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A Rapid Realist Review of Trauma-Responsive Approaches in Children's Homes: The NEST Study

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Systematic Review

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Abstract

Background

Children and young people (CYP) living in children's homes in the United Kingdon (UK) experience high levels of adversity and are at increased risk of poor mental and physical health, educational, and social outcomes. Trauma-responsive approaches (TRAs) within residential care have been proposed to address the impact of trauma by promoting safety, relational care, and organisational responsibility. However, evidence relating to how TRAs work in UK children's homes remains fragmented, conceptually diverse, and poorly operationalised, creating uncertainty and barriers to implementation. This rapid realist review examined how, why, for whom, and in what contexts TRAs can improve care quality and experiences for CYP living in UK children's homes.

Methods

A rapid Realist review began in April 2025, following RAMESES standards and registered with PROSPERO (CRD420251047893). Searches were conducted in June 2025 using six electronic databases, relevant organisational websites and expert recommendation, and updated in April 2026. Evidence was drawn from academic and grey literature published from 2001. Forty-four documents met the inclusion criteria. Data extraction and synthesis used realist logic to develop context-mechanism-outcome configurations (CMOCs). Extensive stakeholder engagement included care-experienced young people, residential practitioners, clinicians, commissioners, and researchers, to guide and prioritise theory development, and validate findings.

Results

The synthesis identified seven core domains underpinning effective TRAs in children's homes: (1) trauma-responsive organisational culture, (2) therapeutic relationships and dyadic models, (3) staff wellbeing and support, (4) training and implementation quality, (5) system-level integration and structural support, (6) CYP-centred practice and empowerment, (7) enabling change. Eighty-six CMOCs explained how relational safety, reflective practice, emotionally co-regulated care, and organisational alignment activate mechanisms that improve staff wellbeing, placement stability, and CYPs emotional wellbeing. Organisational culture and leadership emerged as critical elements in enabling or constraining trauma-responsive approaches.

Conclusions

This review consolidates a heterogeneous evidence base into a coherent programme theory explaining how TRAs operate in UK children's homes. Findings demonstrate that TRAs are most effective when implemented as a whole-system, relational, and reflective approach. The resulting theoretical framework provides robust foundations for co-designing, implementing, and evaluating tailored TRAs to improve outcomes for CYP and to support the residential care workforce.

Background

Children living in residential care are among the most vulnerable young people in society. Despite the intention for children's homes in the UK to provide safety, rehabilitation, and developmental support, the current system is widely described as "fragmented" and "dysfunctional", leading to poor outcomes for those who grow up in care [1]. Many children have experienced significant adversity prior to placement in residential homes. For example, nearly two-thirds of children in care in England enter care following experiences of abuse or neglect [2]. These early traumatic experiences have common long-term negative effects on neurological development, emotional regulation, and mental health [3][4][5][6]. Although residential care is intended to provide stability and therapeutic support, many young people face instability, insufficient support, and environments that may feel unsafe or emotionally unpredictable [7] [8].

The evidence highlights several concerning outcome patterns. Compared to their peers, children with experience of care are much more likely to be excluded from school [9], experience mental health difficulties [10], and come into contact with the criminal justice system [11]. Despite the numbers of children in custody in England and Wales declining, the percentage that have spent time in care has risen from 50% in 2016 to 66% in 2023 [12][13]. This evidence demonstrates the deep overlap between childhood adversity, system involvement, and unmet needs.

Across education, employment, housing, and health, outcomes for care-experienced children and young people frequently fall below those who have not been in care. They have increased risks of social isolation, homelessness, early parenthood, and chronic mental and physical health problems. These challenges continue into adulthood [14] [15], which illustrates the long-term impact of early adversity, when coupled with inconsistent and inadequate support.

Residential care operates within a strained and uneven system, which is undergoing a substantial and rapid shift from public to private sector provision. Currently, most children's homes (84%) are run by the private sector, often at high cost, while local authorities are experiencing declining resources and insufficient placement capacity [16][17]. Staff in children's homes typically work shifts rather than providing continuous care, which can contribute to instability and make it difficult for children to form secure, trusting relationships. Whilst members of staff might also have had difficult childhoods and need to manage significant, daily emotional and psychological pressures, they do not always receive adequate support or training, increasing the risk of burnout, turnover, and further contributing to inconsistent care [18][19].

In this environment, trauma-responsive approaches (TRAs) have gained prominence in aiming to address the significant and complex needs of young people [20]. TRAs are based on the understanding that many of the behaviours commonly seen in residential care settings, such as hypervigilance, aggression, withdrawal, or attention difficulties, might be normal responses to trauma rather than inherent deficits or intentional misbehaviour. Therefore, if care staff understand these behaviours as adaptive responses to adverse experiences, they can respond in ways that promote safety, and recovery.

TRAs emphasise every-day, system-wide relational care, emotional availability, and organisational accountability, rather than viewing trauma-informed work as solely the responsibility of individual practitioners or only the delivery of clinical therapy sessions.

In general, practitioners support the use of TRAs and recognise their relevance to the young people they care for [21]. Certain aspects of TRAs aim to reduce stress and secondary trauma among staff, thereby strengthening their ability to provide stable, nurturing relationships [22]. Whilst for children and young people (CYP), trauma-responsive environments aim to improve placement stability and emotional wellbeing [23]as a foundation for improved outcome patterns.

Importantly, many aspects of TRAs do not require clinical qualifications [24], because a TRA draws on transferable skills, such as interpersonal skills and self-regulation, optimised within a supportive working environment. Therefore, TRAs have potential to be applied effectively by residential workers when appropriate training, supervision, reflexivity, and organisational structures are provided.

Despite its promise, there is a dearth of interventions specifically designed for the unique environment of UK children's homes. Most TRA frameworks have been either developed specifically for other settings (e.g. for clinical, educational, or justice settings) or designed to be generally applicable across many different settings and, therefore, do not address the complexities of UK residential care systems (see Additional file 1). Providers face significant barriers, contextual variation and complexity, including inconsistent inter-agency communication, competing demands, limited resources, and the absence of practical guidance tailored to children's homes. As a result, the implementation of TRAs across homes is uneven, and the quality of care can vary widely.

Terminology

The current literature reflects a diversity of terminology around the topic of Trauma-Responsive Approaches (TRAs). Whilst the term 'Trauma Informed' has been widely used, this is tending to be replaced by 'Trauma-Responsive', which is intended to represent a higher level of practical engagement in day-to-day care. Whilst 'trauma informed' indicates acknowledgment of the causes and effects of trauma, 'trauma-responsive' symbolises the organisationally embedded enactment of this understanding [25]. However, this contrasts with some models such as the Missouri Model [26], which proposes 'fully trauma informed' as the fourth and highest level of a "continuum" of implementation, following being 'aware', 'sensitive', and 'responsive'.

The term 'trauma-responsive' is also variably suffixed with 'care', 'practice' or 'approach', each with their own subtle differences in meaning. Whilst the term 'care' is mostly associated with acts of caring and could be reduced to singular responsive actions, the term 'practice' involves broader practical frontline application to prevent re-traumatisation and respond to the effects of trauma. However, the term 'approach' can be applied to much broader interventions [27]. 'Trauma-responsive approaches' (TRAs) can legitimately encompass whole systems, sometimes being used to include wider services and people in the system that are not 'care-giving' and not 'practitioners'. 'Trauma-responsive approaches' can also

include organisational policies, procedures and cultures as well as interactions and relationships between organisations. For example, engagement with schools, families, health services and other key stakeholders involved in the wellbeing of children and young people in care.

