Trauma and young people

Moving toward trauma-informed services and systems

PHOENIX AUSTRALIA | Centre for Posttraumatic Mental Health

Orygen
The National Centre of Excellence in Youth Mental Health

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Executive summary

Trauma and its impact

Experiences of trauma are common and international studies suggest that between half to two-thirds of young people will have been exposed to at least one traumatic event by the age of 16 years. For young people in contact with the justice system or in the care of family and human services, from refugee backgrounds, those working in armed forces or emergency services, or young Aboriginal and Torres Strait Islanders, the likelihood of having experienced trauma is much higher.

A distinction is often made between Type I and Type II trauma. Type I trauma is generally a single event that involves witnessing or experiencing an event that involves threat of serious injury or death. Type II trauma, on the other hand, involves prolonged and repeated experiences of trauma, abuse or neglect, often referred to as complex trauma. In some cases, trauma reactions can arise without direct exposure to the event (secondary or vicarious trauma) and may even be transmitted to subsequent generations (intergenerational trauma).

Reactions to trauma exposure vary and some young people will even draw strength and personal resilience and fortitude from an adverse or traumatic event. However, for many others, the negative impact of these experiences may persist, exacerbate over time, or develop later in life. The greater the number, and severity, of adverse experiences the greater the risk of mental distress, depression, smoking, disability and unemployment. Individuals with six or more adverse childhood experiences have been found to have a 20-year reduction in their lifespan.

Not surprisingly then, economic evaluations nationally and internationally have reported that trauma results in significant costs to the community, across healthcare, justice systems, family welfare, as well as lost productivity and tax revenue.

In particular, trauma exposure can increase the risk of mental ill-health, lengthen the duration of the illness, compound its severity and complexity, and can impact on treatment response. Posttraumatic Stress Disorder (PTSD) has provided a clinical diagnosis through which the symptoms and impact of trauma can be understood and treated. The more complex the trauma, the more complex the symptoms of PTSD are likely to be. However, it is important to note that trauma-related mental health diagnoses go beyond PTSD and can include anxiety, depression, psychosis, personality disorders, self-harm and suicide-related behaviours, eating disorders, and comorbidity with alcohol and substance misuse.

Seeking help and disclosure

Early intervention for the impact of trauma is critical, particularly in instances where mental ill-health onsets, or is exacerbated, as a consequence. However, many young people do not disclose trauma or seek help. Reasons include multiple systemic barriers which hinder professional help-seeking for trauma, such as personal financial limitations and a lack of service or clinical specialist availability (also well documented across a range of mental health issues).

Other reasons are more personal or experiential. They include: fearing the consequences of disclosure; a lack of trust in professionals or the health system; not knowing how to disclose; or feeling ashamed or embarrassed. For some young people, intergenerational or cyclical trauma also prevents disclosure as it is normalised and/or considered an everyday and accepted part of life. While some young people appear to have their concerns validated through negative professional help-seeking experiences, other young people consider professional help-seeking important and that it can provide a sense of relief or freedom in disclosing the trauma and taking assertive action to address it.

However, many service providers consulted for this report identified inadequate enquiry about/assessment of trauma in young people by youth mental health services. In part this is due to a lack of capacity to respond, concerns about re-traumatisation, a lack of availability and training in assessment tools, or a belief that trauma treatment should be provided separately. As such, there appears to be a need for tools or processes for service providers to improve trauma disclosure among young clients (across multiple contexts). These should be of practical utility in a range of clinical and non-clinical settings and support non-judgmental, validating professional responses.

Trauma-informed care for young people

One of the approaches to improving the capacity for services to increase a sense of safety, trust and understanding, which in turn may support disclosure, is trauma-informed care. This approach has been increasingly adopted across a range of Australian youth-focused service settings. While trauma-informed care is not designed to directly ameliorate any specific symptoms related to trauma exposure, it does aim to provide a service environment (through policy and organisational level strategies and frameworks) that takes account of the specific needs and sensitivities of those who have experienced trauma.

