concerns that LAC may be more likely to experience. So, within this research project it was felt that this could be supported by exploring carers' experiences of supporting LAC for a variety of presentations and needs while also exploring in further detail residential carers' experiences of supporting LAC who self-harm.

My own clinical interests corresponded to this project topic also, as I have always wanted the opportunity to be involved in supporting the mental health needs of young people. This is an interest that has grown more during the process of this project and while working within services supporting the needs of a range of young person population groups during my training. I have also found the fact that current research into carers' experiences is limited to be a source of confusion and something I have reflected upon frequently during this process. If professionals are to provide meaningful interventions, care and support for LAC population groups how can they fail to consider the needs and experiences of people who provide daily direct care for these young people? Professionals may work with a young person for only one to two hours a week, this leaves one hundred and sixty eight hours of a week remaining, if we as professionals fail to account for the value of this amount of time these carer groups are providing support to these young people then how can we remain confident we are offering appropriate and meaningful support.

### **Strengths and limitations within the research process**

Within the empirical paper, participants were residential workers whose roles were to support the daily care needs of LAC aged 10-18, all participants had direct involvement with LAC who had previously self-harmed on multiple occasions. Many of the participants worked in different residential settings, however four participants worked in the same residential setting and while they knew each other and worked together they chose to be

interviewed separately. One staff member noted they had wanted to take part as the colleague from their home had spoken of enjoying the experience and of being given the opportunity to express their views.

A strength of this particular project was the views of residential staff working within the private sector and local authorities were included. This ensured that the views of staff members from a particular company, setting or organisation were not the only views considered. This could have impacted on the findings of the study as it may have influenced how they spoke about the systems in which they worked and how this then impacted their own roles as residential staff. That these staff members were from different organisational settings yet still discussed organisational pressures in the same manner is of clinical value, as it suggests that concerns regarding conflict with their systems is of relevance to multiple residential staff member groups.

However, a limitation of the recruiting process was some organisations were not contacted until the later part of the study, due to ongoing concerns and current staffing issues within those homes. This meant that those staff members had less opportunity to respond to the project.

I made several efforts to ensure information about the study was accessible by ensuring the language used was clear and relevant to roles beyond clinical psychology, due to previous research highlighting inaccessible research project information as a barrier and reason why many staff members in care homes reported not wishing to take part in research projects (Law & Ashworth, 2022).

It must also be considered that the service in which the field supervisor for this project worked provided consultation, formulation, and training support as an outside

service to the organisations participants worked for and some participants may have had interaction with the service in the past. This may have influenced how participants spoke of certain professional services due to my own connections to this service. However, the majority of participants had not received direct support nor had they had previous interactions with the service meaning that potential impact or influence of this on participants' responses was limited. It was also clearly highlighted that the research project was separate from the service itself.

### **Methodological Issues**

Initially, it was hoped that the research project would be able to use group interviews to allow for participants to explore their shared experiences and the meaning they made of these experiences together. However, participants all chose to be interviewed on a one-to-one basis. The original rationale for including the option of group interviews was that staff may be more familiar with discussing their experiences in this format, given the number of team meetings they are likely to attend as part of their roles. The offer of one-to-one interviews was retained for staff who would prefer to discuss their experiences with just the researcher present. Although IPA was originally designed to be used for analysis of one-to-one interviews additional guidelines for applying this to group based interviews were identified and would have been used within these interviews (Palmer et al., 2010).

Within Palmer et al (2010) it is discussed that group interviews using IPA may be of benefit to groups with pre-established relationships, such as staff members working within residential settings. This approach may have enabled staff to further expand upon their

experiences of providing each other with emotional support, something that all staff discussed as having great personal relevance to their roles during their individual interviews.

A group approach to the interviews may have enriched the theme “a bond beyond the role” and enabled further insight into how staff made sense of their relationship together, as the staff, they held this relationship with would have been present to discuss this experience further. The use of group interviews may have also supported other themes in the individual interviews to be further developed, as staff may have been able to highlight aspects of their experience that resonated with other staff within the interview allowing for them to expand on their reflections as a result, which may have been missed within the individual interviews.

It must also be considered that all participants chose to take part via virtual interviews rather than meeting in person. Participants’ preference for this format of interview may have related to their own schedule as residential staff, as often staff have long work hours and are not able to take time away from their duties while on shift so offered to take part in the interviews outside of their workdays or working hours. It is also possible that, due to the need to take part in meetings online during the COVID-19 pandemic, staff were accustomed to online meetings, and this had become the most regular way for these types of meeting to be carried out.

I reflected on this experience of carrying out interviews this way and noted my own disappointment in staff all choosing this format of interview I had hoped to meet the staff in person and felt that I would be able to form a better initial relationship and connection with the staff members in person, as I felt building this connection was a personal strength.

Given that I have not had much experience in carrying out research-based interviews I worried that I might struggle to collect the level of detail needed to carry out in-depth analysis of the interviews using online interviews, especially during the initial interviews. However, recent research has suggested that participants taking part in qualitative research online do not feel that this format of interview prevents them from connecting to the researcher and the topic, instead the issues participants reported related to times when the technology fails and prevents the interview “flow” or process (Saarijärvi & Bratt, 2021). I felt reassured by this research and by reviewing the transcripts of each interview and seeing the depth each participant had gone into in response to my questions.

The use of online interviews also raised my concerns around participants’ own emotional distress given the topic of the interviews. I felt that should the participants become distressed or wish to end the interview I would be unable to offer them any additional support as we may be disconnected from the call. I spent time reflecting on this and noted that these feelings were likely linked to my experiences and ideas of my role as a clinician rather than a researcher. During my clinical work I am used to offering the people I work with emotional containment and being able to support them through times of emotional distress. However, as a researcher that is not my role and it would be inappropriate for me to attempt to offer support in that way, so by ensuring participants were signposted to various sources of support, prior to taking part in the interview, I was ensuring that participants knew where to go so they could be supported without crossing any boundaries as a researcher.

Despite potential limitations and the methodological concerns raised during this thesis project, I believe that the approach taken was effective in attempting to answer the

original research question and provided further insights into an under researched population group. I reflected on this towards the end of the project and thought about how this aligned with my values as a clinician as well as a researcher; I had been able to support an understanding of a topic from a group whose voice is often not heard in research or within clinical work. I feel that this highlights the value carrying out in-depth research can have for the development of overall clinical skills of trainee clinical psychologists.

### **Clinical Implications**

Overall, the findings from both the systematic review and the empirical paper appear to suggest that for those supporting LAC there is currently much need for consideration of the relationship that is developed between staff, their organisations, and the professionals they work with as a system. Participants across both papers highlighted that working with professionals under the pressures of their organisations can often leave them feeling criticised and unskilled. This is then likely to impact on the confidence they have in carrying out their roles. As such it is important that professionals working within these systems reflect on this and consider this in greater detail when working to support LAC's mental health needs or presentations. Professionals and systems may benefit from considering the needs of those supporting LAC alongside the needs of the young person themselves. Participants across both papers also noted occasions they feel supported by the systems in which they work and when this process feels positive.

Many participants highlighted that a key part of when the experience of support alongside professionals is positive it is because a shared and accessible language has been used. They also highlighted that they feel more able to carry out recommendations and make change when these systems consider the resources and skills the carers possess

currently and make sure that effort is made not to offer support or interventions that are not currently out of the skill set of staff or involve resources staff currently struggle to access. This could be supported by both managers within the employing organisations of staff and professionals meeting with staff regarding their perceived strengths and skills prior to making clinical recommendations or developing in-depth formulations. Also, staff could be offered a space to discuss how well they feel able to carry out any recommendations or policies that have been put in place by their organisations or professionals. This could support carers of LAC to feel heard, supported and valued, improving their confidence, and enabling them to engage in better relationships with the young people they support.