'Trauma-Informed Care' (TIC) was used in the early stages of the review as a broadly inclusive term. However, we later adopted 'trauma-responsive approaches' (TRAs), to indicate the culmination of sensitivity, understanding and enactment, from the level of individual actions to an embedded, potentially system-wide level. Whilst this has no bearing on the evidence retrieved and reviewed, this explains any resultant terminological inconsistencies.

Another key area of variation within the broader literature is the conceptualisation of perspectives from which to consider trauma-responsive approaches. For example, making a distinction between clinical treatment and therapeutic cultures, organisational management levels or structure and agency. Each of these perspectives demonstrates a specific focus and subdivision into different components, thereby further increasing the heterogeneity of terminology and approaches (see Additional file 2).

Rationale

This rapid Realist review has been undertaken to inform the NEST Study (**N**urturing **E**nvironments for **S**haping **T**rauma-Responsive Care and Recovery), which aims to address the evidence gap by co-designing and evaluating a trauma-responsive practice framework created specifically for children's homes[28]. Owing to the complexity and variety of children's homes as providers of services, heterogeneity of current evidence on TRAs for these settings, the range of individual needs and organisational settings and wider system considerations, a realist approach has been adopted. A realist review will enable an understanding of how the key principles used in TRAs result in a range of outcomes for different people in different circumstances and ultimately guide the development of interventions that can achieve positive outcomes by supporting relevant mechanisms in a wide range of settings.

Ultimately, the review aims to create a transparent, evidence-informed programme-theory, designed to inform pragmatic intervention development in children's homes in the UK. Thereby, transforming the consistency and therapeutic quality of residential care, supporting staff wellbeing, and improving outcomes for some of the most vulnerable young people in the UK.

Methods

A rapid realist review began in April 2025 to identify how, why, for whom, and in what contexts the various elements of trauma-responsive approaches (TRAs) can improve care quality and experiences for children and young people in children's homes.

A TRA is a complex intervention, and an initial scoping review revealed the heterogeneity of the literature. The complexity of interventions, contextual variation and factors influencing implementation also mean that there is a lack of consistent, high-quality evidence of effectiveness. Whereas there is a wealth of

literature regarding different approaches to, and components of TRAs, with varying attention to causal explanations for expected (and unexpected) outcomes. Hence a realist review was considered appropriate. The realist review protocol was registered with PROSPERO (CRD420251047893). Our review follows RAMESES quality and reporting standards [29].

The review was conducted rapidly, with a focus on a pragmatic design, providing timely and practically useful findings to inform the following co-design, implementation and evaluation elements of the larger study. The review intended to produce an initial programme theory [30] of recovery-focused TRA interventions for children's homes. Following recommendations for rapid realist reviews [31] the process was streamlined by involvement of end-users, topic experts and experts-by-experience throughout the review process. Enabling a focused approach, these stakeholders were engaged to validate, prioritise and focus the review, ensuring consistency with lived experience, inclusion of important evidence and a concentration on pragmatic interventions and key outcomes.

Expert Panels and Community Engagement and Involvement

Engagement with experts was carried out throughout the review, regarding the long-term aim of developing and testing TRA interventions in children's homes. During the theory-refining process, we shared, discussed and prioritised the emergent findings with a Youth Advisory Group and professional stakeholders in facilitated online meetings. The youth advisors consisted of young people with experience of living in children's homes and were recruited through the Care Leavers Association.

Professional stakeholders included a group of 22 experts with an interest in trauma-responsive approaches from local government, the NHS and Universities. These included professionals involved in residential care, counselling, clinical psychology, family interventions, speech and language therapy, service commissioning, research, education and training in trauma informed practice.

Findings were chosen and presented in formats appropriate to the experiences and expertise of the members. For example, theories that resonated with young people with lived experience of care were chosen to make the most of their expertise and insight. These were presented with a heading (e.g. 'Hearing the young person's voice'), an overview of the theory (e.g. 'Young people's involvement in service design leads to empowerment, recovery, and services that truly reflect needs'), and questions to initiate discussion (e.g. 'How can young people be truly supported to influence the care they receive? What are good ways to involve them, so it feels meaningful?').

A face-to-face stakeholder event (October 2025), open to members of wider networks of interested parties and communities of practice was held to check the face-validity of emergent theories, contribute to prioritisation, seek wider views and identify gaps in the evidence [32]. Presentations of emergent findings were followed with facilitated exercises, small-group discussions and whole-room conversations. Throughout the stakeholder engagement process, young people and non-professional carers were remunerated for their time according to NIHR involve rates [33].

Identification, extraction and synthesis of data

Owing to the breadth of the field, the search strategy was designed to be robust, rather than comprehensive, for example despite TRAs being applied in many different settings, we focused on children's residential care only, excluding specialist settings within health, education or the judicial system. Additionally, there was limited, yet focused iterative inclusion of additional literature [31]. Evidence was synthesised from diverse sources (i.e., academic/grey literature, policy, reports, related theory).

We applied the key tasks for a rapid realist review as described by Saul et al [31], adding a selection task (task 6) following identification of potential literature.

1) Development of the project scope

2) Development of specific research questions

3) Identification of how the findings and recommendations will be used

4) Development of search terms

5) Identification of articles and documents for inclusion in the review

6) Selection of articles and documents for inclusion in data extraction

7) Extraction of data from the literature

8) Quality review

9) Validation of findings with content experts

10) Synthesis of the findings

The review was achievable in our given timeframe because our focus was narrow; to develop an initial, rather than a highly detailed 'finalised' programme theory, building upon previous developments in this

field. The application of the key tasks is described in detail below.

1. 1. Development of the project scope: The review process began with a review and refinement of the content area of interest for the review, clarifying this with the knowledge users. We located existing theories and defined the review scope; translating existing literature into concepts to inform our initial programme theory by holding workshops with all members of the project team, professional stakeholders and youth advisors. We used their content expertise to generate potential realist causal explanations, which fitted with the existing theory of change in relation to TRAs, but specific to children's homes.
2. 2. Development of specific research question: Once the project scope had been narrowed, we discussed and agreed on the specific question that the knowledge users were most interested in answering. The following research question guided the review: How, when, why and for whom can a theoretically informed evidence-based trauma-informed care intervention, tailored for children and young people in UK children's homes, improve care quality and experience?
3. 3. Identification of how the findings and recommendations will be used: Discussions were held with the wider study team regarding the information requirements for co-design and implementation of a TRA intervention, and with the stakeholder advisory group concerning practical and theoretical considerations of knowledge translation to further refine the scope and inform the search strategy. The end-users of the review outputs are primarily the study team members involved in the experience-based co-design of the TRA intervention for children's homes. However, owing to the iterative nature of the project, planned outputs from the review were initially focused on a primary consultation period, involving both internal and external consultation activities.
4. 4. Development of search terms: Previously conducted initial searches of formal publications (CINAHL, MEDLINE, Embase, PsychInfo) and grey literature, formed a starting point for development of search terms. We consulted the author of a recent systematic review and meta-ethnography of trauma informed care in children's homes [34] to identify key issues and considerations for evidence searching. As a team, and involving the wider stakeholder group, we collaboratively identified key texts and terms likely to be relevant to the project scope, purpose, and research questions.
5. 5. Identification of articles and documents to be considered for inclusion in the review (both published and grey): Identification of texts began with a list of documents identified by knowledge users, research team members and content experts. In addition, we followed an iterative formal document search process of databases. Further candidates for inclusion were considered through continuous dialogue with stakeholders and by following reference lists in identified documents.

We undertook highly focused searches of electronic databases (CINAHL, PsycINFO, Medline, Embase, AMED & EMCARE). The framework for search terms is shown in Table 1. Additional searches included keyword searches on Google Scholar and searches of relevant websites (e.g. NIHR) to identify documents to refine the initial programme theory. We identified relevant policy/practice guidance from online searches of NHS, social care, and mental health service websites. Documents were downloaded to bibliographic software (RefWorks).

