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Coping Strategies and Trauma-Informed Interventions for Residential Support Workers: We Lean on Each Other

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Abstract
Despite growing attention to trauma-informed care for young people, the experiences and support needs of Residential Support Workers (RSWs) remain underexplored. This study examines how RSWs build and maintain support networks in response to workplace trauma and identifies locally grounded interventions that workers perceive as necessary for their wellbeing and professional sustainability. A qualitative design was employed, drawing on data from 20 semi-structured interviews and five focus group discussions with RSWs. Data were analysed using reflexive thematic analysis, following a six-phase approach. Findings indicate that informal peer support networks serve as the primary and most trusted source of emotional and practical support, often compensating for inconsistent formal systems. Reflective supervision was experienced as uneven and manager-dependent, while safety - particularly staffing levels, consistency, and organisational responses to critical incidents - emerged as foundational to worker wellbeing. Experiences of trauma were further shaped by race and cultural identity, highlighting the need for culturally responsive, localized interventions. The study offers practice-relevant insights into trauma-informed support for RSWs and suggests the development of worker-centred intervention models.

Keywords Residential support workers · Workplace trauma · Peer support networks · Trauma-informed practice · Qualitative thematic analysis

Background

Residential support workers (RSWs) occupy one of the most emotionally demanding positions within the child and youth out-of-home care system. They provide daily support, safety, and relational stability for young people whose histories often include trauma, abuse, neglect, displacement, and chronic instability. While the experiences of children in residential care have received substantial research attention, the parallel emotional burdens carried by the workers who support them remain comparatively underexamined. In practice, RSWs are exposed to repeated accounts of trauma, behavioural crises, and high-stakes decision-making, often within resource-strapped environments (Erlank & Bopape, 2024; Regehr, 2018). Many workers describe the role not simply as a job, but as a constant emotional negotiation between wanting to offer meaningful care and managing the cumulative psychological toll the work can inflict. Their injuries - emotional, relational, and sometimes physical - are rarely acknowledged in organizational or policy discourse, yet these unseen burdens shape both the quality of care they provide and their own long-term well-being.

This study was conducted in Australia, a context shaped by significant policy reforms in child and youth out-of-home care over the past two decades. Nationally, initiatives such as the national standards for out-of-home care and subsequent national framework for protecting Australia's children (Australian Institute of Health and Welfare, 2024) sought to improve placement quality and reduce reliance on residential care which traditionally is viewed as a placement of last resort. Also, initiatives such as the Roadmap for Reform (State Governement of Victoria, 2026) and the Home Stretch campaign (extending care to

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21 years) have reshaped service delivery (McDonald, 2025; Mendes, 2024). Changes in legislation, funding models, and regulatory standards have influenced both the demand for residential support workers (RSWs) and the competencies expected of them. For example, the expansion of therapeutic care models and increased emphasis on trauma-informed practice have required workers to possess specialized skills in emotional regulation, behavioural support, and culturally responsive care (Courtois, 2018; Kor et al., 2021; Steinkopf et al., 2021). The young people entering residential settings are characterized by increasingly present with complex trauma histories, mental health challenges, neurodiverse conditions, and experiences of systemic disadvantage (Gatwiri et al., 2021; Gordon et al., 2023; Montgomery et al., 2025). Consequently, the workforce is required not only to meet higher professional standards but also to navigate diverse cultural, social, and behavioural needs. Understanding the lived experiences of RSWs within this uniquely dynamic Australian landscape is essential for contextualizing their emotional labour, coping strategies, and the systemic pressures that shape both workforce sustainability and the quality of care provided.

A substantial body of literature has documented how helping professionals internalize and absorb the traumatic experiences of those they care for. Concepts such as vicarious trauma, secondary traumatic stress (Bride, 2007; Figley, 2013; Jenkins & Baird, 2002), and compassion fatigue (Cocker & Joss, 2016; Figley, 2013; Wu & Lu, 2025) remain central to understanding the experiences of social workers, counsellors, and other frontline professionals. Research shows that repeated exposure to distressing narratives, behavioural volatility, and crisis management can reshape a worker's worldview, relationships, and physiological responses to stress (Livanou et al., 2024; Pearlman & Saakvitne, 1995; Tsirimokou et al., 2023). In out-of-home care, this risk is particularly acute. Young people in residential settings frequently present with complex trauma histories, including chronic maltreatment, disrupted attachments, and systemic disadvantage (Graham & Johnson, 2021; Greeson et al., 2011). For RSWs, the workplace becomes a site of ongoing emotional labour where trauma is not a singular event but a daily experience of the environment.

Studies specific to residential care have highlighted elevated rates of stress, burnout, and emotional exhaustion among workers due to challenging behaviours, insufficient staffing, limited organizational support, and competing demands of therapeutic and custodial responsibilities (Barford & Whelton, 2010; Czuba et al., 2019; Fong et al., 2022; McFadden et al., 2015; Najmiec, 2020). However, much of this literature focuses on individual-level symptoms and workforce turnover, with relatively little attention given to how RSWs actively cope with trauma exposure. While organizational interventions such as supervision, debriefing, and training are widely recommended, not all workers have access to them (Pawar & Anscombe, 2022). The nuanced ways how workers informally support each other are less frequently researched and documented.

