The TARA Project

Trauma - Attachment- Resilience into Action

PHASE 1

Examining the effects of Graduate Trauma-informed Practice Education on Child Welfare Professionals.

For

Dublin South Central Integrated Service Area,

TUSLA, Child and Family Agency.

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Coláiste na hOllscoile Corcaigh

An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

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Executive Summary

1 Introduction

The TARA (Trauma, Attachment, Resilience into Action) Project represents a successful high-level partnership between the Dublin South Central Integrated Service Area (DSC) of TUSLA, Child and Family Agency (hereafter TUSLA) and University College Cork (UCC). The overarching aim of this partnership is to integrate trauma-informed practices across the service area of DSC to support practice in responding to the complex needs of children and families they encounter. The Project is being approached in two phases. This report presents Phase 1 which delivered and evaluated the *Continuing Professional Development Certificate in Trauma-informed Care: Theory and Practice,* a professional graduate-level education in trauma-informed practice, to DSC professional staff across diverse levels of roles and responsibilities. The findings of this study will inform the second Phase of the Project.

2 Research Objectives

The objective of this current study was to make a significant contribution to practice development to support the implementation of trauma-informed practices in DSC.

This was achieved through the following objectives:

1. The delivery of professional graduate level education in trauma-informed practice that promotes the development of champions, and
2. The examination of the effects of this professional graduate level education through a mixed methods study from all available data sources.

3 Methodology

The study used a mixed methods approach, combining results from two component studies, a quantitative study, and a qualitative study. Participants were recruited from DSC in November 2022, via the nominated gatekeeper, Maria Hayes, Principal Social Worker (PSW). Participants were child welfare professionals across diverse roles and responsibilities (front-line practice, supervision, and management), disciplines (social work, social care, and family support) and teams (child protection, children in care, fostering, after-care and family support). The quantitative study involved a pretest-post-test study and post programme satisfaction questionnaire. The pretest-post-test study used validated measures for

knowledge of trauma-informed care; professional self-efficacy; professional quality of life and intent to leave the agency to assess practitioner outcomes. Data was collected at pre-tested (Time 1, before), post-tested (Time 2, on completion), and post-tested (Time 3, at 16 weeks post programme) to track potential changes, expressed by participants, in the selected measurement scales. The post-programme satisfaction survey, designed for the study, was completed on programme completion to evaluate levels of programme satisfaction. All quantitative data was collected using the online platform Qualtrics survey tool accessible via a student email account, in January 2023, June 2023 and September 2023.

The qualitative study gathered data through three focus groups (in-person=1; online=2) in June 2023 to capture the participants experience of the programme. The findings from each component study were integrated using a triangulation protocol based on all data sources which strengthened the overall study by enhancing the credibility and transferability of the findings. A stakeholder group that consisted of key stakeholders in child welfare practice, was established at the outset of the study that provided support to the research process. A conceptual logic model was developed to guide the research process, towards a proposed theory of change of the programme (Kellogg Foundation, 2004). It was informed by a literature review and developed through Stakeholder Group engagement through an iterative collaborative approach over the study period (see Figure 1, page 18).

4 Professional Graduate Level Education in Trauma-informed Practice

Participants completed the *Certificate in Continuing Professional Development in Trauma-informed Care: Theory and Practice* (University College Cork, 2023). The programme is an accredited university-based programme which awards a level 9, Special Purpose Award, a post-graduate level qualification under the National Framework for Qualifications in Ireland. The programme informed by the evidence base of trauma knowledge and practice through a practice framework, TARA (Trauma, Attachment, Resilience into Action) (Lotty, 2021; 2023). The TARA practice model was developed to support integrating trauma-informed practices in child serving systems of care. The programme was delivered via an online blended format. Participants attended 16 weekly online 1.5-hour live sessions, as well as weekly 1.5-hour pre-recorded lectures and were assessed through two 3,000-word assignments over a 6-month period (see Programme Description Appendix 1).

5 Summary of Key Conclusions

This study found strong evidence for success for the UCC based graduate level programme to support child welfare professionals' capacity to integrate trauma-informed practices into their specific roles. The triangulated data analysis provided evidence in relation to the impact of the programme on *Program Acceptability* [design content, target and experience], *Dynamic Learning Acquisition* [increased capacity of trauma-informed knowledge, amplified self -reflection, practice confidence and in weaving' old and new' practice knowledge together to successfully build capacity for trauma-informed practices]; *Practice Changes* [reported in spheres of child and family practices, practices for Practitioner Resilience and transformative collaborative practices]; *Sustainability* [the need for a shared agency approach, ongoing supports is to sustain progress and address contradictory practices]. The research produced positive results for intended direct outcomes of trauma-informed knowledge, professional self-efficacy, and trauma-informed practices, as conceptualised in the Study Logic Model (see Figure 1, page 18). No significant results were reported for compassion satisfaction and staff retention (neither positive or negative effects). However, participants were hopeful that job satisfaction and staff retention could be supported in the future if trauma-informed practices were implemented in DSC. Furthermore, participants felt that support from executive level through a national agency-wide strategy for the integration of trauma-informed practices would also support future benefits for staff in DSC. Whilst not assessed in this research, the immediate beneficiaries of these changes must be recognised as the children and families which the DSC Area serve.

5.1 Programme Acceptability

Appropriate Design

The programme was designed to extend professionals identified as high-performing individuals who had the capacity to benefit from upskilling, who are currently working in complex child and family welfare practice contexts. For the overwhelming majority of graduates, the programme was appropriately targeted to their professional developmental needs. The programme requires a level of IT proficiency consistent with the current practice climate in child welfare. In particular, completing the programme alongside colleagues from the same team was supportive. Thus, going forward due consideration should be given to more than one team member undertaking the programme together.

Appropriate content

The programme aimed to support child welfare professionals across diverse roles and disciplines at graduate level to integrate trauma-informed practices into their practice role in the Irish context. The programme drew on the TARA practice model (Lotty, 2023),a bespoke Irish model reflecting Irish context, underpinned by contemporary trauma, attachment and resilience theories, and uses applied teaching methods providing students with core practice tools and a resources bank (toolkit). Students (many of whom were experienced practitioners) developed knowledge and applied practice through participation in the programme and were formally assessed through two assignments. These elements of the programme were highly relevant, fit for purpose and accessible.

Appropriate Target

Participants in the programme were crossed diverse levels of responsibilities (front-line practice. supervision and management) and teams (Child Protection and Welfare, PPFS, Fostering, After Care) and disciplines (Social Work, Social Care, Family Support). The capacity for intra-area collaboration was enhanced by taking this area wide approach, supporting the development of relationships and consistent work practices across the DSC area. This has enabled an area wide shared endeavour to support the implementation of trauma-informed practices in DSC.

Strengthening the programme experience

The programme was experienced as very intense in the context of the pressures of working in the current practice climate. Whilst high completion rates were found, more protected time is warranted to enable full engagement and benefit from the programme.

5.2 Impact on professional knowledge gain in trauma-informed practice

The research highlights that the programme has successfully engaged the target cohort in significant knowledge gain in trauma-informed practices. This involves a lived learning experience, a journey of ongoing professional (and personal) development described in this research as *Dynamic Learning Acquisition*. This involved a process with elements of increased trauma-informed knowledge, amplified self-reflection, enhanced practice confidence, and a weaving together of old and new practice knowledge to successfully build capacity for trauma-informed practices.

Increased Trauma-informed knowledge

Clear knowledge gains were made, the principles and theories that underpin trauma-informed practices.

Amplified Self-reflection

Knowledge gains were made in the understanding of burn-out and compassion fatigue and secondary traumatic stress. Furthermore, amplified self-reflection was found, in the context of knowledge gains through a dual reflective process. This dual reflective process enhanced both understanding of trauma impact and trauma-informed interventions that relating to both clients as well as professionals working with trauma.

Enhanced Practice Confidence

Practitioners increased professional self-efficacy supported by in-depth theoretical and applied knowledge, and an extensive resource bank (toolkit) and have demonstrated this professional confidence by creating new trauma-informed practice initiatives and changes across the research site.

Weaving Old and New

Knowledge gain involved integrating new trauma-informed knowledge and practice with existing practice knowledge. This weaving extended to integration of knowledge within other programmes, further strengthening these programmes.

5.3 Improved practices in child and family welfare services

The research highlighted that the programme has successfully engaged the target cohort and has had a positive impact on their individual practice of critical reflection on practice as well as facilitated positive changes in their respective practice roles (front-line practices, supervision, and leadership). The research has presented these strengthening practices through infusing trauma-informed practices based on increased TIP knowledge, increased professional confidence (skills and ability), and integration of existing practice wisdom. Changes were reported in spheres of Child and Family Practices, Practices for Practitioner Resilience and Transformative Collaborative Practices.

Child and Family Practices

The use of more appropriate and empathetic language in practice including in case file notes, court reports, approaches to decision-making in case planning, direct work with clients, and in decisions around referrals were found. Furthermore, the research showed

that the practice changes served to strengthening practitioners applied knowledge and confidence in implementing existing approaches and programmes currently operating in DSC.

Practices for Practitioner Resilience

Practicing 'the pause', that reflected a recognition of heightened work-related stress and deregulation strategies to promote less reactive practice, integration of trauma-informed practices in supervision, as well in team meetings, complex case review meetings, and case conferences were evident.

Transformative Collaborative Practices.

New practice initiatives across teams reflecting new collaborative working practices were evident. Furthermore, new collaborative practices were reported with working with foster carers, strengthening existing approaches with deepening practice knowledge and confidence and in developing a new trauma-informed network with Prevention, Partnership and Family Support (PPFS) partners.

5.4 Opportunities to sustain the changes.

The research places a spotlight on the motivation and commitment of the DSC staff for service change within a practice climate that challenges the implementation of trauma-informed practice. At this juncture there is an opportunity to support these new groundbreaking initiatives led by DSC staff reported in this research. These require ongoing commitment of support at an area level, as well as at national level through a coherent agency wide strategy for integration of trauma-informed practices to successfully embed the practice changes made in DSC.

5.5 Future research

Future research to examine the longer-term impact of the programme is warranted for: implementation of the creative and innovative trauma-informed practices developed by participants, and to in turn assess the impact of these practices on practitioners, children, and their families.

6 Recommendations

At this final stage of the study a number of recommendations are proposed are based on the research process, study findings and conclusions. These recommendations have been

developed in the context of informing Phase 2 of the TARA Project to support trauma-informed practice implementation in the DSC Area.

6.1 Recommendations - Area Level

1. The university–community-based partnership approach is a successful partnership paradigm developing significant knowledge for the integration of trauma-informed practices reflected in Phase 1 of this project. Thus, this paradigm should be used as a model for Phase 2 of the TARA Project.
2. It is recommended that Phase 2 conducts an implementation study to develop and track the practice initiatives that have been developed and are being implemented on foot of the current study.
3. Based on the findings of this research it is recommended that this above-mentioned implementation study, is carried out in partnership with the champions/leaders that have emerged from this study, leading out on new practice initiatives across diverse levels of roles and levels of responsibilities.
4. Phase 2 Stakeholder Group to be established to guide the project, to include representation from each integrated service area within the Dublin Mid Leinster (DML) regional geographical area of TUSLA to support coherence and consistency in the integration of trauma-informed practice across DML.
5. This research recommends ongoing support to sustain this capacity by the provision of monthly TARA based peer support groups and an annual event to support developments and learnings.
6. To support the ongoing work of the project, it is important that the findings be shared broadly in the sector thus, it is recommended that dissemination takes place through agency and practitioner targeted outputs, as well as publications in the research literature.
7. It is recommended that all professional staff across the DSC area undergo this graduate level professional education to promote consistent and collaborative practice.
8. It is recommended that other professionals who work with children and families that come into contact with the DSC area also undergo graduate level professional trauma-informed education.
9. To increase knowledge of the impact of trauma informed practice, an outcome-based study is recommended to assess the impact of trauma-informed practices that

are being embedded across the DSC in relation to children, and their families (parents and foster carers), area wide professional staff and interagency work in Phase 2.

6.2 Recommendations - National Agency level

Based on the evidence from this research the following recommendations are made:

1. The delineation of a coherent agency wide national strategy on the integration of trauma-informed practices beyond local initiatives.
2. The undertaking of a comprehensive mapping exercise of current training initiatives that aim to support trauma-informed practices across all TUSLA regions to assess the current status of trauma-informed practice integration.
3. A TUSLA national framework for trauma-informed education, to ensure consistency of trauma-informed practice integration that meet the needs of differing levels of roles and responsibilities of the child and family agency including the Executive Management Team. This framework should include basic level introductory level training for all child welfare workforce and separate graduate level education for child welfare professionals.

6.3 Recommendations - Programme level

1. Online approaches to curriculum design, delivery and content works well for the development of graduate level education for child welfare professionals, and this should be maintained and embedded into future programme delivery.
2. The programme should be delivered to cohort's representative of a diversity of roles and responsibilities in child and family welfare practice to support collaboration.
3. To ensure this collaborative experience, more than one participant from each team is recommended in each class group.
4. Child welfare professionals undertaking the programme are allotted appropriate protected time to engage fully in the programme.
5. A scaled-up study is recommended that includes a randomized controlled trial to test for further evidence to support the effectiveness of the programme.

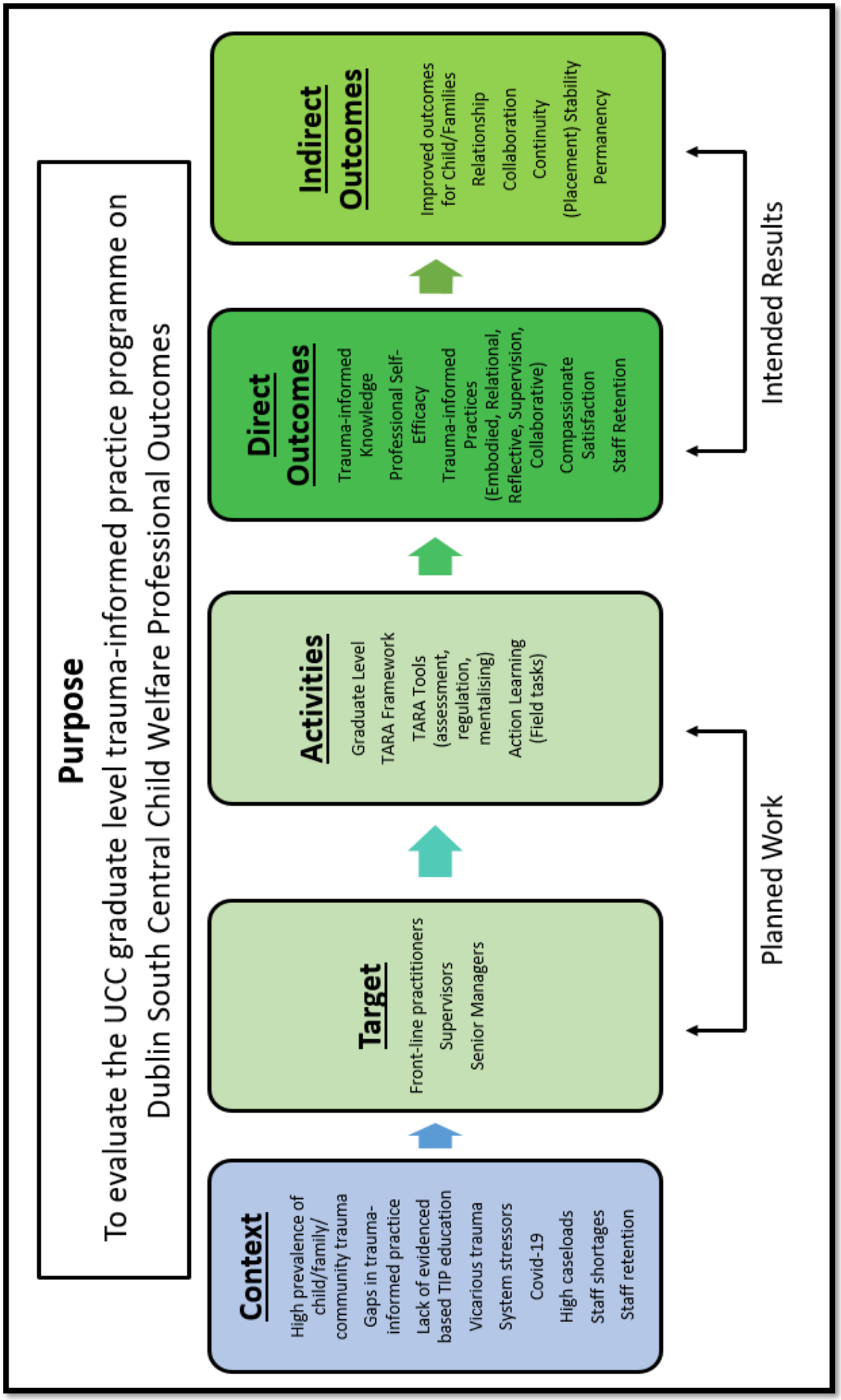

Figure 1: Study Logic Model

Chapter 1: Project Overview

1.1 Introduction

The TARA (Trauma, Attachment, Resilience into Action) Project represents a unique partnership between the Dublin South Central Integrated Service Area (DSC) of TUSLA, Child and Family Agency (hereafter TUSLA) and University College Cork (UCC).