We included documents that: i) focus on TRA for children and young people; ii) consider good quality care in children's homes; iii) are available in English language; iv) published from 2001 onwards. During the screening process (task 6), we identified and flagged documents that are potentially useful for other aspects of the programme, such as implementation or evaluation-focused literature, or influential documents about TRAs more generally. This allowed the review to proceed rapidly with a concentrated focus, whilst maintaining awareness of the broader evidence base and an understanding of potential gaps in the formally reviewed literature.

Table 1
Search Strategy

Intervention:	**Setting:**	**Population:**
Trauma AND	**Children's homes AND**	**Children and young people**
trauma informed OR	Child* care OR	Child* OR
trauma skilled OR	Care home* OR	Young OR
trauma responsive OR	Child* home* OR	Young people OR
trauma sensitive OR	Residential child* care OR	Young person OR
trauma aware*	Residential care OR	Teen* OR
	Child* community care OR	Teenage* OR
	Community home* OR	Adolescen* OR
	Looked after child* OR	Young adult*
	Child* looked after OR	
	Cared for child* OR	
	Cared for young people OR	
	Children who are looked after	

*Indicates that a truncation was used to enable searching for multiple related terms, for example 'Child' or 'Child's/Children/Children's'

6. Selection of articles and documents for inclusion in data extraction: Documents to be taken forward for data extraction were selected from the list of identified documents. To ensure consistency, all documents were screened by the lead author and approximately one-third of all documents were double screened by other members of the review team. Inclusion/exclusion criteria were iteratively developed and agreed in response to uncertainties, ambiguity and contradictions identified by the review team. The wider research team members and the professional stakeholder group were consulted to resolve difficult decisions. All documents not eliminated using information available in the title and abstract were screened using the full text. Texts that were not eliminated, with reference to the inclusion/exclusion criteria were deemed to be 'relevant' for the purposes of the quality review (task 8). Relevance was

appraised according to inclusion of three elements of Trauma Informed Care (TIC) identified by Hanson & Lange [35]; 1. Workforce Development, 2. Trauma Focused Services, and 3. Organisational Environment & Practices. At this stage, documents that had no additional data to add (such as editorials, commentaries, or documents focused on the long-term effects of adverse childhood experiences) were excluded. Inclusion and exclusion criteria are shown in Table 2 and the PRISMA diagram for the searching and sifting processes is shown in Fig. 1.

Table 2
Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Residential children's care home settings	• **[Not relevant setting]*** National context clearly not relevant for UK settings
• Children and young people < 19 years, resident in children's homes and/or children with experience of care homes	• **[Treatment or therapy]** Trauma specific treatments, trauma informed therapy (group or individual interventions to address the effects of trauma (e.g. PTSD)). Also excluded are settings that are specifically focused on treatment, interventions or therapies, such as custodial placements or mental health settings.
• Any type of literature, including empirical studies, reviews, grey literature (e.g. web sites, reports, informal reviews, guidance, policy documents)	• **[Specific focus]** Trauma informed interventions, but with a specific focus, such as sexual health education and family interventions. However, specific elements (such as safety or staff training) that might make up a generally applicable TIC approach should not be excluded
• Trauma informed care (including training, service provision, organisational approaches, policies, procedures and leadership)	• **[Not TIC]** Interventions that might have some similar characteristics or concerns as trauma informed care, but which are from different origins or paradigms (e.g. different types of psychologically-informed approaches to care)
• Interventions closely aligned to trauma informed care (such as 'trauma informed approaches', 'trauma informed practice', 'trauma skilled practice', 'trauma-responsive', 'trauma aware' and 'trauma-sensitive')	• **[General TIC]** Documents that might achieve inclusion criteria in a very small part but are very broad in focus (e.g. involving multiple agencies). Also, documents that only mention TIC as part of the recommendations or conclusions (i.e. not possible to untangle relevant information)
	• **[Not children's homes]** Interventions that are not implemented in, or considered for children's homes. Also to be excluded are secure children's homes, all aspects of the secure estate and judicial system.
	• **[Not including 10–17 year olds]** For example care for very young or older residents only
	• **[Not English]** Not in English language
	• **[Other]** Not achieving criteria to be able to inform theory development in terms of relevance, richness and rigour
	***Notes for 'Not relevant Setting'**: No systematic country inclusion or exclusion to be applied. However, evidence from countries outside the UK might be excluded based on international contexts that preclude comparison with the UK due to substantially different organisations, services, policy, culture, societal norms, practices etc. This might be clear at title/abstract screening stage but might need full text to decide.

1. 7. Extraction of data from the literature: Descriptive elements of documents were extracted by a data extraction team using an extraction template in Microsoft Excel. One tab of the template used one row per reference, to record descriptive information, (e.g. authors, date, title, study design, key findings, conclusions and recommendations). Additionally, we incorporated the first stage of data

interpretation during the extraction phase. Using a separate tab on the extraction template, elements of documents that could help answer the research questions were converted into causal theory statements, using 'if, then, because' structure (where appropriate) and summarised for quick reference. Each discrete theory was recorded on a separate row. To check for systematic errors, data from a third of all references were extracted by two members of the review team. Discrepancies and disagreements were discussed and refinements or additions agreed through regular communication. Previously extracted data was reviewed in light of pertinent refinements to the extraction process. Critical conceptual issues were agreed through discussion with the review team, the wider study team and the professional stakeholder group. At this stage (and subsequently as synthesis progressed), any substantive theories that supported the programme theory (e.g. attachment theory) were also noted.

2. 8. Quality review: Critical assessment of data quality was incorporated into the extraction template and was not used to exclude documents that had made it through the sifting process. The review team selected and appraised documents included at the full text stage, applying the following criteria [36].

- Relevance: Are sections of text within this document relevant to programme theory development?
- Richness: Can the document meaningfully contribute to theory development or testing?
- Rigour: Are these data sufficiently trustworthy to contribute to programme theory development?

Documents had previously been assessed for relevance, through the use of inclusion/exclusion criteria and the three key areas of TRAs [35]. Further quality reviewing assessed richness and rigour, by applying a rating of high, medium or low. Rigour was assessed according to two criteria, 1) trustworthiness of the evidence/source and 2) the coherence/plausibility of arguments [37]. Literature, deemed suitably relevant, was not excluded according to the criteria of richness or rigour. However, during theory building and synthesis, richness was used as an indicator of the relative value of revisiting the text to seek additional theoretical insights or details, whilst measures of rigour were used to indicate relative confidence in the extracted conjectures. Each discrete theory was assessed for level of confidence (high, medium or low) and the reason for this judgement was recorded. This quality assessment index contributed to streamlining the synthesis process.

9. Synthesis of the findings: Data analysis and synthesis included regular discussions with the research team to challenge and debate interpretations. The extracted causal theories, in the form of 'if, then, because' statements were categorised into 8 (later to become 7) topic areas (e.g. Organisational culture, Staff wellbeing and support etc.) with 28 subordinate themes (e.g. under 'Staff wellbeing and support': Moral distress and staff turnover, Professional Identity and Belonging etc.). Next, a realist logic of analysis was applied to these themes, using the extracted data, stakeholder engagement and additional interrogation of source documents and the wider literature to develop context-mechanism-outcome configurations (CMOCs).

The resulting (86) CMOCs (see Additional file 3) aimed to explain when, why, how and for whom the effects and experiences of trauma are influenced by TRAs, leading to intended (and unintended) outcomes in children's homes. Further conceptual work was conducted to ensure theoretical coherence and to develop and describe models in a format intended to be directly translatable to the co-design process.