This gap is significant. Emerging studies suggest that peer-led support networks, reflective supervision, and everyday relational practices among colleagues play a central role in buffering the effects of trauma (Killian, 2008; Knight, 2010). Yet these practices are typically invisible in organizational frameworks, which tend to emphasize compliance, procedures, and risk mitigation over relational, culturally grounded support systems.

Another underexplored area is the influence of identity and intersectionality in shaping how RSWs experience and respond to trauma. Race, gender, socioeconomic background, and cultural identity can profoundly affect workers' sense of belonging, safety, and emotional burden within residential care settings. For example, workers from minority or marginalized communities may face racialized expectations, cultural taxation, or additional pressures to mediate cultural misunderstandings between young people and staff (Getahun, 2022). These dynamics can influence not only the stressors RSWs encounter but also the forms of support they seek and find meaningful. Despite these realities, intersectional analyses remain limited in residential care research (Hudson et al., 2023; van Hartingsveldt et al., 2023), creating an urgent need to understand the diverse ways workers navigate the emotional terrain of their roles.

In light of these gaps, there is growing consensus that trauma-informed care frameworks must extend beyond young people to include the employees who sustain the system. Trauma-informed organizational principles - safety, trust, collaboration, empowerment, and cultural responsiveness - are increasingly recognized as essential for workforce well-being (Fallot & Harris, 2009). Yet for RSWs, trauma-informed principles are often unevenly implemented, leaving workers to rely heavily on one another for stabilizing emotional support, informal mentoring, and sense-making after difficult incidents. Understanding these worker-led coping strategies, and how they can be strengthened through localized trauma-informed interventions, is crucial for developing more resilient and humane residential care environments. This article responds to some of these gaps and needs.

Objectives.

The study explores the peer relationships, reflective practices, and culturally grounded support systems that RSWs rely on to cope with trauma exposure. It further identifies practical, locally informed interventions that can enhance worker well-being and sustainability of their professional services. By centering the voices and lived experiences of

RSWs, the paper contributes to a deeper understanding of resilience in residential care and offers actionable pathways for trauma-informed organizational development.

To maintain clarity and focus, this article addresses the following research questions:

i. What strategies are currently employed by residential support workers to build and maintain support networks in response to trauma?
ii. What localized interventions could be implemented to improve the well-being and professional outcomes of residential support workers dealing with trauma?

Methods

Study Design

This study adopted a qualitative interpretive design, drawing on focus group discussions (FGDs) and semi-structured individual interviews to explore how Residential Support Workers experience trauma, build support networks, and identify locally meaningful trauma-informed interventions. This two-stage design - group exploration followed by interview validation - was selected to balance the generative power of collective narratives with the depth and confidentiality afforded by one-to-one interviewing (Kitzinger, 1995; Kvale & Brinkmann, 2009). A qualitative approach was considered most appropriate given the study's aim to privilege workers' lived experiences, meanings, and interpretations rather than quantify predefined variables (Creswell & Poth, 2016). The analysis was guided by reflexive thematic analysis, as articulated by Braun and Clarke (2006, 2019), which emphasizes researcher reflexivity, interpretive depth, and theoretical flexibility. This approach aligns with the study's focus on understanding how support, safety, and coping are constructed and negotiated within everyday residential care practice.

Study Participants

We used purposive, maximum-variation sampling to recruit frontline residential support workers with direct caregiving responsibilities (i.e., daily shift work, behavioural de-escalation, care planning) and at least two years' experience in a residential role. Inclusion criteria were intentionally broad to capture a range of experiences across age, gender, cultural background, years of service, and employment type (permanent, casual, or agency staff). Exclusion criteria included current incapacity to participate (e.g., on extended leave for acute mental health reasons) people holding management roles and non-provision of informed consent.

A total of five separate focus group discussions (FGDs) were conducted to capture workplace variation while maintaining manageability for in-depth facilitation. Across the five groups, 22 residential support workers participated (Group 1–4 participants; Group 2–5 participants; Group 3–4 participants; Group 4–5 participants; Group 5−4 participants).These group sizes is consistent with established guidance for productive group dynamics (Kitzinger, 1995). Following thematic generation from the FGDs, we conducted 20 semi-structured individual interviews with a purposeful subset of FGD participants and additional RSWs to validate themes, explore sensitive or minority perspectives not fully voiced in groups, and check interpretive fidelity (member validation). A total of 20 residential support workers were recruited for the study, comprised 12 males and 8 females, with age ranges mostly estimated between mid-20s to mid-40s based on work history. Participants' experience in residential care varied from approximately 2 to 25 years and have worked across various youth residential and disability care settings in Australia (See Table 1). Participants originated from diverse cultural backgrounds, including Australian-born, African, South-East Asian, and European heritage, and had prior experience in sectors such as disability support, youth justice, and human services. Shift patterns ranged from morning, day, afternoon, to active night shifts, reflecting the operational diversity of residential care. Sampling decisions were informed by norms for qualitative sufficiency and saturation (Guest et al., 2013), with openness to recruit additional interview participants if new information emerged during analysis.