While the principles of trauma-informed care are widely understood across mental health, juvenile justice, child protection and other youth-focused service systems, the approach appears to be inconsistently operationalised, limiting the ability to ensure quality and develop the evidence base. This could be a result of differing core service goals across systems as well as a lack of clear guidance in government policy and contract documents regarding its implementation and evaluation. Indeed, despite a recent increase in the literature regarding trauma-informed care, most research currently focuses on improvements in awareness and perceived capacity and capability by providers. Significant research gaps remain, including whether trauma-informed program implementation leads to **meaningful outcomes** for young people.

Trauma-specific treatments

Stakeholders consulted for this report identified a number of barriers to providing effective treatment for trauma in young people that can be addressed through assertive policy efforts, workforce development activities and funding arrangements. These barriers included inadequate diagnostic frameworks for young people with complex trauma experiences, a limited number of appropriate mental health practitioners skilled in trauma treatment approaches or an understanding of trauma, and an insufficient number of Medicare Benefits Schedule (MBS) Better Access sessions to provide the support needed.

A literature review conducted for this report also found that, beyond PTSD, there is limited evidence for effective treatment of issues arising from complex trauma in young people, or the impact of trauma on the symptomology and treatment responses across a broad range of mental health diagnoses. This report identifies a need for trials and systematic reviews that respond to these significant research gaps.

A systems approach to trauma

Young people with experiences of trauma, particularly of complex trauma, are likely to be engaged in multiple services and systems that are responding to their immediate needs for safety and wellbeing (including child protection) as well as those responding to or mitigating against the negative impact of trauma on a young person's life (including mental health, physical health, drug and alcohol services, juvenile justice services and education).

However, as the recent Royal Commission into Institutional Responses to Child Abuse found, our current service systems are inadequate in regards to their capability and capacity to respond to the needs of individuals with trauma histories who are involved in, or move in and out of, multiple services (1). The resulting 'merry go round' of service presentations and representations, and the telling and re-telling trauma histories, can contribute to a negative, ineffectual and traumatising experience of the Australian health and human services system. This situation has in part occurred through: a lack of inter- and intra-government leadership and policy; an inconsistent understanding of the implementation of trauma-informed approaches across, and even within, systems; workforce capacity and capability issues; and a lack of targeted funding streams to support efforts to achieve cross-system collaboration for what is, often, a shared client group.

Innovative and regionally responsive mechanisms for cross-sector collaboration to respond to the needs of young people experiencing heightened risk and vulnerability have been developed in Australia and internationally. These approaches have demonstrated improved outcomes for these young people, including in education and housing security.

Opportunities and recommendations

This report identifies a number of opportunities to improve the response to trauma among Australian young people, with a particular focus on improving identification, support and treatment within mental health systems. Across all the actions and activities described below, it is crucial that sector experts (across trauma and youth mental health) and individuals with a lived experience are involved and contribute to their design, implementation and evaluation.

Policy

There is a need for all government mental health policies to recognise the extent and impact of trauma experiences among young people, particularly those who are experiencing mental ill-health.

All Australian governments

1. The Council of Australian Governments (COAG) Health Council should drive a national policy agenda for trauma, recognising it as a matter of national significance that requires a coordinated response from all Australian governments. A key priority should include early intervention to respond to the experience and impact of trauma among youth populations.
2. Through this national agenda, a National Partnership Agreement (NPA) for trauma and young people should be developed and funded by all Australian governments. The focus of this agreement should be the development and implementation of a nationally consistent systems approach for young people who have experienced trauma. This should be informed by:
   - A national expert reference group (including individuals with a lived experience).
   - The literature, models and evidence described in this report.

State and territory governments

3. All state and territory governments should clearly describe responses to 'trauma' and 'adversity' in policies across a range of youth service systems, including mental health, juvenile justice, human and family services (e.g. out of home care, child protection) and education. This should focus on providing a consistent approach to the implementation and translation of trauma-informed care across state and territory funded mental health services.
4. State and territory government mental health policy documents should articulate activities and strategies to build the skills and capabilities of the mental health workforce to deliver evidence-based trauma assessment and treatment.
5. State and territory governments should also consider developing 'youth at risk' or 'vulnerable youth' strategies which can provide a whole-of-government/multi-portfolio response to young people who have experienced trauma.

