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Doctoral Thesis

The role of leadership in residential care services for young people

Munisah Kabir

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Munisah Kabir

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4YW

m.kabir1@lancaster.ac.uk

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	Main text	Appendices (including tables, figures and references)	Total
Thesis Abstract	274		274
Systematic Review	7948	6699	14,647
Empirical Paper	7910	6394	14,304
Critical Appraisal	3933	410	4343
Ethics Section	4942	4765	9707
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Thesis Abstract

The role of leadership in residential care services for young people

The systematic literature review aimed to explore the attitudes of care staff towards Trauma-Informed Care (TIC) in residential care services for young people. Following a literature search of four electronic databases, eight studies were selected for inclusion in the review. Participants discussed how TIC enabled them to develop a greater understanding of the trauma needs of young people, and facilitated improvements in relationships on a systemic level. Barriers to implementation were shared, such as inconsistent interpretations of models creating confusion amongst the team. Clinical implications were also suggested, specifically the need for organisational support with implementation, and the need for continual training to provide greater clarity and understanding on the models of TIC.

The empirical paper aimed to develop a greater understanding of the role of managers in residential care services for young people, specifically considering the challenges they face as part of their role and how they are supported in managing these. The findings highlighted the crucial role managers take in providing direct care and support to the staff team and young people, as well as balancing the organisational expectations. Reflections were offered on how the role has impacted their lives, and the types of support they are able to access for the homes, and for themselves as part of their role. Clinical implications were suggested, specifically how Psychology provision could be beneficial in providing support and containment to managers with their role.

Finally, the critical appraisal identified the crossover between the two papers, and considered issues of cultural inclusivity within the field. Reflections on the research process were offered.

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: M.Kabir

Print name: Munisah Kabir

Date: 30/08/2024

Acknowledgements

Firstly, I would like to thank the participants that took part in the interviews. The time you took out of your busy schedules to participate in the research has not gone unnoticed. I learnt so much from you all, and will always be grateful for the thoughtful stories and reflections you shared. I hope the research has been able to capture the discussions we had.

A huge thank you to Suzanne and Sue for your invaluable support during the whole of my thesis project. I began the course doubting my ability as a researcher, but through your advice and guidance, it is now an area that I am so passionate about and would like to continue in my practice. I really appreciate all the help with recruitment and draft reads, and will miss having our interesting discussions during thesis meetings.

I would also like to thank Stacey for all the guidance you have given me over the past three years on the course. During all the highs and lows of the course, I will always remember the safety I felt from your support. Throughout all the pressures of assignment deadlines and other expectations, you always looked out for my wellbeing first, which I will always appreciate.

Finally, I would like to dedicate this thesis to my husband Mubeen. I really appreciate all the help you gave me in applying to the course, and for the love, patience and kindness you showed me when things got tough over the past three years. You gave me the confidence that nothing is impossible… Without you I would not be where I am today and for that I will always be grateful.

Contents

Chapter 1 : Systematic Literature Review

Munisah Kabir

The attitudes and experiences of care staff towards Trauma-Informed Care (TIC) in residential care services for young people

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Division of Health Research, Lancaster University

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Health Innovation One

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Lancaster

LA1 4YW

m.kabir1@lancaster.ac.uk

Abstract

Background: Research has highlighted how exposure to trauma from a young age can lead to the development of adaptive behaviours in looked after children, where their lack of trust in caregivers can lead to difficulties in building close relationships with their care staff. Research has also looked into how these challenges can lead staff to experience vicarious traumatisation, impacting on staff turnover. There has been a recent shift, where services have attempted to implement Trauma-Informed Care (TIC). TIC provides a framework, where there is a recognition of the impact of trauma for young people, staff and wider networks involved with the homes. This trauma-informed knowledge is then integrated into the policies and practices of residential care homes. The aim of the current review was to synthesise findings from studies that have explored the perspectives of staff attempting to use TIC in their work with young people.

Method: A systematic search of four electronic databases was conducted including PsycInfo, PsycArticles, Academic Search Ultimate, and Child Development and Adolescent Studies. Eight studies were selected for inclusion in the review, and the findings sections of the studies were synthesised using the 3-step approach of thematic synthesis.

Analysis: Four themes were identified from the review: ‘TIC builds an understanding of the needs of young people’, ‘TIC improves relationships’, ‘The role of leadership in providing containment around implementation’, and ‘Challenges to interpreting TIC correctly and the need for training’.

Conclusion: Clinical implications were discussed, specifically the importance of leadership in providing support around the implementation of TIC, and the need for ongoing training to provide clarity on the framework.

Key words: trauma-informed care, organisation, parallel processes, relationships, training

Introduction

There is a large evidence-base to suggest that looked-after children experience greater mental health difficulties in comparison to children that live with their birth parents (Dubois-Comtois et al., 2021; Greger et al., 2016; York & Jones, 2017). These difficulties can be largely influenced by exposure to one or more adverse childhood experiences, whereby the young person has experienced or witnessed abuse, neglect, family dysfunction or loss/separation from parents (Crouch et al., 2019; Martin et al., 2021).

A lot of young people who are living within residential care will have experienced complex or developmental trauma within their early life. The National Child Traumatic Stress Network (2018) defines complex trauma as exposure to multiple traumatic events such as abuse or profound neglect. This may occur early on in a child's life and can have a detrimental impact on their development and sense of self. As the traumatic events often occur at the hands of the caregiver, they can affect the child's ability to form secure attachments, and this lack of safety may affect the child's physical and psychological development.

When a child has experienced early life trauma, and insecurity in their attachment relationships this can impact upon the child's trust in future caregiving relationships. As described by Baylin and Hughes (2016) children who have these experiences adapt to their early environments by developing survival strategies to protect themselves. This can be referred to as 'blocked trust.' The child learns to prioritise their self-defence system, which allows them to remain hyper vigilant to the outside world. In order to keep themselves safe these children often learn to try and read other people's intentions to look out for potential threats. They have learned through their early caregiving relationships that others may abuse, neglect or reject them and they may therefore expect this in future relationships too.

Therefore within a residential care setting where young people have likely experienced significant development trauma and changes in caregiving relationships, they may struggle to easily build trust with carers within the home.

Researchers also pointed out how care staff that work closely with young people can have an increased risk of experiencing vicarious traumatisation, as they manage the distress and risk behaviours of young people on a daily basis (Victorian Auditor-General, 2014). If care staff are not appropriately supported as part of their role, it can lead to burnout and staff turnover, subsequently affecting the ability of staff to form meaningful relationships with the young people they are supporting (Esaki et al., 2013; Middleton & Potter, 2015).

Following the literature, which has recognised the impact of trauma exposure on developmental outcomes in looked after children (Harris & Fallot, 2001; Leitch, 2017), there has been an increasing shift towards residential care services attempting to implement 'trauma-informed care' (TIC) within homes (Selwyn et al., 2017; Whittaker et al., 2016). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) provides the following definition of trauma-informed care: 'A program, organization or system that is trauma-informed realizes the wide-spread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into politics, procedures, and practices, and seeks to actively resist re-traumatization' (p 9). Within residential care settings, knowledge of attachment theory and the impact of trauma exposure on developmental outcomes is sometimes implemented on an organisational level into the policies and practices of the homes (Cannon et al., 2020; Galvin et al., 2022). It has been recommended to provide safety and containment for the young person by addressing their trauma-related needs on both an individual and systemic level to prevent re-traumatisation (Alexander, 2012; Murphy et al., 2017). An important aspect of trauma-

informed approaches involves recognising the emotional impact for staff working with young people, and providing frequent supervision and reflective spaces to prevent vicarious traumatisation (Hanson & Lang, 2016; McFadden et al., 2014). Dermody et al. (2018) similarly acknowledge how trauma-informed practices adopt a 'whole systems' approach with frequent access to other health and social care agencies to enable a culture of positive wellbeing and resilience across organisations and for young people themselves.

The principles of TIC have been adapted in various ways by researchers alongside clinicians to develop therapeutic models and conceptual frameworks that are then implemented across residential care settings (Vamvakos & Berger, 2024). Bailey et al. (2018) conducted a systematic review to investigate the evidence for various TIC models used in residential care services. As part of their review, they assessed the Attachment Regulation and Competency Framework (ARC), the Children and Residential Experiences programme (CARE), and the Sanctuary model. As Bailey et al. (2019) highlighted, one of the challenges with implementing new TIC systems has been lack of input from staff, making it difficult to implement TIC well within residential care organisations. Therefore, this review aimed to include research that looked into staff perceptions of the strengths and limitations of TIC implementation, in order to allow for a better understanding of how staff experience TIC when attempting to implement it within residential care systems.

The current systematic review aimed to explore the attitudes and experiences of care staff working in services attempting to implement trauma-informed care. The primary research question for this review is:

- How do residential care staff perceive and experience trauma informed approaches?

Method

The following review was registered on Prospero prior to the literature search being undertaken to prevent duplication and minimise the opportunity for reporting bias. The registration number is CRD42023424813.

Search Strategy

Google Scholar was used to carry out scoping searches for papers relevant to the topic area, after which PsycArticles was used as part of the process to help refine and develop the searches. From this it could be seen that there was not another recent review on the subject area and it could be demonstrated that there was enough literature to justify the review.

The scoping search was also useful in helping to refine the search terms by reading through the research papers to develop a greater understanding as to the appropriate concepts to use regarding TIC, residential care services and the types of care staff that would be relevant to include in the search. The Spider tool (Cooke, Smith, & Booth, 2012) was additionally used to help refine the search terms, and these were discussed and further refined following conversations with my field and research supervisors. I then met with the university librarian who was able to show me how to apply the search terms in each individual database that I would be using to carry out the searches, and how to use the thesaurus of each database to broaden the searches.

A systematic search of the following databases was conducted in April 2024: PsycInfo, PsycArticles, Academic Search Ultimate, and Child Development and Adolescent Studies. Whilst there are varying interpretations/definitions regarding trauma-informed care and practices, within this review, trauma-informed care refers to the use of a framework that recognises adverse experiences looked-after children may have been exposed to, and systemically embeds interventions regarding the potential impacts of trauma into the policies and practices of a home. The main concepts included in the research question formed the

basis of the terms used in the search strategy. These concepts were: ‘trauma-informed care’, ‘care staff’, and ‘residential care services’. These terms were searched for in the subjects, titles and abstracts of each database. A combination of free-text terms were used alongside the database-specific subject headings that were identified in the thesaurus of each database, to allow for the development of an exhaustive search strategy (see Table 1 for key concepts and search terms).

Selection Criteria

Articles were included in the review if:

- They reported qualitative findings. Articles that had employed a mixed-methods design were also considered to be eligible for inclusion, whereby the data would be extracted from the qualitative findings when conducting the analysis for the review.
- They were published from the year 2010 onwards. With the increasing discourse around TIC over the past decade with a greater understanding and clearer definitions as to what this includes or involves, although there are still varying interpretations of TIC, it was felt that anything published before 2010 would be referring to a different type of provision.
- The focus was on trauma-informed care used in residential care settings for looked-after children.
- They captured the experiences of care staff working directly with young people residing in residential care homes that used a TIC approach in their work. This includes support workers, managers of homes, therapists, social workers, school teachers, etc.
- From the scoping search it could be seen that peer-reviewed research related to the research question was limited, so, in discussion with my supervisors I decided to

broaden the inclusion criteria to include grey literature such as book chapters and dissertations. This would potentially increase the range of studies that could be included but would also minimise potential publication bias. Researchers have highlighted difficulties with research being accepted for publication if it does not produce significant results or striking findings (Malički & Marušić, 2014; Petticrew et al., 2008). Searching for grey literature can help to minimise this type of publication bias. However, upon reflection, whilst it was found that grey literature eligible for inclusion in the review had not been identified, more explicit searches for grey literature could have been undertaken. This could have been done by carrying out further searches using alternative sources, such as unpublished commissioned research reports. This could be an area for future research, whereby further searches are undertaken to explicitly search for grey literature related to the topic area.

Articles were excluded from the review if:

- Articles focussed on therapeutic care more generally as opposed to trauma-informed care.
- Studies assessed the use of trauma-informed care in residential care services for adults rather than young people.
- Studies focussed on therapeutic care in residential treatment facilities for substance abuse, residential homes for people with learning disabilities, or residential care in forensic settings. The reason for this is because these homes have been designed with differing purposes in comparison to residential care homes for looked-after children, which means that the experiences of staff generally within these homes will differ significantly, as would their experiences of delivering trauma-informed care.
- The article was not published in the English language. The reason for excluding these articles was due to restrictions on time and funding to translate the articles to English,

and due to questions of whether online translation tools would be able to provide accurate translations of the articles.

Data Extraction

1499 articles were identified after conducting the search, which were then exported into Endnote software. 1435 articles remained after the removal of duplicate articles. After screening the titles and abstracts of the articles 20 articles remained, where the full-text was read to assess for eligibility. Based on the inclusion/exclusion criteria, seven articles were suitable to be included in the systematic review. After completing forward/backward citation searches of these seven papers, one additional paper was identified, giving a total of eight papers to be included in the review (see Figure 1 for PRISMA diagram that shows the process undertaken during the literature search). Alongside the qualitative research findings being extracted from each article for analysis, data regarding the characteristics of each study were also extracted. Study characteristics related to the country in which the research was undertaken, the aims of the research/research question, participants included in the study, the particular model of trauma-informed care implemented by staff, the methodology undertaken, data analysis strategy used, and summary of key findings (see Table 2 for summary of articles included in the review).

The Galvin et al. (2022) paper did not use the same data as the Galvin et al. (2021) paper. The Steinkopf et al. (2020) study involved three waves of interviews, after which the Steinkopf et al. (2021) paper used the data from the third wave of interviews conducted in the 2020 study.

Quality Appraisal

The Critical Appraisal Skills Programme tool (CASP) was used to appraise the strengths and limitations of the selected studies (Public Health Resource Unit, 2006). This

ten-item tool is commonly used within qualitative systematic reviews, and recommended for those new to research due to the transparency of the framework increasing accessibility (Noyes et al., 2018). It requires the researcher to consider whether the methodology was appropriate in the studies selected for the review, as well as question the value of the findings and whether ethical considerations were considered. The CASP tool is also recognised to contribute towards the first step of analysis when using a thematic synthesis approach, which is the analysis that has been used in the current systematic review (Long et al., 2020).

The ten questions asked in the review required a response of 'yes,' 'no,' or 'can't tell.' The first two questions in the CASP tool were to enable the researcher to rule out any ineligible studies. The other eight questions addressed research design, process of methods and analysis, reflexivity, ethics and implications. Rather than using the 'yes/no/cannot tell' responses used in the tool, it was felt that the rating scale used by Duggleby et al. (2010) would be useful to give each research paper an overall score of quality. This would allow us to establish the stronger papers in comparison to the papers that were rated to have lower quality appraisal scores. A score of one point indicated a weak score, whereby it was deemed that the researcher of a particular study offered little to no justification for a particular issue. A score of 2 points was rated as a moderate score, and this was assigned to papers that addressed a particular issue but did not fully elaborate on it. A score of three points was rated to be a strong store, and it highlighted papers that appropriately justified and explained an issue. The maximum score that could be given was 24. (see Table 3 for quality appraisal of the studies using the CASP tool).

A peer not otherwise involved with the research who acted as a second rater also independently undertook the quality appraisal scoring, in order to increase inter-rater reliability. The adapted approach to CASP scoring used in the research was explained to the peer, who also used the same approach in their scoring of the studies. As the number of

papers eligible for inclusion were quite limited, the peer rated all eight papers. From the quality appraisal of all the papers, the researcher and second rater applied the same scores to most of the items in the CASP tool, suggesting high inter-rater reliability and consistency in the scoring. For the few scores that were rated differently, the researcher and second rater explained their reasoning for the scores and reached a compromise to achieve a final score for the item.

Data Analysis

The method of synthesis used for this review was the Thomas and Harden (2008) approach to thematic synthesis, as this approach allows for flexibility in synthesising the primary findings from qualitative research to identify prominent or recurring themes across the selected papers (Maeda et al., 2022). Participant and author data were treated together in the analysis based on Thomas and Harden's (2008) rationale that rather than drawing distinctions between participant quotes and author interpretations as done in meta-ethnography (Atkins et al., 2008), all data in an article can be considered part of the author's interpretation as their perspective would impact which participant quotes to select and include in the paper.

The three-step approach was followed, whereby data was coded line-by-line to search for concepts that highlighted how participants from studies perceived or experienced TIC within the residential care setting. The codes were added onto an Excel spreadsheet and were then grouped by similarity, for example all codes relating to how the implementation of TIC impacted on relationships were grouped together. This allowed descriptive themes to be identified which stayed close to the themes that had been formed across the selected studies. The third stage of the synthesis involved analysing the descriptive themes to develop broader analytical themes that provided an answer to the research question of the current review,

specifically the attitudes of care staff towards TIC. During this process, multiple supervision meetings were held with the academic supervisor to support with the analysis. The supervisor was able to provide support with refining the themes to ensure they formed a clear narrative. (See Table 4 for thematic grid to show the development from descriptive themes to analytical themes and see Table 5 for examples of stages of analysis for theme 1: "TIC builds an understanding of the needs of young people").

Analysis

Eight studies were considered eligible for inclusion in the current systematic review. One study was conducted in Canada, three in Australia, one in England, two in Norway and one in Estonia. Across the studies, authors used observational research designs, semi-structured interviews and focus groups. Models of TIC used across residential care services included Curriculum-based Risking Connection (RC), Restorative Approach (RA), the Sanctuary Model, Restorative Parenting Recovery Programme (RPPP) and Three Pillars of TIC. Participants across the studies mainly consisted of residential care staff. However, two of the studies were also able to recruit supervisors, therapists and staff in more senior leadership roles as well as care staff. (See Table 2 for summary of articles included in the current review).

The following four papers scored the highest (21 out of 24) in the CASP quality appraisal: Galvin et al. (2022), Parry et al. (2021), Steinkopf et al. (2020), and Vamvakos and Berger (2024). The study by Strompl et al. (2024) scored the lowest, with a score of 17 out of 24. Two of the three highest scoring papers were featured more heavily in the final themes. However, the Steinkopf et al. (2020) paper was present in two of the four themes and the Strompl et al. (2024) paper was present in three of the themes despite being scored as the weakest paper (see Table 6 to see which papers were included in each of the themes).

It was agreed by both raters using the CASP tool that all the papers included in the review had clear aims and the qualitative methodologies used in the papers were considered appropriate to address these aims. A majority of the papers were considered to have scored highly in the research design question as detailed justifications were offered into why particular designs were used. For example Strompl et al. (2024) explained their reasonings for using focus groups as a way of increasing communication amongst team members that could then be implemented in their practice. By contrast, although Galvin et al. (2022) had stated their use of semi-structured interviews, little explanation of their decision-making process was offered. With regards to recruitment strategy, papers varied with the amount of information offered. Those papers that had scored higher such as Vamvakos and Berger (2024), had offered more explanations regarding the selection procedure, the experiences participants had in relation to TIC and inclusion/exclusion criteria. In terms of ethical issues, papers that had scored highly had offered more rigorous explanations as to how they had ensured ethical standards were upheld. For example, Steinkopf et al (2020) included a section to explain how they ensured consent, right to withdraw and anonymity was communicated to participants. By contrast, Baker et al. (2018) had briefly mentioned that consent was obtained from participants, but there was not much more information offered to the reader. In terms of findings, papers that had scored higher such as Vamvakos and Berger (2024) and Galvin et al. (2021) included a clear discussion of the findings, and explicit information was provided regarding the clinical implications of the studies.

Four themes were identified from the synthesis, which will be outlined below with supporting quotes.

Theme 1: TIC builds an understanding of the needs of young people

This theme refers to how staff felt that the implementation of TIC encouraged staff to understand the role of trauma in the current needs of the young people they were caring for. Across studies, participants felt that TIC provided them with the appropriate tools to facilitate meaningful conversations with young people. It was also felt that TIC provided staff with the tools to challenge current organisational policies that may not serve the best interests of children. However, the importance of a shared understanding of trauma-informed policies was pointed out, to allow for consistency of care.