The overarching aim of this partnership is to integrate trauma-informed practices across the service area of DSC, to support practice in responding to the complex needs of children and families they work with. DSC sought to support their understanding of the complexities around the implementation of trauma-informed care within their services, while also upskilling and supporting staff. UCC has provided expertise and experience in the field of the practice of trauma-informed care and university accredited graduate level continuing professional development for DSC child and family professionals.

The project has been approached through two phases. The first phase aimed to deliver and evaluate professional graduate-level education in trauma-informed practice targeted at DSC child welfare professionals. Phase One of the project is presented in this report. Phase One completed an evaluation study, that reported on the effects of graduate-level education in trauma-informed practice on DSC, child welfare professionals. This current study examined if developing practitioners' capacity in trauma-informed practice would support positive practitioner outcomes with the purpose to, in turn improve outcomes for the children and families they work with. The findings of Phase One will inform Phase Two of the project which will examine the implementation and impact of trauma-informed practices across the DSC Area.

1.2 Dublin South Central Integrated Service Area of TUSLA

1.2.1 Practice Context

TUSLA operates within six geographical regions (Dublin North-East, Dublin Mid-Leinster, North-West, Mid-West, South-East and South-West) of Ireland. DSC is one of 17 TUSLA operational integrated service areas located in the Dublin Mid-Leinster region alongside three other service areas of: Dublin South West, Kildare, West Wicklow; Midlands (Laoise, Longford, Offaly, and Westmeath); and Dublin South East/Wicklow. DSC provides a range of services to an assigned population through Prevention, Partnership and Family Support,

Child Protection and Welfare, Children in Care, Fostering and Aftercare Services (HIQA, 2022). The geographical profile of the DSC area spans a large urban and inner-city area of Dublin that have high deprivation and poverty rates. DSC is located south of the river Liffey in Dublin City Centre and also covers Dublin West which includes Ballyfermot, Cherry Orchard, Clondalkin and Lucan/City West. DSC has a population of approximately 305,278 people (HIQA, 2022). Of this, children and young people aged 0 - 17 make up 21.5% of the population, approximately 65,562 and children under 4 years make up 7%, approximately 20,653 in 2016. The population is ethnically diverse and includes representation of Other White (11.8%), Asian/Asian Irish (4.3%), Black/Black Irish (2.5%) and White Irish Traveller backgrounds (0.6%). A total of 8,119 people lives in areas of high social and economic deprivation, 2,457 of whom are children. TUSLA have identified DSC as an area of particularly high disadvantage, with pockets of extreme disadvantage in some communities and is associated with social problems of crime, poverty, poor educational attainment, addiction, domestic violence, parental stress and family breakdown (TUSLA, 2019b; HIQA, 2022).

DSC has a high number of child protection referrals, with 532 referrals in the month of May 2023 reported by TUSLA (2023b). Currently, 5597 children are reported to be in state care nationally, representing a national average for children in care of 4.7 children per 1,000 (TUSLA, 2023a). DSC has the third highest number of children in care per 1,000 children (n = 356) which represents 5.4 children in care per 1,000 (TUSLA, 2023b).Many of the children admitted to care in the DSC area have experienced adversities and significant traumatising experiences from an early age within their home environments. These experiences often have included parental neglect, neglect, emotional abuse, physical abuse and sexual abuse (HIQA, 2022). DSC note there is a high demand for Family Support Services which are provided directly by TUSLA in three sites, Ballyfermot, Donore Ave and the D8 Family Support Service, and through a wide network of community and voluntary services (TUSLA, 2019b). DSC is facing particular challenges in the current practice climate. 1044 (53%) of open cases in the area were unallocated at the end of May 2023, a significant increase from the same period in 2022 (423: 34%) (TUSLA, 2023a). This represents the highest number of unallocated cases recorded in any TUSLA integrated service area nationally, with the national number of open cases remaining unallocated being 5820 (26%). These include cases on duty, unallocated child protection and welfare cases including Children in Care. Of these, 45 cases

were identified as high priority in DSC. Further to this, of the 356 children in care, 80 children did not have an allocated social worker, and 12 children did not have a care plan.

Further to this and compounding these challenges are ongoing staff shortages and retention difficulties. The Health Information and Quality Authority (HIQA) (2022) highlighting that recruitment is an area of ongoing risk. Unfortunately, high levels of staff turnover are a feature of the Irish child welfare agency (Burns and MacCarthy, 2012). Practitioners in DSC are trying to cope with high caseloads, exposure to vicarious trauma in some cases this has included child deaths, a lack of availability and access to trauma-specific evidence-based treatments, and difficulties in interagency partnerships (National Review Panel, 2022).

Further to these challenges, the practice climate in DSC is coping with the aftermath of the COVID-19 pandemic lock downs and restrictions. Many challenges arose both for service users and for practitioners over these testing times which are likely to have further compounded existing challenges within the practice context. Practitioners experienced increased adversity such as uncertainty regarding safety, financial hardship, bereavement, sickness, home schooling, and navigating the ongoing changes with regard to work and home environments (Collin-Vézina, Brend and Beeman, 2020). Practitioners were compelled to adapt and cope as best they could in order to carry out their professional responsibilities as documented in other jurisdictions (Ferguson, Pink and Kelly, 2022). Practitioners in DSC also endured working through an ICT Cyber Attack in 2021 that necessitated the immediate shutdown of all TUSLA systems to prevent further attacks. Further to this, there has been significant impact to services owing to the ongoing crisis in Ukraine relating to the provision of supports and services to those fleeing the war (TUSLA, 2023b).

1.2.2 Background to the Project

In 2021, DSC engaged in a stakeholder consultation process (Burtenshaw, 2021) to explore the knowledge and understanding of trauma-informed practice to inform planning for future work. The process involved interviews with inter and intra agency professionals (n = 22) across child serving systems (child welfare, education, youth justice, youth addiction services) identified by the Building Community Resilience (BCR) in the Dublin South Central Area, and Dublin City South Children and Young Peoples Services Committee (CYPSC). Service users, foster carers and health service professionals were not included (Burtenshaw, 2021). The process identified that services were aware of and interested in the trauma-informed practice. Whilst there was unanimous support for implementing trauma-informed

practice, there was no agreement in how to define trauma-informed practice and or how to go about implementation. Stakeholders highlighted the need for support in conceptualising trauma-informed practice and how to approach its implementation. They identified a gap in professional education for the DSC area that would progress building capacity for trauma-informed practice.

Following the stakeholder consultation above and ongoing data on service delivery, DSC identified the need to embed trauma informed practice in services as a key priority for the area (TUSLA, 2019a).. DSC identified the need for high quality professional education in trauma-informed practice for their practitioners (TUSLA, 2019a; Burtenshaw, 2021).

The TARA Project was established in response to address this need, through a partnership between DSC and UCC. UCC is uniquely placed to support the gaps in trauma-informed care education for child welfare practitioners at graduate level and to provide efficacy-based research. Previous UCC based research produced a promising intervention [*Fostering Connections: The Trauma-informed Foster Care Programme*] that increased foster carers capacity to provide trauma-informed care and reduced child emotional and behavioural difficulties over time (Lotty, 2019). DSC aimed to equip staff to address the trauma they are working with in a more competent, empowered way that will also improve staff retention. DSC also wished to examine the efficacy of this approach, to capture practice-based evidence with a view to informing an implementation plan for the development of trauma-informed practices across their Area. DSC could be a potential pilot for supporting integration of trauma-informed practices across TUSLA services areas towards developing a coherent national strategy.

1.3 Summary

The TARA Project is a partnership between DSC and UCC. The project aims to integrate trauma-informed practices in the DSC Area to support responding to the complex needs of, and improve outcomes for, the children and families who come into contact with DSC. The project was planned in two phases. This report presents Phase 1 which comprised of the delivery and evaluation of a UCC graduate-level programme for DSC practitioners that examined practitioner outcomes which will inform Phase 2 of the project. The practice climate of DSC is described as is the background to the project. The next chapter provides a review of the literature that supported the study.

Chapter 2: Literature Review

2.1 Introduction

The purpose of the literature review was to provide context for the current study. The review was carried out to examine the current and relevant national and international research in the field of child welfare and trauma-informed care implementation, with a specific focus on professional education for child welfare practitioners. The literature search was guided by the overarching aim of the TARA Project which is to integrate trauma-informed practices across the service area of DSC. An iterative strategy was employed that involved the electronic search of academic databases, snowball sampling through hand searches, and reference lists of relevant papers and grey literature. The review informed the research design and the development of a logic model to guide the research process (see Figure 1, page 18).

2.2 Trauma-informed Care

Trauma-informed care (TIC) has been described as a service model approach which endeavours to ensure all levels of the organization are underpinned by an increased awareness, knowledge of trauma impact and intervention that support rather than undermines recovery more effectively (Harris and Fallot, 2001). The principles of TIC are articulated by SAMHSA (Substance Abuse and Mental Health Service Administration, 2014) as, six guiding principles: 1. Safety, 2. Choice, 3. Trustworthiness 4. Collaboration, 5. Empowerment and 6. Cultural Sensitivity. SAMHSA also summaries four assumptions which are referred to the 4 R's that are necessary to underpin TIC. These are:

- R for Realizing the widespread impact of trauma and understanding potential paths for recovery,
- R for Recognizing the signs and symptoms of trauma in children, families, staff, and others involved with the system,
- R for Responding by fully integrating knowledge about trauma into policies, procedures, and practices and
- R for Resisting re-traumatization by actively avoiding re-traumatization of children and the adults who care for them.

TIC has been described as involving a whole system organisational change process which involves change at levels of organisational culture, policies, and practices and furthermore

interagency partnerships (Bloom, 2013). The change process seeks to embed consistency and coherence across systems of care such as child welfare, family support, justice, mental health and education in service provision (Bunting *et al.*, 2019). TIC seeks to drive this consistency of approach through a shared understanding across service systems moving away from siloed approaches embedded in distinct disciplinary paradigms. This process has been described as a paradigm shift cited in the literature as a move away from the question 'what is wrong with you?' towards the more empathetic question 'what has happened to you? (American Academy of Pediatrics, 2014). This paradigm shift reflects changing from a conceptualisation of human experience through a traditionally deficit orientation which individualizes the person's difficulties and minimizes the wider contextual influences to a more compassionate and contextualized standpoint (Lotty, 2019). TIC is distinguished from trauma-specific evidence-based treatment (EBT) which refers to treatment modalities that requires clinical training and supervision (Han *et al.*, 2021).

The implementation of TIC has been driven by the increased knowledge base for trauma impact and amelioration. Notably, the research on the neurobiology of stress (Porges, 2011) and the impact of trauma on brain development (Riem *et al.*, 2015) have been major variables that have driven TIC implementation. The Adverse Childhood Study (ACE) (Felitti *et al.*, 1998) is also considered a seminal study in this discourse as it was the first large-scale epidemiological study to link adverse childhood experiences to subsequent development of a multiple risk factors associated with several leading causes of morbidity and death in adulthood (Kelly-Irving and Delpierre, 2019). Given these developments, TIC purports to embrace a more comprehensive, multidisciplinary understanding of trauma reflecting a biopsychosocial perspective (Goodman, 2017), integrating research from fields of neurobiology, attachment, trauma, and resilience (Bath, Seita and Brendtro, 2018). The literature describes TIC as a strengths-based framework that considers the person's broader ecological context (Bateman and Henderson, 2013; The National Child Traumatic Stress Network, 2016) concerned with issues of social justice, power relationships and human rights (Tseris, 2019b).

2.2.1 Trauma-informed Care and Child welfare systems

Trauma-informed child welfare systems is a concept that has emerged from the discourse in trauma-informed care to improve the quality of care in child welfare systems (Bargeman *et al.*, 2022). The literature recognizes that TIC is highly relevant for child welfare systems

given many children and families that they serve have already experienced significant trauma prior to contact with the system (Ko *et al.*, 2008). In response, a number of conceptualisations have emerged, identifying child welfare practices and initiatives that may be embedded within the system that reflect an awareness of the impact of traumatic experiences on children, caregivers and service providers, and implementation of appropriate responses across training, practices and policies (Hendricks, Conradi and Wilson, 2011; Chadwick, 2012; Beyerlein and Bloch, 2014).

Whilst the literature has not reached conceptual clarity at this juncture, interpretations focus not only on children but also their caregivers and the child welfare workforce who seek to support them. The literature reflects a recognition that, all of these groups are affected by trauma, including primary (acute) traumatic experiences that they may have experienced in the past and the exposure to secondary trauma by caring for, or working with, children and families that have experienced trauma.

2.2.2 Research synthesis for TIC implementation: Child serving systems

A small number of evidence synthesis were identified in this review of TIC implementation across child serving systems. Fernández et al., (2023) reviewed 15 studies to synthesize evidence regarding the current state of TIC in mental health and child welfare services in the USA. Interventions had at least one organizational component: service policy, trauma screening assessment, service planning, administrative support for programme wide trauma informed services, staff trauma training and education and human resource practices. The review highlighted the nascent nature of the field and the lack of conceptual clarity at all levels of description, including at domain and component level, and significant methodological limitations in terms of study designs. They concluded they were unable to synthesize the findings and that the evidence whilst showing promising trends was inconclusive.

A further systematic review by Bargeman *et al.*, (2022) replicated these findings from a synthesis of evidence across multi systems of child welfare, education, health, and social service sectors They reported from a purpose sample of 98 studies predominantly from the USA. They also found conceptual definition of trauma-informed care was lacking in the literature, reflected in a lack of understanding and agreement across care systems. They found a diverse definition for trauma ranging from narrow biomedical diagnostic criteria to broad definitions encompassing psychosocial cultural, and historical components. This led to

poor appraisal of TIC. To address this, the study, following a synthesis of analysis of extracted data from the reviewed literature, produced a conceptual framework to support TIC implementation across multiple systems of care. The framework defines trauma and depicts critical elements of both vertical and horizontal trauma informed care implementation. Vertical implementation includes the bidirectional relationship between trauma affected individual (service user or service provider) and the system service provider. Horizontal implementation is identified as requiring intersectoral collaboration, established referral networks and standardised trauma informed care language to support a mutual resilience for both service users and service providers. The study identified the facilitators and barriers for TIC implementation. They highlight that the lack of access to clearly defined and pragmatic quality TIC workforce education as a barrier for both service users and providers to implementation. Infrastructural and ideological barriers were also identified such as insufficient funding and service provider buy-in. They conclude that TIC requires clear cohesive policies that address operational factors, service providers roles and practice protocols need to be clearly delineated, and necessary financial infrastructure and mechanisms of intersectoral collaboration also need to be put in place.

Research in the UK has also provided reviews of evidence. Notably, the Early Intervention Foundation (EIF) produced a review of trauma-informed practices in children's social care services (Asmussen *et al.*, 2022). In this review, a lot of overlap between existing practices and trauma informed practices was noted. The need for clarity in the identification and evaluation of such practices was highlighted and that TIC should not be used as a replacement for evidence-based trauma specific treatments. A scoping review of trauma informed approaches was carried out in Wales across child welfare, education, health, justice mental health, social services, and maternity services (Addis *et al.*, 2022). They concluded that trauma informed approaches have limited evidence and again were hindered by lack of conceptual clarity and methodological limitations. Lewis *et al.*, (2023) completed a Cochrane style review of trauma-informed approaches being applied internationally across primary and community mental health care settings. They concluded whilst some support was found for provider readiness and sense of community, patient readiness for disease management and access to services provider and patient safety and some patient health outcomes, the overall evidence was limited and conflicting.

Whilst the evidence for system wide implementation at this juncture remains inconclusive, Bargeman *et al.*, (2022) suggests that this is not surprising given the complexity of trauma and the newness of empirical research on TIC. They noted the scientific literature is still working towards establishing consensus regarding TIC that is required to support the quality of evidence research. Building capacity of the child serving systems workforce to implement TIC has been identified as a key implementation strategy (Robey *et al.*, 2021) as well as, trauma-focused services, and organisational change (Hanson and Lang, 2016). Given child welfare systems operate within a wider context of other service systems, interagency partnerships are also a key domain to embed TIC (Hanson and Lang, 2016; Bunting *et al.*, 2019). The literature also highlighted the need for buy-in from the ground up to support implementation (Baker *et al.*, 2020; Bargeman *et al.*, 2022).

2.3 Trauma-informed Education in Child Welfare

2.3.1 Research evidence synthesis for trauma-informed care child welfare education

Research evidence synthesis is lacking in trauma-informed education implementation in child welfare contexts. The current review identified one systematic review that examined the effects of brief in-service practitioner trauma-informed training, non-accredited introductory level (Purtle, 2020). The review included 23 studies, six of which were in child welfare contexts. It reported positive effects for knowledge post training, notably a gap in supporting evidence for changes in practice was identified. There were methodological difficulties, no randomized control trials (RCTs) available, inconsistent use of assessment instruments limited the research strength, and the curriculum was mostly developed by evaluators.

Bunting *et al.*, (2019) carried out a rapid evidence review, consisting of a narrative synthesis of 75 articles on organizational level implementation strategies across child welfare, education, justice, adult social care, primary care, and mental health disciplines in child welfare contexts. Workforce trauma training (non-graduate education) was identified as the dominant strategy with positive overall result for increased knowledge, confidence in trauma-informed principles and practice that were retained over time. Of note, they reported at that time an absence of focus on practitioner self-care and support in training initiatives. Whilst the review reported promising findings, they also noted severe methodological limitations, with no RCTs available and thus, lacking evidence of effectiveness.