Regional service planning and coordination

Effective trauma responses for young people must recognise there are large numbers of young people engaged in mental health services who have complex and severe trauma reactions for whom a systemic response is needed.

6. The Australian Government should engage youth mental health and trauma sector experts to expand on the work of this report and provide nationally consistent guidance for Primary Health Networks (PHNs) on:
   - Understanding the experience and impact of trauma on young people's mental health.
   - The current evidence for effective interventions and treatments.
   - Commissioning to support evidence-based service design and delivery which responds to trauma and young people.
   - Undertaking needs assessment and service planning activities which include trauma-informed care and treatment. This includes identifying:
     - existing services and gaps in mental health service delivery
     - barriers to mental health service access for young people with experiences of trauma and referral uptakes by mental health services from other services
     - overlap or duplications of trauma-focused responses provided by other systems working with young people who have experienced or are experiencing trauma (e.g. human and social services, justice and emergency departments).
7. Through the NPA (described in Recommendation 2), funding should be provided for cross-sector coordinated care and/or service activities at a regional level. These should focus on young people with experiences of trauma who are at risk of homelessness, offending, early school leaving, mental ill-health and substance misuse.

Trauma assessments

While clinical trauma assessment tools have been developed and validated for child and adolescent populations there is a need to develop and validate a trauma assessment tool for young people across the 12-25-year age span. Tools which screen for the symptoms and impact of complex trauma in this age group (as opposed to a PTSD assessment) also appear to be needed.

8. Develop and trial a trauma-informed, youth specific tool to assess the presence and impacts of trauma in young people aged 12-25 years. This would include the following components:
   - *Component One:* Develop an assessment tool which should include a clinically significant threshold point regarding the severity impact of trauma and include PTSD, complex PTSD (C-PTSD) and, broader trauma-related symptoms. With funding provided through Australian research funding bodies, this tool should be tested and validated through a research trial in 10 youth mental health services.
   - *Component Two:* Develop a training package and clinical manual for administering the assessment tool with funding provided by the Australian Government.
9. Once the youth specific trauma assessment tool has been validated, the Australian Government should create a separate Better Access MBS item specifically to undertake this assessment. This item should be available conditional on:
   - a young person being in receipt of a mental health care plan by a GP
   - the clinician being accredited to administer the assessment tool (via successful completion of the training package)
   - the clinician submitting a report back to the GP outlining the symptoms and impact of any trauma reported which will confirm the assessment has been undertaken utilising this tool.

Service delivery and workforce

There is an urgent need to improve the capability and capacity of youth mental health services and psychological service providers to respond effectively to experiences of trauma.

10. The Australian Government should develop a targeted primary mental health care funding package through which a young person with a severe trauma presentation could then be provided with the evidence-based treatment dosage and duration. This should:
    - be made available to services through the Primary Health Networks (PHNs) commissioning processes, with clearly defined specifications and developed with technical expertise and support from Orygen and Phoenix Australia, to ensure national consistency and compliance.
    - utilise funding options through both the MBS (Better Access) Initiative as well as the broader range of service options provided through the Access to Allied Psychologists (ATAPS) program, or the development of individually targeted packages of care clearly tied to the evidence-based treatment modalities
    - match trauma treatment to a stepped-care model delivered by clinicians with advanced practice training. Over a period of 12 months this would increase incrementally to 20 sessions (with review points after 6, 10 sessions and 15 sessions) for those with severe and complex presentations of trauma-related mental ill-health.
11. Increase the number of service providers who are able to respond effectively to trauma among young people and mitigate against the risk of vicarious trauma experienced by staff working with clients who have trauma histories. This should include:
    - COAG to engage a national stakeholder group (including university and training peak bodies and other key professional bodies), to develop and achieve consensus on trauma-related course curriculum. This would be embedded in the education and training for early career professionals likely to work in service systems that have frequent contact with young people who have trauma histories.
    - Orygen, in partnership with the University of Melbourne Youth Mental Health Graduate Program, to develop an advanced practice T*rauma and youth mental health training and supervision package*.
12. Improve awareness of trauma and its impact on youth mental health among young people, their families and the broader youth services sector, including mental health. This should include improvements to information available on government-funded youth mental health websites, such as information on the symptoms and effects of complex, interpersonal, intergenerational and secondary trauma and its effects. Information on clinical assessment should also be updated to recognise trauma as a distinct diagnoses from anxiety disorders (as now recognised in the Diagnostic and Statistical Manual of Mental Disorders, the DSM 5).
13. The National Mental Health Commission, through their remit on monitoring and reporting on mental health and suicide prevention, should include measures specific to the implementation of trauma-informed care where policies and services have identified this as a key service component. This should also be a focus of state and territory mental health commissions with a similar monitoring function.