This approach would also support the idea of developing a better connection within one part of the “three relationships” identified within the empirical paper that may also apply to other carers of LAC. This approach to considering interventions with LAC notes that for an intervention, support or type of consultation to be effective and to provide long term meaningful change it needs to consider the context of the relationship between the carers, the relationship between the carers and the young person and the relationship between the carers and the systems around them (this could be social care and councils for foster and kinship carers and the organisations in which they work for residential workers). By considering the context of these relationships prior to interventions, support or consultation and using this to develop plans and approaches to meet the young person’s needs while continuing to evaluate how these relationships are developing as a result may provide support that is experienced as more meaningful, person centred and supportive by carers and LAC. A visual representation is presented in figure 1.

The purpose of presenting the three relationships this way is to support the idea of seeing the young person at the centre while ensuring the needs of the carer are identified around this and how each relationship needs to be considered in detail to support the carer to support the young person.

However, it must be considered that the idea of these three relationships is based on the findings of the empirical paper of this thesis and as a result has been developed from data gathered from a total of nine participants. Future work could involve sharing this idea with carers, asking for their perspectives on this idea to see if they equally value these three relationships as part of providing care for LAC.

Future research may also be carried out as to the effectiveness of taking this approach to clinical support for LAC by applying support that looks to consider and develop all three relationships and then gathering qualitative feedback as to the experience of taking part in this approach from the perspectives of carers of LAC and the LAC themselves. This could support the development of a clear framework to support for LAC that considers the needs of LAC and their carers.

### **My Own Journey**

During the process of this thesis project, I regularly reflected upon my own values and practice as a clinician and how this may have influenced my approach and focus through this piece of research. To support the separation of my own views and personal therapeutic alignments I used a reflective journal to record my own thoughts and experiences of the research process, as a way to separate these thoughts and prevent them from overly influencing the research process. I reflected frequently on my own desire to develop solutions to the issues that staff members had raised during their interviews and to

try and include this within the research process, however I noted that this may have been a “righting reflex”, as in a desire to fix the problem staff noted quickly, and an attempt to support the distress that staff expressed when talking about their difficulties of working with their organisations and professionals. I reflected on the fact that I was one of those professionals in a sense as my clinical work while on the course has involved large amounts of work with young people and their carers. I at times had a sense of wanting to “right the wrongs” of professionals, that included myself, as part of this research project.

However, I reflected on an important part of my current clinical work to prevent this “righting reflex” from overly influencing how I interpreted the results and the discussion within the empirical paper. I did this by reflecting on the work I have done with carers around helping them identify when they may be attempting to “jump in” with a solution and instead it is better to attempt to “relate” to the issue or experience prior to attempting to provide a solution. I used this to remind myself that I was not in a clinical role during this project and that I needed to “step back” from this aspect of myself as a clinician to ensure that the project represented and gave focus to the experiences of the participants and did not become overly focused on potential recommendations or attempts to fix the issues raised.

I reflected upon this with my academic and field supervisor to ensure I retained my position as a researcher during this project. Throughout the project I was also motivated by the participants themselves, through reading the transcripts and hearing their experiences I wanted to make sure their voices were the key part of this project that is heard, this helped me retain my research focus while remaining connected to my own values, as well as why this project had been chosen in the first place.

As I carried out more interviews, I reflected more on how I may support the voices of staff and carers of LAC in my own practice, I reflected on the emotional impact of these interviews also and hearing the stories of staff and the meaningful relationships they developed with the young people as well as the trauma they had experienced while observing and attempting to support self-harm behaviours. I discussed my feelings with my clinical supervisor during my final placement, working with LAC and their carers, and discussed with them how we may try to represent the voice of carers in more detail within our work. Towards the end of the project, I felt even more motivated to continue working with young people and their carers. I began to reflect on the success stories participants told me and became hopeful of the project supporting positive change, that prioritised the voice of those who took part.

### **Conclusion**

This project has provided further insight into the experiences of multiple carers of LAC, both papers identify the complexity faced by carers of LAC both in carrying out their roles and in receiving support from systems around them. This was achieved through a meta-ethnography of carers experiences of working alongside professionals to support their child in care and through an IPA of residential staff members supporting LAC who self-harm.

Both papers should be seen as a starting point for future research with a population group that remains clinically relevant yet under researched. The process of this project has been challenging at times and there have been multiple aspects of the project that required in-depth reflection during supervision to address. However, my own passion for research with underrepresented groups has grown as a result and I will remain grateful to the participants of the project for sharing their stories and experiences with me. I hope that I

can hold onto the same passion I had for this project in my career working with young people and their carers.

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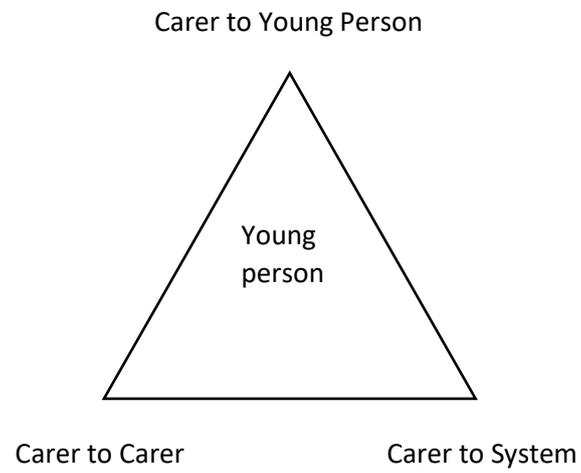
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**Figure 1.**

**The three relationships within the role of carers attempting to hold the young person at the centre of their care:**





**Section Four: Ethical Section**

Steven Sulej

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Steven Sulej

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster LA1 4AT

[S.sulej@lancaster.ac.uk](mailto:S.sulej@lancaster.ac.uk)

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

**Title of Project:** Residential care staff experiences of supporting young people who self-harm

**Name of applicant/researcher:** Steven Sulej

**ACP ID number (if applicable)\*:**

**Funding source (if applicable)**

**Grant code (if applicable):**

**\*If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [\[link\]](#).**

**Type of study**

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, two and four of this form**

Includes *direct* involvement by human subjects. **Complete sections one, three and four of this form**

**SECTION ONE**

**1. Appointment/position held by applicant and Division within FHM** Trainee Clinical Psychologist

**2. Contact information for applicant:****E-mail:** s.sulej@lancaster.ac.uk**Telephone:** 07460849737**Address:** 29 South Wing, The Residence, Kershaw Drive, Lancaster, LA13TG**3. Names and appointments of all members of the research team (including degree where applicable)**

**3. If this is a student project, please indicate what type of project** by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](#))

PG Diploma  Masters by research  PhD Thesis  PhD Pall. Care PhD Pub. Health  PhD Org. Health & Well Being  PhD Mental Health  MD DClinPsy SRP  [if SRP Service Evaluation, please also indicate here: ] DClinPsy Thesis **4. Project supervisor(s), if different from applicant:**

Dr Suzanne Hodge – Lecturer in Health Research, Lancaster University. Research Supervisor

Dr Charlene Rouski- Senior Clinical Psychologist, Changing Minds. Clinical and Research Expertise

Dr Sue Knowles- Consultant Clinical Psychologist Changing Minds. Clinical and Research Expertise

**5. Appointment held by supervisor(s) and institution(s) where based (if applicable):****SECTION TWO**

**Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants**

1. Anticipated project dates (month and year)

Start date:

End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

### Data Management

*For additional guidance on data management, please go to [Research Data Management](#) webpage, or email the RDM support email: [rdm@lancaster.ac.uk](mailto:rdm@lancaster.ac.uk)*

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms'  no

4c. If yes, where relevant has permission / agreement been secured from the website moderator?

no

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users?  no

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain?  no

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

### 8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?  yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

## SECTION THREE

**Complete this section if your project includes *direct* involvement by human subjects**

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

An investigation into the views and experiences of residential care staff who support adolescents who self-harm. The study aims to recruit staff members who work in residential care settings with young people who self-harm, and who have experience of supporting young people who self-harm. The study will involve group interviews with staff members from the same residential setting, will be carried out face to face or via video software and will aim to understand how staff manage the various key aspects of their role, such as compassion and managing risk as an individual and as part of a staff team when providing day to day support for adolescents who self-harm. The study will also consider how this then impacts on the different aspects of their working relationship with the young people they support and fellow staff members. Interviews will be analysed using interpretative phenomenological analysis.