10. Validation of findings with content experts: Once early program theories had been generated, they were reviewed by content experts and practitioners with direct experience in the field and people with care experience. This process ensured that findings represent the experiences of practitioners and experts-by-experience. It also served to prioritise further theory refinement and to indicate any significant gaps that may have been left by the published literature. This conceptual validation was conducted as a continual process throughout the review.

Results

Document characteristics

Of the 44 studies included in the review (Table 3), 77% were from just 4 geographic locations; 11 studies (25%) originated from the USA, 9 (20%) from the UK, 8 (18%) from Canada and 6 (14%) from Australia. Most of the remaining 10 studies were located in East, West and Northern Europe. The exceptions are 1 study that originated from China (Hong Kong) and 1 from South Africa.

Regarding methodological approaches, 18 studies (40%) were qualitative only and of these 15 used a single data collection method. Twelve of these studies used interviews only. There were 11 quantitative only studies (25%), 7 of which were a pre-post design and 4 were a cross-sectional design. There were 6 mixed-methods (qualitative and quantitative) studies (14%), and 5 of these used more than a single data collection method (e.g. interviews and pre-post survey). There were 3 systematic literature reviews and 6 non-empirical publications (e.g. conceptual, discussion or opinion). Further details are shown in Table 3.

Table 3
Documents included in the review

ID	Author	Date	Title	Country
1	Bailey, C. Klas, A. et al. [51]	2019	Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings	Australia
2	Baker, C.N. Brown S. M. et al. [38]	2018	The implementation and effect of trauma-informed care within residential youth services in rural Canada: A mixed methods case study	Canada
3	Brend, D. M. [52]	2020	Residential childcare workers in child welfare and moral distress	Canada
4	Brend, D. M. Collin-Vézina, D. & Daignault, I. V. [53]	2025	Claiming the edge as central: what residential childcare workers need to better serve children and families, Residential Treatment for Children & Youth	Canada
5	Burbidge, C. E. Keenan, J. & Parry, S. [54]	2020	"I've made that little bit of difference to this child": Therapeutic parent's experiences of trials and triumphs in therapeutic children's homes	UK, England
6	Chen Q., Wu Q. et al. [55]	2025	Trauma-Informed Care in Residential Care for Children At-Risk: Preliminary Evidence of Effectiveness	Hong Kong
7	Collins-Camargo, C. Strolin, J. & Akin, B. [56]	2019	Use of Technology to Facilitate Practice Improvement in Trauma-Informed Child Welfare Systems	USA
8	Crawford, K. Campbell, A. D. et al. [57]	2024	The Impact of Trauma-Informed Training for a Youth Residential Center on Staff Attitudes and Behavior	USA
9	Cross, R. [58]	2012	Interpersonal childhood trauma and the use of the therapeutic community in recovery	UK
10	Dacre, V. [41]	2020	Recovering from childhood trauma	UK
11	Donisch, K. Bray, C. & Gewirtz, A. [59]	2016	Child Welfare, Juvenile Justice, Mental Health, and Education Providers' Conceptualizations of Trauma-Informed Practice	USA
12	Esaki, N. Hopson, L. M. Middleton, S. [60]	2014	Sanctuary Model Implementation from the Perspective of Indirect Care Staff	USA
13	Forrest, S. Gervais, R. et al. [61]	2018	Building Communities of Care: A Comprehensive Model for Trauma-Informed Youth Capacity Building and Behavior Management in Residential Services	USA
15	Galvin, E. Morris, H. et al. [62]	2021	Implementation of The Sanctuary Model in residential out-of-home care: Enablers, barriers, successes and challenges	Australia

ID	Author	Date	Title	Country
14	Galvin, E. O'Donnell, R. et al. [63]	2020	Attitudes towards trauma-informed care in residential out-of-home care	Australia
16	Galvin, E. O'Donnell, R. et al. [64]	2022	Residential Out-of-Home Care Staff Perceptions of Implementing a Trauma-Informed Approach: The Sanctuary Model	Australia
17	Garibaldi, P. Jordan, N. et al [65]	2026	Youth-Reported Strengths and Challenges in Illinois Child Welfare Residential Care: An Analysis of Qualitative Data From > 500 Youth	USA
18	Haffejee S., Theron L. et al. [66]	2024	Critical Reflections on the Usefulness of eConnect to a Sample of Child and Youth Care Workers in South Africa	South Africa
19	Improvement Services [67]	2023	Care experience and trauma-informed practice: companion document	UK, Scotland
20	Jenney, A. [68]	2020	When Relationships are the Trigger: The Paradox of Safety and Connection in Child and Youth Care	Canada
21	Kabir, M. [69]	2025a	The attitudes and experiences of care staff towards Trauma-Informed Care (TIC). Ch 1 in The role of leadership in residential care services for young people	England
22	Kabir, M. [70]	2025b	Experiences, challenges and support needs of managers in residential care services for children. Ch 2 in The role of leadership in residential care services for young people	England and Wales
23	Karhu V.M., Peltonen A. et al. [20]	2025	Dyadic and Systemic Trauma-Informed Care in Adolescent Residential Settings: A Systematic Review of Outcomes for Staff, Youth, and Relationships	Finland
24	Kor, K. Fernandez, E. Spangaro, J. [71]	2021	Practitioners' experience of implementing therapeutic residential care: A multi-perspective study	Australia
25	Kostadinov, K. Goodwin, J. et al. [72]	2026	Virtual Reality-Enhanced Training for Trauma-Informed Care Among Residential and Child Mental Health Professionals: Pre-Post Evaluation Study	Germany, Finland, and Bulgaria
26	Kramer, C. S. [73]	2024	“I Felt From That Place”: A Qualitative Case Study of Emerging Practices to Build Youth Peer Supports in Residential Care	USA
27	Lang, J. M. Campbell, K. et al. [74]	2016	Building Capacity for Trauma-Informed Care in the Child Welfare System: Initial Results of a Statewide Implementation	USA

ID	Author	Date	Title	Country
28	LeBel, J. & Kelly, N. [75]	2014	Trauma-informed care. Residential Interventions for Children	USA
29	Lowenthal, A. & Collin-Vezina, D. [76]	2026	At the Crossroads of Compliance and Care: The Question of Power in Trauma-Informed Care Implementation in Child and Youth Residential Care	Canada
30	MacDonald, M. Gillespie, K. [77]	2023	Interrupting a cycle of placement instability with short-term residential care: Trauma-informed family-like relational practice in one specialist unit	UK, North Ireland
31	Matte-Landry, A. Collin-Vézina, D. [78]	2022	Patterns of Change in Restraints, Seclusions and Time-outs over the Implementation of Trauma-informed Staff Training Programs in Residential Care for Children and Youth	Canada
32	Matte-Landry, A. Collin-Vézina, D. [79]	2024	Patterns of change in restrictive measures in residential care: Trauma-informed staff training benefits children and youth who need it the Most	Canada
33	Milne, L. Ratushniak, A. & Nguyen, H. [80]	2024	How adverse childhood experiences impact the professional quality of life of residential care workers: resilience as a mediator for burnout, secondary traumatic stress, and compassion satisfaction	Canada
34	Murphy, K. Moore, K. A. et al. [81]	2017	Trauma-informed child welfare systems and children's well-being: A longitudinal evaluation of KVC's bridging the way home initiative	USA
35	Negrão, M. Veiga, E. et al. [82]	2024	Trauma–Sensitive Residential Care: Perspectives of Portuguese Professionals to Spark Change	Portugal
36	Parry, S. Williams, T. & Burbidge, C. [83]	2021	Restorative Parenting: Delivering Trauma-Informed Residential Care for Children in Care	UK, England
37	Parry, S. Williams, T. & Oldfield, J. [19]	2022	Reflections from the forgotten frontline: ‘The reality for children and staff in residential care’ during COVID-19	UK, England
38	Pulgar, A. Ordiales, R. et al. [84]	2025	Care Practices in Residential Child Homes: Caregiver and Youth Voices	Spain
39	Steinkopf, H. Nordanger, D. et al. [85]	2021	Prerequisites for Maintaining Emotion Self-regulation in Social Work with Traumatized Adolescents: A Qualitative Study among Social Workers in A Norwegian Residential Care Unit	Norway