A more recent scoping review assessed the effects of brief trauma-informed care and practice (TICP) training in Australia for health, mental health, human and social services, education, and justice sectors (McNaughton *et al.*, 2022). Six studies met inclusion criteria. The findings also found severe methodological challenges to limit evidence synthesis. Overall, studies reported an increase in knowledge, satisfaction, and confidence to practice TIC. However, inconsistencies in conceptualization of trauma and TIC were evident and no agreed curriculum was in place for TICP training for professionals in Australia.

2.3.2 Child welfare workforce trauma-informed training initiatives

As child welfare systems move towards adapting to align with TIC, there has been an emergence of child welfare system workforce targeted training initiatives. Private practitioner targeted TIC training is currently being disseminated worldwide, has been criticized (Becker-Blease, 2017) owing to a lack of regulation reflected in the dearth of research on their content, quality and impact. However, the research literature has illuminated a number of studies based on the National Child Traumatic Stress Network (NCTSN) trauma training toolkit developed to support brief in-service training (2 days training) for the child welfare workforce in the USA (Walsh, Conradi and Pauter, 2019). It has been extensively disseminated through various NCTSN partnerships with child welfare agencies across the USA. Earlier efficacy research reported increased trauma-informed knowledge based on pre-test post-test designs (Conners-Burrow *et al.*, 2013; Kenny *et al.*, 2017). However, the research highlighted gaps in bridging the theory to practice, with knowledge not being translated to practice skills (Donisch, Bray and Gewirtz, 2016) leaving significant gaps in the integration of TIC in child welfare systems (Whitt-Woosley, Eslinger and Sprang, 2018). More recent research, which adapted the NCTSN toolkit to include a focus on skills, reported some promising results (Connell *et al.*, 2019). Notably, that training included components of awareness of vicarious trauma and strategies to address it.

A further US based study that involved an interagency initiative to support trauma-informed practice adapted the NCTSN toolkit (Beck *et al.*, 2022). This initiative formed an advisory panel to support this adaptation representing stakeholders across agencies and communities that reflected the training needs of the child welfare workforce. This resulted in incorporating components of vicarious trauma, approximately, 3 days training and included follow-up that built in an action plan to implement learnings. Participants reported high levels of satisfaction, increased knowledge post-training, and at three-month follow-up. The

vast majority reported improved ability to relate to child trauma experience and a third reported they had made changes to how they interacted with children. The study concluded the training was successful in developing trauma-informed approaches as well as skills development. However, no data was collected on child and family outcomes.

In Ireland, no peer reviewed evaluations were available on child welfare workforce TIC brief training, which is now widely available through private providers. These are often one off and offer basic introductory level training (half a day, one day or two days) (Lotty, 2021a, 2023). Such trainings operate outside of the National Framework for Qualifications (NFQ) (National Framework for Qualifcations, 2023) without formal accreditation.

2.3.3 Child Welfare trauma-informed Education and University Partnerships

The literature recognises gaps in trauma education in professional child welfare qualifying degree programmes, resulting in child welfare professionals seeking and relying on post-qualifying supplemental education for professional development in trauma-informed practice (Dublin et al., 2020). In the US, in response, the NCTSN developed the core curriculum on childhood trauma (CCCT) to inform a university-based curriculum at both qualifying and post qualifying levels beyond basic level introductory brief (2-day training) to support in-depth high-quality education for professional child welfare graduates. The CCCT is informed by 12 core concepts for understanding traumatic stress responses in children and families and uses problem-based learning pedagogy through case studies to apply these concepts to complex real-world cases and is delivered by content specific experts (Layne, Strand, *et al.*, 2014). A number of partnerships between child welfare agencies and universities have been established to address the need for university graduate-level education for child welfare professionals (Hernandez-Mekonnen and Konrady, 2017). Whilst the evidence base remains limited, there are a number of studies that have produced promising results, which involve professional graduate level trauma-informed knowledge gain and skills development.

Hernandez-Mekonnen and Konrady (2017) conducted a small-scale case study involving child welfare professionals in supervisory roles who undertook a trauma-informed practice component as part of master's level (level 9) programmes in social work and child welfare education. The study reported increased in trauma informed knowledge and professional efficacy from survey responses. A qualitative analysis extended these results to illuminated increased knowledge and professional efficacy relating to five core themes of: supervision,

secondary traumatic stress, change in language, change in perspective thinking, and understanding and the importance of trauma history. They concluded the programme had informed case practice, supervision roles and supported cultivating champions for the implementation of TIC across child welfare agencies.

A further study in 2020 examined the effects of a CCCT based education developed in collaboration with universities. This was delivered by trained facilitators within their own agencies over a 3-year period to 2625 mental health practitioners from social work, psychology and counselling disciplines with master's level qualifications (Dublin *et al.*, 2020). The study reported retention of learning outcomes over a two-year follow-up (n = 100). The qualitative analysis identified four key impacts on practice: increased empathy understanding of complexity, systematic approaches to case conceptualization and catalysing further trauma learning.

A further university and state-wide (child welfare, schools, and mental health provider) partnership has been established (Woodside-Jiron et al., 2019). This partnership aims to support interagency collaborative trauma-informed practices to address siloed responses to service provision across child serving systems. Professional graduate education was delivered by university faculty and content experts in a hybrid format, providing theoretical and applied knowledge based in evidence to support practice and strengthen existing interventions in place within systems of care over a two-year period. Pre-post findings supported significant improvement in knowledge skills, professional self-efficacy, and interagency collaborative practice.

2.3.4 Other relevant research

Chizimba (2021) highlighted that in the absence of accredited trauma informed practice education, professionals were using their own initiative and personal commitment to develop emerging practice areas with no evidence based and practice confidence. The literature cautions against risk of misinterpretation of trauma theory which may lead to multiple and perhaps competing perspectives of how to intervene. Tseris (2019a) found that trauma discourses strongly underpinned the understanding of child maltreatment and intervention of social workers in mental health services in Australia. However, the ways in which social workers applied trauma-informed concepts were inconsistent. Some social workers' understanding of trauma was used to reinforce a position of expertise, mirroring traditional psychiatric intervention, focusing on the individual's trauma symptoms, while

other social workers' understanding was associated with a collaborative and strength-based approach, as they focused on addressing issues within the person's ecological context.

The need for the translation of the complex concepts from neuroscience effectively and accurately has also been highlighted (Weems *et al.*, 2021). Discourse underscores the need for practitioners to be cognizant of the dangers of focusing on the individual, pathologizing the person's trauma responses and taking a deterministic view to the exclusion of wider societal issues (Frederick, Spratt and Devaney, 2021). Furthermore, to ensure that the application of TIC is reflective of its original intent, the need to engage in critical discourses concerning trauma research and theory is documented (Spratt and Kennedy, 2021). The literature also noted even when quality education is provided that follow-up training and effective supervision to support implementing trauma informed practices are also likely to be required (Dunkerley *et al.*, 2021).

The efficacy of graduate level trauma-informed education on supporting practitioner reduction in STS and professional efficacy is emergent (Hernandez-Mekonnen and Konrady, 2017). Research has found an association with intent to stay (retention) in child welfare practitioners who were open to the principles of TIC when their organization begins adopting a TIC practice model (Bosk *et al.*, 2020). Aligning literature supports key elements of trauma-informed education that seek to address the impact of exposure to vicarious trauma such as self-care skills (Trippany, Kress and Wilcoxon, 2004). De Guzman *et al.*, (2020) found that strategies that support retention of child welfare workers were self-efficacy, peer support, supportive supervision, and organizational support.

Research studies also suggested that increased professional self-efficacy is linked compassion satisfaction and likely to reduce burn-out (Killian, 2008) and support retention (Burns, Christie and O'Sullivan, 2020). This is reflected in trauma-informed training initiatives moving more towards incorporating components that seeks to address vicarious trauma impact on frontline practitioners (Walsh and Bernstein, 2022).

2.4 Summary

The overall evidence to support TIC Care implementation in child serving systems is at an emergent stage. Evidence to support TIC across service systems is promising but remains inconclusive given the gaps in RCTs and comparison methods to measure effectiveness of TIC. This review highlighted the need for unified conceptual clarity on definition and

approach TIC across systems to support implementation. Furthermore, this review highlighted a dearth of empirical research in Ireland on this area of research.

Trauma-informed education for child welfare practitioners is identified as a key implementation strategy for child welfare agencies. Several education initiatives have been identified in this review. Child welfare workforce training centred around two levels: brief introductory level and graduate level. Brief introductory level training reports limited effects, with no data on extensive private training provision. Child welfare professional university graduate level education in the US and Australia, have responded to the need for in depth quality graduate targeted education. The research evidence is at emergent stage, whilst reporting promising results from a basis of pre- post- studies, there were no studies available that reflect a randomized control design. Thus, at this juncture the evidence remains inconclusive.

The literature highlights gaps in child welfare trauma informed education in many jurisdictions and also here in Ireland at different target levels. This review of literature substantiates the importance of developing trauma-informed educational initiatives between child welfare agencies and universities, to ensure high-quality in-depth trauma-informed education is targeted at child welfare professional graduates. This current research is well located as a collaborative initiative between DSC, and UCC to contribute to the emerging knowledge to progress the field. Furthermore, this review substantiates the need to address the dearth of knowledge in the Irish context for trauma-informed practice integration in the child and family agency. The next chapter will describe the study methodology.

Chapter 3: Methodology

3.1 Introduction

This chapter details the research design employed in this study, including a discussion of the research objectives, ethical approval, methodology, study design, stakeholder group, sampling strategy, data collection and data analysis.

3.2 Objectives

The overarching aim of this partnership is to integrate trauma-informed practices across the service area of DSC, to support practice in responding to the complex needs of children and families. The objective of this current study was to make a significant contribution to practice development to support the implementation of trauma-informed practices It was proposed to do this through the following objectives:

1. The delivery of professional graduate level education in trauma-informed practice that promotes the development of champions:
2. The examination of the effects of this professional graduate level education through a mixed methods study from all available data sources.

3.3 Ethical Approval

A dual ethical approval process was followed, with ethical approval granted from both the Social Research Ethics Committee in University College Cork, approved on the 22nd of August 2022 and by the Independent Tulsa Research Ethics Committee, approved on the 16th of November 2023. Participants were provided with an information sheet about the study (Appendix 3) and signed informed consent forms prior to invitation to participate in the study (Appendix 4).

3.4 Research Methodology

The study used a mixed methods approach, combining quantitative and qualitative methods. A mixed methods approach sought to develop integrated findings by drawing from all available evidence and thus, produce more extensive and stronger analysis.

3.5 Research Design

The design of the study drew from the revised guidelines for developing and evaluating complex interventions of the Medical Research Council (MRC) (Craig *et al.*, 2008). The study used a complex mixed methods design that aligned with the MRC framework phase 3 of programme evaluation. This has two key elements: 1. assessing programme effects and 2. evaluating the process. Firstly, a quantitative study, which a pre-test post-test study, was carried out to assess the effects of the intervention and a post programme satisfaction survey. The post-programme satisfaction questionnaire collected data on programme completion.

Secondly, a qualitative study comprising a process evaluation, was completed to gather data on how the programme was experienced. The process evaluation was concerned with gathering data on three main variables identified by the MRC (Moore *et al.*, 2015). These were (1) implementation, how the programme was delivered, (2) the change process, how intervention activities, and participants' interactions with them generated change and (3) contextual issues, how external factors to the programme could impede or strengthen the effects of the programme.

Thirdly, using a concurrent mixed methods model comprising of the two component studies, the quantitative study and the qualitative study, findings were integrated (Figure 3.1). The integration of findings based on all available data strengthened the overall study.

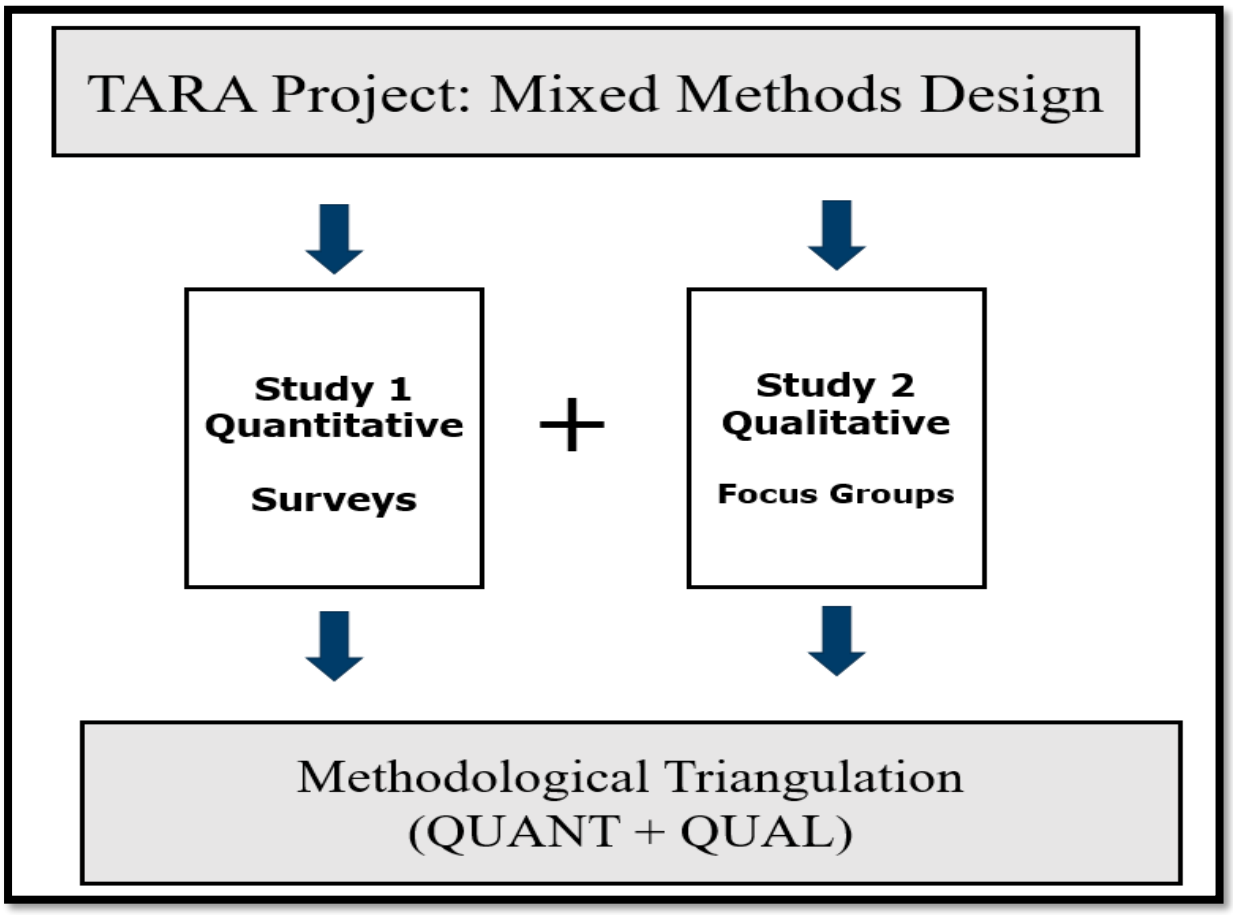

Figure 3.1. Flowchart showing Concurrent Mixed Methods Model. *Note:* (QUAN= Quantitative, QUAL= qualitative).

3.6 Research study stakeholder group.

A stakeholder group was established that provided support to the research process. The group consisted of key stakeholders in child welfare practice. This included the lived experience of contact with child welfare and protection (parents, foster carers, care experienced persons) and multidisciplinary professionals (social work, social care, youth and community work, psychology, teaching, nursing, psychotherapy) who were intra agency and inter agency professionals (Barnardos, Schools, Advocacy groups and Health providers) and academics (see Appendix 2 for membership details). The membership of the Stakeholder Group was agreed in collaboration with the Agency Lead, Maria Hayes, Principal Social Worker (PSW). Six Stakeholder Group meetings were convened over the research period (15 months). Members provided expert review on the research process at meetings and through on-going feedback. Members were also be afforded the opportunity to provide feedback via email, phone, one-to-one meetings throughout the course of the Project to the Principal Investigator (PI)/Project Lead and/or Post-doctoral Researcher. Members views

were seen as an important part of this project and were listened to and taken on board during the course of the project.

3.7 Recruitment and Selection

Participants were recruited from the research site, DSC. Participants were invited to express an interest in participating in the study by the nominated gatekeeper PSW on a voluntary basis. The PI assessed potential participants against an inclusion criterion based on meeting the entry requirements for the program. This was:

- holding a level 8 degree or equivalent qualifications within a relevant field of social work, psychology, social care, youth and community work or family support.

Participants who had previously received the programme or comparable programme were deemed as excluded. All those that expressed an interest met the criteria to participate in this study. These invited participants attended an introductory session by the PI outlining the commitment involved prior to committing to undertaking the programme and participating in the study.