## 2. Anticipated project dates (month and year only)

Start date: December 2021

End date August 2023

### Data Collection and Management

For additional guidance on data management, please go to [Research Data Management](#) webpage, or email the RDM support email: [rdm@lancaster.ac.uk](mailto:rdm@lancaster.ac.uk)

## 3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

This study will aim to carry out 2 to 4 focus groups made up of 3 to 6 participants in each, with a total target sample of 10-15. Participants will be staff members currently working in a residential setting, who have experience of working with young people who carry out self-harm. Participants chosen will be those staff members currently working within the services and those who have done so for at least six months, as it is felt they will be better able to respond to questions regarding their relationships and experiences. There will be no exclusion criteria regarding participant age or gender.

Participation within this study will require that participants speak English due to limited funding and time available to accurately interpret and analyse data in other languages.

## 4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Currently recruitment of participants will be supported by contact with "Changing Minds UK". This service provides psychological consultation into residential care homes for several residential care providers and local authorities in the UK. It also has contact with a wider range of residential care organisations through connections and providing supervision and support. Permission will be sought from each organisation individually, prior to recruiting participants employed by that organisation.

Recruitment will involve contacting managers of residential settings that agree to take part in the study to arrange the sharing of information about the study with staff members via email.

Appropriate information regarding the project and what the study would involve will then be passed on to potential participants via participant information sheets, along with information about how to opt into the study, this would be forwarded on to staff by the care home manager. Staff members would be invited to participate within the study as a group, this way staff would be aware of who they were participating in the groups with from the initial stages of the study. Staff members would then be contacted individually to ensure they met the criteria for the study and that they felt able

and wanted to take part in the study with those staff members from the setting in which they work currently. Any staff members who felt they would not be willing to take part in the study as part of a group from their current residential settings would be free to withdraw without further contact from the researcher at this point

Staff members wishing to participate could then contact the researcher directly by email, this would be done via their manager as to inform the manager of which staff members are taking part in the study. This will be necessary in order to facilitate the participation of staff members from the same home in a group interview during work time. Participants will be sought from a range of appropriate care homes that are a contact of "Changing Minds UK".

The preference for each interview is that it will be carried out face to face with the lead researcher and the staff member groups, at their residential setting. However, should this not be possible but staff member groups still wish to take part within the study then the option of the use of online video conferencing via Microsoft Teams will be offered to staff member groups. This would involve the staff member group taking part via a single computer to maintain the group setting of the interview.

#### 5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data collection and analysis will be conducted using an interpretative phenomenological analysis (IPA) framework (Smith, Flowers & Larkin, 2009). Although IPA generally uses individual interviews, group interviews have been identified as a methodologically appropriate way of collecting data for an IPA study (Palmer et al., 2010).

Group interviews will be conducted with 3-6 participants. Participants are from the same residential setting and the interview will be arranged with the home manager to ensure that it does not disrupt the routine of the home. Where possible, interviews will be conducted in person, in the home. Where staff cannot be on site together or do not feel able to take part in face to face interviews as a staff group, interviews will be conducted via Microsoft Teams. The interviews will last between 60 and 75 minutes and will be recorded. If taking place in person they will be recorded using a Dictaphone and subsequently transcribed by the researcher. If taking place on Microsoft Teams they will be video-recorded using the recording function on Teams, allowing auto-transcriptions to be collected which will later be checked by the lead researcher.

At the start of each interview, the group will be asked to agree some ground rules. The interview will then commence, following a semi-structured interview schedule. Once the interviews have been carried out, time will be given for an immediate debrief should there have been any themes discussed that have caused distress for the participant. This will be offered within a group setting and one to one setting to support the needs of the participant. After this debrief, information will also be given to the participants regarding who they can contact for further support and advice regarding self-harm and their own wellbeing should they begin to feel the interview has impacted on them in anyway.

After the interviews have been completed, the researcher will review and transcribe the recordings in full. The researcher will then analyse each transcript individually. Within the data a differentiation will be made between “individual” experiences that are unique to the participant and “group” experiences that are jointly created by participants, referred in previous research as “The focus group narrative”, keeping the focus groups at a smaller number of participants should support the gathering of both perspectives (Githaiga, 2014). The first step in the analysis is “initial noting” which involves examining content and the use of language on an exploratory level. Once initial notes have been made, initial themes will be developed from these annotations. During this process the lead researcher will keep a reflective journal to prevent the analysis being overly influenced by the researcher’s own assumptions and biases. After initial themes have been developed for each of the transcripts, a set of superordinate themes will be developed across the transcripts by making connections between the initial themes. This will then form the basis of the main body of the report of the project.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Participant identifiable information will be stored electronically within “OneDrive” on the Lancaster University SySTEM, identifiable information in relation to participants will not held in a written format during this project. The information will be encrypted and password protected within OneDrive which only the lead researcher and research supervisor will have access too. The data collected will include audio files, from face to face interviews, video files from any online interviews, emails from participants requesting to take part, transcripts of the interviews and scanned or electronic copies of consent forms. Once the project has been completed and is in publication all audio files, visual files and emails will be permanently deleted by the lead researcher Steven Sulej. Steven Sulej will hold responsibility for the storage of all collected data.

7. Will audio or video recording take place?  no  audio  video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

The portable devices used within this project, a laptop and a secure USB will be encrypted and contain password protection.

b. What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Audio and Video files will be permanently deleted once the projected has been completed and submitted for review

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

Data will be stored for 10 years with the Research Co-ordinator of the Doctorate in Clinical Psychology.

8b. Are there any restrictions on sharing your data ?

Because of the qualitative and potentially sensitive nature of the data, it will not be appropriate for it to be made freely accessible. Individual requests for access to the data would be considered on a case by case basis.

## 9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?  yes

b. Detail the procedure you will use for obtaining consent?

Those willing to participate would complete electronic consent forms after indicating their willingness to take part in the project. This will be done prior to any of the interviews taking place and any participants who do not provide consent will not be interviewed. All consent forms will be completed by participants and it will be advised that participants print the forms off, fill them in, then scan them so that an electronic copy is created which will then be sent to the researcher.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these

potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

One potential risk issue related to this project is the disclosure of certain information that may be distressing for staff members, due to the nature of the topic of self-harm. This will be addressed through explaining this possibility to participants prior to them agreeing to take part, through acknowledging this prior to interviews taking place, through informing participants they can leave the group at any time and through providing details for services that may offer support once the interviews have been completed. Such support will include offering information how to contact Samaritans who are able to provide anonymous support, as well as information regarding how participants may seek further support via their GP from other medical professionals.

Staff members taking part in this project will also have regular support and supervision and due to this and the nature of their work will be familiar with discussing the topic of self-harm and its consequences. Also, the focus of this study is on the relational aspects of the support staff members provide and not specific self-harm behaviours and how they occur.

Participants will be able to withdraw from the study at any point during the interviews should they feel no longer able to take part in the discussions. The data collected within the sections of the interview attended by participants who withdraw will be retained and each participant will be informed of this prior to any interviews taking place in the "ground rules" section at the beginning of all interviews. During this "ground rules" section of the interview all participants will be asked to make some agreements on how they wish to ensure each person is given opportunity to speak along with how others would like the group to conduct itself. Each participant will then sign a piece of paper containing this rules, each group interview may agree upon different rules and this will not replace the formal consent form. Participants who do not consent to the rules or to being recorded will be able to leave before the interview begins.