ID	Author	Date	Title	Country
40	Steinkopf, H. Nordanger, D. et al., [86]	2022a	How do staff in residential care transform Trauma-Informed principles into practice? A qualitative study from a Norwegian child welfare context	Norway
41	Steinkopf, H. Nordanger, D. et al. [87]	2022b	Experiences of Becoming Emotionally Dysregulated. A Qualitative Study of Staff in Youth Residential Care	Norway
42	Strömpl, J. Sindi, I. Lust, M. [88]	2024	Is Trauma-Informed Care Possible without Information? – Experience of Trauma Awareness among Estonian Foster Parents and Residential Caregivers	Estonia & Russia
43	Topitzes, J. Grove, T. et al. [89]	2019	Trauma-responsive child welfare services: A mixed methods study assessing safety, stability, and permanency	USA
44	Vamvakos, C. & Berger, E. [90]	2024	Residential care worker perceptions on the implementation of trauma-informed practice	Australia

The studies included in the review were heterogeneous in terms of approaches, scientific quality and richness of theory. Qualitative studies varied in size and methodological rigour but were mostly exploratory in nature. Quantitative studies were generally of poor quality (e.g. pre-post with no controls) and/or lacked theoretical explanations, linking activities with outcomes. One mixed-methods study [38] explained unexpected negative pre-post results as potential response shift bias [39], demonstrating the inherent weakness of using quantitative-only studies for evaluating complex interventions. Results were therefore inconclusive and difficult to interpret. Mixed methods studies show greatest promise regarding being able to empirically develop, test and refine the complex theories underlying TRAs. The key strength of the body of literature is the triangulation of theoretical concepts demonstrating broad agreement on the potential benefits of TRAs in children's homes. This review was therefore able to construct a large number of theoretical conjectures, often by drawing together theory fragments across various studies.

Main Findings

The findings are thematically organised into the following seven main topics with 28 corresponding subthemes:

1. Trauma-Responsive Organisational Culture
2. Therapeutic Relationships and Dyadic Models
3. Staff Wellbeing and Support
4. Training and Implementation Quality
5. System-Level Integration and Structural Support
6. CYP-Centred Practice and Empowerment
7. Enabling Change

An initial further topic was concerned with ‘Barriers and challenges’. However, despite these being treated as distinct themes in the literature, in terms of theory development, there was substantial crossover with the other topics. CMOCs derived from evidence within this topic were therefore absorbed into the other 7 topics. Our findings are presented in the narrative below, theme by theme. For the knowledge claims made, we provide an indication of the CMOC(s) that support the claim. The number of corresponding CMOCs, therefore, does not necessarily represent the weight of evidence. Rather, it represents the theoretical richness of the subtheme. The square brackets with numbers within them indicate the relevant CMOC, which may be found in Additional file 3.

1: Trauma-Responsive Organisational Culture

The development of a ‘Trauma-Responsive Organisational Culture’ is key for addressing root causes of staff distress, as well as recognising staff distress, responding to reduce its impact and ultimately to improve care quality. Importantly, a trauma-responsive approach should consider recognising and responding to different types of staff distress: moral distress, post-traumatic, secondary, and shared traumatic stress. A successful Trauma-Responsive culture, based on the importance of committed, consistent leaders as role models and facilitators will help to create therapeutic milieus that counteract traumatic cultures.

A trauma-responsive organisational culture requires individual and systemic change, embedding TRA principles into policy, leadership, values and daily practice. This helps to create psychologically safe cultures, thereby reducing staff distress, improving retention, and enhancing therapeutic outcomes for CYP.

1. Addressing root causes of staff moral distress: Staff members whose values do not align with organisational practice, or are unable to meet therapeutic needs, experience moral distress, leading to burnout and turnover, which negatively impacts CYP [1.1.0a-c]
2. Recognising and addressing staff distress: Recognise the signs and symptoms of staff distress and systemically integrate knowledge and principles of TRAs into practices that are supported by policies and procedures, to reduce staff distress and improve care quality. Understand that training about distress introduces obligations to help staff address trauma [1.2.0a, 1.2.0b & 1.2.1]
3. Reflective Practice and Emotional Regulation: Reflection and regulation are essential for TRAs in helping to create therapeutic milieus that counteract traumatic cultures (for example, punitive environments, chaotic systems and emotionally unsafe practices), helping to create a shift from ‘managing behaviour’ to ‘understanding distress’ [1.3.0a, 1.3.0b, 1.3.1a, 1.3.1b & 1.3.2]

2: Therapeutic Relationships and Dyadic Models

Dyadic models like attachment theory and mentalisation underpin therapeutic relationships. Aligned with organisational-level approaches, a successful TRA relies on ‘Therapeutic Relationships and Dyadic Models’ that are central to healing trauma and supporting resilience in children. These approaches focus

on nurturing relationships, developing mutual emotional investment, fostering trust and creating secure attachments. Practitioners and care-experienced young people emphasised the importance of creating a home-like, community of support around the child.

1. Attachment and Mentalisation: Secure attachments and reflective functioning of caregivers, support emotional development of CYP and positive adaptation to adversity [2.1.0 & 2.1.1]
2. Reciprocal Restorative Relationships: Mutual emotional investment between staff and CYP improves wellbeing and developmental outcomes [2.2.0 & 2.2.1]
3. Connection Before Correction: Prioritising relationships over behaviour-management, fosters trust and emotional safety [2.3.0 & 2.3.1]
4. Focus on nurturing relationships: In a pressured work environment, there is sometimes only time to complete the basic required tasks (such as record-keeping). Balancing tasks with nurturing activities results in stronger therapeutic relationships and emotional safety [2.4.0]
5. TRAs improve all relationships: With the emphasis of TRAs on relationships as the primary agent of therapeutic change, the adoption of TRAs has the potential for positive changes in relationships with coworkers, supervisors, and outside professionals [2.5.0]

3: Staff Wellbeing and Support

Within trauma-responsive models, ‘Staff Wellbeing and Support’ is foundational for effective care. It is important that practical support structures are grounded in a positive trauma-responsive culture, in addition to policies and procedures. There are key practical approaches, such as peer-support, supervision and recognition of professional identity that can protect against trauma and distress, thereby reducing burnout and protecting against high staff turnover. Staff wellbeing is therefore critical for providing placement stability and the opportunity for beneficial therapeutic relationships. Supporting this, our stakeholders prioritised organisational approaches that value consistency, shared values, and a culture of improvement.

1. Trauma and distress leading to burnout and staff turnover: In addition to moral distress, staff can also experience a) post-traumatic stress, b) secondary traumatic stress, and c) shared traumatic stress. Importantly, ‘shared traumatic stress’ can refer to situations in which combinations of staff and CYP experience the same collective traumatic event [3.1.0, 3.1.1a, 3.1.1b, 3.1.2, 3,1,3]
2. Workplace Social Support and Supervision: Access to peer support, supervision, and reflective time protects staff wellbeing [3.2.0, 3.2.1, 3.2.2, 3.2.3]
3. Professional Identity, organisational recognition and Belonging: A sense of belonging and recognition enhances resilience and job satisfaction [3.3.0]
4. Support for Managers: When managers have access to internal and external support, such as practical advice, this can protect managers’ wellbeing and prevent them feeling challenged and isolated [3.4.0]

4: Training and Implementation Quality

Effective TRA ‘Training and Implementation Quality’ is reliant on tailored, ongoing training and strong leadership. Training should be practical and considered relevant. It should be based on the experiences of trainees, context-specific, and regularly refreshed. Quality of TRAs is compromised when training is theoretical, disconnected from practice and not updated regarding new situations and experiences. Implementation benefits from strong leadership and demonstrations of organisational commitment to trauma-responsive approaches. When members of staff have learned approaches to ‘behaviour management’ that seem to work, they can be sceptical about new approaches, which they perceive may lead to an increase in disruptive behaviours, critical incidents and the need for containment. Importantly, because TRA implementation is a complex process spanning all levels of organisations it can require years to fully occur, especially considering common barriers such as limited budgets and staff turnover.