3.8 Graduate Level Professional Trauma-informed Education Programme

Particpiants completed the *Certificate in Continuing Professional Developement in Trauma-informed Care: Theory and Practice* (University College Cork, 2023). The programme is an accredited university-based progamme which awards a level 9, Special Purpose Award, a post-graduate level qualification under the NFQ (National Framework for Qualifications, 2023) in Ireland. The programme informed by the evidence base of trauma knowledge and practice through a practice framework, TARA (Trauma, Attachment, Resilience into Action) (Lotty, 2021; 2023). The TARA practice model was developed to support integrating trauma-informed practices in child serving systems of care through a coherent practice orientated approach in response to addressing a gap in trauma-informed practice within the Irish child serving systems (Lotty, 2019). The progamme was delivered via an online blended format. Participants attended 16 weekly online 1.5 hour live sessions, as well as weekly 1.5 hour lectures and were asessed through two 3,000 word assignments over a 6-month period (see Programme Description Appendix 1).

3.9 Study Logic Model

A conceptual logic model was developed to guide the research process, towards a proposed theory of change of the programme (Kellogg Foundation, 2004). It was informed by a literature review, provided stakeholders with a visual representation of the relationships the proposed mechanism and actions of the programme within a causal chain (Bleijenberg *et al.*, 2018). Over the course of the study, stakeholders contributed to the development of the Logic Model refining concepts and target outcomes. Whilst presented here in a linear fashion, the logic model was a working document, developed through a recursive process through an iterative collaborative approach (see Figure 1, page 18).

3.10 Data Collection and Analysis

3.10.1 Quantative Data

Using a pre-test post-test study design, quantitative data were collected over three time points to measure the effects of the intervention on pre-defined outcomes. The participants were pre-tested (Time 1, before), post-tested (Time 2, on completion), and post-tested (Time 3, at 16 weeks post intervention) using validated measures (see Appendix 5 for Research Survey). The inclusion of measures in the study was guided by the study aims. The measures tested for trauma-informed practices which involved examining the following components:

- knowledge of trauma-informed care,
- professional self-efficacy,
- professional quality of life, and
- intent to leave.

The measures employed in this study were developed and validated by the study team. Data were collected collected using the online platform Qualtrics survey tool accessible via a UCC student email account. Participants were also asked to complete a Post-programme Satisfaction Questionnaire upon completion of the programme (see Appendix 6). The data gathered were analysed using IBM SPSS Statistics 28 and SmartPLS 3.

3.10.2 Qualitative Data

All participants who completed the programme were invited to participate in the focus groups through email. Three focus groups were carried out, two online using the Microsoft Teams platform and one in-person in the research site, at a neutral venue. Focus groups

gathered qualitative data through a semi-structured schedule of questions after the programme had been completed (see Appendix 7). The questions were reviewed by the Stakeholder group and revised to incorporate their feedback. 23 participants engaged in the three focus groups and written feedback was received from two participants. The qualitative study used thematic analysis to analyse the focus group data (Braun and Clarke, 2006).

3.10.3 Method of Integration

Methodological triangulation was used to integrate the findings from the two studies, the quantitative study and the qualitative study (Farmer *et al.*, 2006). In accordance with the recommendations of a triangulation protocol, the results of each individual study are reported separately, followed by the integrated findings (Farmer *et al.*, 2006; O'Cathain, Murphy and Nicholl, 2010). At feedback stage, a summary of the triangulated results was presented to the Stakeholder Group on the 6th of November and 11th of December 2023. Feedback and comments were invited from the Stakeholder Group members and the nuances of mixed methods approach explored. The Stakeholder Group members discussed the results and felt that they reflected local practices and contextual influences and the implementation of the programme during the study period.

3.10 Summary

This chapter outlined the methodological framework guiding the current study. The study design was informed by the and used a mixed-methods approach informed by the MRC framework for complex interventions (Craig *et al.*, 2008). The next chapter presents the study findings.

Chapter 4 Study Findings

4.1 Introduction

In this chapter the study findings of the two component studies, quantitative study and the qualitative study are presented. They are presented separated in line with the methodological approach to this study that aimed to integrate all findings at the final stage of the overall study.

4.2 Quantitative Study Results

Quantitative results are presented from the pretest-post-test study and post-programme satisfaction questionnaire. The pretest-post-test study used validated measures for knowledge of trauma-informed care; professional self-efficacy; professional quality of life and intent to leave. The post-programme satisfaction survey, designed for the study, was completed on programme completion to evaluate levels of satisfaction on the programme itself.

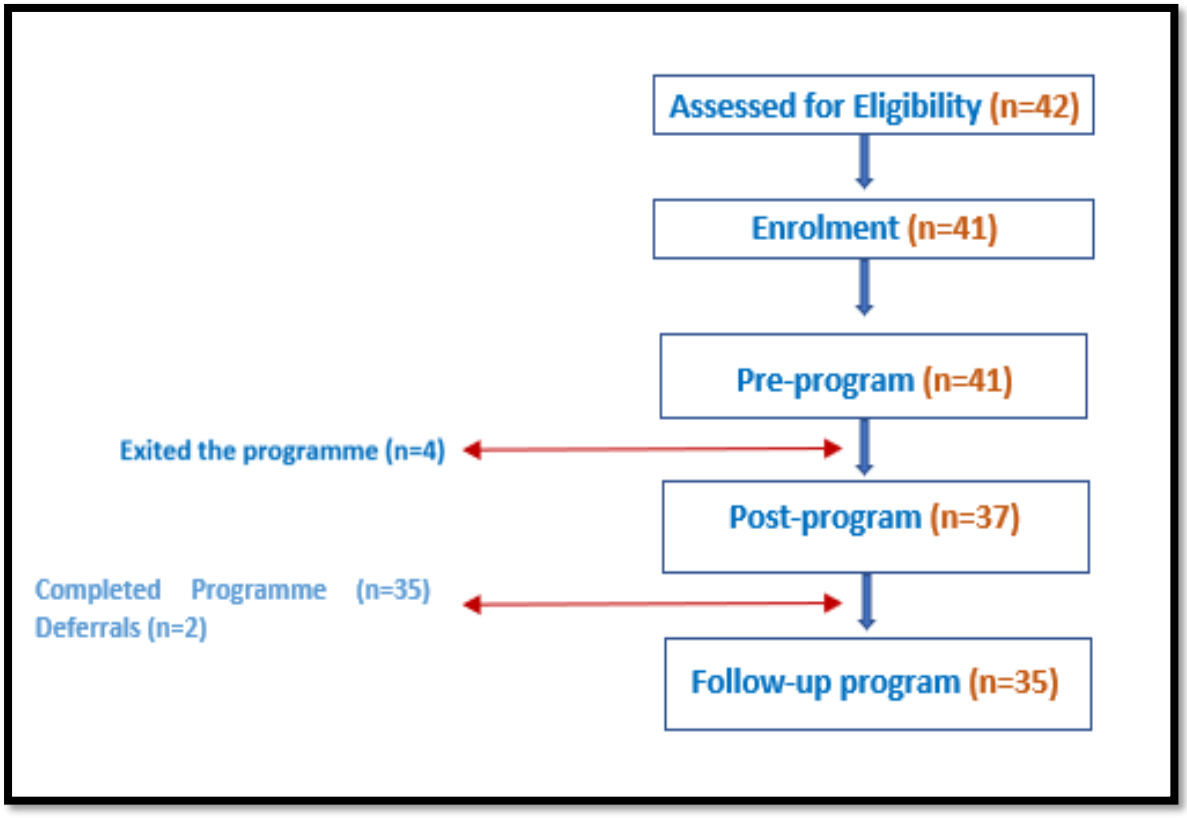

Figure 4.1: Flow chart for study programme participation

4.2.1 Programme Participation

42 were recruited by the nominated gatekeeper, a principal social worker on a voluntary basis, and assessed for eligibility to participate in the study, all met eligibility. 41 agreed to participate in the study. 4 dropped out of the study: 1 owing to information technology (IT) issues, 2 owing to heavy workloads, and 1 left TUSLA in semester one. 2 further participants deferred their programme places until the next academic year owing to personal circumstances. 35 of the 41 participants completed the programme representing 85% rate of programme completion (Figure 4.1). During the study period 5 (12%) participants overall reported that they had left the agency (3 to new posts outside the agency; 2 to full-time further education).

4.2.2 Study Participants

Baseline characteristics of the study participants (n = 41) are described in Table 4.1 above. Overall, the average age of participant was 36 years. Most participants were female (88%, 36), representing a diverse professional group with disciplinary backgrounds mainly social work (61%, 25), and to a lesser extent in social care (17%, 7) and family support (5%, 2). The majority of participants held a third level qualification at Postgraduate (54%, 22) or Graduate (34%,14) level, with main areas of work in Child Protection (56%,23), Family Support (24%,10), Fostering (15%,6) and After Care (5%,2) Teams. The Participants held roles in front-line practice (49%,20), supervision (5%,2) and management (46%,19) roles. The sample on average had 4 years' experience in their current role with an average of 11 years' experience in the sector. The majority did not have previous TIC training (59%,24). 41 completed the survey at Time 1, 27 at Time 2 and 34 at Time 3.

Variable	Number	%
Gender		
1. Female	36	87.8
2. Male	5	12.2
Age (rounded) *based on 40 participants.*		
1. 22 to 28		
2. 29 to 35	10	25
3. 36 to 42	12	30
4. 43 to 58	7	17.5
	11	27.5
Primary Qualification/Discipline		
1. Social Work	25	61
2. Social Care	7	17
3. Family Support	2	5
4. Other	7	17
Highest Educational Achievement		
1. Postgraduate Degree (Masters + PhD)		
2. Undergraduate Degree	22	54
3. Intermediate Certificate	14	34
4. Other	1	2
Main Area of Work	4	10
1. Child Protection/Children in care		
2. Family Support	23	56
3. Fostering	10	24
4. Aftercare	6	15
	2	5
Current Post/Role		
1. Practitioner		
2. Practitioner with supervisory role	20	49
3. Manager	2	5
	19	46
Years Practice in Current Role (rounded)		
1. Less than 1 Year		
2. 1 Year but less than 2 Years	9	22
3. 2 Years but less than 4 Years	9	22
4. 4 Years to 7 Years inclusive	8	19.5
5. 11 Years to 20 Years inclusive	11	26.8
	4	9.8
Total Years Practice in the Sector (rounded)		
1. Less than 2 Years		
2. 2 Years but less than 8 Years	6	14.6
3. 8 Years but less than 15 Years	13	31.7
4. 15 Years but less than 23 Years	7	17.1
5. 23 Years to 29 Years inclusive	8	19.5
	7	17.1
Previous Training in Trauma-Informed Care		
1. No	24	59
2. Yes	17	41

Table 4.1: Study Praticipants Baseline Demographics

4.2.3 Results of Measures

The quantitative results indicate that child welfare professionals were impacted by the programme in three areas related to practice: trauma-informed knowledge, professional self-efficacy, and professional quality of life. The effect size was measured using partial eta squared (Cohen, 1973). Partial Eta Squared = Small effect: $\eta^2 = 0.01$; Medium effect: $\eta^2 = 0.06$; Large effect: $\eta^2 = 0.14$ (Table 4.2).

Validated Scales *Trauma-Informed Practice*	Sig *P Value*	Effect Size[7] *partial* η^2	Effect Size[5] *Interpretation* Time 1 versus Time 2	Effect Size[5] *Interpretation* Time 2 versus Time 3
TIC implementation and principles	<.001	0.704	Large Positive Effect	No change
Neurobiology of stress and trauma	<.001	0.590	Large Positive Effect	No change
Work related stress and trauma	<.001	0.721	Large Positive Effect	No change
Research in adverse childhood experiences	<.001	0.444	Large Positive Effect	No change
Historical and intergenerational trauma	<.001	0.463	Large Positive Effect	No change
Systematic oppression	<.001	0.710	Large Positive Effect	No change
Relative Confidence	<.001	0.426	Large Positive Effect	No change
Skills Competency	.004	0.188	Large Positive Effect	No change
Ability	.006	0.231	Large Positive Effect	No change
Burnout	.035	0.133	Medium Positive Effect	No change
Compassion Fatigue/Secondary Traumatic Stress	.014	0.171	Large Positive Effect	No change
Compassion Satisfaction	.272	0.049	Neutral Effect	Neutral Effect
Thoughts of intention to leave	.528	0.033	Neutral Effect	Neutral Effect
Articulation of intention to leave	.644	0.023	Neutral Effect	Neutral Effect

Table 4.2: Results of Measures Note: Partial Eta Squared = Small effect: $\eta^2 = 0.01$; Medium effect: $\eta^2 = 0.06$; Large effect: $\eta^2 = 0.14$.

Trauma-informed Knowledge

Statistically significant positives effects were found in trauma-informed knowledge at Time 2 of strong positive magnitude for all 6 scales for trauma-informed knowledge. These effects were sustained at Time 3.

1. Trauma-informed Care Implementation and principles – large effect, $\eta^2 = .704$,
2. Neurobiology of stress and trauma – large effect, $\eta^2 = .590$,
3. Work related stress and trauma – large effect, $\eta^2 = .721$,
4. Research in adverse childhood experiences – large effect, $\eta^2 = .444$,
5. Historical and intergenerational trauma – large effect, $\eta^2 = .463$,
6. Systematic oppression- large effect, $\eta^2 = .710$.

Professional Self-efficacy

Professional elf-efficacy was examined using 3 scales; 1. Relative confidence,2. Ability; and 3. Skills competency. Statistically significant positives effects were found in Professional confidence in all 3 scales at time 2, these were sustained at Time 3:

1. Relative Confidence - large effect, $\eta^2 = .426$,
2. Skills Competency- large effect, $\eta^2 = .188$,
3. Ability - large effect, $\eta^2 = .231$.

Professional Quality of Life

Professional quality of life was measured using 3 scales of: 1. Burn-out, 2. Compassion fatigue/secondary traumatic stress, and 3. Compassion Satisfaction. Statistically significant positives effects for 2 scales were found. Participants reported an increased perception of burn-out and CF/STS at Time 2, and this was sustained at 3 months:

1. Burnout - medium effect, $\eta^2 = .133$
2. Compassion fatigue/Secondary Traumatic Stress - large effect, $\eta^2 = .171$.
3. No effects were reported for CS. This result is explored in Chapter 5.

Intention to Leave.

The results did not produce any meaningful effect regarding participants intention to leave the agency after completing the programme. This result is explored in chapter 5.

4.2.4 Results of the Post-Programme Satisfaction Questionnaire

Item	Strongly agree % (n)	Agree % (n)	Neutral % (n)	Disagree % (n)	Strongly Disagree % (n)
1. Relevant to my post	57.1 (16)	35.7 (10)	3.6 (1)	0 (0)	3.6 (1)
2. Programme was interesting.	60.7 (17)	35.7(10)	0 (0)	0 (0)	3.6 (1)
3. Programme was engaging	53.6 (15)	35.7 (10)	7.2 (2)	0 (0)	3.6 (1)
4. Teaching was a good balance of presentations, discussions, and activities	25.0 (7)	53.6 (15)	17.9 (5)	0 (0)	3.6 (1)
5. Lecturers were clear	42.9 (12)	50.0 (14)	3.6 (1)	3.6 (1)	0 (0)
6. Lecturers were effective	49.9 (12)	46.4 (13)	7.2 (2)	3.6 (1)	0 (0)
7. Integration into my role	46.4 (13)	46.4 (13)	3.6 (1)	0 (0)	3.6 (1)
8. Online pre-recordings increased accessibility	49.9 (12)	46.4 (13)	7.2 (2)	0 (0)	3.6 (1)
9. Online live sessions increased accessibility	57.1 (16)	28.8 (8)	9.4 (3)	3.6 (1)	0 (0)
10. Confident programme will impact my practice	50.0 (14)	42.9 (12)	3.6 (1)	0 (0)	3.6 (1)
11. Recommend this programme to my colleagues	53.6 (15)	28.6 (8)	14.3 (4)	3.6 (1)	0 (0)
Item	Highly Satisfactory % (n)	Satisfactory % (n)	Neutral % (n)	Unsatisfactory % (n)	Highly Unsatisfactory % (n)
12. Rate your overall experience	42.9 (12)	50 (14)	3.6 (1)	3.6 (1)	0 (0)

Table 4.3: Post-Programme Satisfaction Questionnaire Results, n=28

The satisfaction questionnaire evaluated levels of satisfaction with the programme using 9 questions that were rated on a 5-point scale. A further open-ended question gathered feedback from participants on what aspects of the training could be improved. Participants reported elevated levels of satisfaction with the programme overall (Item 12: 93%, 28). Participants had a high level of agreement with responses that assessed their satisfaction with programme design, subjective delivery, content, and relevance to practice. The same was true for aspects of the intervention experience: learning methods, engagement and also programme impact: confidence to integrate into practice (see table 4.3).