Participants will be allowed to exit the interview during group discussions should they feel unable to continue due to the nature of the research topic and to prevent further distress or possible trauma from the discussions held.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

As the researcher will be traveling to residential settings for the face to face interviews arrangements will be made prior to attending each setting to ensure the appropriate staff are made aware of the researcher's attendance. Individual settings protocols will always be followed to ensure researcher and staff safety. The researcher's supervisor will be made aware of the arrangements made and the locations at which the lead researcher will be carrying out face to face interviews.

Participants will be contacted via the researcher's university email address not the researchers own personal email account

The researcher will be supported to reflect on any sensitive or distressing aspects of the interview by their research supervisors.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

The outcomes of this project may support staff members' reflections and understanding of self-harm in adolescents and the results gathered could identify areas for potential training for staff teams within the services of those staff who take part. This is due to the focus on how staff manage the different forms of support that are required within their role and as such any difficulties identified by participants in doing so may indicate an area of further need and support for those staff teams supporting adolescents who self-harm. It is hoped that the project will support the development of a training topic for support staff that will be delivered upon completion of the project.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There will be no incentives/payments offered to participants for taking part in this project, participants will not have to travel outside of their usual work pattern to take part and as such will not require reimbursement for travel

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?  yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Maintenance of confidentiality would begin during the initial stages of contact with service managers as information sheets would initially be forwarded on to staff by the home manager to ensure staff contact information remains confidential. Staff members wishing to participate could then contact the researcher via the researcher's university email. Care home managers will be informed of the staff who are taking part in the interviews, so they may support attendance of interviews but they will not have access to the interviews themselves.

Efforts will also be made to ensure anonymity of both participants and any service users they discuss through the use of pseudonyms to protect individual identities of both staff and service users. Any direct quotes taken from the interviews will also be anonymised in both written reports and in any feedback training sessions.

Any potential risk issues will be initially raised and discussed with my research supervisors so the best course of action may be taken. Should any concerns be raised in regard to the practice of the staff members taking part in the interviews, both in regards to how they have supported adolescents and worked with other staff members, this information will be passed on to the care home managers contacted in the initial stages of the study and potentially safeguarding professionals. Any concerns raised by staff members regarding the management team will be passed on to the appropriate manager within the company and potentially safeguarding professionals and the care quality commission.

Should any such concerns arise, if possible, staff members would be informed of the researcher's concerns and of any steps taken. As staff will all currently work within a residential care setting, they will be familiar with this procedure for such occurrences.

All the data within this study will be transcribed by the lead researcher Steven Sulej. Transcripts will be anonymised at the point of transcription, with any identifying information removed or changed to protect the identities of participants, young people, other staff and the care homes involved.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Consultation with current home managers will be carried out during the development of this project, this will take place via one to one discussion and will explore what benefits taking part in this research may have to the homes, to staff members' own development and their practice. It will also be discussed how the outcomes of the research can best disseminated amongst the staff members.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

Summaries of the research will be shared with "Changing Minds" and the staff teams taking part in the study once completed. Key outcomes of the project will be discussed within the organisations that took part and potential training opportunities will be offered to staff teams where appropriate. It is hoped the project will be published with a clinical psychology journal as it is felt this may support future practice and research within the field.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

Additional ethical consideration must be given to how managers will need to know which participants are wishing to take part in or are actively participating in the study so that time may be facilitated within their working hours to attend the interview.

## **Appendix 4-A. Research Protocol**

### **Research Protocol**

Residential care staff experiences of supporting young people who self-harm

Steven Sulej- Trainee Clinical Psychologist

Research Supervisor – Dr Suzanne Hodge- Lecturer in Health Research Lancaster University

Clinical and Research Expertise- Charlene Rouski- Senior Clinical Psychologist Changing Minds

Clinical and Research Expertise- Sue Knowles- Consultant Clinical Psychologist Changing Minds

### **Protocol Version Number: One**

#### **Introduction**

Recent reviews suggest self-harm has increased within the general population over the past twenty years (McManus et al., 2019). Self-harm within this project will be defined as: “an intentional act of self-injury irrespective of the type of motivation or degree of suicidal intent” (Royal College of Psychiatrists, 2010). Self-harm can pose numerous risks to physical health due to the various forms it can take, which may include cutting, burning, self-poisoning or self-asphyxiation. Self-harm is usually more prevalent during adolescence (than younger years or adulthood), and the research suggests that the prevalence during adolescence (Approx. 13-15) has had the most notable increase over recent years (Morgan et al., 2017) one survey study suggests one in four teenagers reported self-harm in the last 12 months along with noting a 23% increase in females and 9% increase in males of the age of 14 (Patalay & Fitzsimons, 2021).

Research within adolescent population groups notes similar life time prevalence rates of self-harm across multiple higher income countries including; Ireland, 12.1% (Doyle, Sheridan, & Treacy, 2017), the UK, 15.5% (Morey, Mellon, Dailami, Verne, & Tapp, 2017) and Australia, 12.4% (De Leo & Heller, 2004). Further research within lower income countries has suggested that rates may be even higher, with a life time prevalence rate of adolescent self-harm ranging between 15.5% and 31.3% within the eight countries reviewed (Aggarwal, Patton, Reavley, Sreenivasan, & Berk, 2017). This suggests

self-harm in adolescents is a global issue. For those adolescents who display self-harm behaviours research has suggested that “relational dynamics” may play a large underlying role, for example adolescents are reported to be much more likely to focus on how the relational aspect of any interventions provided to them was helpful than they are to talk about the actual intervention and its associated strategies (Hassett & Isbister, 2017). Adolescents have noted within recent research that when professionals take the time to get to know them as a person, tried to understand their lives and gave them space to talk about the things that mattered to them, this facilitated the relationship and they experienced support as much more helpful and were more likely to recommend support to others (Idenfors, Kullgren, & Salander Renberg, 2015).

Multiple studies have also noted adolescents’ views regarding how the relational aspect of treatment and support can become negative when it is felt that this is not considered by those providing support. A lack of consideration of these relational aspects of care can lead to a feeling of “isolation” by some adolescents (Owens, Hansford, Sharkey, & Ford, 2016) and suggests that professionals may need to focus on finding ways to connect with adolescents who self-harm on an individual level.

Within the adolescent population those most at likely to display self-harm behaviours or be exposed to factors that may contribute to developing self-harm behaviours are those within residential or supported settings (Harkess-Murphy, Macdonald, & Ramsay, 2013; Hawton et al., 2012). Previous research regarding the experiences of care within this group has noted adolescents want what they felt was genuine care from staff, they felt this was inhibited by staff following policies and procedures and the relational aspect of care provided was more important to their wellbeing than specific interventions and the idea of “being kept safe” (Rouski, Knowles, Sellwood, & Hodge, 2020). Previous research involving staff members supporting adolescents in residential settings has suggested that “control and connection” may serve as a “tension” for staff members with staff

suggesting they struggled with “the dilemma of attempting to form positive relationships with young people and the frequent need to impose “behavioural control”(McLean, 2015).

There is currently a paucity of research that explores the relational aspect of care from the perspectives of staff members supporting those adolescents who self-harm. Past research conducted within residential settings, with staff members providing support has been quantitative in nature, or focused on professionals’ understanding of self-harm as a behaviour (Janackovski, Deane, & Hains, 2020), their thoughts about those who self-harm (Cleaver, 2014; Saunders, Hawton, Fortune, & Farrell, 2012) or focused on relationships between differing professionals working with those who self-harm (Jennings & Evans, 2020). Previous research has also explored staff perceptions of the meanings of self-harm for young people (Evans, 2018), but overall there is a paucity of research which looks at the relational aspects of self-harm from a staff’s perspective. It could be argued that it is important to understand this potential tension better, so that we can understand any potential challenges that this may present when trying to provide both care and safety for young people who self-harm.

Thus, there is a clear need for qualitative research that can support the development of our understanding of how staff members view the relational aspect of the support they provide. This aspect of care can include the relationship between staff and the young person and the staff members and their colleagues. The impact of self-harm on this relational aspect is something that requires further clarification as adolescents within residential care settings can display other “attachment behaviours” that staff members may also find challenging aspect within their relationship with the young person and their peers (McLean, 2015).