Research and knowledge translation to build and disseminate the evidence base for trauma and youth people

A significant number of gaps in the available research evidence have been identified through this briefing, although it is a growing area of interest. The paucity of research available on effective responses and interventions for young people aged 12-25 years across the broad range of trauma experiences needs to be addressed.

14. The National Health and Medical Research Council, the Medical Research Future Fund and the Australian Research Council to respond to gaps in research through supporting a trauma and young person focused research agenda focused on:
    - development and trial of a youth specific trauma assessment tool as per Recommendation 8
    - whether trauma-informed program implementation leads to meaningful outcomes in the short or long-term for young people and their families
    - researching effective and appropriate therapies and interventions (including technology and online interventions) for young people with Complex PTSD
    - including trauma exposure in research on mental health treatments for young people with any presenting conditions
    - a cost-benefit analysis of both trauma-informed care and new and emerging treatment approaches
    - family-centred approaches for young people aged 12-25 years.
15. The Australian Government to fund the development of an evidence clearinghouse dedicated to trauma-informed care and specific treatment in Australia.
    - This would be administered by Phoenix Australia and assist in consolidating different trauma-informed approaches across different populations and age-groups. The Australian Government should also seek co-investment from state and territory governments given the benefits they would also receive in the identification of effective, evidence-based trauma programs and interventions.

Section One

Introduction

Trauma and young people is a report developed through a partnership between Orygen, The National Centre of Excellence in Youth Mental Health (Orygen) and Phoenix Australia, Centre for Posttraumatic Mental Health (Phoenix Australia).

The report has been informed through a review of the academic and grey literature on trauma and young people including prevalence, impacts and the aetiology or concurrence with mental health conditions. A comprehensive review of the national and international literature on trauma-informed care and treatments has been undertaken, including a scan of Australian, State and Territory government's policies and plans across the areas of mental health, suicide prevention, juvenile justice, child welfare, drug and alcohol and homelessness.

A review of evidence was also conducted to identify the most relevant, high quality (controlled studies) treatment outcome research published in peer reviewed literature in the past five years on trauma-specific interventions for young people who are experiencing mental ill-health following the experience of trauma, abuse or neglect. The authors also reviewed the current evidence base supporting trauma-informed care in adolescents. This yielded nearly a hundred peer-reviewed studies, with approximately half of these studies published within the last two years, reflecting the increasing interest in building an evidence base supporting trauma-informed care.

Representatives from the trauma and youth mental health sectors were engaged in consultation at various points in the report's development. This included an online consultation (Appendix 1) of over 20 key national stakeholders in the field of youth services, trauma and/or mental health which was followed up with a face-to-face roundtable event held on 25 May 2017 to further discuss and refine the key findings and recommendations emerging from this work.

To ensure that the report also reflected the views of young people, data was used from a wider project at Orygen, which collected subjective experiences about the facilitators and barriers to help-seeking and disclosure in young people with trauma exposure from online mental health forum posts. A qualitative descriptive approach was utilised in this project to analyse 119 forum posts from beyondblue and 128 posts from ReachOut forums.

Given the identified difficulties in disclosing and help-seeking, the observational nature of internet forum posts allowed access to information about young people's experience of trauma exposure. It also provided access to data about the barriers to disclosure from young people who have not formally disclosed to peers or professionals, rather than from only those young people already in contact with the mental health system.