There was a general consensus that the implementation of TIC led staff to steer away from trying to discipline behaviours that were viewed as 'challenging.' There was instead a greater focus on understanding the impact of trauma on the subsequent needs of young people: "it is absolutely that prompt of 'what has happened to you' and a real shift in not just our thinking, but the language that comes out with that as well" (Galvin et al., 2022, page 659). As staff felt more informed on how previous trauma experiences impacted the current needs of young people in care, they then felt able to focus on setting future goals and supporting young people with a movement towards healing, highlighting the ability of the model to promote positive change, "it means you're working with them you've got a goal for them, to see them into a happy family hopefully for the rest of their lives" (Parry et al.,2021, page 1003).

It was felt that TIC focussed on creating a homely, nurturing environment for young people, "we give them like hugs and we do treat them like our own children" (Parry et al., 2021, page 1003). Participants in Vamvakos and Berger's (2024) study similarly agreed the importance of nurturing environments in increasing a sense of belonging for young people, "If I'm putting myself in [the young person's] shoes, having a homely environment would make me feel safe there. Whereas a clinical environment be like, *stuff this, the walls are*

white, there's nothing going on here. I'm going" (page 7)." However, to enable this to occur, Strompl et al. (2024) highlighted the importance of creating "safety, stability and support".

It was also felt that the adoption of strengths-based approaches gave young people a feeling of empowerment, as their views were increasingly valued in decisions made regarding their care, thus demonstrating how principles of TIC can be used to increase feelings of autonomy in young people, "Should we be so single-minded and stubborn, when we want to be trauma-informed? Our thinking was challenged in a way" (Steinkopf et al., 2020, page 633).

In order to allow for TIC to be truly embedded within a service leading to trauma informed changes, the importance of a shared understanding of TIC at an organisational level was emphasised. A shared understanding would allow for greater consistency of care as there would be an agreement on the sorts of values and visions to promote within the homes:

> We have had staff in the past, that blame these kids and think 'why are they here, get them out of the house, they've damaged that car again'. No one in our team now, would even mention that, they are saying 'oh that poor child, what has happened to him for him to be doing all of this', and that's a real shift in the way that people really think about what happens and those conversations that they have, Sanctuary explains that to them and it all contributes to that general picture (Galvin et al., 2021, page 4).

Theme 2: TIC improves relationships

This theme refers to the views of staff that TIC led to an improvement in relationships between staff and young people, as staff are supported in understanding the trauma-related needs of young people, as well as receiving support in facilitating open and transparent conversations with young people regarding care needs. It was also felt that using TIC in practice allowed for improved communication across the staff team and a greater feeling of

‘togetherness.’ There was also an improved relationship noted with supervisors and across wider networks and staff felt their views were increasingly heard and valued. Additionally, there was an appreciation for how TIC considered the impact of parallel processes that can occur within homes, with the recognition that supporting staff with their own needs and addressing their traumas can then put them in a better place to support young people using TIC.

Most of the papers found that the implementation of TIC allowed for improved relationships between staff and young people. In the study by Galvin et al. (2022), participants felt the Sanctuary Model gave them the tools to facilitate open and honest conversations with young people, thus allowing for the development of trusting relationships, “support them, to help them regulate, and support themselves emotionally” (page 660). Through the development of these positive relationships, witnessing the growth and progress of young people led staff to feel restoration, highlighting how the strengths of these relationships enabled fulfilment for staff and young people alike, "you just think wow this is really working and seeing that difference and seeing them…little children who can cope a little bit better, it’s just amazing" (Parry et al., 2021, page 1003).

There was an appreciation for TIC in the way that as well as focussing on improving relational patterns between staff and young people, there was also a focus on building trusting relationships amongst the staff team, whereby staff were present to support each other through challenging situations, “all of a sudden we are talking about vicarious traumatisation and maybe this is really hard for them and maybe this is something they need help with… co-workers really started to provide support to each other” (Baker et al., 2018, page 672). It was felt that the TIC models facilitated open discussions amongst staff, which they would draw on to improve their methods of communication, “There will be explicit conversations about trauma, about children and young people’s trauma history, but also what happened for this

carer, what might be happening for this group of people" (Galvin et al., 2021. page 6). Similarly, participants in Steinkopf et al.'s (2020) study shared how openness amongst the staff team created a more positive working atmosphere within the homes, "…is a great place to work. We are open-handed and generous, we can disagree about matters, but we discuss it openly, and settle things right" (page 634).

There was also a focus on establishing specific strategies, such as the use of a "buddy system", to create a safe space for staff to support and learn from each other (Vamvakos & Berger, 2024, page 8).

It was felt that the implementation of TIC enabled improvements in relationships between staff and supervisors, due to a greater understanding of the pressures associated amongst both roles. Participant's in Baker et al.'s (2018) study discussed feeling empowered, as supervisors gave them a "voice" in decision making, and through the use of TIC principles, there was a recognition that staff were "doing the best they can" (page 672).

Across studies, participants appreciated the way TIC considered parallel processes, whereby it recognised the impact of trauma on a systemic level, and the way it promoted the need for staff to be appropriately supported so they are then in a position to provide better quality of care to young people:

> It's not actually just about the outcomes for the kids it's about outcomes for our staff. Staff who are feeling supported and protected and safe at work…and I think then as a result, that then trickles down to the direct care work with our young people (Galvin et al., 2022, page 661).

The importance of collaboration between the homes and wider networks was also highlighted across studies, "TIC should be seen as a collaborative practice…These

collaborative relationships are underpinned by a shared goal of ensuring safety, stability and support for the child to meet his or her developmental needs." (Strompl et al., 2024).

Theme 3: The role of leadership in providing containment around implementation

This theme refers to ways in which staff felt that organisational structures and processes had influenced their ability to implement TIC. The importance of TIC models being valued by those in leadership positions was emphasised, to enable them to provide staff with the appropriate reflective practice spaces and supervisory spaces to review their use of TIC models. However, structural barriers to effective implementation of TIC were identified, such as lack of resources and difficulty in approaching supervisors due to busy schedules.

It was generally agreed by participants across studies that the effectiveness of TIC implementation was dependent on the investment of those in leadership positions in the models used. If managers were to understand the principles of TIC, they would be in a better place to support the needs of and understand decision making of staff members, “We know where it has been most successful is when you have your leaders practicing it and expecting it. Not just practicing it, but talking about it, setting the expectation” (Galvin et al., 2021, page 4). Steinkopf et al. (2021) stated that TIC models can place staff in emotionally vulnerable positions as they require staff to address difficult emotions and vulnerabilities that can arise in the work with young people. Thus, they highlighted the importance of managers to be aware of this, so that their leadership role can be used to provide containment around implementing TIC, “As more services adopt trauma-informed practices to address the needs of traumatised adolescents, it is increasingly crucial to acknowledge these emotional costs” (page 199).

The use of reflective practice was highlighted across studies as providing a safe space for staff to openly communicate and share their experiences of implementing TIC.

Participants in Galvin et al.'s (2022) study recognised reflective practice as a containing space where staff had the ability to discuss challenges associated with their role, without fearing judgement from others, "it helps us move, change our practice, adapt… it's also important to just be together, and process some of the things that have happened" (page 661).

However, in a few of the studies participants identified structural challenges that acted as barriers in effective implementation of TIC. It was felt that limited resources was a real barrier to making full use of the model:

> I think that whole area is under-resourced, Sanctuary, the Sanctuary team, the Sanctuary Institute, the clinical staff, and, in every area, I would say is under-resourced…I'm not sure that we have invested in the resources required to be able to really fully embed it (Galvin et al., 2021, page 5).

Participants also reflected upon the lack of space within homes which prevented them from approaching managers for support, "it is hard to talk to a supervisor who has an 'open door policy' when there is no staffing support for a break" (Baker et al., 2018, page 671).

Theme 4: Challenges to interpreting TIC correctly and the need for training

This theme refers to how participants across studies felt that inconsistent interpretations acted as barriers to effective implementation of TIC, as staff felt confused over the correct method of practice. Whilst it was felt that training led to more favourable attitudes towards TIC, on the whole participants across studies felt that training sessions were too theoretical, and pointed out that ongoing, practiced-based sessions were needed to support staff to implement the models within the homes.

As TIC models provided staff with a framework rather than a specific method of intervention, it was felt that this led to inconsistent interpretations of the model amongst the staff team. In the study by Galvin et al. (2021), participants expressed how some of the tools

suggested by the Sanctuary Model led to confusion amongst the team due to them being used inconsistently. For example, participants discussed how red flag meetings were misinterpreted as being a "weapon to use when something's not right" which was believed to be "a problem for us as an organisation" (page 5). Participants in Vamvakos and Berger's (2024) study similarly stated that where principles of TIC were misunderstood, they would not be used in a meaningful way, but rather reduced down to a compliance-based checklist, "I'll take a big document, a checklist for [the young person's] independence mainly…and just go through that with them…and most of the time they don't want to engage in it because it's a big, lengthy document" (page 6).

Participants additionally reported feeling conflicted in trying to use the principles suggested by the model by showing greater understanding towards the trauma needs of young people, whilst still trying to provide consistency in structure and boundaries, "I think one of the mistakes we made initially in implementing TIP, was that we became afraid of setting safe boundaries. We were afraid of triggering something, and we forgot to be safe grown-ups" (Steinkopf et al., 2021, page 633). By contrast, participants in Parry et al.'s (2021) study felt that using TIC made it easier for staff to sustain routines and structure for young people, "the routine, for them is amazing, they know what they're supposed to be doing everyday…and it minimises triggers" (page 1002).

In many of the studies it was felt that lack of ongoing training acted as a barrier to effective implementation of TIC. Participants in Galvin et al.'s (2021) study felt that the training was too "theoretical" and more practice-based training was needed regarding TIC to enable them to "think about the more practical, pragmatic ways of using it" (page 5). They added that the lack of ongoing training led them to forget about the principles of TIC, "it's just not front of mind enough. I have no doubt that a refresher would be valuable" (page 5). One participant in Vamvakos and Berger's (2024) study stated the importance of culturally-

specific training to meet the needs of young people who are from global majority backgrounds, “we’ve got about eight young Aboriginals in our organisation at the moment, and…I think there’s only one training around culture” (page 7). Participants in Baker et al.’s (2018) study felt that training led to more positive attitudes towards trauma informed care, and gave them the tools to implement with young people in the homes, “a framework for…taking some of that theory and transcribing it into how to actually work on the floor with the youth” (page 670).

Discussion

The current systematic review aimed to explore the attitudes and experiences of staff towards TIC in residential care services for young people. Thematic synthesis was used to analyse the findings sections of eight research papers. From the synthesis, four analytical themes were identified: ‘TIC builds an understanding of the needs of young people’, ‘TIC improves relationships’, ‘the role of leadership in providing containment around implementation’, and ‘challenges to interpreting TIC correctly and the need for training.’

The first theme referred to participants’ views that the principles of TIC provided them with the tools to develop a greater understanding of how the trauma of young people might affect their presentation of ‘challenging behaviours.’ Subsequently, rather than trying to discipline the behaviour, there was a focus on understanding their emotional needs. This is congruent with research that has argued the importance of staff recognising behaviours as adaptive rather than irrational and disruptive (Cauffman et al., 2005; Levenson, 2017). Izzo et al. (2010) conducted longitudinal analysis to explore the impact of the CARE model, they found that a focus on the trauma-needs of young people led to a reduction in aggressiveness towards authority figures as well as well as a reduction in missing episodes, highlighting how the implementation of TIC can lead to an increase in positive outcomes.

Participants appreciated how TIC emphasised the importance of shared values, to enable consistency of care within the home. Where individual staff members did not agree upon the shared values held by the organisations in which they worked, participants felt this was detrimental to the effective implementation of TIC, as it would undermine the work of the team. The Cognitive Appraisal Theory similarly proposes that an individual's previous experiences can affect their appraisal of situational change (Smith & Ellsworth, 1985). In the context of attempting to implement particular values within residential care, it may be that prior negative experiences can lead particular staff members to perceive situations or people as threatening (Wang et al., 2021). Thus researchers have suggested that organisations adopt particular leadership styles, such as Servant leadership, whereby those in senior positions work with staff to feel safe in the context of change to enable them to appraise situations more positively (Wang et al., 2021). Koury and Green (2017) highlighted how the role of TIC champions within services can be useful in encouraging changes on an organisational level. This highlights important clinical implications in terms of the role of managers to provide safety and containment to staff within their roles, which may occur through the agreement of shared values, reflective practice spaces and supervision. Appointing TIC champions may also support with oversight of the approach within the care setting.

The second theme referred to participants' reflections that TIC facilitated improvements in relationships between staff and young people, due to encouraging the use of openness and transparency in order to allow for increased communication. This is in line with research on therapeutic models of care that have highlighted the importance of the relationship between residential care workers and young people as they essentially become the primary caregiver, therefore taking the leading role in working to build secure attachments (Arvidson et al., 2011; Treisman, 2017). The current evidence-base is also in support of this, highlighting how the ability to build secure attachment patterns within the

care home setting can be more powerful than even the use of a specific intervention or model (Clarke, 2011; McLeod, 2011). Additionally from an attachment focussed perspective, positive relational processes within the home can support a child to move from a place of blocked trust with caregivers to building safer, trusting relationships (Baylin & Hughes, 2016). Clinical implications are suggested, specifically in relation to staff being supported to build positive therapeutic relationships with the children in their care. This may be through the use of supervision or therapeutic support whereby staff are provided with the opportunity to develop awareness of their own potential trauma histories and attachment patterns and how to navigate this in their practice with young people.

The current review highlighted how the implementation of TIC enabled staff to feel more contained and supported as there was a focus on them receiving support for their own trauma histories, with consideration of how vicarious traumatisation may occur through work with young people. Literature on child welfare systems argued the importance of considering the emotional demands on staff when managing the complex needs of young people with significant trauma histories, and how this can impact on burnout and compassion fatigue (Boyas et al., 2015; Griffiths et al., 2017). Therefore, it is increasingly important that interventions are embedded within organisational practices to support staff with self-awareness and emotional regulation (Griffing et al., 2020). When considering parallel processes, the development of positive relationships at a systemic level can facilitate a ripple effect of openness, collaboration and safety. The Sanctuary Model proposes the development of a trauma-responsive environment, where trauma informed practices and responsive strategies are implemented at all levels of the organisation to support those in senior positions and staff as well as young people (Bloom and Sreedhar, 2008). Clinical implications are suggested, specifically in relation to protecting the psychological wellbeing of those at all levels of the organisation and being aware of the impact of collective or secondary forms of

trauma. Access to psychological support can be useful in supporting staff and managers with the emotional demands of the role, as well as providing consultations on how they are able to better understand the emotional needs of the young people in their care and how they can then support them accordingly.

The third theme highlighted the importance of leadership in the implementation of TIC within the care homes. Participants shared that it was important for them to receive managerial support and containment around challenges, and for this to occur there was a need for those in leadership positions to be as equally invested in the TIC models. Researchers that have specifically looked into the needs of care staff within residential care services have similarly pointed out the need for staff to receive effective supervision in order to promote their wellbeing, increase the quality of care they feel able to provide to young people, and prevent turnover (Baptista et al., 2014; Carvalhais & Formosinho, 2023). Clinical implications are recommended, where it is important that the staff receive adequate supervision within their roles, and a safe space to express any frustrations they may have. Psychologists, who are able to provide training, consultations and support to residential care services, may be able to provide external support to the staff team in managing the challenges of the role. As part of clinical implications, it is also important to consider the impact on residential care managers, as they work closely with staff and young people so will be exposed to similar challenges, as well as facing additional organisational pressures. This is in line with various healthcare leadership models used within the healthcare sector, such as the NHS Healthcare Leadership Model (NHS Leadership Academy, 2013) and the LEADS Leadership Framework (Dickson & Tholl, 2020). These models highlight the importance of those in leadership positions undertaking self-exploration as this can increase their abilities to authentically model cultural change within the setting, thus leading the staff team to also be more willing to implement this change.

In the fourth theme, participants across the selected studies felt that a lack of understanding regarding the principles of TIC acted as a barrier towards implementation. It was felt that where training was provided, it would be beneficial if staff were supported in how to implement the theories behind TIC in practice, in order to meet the specific needs of young people. Conners-Burrow et al. (2013) conducted a study to investigate the impact of TIC training for residential care staff. They found that training led staff to feel more confident in their knowledge of TIC, and subequently embedded it more within their practice. This suggests important clinical implications, specifically the importance of regular training within organisations to provide clarity on the model, answer questions staff may have regarding their understanding of the model and to support staff in implementing principles of TIC into practice.

Strengths and limitations

This was the first review to synthesise literature that has explored the direct attitudes of care staff. As the evidence-base regarding TIC in residential care services for young people is particularly small, it is important that reviews are conducted of the existing literature, so the research is able to inform development of new policies (Emsley et al., 2022). It is also then makes it possible to identify gaps in existing literature and whether further research is needed in a particular area. Another strength lies in the way the findings observed across papers were generally consistent. Participants across studies seemed to agree on how they felt TIC was effective in their practice within the homes, whilst identifying similar challenges that prevented them from implementing the principles. This can allow for useful recommendations to be suggested when thinking about how TIC can be more effectively implemented within services.

Although the inclusion criteria stated that the review aimed to explore the perspectives of all staff working directly with young people where TIC was used, a majority of the studies only included perspectives of residential care workers. This limited the ability of the review to consider the varying perspectives of staff in different roles, which would have been useful to explore. However, this does suggest that there is a gap in the literature, whereby further research is needed to investigate the experiences of staff in other roles in using TIC, such as managers for example.

A limitation of the current systematic review is that ENTREQ guidelines were not followed. The ENTREQ guidelines have been considered useful as they can assist researchers to enhance transparency in the way they promote comprehensive reporting of synthesis of qualitative studies (Tong et al., 2012).

Future Research

Since the current review has suggested clinical implications in relation to the importance of leadership and those in supervisory positions to help oversee the implementation of TIC, it would be helpful for future research to explore this further. Research could be conducted to investigate the views or experiences of managers as they attempt to support the implementation of TIC and the organisational challenges they encounter as part of the process.

It is important to note that the studies selected for inclusion in the review were conducted in European/Western countries, therefore not accounting for the views of staff in residential care homes across the Global South. Upon reflection, African/Asian cultures have been known to implement collectivist methods in their healthcare practice, where there is a focus on a sense of community, as opposed to Western countries where the focus is predominantly on treating the needs of the individual (Hawsawi et al., 2024). Further research

could explore this further, by comparing TIC practices in Western countries to the approaches used in Asian/African cultures. This could provide important implications in the development of new policies, or thinking about ways in which TIC could be adapted to make implementation more feasible.

Conclusion

This review highlights how the implementation of TIC in residential care services for young people can help staff build a greater understanding of the trauma needs of the children in their care. There is also an increased focus on supporting staff at all levels of the organisation to prevent burnout and exhaustion. The findings of this review can be used as a starting point for further research in this area, perhaps exploring how staff in varying roles perceive TIC differently and what their experiences may be. Increasing the evidence-base in this area will allow for policy recommendations to be made.

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Table 1. Key Concepts and Search Terms

Key Concepts	Search Terms
Trauma Informed Care	(DE "Trauma-Informed Care" OR DE "Trauma-focused Care") OR TI (((Trauma-informed OR "Trauma informed" OR trauma-focused OR "Trauma-focused") N3 (care OR therap*)) OR TIC) OR AB (((Trauma-informed OR "Trauma informed" OR trauma-focused OR "Trauma-focused") N3 (care OR therap*)) OR TIC)
Care staff	((child-care OR childcare OR "child care" OR support OR paraprofessional Or para-professional OR care OR therap* OR residential) N3 (worker* Or staff*)) OR AB ((child-care OR childcare OR "child care" OR support OR paraprofessional Or para-professional OR care OR therap* OR residential) N3 (worker* Or staff*))
Residential care homes for young people	((residential OR group OR child* OR "out-of-home" OR out-of-home OR treatment) N3 (home* OR setting* OR care OR facilit* OR centre* OR center*)) OR AB ((residential OR group OR child* OR "out-of-home" OR out-of-home OR treatment) N3 (home* OR setting* OR care OR facilit* OR centre* OR center*))

Table 2. Summary of articles included in the Systematic Literature Review

Author/Country	Research Question	Participant Characteristics	TIC approach used	Data Collection and Methodology undertaken	Key Findings
Baker et al. (2018) Canada	To develop a deeper understanding of TIC implementation and its effects with a specific focus on understanding the mixed program evaluation findings related to vicarious traumatisation.	10 staff members: 5 direct care staff including caseworkers and residential care workers, 5 'other' staff including therapists and supervisors.	Curriculum-based Risking Connection (RC) and Restorative Approach (RA).	8 hours participant observations, 10 in-depth interviews. Descriptive coding methodology.	Key themes: Evidence of successful TIC implementation, vicarious traumatisation, parallel processes in the context of TIC implementation.
Galvin et al. (2021) Australia	To identify the enablers, barriers, organisational successes and challenges experienced by	9 staff members from MacKillop Family Services: 8 executive staff members from the residential out-of-home-care services,	Sanctuary Model	Semi-structured interviews. Thematic analysis.	Four enablers identified for implementing the Sanctuary Model: shared trauma-informed knowledge

decision makers when implementing a trauma-informed, organisation-wide model in residential OoHC.	one HR Manager who participated on behalf of a staff member, 4 males, 5 females.	and understanding, leadership and champions, structures, creativity and flexibility. Three barriers identified for implementing the model: infidelity of the model, lack of practice-based and refresher training, poor resources. Organisational successes experienced through the means of: The Sanctuary commitments, the S.E.L.F framework, reflective practice.