Data Collection

Data were collected within out-of-home care agencies operating in Melbourne, Australia. Agencies included government-funded residential units and non-government organisations (NGOs) providing medium-to-long-term residential care for adolescents. Melbourne's diversity and the policy emphasis on trauma-informed practice made it an appropriate setting for exploring both peer-based coping strategies and localized interventions. Individual interviews followed a semi-structured schedule oriented to theme validation and elaboration. Interviews lasted 30–60 min and provided space for participants to discuss experiences they were reluctant to share in a group (e.g., experiences of discrimination or identity-related stressors)(DiCicco-Bloom & Crabtree, 2006). All sessions were audio-recorded and transcribed verbatim.

Table 1 Demographic composition of study participants (interviews and focus groups)

Data Source	Number of participants	Gender	Age range	Years of experience	Type of residential setting
Individual Interviews	20	12 Male, 8 Female	22– 40+	2–25 years	Youth residential care / out-of-home care settings in Australia
Focus Group 1	4	1 Male, 3 Female	~22–45+	2–20 years	Residential out-of-home care including therapeutic and high-needs placements
Focus Group 2	5	4 Male, 1 Female	~23–32	3–8.5 years	Youth residential care across metropolitan and regional settings
Focus Group 3	4	1 Male, 3 Female	~23–30	3–7 years	Residential care for children and young people in out-of-home care
Focus Group 4	5	4 Male, 1 Female	~24–32	~4–8 years	Youth residential care settings in Australia
Focus Group 5	4	3 Male, 1 Female	22–40+	7–14 + years	Residential youth care and disability-related residential services

Recruitment and Consent

Agency managers and practice leads were contacted initially to explain the study aims and request site support. Recruitment used a combination of (a) emailed study flyers distributed by agencies to eligible staff, (b) in-service presentations where the researcher briefly described the study and answered questions, and (c) optional snowball referral by participating staff. Interested workers were given a plain-language participant information sheet explaining study objectives, confidentiality protections, voluntary participation, and local support options. Written informed consent was obtained prior to participation; audio consent was used when participants joined remotely and could not sign in person. Participants received an honorarium to acknowledge their time and to reduce barriers to participation.

Data Management and Analytic Approach

Transcripts were managed in NVivo to support systematic coding and auditability; and a reflexive thematic analysis approach as described by Braun and Clarke (2006, 2019) was followed. The analytic process involved:

1. Familiarization: this entails reading the transcripts multiple times, noting initial ideas and patterns. Field notes and reflexive memos captured nonverbal cues and facilitator reflections;
2. Generating initial codes: Using an inductive orientation to code a subset of transcripts to generate descriptive codes. Coding was iterative; codes were refined as new data were considered;
3. Searching for themes: Codes were grouped into candidate themes through collaborative mapping sessions; prioritizing themes that demonstrated recurrence across FGDs and were elaborated in interview data;
4. Reviewing and refining themes: Candidate themes were reviewed against the dataset for coherence, distinctiveness, and relevance to the research questions. Disconfirming cases and minority perspectives were actively sought;
5. Defining and naming themes: Themes were named to reflect conceptual depth (e.g., "Informal Peer Debriefing as a Default Support," "Reflective Supervision: A Patchwork Practice," "Cultural Belonging and Hidden Labour");
6. Producing the report: here the researcher selected illustrative quotes, contextualized findings within organizational realities, and linked themes to existing literature and practice recommendations.

Reflexivity and Researcher Positionality

Consistent with reflexive thematic analysis, the researcher acknowledged their active role in knowledge production. The first author has over 10 years of experience working as a Residential Support Worker (RSW) in out-of-home care settings in Australia and brings a culturally and linguistically diverse (CALD) background. This insider position informed access to participants and enhanced sensitivity to the emotional, relational, and cultural dynamics explored in this study, particularly in relation to trauma, identity, and workplace experiences.

While this positioning provided depth of understanding and facilitated rapport with participants, it also required ongoing reflexive engagement to critically examine assumptions and minimise potential bias throughout the analytic process. Reflexive memos were used to document assumptions, emotional responses, and interpretive decisions across all stages of the research process (Braun & Clarke, 2019). Rather than striving for neutrality, reflexivity was treated as a methodological strength, enhancing analytic transparency and depth.

Trustworthiness and Quality Assurance

Trustworthiness was enhanced through methodological triangulation (FGDs and interviews), reflexive memoing, thick description, and transparent documentation of analytic decisions. The study was reported in line with the COREQ checklist for qualitative research to strengthen transparency and rigor (Tong et al., 2007).

Findings

The resultant themes are organized into two overarching categories: Strategies workers use to build and maintain support networks (addressing research question (RQ) i) and Localized trauma-informed interventions that workers say they need (addressing RQ ii.), born from their stories which map the emotional and systemic terrain they describe.

Strategies Workers Use to Build and Maintain Support Networks

Theme 1: "We Lean on Each Other" – Peer Networks as the Emotional Backbone of Survival

Across the dataset, peer support was not just prominent, it was the core survival mechanism. Workers consistently described colleagues as their "frontline family", the people who "get it without needing the backstory" or those who "have your back". These networks formed the first point of emotional release after violent incidents, allegations, or overwhelming behavioural crises.

This was powerfully expressed in the focus group discussion (FGD), where it was reflected:

> Everyone acted like brothers and sisters. And at the end of the day, no matter how tough it was, you still went home feeling happy because you knew everyone had your back. It felt like we were a great team – the bonding was strong. Honestly, that's what kept me going and what keeps me working even now.