Posts were included if the information was publicly accessible without a registration or password, if the lead post was published within the last year at the time of data collection, and if the lead post contained keywords ('trauma', 'posttraumatic stress' and/or 'PTSD', or described experiences commonly cited as being traumatic, such as sexual abuse, physical assault, bullying, serious accident), and if the post was written in English. Posts were excluded if posters identified themselves as being an adult (above 25 years old) or a child (below 13 years old), or included second-hand experiences

that were not self-reports. The current policy paper utilised data coded under the themes of treatment, disclosure and help-seeking.

As forum posts often do not contain identifiable information such as age, location and gender, the extent to which the current analysis can be transferable to all contexts is unknown. Additionally, it is not possible to confirm whether all forum posters were within the age range of 12-25 years old.

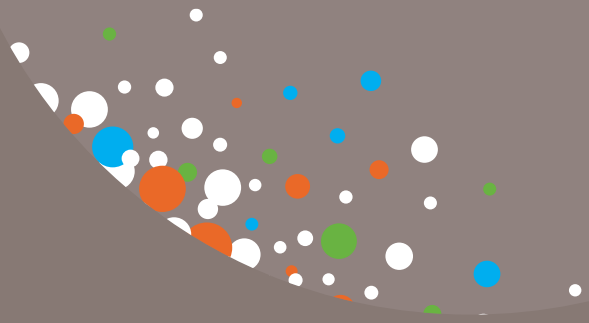
Utilising this breadth of information across the published evidence base, grey literature, policy documents, expert opinion and the experiences of young people, this report aims to provide government policy makers, service planners and providers and the broader community with a series of recommendations on how the response to the effects of trauma among young people can be improved across:

1. Youth-focused mental health policies, services and programs where the dominant frame for responding to trauma is currently through diagnosis and treatment of PTSD.
2. Service systems which are likely to have ongoing and intensive contact with young people who have experienced trauma and adversity, particularly in childhood. Many of these services will be providing care and support to the same young people.

It is important to note that this report does not address or provide recommendations regarding those functions of service delivery that respond directly to current abuse and neglect such as police, child protection services and family violence services.

Further, the word 'trauma' can often be used inconsistently, referring at times to an event and at other times to the psychological impact of an event. Technically, trauma means wound or injury, which applied to mental health, means an injury to a person's psychological or emotional wellbeing. In this report we have endeavoured to use *traumatic event* or *traumatic experience* to refer to an event that has resulted in psychological injury and *trauma* to refer to the injury itself.

The experience of trauma can contribute to, or compound, the development of many different forms of mental ill-health, beyond diagnoses of PTSD.



Section Two

What is trauma and how prevalent is it among young people?

2.1 Definitions

Trauma can occur through exposure to a singular event or compounded cumulative negative experiences and influences that pose a threat to personal safety, wellbeing and, in some instances, life. Trauma can also be a result of being exposed to the death, suffering or injury of another person.

For the purposes of this report, different experiences of trauma (Table 1) are defined which may present differently in young people and/or require a different service or clinical response.

TABLE 1 – EXPERIENCES OF TRAUMA

Type of trauma	Description
Single incident trauma	Single incident trauma is sometimes described in the literature as Type I Trauma and 'relates to an unexpected and 'out of the blue' event such as a natural disaster, traumatic accident, terrorist attack or single episode of assault, abuse or witnessing of such an event' (2).
Complex trauma	Complex trauma is sometimes described in the literature as Type II Trauma and relates to prolonged or repeated traumatic events that often begin in childhood and extend over long periods of time. Typically the events are interpersonal, such as neglect, physical and sexual abuse (5). Experiences of complex trauma are prevalent in young people presenting with a broad range of psychiatric diagnoses and significantly compound the severity and complexity of these presentations.
Secondary trauma	Secondary trauma can arise when someone hears first-hand about the traumatic experience of another, for example professionals working with traumatised populations, including mental health and social workers (3). It can also occur through exposure to accounts of trauma by peers or the media (4).
Intergenerational trauma	Intergenerational trauma is the impact of trauma experienced in parents' lives being passed down to their children. Intergenerational trauma is often discussed in the context of Aboriginal and Torres Strait Islander young people (6) and among children of refugees (7, 8). It can also be experienced by children of veterans and other parents continuing to be affected by their own trauma.