The open-ended question, 'What aspects of the programme could be improved?', gathered feedback on what aspects of the programme participants felt could be enhanced. The data were analysed using thematic analysis (Braun and Clarke, 2006). Two main themes emerged: 1) Heartbreak of Time and 2) Programme Design and Curriculum. The first theme, Heartbreak of Time, was a dominant theme that was represented in most responses (75%; 21/27). Participants felt they needed more time to complete assignments, to undertake prerequisite readings and more time between module 1 and 2 for reflection in the context of extremely high pressurised work demands. Participants felt the time allocated by their Agency was not sufficient and that programme and work demands placed a strain on their work and home life balance. Some suggested that a reduction in recommended readings coupled with shortened pre-recorded materials and less work between sessions might help to relieve the heartbreak of time pressure. Participant 4 captured this theme with the statement:

> *"Learning resources are amazing and a fantastic toolkit to have going forward but was very difficult to get through within the timeframe of the course. Given that many of us are actively working with the effects of trauma on a daily basis it was difficult to find 'headspace' to academically focus on readings etc.".*

The second theme to emerge from the data was: 'Programme Design and Curriculum'. Participants expressed satisfaction with programme design and curriculum. They described the programme as interesting, powerful, applicable with insightful delivery (pre-recorded materials and break-out groups), and highly relevant to their work. They stated that it had increased their understanding of trauma and their confidence to link theory to practice, and they had gained a valuable toolkit for future practice. Suggestions were made to improve the

programme design in terms of more live-sessions, include in-person live sessions, record live sessions, and more focused/directed break-out room tasks. Participant 8 captured this theme in relation to areas of the programme design that could be improved:

> *"Whilst the online pre-recorded material is beneficial - the volume of the work is at times very challenging to achieve with current workload demands. I wonder if the lectures were 2 hours (10-minute break at the 1hour mark) and then the recordings were 20 minutes less, it might make the weekly tasks less daunting. The breakout groups are really beneficial to see how others are doing and thinking".*

4.3 Qualitative Study Findings

4.3.1 Focus Group Participants

All participants who completed the programme (n = 35) were invited to participate in the focus groups. This reflected the purpose of this study to capture the participants experience of the programme. Differences in gender, teams, discipline, and professional roles were represented across the focus groups. The focus groups comprised of three groups (n = 23) and written feedback was received from two participants who wished to participate in the study but were unable to attend the focus groups. Thus, the total number of participants in the study was 25. (Table 4.4).

Gender	Team	Discipline	Role
23 (female) 2 (male)	8 Child Protection & Welfare 5 Fostering 9 Family Support 1 Aftercare	11 Social work 3 Social care 8 Family support 1 Aftercare	5 Principal Social Worker/Manager 7 Supervisor/Team Leader 11 Frontline practitioners

Table 4.4: Focus Group Participants

4.3.2 Focus Group Findings

Four main themes were identified in the study: Programme Acceptability; Learning to Weave the Old with the New; Integration into Practice and Sustaining New Ground. A number of sub themes have merged under each main theme (Table 4.5).

Qualitative Study Themes
Theme 1: Programme Acceptability Sub theme 1: Programme Content Sub theme 2: Programme Delivery Sub theme 3: Programme Target Sub theme 4: Programme Challenges
Theme 2: Learning to Weave the Old with the New Sub theme 1: Knowledge integration Sub theme 2: Dual Learning Process Sub theme 3: Enhancing Self-awareness
Theme 3: Integration into Practice Sub theme 1: Dynamic Mindset Sub theme 2: Trauma-informed Practices Sub theme 3: Collaborative Practices
Theme 4: Sustaining New Ground Sub theme 1: Contradictory Practices Sub theme 2: Shared Agency Approach Sub theme 3: Preventing the Default Back

Table 4.5: Qualitative Study Themes

Theme 1 Programme Acceptability

Participants described the programme as being highly acceptable, reflected through in-depth feedback based on their experiences of core aspects of the programme. These experiences are captured in four sub-themes; Programme Content; Programme Delivery; Programme Target and Programme Challenges.

Programme Content

Participants were very satisfied with the programme, commending the content in relation to the breadth of knowledge and resources in particular the core TARA practice tools. Content

was considered very relevant, accessible, and applicable to participants to support participants' practice. Participants described their satisfaction with programme content in terms of enabling a deepening of their understanding of the impact of trauma, and in particular how to interpret trauma related behaviours both from the perspective of those they work with (children, families, foster carers), their colleagues and themselves in a more coherent way.

> *I think the content is absolutely fantastic…But what has been really helpful is that this has given us a (TARA) framework and a language and a more coherence I suppose in the approach". ID 37*

Scientific rigour was another valuable aspect of the programme, with the evidence-based nature of the programme content described by participants.

> *"It's a highly evidenced based programme. So, you know that your knowledge is solid, and it's got a good foundation, as you said when you share it with others or want to explain it or use it. So that's really good". ID4*

Programme Delivery

Overall, high rates of satisfaction were found regarding how the programme was delivered and assessed. Participants predominantly liked the online nature of delivery in the form of pre-recorded materials, live lectures, supplemented by reading resources and video recordings.

> *"I thought the structure of the programme was great and there was a real kind of obvious formula to it. You know once you got into it and got used to downloading the recordings and looking at some of the readings. And the way it was done out in two Modules". ID 17*

The transferability of some of the video content, particularly the case study materials, was referred to in terms of being relevant, relatable, and helpful when working with children, young people, and carers.

> *"…. there were the videos and there was I think it was Kevie and you could kind of you could link what you were learning to the reactions. And it kind of brings it into focus when you when you're working with young people and foster carers are telling you stories about behaviours…". ID30*

Finally, the value of doing the assignments was highlighted as a means of demonstrating how the learning regarding trauma informed care could be applied as intended in practice.

> *"I suppose to engage in something that really impacts on our practice …. just to be able to have time to see how that's possible … To see how you can actually bring it into your practice by doing the assignments. Because we do so much training and it's been consistent, and it gives us time to really see how we can actually bring it into our practice in a meaningful way". ID17*

Programme Target

Participants were particularly satisfied with the extent to which the programme was targeted at staff across the DSC area from a wide range of teams (pillars) that reflected different roles and responsibilities. Participants viewed this as being very beneficial, facilitating a positive collegiate and non-hierarchical approach to trauma-informed education and encouraging collaborative practice. Indeed, participants contrasted this to previous trauma related training in the child welfare agency which tended to be assigned to smaller numbers of staff of similar grades, and provided on an individual or team basis, and for a shorter duration, through once-off workshops, for instance.

> *"….I find doing it as an Area and having each pillar (involved). Sometimes it's kind of looked at individually, and I love the way on this Programme it was very much everyone was together and it's really kind of given me a sense of like support". ID15*

One participant that was the only staff member from his/her team within the area to participate in the programme suggested that a minimum of two team members be selected to participate in the programme, in order to avoid isolation and support more unified working approach within his/her team.

> *"… just wanted to make that point as well of the value of everybody being able to do it [Programme] and maybe going forward that that's looked at between teams, that there is at least two people on the teams that have done or are doing it". ID1*

Programme Challenges

The issue of time commitment arose for participants, in the context of being very motivated to engage with the programme, as one of the main challenges in participating in the programme and fulfilling the programme expectations.

> *"I could barely make time for the live lectures so was unable to do any additional [Programme] work". ID2*

Another compounding factor making the programme challenging for participants was balancing the programme commitments with their high demand jobs and busy work caseloads. The reality of balancing busy work and family life schedules was also highlighted in terms of a time challenge.

> *"I found the overall experience overwhelming as I had underestimated the amount of work involved. Unfortunately, the Programme overlapped with my caseload becoming extremely busy and so I wasn't able to give it the time and focus it deserved". ID2*

In addition, it was felt that the programme intensity especially with regards to the timing of Modules 1 and 2, which were ran on a weekly basis over an 8-week period each, with a short gap between Modules, required work and at each module end an assignment required to be completed.

> *"…. the gap between when you done the first and the second [Modules] was very close. And I just think given the level of work, it was just very intense. I think if we had a little bit more (time) you could have regrouped a little bit, gone over the stuff from work that was building up, and then given this another burst of energy, you know". ID37*

Theme 2 Learning to Weave the Old with the New

The focus groups discussions generated much feedback on participants' learning experiences based on their participation in the programme. There was a strong sense that a lot of new knowledge was gained and that the participants were leaving the programme with a deeper, holistic understanding of trauma-informed practices, from both a theoretical and applied practice perspective. The various components of theoretical and applied learning can be distilled into three sub themes: Knowledge integration; Dual Learning Process and Enhanced Awareness.

Knowledge integration

Participants discussed learning about theories that underpin the TARA framework including trauma, polyvagal, neuroscience, neurobiology, attachment, mentalising and resilience theories. They described this learning as a process of integrating existing knowledge with new knowledge. Participants found the integration of the learning involved both revised learning and new learning. They describe how this was facilitated in an understandable and applicable way. Participants felt that this was very valuable and provided a coherence to understanding trauma and trauma-informed practice.

> *"And I think from all of it, (the) theoretical underpinnings that we've covered. A lot of us would have been familiar with the likes of trauma, attachment, resilience, but it's (TARA) weaving all those into the additional ones like polyvagal, neuroscience, neurobiology and you know, 'the body holds the score'". ID39*

Dual Learning Process

Participants described a unique element of the programme of learning through a process with a dual focus. This process reflected a core element of the programme (parallel process), in exploring experiences that run in parallel to one another within a relationship, such as the practitioner (self) and their client (other). This dual process involved learning to develop an understanding of the lived experience of trauma, its ongoing impact, and put in place mechanisms to effectively cope and minimise or avoid re-traumatisation for both the self and other. The programme tools and practices were described as very beneficial in engaging in this learning process:

> *"I think for me one of the new learnings is almost an invitation through the [TARA] framework and the different theories is not to just look out on what's going on with the families and the young people, but to actually turn it back and think about ourselves as professionals and how we're influencing the system all the time". ID37*

Participants highlighted the core tools the learnt during the programme, in particular the Thermomotor of Regulation, the Iceberg tool, and the Mentalisation tool, as well as various reflective and regulating activities and practices that supported their learning and awareness of this dual process.

> *"I think the tools developed by [name of Programme Provider] were very accessible as well, like the Thermomotor of Regulation, the Iceberg tool, the Mentalisation tool. All those really practical, accessible, easy to read, kind of infographics made understanding it much easier I think and understanding how to apply it". ID39*

The concept of shame arose as a significant new learning component with participants describing their development of a deeper awareness of the impact shame, reflecting their awareness of the dual process of learning. Participants explained how they applied this deepened understanding of shame across experiences in relation to those they work with (parents and/or children), their colleagues and themselves as professionals. They shared examples of how this new learning, facilitated by core programme tools mentioned above, has helped them to understand more the experience of shame with regards to carrying out their roles, working either directly with children and families, in supervision and management:

> *"One thing we spoke about it was, um, the organisational shame that you feel sometimes we kind of, staff retention, if social workers change for families and you know different services, I would feel that shame for some reason. I would feel that, and it would be apologising, and I would take that pressure on". ID31*

Enhancing Self-Awareness

Linked to learning through a dual process was another frequently discussed learning component of the programme, namely the focus on engaging in self-awareness. Participants explained that this was a unique element of this programme contrasting to other trainings that focused solely on clients' experiences. Participants referred to having a greater insight into the impact of their work and a deeper understanding of how this influences their capacity to carry out their professional roles.

> *", I suppose the TARA project has allowed us look at that in a greater way. I think we always knew that there were impacts. Um, but you know, and I suppose it it's allowing us maybe to give time to ourselves but also to be kind to ourselves". ID17*
>
> *"….. about having permission to say you're not okay. Maybe, hopefully things might improve, where people feel it's okay to ask the question meaningfully, like 'are you actually okay?' ……. And maybe it is as basic as that, as our starting point for someone to say, 'it's okay to not be okay'". ID9*

Participants described how experiencing a process of enhanced self-awareness was reflected into their practice as they were completing the programme. Participants described being more aware about recognising a need to 'pause', being about to recognise current state of arousal (based on the Thermometer of Regulation Tool), articulating this and taking a pause to prevent reactive, defensive orientated practices. Participants also described a growing confidence in articulating their mental/emotional state in a work context. This was viewed as being very beneficial in how to approach their work both with clients (children and families), foster carers and colleagues, with some suggesting that it would promote a more conducive work practice culture. The quote below captures this, describing using the language of the Thermometer of Regulation tool (for example, Red Zone signifying the recognition and naming of being in a hyper-aroused state and needing to take a pause).

> *"And like the confidence to be able to say, 'I know that I am in the Red Zone and like I need to do something about it', rather than just pretending that, you know, you are okay and just going ahead anyway, you know?". ID 15*

Theme 3 Integration into Practice

Theme 3, Integration into Practice represents participants views on how participants have integrated their learning into practice. Rich examples of changes in work practices were shared. These perspectives are captured in three sub-themes: Dynamic Mindset; Trauma-informed Practices and Collaboratives Practices.

Dynamic Mindset

There was a strong sense from the data that a shift in mindset, has taken place amongst programme participants which remained active. The dynamic mindset involved a shift in thinking (perceptions) about clients' histories and presentations in an ongoing sense. This shift aligned with enhanced self-awareness described above. Participants described communicating differently about their clients' experiences, in particular in describing behaviours, with colleagues/team members, foster carers, social workers, other agencies, as well as with clients themselves. This dynamic mindset was described as moving towards (ongoing process) a more trauma-informed understanding of clients' experiences. Participants discussed how this dynamic mindset, was shown in their attitudes and language used in their case notes, child protection conference reports, court reports and referrals to other agencies:

> *it's definitely changed the mindset and the language and, I suppose, it's taking away the behaviours and depersonalising them from the child and taking away that kind of fault blaming language and making sure that we are presenting it in a way that's trauma informed, child-centred, strength focused". ID39*

The dynamic mindset was also linked to a growing sense of confidence in doing their work. Participants explained that they felt more confident in working in a trauma-informed way, this was discussed as being as a result of more clarity in how to integrate trauma-informed practices through the TARA practice model they had learned about through the programme:

> *"I think lots of us had a lot of this kind of knowledge and stuff. But we didn't have a clear framework, or probably even the confidence to deliver this in terms of our understanding and our knowledge". ID 22*

Trauma-informed Practices

Participants described how the programme provided them with a clearer way, *'a kind of map'* ID30, to navigate the complexities of integrating TIPS into their respective roles. They felt this sense of coherence really helped them to understand and to support their clients more. They explained that this led to integrating trauma-informed practices to how they approached decision-making throughout engagement with children and families and foster carers, in terms of case planning and decision-making around referrals.

> *"But like, sometimes a plan was made for a family and when we go in, we say we can't get anywhere with this family because nobody knew that they were traumatised. It's something that we're picking up on now. Like you'd pick up on it later [in the past]. But, because of the learning from this Programme, I could pick it up immediately. By the embodied experience of our clients, going into them, you know?". ID40*

Further examples were shared in changes in how meetings were conducted, in recognition of vicarious trauma exposure owing to the work. These changes involved integrating trauma-informed practices to support naming current experience and calming responses through regulating exercises such as mindfulness and breathing exercises. Participants also shared an increased consciousness of the need for appropriate physical environment for meetings to support safe spaces for meetings and to also support regulated experiences.

> *"So, I suppose if we're having a team meeting now and we're doing like a case formulation or a case discussion, I might invite the staff at the team meeting, say, OK, well, let's have a look at how you positioned yourself. What were you feeling in that moment when that was going on?". ID37*

Participants also discussed how they were integrating trauma-informed practices into supervision sessions. Examples were given of incorporation the use of programme tools and techniques into supervision. There was also an increased consciousness of appropriate physical spaces for supervision, in line with views about meetings.

> *"And then in supervision having more honest conversations with people I'm line managing around how they are really doing. A lot of them are participating in the Programme, so they're able to respond, 'I'm in the Blue Zone' today and you know, we can have a chat about that. And what might help them to move back into the Green Zone". ID19*

Collaborative Practices

Participants described how the programme supported their capacity to support more collaborative working, in different contexts, which they welcomed. This was supported by how the programme was targeted across teams and grades as it facilitated a positive collegiate and non-hierarchical programme experience discussed in Theme 1 (*Programme Acceptability*, sub-theme Programme Target). These collaborative practices, in themselves practice changes, also led to changes to practices in foster care. Participants discussed how they were working in a more collaborative way with foster carers, moving away from "*operating in such a kind of authoritative role" (ID30)* oriented practices*:*

> *"And this is what we want, this is what we want to do. And you bring foster carers on board, and it's a real collective approach as it should be". ID30*

This sense of collaborative working also extended into discussions on how the TARA model aligned well with, and compliments other approaches and programmes used in current practice. Participants named the Circle of Security, Meitheal (PPFS), Non-violence Resistance (NVR), and Restorative Practice approaches as examples of this. Participants described how they were integrating new learnings into these, strengthening their capacity to deliver these with extended knowledge, professional confidence and supporting collaborative practice:

> *"I suppose as well it's made me think about one of the trainings that I was lucky enough to do was to be trained to be a Circle of Security Facilitator. So, while I have to remain authentic to the delivery of that Programme, I do believe that there's so much from the TARA training that the discussions that happen in the Circle of Security Training with foster carers, I just think that I would be able to support richer conversations in that training from this training, if that makes sense". ID12*

The setting up of a trauma-informed practice network to support better inter-agency collaboration and consistency of approach was also highlighted by participants. These participants had focused on this as part of their assignment work with the intention of developing this network going forward:

> *"… as part of our assignment we're developing a trauma informed practice network for our CFN members so that we can encourage these practices in other organisations, not just their own, and hopefully encourage them to go and seek further training". ID34*

Theme 4 Sustaining New Ground

The fourth theme that emerged from the data was Sustaining New Ground. This reflected participants' views on their desire to sustain the progress they had made in positive practice changes across their area and what future supports would be needed to maintain this. The following sub-themes reflects this main theme: Contradictory Practices; Shared Agency Approach and Preventing Defaulting Back.