Similarly, another participant described peer reliance as a practical safety mechanism rather than just emotional support:

> If one person is being targeted or challenged by a young person, the other can step in and engage while they de-escalate or take a moment. It requires strong teamwork, and when that teamwork is missing or not smooth, it becomes very challenging.

Peer debriefs were informal, immediate, and deeply human, such as conversations in the car park, dark humour in the staff room, and reassuring glances during escalations. As one participant put it:

> There've been times when I've had a tough shift, and someone from the team will call to check in asking, 'Jay, do you need help? Do you need someone to talk to?' For me personally, I think I deal with problems a bit differently than others. I feel like I'm mentally strong enough to get through it, but it's still good to know that support is there if I need it.

Workers leaned on one another not simply for emotional reassurance, but for practical wisdom: "Try this instead next time," "He responds better when you give space," "Let me step in." As one focus group member stated, the real support comes from "the person standing next to you." This relational dependence was also evident, where a participant stated:

> He said he's where he is today because of support workers like a few of us who stood by him at the time. It was really inspiring for me, just one more reason to keep going.

However, the reliance on peers was double-edged. When teams functioned well, workers felt held and grounded. But when teams were fragmented by turnover, inexperience, or poor leadership, workers described feeling exposed and alone. A participant captured this vulnerability:

> "Sometimes, you find yourself working overtime or covering long hours because of staff shortages… it made me realise the importance of knowing when to draw the line, when to retreat and when to re-engage.". As several participants noted, the collapse of team cohesion often preceded burnout positioning peer networks not as optional support, but as a structural survival system.

Theme 2: Personalized Rituals of Emotional Boundaries and Self-Preservation

Alongside relational supports, workers developed highly individualized coping rituals – rigid boundaries that helped them survive chronic exposure to trauma. Many described the "ritual of disconnection": sitting in the car for thirty minutes to decompress, going straight to the gym after a night shift, turning off work phones, or having "non-negotiable Sundays" reserved for family.

Some participant described intentional self-care and strategic disengagement:

> When I've had a difficult shift, I like to practice a bit of self-care. I spend time with my family, catch up with friends, and laugh… Sometimes, you survive by switching things up for a while – maybe moving to a different house if your current environment is chaotic, rotating from your usual shift to another, or even working in a different unit while you repair relationships or recover.

Some articulated the emotional toll of maintaining professional composure:

> There were days I'd clock off, go home, and wonder, 'How did I even make it through today without completely losing my mind?' Or, 'How did I manage to stay professional and not act out of character?' Those moments really stay with you.

For others, emotional self-regulation became a professional ethic; as a participant explained:

> The general understanding is that you shouldn't come into a shift if you're not in a good place emotionally, because the clients… tend to absorb your energy… If you go in with negative energy, you're going to get negative energy in return.

While another said: "If someone takes the work home with them, they're going to struggle, because this job can definitely be stressful… So my advice is – unpack it when your shift ends and leave it there."

These practices served as psychological buffers, allowing workers to keep the job from interfering with their personal lives.

Others adopted "strategic engagement" – selectively refusing high-risk shifts, rotating houses to avoid re-traumatization, or carefully managing their emotional investment. Far from avoidance, workers framed these strategies as intelligent self-preservation in an environment where organizational structures often failed to protect them.

For some, culture provided resilience: prayer, meditation, shared food, or family grounding. For others, identity became a vulnerability – particularly for (CALD) workers who navigated both client-directed racism and systemic misrecognition within their organisations.

Theme 3: Reflective Supervision as a Patchwork Practice – Invaluable when Skilled, Harmful when Poor

Workers' experiences of reflective supervision ranged from deeply restorative to entirely absent. When supervisors were skilled, i.e., experienced, empathic, culturally aware, supervision offered a vital space for emotional safety, grounding, and professional growth. Workers described these moments as "being seen."

But for many, supervision existed only on paper, delivered by inexperienced managers or reduced to compliance checks. Several workers described supervision that felt punitive, rushed, or disconnected from reality. For others, it simply didn't happen. A study participant highlighted the protective role of structured debriefing:

> I really think those debriefs should have happened weekly while she was in our care. They would have provided essential support to the workers on the floor." In contrast, another participant described the consequences of unsupported exposure:

> I was thrown straight into the deep end, especially in a company that didn't provide enough education or training to prepare you… It wasn't until I later read about vicarious trauma that I realised I had been carrying her trauma with me.

This inconsistency created inequity; for instance, two workers doing the same job could experience entirely different levels of support depending on the competence and personality/nature of their supervisor.

Workers Need Localized Trauma-Informed Interventions

Theme 4: Safety as the Foundation – "If I don't Feel Safe, I Can't Keep Anyone Safe"

Workers placed safety – physical, psychological, cultural – at the centre of any meaningful trauma-informed intervention. They repeatedly argued that no amount of training or policy could compensate for unsafe working conditions. One participant articulated this clearly:

> If we're not properly trained or equipped – not just from management but also in terms of adequate staffing – it becomes extremely difficult. Some houses should be staffed with at least two people, both during

> the day and at night. But often, we're left short-staffed and exposed.