A key area within the current research that lacks exploration currently is how staff understand and manage the often “dual role” they have of proving emotional containment as well as providing physical safety to adolescents who self-harm. This is an important area of exploration as staff members supporting adolescents often spent long periods of time working alongside certain

adolescents and over time are likely to build positive relationships with those they support. Further exploration of role of these relationships in how staff then manage this “dual role” requires in-depth qualitative exploration.

Within the current literature there is also evidence that adolescents feel that support based around risk can feel “punitive” and “uncaring”(Holland et al., 2020), but again there is a paucity of evidence on how it feels for staff members to implement support that focuses on risk and how they feel this then impacts their overall relationship with the adolescent. Within Holland’s research adolescents felt that professionals often didn’t understand what had lead to their self-harm so didn’t understand their circumstance and situation and as a result, in their view, just looked down on them as someone who “hurts themselves for no reason”. This is where staff’s experiences and views are of interest as those supporting adolescents within a residential care setting are much more likely to have a more in-depth understanding of the individuals circumstance and situation, but is this then applied to how they provide support to that person?

Further qualitative exploration of the relational aspect of care provided to adolescents who self-harm within residential settings, with a focus on the perspective of staff members and the dynamics within the teams they work is needed. Future research also needs to try and understand how staff manage the “tension” of trying to provide care in a way that facilitates and maintains a positive relationship while also maintaining the safety of the adolescent. There is also a lack of research that considers staff members’ perspectives as part of the groups they work within, much of the current literature focuses on the views of the individual staff member. This however, is not the only manner in which they provide support when working with adolescents who self-harm, they are often part of a wider team and aim to work together to provide a continuity of care. As such future research needs to explore group interactions and the understanding of these interactions of staff members in more detail. A qualitative approach to gathering this information, carried out directly within the teams staff work may provide a deeper understanding and insight into staff members experiences.

This research will explore these challenges through the use of qualitative interviews with groups of staff members with experience of supporting adolescents who self-harm within residential care settings. These interviews will be carried out within two to three groups of staff members consisting of three to six participants in each group with the aim of recruiting between ten and fifteen participants in total. Once these interviews are completed Interpretive Phenomenological Analysis (IPA) will be used to analyse the data produced as this approach to qualitative analysis is better suited to providing an in-depth understanding of an identified group's experience. This form of analysis is also better suited to answering the project's identified research questions:

How do staff members within residential care settings manage the possible tensions that arise from an individual and a team perspective when providing care for young people who self-harm? How do these tensions then impact on the relationship staff members have with their fellow staff members and the young people they support?

The outcome of this research will provide further insight into staff perspectives of self-harm and possibly provide further avenues for both future research and staff member develop within the field of adolescent self-harm within residential care.

## **Method**

### **Participants**

This project will aim to carry out between 2 to 4 groups made up of between 3 to 6 participants in each, with a total target sample of 10-15. Participants will be staff members currently working in a residential care, who have experience of working with young people who self-harm, within the last year, within care homes for adolescents. Adolescents will be defined in this project as young people aged between 10-18 years. This age range was chosen as those over the age of 18 are deemed an adult within the "Conventions on the rights of a child" (United Nations, 2002). Participants chosen will be those staff members currently working within the services and those who have done so for at

least six months, as it is felt they will be better able to respond to questions regarding their relationships and experiences as they will still be experiencing these relationships as the interviews take place. There will be no limits placed on the age range, racial background or gender of the staff teams selected for inclusion within this project. Participants will also be sought from a range of residential care providers, that include private providers, charities, and local authorities so as not to limit the project to the views of a single staff team within a single setting. This will support this project to better reflect the diverse range of staff members who provide support within this field.

The sample size was chosen as it was felt that this would be enough participants to allow in-depth exploration of the topic without being too many participants to fit the time frame of the project. It has also been recommended previously that IPA projects for clinical psychology doctorate projects should contain at least 8 to 12 participants to enable in-depth analysis of a topic (Pietkiewicz & Smith, 2014). Although groups will be used as opposed to one to one interviews, an IPA approach to interviews will still be followed alongside guidelines set out for the use of groups within IPA, by one of the original developers of IPA (Palmer, Larkin, De Visser, & Fadden, 2010).

Recruitment of participants will be facilitated by contact with "Changing Minds UK". This service provides psychological consultation into residential care homes for several residential care providers and local authorities in the UK. It also has contact with a wider range of residential care organisations through connections and providing supervision and support.

Recruitment will involve initially seeking permission from each organisation individually, prior to recruiting participants employed by that organisation. The next step will involve contacting managers of residential settings that agree to take part in the study to arrange the sharing of information about the study with staff members. Appropriate information regarding the project and what the study would involve will then be passed on to potential participants via participant information sheets, along with information about how to opt into the study, this would be forwarded on to staff by the care home manager. Staff members would be invited to participate

within the study as a group, this way staff would be aware of who they were participating in the groups with from the initial stages of the study. Staff members would then be contacted individually to ensure they met the criteria for the study and that they felt able and wanted to take part in the study with those staff members from the setting in which they work currently.

Staff groups wishing to participate could then contact the researcher directly by email, this would be done via their manager as to inform the manager of which staff members are taking part in the study. This will be necessary in order to facilitate the participation of staff members from the same home in a group interview during work time.

Any staff members who felt they would not be willing to take part in the study as part of a group from their current residential settings would be free to withdraw without further contact from the researcher at this point

Appropriate staff meetings would then be attended to discuss the project and what the study would involve. Information sheets (See Appendix 1) would then be shared, along with information about how to opt into the study, this would be forwarded onto staff by the home manager to ensure staff contact information remains confidential.

## **Design**

The chosen design for this study will be qualitative group interviews carried out with staff members from the same residential settings, supporting young people who self-harm. The interviews will be conducted by the lead researcher.

The qualitative design of the study will be supported by a data collection and analysis process that uses a phenomenological approach which aims to develop a better understanding of how people understand their own experiences. This meets the project's aim of understanding how staff members understand their own roles when supporting those who self-harm. The use of groups within IPA literature has been suggested to be, potentially, an under used approach that may

support the gathering of in-depth data from groups with a shared experience, it has been noted that groups with preestablished relationships and a previously developed group identity may be more appropriate for the gathering of data related to their own experience compared to groups put together for the sole purpose of research (Tomkins & Eatough, 2010). As such each group will aim to be made up of at least two staff from the same homes that agree to take part in the project.

Should a large number of participants request to take part from a single home, those staff members working within the service for the longest amount of time will be prioritised as they will have more experiences upon which to reflect. Should the staff members agreeing to take part all have similar lengths of time within the service then attempts will be made to balance the genders amongst participants, so that one particular group is not overrepresented, if possible.

To support the analysis a detailed log will be kept by the lead researcher during the collection and analysis of data, this will allow reflection on the interview process and may support adjustments to the interview schedule as what seems important to the discussions in earlier groups can be reflected upon. During the analysis stage this log will support reflection on the researcher's own assumptions and interpretative role. The purpose of this will be to ensure the phenomenological process remains central within the analysis of the data collected.

The lead researcher will also seek guidance and support regarding the development of themes through supervision with research supervisor Suzanne Hodge, this will support reflection and support the lead researcher to identify potential blind spots within the data analysis carried out.

### **Materials**

To support with each interview carried out an interview schedule will be created by the lead researcher to guide questions asked to participants and to support with the expanding of certain topic areas. It is not the purpose of this schedule to limit the questions asked of participants but instead to potentially provide more structured lines of questioning at certain points in the interviews

or to support the researcher and participants to come back to the topic area should it feel that this has been strayed from and is no longer covering topics relevant to the research question. See appendix 2 for a current draft copy of the interview schedule.