Contradictory practices

A sense of frustration was expressed by participants who explained that they are trying to implement TIP within a practice climate that is operating in a contradictory way. They said that the learning they had gained throughout the programme has led them to realise that many practices within their service did not reflect a trauma informed approach. Participants described working in a system that was operating in an '*institutionalised*' and '*crisis-led*' (ID7) way. They described a sense of exasperation as they faced the clash of practice approaches:

> *"I think the thing for me really, I mean, not to be negative, but I think it's frustrating when you kind of have the like the recent knowledge and you know 'we're all in it together' and 'we're all seeing it'. And then you're kind of looking at TUSLA, and maybe how this system doesn't line up to being, you know, trauma informed. Then that's kind of quite frustrating and kind of like you feel like okay 'I know this now' and now it's like, 'Okay where?' 'How can this?' [be implemented?]". ID15*

The crisis-led system climate experienced by participants was also discussed in the context of staff shortages, staff retention challenges, and the very large caseloads/workloads that results from these issues. This organisational climate was regarded as directly contradictory to implementing TIP.

> *"There's so much that can be done quickly, at surface level. But like we're dealing with crisis. We have a retention and a traction issue within the Area that inevitably kind of just puts so much pressure on workers anyway". ID1*

Another contradictory challenge which arose during the discussions with focus group participants was interagency working with some outside organisations. Participants discussed instances of attempting to work in a trauma informed way with professional staff working in schools, An Garda Siochana, and the Child and Adolescent Mental Health Services (CAMHS). However, owing to gaps in TIP understanding they described meeting barriers and a need for implementation of TIP across other organisations to enable a more consistent approach.

> *"I actually had a conversation with a teacher in a secondary school in relation to a young person I am working with. And I was …that we needed to try and be more kind of understanding because of the trauma that young person has experienced over the years in relation domestic violence and stuff. And when I mentioned it, she [the teacher] just didn't want to have the conversation". ID18*

Shared Agency Approach

Participants strongly held the view that that a shared approach within TUSLA for TIP implementation was needed to support the progress they had made. They really valued the (integrated service) area wide approach taken in delivering the programme across DSC. They described this as a 'bottom-up' approach as it reflected an area-based initiative (open to all grades from front-line practitioners to area level management). However, they expressed the view that there was no clear *agency* wide approach to implement TIP nationally. This lack of clarity and was linked to participants describing their sense of disconnection between the area level and the Executive level of TUSLA. They expressed fears that the momentum for practice change that has been built up over the course of the project would

be lost unless they were supported by the executive management team (EMT) of TUSLA. Some expressed concern that TIP may become a "t*okenistic tick box situation*" *(ID1)* on the part of the EMT. Others suggested that the EMT should engage in trauma-informed education to support understanding and connection.

> *"Look, I think in general it needs to be a more macro approach. You know we're all well and good here on the ground, you know, being trauma informed and doing all that. But unless it's understood and appreciated and encouraged and worked from the very top-down, I think we're paddling upstream". ID4*

Participant sense of disconnection from the executive level of TUSLA was linked to their need for acknowledgment by the EMT of the difficult jobs and working conditions they are facing on the ground. Moreover, the need for concrete action to address the ongoing vicarious trauma exposure of practitioners by providing appropriate supports and work environments for staff across the agency was discussed. Indeed, the potential for increasing levels of job satisfaction and staff retention was referred to if practice changes concerning TIP that have been initiated in DSC were supported going forward. Some felt this would encourage a more supportive unified national practice culture within TUSLA.

> *"And also, I think if you get this right and you can implement it and you're coming from like a real shared approach … it gives you more job satisfaction which in turn will hopefully, I know it's a bit of an ask, but that contributes to staff retention, doesn't it?". ID30*

Preventing the default back

As previously referred to, participants valued the programme in terms of its duration over a period of months, thereby enabling in-depth learning. Participants spoke about the importance of sustaining the programme learning and practice changes that have been developed across their service area. They expressed a real concern that without support to embed these changes, practices would revert (default) back to prior to the programme. Participants identified supports of TARA peer groups and an annual event such as a workshop to sustain the motivation and learning built-up during the programme as ways that would support this.

"So, it's brilliant that Dublin South Central and some thanks goes to [XXX-name of Principal Social Worker] for pushing this along, making this happen, it's an amazing initiative here. But it does need to be replicated and in a meaningful way so that you can sustain it. And I think for me the biggest thing here I think it would be a shame if this can't be sustained based on our own experience as practitioners and as a practice model". ID19

4.4 Summary

This chapter has presented the results and findings from the two-component studies (quantitative and qualitative). The data collected from participants consistently explored the key areas which the course was expected to influence. This included factors in relation to knowledge gain, professional efficacy, programme experience, and influence on child welfare practice. The next chapter presents the integrated findings.

Chapter 5: Integration of Findings and Discussion

faction Questionnaire) and the qualitative study (Focus Groups) are presented and discussed. Both the quantitative and qualitative studies were designed to explore various aspects of the evaluation of the programme from differing perspectives. However, these two studies were interconnected and thus, by employing a mixed method approach, the integration of findings aimed to produce more extensive analysis and a more robust evaluation study.

5.2 Integrated Findings

The findings from the quantitative study and qualitative study were compared to assess how they related to each other. This process involved reviewing both datasets to identify the key themes and comparing these themes to identify similarities and differences. The data integration approach identified four meta themes that cut across methods and data sources: 1) Programme Acceptability; 2) Dynamic Learning Acquisition; 3) Changes in Practice 4) Sustainability.

Meta Themes	Convergent Results (QUANT+QUAL)	Complementary Results (QUANT+QUAL)	Qualitative Study only Results (QUAL)
1.Programme Acceptability	Programme Design Programme Content Programme Target Protected Time		
2. Dynamic Learning Acquisition	Increased Trauma-informed Knowledge Amplified Self -reflection Enhanced Practice Confidence	Weaving Old and New	
3. Changes in Practice		Child and Family Practices Practices for Practitioner Resilience	Transformative Collaborative Practices
4. Sustainability		Contradictory Practices Preventing the Default	Shared Agency Approach

Table 5.1: Integration of Findings Note: QUANT=Quantitative Study (Pretest-post-test Study + Post Programme satisfaction Questionnaire); QUAL=Qualitative Study (Focus Groups)

5.2.1 Meta Theme 1: Programme Acceptability

The first Meta Theme for the study is *Programme Acceptability*. Convergence, demonstrating strong evidence, across both studies for the acceptability of the programme. The integration of findings illuminated four subthemes: *Programme Design; Programme Content; Programme Target* and *Protected Time* (Table 5.1). The programme was highly acceptable in terms of a blended approach to learning (Asynchronous and Synchronous) through an online delivery. Asynchronous delivery involved weekly pre-recorded lectures of 1.5-hour duration. Synchronous delivery involved weekly online 1.5-hour sessions hour sessions Overall, the design was regarded as highly accessible, with the majority navigating the internet technology aspects of the programme with ease. The content was overwhelmingly reported by participants as highly relevant to child welfare practice, in terms of begin understandable and applied, thereby clearly enabling translation of theory to practice. The programme targeted diverse levels of role responsibilities (front-line practice and/ supervision and management) and teams (Child protection and Welfare, PPFS (Prevention, Partnership and Family Support), Fostering, After Care) and disciplines (Social Work, Social Care, Family Support). This diversity of participants was also viewed as supporting the building of positive working relationships across the DSC Service Area of TUSLA. Finally, the study found more protected time to engage in the programme is required, with a suggestion for more time between modules, and more time to do assignments, and to fully engage with materials. Despite the highly challenging practice climate, and time pressures, the programme was successfully completed by 85% of participants.

5.2.2 Meta Theme 2: Dynamic Learning Acquisition

The second Meta Theme for the study is *Dynamic Learning Acquisition.* Convergence, demonstrating strong evidence, across both studies for *Dynamic Learning Acquisition*, the living building of knowledge, was found. There were also complementary findings in the qualitative study that extended findings for *Dynamic Learning Acquisition* by providing further supporting information. This was illuminated in four sub themes: *Increased Trauma-informed Knowledge; Amplified Self-refection; Enhanced Practice Confidence* and *Weaving Old and New* (Table 5.1).

Increased Trauma-informed knowledge, where clear knowledge gains were made, was reported across studies on the principles and theories that underpin trauma-informed practices.

Convergence was also found for *Amplified Self-reflection* by knowledge gains in the understanding of burn-out and compassion fatigue and STS. Furthermore, amplified self-reflection was found, in the context of knowledge gains through a dual reflective process. This dual reflective process enhanced both understanding of trauma impact and trauma-informed interventions that relating to both clients as well as professionals working with trauma.

Enhanced Practice Confidence was also found across studies. Practitioners have increased professional self-efficacy supported by a highly relevant, university level programme providing an in-depth theoretical and applied knowledge based in evidence, and an extensive resource bank (toolkit). Furthermore, this confidence was demonstrated in creating new trauma-informed practice initiatives and changes across the research site.

The *Weaving Old and New* sub theme illuminated how this *Dynamic Learning Acquisition* involved integrating new trauma-informed knowledge and practice with existing practice knowledge. The study also found that this weaving extended to integration of knowledge within other programmes, further strengthening these programmes and with an increased confidence.

5.2.3 Meta Theme 3: Changes in Practice

The third Meta Theme for the study is *Changes in Practice*. Complementary findings that supported and overlapped, demonstrating strong evidence across both studies for the Changes in Practice. These were illuminated across the findings in three subthemes: *Child and Family Practices; Practices for Practitioner Resilience*, and *Transformative Collaborative Practices* (Table 5.1).

The study found that *Child and Family Practices* were infused with trauma-informed practices encompassing increased knowledge, increased professional confidence (skills and ability), and integration of existing practice wisdom. In this way, these practices reflected a trauma-informed understanding of child and family behaviours, presentations, and lived and living experiences of trauma. Concrete examples of practice changes included: the use of more appropriate and empathetic language in practice including in case file notes, court

reports, approaches to decision-making in case planning, direct work with clients, and in decisions around referrals and confidence in strengthening existing child welfare practice programmes and strategies.

The study also found *Changes in Practices* that centred around *Practices for Practitioner Resilience*. These practices were also infused by increased knowledge of contemporary trauma theories, increased knowledge of burn-out and CF/STS (awareness, recognition of and impact of STS), increased professional confidence (skills and ability), and the integration of existing practice wisdom, that also reflected an amplified self-reflection (dual reflective process). Concrete examples of practices changes were practising 'the pause', integration of TIPs in supervision, as well in team meetings, complex case review meetings, and case conferences.

Thirdly, *Changes in Practice* were found in *Transformative Collaborative Practices*. These practices were also infused by increased knowledge across contemporary trauma theories, burnt -out, compassion fatigue/secondary traumatic stress, professional confidence (skills and ability), as well as collaborative practice integration of existing practice wisdom, as well as amplified self-reflection (dual reflective process). Concrete examples of practice changes were across DSC between colleagues in developing new practice initiatives across teams demonstrated new collaborative working practices. Furthermore, new collaborative practices were evident with working with foster carers, strengthening existing approaches with deepening practice knowledge and confidence and in developing a new trauma-informed network with PPFS partners.

5.2.4 Meta Theme 4: Sustainability

The fourth Meta Theme for the study is *Sustainability*, reflecting the need to sustain the progress made to date, and to implement TIP going forward. Findings for *Sustainability* were found across both studies and were elucidated in three subthemes: *Contradictory Practices, Shared Agency Approach, and Preventing the Default* (Table 5.1).

Complementary findings were found for *Contradictory Practices*, this reflected the challenges in trying to implement TIPs in a crisis-led, highly pressurised practice climate. Further to this, interagency alignment through a better consistency of approach reflecting TIP is required to support *Sustainability*. In the current practice climate inconsistent approaches across child serving systems (Education, Justice, and Mental Health) remain a

barrier to TIP implementation, There was a hope that if TIP was sustained and implemented this would likely to increase professional satisfaction in the work and overtime would promote staff retention.

Findings for *Shared Agency Approach* was found only in the qualitative study, not surprisingly given this was the not examined in the quantitative study. The study reports the need for a clear agency wide national strategy for supporting TIP implementation to sustain the progress made in the DSC Area, and to support a connectedness and sense of cohesion across the agency.

Finally, complementary findings were found for *Preventing the Default* across studies. The study found learning was sustained at 3-months post programme completion for the study participants. However, despite this sustainment, ongoing supports are required to prevent reverting to practices that do not align with TIP. Types of supports suggested to reinforce *Sustainability* included: annual events, and peer support groups.

5.3 Discussion

The *Continuing Professional Development Certificate in Trauma-informed Care: Theory and Practice* under investigation is a university graduate level trauma-informed education that seeks to support child welfare professionals in the Irish context. The programme was targeted across child welfare professional roles in front-line practice, supervision, and senior management, seeking to increase their capacity to integrate trauma-informed practices into their roles. A mixed methods approach was used to integrate data from two component studies (quantitative and qualitative). This study has produced strong evidence for *Programme Acceptability, Dynamic Learning Acquisition, Changes in Practices* and S*ustainability*.

Programme Acceptability was a major study finding. The programme was designed to accommodate full-time working professionals in child and family welfare practice. The high level of flexibility provided for participants to engage with the content using a blended approach to learning (Asynchronous and Synchronous) through an online delivery was likely to have supported this. Online delivery formats support learning in university level programmes (Koljatic *et al.*, 2004) and has also been found to effect in trauma-informed education delivery (Razuri *et al.*, 2016). This study uniquely included child welfare professionals across differing roles and levels of responsibilities (front-line practice,

supervisor, and senior management. This brought a strength to the programme, providing an education experience that was non-hierarchical and thus supporting collaborative practice. The inclusion of senior managers may prove to be important in the leadership supporting a collective responsibility towards TIC implementation going forward.

The highly relevant and applied focus of the programme, through the TARA practice model, core programme tools and action learning orientation proved to support success in supporting child welfare professional capacity to integrate trauma-informed practices into their existing specific roles. The high levels of completion (85%), reflects a motivation to support the implementation of TIPs and a commitment to changing current practices within a highly pressurised climate context. However, going forward, allotted protected time to engage fully in the programme is necessary.

Dynamic Learning Acquisition was reflected in knowledge gain regarding concepts and theories that inform trauma-informed practices, and gains in professional self-reflection and self-efficacy. These results align with similar studies that reported increased trauma-informed knowledge based on pretest-post-test design (Conners-Burrow *et al.*, 2013; Kenny *et al.*, 2017; Beck *et al.*, 2022). The results also align with similar research showing knowledge gain in terms of an increased confidence to practice TIC (McNaughton *et al.*, 2022). Increased trauma-informed knowledge is important to support TIPs. Firstly, it is an important facilitator of behavioural change as the developing of knowledge provides the foundation to the practical application of the learning (Burke, 2017). Secondly, trauma-informed knowledge is also associated with increased commitment to TIC implementation (Sundborg, 2019).

This study goes further in illuminating the nuances of how TIPs require weaving through existing best practices. Child and Family welfare practices already align with TIPs, based on person centred approaches (relational and reflective practices) which are well-established best practices for with working with those who come into contact with child welfare agencies. Many of these are likely to have significant experience of trauma, such as abuse, neglect, violence, and intergenerational trauma. This research suggests that many practitioners were already using trauma-informed practices, based on existing knowledge and practices, however, did not articulate these as such. These findings align with a recent a review of trauma-informed practices in children's social care services in the UK (Asmussen *et al.*, 2022). This review found there was a lot of overlap between existing practices and

trauma-informed practices. It also highlighted a need for clarity in the identification and evaluation of such practices. This research extends this knowledge in that TIPs may not always involve all new elements in practice but rather supports understanding old and new knowledge, and how they work together. TIP thus, requires knowledge of how established practices knit with trauma knowledge towards influencing practices. This is timely in the face of increasing bureaucratic and managerial led systems of care (McGregor and Quin, 2015). This research illumination of the intertwining of well-established practices with TIPs may be an opportunity to reclaim relational, strength-based practices and refocus practice on person centred approaches (relational and reflective practices).

This study provides evidence that the programme has produced concrete practice changes, clearly having an impact on practice beyond knowledge gain. This is a significant finding given that evidence synthesis for trauma-informed education initiatives highlights the challenges in successfully bridging increased trauma-informed knowledge to changes in practice (Purtle, 2020). This study found creative new concrete practice examples that weaved TIPs through existing practice processes, practices that aim to support building practitioner resilience and practices that support more collaboration. Whilst assessing the impact of these practices on child and family outcomes are beyond the scope of this study, other Irish research aligned with the TARA practice model has produced promising evidence to support improved outcomes for children in foster care (Lotty, Dunn-Galvin and Bantry-White, 2020).

The current study has highlighted the impact of the current practice climate on burn-out and CF/STS on child welfare professionals and thus the need for support to embed TIPs over time that may help address this. The programme has a strong emphasis on practice skills to reduce compassion fatigue/secondary traumatic stress and support practitioner resilience which many of the participants engaged with, as discussed above. However, the findings did not report any meaningful increases in compassion satisfaction. This research suggests that addressing the impact of STS is likely to take time through changes beyond TIP education requiring a wider system level (inter- and intra-agency) approach (de Guzman *et al.*, 2020). However, the current study is an important step towards supporting a culture that gives permission to articulate STS in child welfare practice and support practice changes that reinforce practitioner resilience across the service area. This study illuminated practitioners need for more recognition of secondary trauma amongst front-line practitioners and

resources to support address this from the executive level of TUSLA to successfully implement TIC. This aligns with other research calling also for recognition of CF/STS and support across child-serving systems (Child Welfare, Education, Health, Youth Justice) in other jurisdictions (Bargeman *et al.*, 2022).