1. Practical, Relevant Training: Training should be experiential, context-specific, and regularly refreshed. This can result in embedding principles, increasing consensus and confidence and reducing punitive practices [4.1.0, 4.1.1, 4.1.2, 4.1.3, 4.1.4 & 4.1.5]
2. Barriers to Implementation: Standardised training, lack of clarity, lack of involvement, limited organisational commitment, difficulty demonstrating improvement and resource constraints hinder delivery of TRAs [4.2.0, 4.2.1, 4.2.2, 4.2.3, 4.2.4, 4.2.5, 4.2.6, 4.2.7a, 4.2.7b & 4.2.7c]
3. Reluctance to change: Members of staff can have legitimate concerns about limited effectiveness and negative consequences of TRAs. This reluctance can emerge in various subtle forms, such as the interpretation of new approaches through traditional ways of working [4.2.8a, 4.2.8b & 4.2.9]
4. Leadership and Champions: Visible leadership and trauma champions can drive cultural change and model expectations, especially when there are no negative consequences for seeking help and support [4.3.0, 4.3.1, 4.3.2 & 4.3.3]

5: System-Level Integration and Structural Support

Children’s homes do not operate in isolation. Children and young people in their care often come into contact with other agencies, services and individuals. System-level TRA models create cohesive environments that support both staff and children. Critically, assessment and placement decisions often involve multiple individuals and agencies. Therefore, whilst providing unique challenges, addressing ‘System-Level Integration and Structural Support’ can help to ensure thoughtful, consistent, and coordinated care. Appropriate infrastructure, consistency, and coordinated care are critical for sustainable change.

1. Whole-System TRA Models: Integrated models improve emotional regulation, placement stability, and outcomes [5.1.0, 5.1.1, 5.1.2, 5.1.3, 5.1.4, 5.1.5a-c]
2. Technology and Infrastructure: Updated, useful, accessible systems support data-driven, collaborative, and sustainable practices [5.2.0, 5.2.1 & 5.2.2]
3. Consistency and Coordination: Unified approaches and policies across teams and effective external networking can foster collaborative teamworking, prevent crises, reduce distress, increase access to services and improve therapeutic outcomes [5.3.0, 5.3.1, 5.3.2a & 5.3.2b]

6: CYP-Centred Practice and Empowerment

At the heart of much of the literature regarding trauma-responsive approaches is ‘Children and Young People (CYP)-Centred Practice and Empowerment’. CYP-centred, trauma-responsive approaches, empower children by validating their experiences, promoting agency, and fostering resilience through safe, nurturing relationships. Involvement of CYP in service design and delivery, encouragement of positive peer-support, individualised care, providing emotional safety and applying strength-based approaches are important practical ways to bring about positive change. Potential outcomes of CYP-centred practice include services that reflect the individual needs of CYP, cultivating empowerment and emotional expression, supporting recovery, developing trusting relationships with staff and peers, encouraging feelings of safety and belonging, improved wellbeing, fewer adverse events and prevention of re-traumatisation.

1. Participation of CYP: CYPs involvement in service design and delivery fosters empowerment, recovery and user-focused services [6.1.0, 6.1.1 & 6.1.2]
2. Peer Support: Systems, policies and practices can help to identify opportunities for promoting positive peer support to encourage feelings of safety and belonging [6.2.0 & 6.2.1]
3. Individualised Care and Emotional Safety: Understanding trauma responses and tailoring interventions improves outcomes [6.3.0 & 6.3.1]
4. ‘Resilience’ and Strength-Based Approaches: Supporting healing by focusing on strengths and providing a supportive environment for positive adaptation, rather than having expectations of the individual ‘resiliency’ of CYP [6.4.0]

7: Enabling change

Visible and accountable leadership, together with sympathetic policies, processes and positive culture-change can create an environment that supports, rather than hinders TRAs. We recognised three important aspects of ‘Enabling change’ towards TRAs. Firstly, to encourage the principles of TRAs to become practised and embedded, time allowed to reflect, build relationships and share experiences needs to be legitimised. Secondly, the normalisation of a learning culture supports the ongoing adaptation of TRAs to practical needs of the setting. Thirdly, strong leadership is required to support members of staff that are early adopters of TRAs, to set the cultural ‘tone’ of the environment towards ongoing development. In summary, the importance of creating time and space for trauma-responsive practices is a foundational principle of successful implementation.

1. Creating space: Legitimising time to reflect, build relationships and share experiences allows the principles of TRAs to become practised and embedded [7.1.0a, 7.1.0b & 7.1.1]
2. Learning culture: Normalising developmental activities and being open about mistakes without fear of reprisal supports the ongoing adaptation of TRAs to practical needs of the setting [7.2.0a, 7.2.0b & 7.2.1]
3. Safely supporting change: Balancing psychological safety of staff whilst robustly addressing non-TRA practices and attitudes helps to develop a consistent and coherent approach with strong

leadership [7.3.0]
4. Shared understanding: Agreement on the key principles and practices of TRAs leads to consistency and clarity of delivery, leading to more rapid embedding [7.4.0]
5. Organisational readiness: Organisations that have already adopted a more individualized and relational approach, prior to implementation, provide more fertile grounds for embedding TRAs [7.5.0]

Barriers and Challenges

Barriers and challenges to implementing TRAs were often treated as a separate concern in the literature. However, these were also routinely implied in guidance for the design or implementation of TRA models. For example, 'fragmented systems' are recognised as common barriers. However, the recommendation for 'whole-system integration' can be understood as the need to address the challenges of applying TRAs in fragmented systems. Additionally, whilst 'crisis-driven practices' are seen as a challenge to implementing TRAs, vital components of TRAs are intended to address these challenges through sufficient staffing, trauma-responsive assessments and avoiding emergency placements. Similarly, barriers presented by the 'emotional cost of care and workforce strain' are addressed through various forms of staff support, included as key components of TRAs. Thus, to maintain thematic coherence, the common barriers and challenges have been assimilated into their relevant themes (1–7).

Negative feedback and virtuous cycles

We recognised many negative feedback loops and ways that TRAs can interrupt these. For example, crisis-driven practices can deplete organisational resources for responding to crises, negatively affecting staff wellbeing and retention, thereby reducing capacity overall and the ability to avoid further crises.

Indeed, a key finding of our review is the importance breaking negative cycles and recognising and supporting positive feedback loops when implementing TRAs. Some benefits might only be realised in the longer-term and rely on a prior chain of successful implementation. Our findings describe these theoretical linkages and provide pathways to virtuous cycles of continuous improvement.

As a holistic intervention, an organisational TRA recognises and addresses many barriers and introduces positive actions that are interlinked. These can be tailored to focus on specific system-level, organisational and individual strengths and weaknesses, thereby interrupting negative cycles and promoting virtuous cycles.

For example, when organisations implement TRAs, because staff can feel that they have opportunities to make a positive difference to the lives of CYP, it can lead to improved job satisfaction. When staff experience improved job satisfaction, because they feel positive emotions, they are intrinsically motivated, better able to manage stress, and more likely to provide consistent, high-quality trauma-responsive care to CYP. In turn this can promote improved staff wellbeing, which leads to less illness,

disability and staff turnover. The care they provide is, therefore, more consistent and there are more opportunities for developing positive therapeutic relationships and further integrating TRAs.