Galvin et al. (2022) Australia	To explore and better understand the enablers and barriers of implementation and how these impact on the organisational successes and challenges of adopting The Sanctuary Model, as perceived by residential out-of-home care staff.	38 residential care staff across various residential care homes from the MacKillop Family Services. Staff members included: area managers, coordinators, supervisors, case managers, residential care workers, a principal practitioner, therapeutic specialists (clinicians), and an educator.	Sanctuary Model	Semi-structured interviews, focus groups. Inductive and deductive thematic analysis.	Four key themes: Enablers infuencing implementation, organisational successes of implementation, barriers influencing implementation, and organisational challenges of implementation.
Parry et al. (2021) England	To explore staff experiences of delivering RPRP to young people.	12 staff members working in residential care homes, 4 male, 8 female.	Restorative Parenting Recovery Programme (RPRP).	Semi-structured interviews.	Three key themes: Learning and implementing trauma-informed

				Deductive thematic analysis.	practice and caring, therapeutic practices and relationships, reconciling the ethos with the reality.
Steinkopf et al. (2020) Norway	How are TIP principles based on the three pillar model transformed into practice in a residential care unit for adolescents in Norway?	19 staff members working in a public child welfare residential institution, 7 male, 12 female, age range: 24-65.	Three pillars of TIC, based on the work of Bath (2008).	3 waves of semi-structured interviews: 8 interviews in April 2015, 11 interviews in June 2016, 8 interviews in May 2018. Systematic network analysis, based on the approach by Attride-Stirling (2001).	3 themes: Self-awareness (ability to self-reflect, authenticity and co-regulation abilities), Intended actions (building strength, building mentalisation skills, providing staff availability, setting safe and clear boundaries, collaboration with youth),

					Organisation and cultural practices (organising themes of a commonly shared mindset, stability and routine, cultural safety).
Steinkopf et al. (2021) Norway	What factors characterise situations, contexts, and interactions that elicit, or threaten to elicit, emotional dysregulation among staff in this particular Norwegian residential child welfare unit?	8 staff members working in a public child welfare residential institution, 3 males, 5 females, age range: 24-65.	Three pillars of TIC, based on the work of Bath (2008).	Semi-structured interviews Thematic narrative enquiry based on the approach by Riessman (2008).	3 themes: doubt and emotional strain, emotionally dyregulating experiences linked to prior life experiences, lack of support in challenging situations or in interactions with adolescents.

Strömpl et al. (2024) Estonia	The experiences of foster carers and residential caregivers with trauma-informed care.	13 participants, 11 females and 2 males.	General trauma-informed care practices.	Four focus groups – two groups were with foster parents and two groups with residential care workers (only the findings gathered from residential care workers will be discussed). Thematic Narrative Analysis.	Key theme: need for information about the child's traumatic past.

Vamvakos and Berger (2024) Australia	1: What are the experiences of RCWs implementing trauma-informed approaches into everyday practice? 2: What are the perceived barriers to implementing TIP in residential care, if any? 3: What are RCW's recommendations to improve TIP in residential care, if any?	7 residential care workers, 4 females and 3 males.	Trauma-informed practice based on themes identified by Steinkopf et al. (2020).	Semi-structured interviews. Interpretative Phenomenological Analysis (IPA).	Key themes: self-awareness in practice, self-regulation strategies, adaptable to others, authenticity and integrity, working with intention, promoting self-agency, providing safety, creating conditions for positive change, training and development, professional development opportunities, life experience, team culture, team cohesion, staff

support, organisational responsibilities, listening to and understanding needs of residential care workers.

Table 3. Quality Appraisal of Studies using the CASP tool

	Baker et al. (2018)	Galvin et al. (2021)	Galvin et al. (2022)	Parry et al. (2021)	Steinkopf et al. (2020)	Steinkopf et al. (2021)	Strömpl et al. (2024)	Vamvakos and Berger (2024)
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is the qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	3	2	2	3	3	3	3	3
Was the recruitment strategy appropriate to the aims of the research?	1	2	3	3	2	2	2	3
Was the data collected in a way that addressed the research issue?	3	3	3	3	3	3	3	3

Has the relationship between researcher and participants been adequately considered?	1	1	1	1	2	1	1	1
Have ethical issues been taken into consideration?	1	3	3	3	3	3	3	3
Was the data analysis sufficiently rigorous?	3	3	3	3	3	3	1	3
Is there a clear statement of findings?	3	3	3	2	3	2	1	2
How valuable is the research?	3	2	3	3	2	3	3	3
Total Score	18	19	21	21	21	20	17	21

Table 4. Thematic Grid to show the development from descriptive themes to analytical themes

Analytical theme	Descriptive theme
TIC builds an understanding of the need of young people	- Movement towards shared values - Creation of psychological safety, and focus on healing rather than achieving discipline - Focus on strengths based approaches, empowering young people and staff - TIC gives staff the tools to challenge existing practices
TIC improves relationships	- Improved relationships between staff and young people - Feeling of togetherness, colleague support, improved communication amongst staff team - Improved relationship with supervisors and wider networks, staff felt empowered, given a voice during meetings - Parallel processes
The role of leadership in providing containment around implementation	- Importance of leadership support - The role of reflective practice - Structural challenges, including limited resources and lack of space
Challenges to implementing TIC correctly and the need for training	- Inconsistent interpretations of the model - Balancing TIC implementation with upholding structure and routine - Need for practice-based training

Table 5. Examples of stages of analysis for theme 1: "TIC builds an understanding of the needs of young people"

Key quotes	Initial codes	Descriptive themes	Analytical themes
"Some (RCWs) think rewarding the child now to be good in my shift…but not looking at the holistic view of it. That tomorrow if I don't reward a child in the same way you have, that child doesn't understand. It creates that confusion." (Vamvakos & Berger, 2024, page 8)	Lack of buy-in to the model acting as a barrier to allowing change	Movement towards shared values	Tic builds an understanding of the needs of young people
"These collaborative relationships are underpinned by a shared goal of ensuring safety, stability and support for the child to meet his or her developmental needs (Strompl et al., 2024)	Shared values of safety, stability and support		

“Huge shift in the language.” (Baker et al., 2018, page 670)	Shift in language	
“That’s a real shift in the way that people really think about what happens and those conversations that they have, Sanctuary explains that to them and it all contributes to the general picture.” (Galvin et al., 2021, page 4)	Shared understanding enabling for consistency of care	
“It means you’re working with them you’ve got a goal for them, to see them into a happy family hopefully for the rest of their lives.” (Parry et al., 2021, page 1003)	Sense of hope – focus on long term goals	Creation of psychological safety, and focus on healing rather than achieving discipline
“It is absolutely that prompt of ‘what has happened to you’ and a real shift in not just our thinking, but the language that comes with that as	Movement towards understanding trauma	

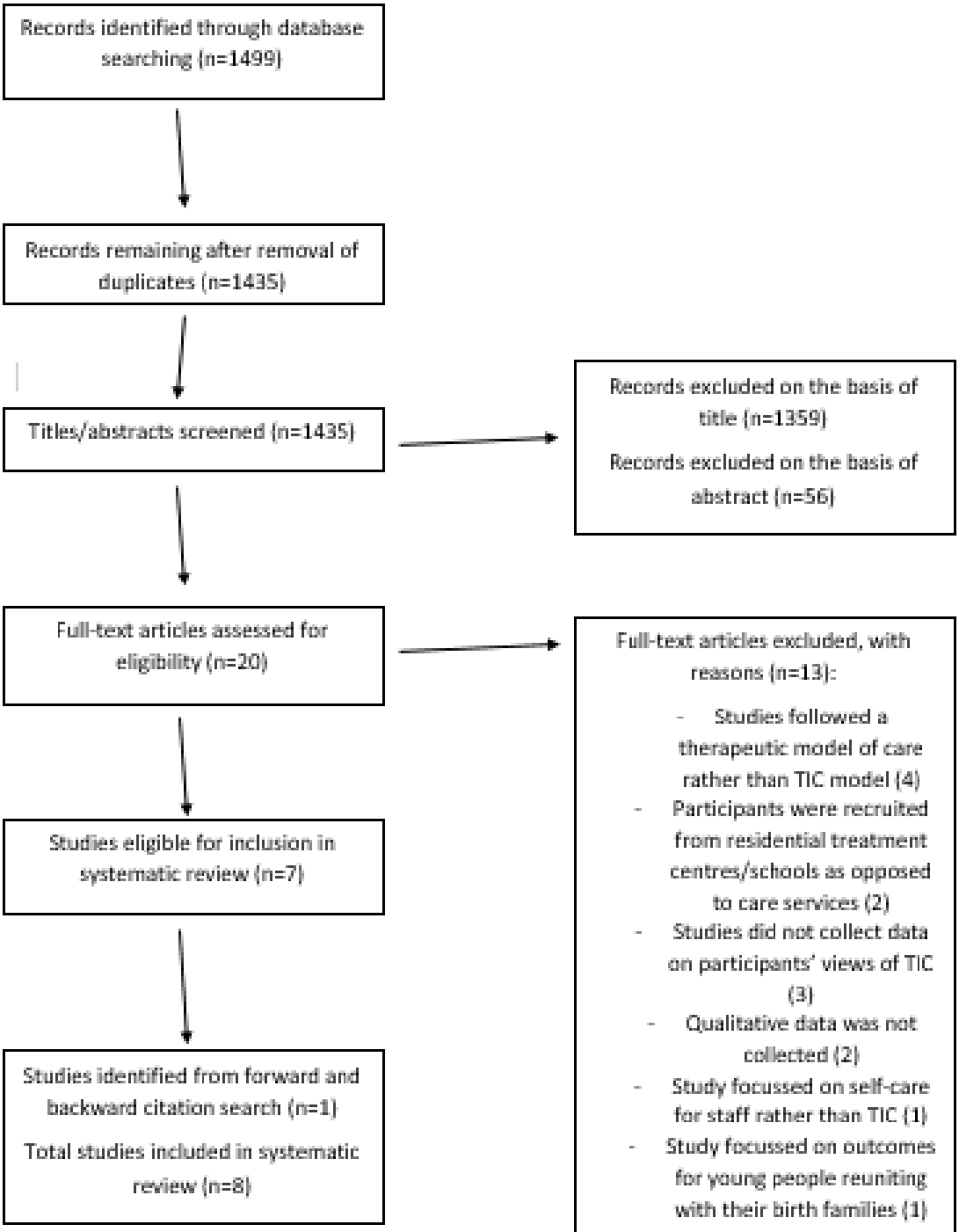
well." (Galvin et al., 2022, page 659)		
"We give them hugs, and we do treat them like our own children." (Parry et al., 2021, page 1003)	Creating a homely, nurturing environment	
"If I'm putting myself in the young person's shoes, having a homely environment would make me feel safe there." (Vamvakos & Berger, 2024, page 7)	Increasing sense of belonging for young people	
"Participants noted the universal adoption within their division of a relational and strengths-based approach to working with youth." (Baker et al., 2018, page 670)	Shift towards relational and strengths based approach	Focus on strengths based approaches, empowering young people and staff
"After a while she said I could go outside and just leave the door open,	Giving young people a voice as a form of empowerment	

she would try to calm herself that way, she wanted to try something new." (Steinkopf et al., 2020, page 633)		
"And I was like 'just sit on the table, eat your food'…and that's something I would get in trouble for." (Vamvakos & Berger, 2024, page 7)	Challenging existing practices	TIC gives staff the tools to challenge existing practices
"Putting the child at the forefront and listening to their wishes and feelings…that works well." (Parry et al., 2021, page 1002)	Open and honest conversations with young people	

Table 6. Table to show the which papers were included in the themes

	Theme 1 – TIC builds an understanding of the needs of young people	Theme 2 – TIC improves relationships	Theme 3 – The role of leadership in providing containment around implementation	Theme 4 – Challenges to interpreting TIC correctly and the need for training
Baker et al. (2018)		X	X	X
Galvin et al. (2021)	X	X	X	X
Galvin et al. (2022)	X	X	X	
Parry et al. (2021)	X	X		X
Steinkopf et al. (2020)	X	X		
Steinkopf et al. (2021)			X	X
Strömpl et al. (2024)	X	X		
Vamvakos and Berger (2024)	X	X		X

Figure 1. Prisma Diagram



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Back to top

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Back to top

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Back to top

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Back to top

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Back to top

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Doctorate in Clinical Psychology | Lancaster University

Chapter 2 : Empirical Paper

Experiences, challenges and support needs of managers in residential care services for children

Munisah Kabir

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Munisah Kabir

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4YW

m.kabir1@lancaster.ac.uk

Abstract

Background: There has been a large amount of research that has explored the needs of children in residential care services. Exposure to adverse childhood experiences increase their risk of developmental trauma, leading to difficulties with emotion regulation and building secure attachments with caregivers. Subsequent research has explored implications for care staff, specifically looking at how they can support young people in their development. There has also been research exploring how staff can be better supported with their wellbeing, due to the emotional constraints associated with their role. However, there has been no research to date that has looked at the role that managers play within the care setting. As their role involves providing direct care to the staff team and young people, whilst balancing organisational needs, it is important to consider how they experience their role, and how they are supported in managing the challenges. The aim of the current research was to explore the role of managers in residential care services for children.

Method: Semi-structured interviews were undertaken online with six managers of residential care homes in the UK. The interviews were analysed using Reflexive Thematic Analysis.

Results: Four themes were identified from the analysis: “Promoting a positive culture within the home”, “You can’t do it on your own’: accessing external support”, “Personal impacts of the managerial role” and “Support received as part of the managerial role”.

Conclusion: Managers have a crucial role in the maintenance of a positive culture within homes, and in encouraging a therapeutically-minded environment. Challenges to their role include difficulties in upholding morale during crisis, and trying to meet the cultural needs of children in the absence of external support. Clinical implications were also discussed.

Keywords: Managers, leadership, residential care services, looked after children

Introduction

Children may be unable to live with their parents, either temporarily or permanently, if their parents cannot safely care for them (Winter, 2006). This may be due to a multitude of reasons, such as the illness or death of a parent, or disabilities affecting the parent's ability to provide adequate care for their child (Rocco-Briggs, 2008; NICE, 2021). Residential care homes are shared spaces with on-site support staff available at times to support the needs of children within those homes (Galik, 2013).

Developmental trauma accounts for difficulties the child may experience in their psychosocial and neurodevelopmental functioning as a result of abuse and neglect in caregiving relationships (Berthelot et al., 2015; D'Andrea et al., 2012). Pat-Horenczyk et al. (2015) similarly argue that disruptions to secure attachment patterns can affect emotion regulation, autonomy, and the ability to achieve developmental milestones at the same pace as that of a typical child.

The complex needs of young people within residential care services have important implications for care staff. Researchers have emphasised the importance of a secure and positive relationship between care staff and children (Coady, 2014; Timmerman et al., 2017). It has been shown that the relationships developed between the staff and children significantly shape the child's experiences and can act as a model for future relationships (Howe et al., 2000; Zegers et al., 2006). Qualitative studies with young people highlight the importance they place on their relationships with staff, whereby they believe that a trustworthy and consistent relationship allows them to feel secure and maintain positive wellbeing (Augsberger & Swenson, 2015; Gallagher & Green, 2012).

However, care staff face challenges including resource limitations, and limited access to health and social care services that can affect the care they are able to provide to young

people (Berridge et al., 2012). Difficulties in accessing additional psychological or emotional support for a child can mean that their needs are not being properly met (Castillo et al., 2012). Frequent staffing changes, staff absences or frequent changes in shift patterns can affect the ability of staff members and children to build stable and trusting relationships (Degner et al., 2010; Hannon et al., 2010). Steels and Simpson (2017) also highlighted difficulties in accessing therapeutic training for staff, which means staff may not have the relevant experience or training to know how they can best support the children in their care, and meet their emotional or risk-related needs.

When considering implications in the challenges faced by care staff, it is important to consider the role that managers play within the care setting, and how they experience the complex dynamics of the residential care system. The role of the manager is also crucial in providing regular supervision and emotional support to staff, alongside therapeutic training (Clough et al., 2006). Rocco-Briggs (2008) similarly discussed the importance of leadership to support staff to be aware of their own relationship patterns/psychological challenges and how this may influence their work with children. The role of the manager is also important in empowering the staff team and promoting positive cultural change by 'changing the narrative,' which can allow staff to recognise the value they add to the lives of young people, whilst also providing young people with a foundation to develop healthy relationship patterns that they can enact in future relationships (Anglin, 2004; Gibson et al., 2004).

Smith et al. (1989) used the term 'parallel processes' to explain how, when two or more systems join together, whether this be on an individual, group, or organisational level, the systems develop similar affects, cognitions and behaviour. Within the context of residential care services, Bloom (2010) argued that organisational pressures and staff's own potential histories of trauma, which may be similar to those of children, mean parallel processes may be present in terms of psychological difficulties and stressful environments for

both staff and children. When considering parallel processes, it is then important to consider how they impact upon managers as they balance the dynamics of expectations placed on them by their superiors, along with managing the staff team and the needs of children. Given the complex needs of children in residential care homes and the challenges faced by staff in supporting them, it is important to consider the role of managers and how they fit within this system. As part of this theory, it is also important to be aware of the 'ripple effect' that can occur, as the way in which managers practice their role has a subsequent impact on the staff team and children in their care. Therefore, if managers are appropriately supported in their role, they can better look after staff who are then able to better support the children in their care.

There is currently no qualitative research exploring managers' experiences of managing residential care homes. However, Hicks et al. (2009) examined the varied management structures and processes across 45 residential care homes in England, and the impact of these on outcomes for children. Multi-level analysis was used to bring together the various forms of quantitative and qualitative data gathered through interviews and surveys of managers, residential care staff, young people, social workers and other members of staff involved with the homes. The researchers suggested important implications for managers in enabling effective leadership to be maintained within the homes. These implications focussed on the role of the manager in creating and maintaining an efficient staff team, in which leadership was essential to maintain positive morale, decide on a consistent approach to the work with children and achieve unity amongst staff members. Implications for relevant training were also discussed, whereby researchers suggested that when accessing training for staff, it was important for managers to consider a balance between allowing for an increase in knowledge whilst also encouraging cultural growth (Hicks et al., 2009). This research therefore highlights the importance of the residential care manager position, however, there is

currently no research which further explores this qualitatively from the managers' perspective.

The aim of the current research was to develop a greater understanding of how managers perceive and experience their role. We aimed specifically to understand how they experience and manage the psychosocial dynamics of the care home, how they manage the practical challenges of the role, and how they are supported to manage the inherent challenges of the role.

Method

Design

A qualitative approach was used based on reflexive thematic analysis [RTA] (Braun & Clarke, 2019). The reason for using a qualitative approach was because there is a lack of research into the role of managers within residential child care settings and a qualitative approach allowed for a more exploratory approach to be taken than if a more structured, questionnaire-based approach had been adopted.