Safety failures were not abstract. A participant described a life-threatening incident:

> She started saying she wanted to kill herself and ran out of the house, onto the street… I was on the phone with the police… Somehow, the truck driver managed to swerve just in time… I still carry that moment with me. Every single day. It doesn't leave you.

Similarly, another participant recounted an extremely stressful incident involving a young person with a knife and wrench: "A few of them ended up forcing their way into the office… one of them managed to grab my car keys and ran off. I quickly realized what had happened… He then threw a few punches at me. I blocked them and stepped away. But then he went back inside, grabbed a wrench and a butter knife, and started chasing me and my colleague down the street".

Another participant said: "If the management doesn't ensure that my work environment is safe, how am I supposed to provide safety for the young person I'm looking after?"

These narratives anchored workers' insistence that safety is not a luxury but a trauma-informed necessity.

They identified three non-negotiables:

1. Double-staffing and an end to lone shifts.

Being left alone during violent incidents was described as one of the most traumatic aspects of the work. Workers insisted that double-staffing is not a luxury but an essential safety requirement.

ii. Consistency of boundaries and team responses.

Inconsistent rules, unpredictable enforcement, and mixed messages often across shifts created instability for both staff and young people. Workers saw consistency not as discipline but as a trauma-informed necessity.

iii. Timely, transparent support during and after allegations.

False allegations were experienced as deeply traumatic, especially for CALD workers who felt they were presumed guilty as charged before they could tell their side of the story. When responses were slow, vague, or punitive, workers' trust in leadership deteriorated sharply. Conversely, swift, transparent support restored morale and dignity.

Theme 5: Cultural Belonging and the Hidden Labour of Navigating Race, Identity, and Misrecognition

Identity shaped how workers experienced trauma, accessed support, and were perceived by colleagues and young people. One study participant described the emotional vulnerability of cultural proximity:

> "The first young person I ever worked with was a very personal experience for me. I'm South Sudanese myself, and she was half Sudanese… watching her being taken away from her parents… that was very triggering for me." Similarly, another participant noted:

> "Just seeing my own people – kids from a similar background – that really affected me… It leaves a mark, one way or another. It's not something you just brush off at the end of a shift." CALD workers described facing racial slurs from young people, feeling scrutinized or disbelieved during allegations, navigating cultural stigma around help-seeking, and performing the extra labour of "proving" their competence. This was encapsulated in a participants recollection that: "Then on the negative side… Sometimes they use racial slurs against you. And there are also false allegations. These are some of the things that happen, and they can really wear you down." These experiences were often invisible to managers, leaving workers feeling unprotected.

A participant recounted their experiences with racial stereotyping:

There have definitely been times when I've worked with clients who had preconceived ideas about people based on skin colour… In those moments, I try to see it as an opportunity. It's a chance to represent something different - to challenge those stereotypes…" ; and additionally, used the opportunity to learn from cultural differences as was succinctly recounted here:

Working with Indigenous clients, for example, was a huge learning curve for me. The intergenerational trauma they've experienced is significant, and I came to realize that some of our responses to certain behaviors or situations - if we're not careful, can actually trigger that trauma.

A trauma-informed system, they argued, must explicitly address cultural safety and embed anti-racist practices into supervision, incident reviews, and leadership decisions.

Theme 6: "We Need to be Seen and Heard" – Workers' Blueprint for a Truly Trauma-Informed System

Workers did not simply critique existing structures they articulated a clear, hopeful blueprint for what real trauma-informed practice would look like. One participant summarised this ethos:

> Looking after yourself is very important in this industry. If you don't take care of yourself, you won't be able to support the client in the first place. That's why management in every organization should prioritise the safety and wellbeing of staff.

Another participant said:

> …Maybe it's about improving the process - maybe just being heard… Employees… really need to feel heard by the organization… giving staff the opportunity to engage in feedback processes - like a suggestion box… Simple, but effective.

They envisioned: (i) Genuine frontline voice in organisational decisions; (ii) Regular, skilled, reflective supervision, not box-ticking; (iii) Dedicated wellbeing officers for non-punitive check-ins; (iv) Mandatory, paid team-building to maintain cohesion; (v) Proactive relief after critical incidents (e.g., paid time off); (vi) Training delivered by people with real frontline experience; (vii) Systems that prioritise staff safety before documentation or procedure.

Furthermore, a recurring sentiment across interviews and the FGD was: "If the organisation took care of us the way we take care of the kids, everything would change ."

Discussion

This study set out to understand how residential support workers (RSWs) in out-of-home care make sense of the emotional demands of their work, the kinds of support networks they rely on, and the trauma-informed interventions they believe are needed. The findings reinforce long-standing evidence that residential care work is emotionally complex, and often undertaken within resource-strained organisational environments (Barford & Whelton, 2010; Mclean et al., 2011). The results also extend the literature by providing a vivid, grounded account of how workers construct their own micro-systems of support in the absence of consistent organisational structures. The discussion below connects these findings with existing research, highlights the centrality of peer relationships, and argues for the development of localised, culturally responsive trauma-informed interventions that reflect the realities of residential care work.