Adversity is a term often used in trauma literature, sometimes interchangeably, although the term refers to experiences of disadvantage and difficulties which may or may not necessarily be traumatising or deeply distressing. For example, the list of Adverse Childhood Experiences (ACEs) which were developed through an important longitudinal American study, relate to a broader set of experiences which include 'experiences of neglect, abuse or violence within the family, being forced to take on adult responsibilities (as in the case of young carers), or living in households where people are misusing substances' (9) p5.

2.2 Trauma and mental ill-health

It is now well recognised that the experience of trauma can contribute to, or compound, the development of many different forms of mental ill-health, beyond diagnoses of PTSD (Figure 1). In an Australian study, around two in three children and adolescents attending a Child and Adolescent Mental Health Service (CAMHS) were found to have experienced an adverse event within the past 12 months with 20 per cent experiencing three or more of these adversities (10). Historically, research has shown that an overwhelming majority of public mental health clients (including adolescents in inpatient care) have multiple experiences of trauma (11, 12).

Trauma experiences can increase the risk of onset of mental ill-health, lengthen the duration of the illness, compound the severity and complexity of mental ill-health and impact on responses to treatment (13). Further, the experience of severe mental ill-health such as psychosis and some associated service responses and treatment interventions can, in and of itself, be traumatising for young people (14).

Trauma-specific diagnoses

Posttraumatic stress disorder (PTSD) – is a particular set of reactions that can develop in people who have been through a traumatic event which involved experiencing or witnessing actual or threatened death, serious injury, or sexual violence (15). PTSD was removed from anxiety disorders and is now recognised in the DSM-5 as a separate disorder. Among children and young people, around one in six will develop PTSD after a traumatic event although this varies widely across type of trauma experienced and gender (e.g. lowest for boys with non-interpersonal trauma, highest for girls with interpersonal trauma) (16). PTSD is only one clinical manifestation following a traumatic event or experience and it is important that responses to trauma are inclusive of a much broader range of clinical and behavioural presentations.

Complex PTSD (C-PTSD) – is a psychological response to repetitive, prolonged trauma involving harm or neglect particularly during childhood. It extends beyond the core PTSD reactions to impact on (1) emotion processing, (2) self-organisation and (3) relational functioning (17). While not recognised as a clinical diagnosis in the DSM-5, C-PTSD is increasingly referred to in the literature with varying levels of support as a distinct diagnosis requiring a different treatment response.

Other trauma-related mental health conditions

A significant body of literature describes the association between childhood trauma and the increased risk for mental ill-health in adulthood, with many mental health problems having their onset in adolescence or young adulthood (18). These illnesses are often part of the sequelae of trauma and can be present with or without PTSD and C-PTSD symptoms. They include (but are not limited to):

Anxiety – Early emotional trauma has been shown to be a risk factor for the development of anxiety disorders (panic, generalised anxiety and social anxiety) with those with early emotional trauma being 1.9 to 3.6 fold more likely to develop anxiety disorders than those without early emotional trauma (19).

Depression – Childhood experiences of emotional abuse and/or neglect have been shown to be strongly associated with depression. Associations have also been identified for childhood sexual abuse, physical abuse and experiences of domestic violence (20). Children who had experienced physical or multiple types of abuse appear to be at heightened risk of developing a lifetime major depressive disorder in early adulthood (21).

Psychosis – Experiences of physical and/or sexual abuse are common in young people presenting with first episode psychosis and a number of studies have demonstrated some evidence to suggest a relationship between childhood trauma and psychotic disorders (14).

A recent systematic review and meta-analysis found traumas in childhood were associated with symptoms of hallucinations and delusions within psychotic disorders (22). Young people with these experiences were also more likely to present with a comorbid diagnosis at program entry and more likely to attempt suicide during treatment (23).

Personality disorders – Exposure to trauma prior to and during adolescence (including abuse and also adverse environments and maladaptive parenting) has been found to have significant impacts on personality development and increases the risk of a young person developing Borderline Personality Disorder (BPD) (24). A comprehensive review of evidence published between 1995 and 2007 found support for a causal relationship between childhood trauma and the development of BPD (25) although there continues to remain debate on this in the recent literature.