Another important example of a virtuous cycle is providing staff time and 'space' for reflective practice. Whilst this might seem challenging in a high-pressure, under-resourced environment, there is evidence that this can create virtuous cycles that ultimately free-up time, for example, by reducing crises, improving teamworking, minimising absenteeism and improving retention. Therefore, there are opportunities for cumulative returns on investment, whereby initiating small changes can begin to unlock capacity to make further change.

Defining the term 'trauma-responsive approach'

Whilst there are some definitions of trauma-responsive approaches in the literature, these are either designed to be generally applicable to all settings, designed for specific purposes (e.g. mental health care) or specifically focused on settings other than children's homes [40]. For our purposes, we required a definition that was derived from this Realist review, and which could be refined and developed through the co-design process. The following definition was constructed to encapsulate the key principles contained in our initial programme theory.

A trauma-responsive approach is a whole-system, relational, reflective and values-driven approach, based on individual participation and an organisational commitment to uphold trauma-responsive practice. A trauma-responsive approach in children's residential care supports children, young people and the workforce to feel safe, connected to one another, and empowered. It aims to reduce distress and enhance wellbeing by preventing harmful, crisis-driven or reactive practices. A trauma-responsive approach promotes stable, trusting relationships that enable healing and transformation in a nurturing environment for all. A trauma-responsive approach embeds safe and transparent practices to enable people and organisations to continually learn and develop.

Discussion

A consideration of the wider literature confirmed that the conceptualisation of what a TRA is, as well as what elements should constitute a TRA, are uncertain. The landscape is potentially confusing for any organisation, or individual children's home, wishing to implement a TRA. However, there are some key conceptual anchors that offer a coherent direction for future consolidation and focused development.

Rather than contradicting or redefining current evidence for trauma-responsive approaches, the findings consolidate a diverse range of perspectives. Synthesis of data has been prioritised and informed through intensive stakeholder involvement and engagement to ensure practical relevance. The study identified seven core domains for framing effective TRAs in children's homes: (1) trauma-responsive organisational culture, (2) therapeutic relationships and dyadic models, (3) staff wellbeing and support, (4) training and implementation quality, (5) system-level integration and structural support, (6) CYP-centred practice and empowerment, and (7) enabling change.

The key benefit of this study is the realist approach to synthesis. Eighty-six CMOCs provide a detailed description and explanations of how positive outcomes can be expected through the implementation of TRAs. Prior to this review, the literature was characterised by a lack of theoretical clarity. Alternatively, a focus on psychological, substantive theory (such as attachment theory) tended to omit or gloss over the practicalities of associated interventions. Complex interventions tended to be described with varying degrees of attention to how they might bring about a host of outcomes, which might be reliant on each other or seemingly unrelated. This study has explicitly defined relationships and interdependencies between key outcomes. Notably, with the observation of negative feedback loops and virtuous cycles, which can inform effective tailoring of interventions.

Our findings explain how safe, nurturing relationships, social support, reflective practice, emotionally regulated care, practical training and organisational alignment activate mechanisms that improve staff wellbeing, placement stability, and CYPs emotional wellbeing. Organisational culture and leadership emerged as critical in enabling or constraining trauma-responsive approaches, specifically in terms of 'providing space' for thoughtful, reflective practice and promoting a learning culture.

With stakeholders, we developed and refined a definition of a trauma-responsive approach (TRA) model for UK children's homes and prioritised key mechanisms that can be supported through individually tailored interventions that are suitable and appropriate across the sector. These generative causal theories have been designed to feed into an ongoing experience-based co-design and Realist Evaluation process to further refine practical, effective interventions capable of spreading trauma-responsive approaches throughout UK children's homes.

Comparison with existing literature and implications for practice

In much of the previous literature, 'trauma-informed care' implied knowledge of the effects of trauma and an understanding of prevention of re-traumatisation by frontline carers. However, a 'trauma-responsive approach' signifies a shift in meaning to a whole-system, coordinated and coherent set of values that direct actions and drive development of positive cultures [27].

The findings of this review indicate that a TRA can be applied in residential children's homes when therapeutic work is understood to include the relational, day-to-day and social environment of the home. Across the programme theory, everyday interactions, rather than discrete therapeutic sessions, were found to form the primary situations through which emotional safety, trust, and developmental recovery are fostered [41]. This is echoed in studies where caregivers describe the emotional intensity, relational complexity, and daily meaning-making involved in providing care for children and young people who have experienced trauma [42][43]. These insights reinforce the premise that therapeutic change relies on the quality of everyday relational experiences within the residential environment.

Therefore, an important target for a TRA within the home environment is to support frontline staff to develop and maintain a therapeutic relationship with the children, which should be mirrored in the supervisory and organisational support in place for the staff [44]. In the context of shift work and high

staff turnover, this reflective supervisory framework serves as a critical buffer against the moral distress that occurs when practitioners want to provide relational care but feel constrained by systemic resource or time pressures. Legitimising this reflective space actively restores staff psychological capacity, working towards mitigating the burnout that threatens placement stability. Based on the findings of the review, a therapeutic relationship between residential care staff and a child in this context can be defined as a trust-based, emotionally attuned, reflective and developmentally sensitive relationship. The caregiver provides consistent, reliable, and nurturing interactions that promote safety, co-regulation, and positive adaptation. This therapeutic relationship is grounded in the child's lived experiences of being understood, emotionally held, and valued, and it develops through everyday relational encounters.

These findings highlight the importance of relationship-based practice within TRAs, characterised by *connection before correction* [45], prioritising emotional safety, and engaging in relational repair. These relational practices reflect therapeutic approaches used in foster and residential care, where trust, attunement, dependability, and authenticity are recognised as the foundation for healing [46]. Caregivers in residential settings describe ‘steady rhythms of care’ in which sensitive responsiveness, and shared emotional investment help to develop trust and support children’s capacity for positive relationships [47]. The ‘rhythm’ of care has also been identified as an important therapeutic approach through stakeholder consultations within this review, and a defining feature of trauma-responsive care, to support predictability and to help create a sense of safety.

At the level of substantive theories, these findings align with reflective caregiving frameworks, such as mentalisation-based and attachment-informed models, which emphasise fostering secure relationships, and an understanding of the internal states that underlie behaviour. Across the literature, reflective practice is understood to be key for caregivers to interpret children’s cues, regulate their own emotions, and maintain attuned relationships [42] [43]. Attachment-based interventions reinforce the central role of attuned, reflective, and consistent caregiving in supporting developmental recovery [48]. Crucially, operationalising these frameworks does not require formal clinical qualifications. For example, mentalisation can be framed for frontline staff as the practical skill of ‘standing in the child’s shoes’, to understand the underlying distress driving an escalating behaviour, making the approach accessible during daily shifts.

Consequently, whilst the review emphasises continued and consistent reflective and relational practices, rather than discrete therapeutic interventions, there are clearly specific models from evidence based therapeutic work that can be drawn upon to inform a bespoke TRA within homes for cared for children. Indeed, despite the historical point of difference between creating a therapeutic milieu and providing access to specific clinical therapies (e.g. [49]), this review has emphasised the importance of consistent, coherent approaches at a system-level.

Another key finding of the review with direct implications for practice is that punitive or chaotic responses to needs, events, and communications undermine therapeutic intent. Whereas predictable, emotionally regulated, and relationally sensitive environments foster safety and co-regulation [46]. When

co-regulation is a necessary precursor to self-regulation, as is often the case for children in care who have experienced relational trauma and loss, both relational safety and felt safety become essential conditions.