### **Procedure**

Initially information will be provided to residential care managers working within the various settings who are contacts of "Changing Minds". This information would be regarding the study, its purpose and what is to be expected of participants taking part. Residential care managers will then pass this information onto all members of their staff team within their residential setting. Staff member groups will then referred themselves into the study as a group via their residential care home manager, but only if they wish to take part in the study and consent to communicating with the researcher and to taking part in group based interviews will they be approached regarding taking part in this project. Line managers will be made aware of those staff groups within their residential setting who wish to participate in the study so that they are able to support the staff member to attend the group interviews within their work time.

Those staff groups who consent to being contacted and are interested in taking part in the project will be contacted via email by the lead researcher and will be provided with an information sheet and a formal consent form (See appendix 3) for the study.

Efforts will be made to coordinate with the managers and various staff team members so that multiple residential settings are able to participate, consideration will be given to the shift patterns of staff teams to enable staff groups to participate as a group and as not to disrupt the routine of the setting. Although all members of staff within a setting will be contacted, via their manger, regarding the study it may not be possible for all staff members to attend the interviews.

Potential participants will be encouraged to ask any questions they may have prior to consenting to taking part in the study and will be informed that they may decline to take part at any stage or may

withdraw at any point in the project prior to publication of results. Should a participant request to withdraw after they have participated in a group interview it may not be possible to remove their data from the analysis, however, any quotes made by them during the interviews will be removed from the final report.

The preference for each interview is that it will be carried out face to face with the lead researcher and the staff member groups, at their residential setting. However, should this not be possible, but staff member groups still wish to take part within the study then the option of the use of online video conferencing via Microsoft Teams will be offered to staff member groups. This would involve the staff member group taking part via a single computer to maintain the group setting of the interview.

At this stage participants will have read the information sheet and provided consent to take part in the group interviews via online video or direct interview. Participants will be informed of how the data from the online interviews will be recorded via the video function included with Microsoft Teams and those taking part in the interviews will be recorded via dictaphone. All data collected will be stored securely, both the lead researcher and the research supervisor will have access to this data. This will enable the research supervisor to listen to early interviews and check recording if necessary, this would occur in the case where something in an interview has raised cause of concern. Participation in the study will require consent to being recorded during the interviews, each participant will be reminded that the interviews are being recorded prior to the interviews starting. Should a participant feel they no longer consent to being recorded they will be able to leave the interview and not take part in the study.

Information on how to use and access the video software will be provided to participants via their email of choice, once they agree and consent to take part within the project. Information will also be provided to staff of how the topics discussed will relate to self-harm so that participants are

aware and prepared to discuss this topic in detail. This information will be included within the participant information sheet (See appendix one).

Participants will then be placed in one of the two to four interview groups, this will be based on the residential care home in which the participant works, with a minimum of two staff members taking part in each interview.

Online Interviews will use the video recording software within the video call programme used; this will be done to support future transcription and analysis of the data collected during interviews.

Transcription will be carried out by the lead researcher via typing this up within a password protected document. Video transcribing software will be initially used before being corrected for any inaccuracies via the lead researcher.

The interview audio and video files will be stored on the lead researcher's laptop in a password protected and encrypted folder, as well as being stored electronically within "Onedrive" on the Lancaster University SySTEM, identifiable information in relation to participants will not held in a written format during this project. The information will be encrypted and password protected within Onedrive which only the lead researcher and research supervisor has access to. Videos of the interviews will only be held until data analysis has been completed and after this will be deleted so they are no longer able to be accessed.

Consent forms will be sent out electronically to participants, this will also allow the email to constitute part of the consent. Completed consent forms will be signed by participants, scanned and emailed back to the lead researchers university email. These documents will then be saved in a secure Onedrive folder.

Analysis of data and the developed themes will be stored within both a computer text file that will be password protected and held within a written "map" to supported with the connection of themes, this written map will have no participant identifiable information recorded within in it and

will be stored in the desk of the lead research which is behind a locked door which only the lead researcher has access to.

The interviews themselves will last between 60 and 75 minutes, unless participants wish to withdraw in-which case that participant will be allowed to leave immediately. Should this occur time will then be spent checking in with the remaining participants to see if they feel able to continue with the interview, or if they would like to reschedule or withdraw completely from the project, should they feel unable to continue.

Once the interviews have been carried out, time will be given for an immediate debrief should there have been any themes discussed that have caused distress for the participant. This will be offered within a group setting and one to one setting to support the needs of the participant. After this debrief, information will also be given to the participants regarding who they can contact for further support and advice regarding self-harm and their own wellbeing should they begin to feel the interview has impacted on them in anyway. Participants will have the lead researcher's university email address and as such will be able to contact the researcher after the interview should they wish. The lead researcher would also get in touch with the field supervisor Dr Sue Knowles and pass on any concerns raised by the staff member, once consent to do this has been gained from the staff member.

Once the interviews have been completed the data will then be analysed and the themes and key quotes from the study will be shared with the participants to ensure their points of view have been represented accurately. During this initial stage, this will be done via the email address chosen by the staff team member. Should they have concerns or feel incorrectly represented, participants will have the option of withdrawing from the project or will be offered an opportunity to clarify their views or quotes in more detail so that they can then be adjusted within the project's data and future analysis.

## **Proposed Analysis**

The intended method of analysis for this project will be within an IPA framework identified by Smith, Flowers and Larkin. The analysis process will begin with “immersing oneself within the data” (Smith, Flowers & Larkin, 2009) which refers to reading through each transcript multiple times. To support this each group interview will have an audio or video recording that the researcher will review and transcribe individually. At this stage the analysis will involve, reading and re-reading the transcripts for each interview as well as listening to interview recordings. This will enable “active engagement” with the data. The next step will involve “initial noting” which involves examining content and the use of language on an exploratory level.

Once initial notes have been made regarding the information collected within an interview, initial themes from within this interview will be developed.

This process will be completed for each individual interview transcript. Once initial themes have been developed for all the transcripts, there will be a search for connections among the themes and a final set of superordinate themes developed. The use of a reflective journal will support this prior to the formal data analysis being carried out. This will then form the basis of the main body of the report of the project. Attention will be paid during the analysis to the “double hermeneutic” that underpins IPA (Smith, Flowers and Larkin, 2009), this involves the lead researcher being aware of their own position of understanding and sense making as they then make sense of participants sense making. This means that the lead researcher’s own views and perceptions will be held in mind and reflected upon during the analysis process so that they do not overly influence the analysis.

Although the style of interview within this study may be different to the original IPA approach outline by Smith, Flowers and Larkin, it has been suggested that this approach to data analysis is still relevant and can still provide insight into the data collected (Palmer et al., 2010). Within the data a differentiation will be made between “individual” experiences that are unique to the participant and “group” experiences that are jointly created by participants, referred in previous research as “The

group narrative”, keeping the groups at a smaller number of participants should support the gathering of both perspectives (Githaiga, 2014). Key themes identified within the project will be differentiated in the results section of the report as representing either the “individuals” experience or the “group” experience of the staff members within their role working with adolescents who self-harm.

### **Practical Issues**

This research project may carry out interviews using online video software should a staff member group prefer this format and will use Microsoft teams if possible. This is a free to access software. Online interviews were chosen as an option to support those staff member groups who feel more comfortable talking in this format or who would find it easier to take part in the project via this format. It is thought that online interviews as an option may support participant uptake as it will support those staff members who may have concerns regarding social distancing.

Staff member groups will be supported to attend interviews as a group, so they will participant within the same room using the same computer. It is thought this will reduce the possibility of technical issues and allow these interviews to retain the sense of being a group-based interview.

Checks will be made as to the strength of the signal of any video calls to ensure that all participants can be heard during the interviews, these checks will take place prior to any interview questions being asked and will involve asking participants to confirm that they can hear the researcher. Should an issue with internet connection occur during the interviews a small break will be taken, and support will be offered to the participant group if they wish to reconnect and continue the interview.

There may be some travel related costs for the lead researcher for those interviews that are carried out face to face within residential settings.