The research did not produce any meaningful findings regarding participants intention to leave the agency after completing the programme. However, it is notable that of the 41 participants at baseline, over the course of the study 5 (12%) left the agency (3 moved to other agencies and 2 to full-time education). This reflects the existing difficulties in staff retention in the research site which is operating in highly challenging practice conditions. Thus, it may have been the case that those that had an intention to leave had left the agency prior to data being collected post-programme. The research did find a hopefulness that if TIP was implemented this would support satisfaction in the workplace and overtime may promote staff retention. This is important given an association with intent to stay (retention) by child welfare practitioners who were open to the principles of TIC being adopted within their organisation has been reported elsewhere (Bosk *et al.*, 2020). Nevertheless, intention to stay or leave is likely to involve a complex intersecting factors across individual, relational, organisational and community spheres (Kim and Kao, 2014; Wilke *et al.*, 2018).

A key feature of TIC implementation is building workforce capacity to engage in trauma-informed practices (TIPs). This research found knowledge gain and application to practice, through the TARA practice model. However, challenges were highlighted with regards to sustaining progress and implementing TIPs beyond the integrated service area of DSC. Implementing TIP in a practice climate that is crisis-led and under resourced has been highlighted here and elsewhere as a significant barrier (Smith and Monteux, 2023). The commitment to this project, to learning and to development of new initiatives are a testament to the highly motivated professionals who participated in this research. They are working daily in complex child and family welfare practice within a crisis-led practice climate that challenges integration of TIPs. Despite this, they have demonstrated high levels of motivation for service change. This research has been able to shine the light on their practice and support dissemination of practitioner outputs (Lotty and Hayes, 2023; McCormack and Campbell, 2023). However, the study clearly found a need for ongoing support to ensure changes are embedded over time. Similar research that reported positive

results for skills development, that included follow-up supports and action plans to embed learning (Beck *et al.*, 2022). Thus, an implementation plan with such supports is likely to sustain learning and practice changes. Going forward, dissemination of this work, to support an implementation plan is required. Inadequate dissemination strategies may undermine implementation (Proctor, Powell and McMillen, 2013). Thus, attention to an on-going dissemination process with key stakeholders to include publications in the research literature, agency and practitioner targeted conferences and publications is planned.

TUSLA have identified trauma-informed practices as a key service need in the service spheres of alternative state care for children, i.e., foster care (TUSLA, 2022a) and residential care (TUSLA, 2022b). However, no clear strategy has been put in place. This research has highlighted the need for a coherent agency wide strategy, beyond local area level initiatives. This is likely to support a more connected agency culture and support the innovative and ground-breaking practice initiatives in DSC. Indeed, this is in line with implementation theory, which suggests that individual-level interventions, such as professional education, will only lead to behaviour change when the overarching system is supportive and facilitative of the programme of change (Fixsen *et al.*, 2009).

Further to an agency wide coherent strategy, a broader system wide approach across child serving systems is required to sustain the progress made in DSC and support further TIP implementation. Consistent with international research (Bargeman *et al.*, 2022), this research highlights those inconsistencies of approaches across child serving systems places barriers to TIP implementation. However, despite this, innovative practice changes in the DCS in developing collaborative practices and networks are likely to support the reduction of such barriers.

5.4 Summary

In this chapter, the study findings using a mixed-methods approach has been presented and discussed. This approach of integrating the findings based on all available data sought to strengthen the overall study by enhancing the credibility and transferability of the findings. In the final chapter, the major conclusions and recommendations are presented.

Chapter 6 Conclusions and Recommendations

6.1 Introduction

At the final stage of this study the conclusions of the study and recommendations are presented.

6.2 Summary of Key Conclusions

This study represents a successful high-level collaboration between the Dublin South Central Integrated Service Area of TUSLA and University College Cork. The study's objective was to explore the impact of professional graduate education in trauma-informed practices on child and family welfare professionals. This objective for Phase 1 of the TARA Project, sits within an overarching aim to integrate trauma-informed practices across the service area of DSC, to support practice in responding to the complex needs of children and families. This evaluation found strong evidence for success for the UCC based graduate level programme to support child welfare professionals' capacity to integrate trauma-informed practices into their specific roles. The triangulated data analysis provided evidence in relation to the impact of the programme on *Programme Acceptability* [design content, target and experience], *Dynamic Learning Acquisition* [increased capacity of trauma-informed knowledge, amplified self -reflection, practice confidence and in weaving' old and new' practice knowledge together to successfully build capacity for trauma-informed practices]; *Practice Changes* [reported in spheres of child and family practices, practices for Practitioner Resilience and transformative collaborative practices]; *Sustainability* [the need for a shared agency approach, ongoing supports is to sustain progress and address contradictory practices]. The research produced positive results for intended direct outcomes of trauma-informed knowledge, professional self-efficacy, and trauma-informed practices, as conceptualised in the Study Logic Model (see Figure 1, page 18). Whilst compassion satisfaction and staff retention effects were not reported, participant were hopeful that if trauma-informed practices were implemented in DSC and supported at the executive level with an agency-wide strategy for the integration of trauma-informed practices, this is likely to support increased job satisfaction and staff retention. Whilst not assessed in this research, the immediate beneficiaries of these changes must be recognised as the children and families which the DSC Area serve.

6.2.1 Programme Acceptability

Appropriate Design

The programme was designed to extend professionals identified as high-performing individuals who had the capacity to benefit from upskilling, who are currently working in complex child and family welfare practice contexts. For the overwhelming majority of graduates, the programme was appropriately targeted to their professional developmental needs. The programme requires a level of IT proficiency consistent with the current practice climate in child welfare. In particular, completing the programme alongside colleagues from the same team was supportive. Thus, going forward due consideration should be given to more than one team member undertaking the programme together.

Appropriate content

The programme aimed to support child welfare professionals across diverse roles and disciplines at graduate level to integrate TIPs into their practice role in the Irish context. The programme drew on the TARA practice model (Lotty, 2023),a bespoke Irish model reflecting Irish context, underpinned by contemporary trauma, attachment and resilience theories, and uses applied teaching methods providing students with core practice tools and a resources bank (toolkit). Students (many of whom were experienced practitioners) developed knowledge and applied practice through participation in the programme and were formally assessed through two assignments. These elements of the programme were highly relevant, fit for purpose and accessible.

Appropriate Target

The students participating in the programme crossed diverse levels of responsibilities (front-line practice. supervision and management) and teams (Child Protection and Welfare, PPFS, Fostering, After Care) and disciplines (Social Work, Social Care, Family Support). The capacity for intra-area collaboration was enhanced by taking this area wide approach, supporting the development of relationships and consistent work practices across the DSC area. This has enabled an area wide shared endeavour to support the implementation of trauma-informed practices in DSC.

Strengthening the programme experience

The programme was experienced as very intense in the context of the pressures of working in the current practice climate. Whilst high completion rates were found, more protected time is warranted to enable full engagement and benefit from the programme.

6.2.2 Impact on professional knowledge gain in trauma-informed practice.

The research highlights that the programme has successfully engaged the target cohort in significant knowledge gain in trauma-informed practices. This involves a lived learning experience, a journey of ongoing professional (and personal) development described in this research as *Dynamic Learning Acquisition*. This involved a process with elements of increased trauma-informed knowledge, amplified self-reflection, enhanced practice confidence, and a weaving together of old and new practice knowledge to successfully build capacity for trauma-informed practices.

Increased Trauma-informed knowledge

Clear knowledge gains were made, the principles and theories that underpin trauma-informed practices.

Amplified Self-reflection

Knowledge gains were made in the understanding of burn-out and compassion fatigue and STS. Furthermore, amplified self-reflection was found, in the context of knowledge gains through a dual reflective process. This dual reflective process enhanced both understanding of trauma impact and trauma-informed interventions that relating to both clients as well as professionals working with trauma.

Enhanced Practice Confidence

Practitioners increased professional self-efficacy supported by in-depth theoretical and applied knowledge based in evidence, and an extensive resource bank (toolkit) and have demonstrated this professional confidence by creating new trauma-informed practice initiatives and changes across the research site.

Weaving Old and New

Knowledge gain involved integrating new trauma-informed knowledge and practice with existing practice knowledge. Tis weaving extended to integration of knowledge within other programmes, further strengthening these programmes and with an increased confidence.

6.2.2 Improved practices in child and family welfare services

The research highlighted that the programme has successfully engaged the target cohort and has had a positive impact on their individual practice of critical reflection on practice as well as facilitated positive changes in their respective practice roles (front-line practices, supervision, and leadership). The research has presented these strengthening practices

through infusing trauma-informed practices based on increased TIP knowledge, increased professional confidence (skills and ability), and integration of existing practice wisdom. Changes were reported in spheres of Child and Family Practices, Practices for Practitioner Resilience and Transformative Collaborative Practices.

Child and Family Practices

The use of more appropriate and empathetic language in practice including in case file notes, court reports, approaches to decision-making in case planning, direct work with clients, and in decisions around referrals. Furthermore, the research showed that the practice changes served to strengthening practitioners applied knowledge and confidence in implementing existing approaches and programmes currently operating in DSC.

Practices for Practitioner Resilience

Practicing 'the pause', that reflected a recognition of heightened work-related stress and deregulation strategies to promote less reactive practice, integration of trauma-informed practices in supervision, as well in team meetings, complex case review meetings, and case conferences were evident.

Transformative Collaborative Practices.

New practice initiatives across teams reflecting new collaborative working practices were noted. Furthermore, new collaborative practices were evident with working with foster carers, strengthening existing approaches with deepening practice knowledge and confidence and in developing a new trauma-informed network with PPFS partners.

6.2.3 Opportunities to sustain the changes.

The research places a spotlight on the motivation and commitment of the DSC staff for service change within a practice climate that challenges the implementation of trauma-informed practice. At this juncture there is an opportunity to support these new groundbreaking initiatives led by DSC staff reported in this research. These require ongoing commitment of support at an area level, as well as at national level through a coherent agency wide strategy for integration of trauma-informed practices to successfully embed the practice changes made in DSC.

6.2.4 Future research

Future research to examine the longer-term impact of the programme is warranted for: implementation of the creative and innovative trauma-informed practices developed by

participants, and to in turn assess the impact of these practices on practitioners, children, and their families.

6.3 Recommendations

At this final stage of the study a number of recommendations are proposed are based on the research process, study findings and conclusions. These recommendations have been developed in the context of informing Phase 2 of the TARA Project to support trauma-informed practice implementation in the DSC Area.

6.3.1. Recommendations - Area Level

1. The university–community-based partnership approach is a successful partnership paradigm developing significant knowledge for the integration of trauma-informed practices reflected in Phase 1 of this project. Thus, this paradigm should be used as a model for Phase 2 of the TARA Project.
2. It is recommended that Phase 2 conducts an implementation study to develop and track the practice initiatives that have been developed and are being implemented on foot of the current study.
3. Based on the findings of this research it is recommended that this above-mentioned implementation study, is carried out in partnership with the champions/leaders that have emerged from this study, leading out on new practice initiatives across diverse levels of roles and levels of responsibilities.
4. Phase 2 Stakeholder Group to be established to guide the project, to include representation from each integrated service area within the Dublin Mid Leinster (DML) regional geographical area of TUSLA to support coherence and consistency in the integration of trauma-informed practice across DML.
5. This research recommends ongoing support to sustain this capacity by the provision of monthly TARA based peer support groups and an annual event to support developments and learnings.
6. To support the ongoing work of the project, it is important that the findings be shared broadly in the sector thus, it is recommended that dissemination takes place through agency and practitioner targeted outputs, as well as publications in the research literature.
7. It is recommended that all professional staff across the DSC area undergo this graduate level professional education to promote consistency of the approach.

8. It is recommended that other professionals who work with children and families that come into contact with the DSC area also undergo graduate level professional trauma-informed education.
9. To increase knowledge of the impact of trauma informed practice, an outcome-based study is recommended to assess the impact of trauma-informed practices that are being embedded across the DSC in relation to children, and their families (parents and foster carers), area wide professional staff and interagency work in Phase 2.

6.3.2 Recommendations - Agency Level

Based on the evidence from this research the following recommendations are made:

1. The delineation of a coherent agency wide national strategy on the integration of trauma-informed practices beyond local initiatives.
2. The undertaking of a comprehensive mapping exercise of current training initiatives that aim to support trauma-informed practices across all TUSLA regions to assess the current status of trauma-informed practice integration.
3. A TUSLA national framework for trauma-informed education, to ensure consistency of trauma-informed practice integration that meet the needs of differing levels of roles and responsibilities of the child and family agency including the Executive Management Team. This framework should include basic level introductory level training for all child welfare workforce and separate graduate level education for child welfare professionals.

6.3.3 Recommendations - Programme Level

1. Online approaches to curriculum design, delivery and content works well for the development of graduate level education for child welfare professionals, and this should be maintained and embedded into future programme delivery.
2. Targeting across diverse levels of roles and responsibilities is a real strength of the programme nurturing collaborative practices, thus programme should be delivery to cohort's representative of a diversity of roles and responsibilities in child and family welfare practice.
3. To ensure this collaborative experience, more than one participant from each team is recommended in each class group.
4. Child welfare professionals undertaking the programme are allotted appropriate protected time to engage fully in the programme.

5. A scaled-up study is recommended that includes a randomised controlled trial to test for further evidence to support the effectiveness of the programme.

6.4 Concluding Remarks

This study represents the coming together of the DSC service area, TUSLA and UCC with a shared vision to improve practices that support child and families and the staff who serve them through the integration of trauma-informed practices. Addressing the complexities of implementing trauma-informed approaches in child serving systems remains at an emergent stage in Ireland and internationally. This study is important and unique in that it has developed the knowledge on how to progress embedding trauma-informed practices within the complexities of child welfare practice to improve service provision and care for children and families with diverse and complex needs in Ireland. This study makes an important step, through supporting an integrated approach to 'weave together' existing practice wisdom and new insights from contemporary trauma theory and trauma-informed approaches through the TARA practice model. The TARA model is focused on amplifying and strengthening best practice to support practitioners working with the complexities of intersectional experiences of trauma to improve quality of care in the Irish context. The study has provided promising evidence that the UCC graduate programme is effective in enhancing professional capacity to integrate trauma-informed practices into existing practices through the TARA model.

In conclusion, Phase One has been completed and the effects of graduate level trauma-informed practice education on DSC, child welfare professionals have been reported. The next step is Phase Two of the project which will examine implementation and impact of trauma-informed practice across the DSC Area. It seems appropriate to conclude this report with the words of a research participant who summed up the potential opportunity to support practice through this project.

> *"We've been trying really hard. We've been doing the best we can with the information and knowledge and skills that we have. So you know and, that (the programme) has, kind of, confirmed that in a way for us, I think for all (of us) and for me in some manner… but now it's giving us more information and skills and tools to work even, I supposed to take on that trauma-informed approach, (so) that we can work even better and build on those and to do better job, to lessen the shame,.. you know for …how we represent our organisation as well as our teams and our service". (ID17)*

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Appendices

Appendix 1 Programme Description

Title of Programme

Certificate in Continuing Professional Development in Trauma-informed Care: Theory and practice

Award Type & NFQ Level

Level 9 Special Purpose Award

Course Outline

This Certificate in Continuing Development in Trauma-informed Care is designed to meet the educational and professional skills needs for front-line practitioners in the integration of trauma-informed practices into their role as a response to working with children, young people, adults and/or their families who have experienced trauma. The programme focuses on both developing practitioner's understanding of the lived and living experience of trauma and effectively intervening with those that have experienced trauma across the life span. The programme is practice orientated and focuses on integrating trauma-informed practices through a practice framework that was developed by Dr Maria Lotty, entitled TARA (Trauma, Attachment, Resilience into Action) (see Lotty, M., 2021;2023).

Programme Objectives

The aim of the programme is to provide continued professional development to practitioners working with children, young people, adults and/or their families who have experienced trauma. The programme aims to develop the practitioner's knowledge of the theoretical underpinnings of trauma-informed care and its application to his/her professional practice through a process of reflective enquiry.

Course Content

The programme examines the theoretical base of the practice of trauma-informed care in an accessible and applicable way with attention to the trauma, stress response system, polyvagal, attachment, mentalising and resiliency theories. The programme introduces students to the applications of the approach in their practice

role providing an introduction to the practice of trauma-informed care methods of intervention. The programme also explores students' critical thinking on the current debates about the implementation of the practice of trauma-informed care and the impact of vicarious trauma. Students complete two modules, the first model focus on understanding of theory and principles that during trauma-informed care. The second modules focus on the application of trauma-informed acre into practice.

Program Learning Outcomes

On successful completion of this programme, students should be able to:

- Articulate the principles and theories that underpin the trauma-informed care approach.
- Critically engage in and appraise the current debates in relation to trauma-informed care.
- Recognise and explain the pervasive nature of trauma impact on developmental domains.
- Critically understand the methods of trauma-informed care.
- Apply methods of intervention to a case study developed specific to own professional role.
- Recognise the role of trauma-informed self-care skills in mediating vicarious trauma.
- Reflect upon and articulate own professional development arising from the process of completing this programme.