Peer Support as the Central Coping Mechanism

A major contribution of this study is the clear affirmation that peer support operates as the emotional backbone of survival for RSWs. Workers consistently described colleagues as the people who "get it without needing the backstory," positioning peer relationships as their first line of debriefing, learning, and emotional regulation. This aligns strongly with research showing that peer cohesion acts as a protective factor against burnout, secondary traumatic stress, and job turnover in residential settings (Barford & Whelton, 2010; Lizano et al., 2014; Olaniyan et al., 2020; Xu et al., 2024). In the broader trauma literature, informal peer conversations have been shown to help workers metabolise difficult emotions and restore a sense of shared meaning after exposure to client trauma (Bride, 2007; Newell & MacNeil, 2010). Rather than functioning as isolated acts of coping, peer support practices operated as an embedded relational infrastructure through which workers collectively regulated distress, restored psychological safety, and sustained their capacity to remain in emotionally demanding roles.

Importantly, the findings also highlight the fragility of this system. When teams were fragmented through turnover or poor leadership, workers described a sharp decline in their sense of safety and resilience. This reflects previous research demonstrating that fragmented teams increase emotional exhaustion and reduce the availability of co-regulation within high-stress environments (Mclean et al., 2011; Olaniyan et al., 2020). Thus, while peer support functions as a powerful emotional and relational buffer, it is not sufficient on its own to sustain worker wellbeing, particularly in contexts where organisational structures undermine consistency, stability, and safety. In such settings, informal peer networks often operate as compensatory systems, filling gaps left by inconsistent supervision, unstable staffing, and uneven managerial responses to critical incidents. This places an unsustainable burden on workers to support one another in the absence of reliable institutional care, reinforcing the need for trauma-informed organisational systems that structurally embed safety, continuity, and accountability alongside peer-based support.

Individual Boundaries and Personalised Coping Routines

Workers' individual coping approaches such as gym routines, time in the car decompressing, rigid boundaries around time off, or prioritising family rituals, mirror established evidence that self-regulated boundary setting is key

for managing chronic exposure to trauma (Killian, 2008; Rienks, 2020; Sabin-Farrell & Turpin, 2003). Many of the strategies identified in this study map closely onto what the literature describes as "emotion-focused coping" and "adaptive detachment," both of which help buffer the effects of secondary traumatic stress when organisational support is limited (Baird & Kracen, 2006; Chapman et al., 2024).

However, their responses also nuance this literature by showing that these practices are not simply "self-care" – but intentional, strategic acts of psychological preservation. The narratives demonstrate that workers actively calibrate their emotional availability, especially when organisational structures fail to provide consistency or safety. This extends existing research by framing self-preservation not as a personal deficit or avoidance strategy, but as a rational response to systemic gaps (Figley, 2013).

Reflective Supervision: Inconsistent, but Transformative When Done Well

Reflective supervision emerged as a paradox. When supervisors were skilled, empathic, and experienced, workers described the process as restorative and grounding. This aligns with literature showing that reflective supervision fosters emotional processing, reduces burnout, and enhances trauma-informed care practices (Gibbs, 2001; Knight, 2020).

However, the majority of participants described supervision as irregular, rushed, or entirely absent, echoing the persistent gap between the policy promise of reflective supervision and the reality of implementation in residential care (McPherson & Macnamara, 2021). Research consistently shows that under-trained supervisors, high turnover, and administrative overload undermine supervision quality and leave frontline workers unsupported (Griffiths et al., 2020; Mor Barak et al., 2009). Rather than reflecting isolated supervisory practices, these patterns point to a deeper organisational fragmentation in how care, support, and responsibility are structured. When reflective supervision is not embedded as a consistent organisational standard, it becomes contingent, personalised, and unevenly distributed, producing informal hierarchies of care among workers. This undermines trauma-informed principles of safety, equity, and predictability, and shifts responsibility for psychological protection away from institutions and onto individual managers and workers themselves. (Paustian-Underdahl et al., 2017).

The Foundational Role of Safety in Trauma-Informed Care

Workers in this study placed safety – physical, emotional, and cultural – at the centre of what it means to be trauma-informed. This echoes the foundational principles outlined by the Substance Abuse and Mental Health Services Administration (2014), where safety is the first pillar of trauma-informed practice. For these workers, trauma-informed care was not primarily about training modules or documentation; it was about working in pairs or teams per shifts, consistent behavioural responses across shifts, and immediate, transparent support after allegations. The literature supports this emphasis. Research has shown that frequent exposure to violence, threats, and unpredictable behaviour significantly increases the risk of burnout, compassion fatigue, and PTSD symptoms among residential care workers (Ireland et al., 2022; Kilby et al., 2025; Rudkjoebing et al., 2020). Lone working – something many workers in this study described as terrifying – has been directly linked to increased injury risk and psychological distress. Consistent staffing practices and predictable routines have been shown to stabilise both workers and young people, reducing critical incidents and improving relational safety (Mclean et al., 2011).

Cultural identity, racialized labour, and the invisibility of cultural safety

One of the most significant contributions of this study is the insight that CALD workers experience additional layers of vulnerability – racial slurs from young people, increased suspicion during allegations, and cultural stigmas around help-seeking. These findings resonate with literature that argue that cultural safety remains underdeveloped in Australian care settings despite repeated calls for reform (Johnstone & Kanitsaki, 2007; Magee et al., 2024; Oates, 2020),.