**Ethical concerns**

One potential risk issue related to this project is the disclosure of certain information that may be distressing for staff members, due to the nature of the topic of self-harm. This will be addressed through explaining this possibility to participants prior to them agreeing to take part, through acknowledging this prior to interviews taking place, through informing participants they can leave the group at any time and through providing details for services that may offer support once the interviews have been completed. Such support will include offering information how to contact Samaritans who are able to provide anonymous support, as well as information regarding how participants may seek further support via their GP or from other medical professionals.

Efforts will be made to ensure confidentiality of both participants and any young people they discuss; pseudonyms will be used to protect individual identities of both the staff team members and the young people they support. Themes will not focus specifically on individual young people, but the relational dynamics between young people and staff from a staff's perspective. Any potential risk issues that relate to the physical safety and overall wellbeing of staff or young people will be initially raised and discussed with the lead researcher's research supervisors so the best course of action may be taken

Should any concerns be raised in regard to the practice of the staff members taking part in the interviews, both in regards to how they have supported adolescents and worked with other staff members, this information will be passed onto the line managers contacted in the initial stages of the study and potentially safeguarding professionals. Any concerns raised by staff members regarding the management team will be passed onto the relevant senior manager within the organisation.

Were the researcher to have concerns about a participant, that individual would be informed of the researcher's concerns directly once the interview had been completed and would be informed, if

this is possible, that further steps will be taken, this will ensure transparency and enable staff to provide further clarification to identify if further concerns are warranted.

### **Timescale**

July-September 2021- Complete Thesis contract / action plan meeting and gain organisational approval from residential settings.

October – December 2021- Hand in complete draft ethics proposal. Finalise ethics proposal and submit for approval. Decide on topic for Systematic Literature Review chapter and begin collecting references. Obtain ethical approval and begin draft of systematic literature review.

December 2021- January 2022- Begin Data collection-

January 2022- March 2022- Continue data collection. Begin data analysis. Draft introduction to empirical paper. The data collection stage may be extended beyond this period to account for any issues regarding gathering of participants, it is the aim of this project that this will ideally be no longer than an additional month.

April 2022- June 2022- Review literature for Systematic review. Identify topic for critical appraisal chapter

July-2022- September 2022- Draft results and discussion of systematic literature review chapter. Complete analysis of data. Draft results and discussion of empirical paper

September 2022 – December 2022- Draft critical appraisal. Final drafts of other chapters. Final formatting of thesis.

January 2023- March 2023 – Review of project and Submission

April 2023- August 2023- Viva voce examination. Corrections to thesis as required

September 2023- Results and outcomes of project, in its finalised form, feedback to participants and other interested staff members within “Changing Minds”

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## Appendix 4-B. Governance Checklist

**ACP Governance checklist**  
enter text.

**ACP ref:** [Click here to enter text.](#)

### **Introduction**

Please complete all sections (1 to 4) below. If none of the self-assessment items apply to the project then you do not need to complete any additional LU ethics forms.

Further information is available from the [Research a Support Office website](#).

Note: The appropriate ethics forms must be submitted and authorised to ensure that the project is covered by the university insurance policy and complies with the terms of the funding bodies.

**Name:** Steven Sulej

**Department:** Doctorate in Clinical Psychology

**Title of Project:** Residential care staff experiences of supporting young people who self-harm

**Supervisor** (if applicable): Dr Suzanne Hodge

### **Section 1A: Self-assessment**

**1.1** Does your research project involve any of the following?

- a. Human participants (including all types of interviews, questionnaires, focus groups, records relating to humans, use of internet or other secondary data, observation etc)
- b. Animals - the term animals shall be taken to include any non-human vertebrates, cephalopods or decapod crustaceans.
- c. Risk to members of the research team e.g. lone working, travel to areas where researchers may be at risk, risk of emotional distress
- d. Human cells or tissues other than those established in laboratory cultures
- e. Risk to the environment
- f. Conflict of interest
- g. Research or a funding source that could be considered controversial
- h. Any other ethical considerations

*Section 1A response:*  Yes - complete Section 1B

No - proceed to Section 2

### **Section 1B: Ethical review**

If your research involves any of the items listed in section 1A further ethical review will be required. Please use this section to provide further information on the ethical considerations involved and the ethics committee that will review the research.

If your research is not being reviewed by an NHS Research Ethics Committee, any other external ethics committee or one of the Lancaster University local ethics committees (e.g. Psychology Department Ethics Committee, Faculty of Health and Medicine Research Ethics Committee) then it will be considered by the University Research Ethics Committee (UREC).

UREC offers an expedited short form review for more straightforward projects and more in depth review by the full committee for projects that raise more complex issues. Further information is available from the [Research Support Office website](#); if you are unsure of the approval route to use for your project please contact the [Research Ethics Officer](#) for advice.

Ethical approval is not required at the time the proposal is submitted, but please remember to allow sufficient time for the review process if it is awarded. The ethical review process can accommodate phased applications, multiple applications and generic applications (e.g. for a suite of projects), where appropriate; the [Research Ethics Officer](#) will advise on the most suitable method according to the specific circumstances.

**1.2** Please indicate which item(s) listed in section 1A apply to this project (use the appropriate letter(s), eg a,c,f)

Items: Human Participants

**1.3** Please indicate which committee(s) you anticipate submitting the application to:

- NHS ethics committee
- Other external committee
- LU FST REC
- LU FHM REC
- LU FASS & LUMS REC
- AWERB (animals)

**1.4** If item (d) in section 1A (human cells or tissues other than those established in laboratory cultures) applies to your project - please confirm that you will comply with the relevant aspects of the Human Tissue Act (See here: <https://www.hta.gov.uk>)

- Confirmed

## **Section 2: Project Information**

This information in this section is required by the Research Support Office (RSO) to expedite your proposal and/or award

**2.1** If a statement of institutional commitment is required by the funder (such as a letter of support from the VC or PVC Research), please indicate below and liaise with RSO as soon as possible.

- Statement of institutional commitment required

Please note: If match funding is required please inform RSO (if you have not already done so). It is the PI's responsibility to notify their HoD that match funding is required before the costing is submitted for approval.

**2.2** If the establishment of a research ethics committee is required as part of your collaboration, please indicate below. (This is a requirement for some large-scale European Commission funded projects, for example.)

- Establishment of a research ethics committee required

**2.3** If the research involves either the nuclear industry or an aircraft or the aircraft industry (other than for transport), please provide details below. This information is required by the university insurers.

*Section 2 notes:* [Click here to enter text.](#)

### **Section 3: Guidance**

The following information is intended as a prompt and to provide guidance on where to find further information. Where appropriate consider addressing these points in the proposal.

- If relevant, guidance on data protection issues can be obtained from the Data Protection Officer - see [Data Protection website](#)
- If relevant, guidance on the Freedom of Information Act can be obtained from the FOI Officer - see [FOI website](#)
- The University's Research Data Policy can be downloaded [here](#)
- The health and safety requirements of each research project must be considered, further information is available from the [Safety Office website](#)
- If any of the research team will be working with an NHS Trust, consider who will be named as the Sponsor (if applicable) and seek agreement in principle. Contact the [Research Ethics Officer](#) for further information
- If you are involved in any other activities that may result in a conflict of interest with this research, please contact the [Head of Research Services](#) (ext. 94905)
- If any of the intellectual property to be used in the research belongs to a third party (e.g. the funder of previous work you have conducted in this field), please contact the [Intellectual Property Development Manager](#) (ext. 93298)
- If you intend to make a prototype or file a patent application on an invention that relates in some way to the area of research in this proposal, please contact the [Intellectual Property Development Manager](#) (ext. 93298)
- If your work involves animals you will need authorisation from the University Secretary and may need to submit an application to AWERB, please contact the [University Secretary](#) for further details
- Online Research Integrity training is available for staff and students [here](#) along with a Research Integrity self-assessment exercise.

**3.1** I confirm that I have noted the information provided in section 3 above and will act on those items which are relevant to my project.