RTA was chosen over other forms of thematic analysis because it emphasises the active role of the researcher in interpreting the data, encouraging a more fluid and creative approach that is not dependent on a rigid coding framework (Braun & Clarke, 2020a). This fitted firstly with the exploratory, nature of the study and, secondly, because my interest in the topic was partly influenced by my prior experiences of working as a support worker in a residential care home for people with learning difficulties. RTA enabled me to acknowledge those experiences in informing my approach to the research but also ensured that I remained aware of my own preconceptions. For example, when participants discussed the lack of cultural diversity within the field, this is something I resonated with due to previously working in a predominantly White British setting whilst coming from a South Asian background. Reflecting upon this in supervision during the data collection and analysis

process meant that I was able to pay particular attention to understanding the significance of these experiences for participants, guided by my own experiences, but ensuring that the analysis was grounded in the experiences of the participants.

Consideration was also given to using Interpretative Phenomenological Analysis (IPA), however because this was the first research looking at managers' experiences, it was felt to be important to allow for a broad exploration of different aspects of the role, including space for description as well as interpretative detail. It was felt that this would be most beneficial in informing the next steps for future research as well as highlighting the range of issues raised across participants.

Sampling considerations

Braun and Clarke (2019b) state that when considering the amount of data items collected, it is important to consider that RTA is based on the researcher's interpretation of the data, which is open to subjectivity. As such, they argue that the number of participants to include is subjective and cannot be fully determined ahead of the data collection process. My supervisor and I agreed in the design phase that aiming to include 8-15 participants would provide enough data to generate robust themes, as well as considering the time restrictions associated with the research project. However, because of difficulties with recruitment, data collection came to halt after the sixth participant had been interviewed.

Three managers of residential care homes had expressed an interest in taking part in the research, however due to busy work schedules interviews could not be arranged despite several attempts to do so. We considered pursuing other routes to extend data collection, however, this would have been difficult to set up within the time left for the project. We also decided to code and develop provisional themes from the existing interview data in order to gauge whether further data was needed. As a result of this process we decided that there was

sufficient information power (Malterud et al., 2015) within the data produced from these six interviews to develop a robust analysis.

Participants

Six managers working in residential care settings across England and Wales were recruited. Deputy managers and area managers were excluded as the responsibilities and experiences involved with their role are different to those of registered managers. Another exclusion criterion was managers responsible for homes specifically set up for young people with learning disabilities. The reason for this was that the dynamics of these homes are different to residential homes for looked-after children, so the experiences of managers may differ significantly. The final inclusion criterion was for managers to have been in their role for two years, as this meant they would have a greater breadth of experience to reflect upon.

Prior to participation, managers were asked to complete questionnaires which contained details of their demographic information. The ages of participants ranged between 30-65 years. Four of the participants identified as female, and two as males. Five participants were of White British ethnic background, and one participant was from a global majority background. The six participants were managers of residential homes across three different services; four managers worked within a local authority, one worked for a private organisation, and one participant worked for the charity sector. The length of time participants had been managers of residential care homes for ranged from 2-17+ years. The following pseudonyms have been used to protect the anonymity of the participants: Carol, Amy, John, Simon, Ava and Rachel.

Recruitment

The research was advertised via the field supervisor to a range of residential care services within the UK. Posters were circulated through senior managers to potential

participants, who were then asked to get in touch with the field supervisor or researcher if they wished to take part (see Chapter 4: appendix 4-C for recruitment poster). The researcher responded to managers thanking them for their interest in the study, and forwarded the information sheet, which contained more information about the research (see Chapter 4: appendix 4-B for information sheet). The consent form (see Chapter 4: appendix 4-D for consent form) and demographic questionnaire (see Chapter 4: appendix 4-E for demographic questionnaire) were also sent in the same email, and managers were asked to complete these and send them back prior to the interview taking place.

Ethical Considerations

Ethical approval was obtained from the Lancaster University Faculty of Health and Medicine Research Ethics Committee (see Chapter 4: Appendix 4-H for letter of ethical approval).

Data Collection

Interviews took place online via Microsoft Teams between July 2023 and June 2024, and ranged from 40-90 minutes. Microsoft Teams was used to record and transcribe the interviews. The interviews were semi-structured, where a topic guide was used to ensure the topics covered addressed the research question. This ensured there was flexibility to ask follow-up questions/alternative questions not included in the topic guide to aid more in-depth discussions (see table 1 for interview guide). The interview guide was developed following conversations that were held jointly with the field supervisor and research supervisor. A meeting was also held with an area manager of a residential care service, and discussions held during the meeting were useful in informing the topics and questions developed. The main areas to be covered to capture the aims of the research question were outlined, and these included experiences of being a manager, practical challenges of the role, support received as

part of the role, etc. For each topic area, more specific questions were then developed as a guideline to ask participants during the interviews. Examples of questions included, “what support do you receive in your role as a manager?”, and “how do you manage relationships within the team?”

Data Analysis

After data collection, the six-step method of thematic analysis outlined by Braun and Clarke was adhered to (Braun & Clarke, 2019). After conducting and transcribing the interviews, I read through the transcripts again to increase familiarity with the dataset, taking notes of initial impressions. This was followed by systematically coding the entire dataset for interesting features that related to how participants experienced their roles within the residential care setting (see Table 2 for example transcript from an interview with a participant). The codes were added to a spreadsheet, and analysed to develop patterns across the data. A set of provisional themes were developed (see Appendix 2-A) which were reviewed and revised to better address the research aims (see Table 3 for thematic grid to show development from quotes, to codes, to themes). The themes were written up, with extracts from the data used to support the themes. As outlined by Braun and Clarke (2020a), a more creative and fluid approach was taken in the analysis process, whereby rather than following the six-step framework in a rigid manner, I would move back and forth between each step. For example, during the write up process there were revisions made to the codes included in each theme if it was felt that a particular code fit better in a different theme. Throughout the analysis process multiple supervision meetings were held with the research supervisor to discuss the development of the coding process and themes. The research supervisor provided support with refining the themes to ensure that across the themes there was a clear narrative that provided insight into managers’ experiences, whilst ensuring that there was no overlap across the themes. For example when developing the provisional

themes, two separate themes of ‘Pressures of the role’ and ‘Experiences of the role’ had been developed. Supervision was useful in thinking about how these themes could be refined to enable them to move towards being more analytical rather than descriptive. These two themes were then combined to create the final theme of ‘Personal impacts of the managerial role’ which captured elements of both themes. Having frequent supervision meetings also ensured that there was an added level of credibility and trustworthiness to the analysis, by making sure that we were staying close to the primary data and reviewing the analysis at each point. Additional supervision meetings were also held with the field supervisor to support with the analysis process and both supervisors provided feedback of the written findings. One of the discussions that arose was regarding the data around lack of diversity amongst managers in residential care settings and the impact of this on young people from global majority backgrounds. Whilst it felt important for this to be an explicit theme, supervision was helpful in considering how my own background and experiences might predispose my interpretations of the data and wanting to give more space to this issue. As lack of diversity was an issue that was only raised by one participant and briefly mentioned by another, it was agreed in supervision that it would be better to mention this as an area for future research rather than prioritising it as a theme in the findings section. This would allow us to ensure that the themes that were included were capturing the broad experiences of the all the participants interviewed, as opposed to a theme drawing on the experiences of only a few participants.

A Constructivist epistemological stance was taken, based on the belief that knowledge and perceptions of reality are constructed through social interactions and experiences (Burns et al., 2022). This stance aligned with the aim of the study in exploring the experiences of managers within their role. This stance also aligned with the flexible nature of the RTA approach, as RTA does not require a particular epistemological stance to be taken and its

reflexive element accounts for the role the researcher takes in interpreting the data and how this will be influenced by their own experiences and backgrounds (Braun & Clarke, 2020a).

Results

Four themes were developed from the data.

Theme 1: Promoting a positive culture within the home

There was a consensus amongst participants that an important part of the managerial role was to create and maintain a positive and nurturing environment within the homes with the staff team and children. Promoting shared values that were both accepted and equally valued by the staff team was seen to be more effective than adopting an authoritarian approach to leadership:

> You can rule with an iron fist if you want to, but I think that doesn't work. What you've got to do is get staff teams that are buying into what your culture is, what your ethos is, what your passion is (John).

Simon felt that a benefit to implementing a shared culture of values, such as kindness, openness and transparency, was that the team were "singing off the same page," which allowed challenges to be addressed "positively and constructively."

To enable the development of a positive culture, participants shared that they worked closely with staff to build positive working relationships amongst the team. Various strategies were used to enable this:

> We had offsite team building days where we had a bit of fun and got to know each other and we did a lot of exercises around what triggers you, what behaviours do you find really difficult, just so that we can support and look after each other on shift as well (Amy).

Ava similarly discussed the importance of team building exercises, “if I invest in them then therefore the children should feel that benefit and I should feel that benefit.” Rachel discussed the advantages of using “role modelling” as part of her managerial role as a way of building positive relationships within the home, whereby she would try to model healthy patterns of relationships with the team that staff could then implement in their work with young people.

There was an emphasis on focussing on the strengths of the children to foster the development of the positive culture. John discussed how he used photography to capture positive moments young people have experienced, to ensure that their stay in residential care steered away from the institutional elements of care and focussed on building a nurturing environment:

> I want the files in the homes to replicate the care that young people receive…if young people request their files when they become adults I don’t want them to just see incident records, I want them to see they’ve been to the beach or they used to sit there and play monopoly.

To foster a nurturing environment, importance was placed on methods of communication, whereby participants encouraged the use of certain types of language, “We don’t call them debriefs. We say we should have a check-in after last night and things like that. So the language we use is very different (Amy)”.

However, whilst participants felt that much of their role involved the sustenance of a positive culture within the homes, there were challenges to achieving this. Participants felt that challenges occurred where individual staff members had their own values that conflicted with the therapeutic approach that is encouraged in the homes, “the biggest challenge for me is getting staff to understand that these are traumatised children, their brain is damaged by the trauma they have...you can’t have the same rules as you would have at home for your own

children (Carol)". It was also shared that during periods of crisis, participants experienced greater difficulty in upholding staff morale, "I was challenging the negative environment and then staff have gone off sick, so that's been really difficult (Amy)".

In summary, participants generally agreed that an important part of their role involved the creation and maintenance of a shared culture, whereby certain values such as respect and kindness were encouraged to foster the development of a positive therapeutically-minded culture within the homes. However, participants identified challenges to promoting a positive culture when there were conflicting values held by individual staff members, or during moments of crisis which had a detrimental impact on staff morale.

Theme 2: "You can't do it on your own": accessing external support

This theme refers to challenges participants experienced in ensuring the needs of children were met, as well as their experiences of accessing external support.

It was felt that part of the managerial role required challenging agencies and existing practices where it was deemed to be in the best interests of the child. Amy discussed how an important part of her role involved advocating for the young people in her care where other agencies are suggesting placement moves for young people presenting with challenging behaviours.

Participants that managed homes that were owned by the local authority expressed difficulties in challenging the local authority when they tried to seek emergency placements for other young people that would not suit the needs of the young people already residing there:

> We've got to think about the impact, the young people we've got are settled. You've got to think about those children. I think sometimes they look at the one child that's in crisis, but not what the domino effect could be on other people (John).

Amy expressed similar frustrations with regards to local authority challenges, and felt there was increased autonomy in the decisions made when she previously worked in a home within the private sector.

With regards to accessing external support, Carol felt that accessing mainstream services was difficult, "getting CAMHS is also a huge practical problem. There is just not a CAMHS service out there." She discussed the detrimental impact this had for young people as it meant they were left with unmet needs, "children end up locked up in secure services for their own safety because it wasn't recognised that they've got mental health problems".

Although John agreed that access to CAMHS services was difficult, he felt it was important as part of his role to be creative and look beyond mainstream services for support, "it's about making sure we know what other services are out there".

By contrast, it had been stated that networking with third sector agencies during the initial set-up of the homes and frequent check-ins with their agencies meant that they were more readily available to provide support for young people when needed, "Our networking as a home is incredible…But I do think it was impacted by the fact that we'd already built relationships with them before we opened (Amy)". Simon similarly discussed the importance of ongoing liaisons, which he implemented into his managerial role:

> It's also just about having that network isn't it…it's often not what you know, it's who you know, it's getting the key to the door and just saying oh what do you think about this?

Simon discussed the benefits to young people of different agencies working collaboratively:

> It's about bringing those agencies together and making a real difference…what's the saying, it takes a village to raise a child doesn't it. You can't do it on your own, you need the support of other agencies and other people around you.

There was an appreciation for specific access to psychological services in providing therapeutic support in the work with children. Rachel described the usefulness of engaging in consultations with a psychology service in supporting staff to reflect upon the reasons behind challenging behaviours observed in children, as well as working with staff to increase self-awareness in their own relational patterns, "and how that applies to interactions as well." John additionally discussed the usefulness of consultation with psychologists in being able to establish psychological safety for the staff team as well as supporting staff members following incidents, "it has been really good around helping us to figure out who we are, what we all need and that makes people feel more psychologically safe I think as well then."

In summary, participants reflected on how their role involved advocacy and for them to question existing regulatory practices in order to meet the needs of the children in their care. Whilst participants discussed experiencing difficulties in accessing mainstream services to support young people and staff, they used creativity to seek assistance from third sector organisations that could provide tailored support. Participants also strongly valued support from psychology services, as they felt that the therapeutic intervention enabled staff to gain a better understanding of the reasons behind challenging behaviours in young people. Therapeutic consultations were also believed to be useful in providing psychological safety for the staff team, and allowing staff to increase awareness into their own relational patterns which would then influence their work within the homes.

Theme 3: Personal impacts of the managerial role

This theme refers to how participants experienced the complex dynamics of their managerial role within the residential care setting, in terms of the emotional experiences the role has had for them, and the impact on their lives, including issues related to diversity.

It was generally agreed amongst participants that the role involved conflicting feelings of stressfulness as well as satisfaction from seeing positive change, “it is emotional chaos because it is absolutely brilliant when you see staff develop. It’s brilliant when you see children develop. But equally, it can be extremely stressful when children aren’t developing as they should” (Carol).

There was also a general consensus regarding the magnitude of the impact the role has on participants’ lives, “residential care is a lifestyle not a job, it impacts everything, and it’s a whole different way of thinking. You have to completely invest in these young people” (Amy). This made it difficult for them to obtain a healthy work/life balance, “I said to my wife that I sold my soul to this local authority for a long time” (Simon). Participants discussed how this difficulty was exacerbated by being on-call, “it is constant pressure because as a manager I’m on call 24/7. The only time I’m not on-call is when I’m on holiday and even then they’ll try a cheeky phone call” (Carol). Amy reflected upon the pressure she felt of being legally responsible for the homes, “there are very few roles that you are legally responsible for 24-7, 365 days of the year. Yes, ok I can still have somebody on call, but it doesn’t matter who’s on call I’m still legally responsible and that weighs down.”

Whilst it was believed that the role required a huge commitment from participants, they made continual efforts to establish boundaries in order to protect their own wellbeing. Rachel discussed how her attempts to uphold boundaries has been a gradual learning process over time as she has settled into her role. Whilst she saw herself as “hyper aware” when she first became a manager on-call, the understanding that other support systems are always present through the availability of other managers, the police, etc. allowed her to become more accepting of the fact that she might not always be available straight away. Rachel also discussed the importance of communication with the staff team so they are aware of what her boundaries are in terms of availability for support. John similarly discussed the importance of

time management within a managerial role as a way of establishing boundaries, “be very, very structured with time management because the ability to get pulled from pillar to post when you first step up can unravel really quickly.”

In summary, participants agreed that the managerial role involved conflicted feelings of stress in managing the varied needs of the staff team and young people, as well as feelings of reward in seeing their positive development. Whilst participants felt the role had a huge impact on their lives due to the great deal of time and investment required from them, they did attempt to put boundaries in place as a way of maintaining their own wellbeing.

Theme 4: Support received as part of the managerial role

This theme explores the support that participants received as part of their managerial role as well as considering other sources of support that were important to them.

In theme two, Carol felt there was not much support available from external agencies to support the young people in her care. Carol felt similarly about the support available to her as a manager, “there’s not really a huge amount of support for managers.” However, Carol seemed accepting of this, and was of the belief that the role of a manager is challenging and isolating, and thus requires a certain type of resilience to effectively manage the demands of the role, “that’s the job, get on with it. If you’re not the type of manager that can manage your own emotions and support the staff, you’re not going to be in the job very long.” By contrast, the other participants that took more proactive approaches in seeking external support for staff and young people through the use of networking and searching for third sector agencies, also acknowledged the importance of seeking support for themselves. Amy and John felt it was important to utilise support from other sources due to the role being “lonely” and “isolating”.

Participants reflected upon internal sources of support they received as part of their role. This could be in the form of supervision with their line managers, which provided "containment around frustrations" (John), or support from deputy managers of the homes who were able to assist with decision-making or offering a different perspective on a particular situation, "I have two deputy managers that are like absolutely amazing. One who has a social work background…we have good communication between us, you know bouncing decisions off each other" (Simon). Another important source of support was colleagues who managed other homes, which provided managers with containment, "knowing there is a manager you can always go to" (Rachel). Amy also discussed support from other managers through social media, "I'm in a WhatsApp group for registered managers and there's over 1000 people in there, and it is the best community because I can just ask any question and somebody's got some sort of advice for me." Amy felt that practical support from other managers was useful at times where she was struggling with the workload, "he's supporting me with my rota at the moment because just two weeks ago I emailed and said nope, I'm struggling, need some help." Ava discussed how peer support came in different forms, whereby it was helpful for one manager to do "the kicking" by providing "brutally honest" responses, whilst another manager may provide more "nurturing" support, whereby they are present to provide validation for difficult emotions. John discussed the role he takes in supporting his peers, whereby he felt that "humour" was a useful mechanism to cope with difficult situations as it allows colleagues to feel "connected and safe."

Participants also discussed how support from their own families was invaluable in managing the long hours associated with their role, "I'm very lucky to have retired parents and a husband who also works shifts. So we were able to balance it out" (Amy).

There was a strong appreciation for external support received from psychological services, whereby participants felt that the support was invaluable in identifying coping strategies to manage the challenges associated with their roles, “I think it’s made me much more resilient as well and be able to have those different tools and strategies to deal with the challenges that the job brings” (Rachel). It was also felt that the support provided containment and a safe space in which managers were able to offload difficult emotions experienced as part of the role, “when I’ve been frustrated around stuff I’ve had 1:1 sessions and to be able to talk in a really safe space and I’ve just vented over how I’m feeling really unregulated, but feeling safe to do that” (John). John described how having this space to offload emotions has then allowed him to think practically about how he can then support the staff team with similar difficulties they may be experiencing, “Then going how do I support my staff team in this?”

In summary, there was a noticeable contrast between Carol’s perceptions of support available to her within her managerial role, and that of the other participants who felt much more support was available through varying sources both internally and externally. This may be partly influenced by the home that Carol managed being run by a private organisation, whereas the other participants managed homes that were owned by the local authority, so they may have better opportunities for networking or accessing support from other public sector organisations. Participants generally felt that support from their own line managers and colleagues was particularly useful in providing practical solutions to problems, as well as providing containment and validation in difficult situations. Participants also valued external support from psychology services in providing them with the tools to cope with challenging situations, which participants then felt able to model with their staff team.

Discussion

This study aimed to develop a greater understanding of the experiences of managers working in residential care homes for children, by exploring their experiences of managing the complex psychosocial dynamics of the home, potential challenges they face as part of their role and how they are supported to manage these challenges.

Four themes were developed from the data analysis: ‘Promoting a positive culture within the home’, ‘You can’t do it on your own: accessing external support’, ‘Personal impacts of the managerial role’ and ‘Support received as part of the managerial role’. Amongst participants there was a general consensus that an important part of their role involved the creation and maintenance of a shared culture, whereby they encouraged the staff team to adopt a similar set of therapeutically minded values to create a safe and nurturing environment for the young people. It was also felt that through providing direct care and empowering the staff team and supporting them to progress in their roles, it would have a positive impact on the quality of care delivered to the young people. There were differing views on how accessible external support was, whereby one participant found it almost impossible to access support, some participants felt they had to use creativity to access support from third sector groups due to the difficulty in obtaining support from mainstream services, and others felt that frequent networking made it easier to seek support later on. Support from psychology services was also greatly valued, whereby participants felt consultations were useful for staff in thinking about reasons behind challenging behaviours observed in young people. Participants found psychology services useful in supporting them within their roles, as they felt them to be containing spaces in which they were able to offload difficult emotions, as well as think about effective tools to manage difficult situations, to allow them to then support the staff team better.