The hidden labour of constantly "proving" competence, managing racialised interactions, and navigating cultural expectations around emotional expression is rarely acknowledged in organisational policy. The present study adds empirical weight to the argument that trauma-informed systems must explicitly include cultural safety as a core element, not an optional add-on. Workers' narratives highlight that without cultural belonging, other safety measures feel incomplete.

Workers' Blueprint for a Trauma-Informed System

A central finding of this study is that workers articulated a coherent, practice-based understanding of what trauma-informed systems should look like, grounded not in abstract principles but in daily operational realities such as staffing

stability, relational safety, peer governance, responsive supervision, and organisational accountability. Rather than positioning trauma-informed practice as a top-down framework to be implemented, participants described it as something already enacted informally through peer structures, collective coping practices, and locally developed support mechanisms. This shifts the conceptual framing of RSWs from passive recipients of organisational care to active producers of trauma-informed knowledge and system design. Their recommendations – voice in decision-making, consistent supervision, wellbeing officers, incident-responsive leave, skilled training, and team-building – echo and extend recent scholarship advocating for relational, contextually grounded trauma-informed organisational cultures (Levenson, 2017).The difference is that these recommendations emerged directly from frontline narratives, offering a level of authenticity and practicality often missing from top-down policy documents. The findings contribute meaningfully to the literature by proposing localized, worker-driven intervention pathways that reflect the cultural, emotional, and operational realities of Melbourne's residential care environment.

In sum, the findings highlight that trauma-informed care for young people is inseparable from trauma-informed care for the workers who support them. A system that prioritises worker safety, cultural belonging, and relational connection is not only more ethical but more effective. The stories shared by these workers offer both a critique and a roadmap – evidence-based, emotionally grounded, and urgently needed.

Implications for Practice

The findings of this study reinforce what many practitioners in Out-of-Home Care (OOHC) already know but often struggle to articulate within organisational structures; which is that the emotional labour of residential support work is profound, cumulative, and largely invisible.

Supporting young people with complex trauma inevitably exposes workers to secondary traumatic stress, compassion fatigue, and, over time, burnout. Yet these impacts are not inevitable outcomes; they are, in many ways, symptoms of system-level gaps. This section outlines practical, actionable steps that OOHC agencies, policymakers, and training institutions can adopt to create safer, more sustainable practice environments for RSWs.

i. Normalising trauma exposure as an occupational reality.

One of the most significant practice implications is the need for organisations to openly acknowledge trauma exposure as inherent to residential care work. Far too often, emotional strain is interpreted as individual weakness rather than a predictable response to chronic trauma environments. Agencies should integrate discussions of vicarious trauma, emotional exhaustion, and coping strategies into everyday supervision, team meetings, and reflective practice sessions. Normalising this experience reduces stigma and encourages early help-seeking before problems escalate.

ii. Embedding routine, high-quality reflective supervision.

Reflective supervision needs to shift from being an administrative task to a protected supportive space where workers can process emotionally heavy experiences. Supervisors should be trained in trauma-informed leadership, including how to identify early warning signs of worker distress, strategies for co-regulation, and the use of reflective questioning. Organisations should commit to minimum supervision frequencies and ensure that sessions are uninterrupted, confidential, and psychologically safe.

iii. Strengthening organisational trauma-informed culture.

A trauma-informed organisation does not focus solely on the needs of young people, it extends that same ethos to staff. Practical steps toward this include:

a) Providing clear communication channels and predictable routines within the workplace.
b) Ensuring fair workloads and adequate staffing levels to reduce crisis-driven environments.
c) Training all staff (including managers, HR teams, casual relief workers, and allied professionals) in trauma-informed principles.
d) Encouraging collaborative, team-based responses to challenging behaviours rather than isolating responsibility on individual workers.

iv. Investing in professional development focused on emotional resilience.

Training programs for RSWs tend to emphasise behavioural management, crisis response, and documentation requirements. While essential, these do not equip workers to navigate the emotional realities of their role. Agencies should prioritise training in:

a) Emotional resilience and stress regulation.
b) Psychological first aid.
c) Mindfulness and grounding techniques.
d) Boundary-setting and healthy emotional detachment.
e) Peer-support facilitation.

These skills help workers sustain themselves in high-intensity environments and promote greater job satisfaction and retention.

v. Implementing peer support structures.

Peer support is one of the most effective yet underused forms of protective intervention. Agencies should develop structured peer-support networks, where RSWs can share experiences, debrief informally, and access mentoring from more experienced staff. Peer groups can also serve as early detection systems when a colleague is struggling, ensuring timely intervention.

vi. Prioritising Worker Safety in Policy and Program Design.

Any trauma-informed residential care model must ensure that worker wellbeing is treated as a core component, not an afterthought. This means:

a) Integrating worker wellbeing into organisational policy documents;
b) Incorporating staff safety considerations into incident review processes;
c) Allocating budget lines specifically for staff wellbeing initiatives;
d) Developing crisis-response protocols that include psychological follow-up for staff.

Policies should make explicit that staff are not expected to manage chronic high-risk situations without appropriate support, training, and resources.

vii. Creating opportunities for recovery and rest.

Given the sustained emotional loading of residential care work, agencies should encourage practices that protect and replenish the psychological resources of workers. Examples include:

a) Ensuring adequate leave for rest and recovery;
b) Offering roster patterns that minimise sleep disruption and exhaustion;
c) Providing access to Employee Assistance Programs (EAP) with clinicians trained in trauma and child protection contexts;
d) Allowing mental health days without punitive consequences.

viii. Strengthening cross-sector collaboration.

OOHC workers often operate within complex systems involving education, mental health, justice, and child protection services. Interagency collaboration reduces the emotional burden on RSWs by spreading responsibility and ensuring holistic support for young people. Regular cross-sector case conferences, joint training sessions, and unified care plans can significantly reduce role strain and feelings of isolation among workers.

ix. Building evidence-based organisational responses.

Finally, agencies need to move beyond ad-hoc responses to worker trauma and instead adopt evidence-based frameworks grounded in current research. This includes:

a) Conducting periodic staff wellbeing audits.
b) Monitoring rates of burnout, turnover, and psychological injury claims.
c) Evaluating the effectiveness of wellbeing programs.
d) Involving frontline workers in program co-design.

Embedding evaluation into organisational practice ensures that supports remain relevant, responsive, and aligned with the realities on the ground.

Ultimately, the wellbeing of Residential Support Workers is inseparable from the quality of care provided to young people. Investing in trauma-informed organisational cultures, reflective supervision, and sustainable working conditions is not only an ethical responsibility, it is central to improving outcomes for the young people who rely on these services. When workers feel valued, supported, and emotionally safe, they are better positioned to offer stable, compassionate, and effective care.

Limitations

As with any qualitative inquiry, this study is shaped by a number of limitations that should be acknowledged with transparency. First, the findings are grounded in the experiences of a specific group of Residential Support Workers operating within a particular regional and organisational context. While the themes resonate strongly with broader literature on worker trauma in Out-of-Home Care, the depth and nuance of these experiences may vary across different agencies, cultural contexts, or care models. This means that the transferability of the findings should be approached thoughtfully rather than assumed.

Second, the reliance on self-reported accounts introduces the possibility of recall bias or emotional filtering. Participants may amplify or understate certain experiences based on the timing of the interview, their emotional state, or their relationship with their employer. Although efforts

were made to create a safe and non-judgmental interview environment, it is possible that some participants withheld sensitive information out of fear of organisational repercussions or personal discomfort.

Third, the study captures a snapshot in time rather than the evolving nature of trauma exposure among support workers. Residential care is dynamic – policies shift, staffing changes occur, and the needs of young people fluctuate – meaning that worker stress and resilience may look different across seasons and organisational cycles. A longitudinal design may have offered a deeper understanding of how trauma exposure accumulates or diminishes over time.

These limitations do not undermine the credibility of the findings; rather, they highlight the complexity of studying trauma in human service settings and the need for continued research in this area.

Conclusion

This study sheds light on an important but often overlooked reality: Residential Support Workers carry an immense emotional burden as they support young people living with the effects of profound trauma. Their work is deeply relational, frequently unpredictable, and emotionally taxing in ways that cannot be fully understood through policy documents or organisational reporting alone. By listening closely to workers' lived experiences, this study reveals not only the weight of their challenges but also their resilience, commitment, and genuine desire to make a difference in the lives of young people. The findings make it clear that trauma exposure among RSWs is not merely an individual issue; it is a systemic concern that requires coordinated organisational and policy responses. When workers are unsupported, overstretched, or left to navigate traumatic incidents in isolation, the consequences ripple outward affecting team cohesion, organisational stability, and ultimately the quality-of-care young people receive. Conversely, when workers feel valued, protected, and emotionally safe, they are better equipped to provide the predictable, nurturing environments that are essential to healing and recovery. In highlighting these dynamics, this study contributes to the growing call for trauma-informed organisational cultures that extend support not only to children and young people but also to the adults who care for them. It underscores the importance of reflective supervision, peer support, adequate staffing, and workplace practices that prioritise psychological safety. Most importantly, it reminds us that the well-being of Residential Support Workers is inseparable from the wellbeing of the young people they serve. Ultimately, addressing worker trauma is not just a workforce issue, it is a child welfare issue. By investing in the emotional health and professional sustainability of RSWs, organisations and policymakers can make meaningful strides toward creating safer, more stable, and more compassionate Out-of-Home Care environments. This study is a step in that direction, offering insights that can inform practice, shape policy, and inspire further research.

Author Contributions J.O. conceived and designed the study; led the ethics application; conducted data collection including focus group discussions and individual interviews; performed data analysis using reflexive thematic analysis; and drafted the manuscript. D.N.M. and M.P. provided academic supervision, contributed to the conceptual framing and methodological rigor of the study, and critically reviewed and provided feedback on manuscript drafts. All authors reviewed and approved the final manuscript.

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Data Availability No datasets were generated or analysed during the current study.

Declarations

Competing interests The authors declare no competing interests.

Ethical Approval Ethical approval was obtained from the University Human Research Ethics Committee and adhered to the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2023). Ethical approval was obtained prior to data collection. Participants were provided with detailed information about the study and gave informed consent before participation. Confidentiality was ensured through the use of pseudonyms and removal of identifying details from transcripts. Given the emotionally sensitive nature of the discussions, participants were reminded of their right to pause or withdraw at any time. Information about support services was made available should participation raise distress. Ethical conduct followed established guidelines for qualitative research involving vulnerable populations and frontline workers (Tracy, 2024).

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