Only within this sense of safety can a young person begin to experience soothing through co-regulation. Under certain conditions, this can then be internalised to support self-regulation. Emotional safety, identified in both the programme theory and existent research as a prerequisite for change, relies on coherent, reliable, and emotionally attuned caregiving. When caregivers maintain emotional steadiness and repair ruptures sensitively, children develop greater trust, regulation, and openness to support [47] [46]. In these situations, this is a process through which caregivers can create an open door for a young person to engage with care and support. Creating entry points for a young person to engage with care and create safe relationships is particularly important as so many children in care will have been let down by caregivers in the past and may understandably hold reservations about the safety and reliability of future caring relationships.

Finally, a TRA seems to be strengthened by alignment with trauma-informed systems that can wrap around the frontline workforce, children and young people. It is important that the safety and consistency of the TRA is matched and held by multisystemic consistency within the organisation, where there is a shared language to foster communication, and coordinated care. This alignment supports stability and reduces fragmentation for young people and frontline staff in residential care [34] [50], and as a result the TRA itself can be protected and nurtured.

In summary, a TRA in residential children's homes needs to be inherently relational, supported through reflective practice, underpinned by relevant therapeutic models, and nurtured through sustained organisational commitment. In homes for cared for children, TRAs are most effective when they cultivate emotionally attuned and predictable environments, in which children and staff can experience safety, trust, and growth from trauma together, through relational reflective practice.

Strengths, limitations and future directions

This was a rapid Realist Review and, as such, has some inherent limitations. The search was focused, rather than extensive and there was limited scope for iteratively exploring emergent areas of theory. However, the impact of these limitations was mitigated through embedding a longitudinal program of stakeholder engagement to ensure that the review remained focused yet informed, as key literature, and perspectives were considered. This allowed the work to be firmly located within the broader context of key texts, even when these did not make it through to the formal evidence extraction. Indeed, it could be considered a strength that the focus of the work, on children's homes only, ensured that assumptions were not required regarding the relevance of data for this setting.

The initial programme theory developed through this review will require further prioritisation, refinement with stakeholders (including care staff and care experienced children and young people) and

development into clear, practical guidance and resources, which can be implemented and evaluated. However, the review has established a set of key conceptual anchors for this further development work.

Conclusions

This rapid realist review set out to answer the research question ‘How, when, why and for whom can a theoretically informed evidence-based trauma-informed care intervention, tailored for children and young people in UK children's homes, improve care quality and experience?’ Whilst set within the context of the broader field of literature, the review drew on evidence from 44 documents and was guided by the knowledge and experience of a range of stakeholders and people with lived experience, to identify the underlying theory regarding important aspects of trauma-responsive approaches (TRAs). Following a 10-task process, evidence was synthesised to explain how TRAs can be implemented to bring about positive, effective change in children’s homes in the UK.

Evidence in this field has been characterised by diversity in approaches, perspectives, focus and terminology, contributing to confusion regarding effective implementation of TRAs. This research has objectively consolidated a heterogeneous body of literature into seven key topics and 28 sub-themes, which have been rigorously synthesised into 86 detailed CMOCs. These are now ready to be refined and tested as well as forming a thematic framework to categorise emerging theories. This has important implications for providing a clear direction for the co-design and implementation of TRAs in UK children’s homes. The findings will be of interest to anyone with an interest in the use of trauma-responsive approaches, specifically in residential settings.

Abbreviations

CMOC: Context, Mechanism, Outcome conjecture

CYP: Children and young people

NIHR: National institute of health and social care research

NEST: Nurturing Environments for Shaping Trauma-Responsive Care and Recovery9

PTSD: Post-traumatic stress disorder

TRA: Trauma-responsive approach

TIC: Trauma-informed care

Declarations

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Conflict of interests

The authors are not aware of any conflicts of interest.

Ethics Declaration

Not applicable.

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Figures

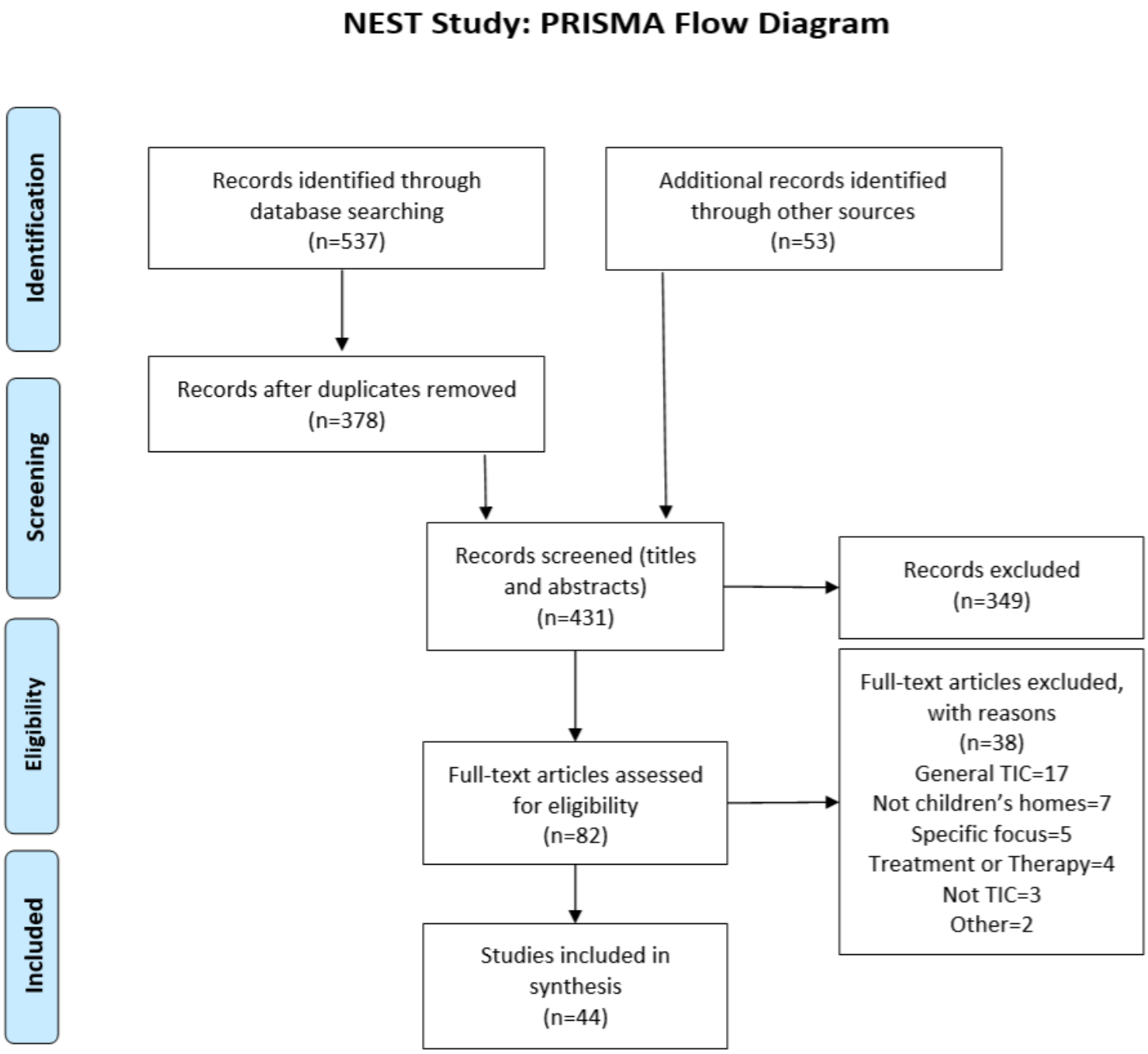


Figure 1

PRISMA diagram

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