Creating a therapeutically minded environment. It had been discussed that the aim of creating a positive culture was to foster a therapeutically-minded environment, whereby rather than the focus being on disciplining challenging behaviour, healthy relational patterns and stable attachments were at the forefront to account for the trauma needs of the young people. This is accounted for in the growing evidence-base that highlights the importance of residential homes providing trauma-informed care at an organisational level as well as during the direct care of young people, to enable them to build secure attachment patterns with caregivers to allow for positive outcomes as they transition out of care (Dermody et al., 2018; Hummer et al., 2010; Whittaker et al., 2015).

Participants placed increasing importance on developing positive relationships between themselves as managers and the staff team to support the maintenance of a containing and nurturing space in which young people reside. There is growing evidence to suggest that as part of creating a therapeutically-minded environment within residential care, there needs to be a focus on supporting staff members within their roles due to the high emotional demands of the work (Eenshuistra et al., 2019; Leipoldt et al., 2019; Sellers et al., 2020). Whilst certain challenges of the role cannot be removed, if organisational structures are in place to provide support to staff members, such as the maintenance of a positive culture, this can allow the staff team to feel valued and supported, thus reducing feelings of burnout and staff turnover (Bakker & Demerouti, 2017; Glisson et al., 2012).

There are various leadership models that increasingly emphasise the need for more compassionate approaches to management and care as a way of improving relationships within organisations and protecting psychological wellbeing systemically. Open Dialogue encourages a community based, social network approach to increase collaboration (Razzaque & Stockmann, 2016), whilst Laloux's Model of Stages of Organisational Change (2014) thinks about ways in which organisations can move away from hierarchical practices to

embedding greater compassion within their culture. The Buurtzorg approach similarly recognises that staff are able to thrive in situations where they are provided with autonomy and trust, subsequently providing service users with better quality care (Kreitzer et al., 2015). Thus, when considering clinical implications, the role of psychologists can be useful in influencing the culture within residential care settings by providing support to managers in the form of conversations and support with specific issues. They can also provide team-based interventions or reflective practice for the staff team in order to encourage openness and practice compassion-based work which managers can then model themselves with the staff.

Access to psychological support. There was a great appreciation amongst participants for the support received through psychological consultations, as they were able to receive support in their roles as managers, as well as thinking about meeting the needs of the staff team and children. Silver et al. (2015) argue for the importance of early intervention and providing trauma-informed support, training and consultation on a systemic level. In regard to addressing wellbeing needs and mental health difficulties for looked after children and responding to their previous trauma, the importance of accessing support from Clinical Psychology services has been emphasised. Clinical Psychologists often work closely with residential care services to provide ongoing therapy, training, and consultation as they are able to provide a greater insight into the impact of adverse childhood experiences, and effective therapeutic approaches that can support with the distress faced by young people. They can also support staff with managing the emotional demands of the role, by creating a safe space for staff to be aware of their own psychological challenges and the impact of secondary traumatisation that may occur from working with the young people in their care. It is important to note that not all residential care services have access to psychology provision, however the findings from the current study highlight the usefulness that therapeutic support can have in supporting residential care settings as a whole.

Responsibilities of the role and support. In the current study participants reflected upon the constant pressures associated with the role as they were legally responsible for the care of the young people even during the hours in which they were not contracted to work. Mahara et al. (2024) conducted a scoping review on the wellbeing of managers working within residential care services for older adults, and similarly highlighted the need for adequate support. They found that ongoing contextual difficulties such as staff shortages, challenges accessing resources and ongoing stress led to detachment from the role, impacting on managers' ability to provide effective leadership and subsequently leading to burnout.

A majority of the participants in the current study felt they received adequate support in dealing with the pressures of the role through supervision from their own line managers and support from colleagues, as well as access to psychological services. However, it is important to note that not all managers have access to such frequent support. Woodward and Ruston (2022) pointed out the effectiveness of interprofessional collaboration amongst care homes and healthcare professionals in empowering support staff through the development of trusting relationships whereby support can be readily accessed. A similar view was taken by Willumsen and Hallberg (2003) whereby they highlighted the benefits of multi-agency collaboration in allowing for continuity of care and the sharing of different perspectives to serve the best interests of the young people. In terms of clinical implications, improved communication across agencies would be beneficial in increasing awareness of the existing pressures across services. This would allow for agencies to build tolerance and support for each other, with the hope of improving collaboration to meet the needs of the children in care.

The concept of parallel processes is also demonstrated in the current context, specifically with one participant where Amy mentioned that staff would go off sick when struggling to manage difficulties presented by young people and this had a detrimental impact on her own wellbeing. Clinical implications are suggested, specifically in terms of

organisations adopting more systemic approaches to wellbeing and a movement away from individualism. For example, the 2017 British Psychological Society paper, 'Psychology at Work' highlighted the importance of creating a culture of safety. Guidance during the COVID-19 pandemic also advocated for leadership approaches and relational processes to be prioritised over specific individual therapies (Highfield et al., 2020). However, where much of the research has considered the role of leaders in supporting with better wellbeing, it is important to note that leaders themselves are not immune to the emotional challenges faced by staff members of the same organisation. As such, the role of Psychologists could be invaluable in these settings as they can offer consultation and support to leaders as a way of influencing wider organisational strategy and culture (Conriff, 2022). Thus, when considering the concept of parallel processes, where managers are supported as part of their role and in maintaining their own psychological wellbeing, they are then placed in a better position to manage the demands of their role and model the support they receive when providing direct care to their staff team and children (Bloom, 2010).

Strengths and Limitations

Whilst there has been a volume of research that has explored the experiences of young people and care staff within residential settings, this is the first study exploring the perspective of managers. The findings of this study provide important clinical implications regarding the role that managers play within the residential care setting, as well as suggestions of how they can be better supported within their role.

It is important to acknowledge that the field supervisor involved with the current research worked for the psychology service that provided consultation, training and support to most of the participants that were interviewed. As such, their experiences may not be

applicable to other managers working in residential care settings who do not have access to psychology provision.

Another limitation of the current research was that recruitment strategy involved the field supervisor contacting various residential care services to invite managers to participate. Whilst recruitment was ongoing for approximately 11 months, it may have been beneficial to use other methods of recruitment during this time, such as inviting managers to participate through social media, etc.

Future Research

Whilst the current study was an effective starting point in considering the experiences of managers within the residential care system, further research could focus on using quantitative methodology that could be distributed to a greater number of managers across different geographical areas, in order to build on the findings gathered and determine generalisability.

As a majority of the participants were from White British backgrounds, the sample size was quite limited in terms of cultural diversity. This is something that could be useful to consider within future research, in order to increase understanding of the experiences of those working in residential care settings with regards to cultural diversity and inclusivity.

Conclusion

This study aimed to develop a greater understanding of the role of managers working in residential care services for young people. Findings demonstrated the role that managers play in creating and maintaining a positive culture within the home, balancing the needs of care staff as well as young people residing in the homes through supervision, advocacy and empowering staff and young people, as well as accessing external support to foster the development of a therapeutically minded environment. Findings also explored challenges

managers face as part of their role, in terms of difficulties in managing continual pressures and expectations, upholding staff morale during periods of crisis and trying to meet the cultural needs of young people. Finally, there was consideration of support managers receive as part of their role, whether this is through internal supervision by their line managers, or externally through other agencies such as psychological support.

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Table 1. Interview Guide

Topics/ areas to cover	Potential questions
Role as a manager	Please could you start by telling me about your role? What are some of the daily tasks you undertake in your role as a manager? Please could you talk about the route you took to becoming a manager?
Experiences of being a manager	How have you found your experience of working as a manager in a residential care setting? What are the biggest challenges as part of your role? What are the best parts of your role?
Managing psychosocial dynamics	How do you see your role as part of the staff team? How do you manage relationships within the team? What role do you have in supporting staff in their work with young people? What are the biggest challenges you face in supporting the staff team?
Practical challenges	Can you identify any practical challenges in your role as a manager? • If you are able to identify challenges, how do you manage these challenges? • Do you receive any support in managing these challenges?

Support received as part of role	What support do you receive in your role as a manager? Do you have access to other services, such as psychology services? If so, what have your experiences been with this? How do you find maintaining a work/life balance in your role as a manager? Are there reflective spaces/groups for managers that you are a part of, which allow you all to share your experiences? What guidance would you give to other managers, or to someone working towards becoming a manager?

Table 2: Example transcript from an interview with a participant

Transcript	Initial impressions/codes
Researcher: Ok, so what are some of the daily tasks that you undertake in your role as a manager?	
Participant: Lots of emails, they're sort of the bane of my life really. And and if I'm not careful, I can sort of get sucked into them and feel like I've, I've done nothing else all day. But it's, you know, sort of overseeing the the day-to-day running of the homes, making sure that that the, you know, the environments appropriate for the young people and meeting their needs and speaking to the young people, making sure I'm, you know, sort of gathering their views on how they feel that, you know, living in the home is. And if there's any issues that they have or any issues between particular staff and young people that I'm supporting to manage them. Supervision of staff, managing the health and safety in the homes, writing reports. So if if there's care proceedings ongoing for for young person who's accommodated, I might have to write statements for court reports to Ofsted if there's been a significant incident. Or you know after you know it's time for me quality of care report to to go in and writing those. Attending any multi agency meetings, risk management meetings, Missing from care meetings, education meetings, safeguarding reviews. What other sorts of meetings do we do? Health meetings? Lots and lots, Lots and lots of multi agency meetings really. If there have been any safeguarding concerns relating to members of my staff that was overseeing ladder investigations and making sure I'm communicating with with XXX ladder officer to to get those resolved, and capability or disciplinary issues with with staff making sure Staffs trainings right. I do deliver some training as well. So I'm a Safety Interventions, Physical Interventions Trainer for the service, making sure my own trainings in date and then some, you know, taking care of my	Responsibilities of the role – balancing line management duties with providing direct care of staff and young people. Making the home safe and nurturing for young people Managing psychosocial dynamics within the home. Responsibilities of the role – managing incidents. Liaising with other agencies regarding the needs of young people. Supporting staff with development through training and providing emotional support. Taking care of own wellbeing.

own personal development and my own well-being as well, signposting staff to well-being services, supporting them if they've been off work, sick and you know, managing absences. There's probably lots and lots of other things on a day-to-day basis, but that's, I think that's a pretty good rundown.	
Researcher: Yeah Thank you. That's been really helpful. It seems like there's quite a lot that you have to manage like on a day-to-day basis in terms of like looking after the needs of the young people but also supporting staff and supporting yourself as well and kind of taking that time for yourself.	
Participant: Yeah, yeah, it is. I'm never bored and it can be a real juggle and you know it's really tricky to get that that balance right. I don't think I very rarely finish a day or a week and and think yeah I've got that balance spot on and I've done everything that's on me To Do List. I think if that ever happened I'd I'd feel like I'd entered the Twilight zone. I think something weird was going on	Practical challenges of balancing different parts of the role. Becoming accustomed to the demands and pressures of the role.
Researcher: Because there's always like quite a lot to like kind of balance and yeah and I guess as you take one thing off there's always something else that gets added to the list as well.	
Participant: Yeah. Yeah, definitely.	
Researcher: So I guess my next question is what would you say is like one of the biggest challenges as part of your role?	
Participant: I think it is that sort of managing sort of competing demands because I like to be quite organized and structured. So, you know, I have my idea of what I want to get done every day and I've, you know, sort of planned my day out, but that can, you know, sort of quickly turn on a sixpence. There can be some, you know, sort of crisis in the home with a young person or somebody goes off sick. I didn't mention rotas did I. I don't know how I forgot rotas where when they	Challenges of the role – needing to be flexible due to periods of crisis or certain demands that need prioritising.

consume so much to have a time as well. But, you know, something like that can happen and I've got to, you know, completely change my plans for the day and then it's trying to find the time then to to catch up on those things that I should have been doing that day. So that can be be I think one of the biggest challenges.	Conflicts of wanting to be organised and have a set routine which cannot be stuck to during moments of crisis.
Researcher: And how do you kind of manage that prioritization and kind of having to like kind of having to decide what takes the most priority? How do you kind of deal with that?	
M: It's it's difficult to me. I've been how long I've been doing this job. Now I think nearly six years I've been a registered manager and I wouldn't say it's got any easier because the needs of our young people have have changed quite drastically. And even if, you know, you say I'm working with a young person who's got autism, which I've I've done a lot, No two of those young people will be the same. So what I've done or applied for one young person might not necessarily be right for them, but I think it's it's using the support that's that's around me. I'm really lucky that the management team that are working like my my colleagues, they're very supportive, very knowledgeable. We've all got you know different strengths and we we know that we can you know approach each other for that support. And my line manager, she's really supportive as well and a really good sounding board that if I am like struggling with what to do with something or whether I am making the right decisions, I know I can. You know, I can go to her and sort of say what I'm I'm thinking about doing or or what you know what my perspective on a situation is. And you know, most of the time it's just she does that not to give me any extra advice. She knows that I know what to do. It is just like so being there as a as a sounding board and and the team as as as well. You know, using the different strengths and	Difficulties in prioritising tasks, feeling like increase in experience does not make it easier to do. Tailoring support according to the needs of the young person. Utilising support networks to help with the demands of the role. Usefulness of colleague support, each colleague drawing on their own strengths to support each other. Support from line manager - can be in the form of advice or as a listening ear. Recognising the skills of the staff team, supporting them in implementing these skills effectively within the home. Delegating tasks to the staff team to ease the pressures of the managerial role, finding a balance to prevent burnout in the team. Delegating tasks helping with empowering the staff team.

capabilities in my team, which again is it can be a challenge because they, you know, they have an equally difficult job and they're on the shop floor, you know, looking after the young people and managing those behaviours first hand. So that that is something I suppose I find a little bit more difficult because I don't want to feel like I'm putting extra work on to them. But then also it's you know it's about still empowering them and you know getting them to do some of the meetings or you know some things that are you know, I can think actually I don't need to be there and I know that they can do, you know, just as good a job as I was going to do. I think that's something that over the years I've learnt to you know sort of let go of the the reins a little bit with with some things and not be so controlling over everything which can be that is a you know sort of hold my hands up that that is something that I found difficult because you know ultimately the homes are in my name. They're they're my responsibility. It's my registration and you know whatever happens in in those homes it is a, you know it's a reflection on me as as the manager. But so yeah, I've had to sort of, you know, recognize where I can delegate and and sort of let go of those rains a bits to help myself, but also to make sure that I'm still empowering my team and and developing people.	Feeling pressured by the legal responsibility of being a manager, learning healthier boundaries to help manage this.

Table 3. Thematic Grid to show development from quotes, to codes, to themes

Themes	Example Codes	Statements from participants
Promoting a positive culture within the homes	Recognising shared values	"What you've got to do is get staff teams that are buying into what your culture is, what your ethos is, what your passion is" (John).
	Creating a nurturing environment	"We don't call them debriefs. We say we should have a check-in after last night and things like that. So the language we use is very different" (Amy).
"You can't do it on your own": accessing external support	Difficulties to accessing mainstream services	"Getting CAMHS is also a huge practical problem. There is just not a CAMHS service out there" (Carol).
	Importance of collaborative practice	"It's about bringing those agencies together and making a real difference…what's the saying, it takes a village to raise a child doesn't it" (Simon).
Personal impacts of the managerial role	Impact of the job on lifestyle	"I said to my wife that I sold my soul to this local authority for a long time" (Simon).
	Difficulties of achieving a work/life balance	"it is constant pressure because as a manager I'm on call 24/7" (Carol).

Support received as part of the managerial role	Practical support received from colleagues	"he's supporting me with my rota at the moment because just two weeks ago I emailed and said nope, I'm struggling, need some help" (Amy).
	Access to Psychology provision	"I think it's made me much more resilient as well and be able to have those different tools and strategies to deal with the challenges that the job brings" (Rachel).

Table 4: Table to show which participants contributed to each theme

	Theme 1 – Promoting a positive culture within the home	**Theme 2 – "You can't do it on your own": accessing external support**	**Theme 3 – Personal impacts of the managerial role**	**Theme 4 – Support received as part of the managerial role**
Amy	X	X	X	X
Ava	X			X
Carol	X	X	X	X
John	X	X	X	X
Rachel	X	X	X	X
Simon	X	X	X	X

Appendix 2-A: Development of provisional themes from codes

1	Promoting a positive culture within the home	Importance of being flexible in case of any changes
2		Encouraging a culture of kindness amongst staff, which can then be modelled with young people
3		Recognising shared values
4		Encouraging staff to adopt trauma-informed care in their work with young people
5		Creating a nurturing environment for young people to reside in
6		Building cohesion amongst staff team through training prior to opening
7		Use of language to avoid institutional feel
8		Modelling healthy relationships with staff that they can then practice with young people
9		Upholding staff morale
10		Challenging negativity
11		Development of respect between manager and staff team
12		Importance of spending time with the staff team
13		Ensuring everyone feels valued
14		Capturing positive moments during interactions with young people
15		Working collaboratively with young people
16		Openness and honesty
17	Managing workload	Unhealthy work/life balance impacting on work quality
18		Difficulties of dual management
19		Feeling overwhelmed with the workload
20		Difficulty of work/life balance due to being on-call
21		Feelings of stress due to difficult work/life balance
22		Pressure of legal responsibility associated with the role
23		Lifestyle impact of the role
24		Pressures from every angle, doubts about being in the role
25		Balancing line management with direct care of staff and young people
26		Considering self-wellbeing and development as part of job role
27		Importance of time management
28		Importance of delegation to maintain wellbeing
29		Saying no
30	Supporting staff development	Supporting staff with personal and professional difficulties
31		Supporting staff in their progression
32		Supporting staff in developing their confidence
33		Providing containment for staff, space to offload emotions
34		Reflective practice with staff team
35		Reflecting on areas of strength and development - impact of Ofsted
36		Management of risk and health and safety
37		Impact of missing episodes on staff wellbeing
38		Impact of care on the wellbeing of young people
39	Support for staff and young people	Advocating for young people
40		Building attachments and stable relationships for young people
41		Importance of considering trauma when providing care to the child
42		Supporting physical health needs, emotional needs and learning disabilities of young people
43		Being alert for crisis situations
44		Importance of providing person-centred support
45		Matching staff skill sets with the needs of the young people
46		Providing bespoke training
47		Therapeutic frameworks used in care - FIELDS
48		Therapeutic framework used in the way the home is run - IFS, working towards a model of returning back home
49	Access to services	Use of OT to assess sensory aspects
50		Working alongside CAMHS to understand presentations of challenging behaviours
51		Advantages of linking different agencies together
52		Children's assessment centre - consisting of MDT
53	Pressures of the role	Scrutiny from police
54		Difficulty with recruitment
55		Difficulty with recruiting diverse workforce
56		Pressures from the company to take on young people
57		Impact of staff sickness
58		Feelings of helplessness during difficult moments with staff team
59		Difficulties of local authority pressures and restrictions
60		Difficulty of managers above not understanding residential life
61		Lack of support considering the legal responsibility of the role
62		Complex dynamic of protecting the best interests of the young people and staff vs business requirements
63		Pressures of ofsted, confidence to challenge expectations
64		Feelings of isolation in the role
65		Managing criticism from other agencies

66	Experiences of the role	Job satisfaction from seeing young people progressing
67		Difficulties of job impacting own wellbeing
68		Advantage of manager role – still having the opportunity to interact with young people and staff directly
69		Constant learning process occurring in the role
70		Emotional rollercoaster – rewarding feeling vs stress
71		Ability to make a difference and influence people
72		Emotional impact of the role
73		Establishing boundaries to protect wellbeing
74	Route to becoming a manager	Wanting to influence others
75		Learning from previous experiences
76		Feeling comfortable to ask for help
77		Importance of gaining experience before taking on managerial role
78		Progression to manager role from support worker role
79		Changing professions

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

Manuscript Submission Guidelines:

This Journal is a member of the Committee on Publication Ethics.

Please read the guidelines below then visit the Journal's submission site http://mc.manuscriptcentral.com/ccpp to upload your manuscript. Please note that manuscripts not conforming to these guidelines may be returned.

Only manuscripts of sufficient quality that meet the aims and scope of Clinical Child Psychology and Psychiatry will be reviewed.