Course Practicalities

The programme is delivered in a blended format, part-time on-line with 1.5 hours pre-recorded materials and 1.5 hours live lecture per week.

Assessment

The programme is assessed through 2 X 3000-word assignments. These are set at the end of each module.

Reference

Appendix 2 Stakeholder Group Membership

Name	Affiliation
Eleanor Bantry-White	Professor of Applied Social Studies, UCC
Bernard Barrett	National Research Office, TUSLA
Mariah Curtin	Clinical Psychologist, Dublin South Central, TUSLA
Clare Dean	Assistant Director, Barnardos
Orna Giblin	Adult Continuing Education Lecturer, UCC
Catherine Hanley	Assistant Director of Public Health Nursing, HSE
Maria Hayes	TARA Project Agency Lead, Dublin South Central, TUSLA
Brian Johnston	Director, Candle Community Trust
Noreen Kearns	Post-doctoral Researcher
Donal Kennedy	Parental representative
Anne Kiely	General Practitioner and Tutor, School of Medicine, UCC
Peter Lane	Advocacy Officer, EPIC
Maria Lotty	Principal Investigator, Adut Continuing Education, UCC
Shirley Martin	College Lecturer, Applied Social Studies, UCC
Sinead McFadden	Principal Social Worker, Dublin South Central, TUSLA
Eilish Meagher	Primary School Principal, Dublin 8
Jennifer Minto	Parental representative
Anita Moore Martin	Foster Carer, TUSLA
Lyn Mulligan	Fostering Social Worker, Dublin South Central, TUSLA
Maura O Donoghue	Adult Continuing Education Lecturer, UCC
Tadgh O Shea	Statistical Expert, Munster Technological University
Nicole Wynne	Social Care Leader, TUSLA
Amanda Roche	Parental representative

Appendix 3 Information Sheet

Thank you for considering participating in this research project. The purpose of this document is to explain to you what the work is about and what your participation would involve, to enable you to make an informed choice if you wish to express an interest in participating.

The purpose of this study is to examine the effects of Trauma-informed Care education on practitioner's practice.

If you are selected to participate, you will be asked to take part in the following:

1. Complete the **Continuing Professional Development Certificate in Trauma-informed Care: Theory and practice.** This is a 16-week online programme run by University College Cork and involves completed two assignments. The details are available at this link: https://www.ucc.ie/en/ace-ccpdtc/ (University College Cork, 2023)

2. You will be asked to complete an **online survey** at four time points, firstly before you start programme, on completion, then 6 months later and then 12 months later.

3. You will also be invited to attend an **online focus group** after the programme, which will be facilitated by a member of the research team. This focus group will be video recorded and is expected to take 30-40 minutes to complete.

4. You will be asked to complete a short online programme evaluation form.

Participation in this study is completely voluntary.

Should you choose to do so, you can refuse to answer specific questions. You maintain the right to withdraw from the study at any stage up to the point of data submission. Thus, you can decide to withdraw from the study prior to completing the survey at each time point. Once you have completed the online survey at time point 1, you cannot withdraw from that part of the survey, but you can withdraw from the survey at time point 2 if you wish, and/or time point 3. At this point, your data will be collated with that of other participants and can no longer be retracted.

If you participate in a focus group, you can choose to withdraw your contribution at any time in the subsequent two weeks after the conclusion of the focus groups, However, the

researchers will attempt to delete your data but that might not be completely effective as the recording will be an amalgam of voices.

All the information you provide will be kept confidential and anonymous and will be available only to the Research Team. The only exception is where information is disclosed which indicates that there is a serious risk to you or to others.

In the case of risk to a child, the information will be disclosed to the Child and Family Agency Tusla in accordance with the Children's First Act (2015) (Government of Ireland, 2015). This includes information of historical disclosures of child abuse. In the case of risk to you, the nominated gatekeeper in your area will be informed who will offer assistance. Please be aware, however, that while we can guarantee that we will maintain confidentiality, we cannot guarantee that group members will do the same.

Once the focus group is completed, the recording will immediately be transferred to an encrypted laptop. The data will then be transcribed by the researcher, and all identifying information will be removed. The Microsoft Teams recording will be deleted 6 months after transcribing and only the anonymised transcript will remain.

All information you provide will be confidential and your anonymity will be protected throughout the study and the future.

Your participation in this study will have no bearing on the successful completion of the programme. All data will be stored on a University College Cork supported cloud storage platform OneDrive. The data will be stored for minimum of ten years. The information you provide may contribute to research publications and/or conference presentations.

We do not anticipate any negative outcomes from participating in this study. Should you experience distress arising from participating in the research, you may contact the nominated gatekeeper, Principal Social Worker, Maria Hayes at: mariat.hayes@tusla.ie, who will direct you to assistance. This study has obtained ethical approval from the UCC Social Research Ethics Committee and the Tusla Ethics Research Committee.

If you have any queries about this research, you can contact me, the Principal Investigator, Dr Maria Lotty at: maria.lotty@ucc.ie

Appendix 4 Consent Form

Research Consent Form

Thank you for your expression of interest to participate in this study. If you wish to take part in this study, please complete the consent form.

I……agree to participate in Dr Maria Lotty's research study.

The purpose and nature of the study has been explained to me in writing.

I am participating voluntarily.

I agree to complete the research online surveys.

I agree to participate in a focus group after completing the *Continuing Professional Development Certificate in Trauma-informed Care programme*: yes ☐ no ☐

I give permission for my focus group to be video recorded.

I understand that I can withdraw permission to use my data within two weeks of the focus group, in which the researcher will attempt to delete my material; however, for the reasons outlined above, I understand that this may not be completely effective. All Microsoft Teams recording files will be deleted 6 months after the transcript is complete.

I understand that data from fellow participants in the focus group will be retained.

I understand that anonymity will be ensured in the write-up by disguising my identity. I also undertake to maintain the confidentiality of the focus group.

I understand that disguised extracts from the focus group (e.g., my name / location won't be used) may be quoted in presentations and publications (e.g., article, book chapter, student thesis, social media publicity of the study's findings, etc.), if I give permission below (please tick one box):

I agree to participate in this study ☐

I do not agree to participate in this study ☐

Signed: ……. Date: ……..

PRINT NAME: …….

Appendix 5 Research Survey

TARA Research Study

Q4 **WELCOME TO THE TRAUMA-INFORMED PRACTICE EDUCATION RESEARCH STUDY BEING CONDUCTED BY UNIVERSITY COLLEGE CORK.** Information about the study

The purpose of this study is to examine the effects of the Trauma-informed Care education on practitioner's practice. As a selected participant in this study, you are invited to complete the following online survey. Participation in this study is completely voluntary. There is no obligation to participate, and should you choose to do so you can refuse to answer specific questions or decide to withdraw from the study prior to completing the survey. All information you provide will be confidential and your anonymity will be protected throughout the study and the future. You maintain the right to withdraw from the study at any stage up to the point of data submission. At this point, your data will be collated with that of other participants and can no longer be retracted.

The anonymous data will be stored on a University College Cork supported cloud storage platform OneDrive. The data will be stored for minimum of ten years. The information you provide may contribute to research publications and/or conference presentations. We do not anticipate any negative outcomes from participating in this study. However, you will be asked to reflect on your feelings, experiences of the impact of working with trauma and symptoms that may appear your own life and your confidence at work.

If the survey raises any issues or concerns for you about your wellbeing or health, please contact the nominated gatekeeper, Principal Social Worker, Maria Hayes at: mariat.hayes@tusla.ie, who will direct you to assistance and/or avail of the confidential Tusla Employee Assistance Programme.

It should take 20 minutes to perform.

Your contribution is a valuable part of this research which aims to support future improvements in your organisation.

This study has obtained ethical approval from the UCC Social Research Ethics Committee and the Tusla Ethics Research Committee. If you have any queries about this research, you can contact me, the Principal Investigator, Dr Maria Lotty at: maria.lotty@ucc.ie

Please answer the following questions prior to completing the survey.

Do you consent to participate in this study?

Yes ☐ No ☐

Are you over the age of 18 years?

Yes ☐ No ☐

Section 1: Background Information (included at Time point 1 survey only)

Please answer the following questions:

1. What is the title of your post/current role ? _____
2. What is your main area of work: Child Protection, Fostering, Family Support or please state other?_____ _____
3. How many years are you in this role?_____
4. How many years' professional practice experience do you have? _____
5. What is your highest level of formal education: Certificate, Diploma, Degree, Masters, PhD or other?_____
6. What age are you ? _____
7. How do you describe your gender: Male, female or other?_____
8. Have you undertaken previous training in Trauma-informed Care?_____

Please describe (in-person training/webinars/books):

_____

Section 1: (for Time point 2, 3 and 4)

Please answer the following questions:

1. Are you in the same post/ role as you stated in the last survey? _____

If not, please state:

2. Are you working within the same organisation as your previous post?_____
3. What is the title of your new post?_____

Section 2: Please select the answer that most closely represents your knowledge:

1. I understand the signs and symptoms of work-related stress including secondary traumatic stress, vicarious trauma, compassion fatigue, and burnout.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

2. I can tell the difference between secondary traumatic stress, vicarious trauma, and burnout.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

3. I can explain to others, the difference between secondary traumatic stress, vicarious trauma, and burnout.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

4. I know the importance of self-care for the workforce.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

5. I know the principles of Trauma Informed Care.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

6. I can explain, to others, the principles of Trauma Informed Care.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

7. I know how to review policy, practice, and procedures using a trauma lens.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

8. I can identify strategies to be more trauma informed in my agency.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

9. I understand the difference between trauma specific services and trauma-informed care.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

10. I understand the reasons why individuals respond to trauma differently.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

11. I can explain, to others, the reasons why individuals respond to psychological trauma differently.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

12. I understand that a stress response can be activated in the absence of real threat.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

13. I understand how psychological trauma can affect cognitive process such as memory, attention, and perception.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

14. I can explain, to others, how psychological trauma can affect cognitive process such as memory, attention, and perception.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

15. I understand how psychological trauma can affect relationships and attachment.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

16. I understand how psychological trauma can affect emotional regulation.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

17. I know the signs of an acute stress response.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

18. I know what is happening in the mind and body during an acute stress response.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

19. I understand why unresolved psychological trauma exposure has a cumulative impact over time on individual, family, organizational, and community functioning.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

20. I know about the Adverse Childhood Experiences (ACE) study conducted by Kaiser Permanente and the CDC.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

21. I know which types of trauma experiences were included in the ACE study.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

22. I understand the dose-response relationship between adverse experiences and negative outcomes.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

23. I can explain, to others, the findings from the ACE study.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

24. I am familiar with the ACE pyramid and how adverse childhood experiences influence health and well-being.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

25. I understand how vulnerability to psychological trauma can be transferred from one generation to the next.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

26. I know one method of transferring vulnerability to psychological trauma from one generation to the next is biologically through altered DNA.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

27. I understand how economic inequities influence experiences of trauma and adversely affect access to resources that facilitate resilience and recovery.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

28. I understand how race, class, gender, sexual orientation, religion, and national origin can result in disproportionate trauma exposure.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

29. I understand how vulnerable and marginalized people and their communities can be differentially impacted by trauma.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

30. I understand how historical and structural oppression may create traumatic conditions and psychological trauma.

Completely Untrue ☐ Somewhat Untrue ☐ Somewhat True ☐ Completely True ☐

Section 3: Please select the answer that most closely represents your view:

1. I have confidence in my ability to do my job.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

2. There are some tasks required by my job that I cannot do well.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

3. When my performance is poor, it is due to my lack of ability.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

4. I doubt my ability to do my job.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

5. I have all the skills needed to perform my job very well.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

6. Most people in my line of work can do this job better than I can.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

7. I bring expertise to my job.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

8. My future in this job is limited because of my lack of skills.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

9. I am very proud of my job skills and abilities.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

10. I feel threatened when others watch me work.

Strongly Disagree ☐ Disagree ☐ Neither Agree/Disagree ☐ Agree ☐ Strongly Agree ☐

Section 4: Please select the answer that most closely represents your view:

1. I am happy.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

2. I am preoccupied with more than one person I work with.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

3. I get satisfaction from being able to support people.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

4. I feel connected to others.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

5. I jump or am startled by unexpected sounds.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

6. I feel invigorated after working with those I support.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

7. I find it difficult to separate my personal life from my life as a practitioner.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I am supporting.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

9. I think that I might have been affected by the traumatic stress of those I support.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

10. I feel trapped by my job as a practitioner.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

11. Because of my post, I have felt "on edge" about various things.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

12. I like my work as a practitioner.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

13. I feel depressed because of the traumatic experiences of the people I support.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

14. I feel as though I am experiencing the trauma of someone I have supported.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

15. I have beliefs that sustain me.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

16. I am pleased with how I am able to keep up with practice techniques and protocols.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

17. I am the person I always wanted to be.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

18. My work makes me feel satisfied.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

19. I feel worn out because of my work as a practitioner.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

20. I have happy thoughts and feelings about those I support and how I could help them.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

21. I feel overwhelmed because my caseload seems endless.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

22. I believe I can make a difference through my work.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I support.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

24. I am proud of what I can do to help.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

25. As a result of my [helping], I have intrusive, frightening thoughts.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

26. I feel "stuck/bogged down" by the system.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

27. I have thoughts that I am a "success" as a practitioner.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

28. I can't recall important parts of my work with trauma victims.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

29. I am a very caring person.

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

30. I am happy that I chose to do this work

Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Very Often ☐

Section 5: Please select the answer that most closely represents your experience:

1. I intend to remain employed at my organisation. Yes ☐ ☐ No
2. I have thought about leaving my post. Yes ☐ ☐ No

If you have thought about leaving, please answer the following:

1. How often have you thought about leaving your post?

Almost never ☐ Some of the time ☐ Often ☐ Very often ☐ Almost everyday ☐

2. How often have you spoken with friends/spouse/partner about leaving your post?

Almost never ☐ Some of the time ☐ Often ☐ Very often ☐ Almost everyday ☐

3. Have you looked for a new post on the Tusla Hub?

Every few months ☐ Monthly ☐ Weekly ☐ Daily ☐

4. Have you looked for a new post on the internet or in the paper?

Every few months ☐ Monthly ☐ Weekly ☐ Daily ☐

5. Have you sent out your CV and/or completed applications and if so how many?

None ☐ Yes 1-2 times ☐ yes 3-4 ☐ yes 5-6 ☐ yes 6+ ☐

6. Have you got any job interviews and if so how many?

None ☐ Yes 1-2 times ☐ yes 3-4 ☐ yes 5-6 ☐ yes 6+ ☐

Thank you for completing this survey.

Appendix 6 Satisfaction Survey

TARA End of Programme Evaluation Survey

June 2023

Q1 WELCOME TO THE TRAUMA-INFORMED PRACTICE EDUCATION RESEARCH STUDY BEING CONDUCTED BY UNIVERSITY COLLEGE CORK.

The purpose of this short survey is to gather your views on the Trauma-informed Care Programme which you have recently completed. We are interested in your opinions of a number of aspects of the Programme including content, delivery, teaching methods, and format. At the end of the survey, there is an opportunity to share your thoughts on how the Programme could be improved.

All information you provide will be confidential and your anonymity will be protected throughout the study and the future.

The survey should take approximately 5 minutes to complete.

Your contribution is a valuable part of this research which aims to support future improvements in your organisation. If you have any queries about this research, you can email the Principal Investigator, Dr Maria Lotty at: maria.lotty@ucc.ie

Please answer the following question:

How would you rate your overall experience of the programme?

□ Highly satisfactory □ Satisfactory □ Neutral Unsatisfactory □ Highly Unsatisfactory

Please select the answer that most closely represents your experience:

I would recommend this programme to my colleagues:

Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree ☐

The content delivered was relevant to my post:

Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree ☐

The programme was interesting and engaging:

Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree ☐

The teaching methods had a good balance of presentations, discussion, and activities.

Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree ☐

The lecturers were clear and effective:

Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree ☐

I will be able to integrate my learning into my role:

Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree ☐

The format of how the programme was delivered i.e., online with pre-recorded materials and online live sessions, made it more accessible:

Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree ☐

What aspects of the programme could be improved?

Thank you for providing feedback, your views are a valued part of this research.

Appendix 7 Focus Group Questions

TARA Research Focus Group Questions May 2023

1 Reflections on your overall experience of participating in the Continuing Professional Development (CPD) Certificate in Trauma-informed Care: Theory and Practice Programme.

2 How relevant was this programme to your practice?

3 3 What were the main components of the Programme (Modules 1 & 2) which worked best? (Examples please)

4 Can you discuss any knowledge you have gained from the Programme regarding the theory and principles of trauma-informed care and application (i.e., Modules 1&2)? Please give examples.

5 Do you intend to or already have applied the learning of trauma-informed care into your current practice? Can you give any examples of how you have done this?

6 Has completing this programme changed how you think (reflecting) about and/or feel about your practice in any way, considering your specific role:

(a) yourself

(b) the service users/children and families you work with/your supervisee.

Can you give any examples?

7. Has this Programme influenced how you view your career in any way?
8. What were the main aspects of the Programme that could be improved?
9. What do you need going forward to support you in implementing TIP in your work?
10. Are there any other comments you would like to make regarding your experience of this Programme?


UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh


ACE
Adult Continuing Education at UCC


ISSS21
Institute for Social Science in the 21st Century


TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency