Committed, Caring and Compassionate: Co. Kildare Workforce Wellbeing, Attitudes toward Trauma-informed Care, COVID concerns and Ongoing Training Needs

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Overview

This report details the results of a professional training needs analysis, which was undertaken by Kildare Children and Young People's Services Committee (CYPSC), in collaboration with Maynooth University and Kildare Youth Services, in response to a key priority in relation to workforce development as identified in Kildare CYPSC three-year Action Plan (2019-2021). The training needs analysis was targeted at all professionals working with children, young people and/or families in Co. Kildare. An online survey was designed and distributed to agencies and individuals across the county. In addition to exploring completed CPD and future training needs, the survey also included questions on COVID-19 challenges and training needs, as well as exploring professional wellbeing, self-compassion and attitudes toward trauma-informed care. A total of 132 participants (79% female) completed the survey. Results showed key priorities for training in areas of trauma-informed practice, cultural diversity, parenting support, mental health, and domestic violence. The study also found that Kildare professionals are faring well in terms of their own wellbeing, although the Covid-19 pandemic created new and diverse challenges. It highlights the diverse range of skills and expertise held by professionals in County Kildare. It also apparent that there is considerable interest in engaging in further CPD and that Kildare professionals endorse empathy-oriented and relationship-focused values and dispositions. A number of recommendations about ongoing work force development are provided.

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The Research Context

Introduction

This paper reports on the findings of a professional training needs analysis undertaken by Kildare Children and Young People's Services Committee (CYPSC). The training needs analysis was undertaken in response to a key priority identified in the current Kildare CYPSC Action Plan (2019-2012), which was to support the workforce in Co. Kildare, in order to enhance their capacity to deliver quality services and supports to children, young people and families throughout the county.

The Role of Children and Young People's Services Committee

Children and Young People's Services Committees (CYPSC) are a key structure identified by Government to plan and co-ordinate services for children and young people in every county in Ireland. The overall purpose is to improve outcomes for children and young people through local and national interagency working.

CYPSC are county-level committees that bring together the main statutory, community and voluntary providers of services to children and young people. They provide a forum for joint planning and co-ordination of activity to ensure that children, young people and their families receive improved and accessible services. Their role is to enhance interagency co-operation and to realise the national outcomes set out in *Better Outcomes, Brighter Futures: the national policy framework for children and young people 2014 - 2020*.

Thus, each county level CYPSC works towards achieving five national outcomes – these are that children and young people:

- Are active and healthy, with positive physical and mental wellbeing
- Are achieving full potential in all areas of learning and development
- Are safe and protected from harm
- Have economic security and opportunity
- Are connected, respected and contributing to their world

The ultimate goal of CYPSCs is to improve outcomes for all children and young people in Ireland.

Kildare CYPSC was established in 2010 with a co-ordinator appointed in 2011. Representatives on Kildare CYPSC come from a range of statutory, voluntary and community organisations working in the county (see Appendix A CYPSC Membership). Kildare CYPSC identifies priority areas for the county (based on consultation, review of literature, data analysis etc) and develops three-year action plans to target these priorities. The county is currently working off its third action plan (2019-2021).

Brief Profile of Kildare

Kildare CYPSC acknowledges the positive characteristics of the county, particularly the range of natural amenities available, the supports provided to families and the dynamic approach to inter-agency working that exists. Overall however, the data contained in the Action Plan highlights historic under investment in services in County Kildare, a large and growing population of children and young people, high levels of need for disability services, youth mental health and domestic violence services, as well as geographic gaps in existing service coverage, high rates of suicide, mortgage indebtedness, and nearly 10% of the population living in marginalised or disadvantaged communities. Kildare CYPSC has thus concluded that service levels in Co. Kildare are not sufficient to meet the needs of our children, young people and families.

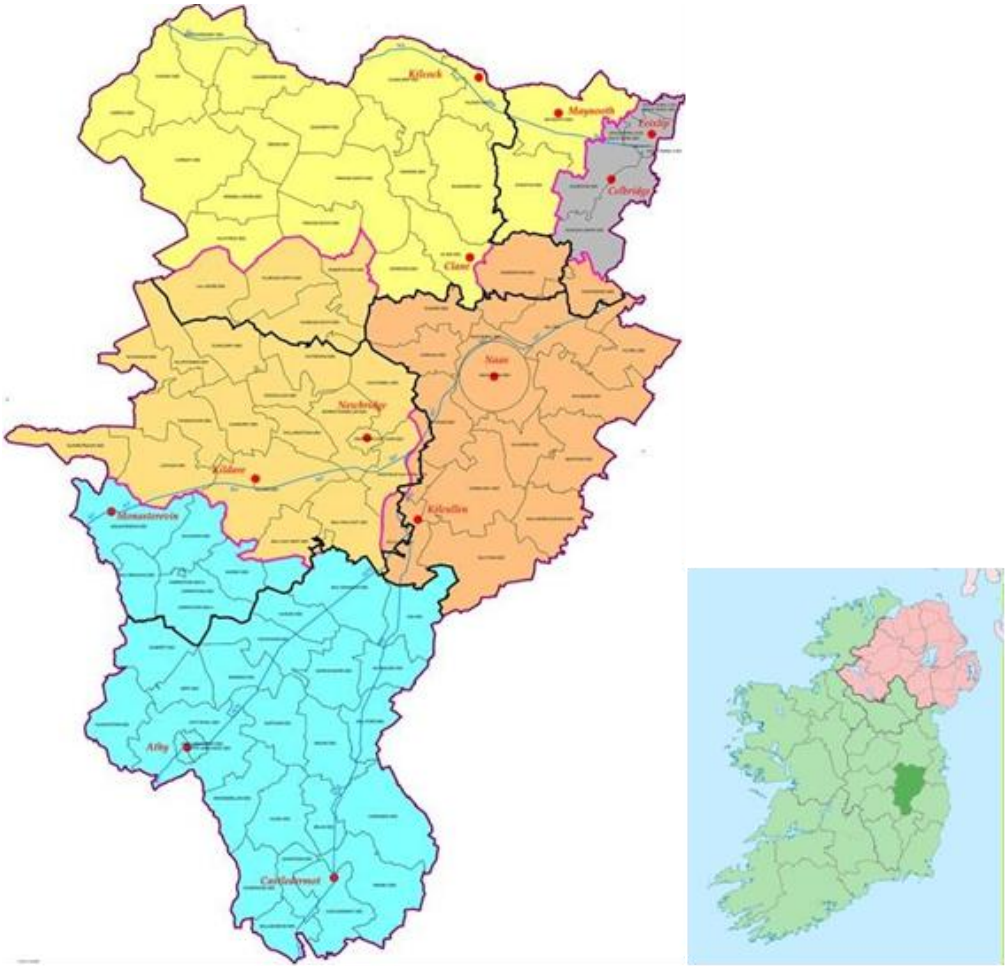

Figure 1 Map of Co. Kildare

Notable Characteristics and Features of Co. Kildare[1]
• Kildare is a significant population base within the State (4.7% of the total). As a county, it has the fifth highest population, with only Dublin City, Cork County, Fingal and South Dublin with higher populations. • Kildare has a rapidly growing population. From 1996-2016, the growth rate is second highest in the State. • Kildare has the highest rate of young people aged 0-24 years in the State (81, 517/36.6%). • The birth rate in Co. Kildare exceeds the national birth rate. • Kildare is a diverse county in terms of population density, with a clear rural/urban mix. Approx. 72% of the county's population live on 5% of the county's total land area. • There are a high number of lone parent families with children under 15 in Co. Kildare. The 5th highest number in the State. • Co. Kildare has lower than national and regional rates of Travellers. Most Travellers in the county live in urban areas, with highest rates in the towns of Newbridge and Athy. • Co. Kildare has the 6th highest number of people with a disability in the State. This represents an increase of 13% since 2011. • Polish nationals represent by far the largest non-national community living in Co. Kildare. (30% of all non-nationals/3.3% of total population). • There are 2 Asylum Seeker Direct Provision Centres in Co. Kildare • Co. Kildare has a well-educated population, with 36.3% of the population with a third level degree or higher. However, there is clear geographical disparity in education attainment across the county. The west and southwest of the county have much lower rates, with Athy Municipal District having a rate of 24.9%. • A rate of progression to third level education by students from Co. Kildare has been recorded as 78%. This is the 11th lowest rate in the State. • The number of young people aged 16-25 years old who are not engaged in education, training or employment in the county is estimated to be 1100. • Kildare is a commuter county. A significant proportion of the workforce travel outside the county for work (39.1%/37340). • Co. Kildare has the 8th highest number of U25 year olds on the Live Register in the country after Dublin, Cork, Donegal, Wexford, Galway, Limerick and Louth. The rate of U25s on the Live Register in both the Athy and Newbridge offices substantially exceed the national average. • Kildare has an active property market, with increasing prices for rents and sales. • Since 2011, the total number of Private Rented households in Co. Kildare has increased by 3.7%. A sizeable proportion of Private rented housing is supported via State intervention funding schemes such as RAS, HAP and Rent Supplement. • There is a high level of mortgage indebtedness in the county. Kildare has the 5th highest number of Owner Occupiers with a Mortgage in the country and the 3rd

[1] Taken from the current Co. Kildare Children and Young People's 5-year plan, available here: https://www.cypsc.ie/_fileupload/Documents/Resources/Kildare/KildareCYPP20192021FINAL.pdf

highest rate.

- The number of recorded suicides in Co. Kildare in 2017 is the 3rd highest in the State.
- Over 1000 1-2-1 support sessions were provided to women by the local Domestic Violence support service in 2018. 38 women and 83 children were accommodated in the refuge. The service was unable to meet refuge requests for 150 women and 243 children.
- The total number of children in care in Kildare/West Wicklow Tusla area in 2018 was 148. The 2 most common primary reasons for admission were children welfare concerns and neglect. The total number of child protection and welfare cases in the area as of Dec 2018 is 742.
- There are 20,592 people in Co. Kildare living in small areas deemed to be disadvantaged, very disadvantaged or extremely disadvantaged, which represents 9.25% of the total population.

The local area needs analysis identified that in addition to the overall need for enhanced service levels across a range of essential services, a concerted inter-agency approach is required in relation to a number of key priority areas over the 3 years period (2019-2012). Table 1 details these priorities:

Table 1 Key Priorities Areas identified in Kildare CYPSC Action Plan (2019-2020)

Mental Health and Wellbeing	Domestic Violence
Family Support	Childcare Infrastructure
Parent Support	Inclusion of minority groups
Youth Facilities and Activities	Inter-Agency Coordination
Substance Misuse	Workforce Development
Progression Pathways in education, training and employment	Youth Participation
Child and Youth Development	Resourcing

Workforce Development

As the above table shows, workforce development was identified as a key priority area for Kildare CYPSC. Within the Action Plan, Kildare CYPSC articulated its commitment to supporting the workforce; both to value and acknowledge the workforce in their own right, and also to ensure quality services for children and young people by strengthening possibilities for professional development.

Recognising the importance of a co-ordinated, responsive approach to addressing workforce development, Kildare CYPSC committed to undertaking a training needs analysis of professionals working with children, young people and families in the county and to seek funding for training delivery in response to findings.

The commitment to workforce development aligns well with national and international best practice, as it is well recognised that the skills, knowledge, competencies, values and attitudes of the workforce delivering services for children are a determining factor in the quality of those experiences (Early & Bubb, 2004). Thus, national agencies like Tusla require a CPD strategy to ensure that staff members maintain up-to-date knowledge and skills as a foundation for professional practice (Tusla, 2016). The National Standards for the Protection and Welfare of Children (HIQA, 2012: Standard 5) advocates the need for regular training needs analyses and monitoring to ensure the delivery of effective and safe services.

The primary focus of the current work was to undertake a training needs analysis to ascertain the types of continuous professional development (CPD) that professionals have availed of and implemented in their practice, and to explore their current and future training/CPD needs. A Training Needs Analysis involves the identification of new knowledge, skills, attitudes and values that people require to meet their own and their organisation's development needs (Donovan & Townsend, 2004). The key aim of this study was to identify and analyse the CPD needs of staff and to identify gaps between current and required levels of knowledge skills, attitudes and values. The analysis targeted professionals across all sectors in Co. Kildare who work with children, young people and/or families.

A secondary aim of this research was to explore the professional wellbeing of the workforce. With growing awareness of the prevalence and impact of childhood adversity and the challenges this can pose for professional wellbeing, exploring these areas was deemed important in the context of the current work. Furthermore, given that the COVID-19 pandemic coincided with this training needs analysis, it was deemed important to include a small number of questions to enable participants respond to any pandemic-specific training needs or professional challenges.

Adverse Childhood Experiences and Trauma-informed practice

Given the prevalence and public health impact of Adverse Childhood Experiences (ACEs) and trauma, many human service settings are grappling with how to best address the effects of traumatic stress on clients, service users or students they serve.

Trauma-informed practice (TIP) is a term coined in the 1990s to describe service delivery that integrates an understanding of the pervasive biological, psychological, and social sequelae of ACEs and trauma with the ultimate aim of ameliorating, rather than exacerbating, their effects (Harris & Fallot, 2001; SAMHSA, 2014). Trauma-informed systems have the potential to help individuals affected by ACEs and trauma to feel safe, recover from trauma, and regain positive developmental trajectories (SAMHSA, 2014).

Both nationally and internationally, there is increased recognition of the need to raise awareness of the impact of trauma and to develop a trauma-informed workforce. Scotland, for instance, has developed a workforce development plan 'Knowledge and Skills Framework for Psychological Trauma' which will see all frontline services become trauma-informed (NHS Education, 2017). In Ireland, the recently published mental health policy, *Sharing the Vision* (DoH, 2020) asserts that services supporting mental health will adopt trauma-informed approaches to care, based on lived experience and individual need. This policy recommends that everyone at all levels of service provision have a basic

understanding of trauma and how it can affect families, groups, organisations and communities as well as individuals (Sharing the Vision, 2020).

However, little is known about professionals' attitudes toward TIP, or potential barriers and facilitators that indicate a readiness for implementing TIP; this is particularly true within the Irish context. Thus, it was considered important to explore professionals' attitudes in relation to TIP as part of the current study.

Professional Quality of Life, Secondary Traumatic Stress and Self-Compassion

It is recognised that professionals working with children who have experienced ACEs and trauma often report high levels of occupational stress, with serious implications for themselves, their clients, and their organisation as a whole. A growing literature has identified clinical work-related distress, including burnout and secondary trauma, experienced by practitioners who work with patients with histories of trauma, partner violence, drug abuse, suicidality and affective, anxiety and other serious disorders (Cohen & Collens, 2012; Salston & Figley, 2003). The emotional toll can jeopardize professionals' own mental health in the form of emotional exhaustion, depersonalization, compassion fatigue, vicarious trauma and lowered self-efficacy (Jenaro, Flores, & Arias, 2007; Newell & McNeil, 2010).

Furthermore, as noted above, Kildare has a large and growing population with high demand for services, yet the historic under investment means that service levels in Co. Kildare are not sufficient to meet the needs of our children, young people and families. Underinvestment in core services can impact staff wellbeing, potentially leading to stress and burnout (Earl, 2010). At present, little is known about the wellbeing of Co. Kildare professionals working with children, young people and families. The current work sought to address this gap in knowledge.

Compassion is a promising construct for frontline professionals in terms of its ability to promote psychological wellbeing and resilience to stress, as well as increase sensitivity to detect, tolerate and respond to distress in others (Gilbert et al., 2011). However, the potential benefits of self-compassion are yet to be thoroughly explored across diverse occupational groups. This study will advance existing knowledge by exploring the role of self-compassion in occupational stress and secondary traumatic stress, as well as how it contributes to a willingness to respond to distress in clients/students through trauma-informed practice.

COVID-19 Pandemic

The global COVID-19 pandemic has impacted professional work roles in a multitude of ways. It has exacerbated existing inequalities and this places new and increased demands on services (Fore, 2020). At the same time, services have had to change the way they operate in order to respond to their service users/clients as well as work within changing public health regulations and guidance. All of this brings increased demands and stress on professionals. Indeed, increases in stress and burnout in frontline professionals as a result of the pandemic have been highlighted (Tuzovic & Kabadayi, 2020; O'Toole & Simovska, forthcoming). Thus, within the context of the current study, it was deemed important to ascertain key COVID-related workplace challenges as well as any COVID-specific CPD needs. The following research questions guided this study:

Research Questions

1. What types of continuous professional development (CPD) training have professionals availed of and implemented in their practice?
2. What current and future training/CPD do professionals need/want?
3. How do respondents rate their professional quality of life?
4. What are respondents' attitudes towards and readiness for implementing trauma-informed practice (TIP)?
5. How do respondents rate their level of self-compassion?
6. What is the relationship between attitudes related to trauma-informed practice, self-compassion, and professional quality of life?
7. What are participants' key COVID-related workplace challenges and what do they have COVID specific CPD needs?

Methodology

Participants and Sampling

All professionals working with children, young people or families in Co. Kildare were eligible to participate. This included gardai, teachers, social workers, youth workers, psychologists, health care workers and more.

Participants were recruited primarily through email notification of the study from their organisation or from the Kildare CYPSC co-ordinator. In addition, details of the study and a link to the survey were advertised on social media.

The survey was open from May 11th - August 20th, 2020.

Survey Design and Structure

The survey was designed collaboratively with input from the research team, Kildare CYPSC, and Kildare Youth Services. It was an online survey, designed and presented using the Bristol online survey platform. The survey structure was as follows

- Information and consent form.
- Part I: Demographic questions: age range, gender, ethnicity, work role, organisation.
- Part II: CPD completed and applied in work setting; categorised under the following headings:
    - Parent support
    - Mental health
    - Substance misuse & preventing offending behaviour
    - Sexuality, relationships and domestic violence
    - Broad relational training approaches
    - Leadership, management & governance
- Part III: CPD needed
    - Participants were asked to identify top 3 training needs
    - Open ended Question: any new or emerging Covid-19 related training needs
- Part IV: Standardised measures of wellbeing, compassion and attitudes to trauma-informed care
    - Attitudes toward trauma-informed care (ARTIC)
    - Professional Quality of Life (ProQoL)
    - Self-Compassion questionnaire (SCS-SF)
    - Final open-ended Question: any Covid-19 related challenges

The Professional Quality of Life scale (ProQol5; Stamm, 2010) asks participants to reflect on relationships and compassion towards people they work with. The scale yields two aspects of professional wellbeing: Compassion Satisfaction (CS) and Compassion Fatigue (CF). CS describes the degree of satisfaction derived from doing your job well. Compassion fatigue is comprised of Burnout (BO) and Secondary Traumatic Stress (STS). BO is associated with a loss of hope and difficulties to carry out work duties effectively. STS asks about exposure to the trauma of others through work. The scale has been used in different contexts internationally and has been psychometrically validated (Stamm, 2010).

The SCS-SF (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) is a validated measure used to assess levels of self-compassion. The brief version of the scale was in this study

The ARTIC scale (ARTIC-35; Baker, Brown, Wilcox, Overstreet, & Arora, 2016) captures participants' attitudes towards trauma-informed care. It consists of five subscales which assess participants views on (1) the underlying causes of problem behaviour and symptoms, (2) responses to problem behaviour and symptoms, (3) on-the-job behaviour, (4) self-efficacy at work, and (5) reactions to work.

Ethical approval for this study was granted by Maynooth University Social Science Ethics Committee. Information and consent forms for participants are presented in Appendix B.

Findings

Overall, data from 132 participants was included in the analysis on the basis that they have indicated that they work with children, young people or families in Kildare. Participants were asked if they also worked in a different location; overall, 31.5% (N=41) indicated that they also worked in that field in west Wicklow, 20% (N=26) indicated that they work in a region other than Kildare or West Wicklow.

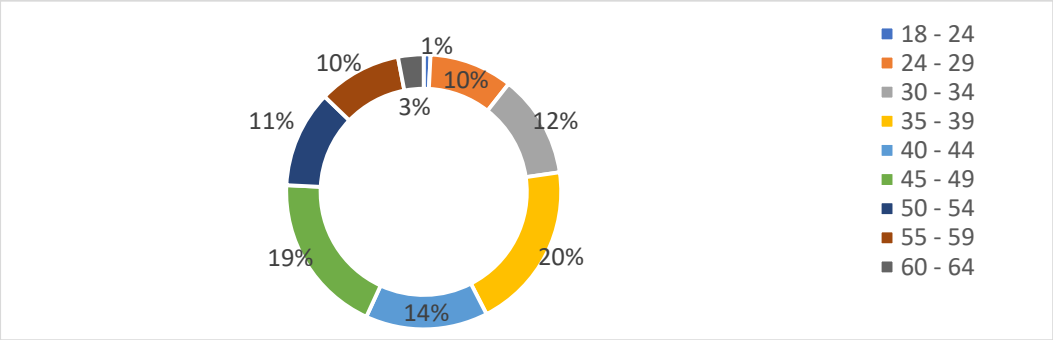

Figure 2 Age Breakdown

The majority of the sample was female (79.5%; N=105), and 92.4% (N=122) categorised themselves as White Irish, 7.6% (N=10) as any other White background. Figure 2 shows the age breakdown of the overall sample. The median age was between 35 and 39.

Participants were asked about their job title and the organisation they work for. These have been grouped into eight different areas, and are detailed in Figure 3 (see Appendix F Service Sector Breakdown). Participants indicated that they have spent between 2 months and 38 years working in that field, with an average of 13.55 years (SD=8.95). The average time participants have worked in their current role was 6.94 years (SD=7.35), the overall range was between 2 months and 32 years. About a quarter of participants (25.8%; N=34) have only ever worked in this field in the role they hold at the moment.

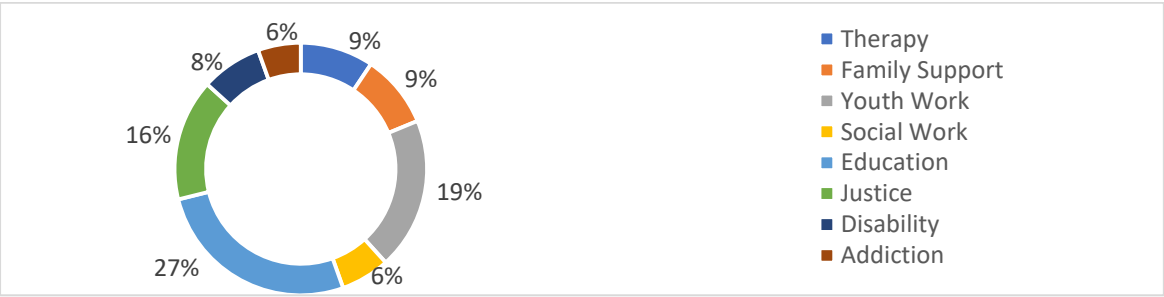

Figure 3 Field of Work. Note, N: 128. A small number of participants could not be categorised.

CPD Completed

Participants were given lists with existing training courses and were asked to indicate which of these courses they had completed over the last ten years. Participants were also asked if they applied the learning, knowledge, or skill set gained from the training in their work with children, young people and families. Figure 4 displays the ten most frequently completed courses. The full list can be found in Appendix C Completed Courses. Figures 4 toFigure 10 provide further detail on completed training courses, sorted by theme. Each graphic displays

the percentage of participants that indicated that they had completed a course, and applied it to their work.[2]

The average number of completed courses was 8.14 (SD=5.2). The range was between zero and 31 courses, with about a third of participants indicating that they had completed between three and six courses within the last ten years.

Most Frequently Listed CPD Courses

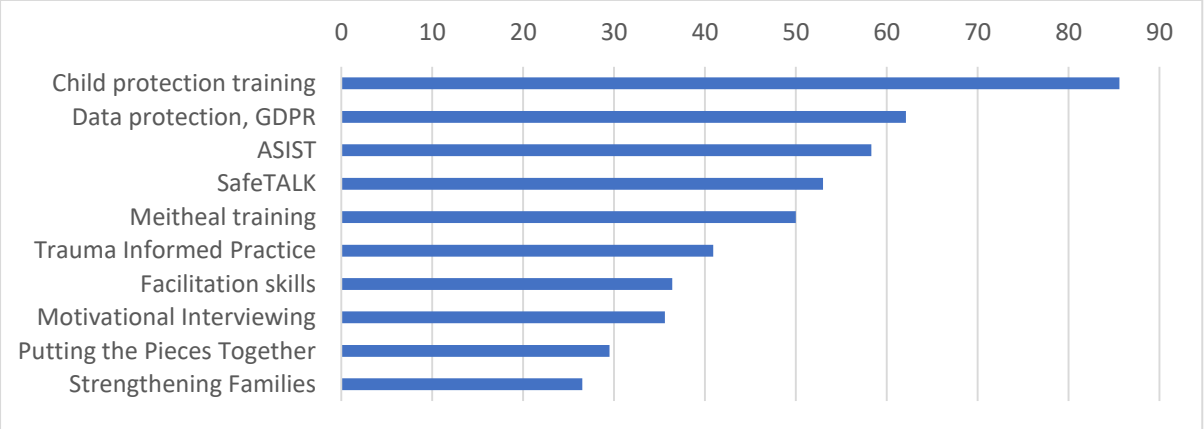

Figure 4 The most frequency listed CPD courses overall. Note: Percentage of participants that indicate that they have completed a specific CPD course.

Parent Support

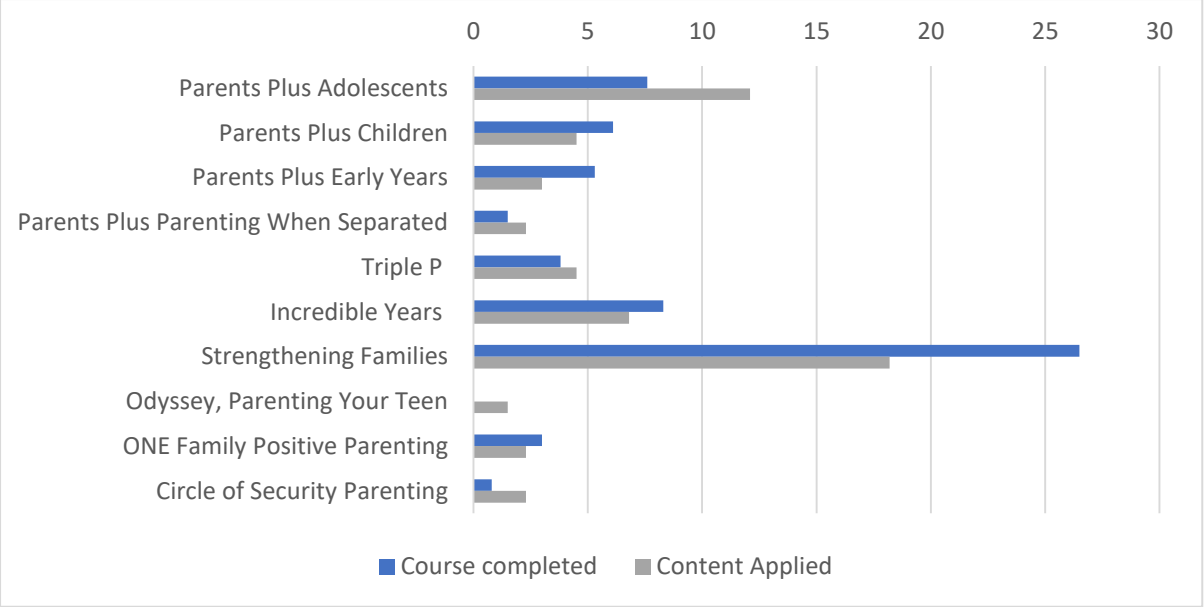

Figure 5 Percentage of participants that indicate that they have completed (blue) and applied (grey) Parent Support courses.

[2] Note the percentage axis in Figures 5-10 are scaled differently; this should be borne in mind when comparing across figures. Appendix C lists courses without themes.

Mental Health

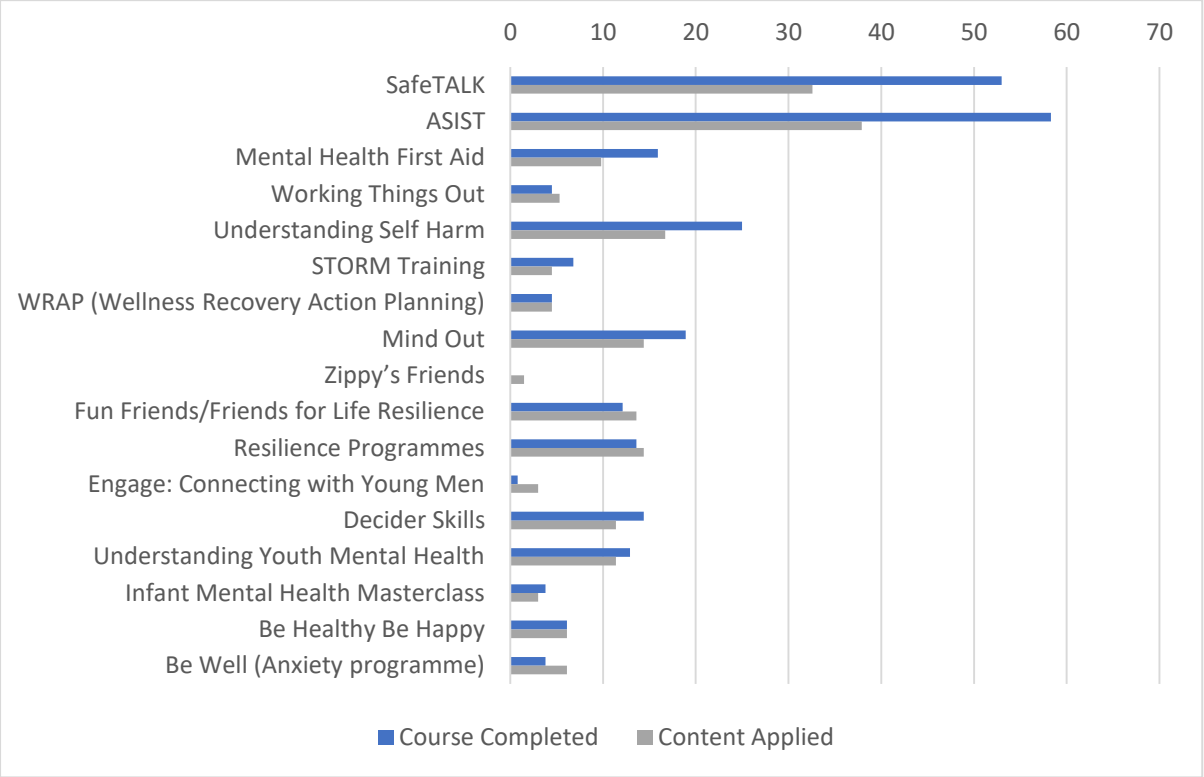

Figure 6 Percentage of participants that indicate that they have completed (blue) and applied (grey) Mental Health courses.

Substance Misuse/ Preventing Offending Behaviour

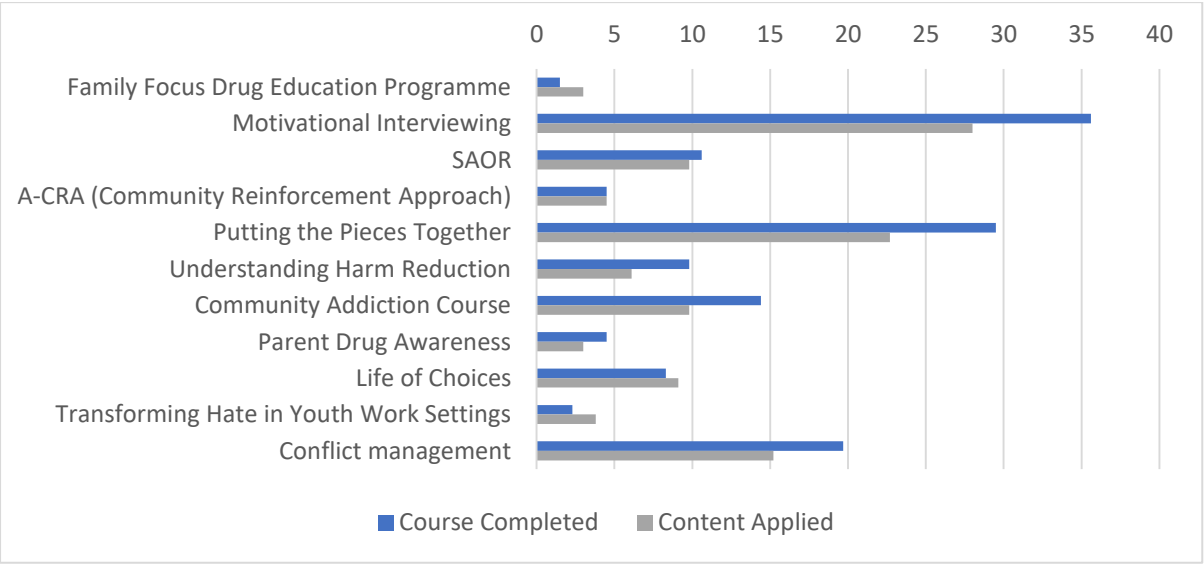

Figure 7 Percentage of participants that indicate that they have completed (blue) and applied (grey) Substance Misuse/Preventing Offending Behaviour courses.

Sexuality, Relationships, & Domestic Violence

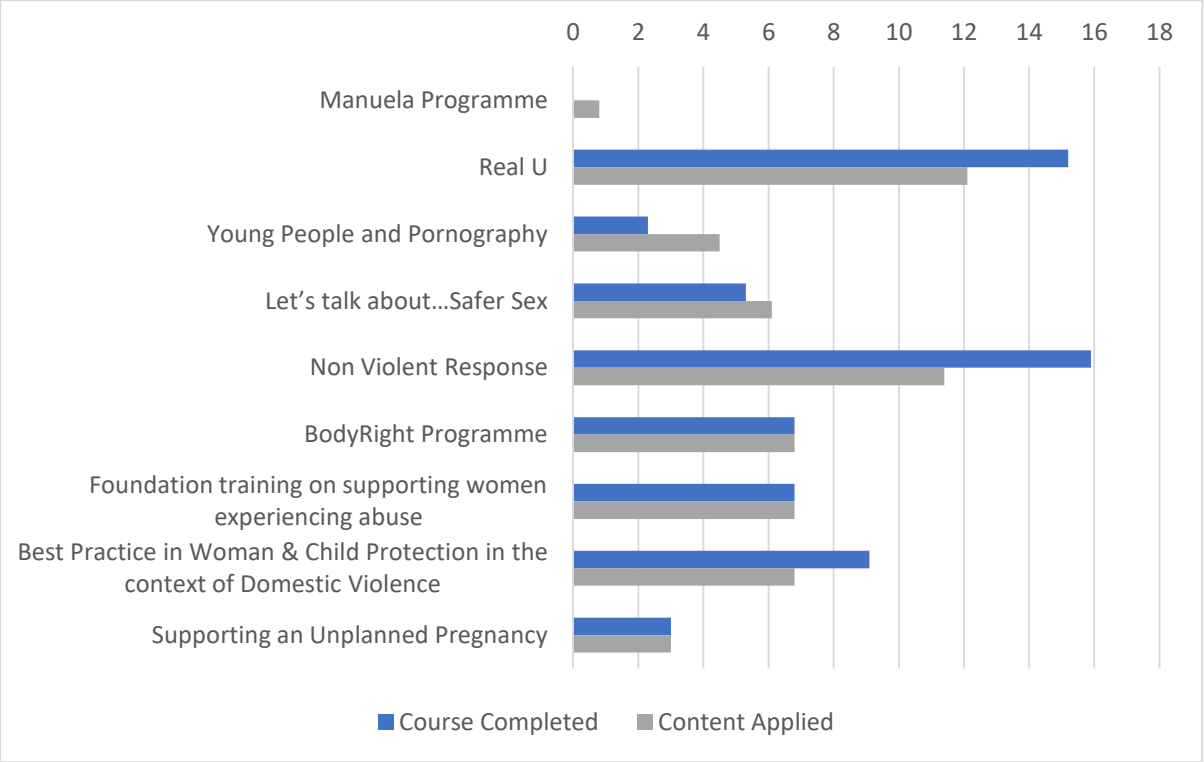

Figure 8 Percentage of participants that indicate that they have completed (blue) and applied (grey) Sexuality, Relationships, & Domestic Violence courses.

Broad Relational Training Approaches

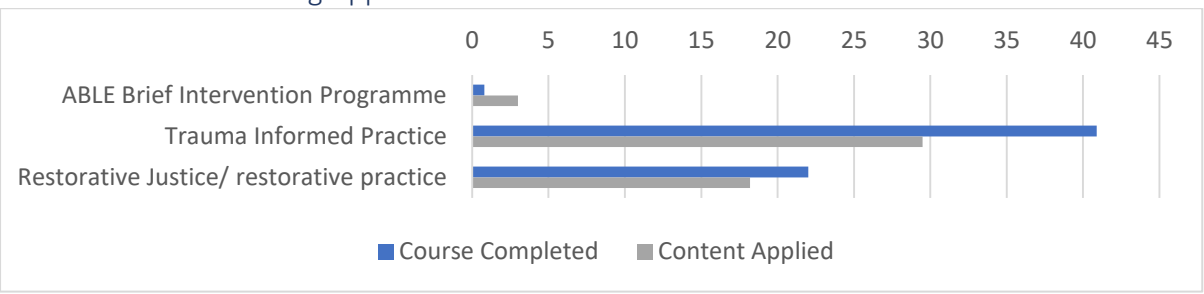

Figure 9 Percentage of participants that indicate that they have completed (blue) and applied (grey) Broad Relational Training approaches courses.

Leadership, Management, Governance

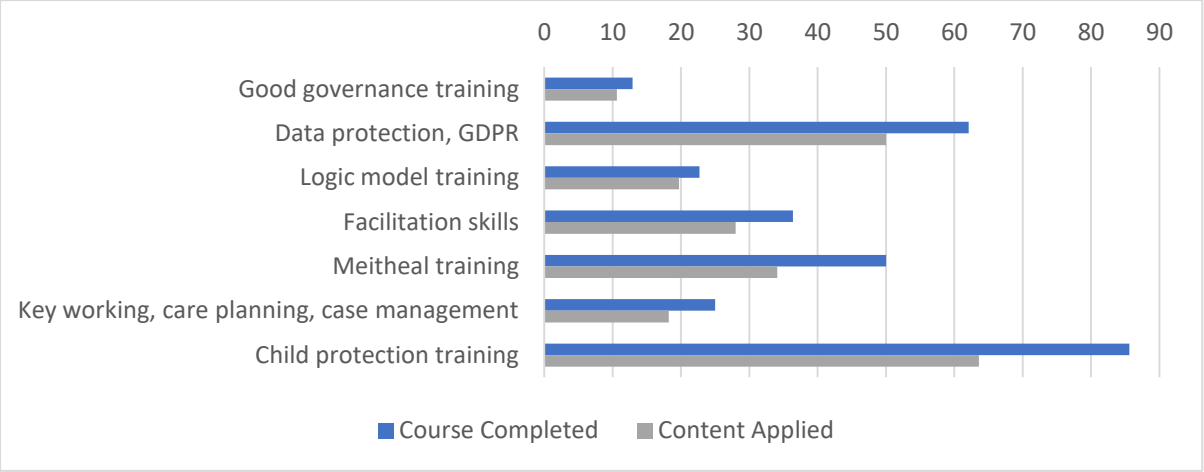

Figure 10 Percentage of participants that indicate that they have completed (blue) and applied (grey) Leadership, Management, Governance courses.

Additional Courses Completed

The survey also prompted respondents to report any other training courses they had completed, but were absent from the lists provided. There was no clear theme from these responses. Respondents noted a diverse range of courses, both university degrees and accredited training, as well as non-accredited CPD. Examples included First Aid, Therapeutic Crisis Intervention, supervision, Cygnet parent support training, infant massage, complaint handling, Reiki, mindfulness, non-violent resistance and more.

Training Needs

Participants were asked to indicate their top the training needs across all courses listed. As can be seen in Figure 11 Courses most frequently selected as a training need. the three most frequently listed courses were Mental Health First Aid (17%), Resilience Programmes (15%), and Trauma Informed Practice (13%). Other frequently named courses are listed in Appendix D Training Needs. Figures 11 toFigure 17 provide the percentage of participants that indicate a training course as their top three training need, sorted by theme.

Most Frequently Selected Training Needs

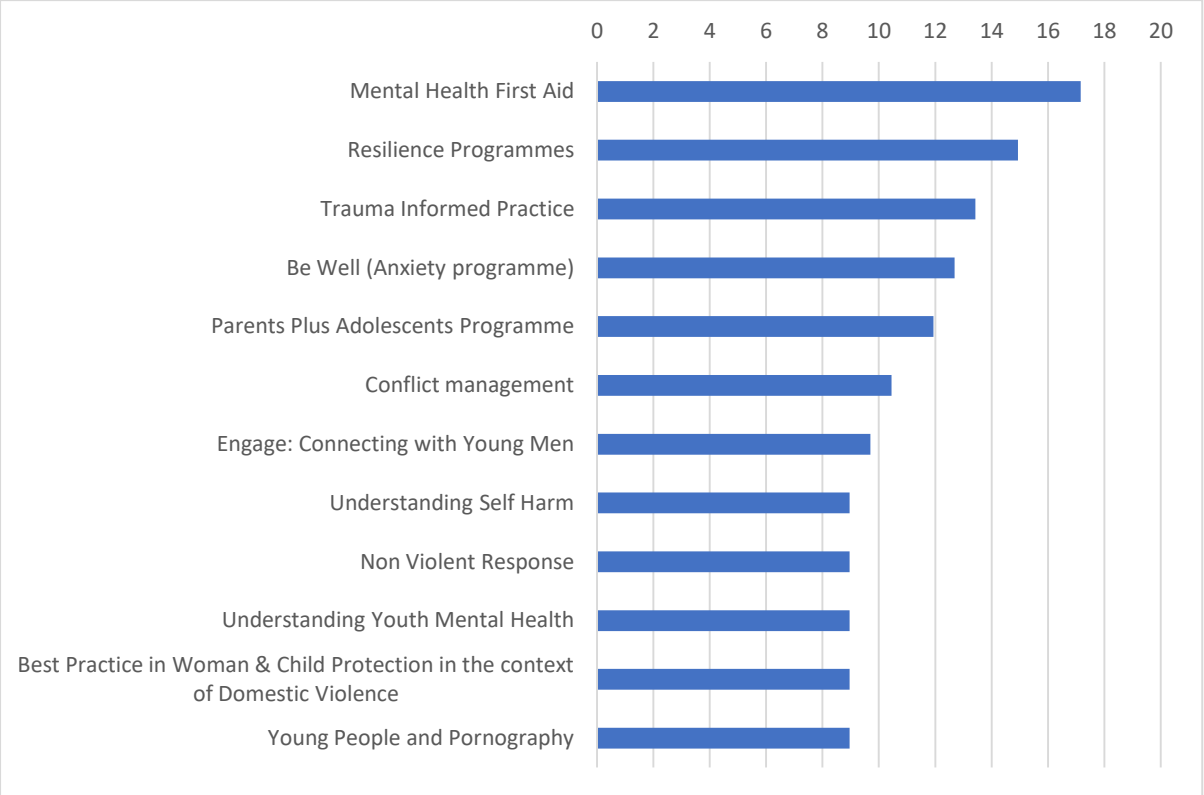

Figure 11 Courses most frequently selected as a training need. Note: Number indicates the percentage of participants that indicate that a specific course is among their top three training needs.

Parent Support

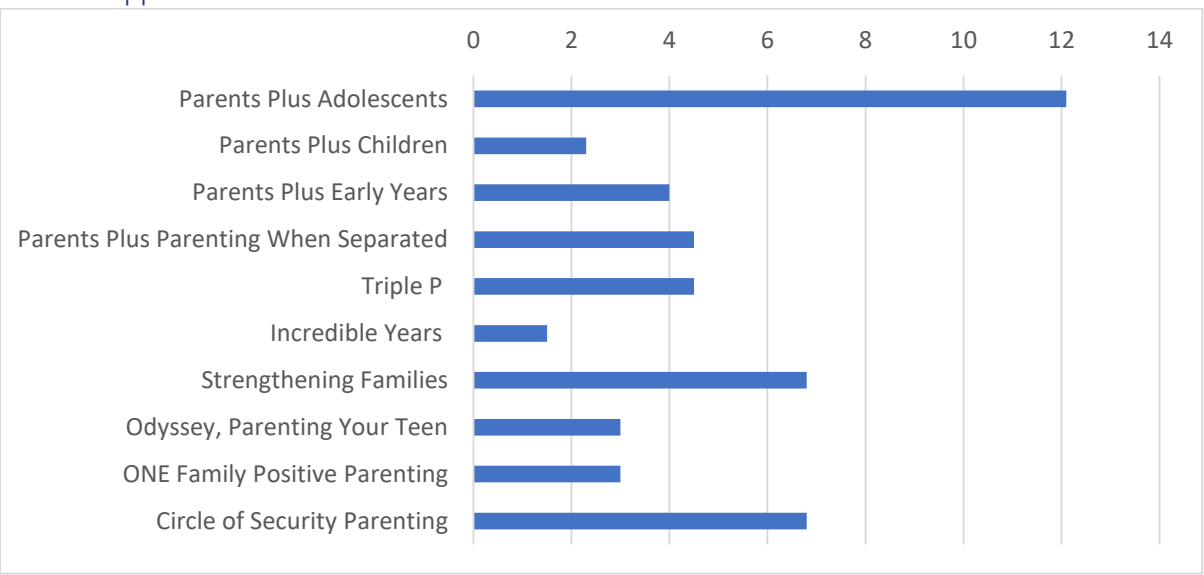

Figure 12 Percentage of participants that listed a Parent Support Course as a top three training need.

Mental Health

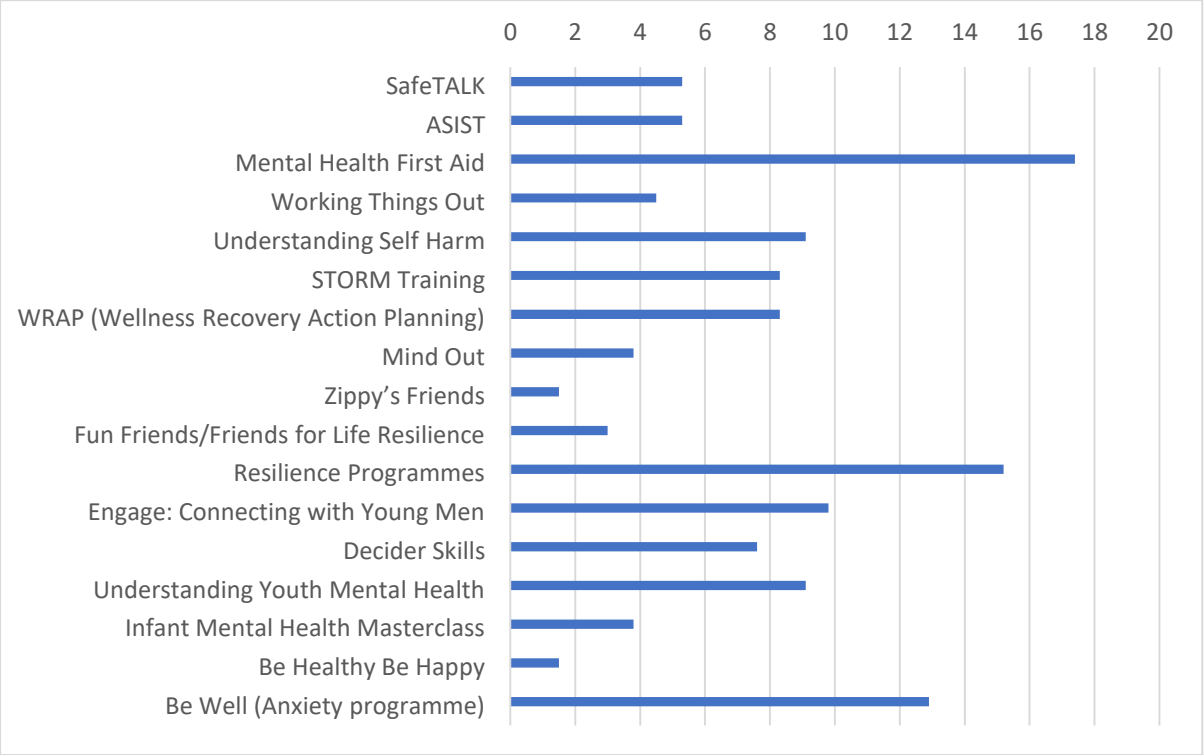

Figure 13 Percentage of participants that listed a Mental Health Course as a top three training need.

Substance Misuse/ Preventing Offending Behaviour

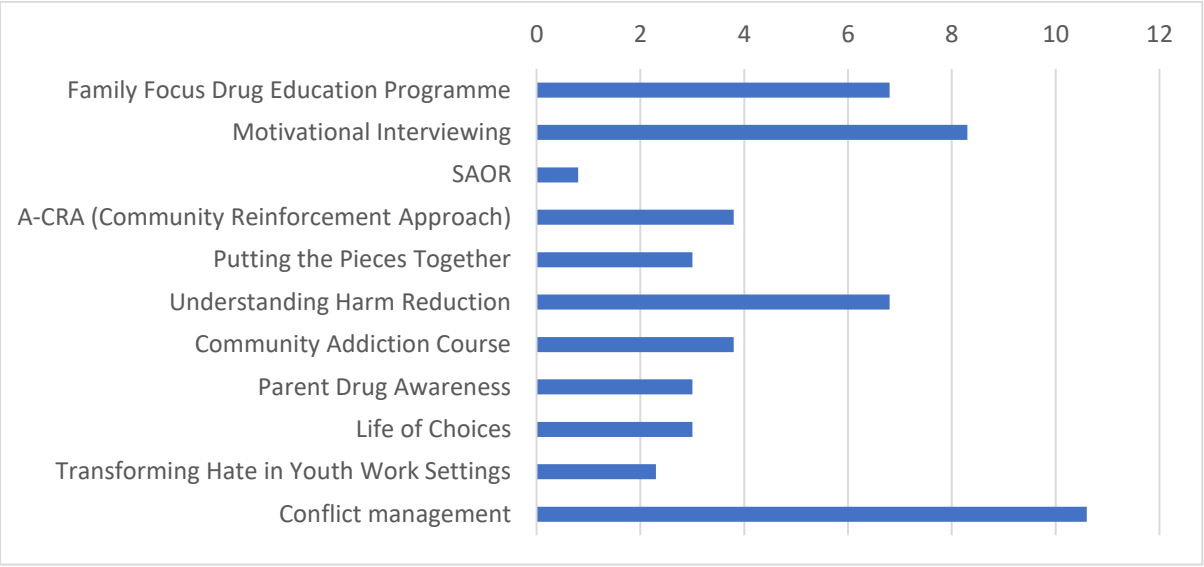

Figure 14 Percentage of participants that listed a Substance Misuse/Preventing Offending Behaviour Course as a top three training need.

Sexuality, Relationships, & Domestic Violence

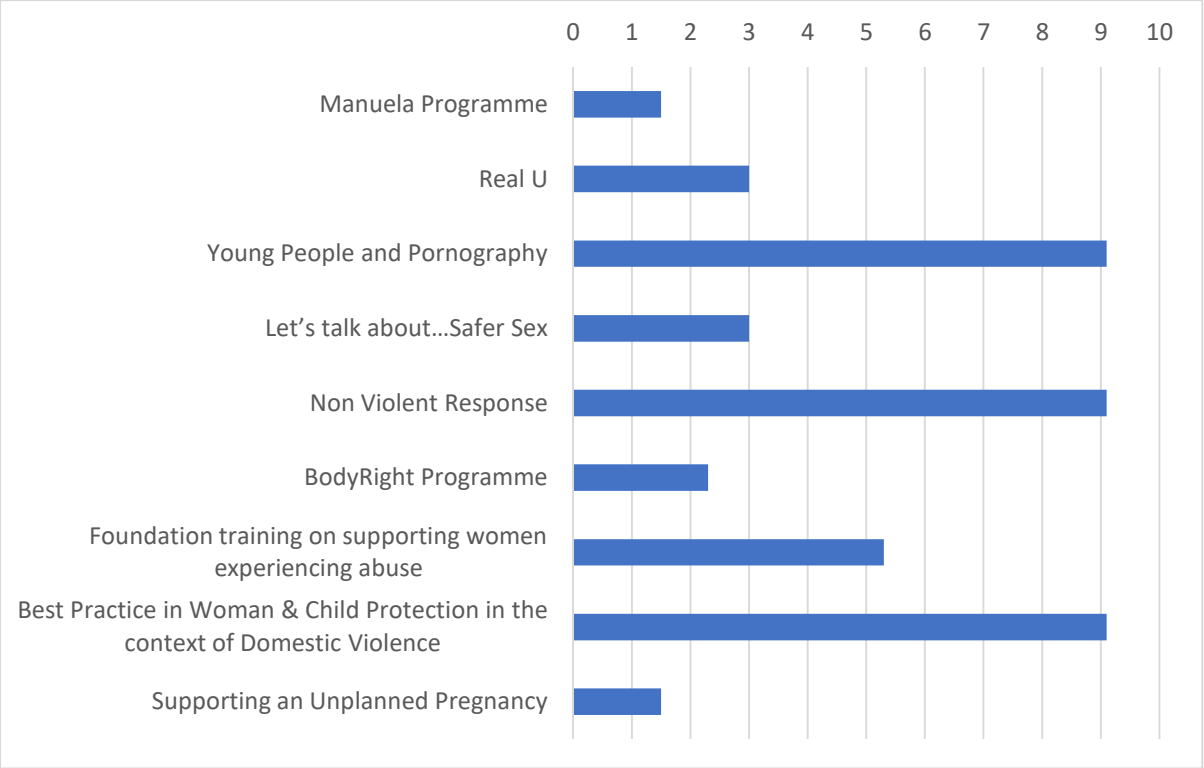

Figure 15 Percentage of participants that listed a Sexuality, Relationships, & Domestic Violence Course as a top three training need.

Broad Relational Training Approaches

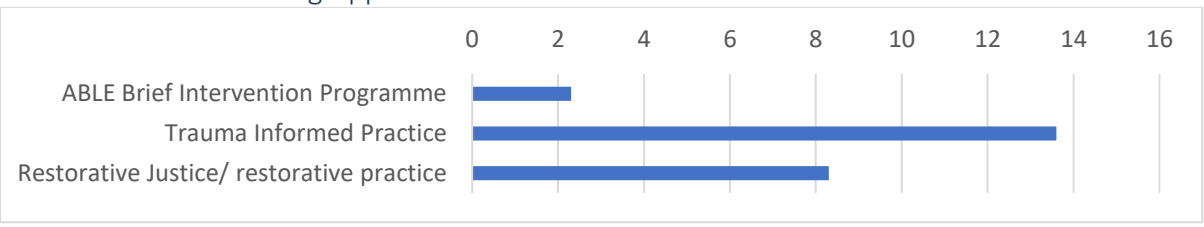

Figure 16 Percentage of participants that listed a Broad Relational Training Approaches Course as a top three training need.

Leadership, Management, Governance

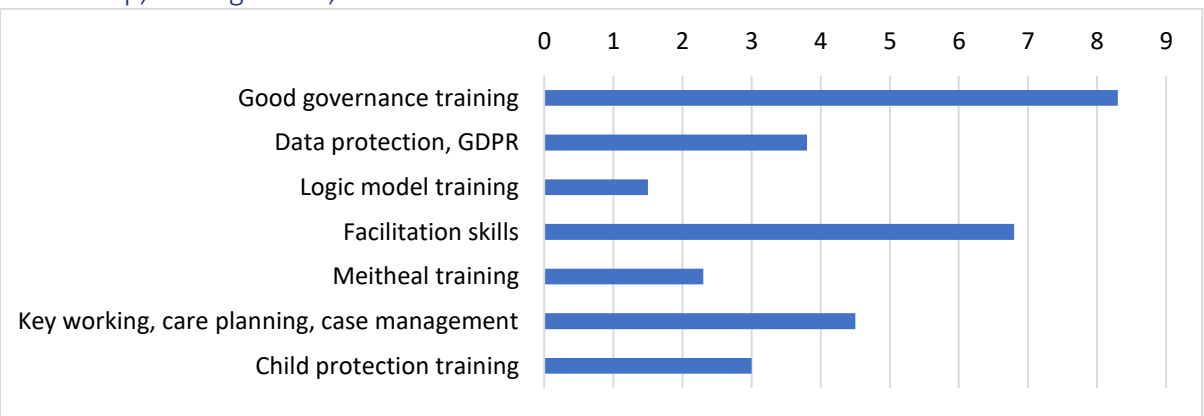

Figure 17 Percentage of participants that listed a Leadership, Management, Governance Course as a top three training need.

The results presented above do not take into consideration that some courses already had a substantial uptake and might thus be less frequently selected as a training need. To gauge the relative priority of training programmes, a second analysis of training needs excluded participants who had already taken a specific course. The resulting percentage indicates what proportion of participants - who have not yet completed the course- list a certain course as a top three training need. This change in counting provides a list of relative training needs priorities, and the most frequently selected courses, as displayed in Figure 18, were: Trauma Informed Practice (23%), Child Protection Training (21%), Mental Health First Aid (20%), Resilience Programmes (17%) and Be well - Anxiety Programme (13%). A more comprehensive list can be found in Appendix E Relative Training Needs

The combination of both tallying approaches provides a list of courses that are frequently mentioned *and* already have a high uptake. Some of these are general courses, such as Child Protection and Data Protection Training. Others that fall into this category are ASIST (Applied Suicide Intervention Skills Training), SafeTALK, Trauma Informed Practice, Facilitation Skills, Motivational Interviewing, Strengthening Families Programme, Understanding Self Harm, Restorative Justice and Conflict Management.

Figure 18 List of most frequently selected training needs among participants who had not completed the course yet.

Professional Training Needs broken down by Sector

For a more refined analysis of training needs, data were broken down into eight service sector categories. These were: Addiction, Disability, Education, Family Support, Justice, Social Work, Therapy and Youth Work. CPD needs varied somewhat by sector. Table 2 shows courses which were listed as top three training needs by sector. These need to be interpreted with caution however, given the small sample size.

Table 2 Training Needs According to Sectors

Sector	Course	Percentage
Therapy	Parents Plus Adolescents Programme	33
	WRAP (Wellness Recovery Action Planning)	33
	Trauma Informed Practice	25
	Restorative Justice/ restorative practice	25
Family Support	Resilience Programmes	25
Youth Work	Mental Health First Aid	28
	Resilience Programmes	24
	Parents Plus Adolescents Programme	20
	Trauma Informed Practice	20
	Non Violent Response	20
Social Work	Resilience Programmes	25
	Parents Plus Adolescents Programme	25
	STORM Training – Suicide Prevention and Intervention skills	25
	Be Well (Anxiety programme)	25
	Decider Skills	25
	Understanding Self Harm	25
Education	Good governance training	21
	Conflict management	21
Justice	Mental Health First Aid	35
	Be Well (Anxiety programme)	35
	Resilience Programmes	20
	Motivational Interviewing	20
Disability	Facilitation skills	30
	Best Practice in Woman & Child Protection in the context of Domestic Violence	30
	Mental Health First Aid	20
	Understanding Harm Reduction	20
Addiction	Be Well (Anxiety programme)	29
	Decider Skills	29
	Understanding Self Harm	29
	ASIST - Applied Suicide Intervention Skills Training	29

Additional Training Needs

The survey included an open-ended question which allowed respondents to identify any additional training needs they may have. Although already listed in the survey, trauma work and trauma-informed practice were frequently mentioned across different service sectors. Understanding attachment/attachment-based interventions and training in diversity and cultural competencies were also noted.

Additionally, some respondents mentioned the need for training in specific therapeutic approaches including, Eye Movement Desensitisation and Reprocessing (EMDR), Emotion Focused Therapy, Systemic Family Therapy, Dyadic Developmental Psychotherapy. Others mentioned the need for upskilling in particular issues that were coming up for them in their practice, such as sexting and parental alienation. Social media training was also noted from a public relations perspective and as a means of reaching and engaging with young people. The need for CPD in the area of mental health was again noted, particularly youth mental health, but also intellectual disability and mental health.

Some participants expressed surprise at the range of courses that exist and one suggested that a directory of available CPD would be very helpful:

> *"For most service providers it's about knowing what resources exist to help them in their role, and how and where to request them. Service provider staff are often unaware of the array of resources available. A directory of services, including a brief synopsis of each under headers, with a responsible service contact would be so beneficial for anyone taking up a position in a given area/county, maintaining a quality service to its user base, or developing good working relationships with other stakeholders."* (professional in the justice sector)

An interest in and a willingness to engage in CPD was also evident in the responses:

> *"…there are many more than just three [CPD courses] I would like to pick...*
> *Many of these options are so relevant to our work."*
> *"I am always willing to upskill"*
> *"I would like to do many of the above courses for CPD"*

COVID-19 Related Training Needs

Regarding COVID related needs, unsurprisingly many respondents desired support in the area of online facilitation. This included, creative approaches to engaging young people remotely, digital youth work, up-skilling in IT, blended eLearning approaches, online therapy, tele-health, tele-therapy, remote counselling skills, online engagement platforms, engaging young people, families, parents digitally.

Respondents also noted concerns about rises in anxiety, domestic violence, COVID-related trauma, isolation, and mental health difficulties amongst the children, young people or families they work with. They felt training in these areas would be beneficial.

The need for support in managing a service through a pandemic was also noted and one participant suggested "*increased self-care and mental health supports for staff would be great"*. Others noted that CPD had been cancelled due to the pandemic and they were hopeful it would re-scheduled.

COVID-19 Challenges

A number of COVID-specific challenges were noted. Many respondents reported feeling a sense of disconnection, loneliness and isolation. Respondents noted the fundamental

importance of relationships in their professional work and many reported missing face-to-face contact with the children, young people or families they serve.

> *"The young people are the reason I do this and without them it's been a struggle"* (Youth Worker)

> *"Having so much time used in non-contact with pupils leaves a hollow and unfulfilling feeling as there's no feedback or gratification for a good lesson or resource in school."* (Education Professional)

Without the benefit of face-to-face interactions, it was difficult to read and interpret body language and facial expressions. For many respondents, this compromised their professional judgement and led, in some cases, to feelings of powerlessness and inadequacy.

> *"I have experienced feelings of inadequacy in relation to providing the best quality of service to my service users. As I have to provide most of the service by phone call, I don't feel I have been able to do the best I can for the young people I work with. I have experienced feelings of powerlessness and anxiety in relation to my work."* (Professional in Addiction Services)

> *"[It is] difficult to carry out socially distanced home visits where you are trying to show empathy and build relationships from 2m away."* (Youth Worker)

> *"I feel like I needed to actually be in the same room of as my clients. Remote work is difficult for me to feel like I am doing my job correctly"* (Therapist)

> *"The key to our work is working with young people and families on building on relationships. Often when working with a young person you can tell just by their body language what space they are at that day etc and work with that. However, it's much more difficult when we can't work on one to one with our young people. Yes, we have kept in contact by phone/online but it is a very artificial environment and not the same. Also, some young people not as comfortable talking this way as they would be in school environment."* (Education Professional)

> *"I worry that children with learning difficulties are falling further behind, and how we can best support them with all the uncertainty ahead. I also worry that remote working will be seen as a viable alternative to face to face work, as I don't believe it can be".* (Educational Professional)

The lack of face-to-face contact also meant that participants felt they were not able to manage risk as well as before:

> *"[It is] difficult to manage risk when we cannot get eyes in the house, cannot speak to the children outside of the home, cannot speak to*

possible victims of abuse away from the alleged perpetrator… the list goes on…." (Youth Worker)

"Providing support over the phone particularly with new clients is challenging as I have to try and determine if they are being overheard or coerced, if they are in an abusive situation, for example" (Family Support Worker)

Participants were often acutely aware of the challenges that the pandemic was posing for particular children and families, and found the situations that some children were in distressing.

"Knowing that for some children, home is not their safest/happiest place…Not being able to be there for them when they needed it….That really got to me…Seeing children crying when they received the food parcel at their door that I delivered because they "didn't know we care that much". Isolation of those children was heart-breaking." (Education Professional)

Issues with privacy and maintaining confidentiality were also noted:

"…having to make calls or zoom videos at home to people I support, but not feeling my space is fully confidential." (Youth Worker)

Many participants reported tiredness and fatigue from balancing work and parenting roles. Many also had concerns about close family members who have underlying conditions. The pandemic brought additional workplace pressures for some respondents and some found themselves navigating new professional boundaries. These concerns are captured in the following quotes:

"I am living with my partner who has an underlying medical condition and I am fearful of bringing home the virus and causing his death" (Social Care Professional)

"Not being able to separate work space from home space and having more difficulty in switching off…a stressful working environment of an apartment with no outdoor space, partner, teenage child and barking dog" (Youth Worker)

"I have experienced feelings of overwhelm and a lack of focus at times particularly as I am also trying to provide schooling for my children. My mental health has certainly been affected and I am concerned that when I return to centre-based work that I will be at my best for the young people that I work with." (Professional in Addiction Services)

"I also feel a lot more tired both physically and mentally from increased phone use and screen time .I have noticed that I experience headaches more regularly which would normally not be a regular occurrence for me, and providing support in absence of face to face contact requires a lot more concentration" (Family Support Worker)

"[I have] very high expectations of what I should achieve in my role…. this time has been very stressful and has meant work has had to take priority and my child and parents have had to come in second place. I feel very guilty that I could not put my child first during the pandemic." (Education Professional)

"I felt extra pressure initially to connect with learners and so took this on as my responsibility and felt it was my failing if they didn't connect. Also due to the new way of working I became more aware and involved in their home life/situations/stresses/issues and so boundaries were blurred in that I felt I had to respond to emails etc outside the working hours, I was accessible to them at any time so I felt I had to respond" (Education Professional)

Some respondents noted that the pandemic had some positive impact on their professional lives:

"Due to less red tape it has been great to be able to get out and do my job better and put more time into it and less into moving paper" (Professional in Justice Sector)

"Embraced new concepts as a "very positive teaching resource" (Education Professional)

"There are always challenges, it's about adapting, improvising and seeing them as opportunities to learn and develop" (Professional in Justice Sector)

Professional Quality of Life

Participants showed healthy levels of professional quality of life. Figure 19 shows the three subscales broken down by groups. Most participants fell into the *average* or *high* category on the Compassion Satisfaction subscale with M=40.36 (SD=5.24). More than half of participants were within the low category of Burnout with M=21.29 (SD=5.14), and Secondary Traumatic Stress with M=20.03 (SD=5.30). There were no significant differences in professional quality of life across sectors.

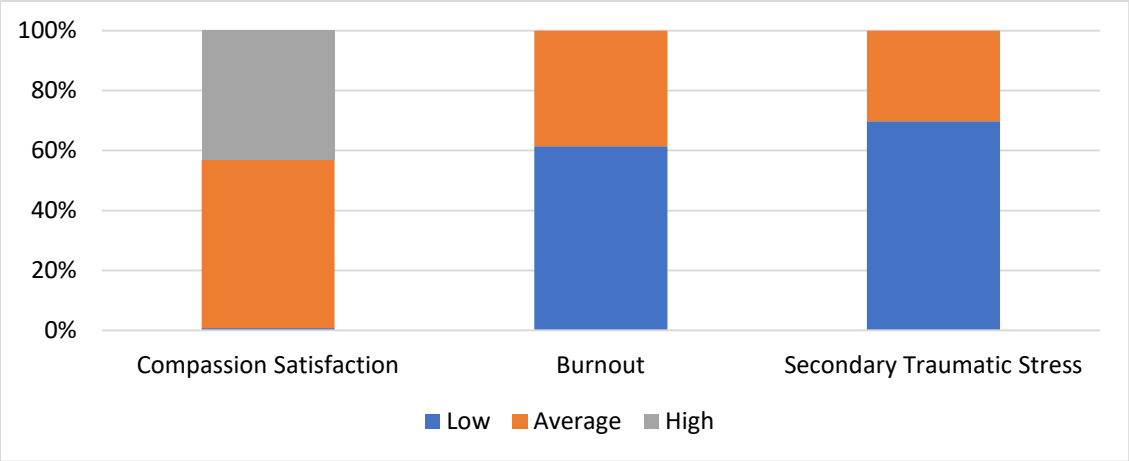

Figure 19 Professional Quality of Life

Self-Compassion Scale

The average self-compassion score was 3.43 (SD=0.54). As can be seen in
Figure 20, the majority of participants scored high or moderate on self-compassion, with 4.5% of participants scoring low on self-compassion. There were no substantial differences in levels of self-compassion across sectors.

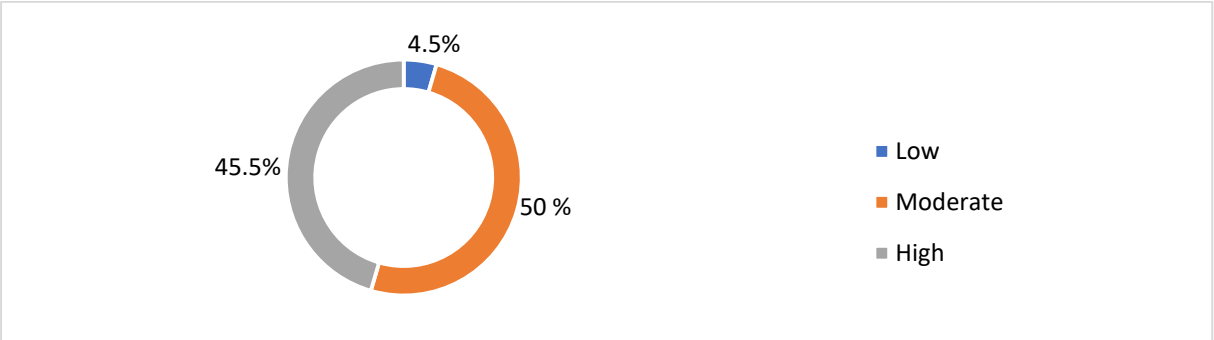

Figure 20 Self-Compassion

Attitudes Related to Trauma-Informed Care

Overall, participants scored high on the ARTIC on average, meaning they have positive attitudes towards and a willingness to implement trauma-informed practices. Figure 21 displays the mean scores on the total ARTIC score, and the five subscales. The ARTIC scale is relatively new, thus there are no norms or benchmarks available against which to compare our current sample or provide an indication of what is a low, moderate, and high score. However there are a small number of studies, which have used the ARTIC and these can be used as a comparison. Along with the results from the current study, Figure 21 provides mean scores from a study with Irish teachers (N=377; O'Toole & Dobutowitsch, in preparation) and median values from an Australian study with residential care workers (N=31; Galvin et al., 2020).

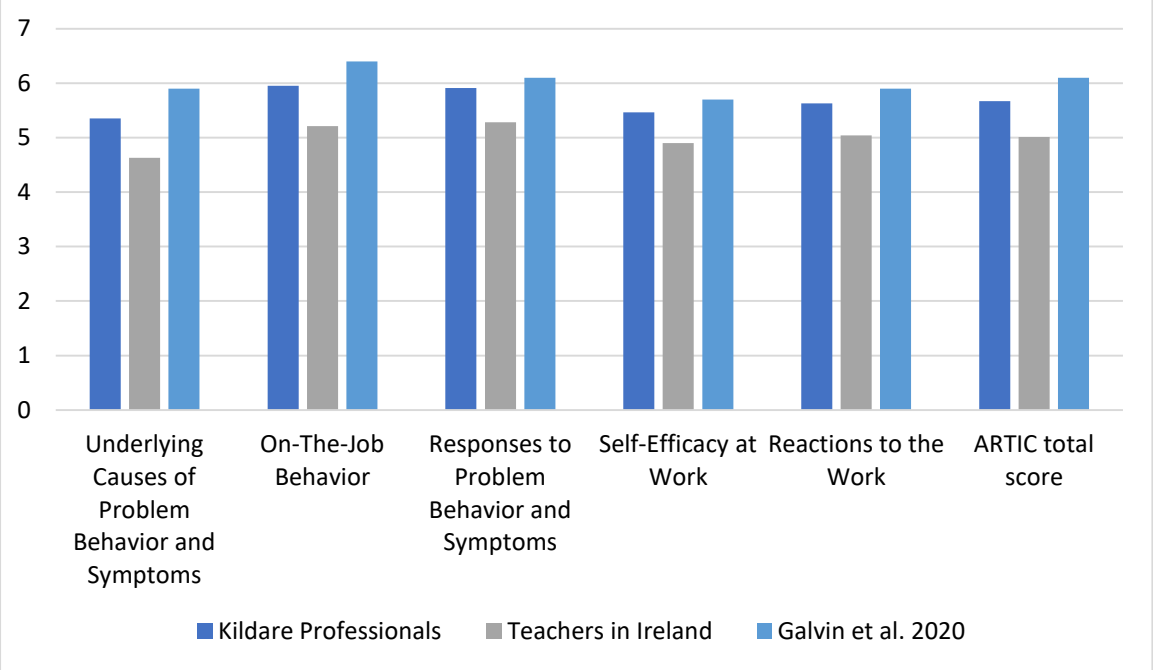

Figure 21 Attitudes Related to Trauma-Informed Care

Associations Between Measures

The relationship between professional quality of life, self-compassion, and attitudes to trauma-informed care was explored using correlational analysis. Table 3 lists correlation coefficients for the measures and relevant subscales. Both professional quality of life and self-compassion are associated with more positive attitudes toward trauma-informed care. There is a small correlation between the ARTIC and self-compassion, and a small negative correlation with secondary traumatic stress. High levels of compassion satisfaction and low levels of burnout are associated with more positive attitudes to trauma-informed care.

Table 3 Spearman's Correlation Between the Three Standardised Measures

	1	2	3	4	5	6	7	8	9	10
1 ProQOL Compassion Satisfaction	1									
2 ProQOL Burnout	-.660**	1								
3 ProQOL Secondary Traumatic Stress	-.227**	.573**	1							
4 Self-Compassion Scale	.437**	-.552**	-.430**	1						
5 Underlying Causes of Problem Behaviour and Symptoms	.255**	-.225**	-0.098	0.089	1					
6 Responses to Problem Behaviour and Symptoms	-.229**	-.192*	.209*	.670**	.601**	1				
7 On-The-Job Behaviour	-.294**	-0.1	.259**	.649**	.318**	.435**	1			
8 Self-Efficacy at Work	-.588**	-.333**	.410**	.359**	.498**	.607**	.562**	1		
9 Reactions to the Work	-.447**	-.185*	.314**	.502**	.807**	.787**	.813**	.562**	1	
10 ARTIC Total	.493**	-.478**	-.251**	.345**	.601**	.435**	.562**	.682**	.793**	1

**. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).

Conclusions

There was good representation of professionals from across various sectors and age groups. However, in relation to ethnicity, the sample was very homogenous. All participants identified as White and the vast majority (92%) as White Irish. No participant identified as Irish Traveller, Black, Asian, Chinese, or other ethnic minority.

There was high uptake in a range of CPD courses, especially the Strengthening Families programme, Safe Talk, ASIST, Motivational Interviewing, Real U, Non-Violent Resistance, Trauma Informed Practice, Data Protection and Child Protection.

Respondents were interested in a broad range of professional training and CPD courses. The most sought after CPD courses included:

- Parent Plus Adolescent Programme
- Mental health First Aid
- Non-Violence Resistance
- Conflict Management
- Young people and pornography
- Woman and child protection in context of Domestic Violence
- Trauma Informed Practice

When professional training needs were considered in relation to the various sectors, there was no single training course that was top of the list of CPD needs across sectors. However, amongst the most sought after CPD courses were the Parent Plus Adolescent Programme, Be Well Anxiety Programme and resilience programmes.

Participants were asked to indicate any other training needs they had in addition to those already listed in the survey. Although trauma-informed practice was listed, it was again frequently mentioned across different professional sectors. In addition, understanding attachment/attachment-based interventions and training in diversity and cultural competencies were also frequently mentioned by respondents across sectors.

There was both a high uptake and a high demand for CPD in particular areas, especially Trauma-informed practice and non-violent resistance, indicating an ongoing or continuous need for training in these areas.

Specific to the COVID-19 pandemic, participants noted a need for training in online facilitation. There was also request for greater support for staff mental health and wellbeing.

It is worth drawing attention to an important difference in the types of training courses that are sought after. Some courses (e.g. Parent Plus Adolescent Programme and non-violent resistance) are discrete, standardised and manualised programmes with very focused outcomes. Others such as trauma-informed practice and cultural diversity training are much broader in orientation; they are about building knowledge and infusing the learning across all aspects of organisational culture, which means attending to organisational dynamics, leadership, the social milieu, organisational structures, policies and procedures, and so on. Standardised training programmes tend to be easier to roll out. It will be important to

ensure necessary resources to facilitate high quality provision of training in the broader areas of trauma-informed care and cultural diversity, with follow-up supports for organisations as necessary.

The survey also prompted respondents to indicate any COVID-19 related challenges they had experienced. Many participants reported feeling compromised in their roles. The lack of face-to-face contact meant reduced ability to read body language and non-verbal communication. As a result, participants felt they were unable to do their jobs properly, unable to care or support their clients/students and in some cases unable to manage risk. It was clear this caused participants considerable stress and a sense of powerlessness. This could be likened to what is referred to in literature as '*moral distress*' (Jameton, 1984), which describes the inability, due to perceived constraints, to fulfil the moral obligations that those in healthcare or other support roles assume to others.

Despite the challenges that participants recounted, their self-reported professional quality of life was in the average to high range. Their experiences of secondary traumatic stress and burnout were low to average. In addition, participants in this study reported above average levels of self-compassion, which may have been a protective factor in buffering against stress and burnout. These are positive findings; however, given that participants self-selected to complete this survey, it is possible that the results capture a particular cohort of personnel who are particularly interested in professional development and likely to have self-care structures and supports in place to nurture their wellbeing. Thus, the extent to which these results generalise to the entire Kildare workforce is unclear.

Participants in this study also expressed positive attitudes, values and dispositions in relation to trauma-informed care, which is another positive finding (notwithstanding the sampling issues). Indeed, given the historic underinvestment in core services in Co. Kildare, coupled with high demand, it is heartening that, despite the possibility of being overstretched, professionals endorsed empathy-oriented and relationship focused attitudes and behaviours, as demonstrated by their responses on the ARTIC scale.

In many respects, the results of this survey are unsurprising when considered in relation to the profile of County Kildare (see introduction). County Kildare has two Direct Provision Centres, high demand for domestic violence services, high prevalence of suicides and considerable numbers living in areas of socio-economic disadvantage. Our findings in relation to demands for training in mental health, domestic violence, cultural diversity make sense in light of this county profile.

Furthermore, the results of this survey dovetail with Kildare CYPSC Action Plan (2019-20121), in that many of the areas of training identified by participants are considered priority areas in the Action Plan including mental health, parent support, domestic violence and inclusion of minority groups.

Overall, the survey highlighted the diverse range of skills and expertise held by professionals in County Kildare, considerable interest in engaging further with CPD as well as very positive empathy-oriented and relationship-focused values and dispositions. This is a very positive finding highlighting the enthusiasm and commitment of the County Kildare workforce.

Recommendations

Key training and CPD requirements

- Prioritise training in areas of:
    - Cultural diversity
    - Domestic violence (best practice in woman and child protection)
    - Family and parenting supports (Non-Violent Resistance, Parent Plus Adolescent Programme)
    - Mental Health (Mental Health First Aid, Be Well Anxiety Programme, Suicide Prevention programmes),
    - Trauma-Informed Practice
- Ensure resources to facilitate high quality training provision along with necessary follow-up supports for organisations; this is particularly important with respect to trauma-informed practice which envisages a wider cultural shift in organisational structures, policies and practices.

Develop a co-ordinated, county-wide, cross-sectoral approach to CPD

- Initiate inter-agency discussion and collaboration to ensure a coordinated approach to CPD
- Encourage individual agencies to share their workforce development plans, and monitor CPD of personnel
- Consider the feasibility of developing a directory of available training and CPD courses and of circulating a calendar of upcoming training to agencies in the county.

Respond to the need for greater cultural diversity

- As above, provide high quality cultural diversity training.
- Initiate conversations with CYPSC member organisations with the purpose of developing a plan for increasing the cultural and ethnic diversity of Kildare workforce.
- Ensure representation of minority, ethnic groups on Kildare CYPSC and at county level fora.

COVID-19 related needs

- Given the likelihood of continued disruption to normal workplace practices and the possibility of pivoting back to online or tele-based interactions, it seems important to ensure provision of training necessary for upskilling in online facilitation.

The wellbeing of personnel

- Our work force is our most valuable asset, it is important to harness the positivity and enthusiasm demonstrated by the Kildare professionals by creating systems, policies, conditions and supports to allow our organisations and their staff to flourish.
- Consideration should be given to the provision of reflective supervision for staff across different sectors (at present counsellors, psychotherapists, social workers

avail of profession supervision as an integral part of their work, it would likely be beneficial to facilitate other professions that have not traditionally had access to supervision to avail of it).

- Ensure attention to staff validation, wellbeing and self-care across the various CPD training offered in the county.

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Appendix A CYPSC Membership

Kildare CYPSC Membership October 2020

Organisation	Member	Role
Co. Kildare LEADER Partnership	Pat Leogue	General and Social Inclusion Manager
Department of Employment Affairs and Social Protection	Sinéad Goodwin	Area Manager Kildare
Family Resource Centres	Angela Morrissey Kenny	Manager, Curragh Family Resource Centre
Garda Siochána	Brian Cagney	Garda
HSE	Geraldine Peelo	Manager Primary Care
	Adrienne Devlin	Project Lead Assessment of Need
	Shaista Zaidi	OT Manager, CAMHS
Irish Primary Principals Network	Marion Sherlock	Principal
Kildare and Wicklow Education and Training Board	Lorraine Flynn	Youth Officer
Kildare County Childcare Committee	Julie McNamara	Chief Executive Officer
Kildare County Council	Sonya Kavanagh (Vice Chair)	Director of Service
Kildare Youth Services	Tom Dunne	CEO
Maynooth University	Catriona O'Toole	Lecturer in Psychology of Education and Course Leader of the Masters in Education (M.Ed.)
National Educational Psychological Service	Annette Corkery/Brenda Hughes	Senior Educational Psychologist
Probation Service	Deirdre Matthews	Senior Probation Officer
South West Regional Drugs and Alcohol Task Force	Lisa Baggott	Coordinator
Teach Tearmainn	Lorraine Rowan	Manager
Tusla, Child and Family Agency	Audrey Warren (Chair)	Area Manager
	Caroline Sheehan	Senior Manager, Prevention Partnership & Family Support
Tusla, Educational Welfare Service	Amanda Cullen	Senior Education Welfare Officer

In addition to the main Committee, Kildare CYPSC has a number of Sub Groups to support the implementation of the Children and Young People's Plan.

Appendix B Information and Consent Form

Training Needs Analysis – Professionals working with children, young people and Families in Co. Kildare

Information about the Study

Purpose of the Study

The purpose of this survey is to explore the current and future training needs of professionals working with children, young people and families in County Kildare. The survey also seeks to explore professionals' wellbeing, occupational stress and levels of self-compassion.

This project is led by Dr Catriona O'Toole and Dr Mira Dobutowitsch at Maynooth University, and is supported by Kildare Children and Young People's Services Committee (CYPSC) and Kildare Youth Services (KYS).

What will the study involve?

The study will involve completing an online survey, which will take approximately 15-20 minutes.

The first part of the survey will ask you to indicate what kind of training or CPD you have completed to date and what needs you have for further CPD. The second part of the survey consists of three questionnaires; these ask about your professional quality of life, your views on challenging behaviour of clients/service users and how this impacts you, and your level of self-compassion. They questionnaires are designed to assess how rewarding and/or stressful you perceive your work environment to be, and the extent to which you extend warmth and understanding toward yourself. We also ask about any new training needs or work place challenges that may have emerged for you since the Covid-19 pandemic.

Who has approved this study?

This study has been reviewed and received ethical approval from Maynooth University Research Ethics committee. You may have a copy of this approval if you request it.

Why have you been asked to take part?

You have been asked because you work with children, young people and/or families in County Kildare.

Do you have to take part?

No, you are under no obligation whatsoever to take part in this research. However, we hope that you will agree to take part and give us some of your time to complete the questionnaire. The study gives you an opportunity to have your say regarding ongoing training and CPD. The results will help organisations make plans for staff development. However, we cannot guarantee that any or all of the training courses that you might like, will be provided.

It is entirely up to you to decide whether or not you would like to take part. If you decide to do so, you will be asked to give consent, If you decide to take part, you are still free to withdraw at any time without giving a reason up until the point of clicking "submit" on the final page of the questionnaire. Since data are collected anonymously, it is not possible to withdraw afterwards.

What information will be collected?

The first section of the questionnaire will ask you about different CPD or short training courses that you may have completed, and whether you found them useful or not. It will also ask you a few questions about yourself (age, gender) and your work role. If you do not want to complete a particular item on the questionnaire you can leave it blank.

The second section explores different attitudes or perspectives you may have in relation to your work, including how rewarding or stressful your work is for you, and the extent to which you tend to be compassionate towards yourself.

Will your participation in the study be kept confidential?
Yes, all information that is collected about you during the course of the research will be kept confidential. You will not be asked to provide your name. You will be asked about your work role. All data collected will be encrypted and stored on a password protected computer and will only be accessed by the researchers (Dr Catriona O'Toole and Dr Mira Dobutowitsch). No information will be distributed to any other unauthorised individual or third party.

It must be recognised that, in some circumstances, confidentiality of research data and records may be overridden by courts in the event of litigation or in the course of investigation by lawful authority. In such circumstances the University will take all reasonable steps within law to ensure that confidentiality is maintained to the greatest possible extent.

What will happen to the information which you give?
All the information you provide will be kept secure in such a way that it will not be possible to identify you. This means that data on work roles will be collapsed into broader categories so that individuals cannot be identified. On completion of the research, the data will be retained on the Maynooth University server. After ten years, all data will be destroyed (by the Principal Investigator). All electronic data will be reformatted or overwritten by the Principal Investigator in Maynooth University.

What will happen to the results?
The data will be analysed and summarised and shared with Kildare Children & Young People's Services Committee. Findings may also be presented at national and international conferences and may be published in scientific journals. A copy of the research findings will be made available to you upon request (please email: XXX).

What are the possible disadvantages of taking part?
While we do not envisage any disadvantages, it is possible that reflecting on your work may remind of difficulties and stressful professional experiences.

What if there is a problem?
If you experience any distress following the survey you may contact AWARE (01 676 6166) or the Samaritans (116 123).

If during your participation in this study you feel the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the Maynooth University Ethics Committee at XXX. Please be assured that your concerns will be dealt with in a sensitive manner.

Any further queries?
If you need any further information, you can contact: XXX. If you agree to take part in the study, please complete and the consent section below.

Thank you for taking the time to read this

Consent:

I agree to participate in this research study titled 'Professinal training needs, self-compassion, stress and training needs of professionals working with children, young people and families'.

- I confirm that I am 18 years old or over.
- I have understood the purpose and the nature of the study and I have been able to ask questions, which were answered satisfactorily.
- I am participating voluntarily.
- I understand that I can withdraw from the study, without repercussions, at any time, whether that is before it starts or while I am participating.
- I understand that I can withdraw permission to use the data right up to clicking "submit"
- It has been explained to me how my data will be managed.
- I understand the limits of confidentiality as described in the information above.
- I understand that my data, in an anonymous format, may be used in further research projects and any subsequent publications if I give permission below

For your information the Data Controller for this research project is Maynooth University, Maynooth, Co. Kildare. Maynooth University Data Protection officer is Ann McKeon in Humanity house, Room 17, who can be contacted at ann.mckeon@mu.ie. Maynooth University Data Privacy policies can be found at https://www.maynoothuniversity.ie/data-protection.

Appendix C Completed Courses

Percentage of participants who have completed specific courses (courses below the 5% mark are excluded)

Course	%
Child protection training	85.6
Data protection, GDPR	62.1
ASIST - Applied Suicide Intervention Skills Training	58.3
SafeTALK	53
Meitheal training	50
Trauma Informed Practice	40.9
Facilitation skills	36.4
Motivational Interviewing	35.6
Putting the Pieces Together	29.5
Strengthening Families Programme	26.5
Understanding Self Harm	25
Key working, care planning, case management	25
Logic model training	22.7
Restorative Justice/ restorative practice	22
Conflict management	19.7
Mind Out	18.9
Mental Health First Aid	15.9
Non Violent Response	15.9
Real U	15.2
Decider Skills	14.4
Community Addiction Course	14.4
Resilience Programmes	13.6
Understanding Youth Mental Health	12.9
Good governance training	12.9
Fun Friends/Friends for Life Resilience programmes	12.1
SAOR (Screening and Brief Interventions for Alcohol Use)	10.6
Understanding Harm Reduction	9.8
Best Practice in Woman & Child Protection in the context of Domestic Violence	9.1
Life of Choices	8.3
Incredible Years	8.3
Parents Plus Adolescents Programme	7.6
STORM Training – Suicide Prevention and Intervention skills	6.8
Foundation training on supporting women experiencing abuse	6.8
BodyRight Programme	6.8
Parents Plus Children's Programme	6.1
Be Healthy Be Happy	6.1
Parents Plus Early Years Programme	5.3
Let's talk about…Safer Sex	5.3

Appendix D Training Needs

Percentage of participants who indicated courses as top 3 training needs (courses below the 5% mark are excluded)

Course	% Top 3
Mental Health First Aid	17.16
Resilience Programmes	14.93
Trauma Informed Practice	13.43
Be Well (Anxiety programme)	12.69
Parents Plus Adolescents Programme	11.94
Conflict management	10.45
Engage: Connecting with Young Men	9.70
Understanding Self Harm	8.96
Non Violent Response	8.96
Understanding Youth Mental Health	8.96
Best Practice in Woman & Child Protection in the context of Domestic Violence	8.96
Young People and Pornography	8.96
Motivational Interviewing	8.21
Restorative Justice/ restorative practice	8.21
Good governance training	8.21
STORM Training – Suicide Prevention and Intervention Skills	8.21
WRAP (Wellness Recovery Action Planning)	8.21
Decider Skills	7.46
Facilitation skills	6.72
Strengthening Families Programme	6.72
Understanding Harm Reduction	6.72
Family Focus Drug Education Programme	6.72
Circle of Security Parenting Programme	6.72
ASIST - Applied Suicide Intervention Skills Training	5.22
SafeTALK	5.22
Foundation training on supporting women experiencing abuse	5.22

Appendix E Relative Training Needs

Percentage of participants who indicated a particular course as a top 3 training need when those who have already completed the course are excluded (courses below the 5% mark are excluded)

Course	% Top 3
Trauma Informed Practice	22.73
Child protection training	20.73
Mental Health First Aid	20.41
Resilience Programmes	17.27
Be Well (Anxiety programme)	13.19
Conflict management	13.01
Parents Plus Adolescents Programme	12.92
Motivational Interviewing	12.75
ASIST - Applied Suicide Intervention Skills Training	12.53
Understanding Self Harm	11.94
SafeTALK	11.11
Non Violent Response	10.65
Facilitation skills	10.56
Restorative Justice/ restorative practice	10.52
Understanding Youth Mental Health	10.28
Best Practice in Woman & Child Protection in the context of Domestic Violence	9.85
Data protection, GDPR	9.85
Engage: Connecting with Young Men	9.78
Good governance training	9.42
Young People and Pornography	9.17
Strengthening Families Programme	9.14
STORM Training – Suicide Prevention and Intervention Skills	8.81
Decider Skills	8.72
WRAP (Wellness Recovery Action Planning)	8.60
Understanding Harm Reduction	7.45
Family Focus Drug Education Programme	6.82
Circle of Security Parenting Programme	6.77
Key working, care planning, case management	5.97
Foundation training on supporting women experiencing abuse	5.61

Appendix F Service Sector Breakdown

Breakdown of personnel into eight service sector categories:

- Addiction includes HSE addiction services, ARAS, HOPE cottage, South Western Regional Drug and Alcohol Task Force and HALO
- Disability includes KARE, Enable Ireland, St John of Gods, HSE occupational therapists and physiotherapists, HSE Network Disability Teams
- Education includes Primary and Post Primary teachers, early childhood educators, Youthreach, School Completion Programme Coordinators, SEN co-ordinator, NEPS educational psychologists, Maynooth University student support, Education Welfare Officers
- Family support includes Domestic Violence services, Family Resource Centres, Tusla Family Support Service
- Justice includes Gardai, Garda Youth Diversion Project
- Social work includes Tusla social workers
- Therapy includes counsellors and psychotherapists across for instance, HSE and Kildare Youth Services
- Youth work includes youth project workers/assistants, Kildare Youth Services, Foróige