There are no fees payable to submit or publish in this journal.
As part of the submission process you will be required to warrant that you are submitting your original work, that you have the rights in the work, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere, and that you have obtained and can supply all necessary permissions for the reproduction of any copyright works not owned by you.

If you have any questions about publishing with SAGE, please visit the SAGE Journal Solutions Portal

1. What do we publish?

1.1 Aims and scope

Before submitting your manuscript to Clinical Child Psychology and Psychiatry, please ensure you have read the Aims & Scope.

1.2 Article types

Clinical Child Psychology and Psychiatry is interested in advancing theory, practice and clinical research in the realm of child and adolescent psychology and psychiatry and related disciplines. Articles should not exceed 6,000 words (including abstract, references, tables and all other elements) and be clearly organized, with a clear hierarchy of headings and subheadings (3 weights maximum). Manuscripts exceeding the word limit cannot be considered for publication by the editor.

- Registered reports.

These submissions are reviewed in two stages. In Stage 1, a study proposal is considered for publication prior to data collection. Stage 1 submissions should include the complete Introduction, Method, and Proposed Analyses. High-quality proposals will be accepted in principle before data collection commences. Once the study is completed, the author will finish the article including Results and Discussion sections (Stage 2). Publication of Stage 2 submissions is guaranteed as long as the approved Stage 1 protocol is followed and conclusions are appropriate. Full details can be found here.

1.3 Writing your paper

The SAGE Author Gateway has some general advice and on how to get published, plus links to further resources. SAGE Author Services also offers authors a variety of ways to

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When writing up your paper, think about how you can make it discoverable. The title, keywords and abstract are key to ensuring readers find your article through search engines such as Google. For information and guidance on how best to title your article, write your abstract and select your keywords, have a look at this page on the Gateway:

How to Help Readers Find Your Article Online.

Back to top

2. Editorial policies

2.1 Peer review policy

The Editor will screen manuscripts for their overall fit with the aims and scope of the journal, especially in terms of having clear relevance for clinicians. Those that fit will be further reviewed by two or more independent reviewers in terms of merit, readability and interest.

2.2. Authorship

All parties who have made a substantive contribution to the article should be listed as authors. Principal authorship, authorship order, and other publication credits should be based on the relative scientific or professional contributions of the individuals involved, regardless of their status. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis.

2.3. Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References.

2.3.1. Third party submissions

Where an individual who is not listed as an author submits a manuscript on behalf of the author(s), a statement must be included in the Acknowledgements section of the manuscript and in the accompanying cover letter. The statements must:

Disclose this type of editorial assistance – including the individual's name, company and level of input

Identify any entities that paid for this assistance

Confirm that the listed authors have authorized the submission of their manuscript via third party and approved any statements or declarations,

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Please ensure that a 'Declaration of Conflicting Interests' statement is included at

the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that 'The Author(s) declare(s) that there is no conflict of interest'. For guidance on conflict of interest statements, please see the ICMJE recommendations here.

2.5. Declaration of conflicting interests

Clinical Child Psychology and Psychiatry encourages authors to include a declaration of any conflicting interests and recommends you review the good practice guidelines on the *SAGE Journal Author Gateway.*

It is the policy of Clinical Child Psychology and Psychiatry to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles.

Please ensure that a 'Declaration of Conflicting Interests' statement is included at

the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that 'The Author(s) declare(s) that there is no conflict of interest'. For guidance on conflict of interest statements, please see the ICMJE recommendations here

2.6 Research ethics and patient consent

Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki.

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, and all papers reporting animal and/or human studies must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval. Please ensure that you have provided the full name and institution of the review committee, in addition to the approval number.

For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written

informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative.

Please also refer to the ICMJE Recommendations for the Protection of Research Participants

Back to top

3. Publishing Policies

3.1. Publication ethics

Clinical Child Psychology and Psychiatry and SAGE take issues of copyright infringement, plagiarism or other breaches of best practice in publication very seriously. We seek to protect the rights of our authors and we always investigate claims of plagiarism or misuse of published articles. Equally, we seek to protect the reputation of the journal against malpractice. Submitted articles may be checked with duplication-checking software. Where an article, for example, is found to have plagiarised other work or included third-party copyright material without permission or with insufficient acknowledgement, or where the authorship of the article is contested, we reserve the right to take action including, but not limited to: publishing an erratum or corrigendum (correction); retracting the article; taking up the matter with the head of department or dean of the author's institution and/or relevant academic bodies or societies; or taking appropriate legal action.

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3.3. Open access and author archiving

The preferred format for your manuscript is Word. LaTeX files are also accepted. Word and (La)Tex templates are available on the Manuscript Submission Guidelines page of our Author Gateway.

Back to top

4. Preparing your manuscript for submission

4.1. Formatting

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4.2. Artwork, figures and other graphics

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4.5. English language editing services

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using SAGE Language Services. Visit SAGE Language Services on our Journal Author Gateway for further information.

Back to top

5. Submitting your manuscript

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IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past

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If you would like to discuss your paper prior to submission, please refer to the contact details below

Arpita Bhattacharya: arpita.bhattacharya@sagepub.in

5.1. ORCID

As part of our commitment to ensuring an ethical, transparent and fair peer review process SAGE is a supporting member of ORCID, the Open Researcher and Contributor ID. ORCID provides a unique and persistent digital identifier that distinguishes researchers from every other researcher, even those who share the same name, and, through integration in key research workflows such as manuscript and grant submission, supports automated linkages between researchers and their professional activities, ensuring that their work is recognized.

The collection of ORCID iDs from corresponding authors is now part of the submission process of this journal. If you already have an ORCID iD you will be asked to associate that to your submission during the online submission process. We also strongly encourage all co-authors to link their ORCID ID to their accounts in our online peer review platforms. It takes seconds to do: click the link when prompted, sign into your ORCID account and our systems are automatically updated. Your ORCID iD will become part of your accepted publication's metadata, making your work attributable to you and only you. Your ORCID iD is published with your article so that fellow researchers reading your work can link to your ORCID profile and from there link to your other publications.

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You will be asked to provide contact details and academic affiliations for all co- authors via the submission system and identify who is to be the corresponding author. These details must match what appears on your manuscript. At this stage please ensure you have included all the required statements and declarations and uploaded any additional supplementary files (including reporting guidelines where relevant).

5.3. Permissions

Please also ensure that you have obtained any necessary permission from copyright holders for reproducing any illustrations, tables, figures or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please see the Copyright and Permissions page on the SAGE Author Gateway.

Back to top

6. On acceptance and publication

6.1. SAGE Production

Your SAGE Production Editor will keep you informed as to your article's progress throughout the production process. Proofs will be sent by PDF to the corresponding author and should be returned promptly. Authors are reminded to check their proofs carefully to confirm that all author information, including names, affiliations, sequence and contact details are correct, and that Funding and Conflict of Interest statements, if any, are accurate.

6.2. Online First publication

Online First allows final articles (completed and approved articles awaiting assignment to a future issue) to be published online prior to their inclusion in a journal issue, which significantly reduces the lead time between submission and publication. Visit the SAGE Journals help page for more details, including how to cite Online First articles

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7. Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the Clinical Child Psychology and Psychiatry editorial office as follows:

Prof. Deborah Christie, Editor, email: deborah.christie2@nhs.net For journal queries: ccp@sagepub.com

Chapter 3 : Critical Appraisal

Munisah Kabir

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Munisah Kabir

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4YW

m.kabir1@lancaster.ac.uk

Critical Appraisal

Summary of the Research

There is a large evidence base acknowledging how adverse childhood experiences that have led young people to be separated from their parents increase the risk of them developing developmental trauma (Van der Kolk et al., 2019). Difficulties with emotion regulation and insecure attachment patterns are examples of factors that can act as barriers towards young people achieving a sense of stability when moving into residential care services (Cyr et al., 2010). Whilst this has implications for care staff as they take the role of primary caregiver, staff may also face challenges in building meaningful relationships with young people (Esaki et al., 2013). For example, lack of therapeutic training means staff may be unable to make sense of presenting 'challenging behaviours' and where they are coming from. Staff may also face organisational challenges such as lack of access to external resources or support (Galvin et al., 2022).

As Trauma Informed Care (TIC) is increasingly used within residential care services, the systematic review aimed to explore the attitudes and experiences of care staff in using TIC within homes. Eight papers were selected for the review, whereby thematic synthesis was used to develop a greater understanding of staff perceptions of TIC. Four themes were developed: 'TIC builds an understanding of the needs of young people,' 'TIC improves relationships,' 'the role of leadership in providing containment around implementation,' and 'challenges to implementing TIC correctly and the need for training.' It was felt that a shared understanding of the principles of TIC allowed for a positive change on an organisational level, as there was a shared goal to increase sense of safety and allow for feelings of empowerment for young people and care staff. Improvements in relationships were also noted between staff and young people, amongst the staff team, and between the staff team, supervisors and wider networks involved with the care of the young people, as TIC

encouraged the maintenance of openness and transparency as well as improved communication which was recognised as increasing collaboration. The importance of leadership in providing support and containment in the application of the model was considered. It was felt that lack of understanding of the principles of TIC acted as a barrier to implementation, highlighting the need for continual training. Clinical implications were suggested, whereby the importance of investment in TIC on a leadership level was emphasised in order to provide practical support to staff with implementing the model, but also to provide emotional support due to the difficult emotions that may arise from the relational aspects of the approach. The need for regular ongoing training and reflective practice was also highlighted in order to support staff to think about how to apply the theory behind the models in their practice within the homes, as well as review aspects of TIC that work well or things they need further support with.

Whilst there has been a great deal of research that has focussed on the needs of young people and the subsequent implications for residential care staff, there has been no research specifically looking at how managers fit into the dynamics of the homes. Therefore, the aim of the empirical paper was to explore the role of managers within residential care services. Thematic analysis was used to analyse the findings from interviews with six participants. Four themes were identified: 'promoting a positive culture within the home,' '"you can't do it on your own": accessing external support,' 'personal impacts of the managerial role', and 'support received as part of the managerial role'. Clinical implications were discussed, specifically the importance of reflective practice sessions to discuss and agree upon shared values that can maintain a positive culture within the home, and create a sense of safety and consistency for the staff team and young people. There was also a focus on regular team building sessions to boost staff morale and increase meaningful relationships amongst the team. The benefits of accessing psychology provision were also acknowledged in providing

support and containment to managers as they navigate the challenges of the role, whereby they can use the tools from psychology support in their own practice with the staff team.

Crossover between the Two Papers

As previously mentioned, there is a great deal of research that has focussed specifically on care staff within residential care services. This can also be seen within the systematic review. The inclusion criteria for the review stated that studies carried out with any staff working with young people within homes that used a model of TIC in their practice would be eligible for inclusion. This would have been inclusive of social workers, managers, or other professionals involved with the direct care of young people. However, all eight papers that had been selected for inclusion had gathered data mainly from residential care staff. This highlights the need for further research to be conducted to explore the role that managers play within the care system, or approach a more systemic viewpoint when studying the work that takes place within residential care, where organisational factors/challenges are considered throughout the study and how managers cope with these pressures, as well as how these implicate the staff team and young people.

In both the systematic review and empirical paper, there is an observable crossover that can be seen within the findings, specifically in relation to the importance of change on a systemic level. In the systematic review there was an appreciation from participants across the selected studies in the way models of TIC enabled positive change, as the principles of TIC focussed heavily on the creation of shared values, as well as a focus on the impact of trauma on subsequent care needs (Baker et al., 2018). It was felt that establishing a shared set of values enabled staff to achieve a shared vision for the homes, as well as using strengths-based approaches to empower young people (Galvin et al., 2021). Although TIC was not specifically named by participants during the interviews for the empirical study, it was clear

that participants placed importance on values that can be linked to trauma-informed approaches. For example, similar to findings from the systematic review, findings in the empirical paper showed how staff recognised the importance of their role in maintaining a shared culture of values, as well as fostering a nurturing environment by capturing positive moments observed in the young people and staff team to enable feelings of empowerment.

Both the systematic review and empirical paper also highlighted the importance of maintaining healthy relational patterns within the home. In the systematic review participants reflected on how they drew on principles of TIC to enable them to facilitate improved communication with others, and in maintaining open and transparent relationships with young people. Participants agreed how this led to an improvement in relationships within the home with the young people and amongst the staff team, but also with wider networks (Parry et al., 2021). The findings in the empirical paper discussed how managers felt an important part of their role was to encourage the development of meaningful relationships amongst the staff team, whereby they worked to boost staff morale and team-building exercises were also used to achieve this. There was a recognition of the emotional demands of the role for care staff and managers, so the importance of drawing on sources of support was emphasised to protect the wellbeing of the team.

With regards to clinical implications, the systematic review highlighted the importance of leadership in supporting care staff in the implementation of TIC within their roles, with the practical aspects and also in providing containment around the model. It is important to recognise that care staff will be exposed to the complex needs of young people on a daily basis, and they may also be encountering their own personal challenges or have their own trauma histories that could be triggered during their work with young people. If the responsibility of managing these challenges is left for staff to cope with themselves, it may have a detrimental impact on their wellbeing leading to burnout and increased staff turnover.

An aspect of TIC that is widely praised is the way it accounts for systemic factors within the residential care setting, by focussing on the needs of staff members and providing adequate support for them, as well as working to meet the needs of young people in care. In the empirical paper participants discussed at great length how they invested much of their time within their roles to provide this recommended support for staff members, either by providing supervisory support themselves, or signposting staff to psychology provision or other forms of support. However, it is important to acknowledge that managers who work within residential care services have often worked up from their previous roles as support staff, and may not necessarily have all the relevant qualifications or experience either.

Managers are also required to hold a lot of responsibility, as they aim to spend much of their time providing direct care and support to staff and young people, as well as managing the pressures from the organisation itself or other external agencies. One manager discussed how the level of responsibility they were faced with impacted their wellbeing, and another manager discussed how, whilst they are contracted to work a set number of hours, they are required to make a lifestyle commitment to the role due to the level of responsibility involved. It is therefore important to ensure that managers receive the adequate support within their role, to provide them with a safe space in which they can offload difficult emotions, as well as providing them with containment as they navigate the various pressures associated with the role. The term ‘parallel processes’ was used across both papers, and is useful in highlighting the importance of creating psychological safety at all levels of the organisation. Where managers are supported within their role and in maintaining their own wellbeing, they are likely to be in a much better place to support staff, who can subsequently provide better quality of care to young people. Whilst this has been mentioned in the discussion section of the empirical paper, it seems the role of psychology within residential care services is crucial in providing therapeutic support and containment on a systemic level.

Issues of Cultural Diversity

In the empirical paper it was understood that there was a lack of cultural diversity within the profession. One of the participants discussed the difficulties they experienced in recruiting a diverse workforce, whilst another participant shared how they felt there was a noticeable barrier preventing individuals from global majority backgrounds in entering leadership roles. Whilst I was not able to explore this in greater detail in the empirical paper, the lack of research that has explored cultural diversity in the residential care workforce highlights that this is an area that needs further research. Chua et al. (2023) argued that as the UK is becoming increasingly culturally diverse, this needs to be accounted for across organisations. Whilst surface-level inclusivity may exist through the recruitment of employees from global majority backgrounds, more efforts need to be made to ensure that inclusivity is deeply rooted within the structures and processes of services at an organisational, team and individual level (Brimhall et al., 2017; Kuknor and Bhattacharya, 2021). Yadav and Lenka (2020) similarly emphasised that if the needs of global majority employees are not properly accounted for, it can increase the risk of interpersonal conflicts, attrition, discrimination and communication breakdown. Hussain et al. (2020) argued the need for organisations to embrace the differing perspectives in thought processes and creativity that staff from different cultural backgrounds can bring as this can contribute to the development of new ideas and positive change. The importance of valuing the ideas of employees is essential to promote psychological safety within the workplace (Harvey, 2013), and within residential care settings it may allow support staff from global majority backgrounds to feel more supported in entering leadership positions.

My Reasons for Choosing this Research

Prior to starting the doctorate course, I took on the role of a support worker in a residential care home for adults with learning disabilities for approximately 18 months. One month into entering my role, the COVID-19 pandemic had hit, which I observed had a huge impact on the organisation within which I worked. As managers were not permitted to enter homes due to the lockdown, it had a detrimental impact on communication between support staff and managers. Amongst support staff there was a shared sense of feeling unsafe due to the lack of managerial presence within the homes. However, I was able to observe that from the perspectives of the managers there was a sense of helplessness as they felt unable to provide further support due to regulatory restrictions. I was able to develop good relationships with my managers at the time, and gain an understanding of how their role required them to manage expectations from higher bodies as well as supporting staff on the 'ground floor.' I was interested in the complexity of the dynamics that occurred and how changes in one area of the home significantly influenced other areas.

Whilst this is not linked to my role as a support worker, I previously worked as a teacher in a high school, whereby my role involved mentoring adolescents who presented with 'behavioural challenges.' Quite soon into my work with the young people, I recognised how these young people had hopes and aspirations for the future, but unhelpful labels that had been placed on them made them doubt their own abilities. For example, if they were viewed as disruptive by teachers, the pupils felt they became scapegoated, which led them to then start being disruptive in classes due to feelings of hopelessness as they struggled to remove the label. In these circumstances, whilst the pupils were in need of support, it made me think more systemically in terms of how the type of care received from authority figures can influence the level of trust young people have in them. It also highlighted for me the importance of relational patterns of work and the need to emphasise the strengths and capabilities in young people to increase their engagement and levels of aspiration.

When the opportunity arose to carry out research exploring the role of managers in residential care settings for young people, based on my previous experiences of working as a support worker and mentoring young people within my teaching role, I felt very passionate about conducting this research. I felt interested in learning more about the attachment needs of young people in residential care, and the implications this carries for organisations. Upon carrying out an initial scoping search into this area of research, I could see that there was an abundance of literature that has explored the varying needs of young people in residential care as well as research that has investigated the implications for care staff, and how care staff experience their role within the home. In studies that had been carried out with care staff, implications were suggested for managers, regarding a leadership requirement to support staff with the emotional demands of the role, or in accessing external support. However, there had been no studies directly exploring the role of managers within the residential care setting. As managers work so closely with staff and young people and are faced with a great deal of pressure due to being legally responsible for the homes, I felt that this was an important area of research that warranted more attention.

My Reflections on the Research Process

My field supervisor who works closely with residential care services was really supportive in approaching organisations to seek participants who would be interested in taking part in the study. In terms of recruitment, I would receive initial emails from managers across various services to express their interest in taking part, however upon my response to the emails I felt it was difficult to maintain this contact to be able to arrange an interview. There was also one occasion where an interview had been scheduled but the manager was not able to meet at the last minute due to a crisis that had occurred in the home. I could see that difficulties in arranging interviews with managers was a result of how busy they were. In my supervision, I reflected upon how it sometimes felt difficult to approach managers multiple

times asking them to take part in the study, as I experienced feelings of guilt and burdensomeness repeatedly asking them to participate whilst I could see that they needed to prioritise the pressures of their role. However, these feelings were outweighed by my recognition that the research was important and in the long term would hopefully be of great value to managers. Whilst it might have been difficult to arrange interviews in the moment, I could see that understanding the challenges they experience and how they are supported or feel they could be better supported to manage their roles, could have important clinical implications. I really appreciated the time participants took to take part in the interviews, and I could see how invested they were in contributing to the research in the way they provided detailed and thoughtful responses to my questions. It is also important to note however that during a few of the interviews, the participants needed to pause the interview midway due to being called for support by a staff member. One participant reflected on the irony as they were discussing how they frequently received phone calls from staff members for advice or assistance, and at the same moment during the interview they received a call from a member of the team. This clearly illustrated just how high-pressured their role was and how managers invest such a huge part of their lives to their job in order to support their team and the young people, clearly articulating a need for support to be focussed around managers as well. I also noticed that the participants I interviewed seemed to adopt quite a therapeutically-minded outlook within their practice. This may have been based on the models of therapeutic care used within their organisation, but I also noticed that a majority of the participants had access to psychology provision. They reflected upon how beneficial they found this in providing containment for themselves as they managed the emotional demands of the role. The care they received from psychologists allowed them to role model these patterns of behaviour towards staff, again highlighting the impact of parallel processes across different levels of the organisation.

During some of the interviews, there were certain reflections offered by participants that sparked emotional reactions in me. One example of this is when a few of the participants had mentioned that they struggled to achieve a work/life balance because outside of their working hours they were still expected to be on-call in case of crisis. A few participants discussed how they would alternate on-call hours with other managers, whereby one manager would be on-call for a few nights, and another manager would take over afterwards. However, one manager mentioned that this method was not found to be effective within their organisation, so they would be on-call all the time for the staff team, unless the manager was on annual leave. Hearing this made me experience feelings of shock and sadness for the managers, as this is a lot of responsibility for them to hold on a continual basis. A participant who was from a global majority background also reflected upon challenges they have experienced at work due to micro-aggressive comments made by others. They mentioned that they were working for organisational policies to be put in place to prevent systemic racism from occurring. As someone who identifies as coming from a global majority background myself, I could relate to the feelings of frustration and helplessness the participant felt in terms of having these experiences of feeling 'othered'. These feelings of frustration were also based on my views that it should not just be the responsibility of individuals from global majority backgrounds to challenge systemic practices that are not culturally inclusive. It seems that more work is needed in this area on a wider organisational level, where it is the responsibility of the whole organisation to make workplaces and residential care services more accessible and inclusive for individuals from diverse backgrounds. However, during the interviews it was important for me to keep in mind my role as a researcher rather than a clinician, where the focus was on the participants being the experts of their own experiences rather than the interview becoming more of a therapeutic interaction. It was really helpful to

reflect upon this during supervision, to ensure I was able to sit with these thoughts whilst ensuring that they did not influence my analysis in any way.

My own journey

Prior to starting the Clinical Psychology doctorate course, I did not feel very confident in my research abilities and initially found the idea of completing a thesis project quite daunting. However, I have thoroughly enjoyed completing the thesis, and it has been a really valuable learning experience. I feel I have had the opportunity to learn a great deal about residential care services, as well as recognising the importance of building meaningful relationships systemically. As I aim to move towards working as a qualified Psychologist within a Child and Adolescent Mental Health Service (CAMHS), I hope the knowledge and understanding I have gained from conducting the research can be carried forward into my practice with young people and families. One of the clinical implications suggested in the systematic review and the empirical paper was the role of Psychologists in supporting the team. I recognise the importance of my role as a Psychologist in advocating for organisational change in order to provide the best quality of care and meet the needs of the clients I work with. I also hope I am able to look out for the wellbeing of my colleagues in the service and support them, especially considering the emotional demands associated with the role. Whilst I initially doubted my ability as a researcher, I learnt a great deal from completing the research process. I recognise the value and importance of research in providing useful recommendations for policy and practice, and feel that I would like to continue engaging with research in some way so I am able to contribute to the evidence-base and ensure that I am updating my learning.

Conclusion

The systematic review explored how the implementation of TIC within residential care services for young people allowed for positive change to be achieve on a systemic level for young people and staff. Clinical implications were suggested, specifically the importance of leadership in supporting care staff with effective implementation and containment in using models of TIC. The empirical paper explored the role that managers take within the residential care setting, as they provide direct care to staff and young people as well as managing organisational pressures. Implications were suggested, in terms of providing support to managers as they hold responsibility of managing the complex dynamics of the homes. Whilst the research process has been challenging at times, I have thoroughly enjoyed completing the thesis and it has been an invaluable learning experience. I particularly enjoyed engaging in the data collection process, and hearing the thoughtful reflections and stories shared by the participants. I hope this project is an effective starting point for more research to be conducted on how managers can be supported within their roles, and I hope it can contribute towards positive change.

References

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Chapter 4 : Ethics Section

Munisah Kabir

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:

Munisah Kabir

Doctorate in Clinical Psychology

Faculty of Health and Medicine

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4YW

m.kabir1@lancaster.ac.uk

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval of Research

Research Ethics Application Form v1.9.0

Research Ethics Application Form v1.9.5 RECR

The Role of Managers in Residential Care Services for Young People - Approved

Information Regarding this Research Project

Are you conducting a research project?

(for more information on research projects please see our ethics pages)

(•) Yes ( ) No

Does your research only involve animals?

( ) Yes (•) No

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

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

Which Faculty are you in?

Faculty of Health and Medicine

Which department are you in?

Health Research

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

○ Yes ◉ No

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

○ Yes ◉ No

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

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

Is this an amendment to a project previously approved by Lancaster University?

○ Yes ◉ No

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

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

Project Information

Please confirm/amend the title of this project.

The Role of Managers in Residential Care Services for Young People

Estimated Project Start Date 04/01/2023

Estimated End Date 30/08/2024

Is this a funded Project?

○ Yes ◉ No

Research Site(s) Information

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

◉ Yes ○ No

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

Online interviews via Microsoft Teams will be used, with the option of face to face where desirable for the interviewee and feasible. This may be in a residential care setting, or an external place chosen by the interviewee.

Applicant Details

Are you the named Principal Investigator at Lancaster University?

○ Yes ◉ No

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

First Name

Munisah

Surname

Kabir

Department

DClinPsy

Faculty

Health and Medicine

Email

m.kabir1@lancaster.ac.uk

Principal Investigator

Search for principal investigator name: *If you cannot find the PI in the system please contact rso-systems@lancaster.ac.uk to have them added.*

First Name

Suzanne

Surname

Hodge

Department

Health Research

Faculty

FHM

Email

s.hodge@lancaster.ac.uk

Supervisor Details

First Name

Suzanne

Surname

Hodge

Department

Health Research

Faculty

FHM

Email

s.hodge@lancaster.ac.uk

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

○ Yes ◉ No

Additional Team Members

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

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

Please list all external contacts here:

First Name

Susan

Surname

Knowles

Organisation

Details about the participants

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

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

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

8

What's the maximum number of expected participants?

15

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

(•) Yes ( ) No

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

(•) Yes ( ) No ( ) I don't know

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

( ) Yes (•) No ( ) I don't know

Is your research with any vulnerable groups?

(Vulnerable group as defined by Lancaster University Guidelines)

○ Yes ◉ No ○ I don't know

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

◉ Yes ○ No

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

○ Yes ◉ No

Is your research with adult participants (aged 18 years, or older) in private interactions (for example, one to one interviews, online questionnaires)?

◉ Yes ○ No

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

○ Yes ◉ No ○ I don't know

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

○ Yes ◉ No

Is your research with adult participants (aged 18 years, or older) in private interactions (for example, one to one interviews, online questionnaires)?

◉ Yes ○ No

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

○ Yes ◉ No ○ I don't know

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

◉ Yes ○ No ○ I don't know

Could the study induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life?

◉ Yes ○ No ○ I don't know

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

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

(•) Yes ( ) No ( ) I don't know

Does the study involve any of the following:

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

( ) Yes (•) No ( ) I don't know

Details about Participant relationships

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

( ) Yes (•) No ( ) I don't know

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

( ) Yes ( ) No ( ) I don't know (•) N/A

Will you be using a gatekeeper to access participants?

(•) Yes ( ) No ( ) I don't know if I will be using a gatekeeper

The gatekeeper will be in a position of authority or have influence over potential participants (e.g., a teacher or manager). However, I will take the gatekeeper's assurance that they will stay completely impartial and that I will ensure that there is no perceived pressure to participate, and I will explain to participants that their decision on whether to participate or not will have no effect on their treatment or rights (e.g., learning or assessment).

(•) Yes ( ) No ( ) I don't know

The gatekeeper will be able to tell who has participated (e.g., participants' responses will be made directly to the gatekeeper or if the researcher will inform the gatekeeper of who has participated), but I have assurance that they will not use this knowledge to treat participants differently.

(•) Yes ( ) No ( ) I don't know

Will participants be subjected to any undue incentives to participate?

( ) Yes (•) No ( ) I don't know

Participant data

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

- (•) Yes
- ( ) No

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

- (•) Yes
- ( ) No

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

- ( ) Yes
- (•) No

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

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

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

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

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

- ( ) Yes
- (•) No

Online Sources

Does your research comply with the site(s) terms and conditions? Before completing the section below please read the 'Social Media Guidance for Researchers'

- (•) Yes
- ( ) No
- ( ) It's unclear in the terms and conditions

Is there a reasonable expectation of privacy?

- (•) Yes
- ( ) No

Because there is a reasonable expectation of privacy, you must obtain consent from site users. Therefore you will need to upload a copy of the Participant Information Sheet & Consent form that you intend to use to obtain their informed consent.

General Queries

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

- ( ) Yes
- (•) No
- ( ) I don't know

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

○ Yes ◉ No ○ I don't know

Can the research results be freely disseminated?

◉ Yes ○ No ○ I don't know

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

○ Yes ◉ No ○ I don't know

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

○ Yes ◉ No ○ I don't know

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

○ Yes ◉ No ○ I don't know

REC Review Details

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

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

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

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

Questions for REC Review

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

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

Studies have shown that young people living in residential care homes are more likely to experience mental health difficulties than young people living with their parents. It is important for support staff to receive the appropriate training to help them support young people in their care. It would be useful to see how these challenges affect managers of care homes, in terms of their role in meeting the needs of young people, and the challenges they experience. The aim of the study is to interview 8-15 managers, to find out more about their role within the residential care setting, how they are supported in their role and how they manage potential challenges. This could help us find out if there is any psychological support that could be given to managers that would help them in their management of staff and promote their wellbeing.

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

To develop a greater understanding of the role of managers in residential care services, how they support staff and young people, and how they manage practical challenges. To consider how managers are supported in their role.

To develop a greater understanding of the role of managers in residential care services, how they support staff and young people, and how they manage practical challenges. To consider how managers are supported in their role.

Participant Information

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

I will recruit 8-15 participants for data collection, depending on when theoretical sufficiency has been achieved (Braun & Clarke, 2022). The sample size is small enough to allow for in-depth data to be collected for each participant, but large enough to include a range of different types of experience and perspective. The inclusion criteria requires participants to be managers of residential care homes; managers who are responsible for either one care home or multiple care homes are both eligible for inclusion in this study. Another inclusion criterion will be that managers need to have been in their role for a minimum of two years. This is to ensure that they have had enough experience in their role to be able to explain some of the challenges that may be associated with their role. Deputy managers and area managers will be excluded from this study as their roles and experiences will differ. Managers of residential care homes specifically run to support young people with learning disabilities will be excluded from the study, as the dynamics of these homes tend to work differently to those of typical residential care homes. No other inclusion or exclusion criteria will be applied, although demographic information will be collected from participants in terms of their age group, gender, ethnicity, years of experience in their role as a manager, qualifications, and the route they took to becoming a manager. The field supervisor supporting my research has connections with managers across various residential care services, so will be able to support me with the recruitment process. If more participants are still needed, recruitment will occur through social media, whereby posters containing information about the study will be sent to residential care services, inviting managers to participate.

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

Participants will be given an information sheet containing the details of the study, so informed consent is gained prior to the interview stage. Participants will be informed of their right to withdraw from the study at any point during the interview, and for up to two weeks after. If a participant chooses to withdraw, their consent sheet and demographic information questionnaire will be deleted, along with their transcript. The anonymity of participants will also be protected as consent sheets will be stored securely, and any identifiers will not be included in the transcripts. Participants will be asked not to mention the name of the care home (s) they work at, or names of people, such as staff or the young people in their care. If these are accidentally said, they will be anonymised by myself when typing up the transcript. Whilst it is not anticipated that the interview will lead participants to feel distressed, if this does occur the distress protocol will be followed. If participants disclose any information that suggests that young people or staff may be at risk, the research supervisor and field supervisor will be contacted in the first instance where it will be decided if it needs to be reported or not.

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

Participants will be asked to complete a demographics questionnaire, which will ask questions about their ethnicity, gender, age, how long they have been qualified and any formal qualifications they may have.

Please describe how the data will be collected and stored.

The interviews will be stored securely on OneDrive until the thesis has been examined, after which they will be deleted.
The consent forms and demographic questionnaires will also be securely stored on OneDrive until the thesis has been examined, after which they will be deleted.
The transcript will be stored securely for 10 years after the thesis has been examined, after which the copies will be destroyed. The transcripts will not contain any identifying information in order to protect the anonymity of participants.

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

The trainee will be responsible for deleting the consent forms and demographic questionnaires after the thesis has been examined, along with the interview recordings. Consent forms, demographic questionnaires, interview transcripts and the coded data produced during analysis will be retained for 10 years after the thesis has been examined. These will be retained by the DClinPsy administration team at Lancaster University, and shared with my research supervisor upon request. After the final version of the thesis has been completed, I will share the OneDrive folder I used to store the data during the study, with Sarah Heard from the administration team. She will then save it on a password protected file space on the server.

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

Please see the distress protocol in the research proposal.

You have selected that there is a risk that the nature of the research might lead to disclosures from the participant. What kind of information might participants disclose? How will you manage that situation?

Participants may disclose the name of the service they work for, service users or other members of staff. If this does happen, these names will be left out when transcribing the interviews. If participants disclose any information that suggests that young people or staff may be at risk, the research supervisor and field supervisor will be contacted in the first instance where it will be decided if it needs to be reported or not.

Participant Relationships

Your answers about gatekeepers has indicated that there is a power imbalance due to gatekeepers knowing the identity of participants. Please explain the situation and how you plan to mitigate and manage the effects of this.

Whilst some participants will be recruited by contacting their managers, whatever will be discussed in the interview will remain confidential, and their managers will not know what they have spoken about. Participants will also be told this before the interview.

Participant Data

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

The interviews will be video recorded, or audio recorded if participants prefer. This is to help me when writing up the transcripts, so that everything participants said is included. It also means that during the interview, I can give my full attention to the interview, allow the participant to feel heard, as I do not have to spend time taking notes during the interview. Recording will be done on Microsoft Teams.

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

The participant information sheet will contain information about recording, why it is needed, how it will be stored and when it will be deleted.

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

The recordings will be stored securely on OneDrive. The research supervisor will also have access to them, with the aim of watching one interview to see that it has been going ok. The recordings will be deleted after the thesis has been examined. This is in case I need to refer back to the recordings at any point.

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

Participants will be told that they have the right to withdraw their data at any point for up to 2 weeks after the interview. They will be told that the reason why data cannot be erased after this point is because it will have already started to be analysed to search for themes and codes, so will be difficult to identify which transcript belongs to them.

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

(•) Yes ( ) No

Explain what steps you will take to protect anonymity.

The transcripts will be made anonymous by removing any identifying information including names, these typed versions will be deleted 10 years after the interviews have taken place. Anonymised direct quotations may be used but names will not be attached to them. All personal data will be confidential and will be stored securely on OneDrive.

Information about the Research

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

The study will be written up as a thesis, with the hope that this will eventually be submitted for publication in an academic journal. When participants take part in the study, at the end of the interview they will be asked if they would like to receive a summary of the thesis once it has been completed. A written summary of the thesis will be sent to those participants that request it. A summary of the findings may also be presented in an annual conference held for practitioners working in residential care services.

Online Sources

You have indicated site users have a reasonable expectation of privacy and therefore you will need to obtain consent to use their data for this project. Please explain how you propose to obtain consent.

The information sheet containing details about the study will be given to participants, and written consent will be obtained via a consent form.

Data Storage

How long will you retain the research data?

The interview recordings will be kept up until the thesis has been examined, after which they will be deleted. The transcripts will be stored for 10 years after the thesis has been examined, after which it will be deleted. Consent forms, demographic questionnaires, interview transcripts and the coded data produced during analysis will be retained for 10 years after the thesis has been examined. These will be retained by the DClinPsy administration team at Lancaster University, and shared with my research supervisor upon request. After the final version of the thesis has been completed, I will share the OneDrive folder I used to store the data during the study, with Sarah Heard from the administration team. She will then save it on a password protected file space on the server.

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

The interviews will be stored securely on OneDrive until the thesis has been examined, after which they will be deleted.
The consent forms and demographic questionnaires will also be securely stored on OneDrive until the thesis has been examined, after which they will be deleted.
The transcript will be stored securely for 10 years after the thesis has been examined, after which the copies will be destroyed. The transcripts will not contain any identifying information in order to protect the anonymity of participants.

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

The consent forms and demographic questionnaires will be deleted after the thesis has been examined along with the video recordings. Email addresses of participants that wish to know the outcome of the study will be kept and stored on OneDrive, but this will be deleted after the outcomes have been sent out to them. The transcripts will anonymise any identifiable information.

Project Documentation*

Important Notice about uploaded documents:

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

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

FST Ethics Webpage

FHM Ethics Webpage

FASS-LUMS Ethics Webpage

REAMS Webpage

☑ I confirm that I have followed the guidance.

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

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

- ☑ Research Proposal (DClinPsy)
- ☐ Advertising materials (posters, emails)
- ☐ Letters/emails of invitation to participate
- ☐ Consent forms
- ☐ Participant information sheet(s)
- ☐ Interview question guides
- ☐ Focus group scripts
- ☐ Questionnaires, surveys, demographic sheets
- ☐ Workshop guide(s)
- ☐ Debrief sheet(s)
- ☐ Transcription (confidentiality) agreement
- ☐ Other
- ☐ None of the above.

As you are in a DClinPsy course please upload your Research Proposal for this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Research Proposal	Research Protocol Ammended	Research Protocol Ammended.docx	10/03/2023	2	2.0 MB

Please upload all consent forms to be used in this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Consent Form	Participant Consent Form	Participant Consent Form.docx	05/01/2023	1	56.5 KB

Please upload all Participant Information Sheets:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Participant Information Sheet	Participant Information Sheet	Participant Information Sheet .docx	05/01/2023	1	60.9 KB

Declaration

Please Note

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

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

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

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

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

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

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

Signed: This form was signed by Dr Suzanne Hodge (s.hodge@lancaster.ac.uk) on 20/04/2023 12:24

As you have stated that you are not the PI you will need to have the PI sign off on this application.

As the applicant please click "Request". *Please note that you cannot request a signature from yourself.*

Signed: This form was signed by Dr Suzanne Hodge (s.hodge@lancaster.ac.uk) on 20/04/2023 12:24

Please read the terms and conditions below:

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

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

Signed: This form was signed by Munisah Kabir (m.kabir1@lancaster.ac.uk) on 10/03/2023 12:47

Appendix 4-A: Research Protocol

The role of managers in residential care services for young people

Applicant: Munisah Kabir (Trainee Clinical Psychologist at Lancaster University)

Research Supervisor: Dr Suzanne Hodge (Research Supervisor at Lancaster University)

Field Supervisor: Dr Sue Knowles (Consultant Clinical Psychologist)

Introduction

There are currently around 80,850 young people in England who have been placed in a residential care setting (Statistics: looked-after children, 2021). Alternative care arrangements are made for children either temporarily or permanently when their parents are not able to care for them. This may be due to a risk of harm to the child, illness or death of a parent, children who are in the UK as refugees without their parents, children in residential treatment settings due to emotional or behavioural challenges, etc (Rocco-Briggs, 2008). In the UK, children may be placed in Local Authority Care (LACs) or homes in third sector organisations. LACs are split into secure children's homes, residential special schools, short-break only children's homes, and residential care homes, which is where most children are placed (Office for National Statistics, 2022).

80% of young people in residential care settings are reported to experience mental health difficulties in comparison to 64% of young people living with their parents. These challenges may lead to a poorer quality of life, in terms of self-esteem, emotional wellbeing, and the young person's ability to sustain relationships with others (Steels & Simpson, 2017).

Support workers in residential care settings have a key role to play in supporting young people, collectively taking the role of primary caregiver (Sulimani-Aidan, 2014). Studies have shown that support workers are able to utilise their qualities to develop strong bonds with the children in their care, allowing young people to develop secure attachment patterns (Harriss et al., 2008). McLean (2013) identified the dynamics that can influence staff's ability to manage challenging behaviours.

Many children that enter the care system have experienced complex trauma which support workers may not be equipped to deal with, due to the lack of specialist training and support from other services (Steels and Simpson, 2017). This can make it difficult for staff to understand and manage the difficult behaviours presented by young people in their care. As they have to provide support for a group of young people, it may not always be possible for staff to provide individual support for those children that might need it, and so challenges presented by young people may not be properly dealt with (Castillo et al., 2012).

There is little research into the role of managers in residential children's homes. However, the importance of their leadership role has been highlighted (Hicks, 2008) and is reinforced by evidence that the social and organisational environment of the care home impacts on the quality of relationships between staff and young people, which in turn impacts on the mental health of young people (Silva et al. 2022). There is currently no research that has studied how the needs of young people in residential care implicate managers, in terms of the roles that managers play in the care of young people, their experiences of managing staff, and challenges they face. By looking at the literature on the impacts that exist for care staff, it is understandable how this may have a ripple effect, whereby managers are also affected within this complex dynamic (Esaki et al., 2013). The current study aims to explore how residential care home managers experience managing the psychosocial and organisational environment of the home. It is important to see how organisational pressures, budget cuts and staffing pressures affect the experiences of managers, and what support is currently in place for them. The implications of this study would have relevance to clinical psychology, as Clinical Psychologists often provide support within residential care settings, with a focus upon supporting the therapeutic milieu of the service, and the staff within, amongst other roles.

Research Question

How do residential care managers experience their overall role, including their support of staff, young people, team dynamics, and wider systemic factors? How do they manage the complex interplay of the different aspects of their role?

Method

Design

The study will be of a qualitative design, using semi-structured interviews. The data will be analysed using reflexive thematic analysis (Braun & Clarke, 2022). This will allow me to take into consideration the diversity of experiences different managers will have, and as an inductive approach it does not require me to have any assumptions or expectations of what sort of information I will find.

Participants

I will recruit 8-15 participants for data collection, depending on when theoretical sufficiency has been achieved (Braun & Clarke, 2022). The sample size is small enough to allow for in-depth data to be collected for each participant, but large enough to include a range of different types of experience and perspective. The inclusion criteria requires participants to be managers of residential care homes; managers who are responsible for either one care home or multiple care homes are both eligible for inclusion in this study. Another inclusion criterion will be that managers need to have been in their role for a minimum of two years. Deputy managers and area managers will be excluded from this study as their roles and experiences will differ. Managers of residential care homes specifically run to support young people with learning disabilities will be excluded from the study, as the dynamics of these homes tend to work differently to those of typical residential care homes. No other inclusion or exclusion criteria will be applied, although demographic information will be collected from participants in terms of their age group, gender, ethnicity, years of experience in their role as a manager, qualifications, and the route they took to becoming a manager. The field supervisor supporting my research has connections with managers across various residential care services, so will be able to support me with the recruitment process. If more participants are still needed, recruitment will occur through social media, whereby posters containing information about the study will be sent to residential care services, inviting managers to participate.

Materials

A laptop will be needed to record the interviews (see appendix E for the data management template). The same laptop will be used to record the online interviews and face-to-face interviews. The information sheet (see appendix A), consent sheet (see appendix C) and demographics questionnaires (see appendix D) will be emailed to participants beforehand to complete, but if they haven't been completed, the participant will have a chance to complete them before the interview. A copy of the interview schedule will also be needed to guide the topics during the interview (see appendix G).

Procedure

Following ethical approval, an email will be sent to various residential care services via the field supervisor. The email will contain the recruitment poster (see appendix B) and the participant information sheet. Managers will be told to contact me via my university email address if they are interested in taking part in the study. If enough participants are not recruited through the field supervisor, the recruitment poster will be sent out to residential care services via social media (Instagram, Facebook and Twitter), to invite managers to participate. I will post the poster on the social media sites, and the information that will be used in the body of the email (see appendix B) will be used as the caption. If I am able to find any residential care services on these social media sites, I will message them directly inviting them to look at my recruitment poster. My university email address is included in the poster so managers are able to contact me if they wish to participate.

Once the interview date and location (either online or in-person) has been confirmed with the participant, they will be sent a copy of the participant information sheet, as well as a consent form and demographic information questionnaire to complete, and are asked to email this back to me before the interview.

The interviews will take place either online or in-person, and will last approximately 60 minutes. The aims of the research will be explained to the participant, and I will ask if they have questions or if there is anything they do not understand. I will check the consent form and demographics information questionnaire have been completed, and then the interview will begin, at

which point I will start the recording. At the end of the interview, I will stop the recording, thank the participant for taking part and answer any questions they may have. Whilst it is unlikely that the topics covered in the interview will be distressing for participants, a distress protocol has been included in case it is needed (see appendix F).

Participants will be asked if they would like a summary of the research findings once the study is completed. If they would like one, their email addresses will be kept on a secure OneDrive folder until after examination, to allow dissemination of the summary.

Proposed Analysis

Reflexive thematic analysis will be used (Braun and Clarke, 2022). This will allow me to take into consideration the diversity of experiences different managers will have, and as an inductive approach it does not require me to have any assumptions or expectations of what sort of information I will find.

Ethical Concerns

Participants will be given an information sheet containing the details of the study, so informed consent is gained prior to the interview stage. Participants will be informed of their right to withdraw from the study at any point during the interview, and for up to two weeks after. If a participant chooses to withdraw, their consent sheet and demographic information questionnaire will be deleted, along with their transcript. The anonymity of participants will also be protected as consent sheets will be stored securely, and any identifiers will not be included in the transcripts. Participants will be asked not to mention the name of the care home (s) they work at, or names of people, such as staff or the young people in their care. If these are accidentally said, they will be anonymised by myself when typing up the transcript. Whilst it is not anticipated that the interview will lead participants to feel distressed, if this does occur the distress protocol will be followed. If participants disclose any

information that suggests that young people or staff may be at risk, the research supervisor and field supervisor will be contacted in the first instance where it will be decided if it needs to be reported or not.

Timescales

- January – March 2023 – obtain ethical approval, Draft introduction and method of systematic literature review chapter.
- April – June 2023 – Draft introduction and method to empirical data, data collection, begin analysis.
- July – September 2023 – Complete data collection, review literature for systematic review, identify topic for critical appraisal chapter.
- October – December 2023 – Draft results and discussion of systematic literature review chapter, complete analysis of data, draft results and discussion of empirical paper.
- January – March 2024 – Draft critical appraisal, final drafts of other chapters, final formatting of thesis, submit thesis.
- April – August 2024 – viva, corrections to thesis.

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Appendix 4-B: Participant information sheet

Participant Information Sheet

The Role of Managers in Residential Care Services for Young People

My name is Munisah Kabir and I am conducting this research as a student in the Doctorate of Clinical Psychology programme at Lancaster University. The research is being supervised by Dr Suzanne Hodge, Lecturer in Health Research at Lancaster University and Dr Sue Knowles, Consultant Clinical Psychologist.

What is the study about?

The purpose of this study is to develop a greater understanding of the role of managers in residential care services for young people. This is in terms of the role that you as a manager play within the residential care setting, how you are supported in your role and how you manage potential challenges that may occur.

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 an interview lasting about 60 minutes, either online or in-person. You will be asked questions in relation to your role as a manager within the residential care setting; how you experience and manage the dynamics within the residential care home, how you manage the practical challenges of the role, and how you feel you are supported to manage challenges that may occur as part of this role.

Do I have to take part?

It is completely up to you whether you choose to take part in this study or not. You can stop participating in this study at any point. You also have the right to ask for your data to be withdrawn at any point for up to 2 weeks after the interview has been completed. The reason for this 2 week time limit is because after that time the data will be used to analyse along with the data from other participants, and so will not be possible to identify.

Will my data be Identifiable?

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

- Recordings will be deleted once the project has been examined.
- The typed version of your interview will be made anonymous by removing any identifying information including your name, these typed versions will be deleted 10 years after the interviews have taken place. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them. All reasonable steps will be taken to protect the anonymity of the participants involved in this project.
- All your personal data will be confidential and will be kept separately from your interview responses.
- The files containing the recordings and any forms with identifiable information will be stored in University approved secure cloud storage, that only the researchers

involved in the study will have access to. These will be deleted following examination of the thesis.

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 summarised and reported as part of my thesis and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

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

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:

Munisah Kabir, email address: kabirm1@lancaster.ac.uk.

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:
Suzanne Hodge, email address: s.hodge@lancaster.ac.uk.

If you wish to speak to someone outside of the Doctorate Programme, you may also contact:
Dr Laura Machin Tel: +44 (0)1524 594973

Chair of FHM REC Email: l.machin@lancaster.ac.uk

Faculty of Health and Medicine

(Lancaster Medical School)

Lancaster University

Lancaster

LA1 4YG

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

Resources in the event of distress

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

- **Samaritans – available 24/7.** You can call 116 123 (free from any phone), email jo@samaritans.org or visit some branches in person. You can also call the Samaritans Welsh Language Line on 0808 164 0123 (7pm–11pm every day).

- **SANEline – available 4:30pm-10:30pm every day.** You can call 0300 304 7000.

- You can self-refer to Mindsmatter on their website: https://www.lscft.nhs.uk/services/psychological-therapies/mindsmatter.

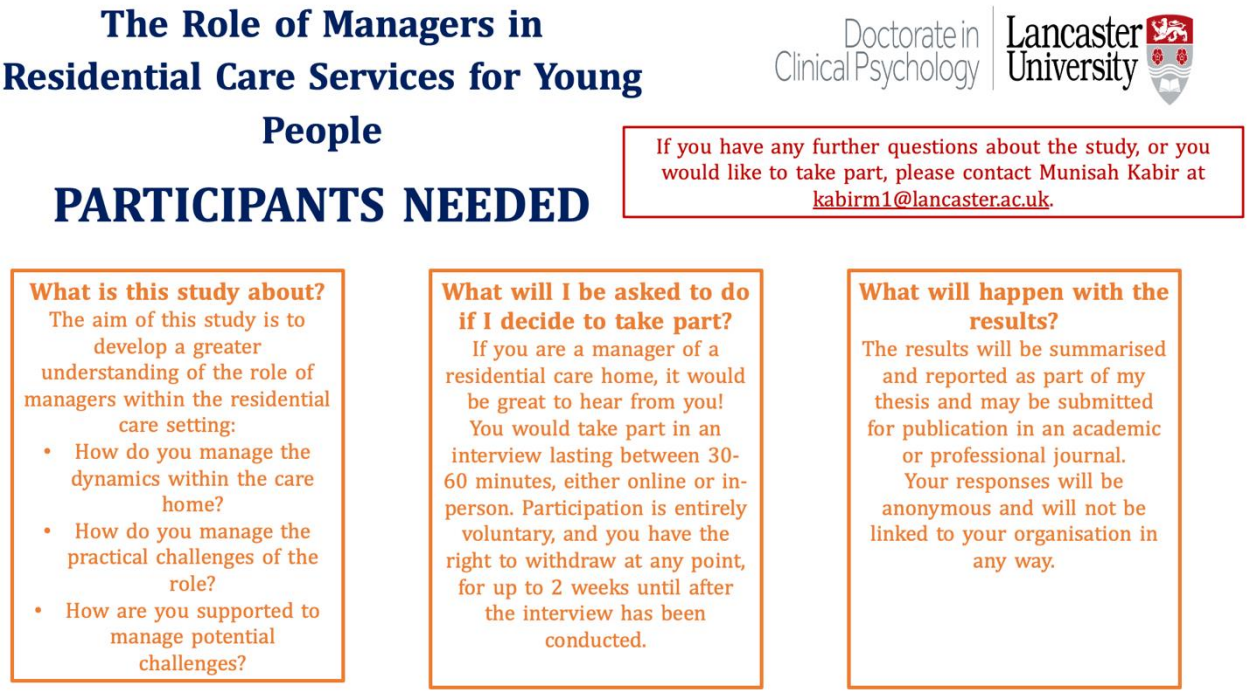
Appendix 4-C: Recruitment poster and email to send to managers

Dear XXX,

I hope you are well. My name is Munisah Kabir and I am a trainee Clinical Psychologist studying on the Doctorate programme at Lancaster University. For my thesis, I am interested in exploring the role of managers in residential care services for young people. If you are a manager of a residential care home for young people, I would like to invite you to take part in my study ! Please see attached the poster for more details. If you have any further questions or if you would like to take part, please do not hesitate to contact me on my email : kabirm1@lancaster.ac.uk. I look forward to hearing from you soon.

Best wishes,

Munisah



Appendix 4-D: Participant consent form

Participant Consent Form

The Role of Managers in Residential Care Services for Young People

Name of Researchers: Munisah Kabir: kabirm1@lancaster.ac.uk, Suzanne Hodge: s.hodge@lancaster.ac.uk, Susan Knowles.

Please tick each box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during my participation in this study and within 2 weeks after I took part in the study, without giving any reason. If I withdraw within 2 of taking part in the study my data will be removed.	☐
3. I understand that any information given by me may be used in future reports, academic articles, publications or presentations by the researcher/s, but my personal information will not be included and all reasonable steps will be taken to protect the anonymity of the participants involved in this project.	☐
4. I understand that my name/my organisation's name will not appear in any reports, articles or presentation without my consent.	☐
5. I understand that any interviews will be recorded and transcribed and that data will be protected on encrypted devices and kept secure.	☐
6. I understand that data will be kept according to University guidelines for a minimum of 10 years after the end of the study.	☐
7. I agree to take part in the above study.	☐

_____ _____ _____

Name of Participant Date Signature

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_____

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

Appendix 4-E: Demographics questionnaire

Participant Demographics Questionnaire

The Role of Managers in Residential Care Services for Young People

Name of Researchers: Munisah Kabir: kabirm1@lancaster.ac.uk, Suzanne Hodge: s.hodge@lancaster.ac.uk, Susan Knowles: sueknowles@changingmindsuk.com.

Thank you for choosing to take part in this study. Please could you answer the following questions:

1. What is your age?

   ……

2. What is your gender?

   ……

3. What is your ethnicity?

   ……

4. How long have you been working as a manager in this job role?

   ……

5. Do you have any formal qualifications? If so, please state what they are.

   ……

   ……

Appendix 4-F: Data management template

1. Data Collection

Qualitative data will be collected through interviews with 8-15 participants. The interviews will be video recorded via Microsoft Teams, with the option of turning off the camera if participants do not wish for their face to be shown.

Consent forms and demographic questionnaires will also be collected.

2. Documentation and Metadata

All interviews will be transcribed and will then be analysed using thematic analysis, whereby the transcripts will be coded and themes identified from the data.

3. Storage, Backup and Security

The interviews will be stored securely on OneDrive until the thesis has been examined, after which they will be deleted by myself.

The consent forms and demographic questionnaires will also be securely stored on OneDrive and destroyed 10 years after the thesis has been examined by the DClinPsy administration team at Lancaster University.

The transcript will be stored securely for 10 years after the thesis has been examined, after which the copies will be destroyed by the administration team. The transcripts will not contain any identifying information in order to protect the anonymity of participants.

4. Ethics and Legal Compliance

Participants will be given an information sheet containing the details of the study, so informed consent is gained prior to the interview stage. Participants will be informed of their right to withdraw from the study at any point during the interview, and for up to two weeks after. If a participant chooses to withdraw, their consent sheet and demographic information questionnaire will be deleted, along with their transcript. The anonymity of participants will also be protected as consent sheets will be stored securely, and any identifiers will not be included in the transcripts. Participants will be told not to mention the name of the care home (s) they work at, or names of people, such as staff or the young people in their care.

5. Selection and Preservation

There are no plans for data-sharing. Consent forms, demographic questionnaires, interview transcripts and the coded data produced during analysis will be retained for 10 years after the thesis has been examined. These will be retained by the DClinPsy administration team at Lancaster University, and shared with my research supervisor upon request. After the final version of the thesis has been completed, I will share the OneDrive folder I used to store the data during the study, with Sarah Heard from the administration team. She will then save it on a password protected file space on the server.

6. Data Sharing

The OneDrive folder, which will contain the consent forms, demographic questionnaires, transcripts and video recordings will be shared with the research supervisor, who will be watching one of the video interviews.

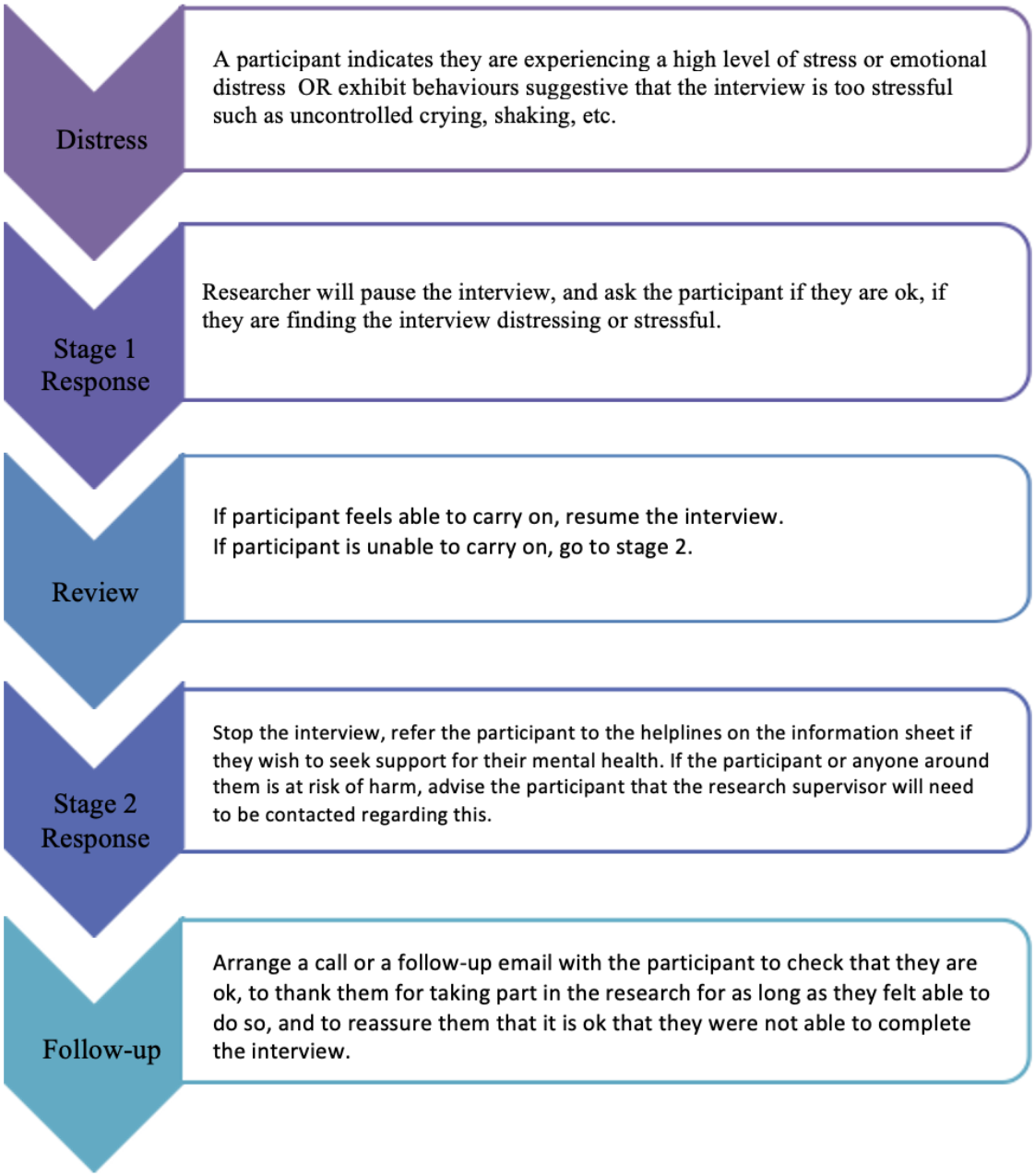
7. Responsibilities and Resources

The researcher (Munisah Kabir) will be responsible for the data up until the thesis has been examined, after which everything besides the transcripts will be deleted. Following examination of the thesis, the responsibility of the copies of the transcripts will be given to …. at Lancaster University to store for 10 years, after which they will be destroyed.

Appendix 4-G: Distress Protocol

Distress Protocol

(Modified from : Draucker C B, Martsolf D S and Poole C (2009) Developing Distress Protocols for research on Sensitive Topics. Archives of Psychiatric Nursing 23 (5) pp 343-350)



Appendix 4-H: Letter of ethical approval

Name: Munisah Kabir

Supervisor: Suzanne Hodge

Department: DClinPsy

FHM **REC Reference:** FHM-2023-0944-RECR-2

Title: The Role of Managers in Residential Care Services for Young People

Dear Munisah Kabir,
Thank you for submitting your ethics application in REAMS, Lancaster University's online ethics review system for research. The application was recommended for approval by the FHM Research Ethics Committee, and on behalf of the Committee, I can confirm that approval has been granted for this application.

As Principal Investigator/Co-Investigator your responsibilities include:

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

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

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

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

Yours sincerely,

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