- Confirmed

### **Section 4a: Statement Part 1**

**4.1** I confirm that while preparing this application I asked for and received advice from the following people (minimum 2 colleagues who are not closely involved with the proposal i.e. excluding staff named on the proposal)

Names: Kirstie Homes- Residential Care Manager Stacey Hegarty- Registered Care Manager



## Appendix 4-C Letter of Ethical Approval



Applicant: Steven Sulej  
Supervisor: Dr Suzanne Hodge  
Department: DHR  
FHMREC Reference: FHMREC21035

30 November 2021

**Re: FHMREC21035**  
**Residential care staff experiences of supporting young people who self-harm**

Dear Steven,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal 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 licenses 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 details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: [fhmresearchsupport@lancaster.ac.uk](mailto:fhmresearchsupport@lancaster.ac.uk)

Yours sincerely,

A handwritten signature in black ink that reads "T. Morley".

Tom Morley,  
Research Ethics Officer, Secretary to FHMREC.

## Appendix 4-D

### Participant Information Sheet

**Study Title: Residential care staff experiences of supporting young people who self-harm**

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](http://www.lancaster.ac.uk/research/data-protection)

My name is Steven Sulej and I am conducting this research as a Trainee Clinical Psychologist in the Clinical Psychology doctorate programme at Lancaster University, Lancaster, United Kingdom.

#### **What is the study about?**

Staff members supporting young people who self-harm face many challenges, one of which is managing the strong emotions that arise when witnessing self-harm. It can also be challenging to provide compassionate care for the young person while also managing risks. The purpose of this research project is to understand how staff manage the challenges of supporting young people who self-harm, and how this then impacts on their relationship with the young people they support and with their fellow staff members. It is hoped that this information will be used to improve the ways that staff are supported, through guidance to organisations and training for working with adolescents who self-harm.

#### **Why have I been approached?**

You have been approached because the study requires information from staff teams who provide daily support to young people who self-harm within a residential care setting for adolescents.

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

If you decide you would like to take part, you would be asked to take part in a group interview with other staff members from the setting in which you currently work, who have also supported adolescents who self-harm. The groups will involve between two to six staff members from your current residential setting. Those taking part will be invited to talk about their experiences of working with young people who self-harm in residential care homes, both as an individual and as part of a staff team. I am interested in understanding what this is like for staff members, and especially how they manage the challenge of providing care and support to a young person who self-harms whilst managing risk. The interviews will last between 60 and 75 minutes.

If possible, the interviews will be carried out in person. However, it may be possible to do the interview by videoconference (Microsoft Teams) if arranging a face to face interview is not feasible or if the staff group prefer this.

Each interview will be audio recorded if carried out face to face and will be video recorded if taking place via Microsoft teams so that I may type it up afterwards. If you decide to take part you will be asked to give consent to being recorded. These recordings will be stored in a secure and encrypted file space on OneDrive which only Steven Sulej and his research supervisors will have access too. These recordings will be deleted once the project has been submitted. The typed transcript will also be password protected and saved in OneDrive.

### **Do I have to take part?**

No. It's completely up to you to decide whether or not you take part in this project. If you do initially decide to take part but then change your mind, you will be able to withdraw. If you withdraw after you have taken part in a group interview, it might not be possible to remove all the information you have given as it will have been pooled with the information from other participants. However, in this situation, no quotations would be included from you in the final report.

You will probably be asked to take part in an interview with other members of your staff team. However, each staff member will be contacted individually to check that they have worked within the service for at least six months at the time of interview, and that they feel able to take part in an interview with the other staff members willing to participate in the study from their current place of work.

If you would like to take part in the study please contact the researcher directly via the email address: [s.sulej@lancaster.ac.uk](mailto:s.sulej@lancaster.ac.uk). The residential care manager of those who wish to take part in the project will be informed of the wish to take part to support those taking part to attend the interview. This will be done to support staff member groups to take part in the planned interviews during their work time.

Residential care managers will not have access to the videos taken of the interviews nor will they be given information about the comments made by those taking part in the interviews that relates to the research topic.

### **Will my data be anonymous and confidential?**

As far as possible, the identity of all who take part will be kept anonymous and identifiable information such as your name and place of work will be anonymised during all stages of this project. However, it is likely that you will be taking part in an interview with other staff members you work with on a regular basis and so it will not be possible to guarantee complete anonymity. I will discuss this with you individually before arranging the interview to make sure you are happy to be in the same group with other staff members from your current residential setting.

The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data

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?**

The results will be written up as part of my doctoral thesis and may be submitted for publication in an academic or professional journal. A summary of the research findings will also be produced and a copy sent to all participants as well as to the residential care providers involved in the study. The findings may also be presented to the organisations that took part. The aim of this presentation will be to provide information about the results of the project in way that may support staff member training and development in the future.

**Are there any risks?**

As part of this project you will be asked to speak of your experiences of working with those who self-harm. This can be a difficult topic due to the distressing nature of self-harm. Although the focus of this project is not for staff members to describe specific self-harm incidents there may be times where these incidents are mentioned and discussed. Time will also be spent in the interviews discussing the impact of self-harm on the relationships staff develop with the young people they support. This could also be distressing for some. Should at any point you feel unable to continue with the interview and feel you have become distressed as a result, you will be able to leave the interview or take break for a period of time if you would prefer. Further information around possible support options will be offered if this is something that those taking part feel they need or want.

**Are there any benefits to taking part?**

Although you may find participating interesting, there are no individual benefits in taking part.

**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:

Steven Sulej- Trainee Clinical Psychologist- s.sulej@lancaster.ac.uk

Research Supervisor – Dr Suzanne Hodge- Lecturer in Health Research Lancaster University-

s.hodge@lancaster.ac.uk

Research Supervisor- Sue Knowles- Consultant Clinical Psychologist Changing Minds

**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 C. Smith

Division Tel: (01524) 592282  
Title; Research Director  
Email: [i.smith@lancaster.ac.uk](mailto:i.smith@lancaster.ac.uk)  
Division: Clinical Psychology Training Programme  
Lancaster University  
Lancaster  
LA1 4YW

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

Dr Laura Machin Tel: +44 (0)1524 594973  
Chair of FHM REC Email: [l.machin@lancaster.ac.uk](mailto: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

Mind (Mental health charity)  
Infoline: [0300 123 3393](tel:03001233393) Email: [info@mind.org.uk](mailto:info@mind.org.uk)  
Post: Mind Infoline, PO Box 75225, London, E15 9FS

## Appendix 4-E

### Consent form for Participants



Residential care staff experiences of supporting young people who self-harm

Participant Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

**Please tick each statement:**

I have received and understood the Study Information about the project: Residential care staff experiences of supporting young people who self-harm

Please tick \_\_\_\_\_

I have been able to ask questions about the study and these answered in a way that I understand and am happy with.

Please tick \_\_\_\_\_

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 place of work, Changing Minds or Lancaster University

Please tick \_\_\_\_\_

I understand that I am free to stop taking part in the project at any time, without giving any reason.

Please tick \_\_\_\_\_

I understand that my group interview will be audio recorded and then made into an anonymised written transcript stored securely at Lancaster University

Please tick \_\_\_\_\_

When interviewed as a group I can also refuse to answer a question and ask to stop taking part at any time without having to give an explanation.

Please tick \_\_\_\_\_

I understand any information I give will remain confidential and 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:

Research Supervisor – Dr Suzanne Hodge- Lecturer in Health Research Lancaster University

Clinical and Research Expertise- Charlene Rouski- Senior Clinical Psychologist Changing Minds

Clinical and Research Expertise- Sue Knowles- Consultant Clinical Psychologist Changing Minds

Please tick \_\_\_\_\_

I understand some anonymised quotes from the study may be used in reports and academic papers but these will not be shared in other ways.

Please tick \_\_\_\_\_

I agree to take part in the above study.

Please tick \_\_\_\_\_

Name of researcher: Steven Sulej

Signature \_\_\_\_\_

Date \_\_\_\_\_

**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**