Self-harm and suicide-related behaviours – Childhood abuse and neglect have been associated with suicidal ideation and attempts across adolescents in community, clinical, and high risk samples across all demographics, mental health conditions, family and peer factors, with stronger associations found for sexual and emotional abuse compared to physical abuse and neglect (26). PTSD has also been associated with increased prior attempts of suicide and current suicidal ideation in the general population (but not suicide itself) (27).

Eating disorders – A recent study found that PTSD was observed in 33.9 per cent of patients (general population) with an eating disorder. No differences for type of eating disorder were found, although the severity of eating disorder was higher among those also experiencing PTSD (28). In particular, sexual abuse, as well as other types of abuse and neglect in childhood, have been widely linked to increased risk of eating disorders in children, adolescents and adults (29-31).

Complexity and comorbidity

Responses related to, or compounded by, trauma are complex. The idea that a mental health diagnosis of PTSD is, in and of itself, sufficient to understand and respond to the myriad of impacts, responses and effects of complex (as well as secondary and intergenerational trauma) has been challenged by many in the sector (12). Issues regarding the current application of the evidence base for PTSD treatment across the complexity of trauma presentations and experiences are also discussed in Section Seven of this report.

> “Young people with a history of prolonged and repeated trauma (as opposed to trauma that is time limited or related to a single traumatic event) present with clinical characteristics that transcend the current criteria.”
>
> **Service provider**

Responses need to be multifaceted (32) and address:

- a range of symptomology;
- the underlying causes of trauma (which may still be being experienced);
- and the impacts across the individual’s lifespan (as well as the following generations) including: disengagement from social, educational and economic participation, homelessness, drug and alcohol use, mental illness, self-harming behaviours and family breakdown. (33).

For example, stakeholders described the complexity of working with a young person who had a history of sexual abuse, who was presenting with symptoms of psychosis, compounded by substance abuse issues, who was also experiencing homelessness, unemployment and suicidal ideation.

As such, there appears to be a need for the following:

- Inclusion of complex trauma presentations in diagnostic frameworks for appropriate and effective mental health care and treatment to be provided
- stronger policy and system drivers for responses across human services, mental health, substance abuse, housing and relationship services (32).

> “The majority of young people will require an approach that is tailored specifically to their needs, the type of trauma they have experienced, the severity of this, the age when this trauma occurred. Much of this is not taken into account by many mental health services when developing a treatment plan for young people.”
>
> **Service provider**

Figure 1. Trauma-specific diagnoses and related mental health conditions

2.3 Prevalence of trauma among young people and youth populations in Australia

While there is limited Australian data available specifically on the experiences of trauma in young people, the literature suggests that between 57-75 per cent of Australians will experience a potentially traumatic event at some point in their lives (34, 35). International studies also suggest around half to two-thirds of young people will have been exposed to at least one traumatic event by the age of 16 years (36, 37). For Aboriginal and Torres Strait Islander young people, trauma experiences are more likely to be a complex combination of both current and intergenerational experiences of trauma.

In 2007, among the general population of Australian young people aged 16-24 years, 15 per cent were affected by anxiety disorders of which the most common was PTSD[a] (38).

Experiences of trauma are common among particular groups of young people in Australia including:

- **Children and young people who live in out-of-home care** (39) most commonly because of issues of abuse or neglect (40), this includes approximately 43,009 Australian young people (41). 60 per cent have been found to have a major psychiatric disorder diagnosis with posttraumatic stress among the most common (41). Children and young people in, or who have left, out-of-home care have an increased likelihood of mental health issues and attempting suicide as adults than their peers who have not been in care (42).
- **Young people who are under youth justice supervision**, of whom there are approximately 5,600 in Australia on an average day (43). 80 per cent of young people in detention have been found to have experienced trauma (44). A survey of young people in juvenile detention in NSW found that 81 per cent of females and 57 per cent of male young people reported that they had been abused or neglected (45). Further, a Victorian Department of Health and Human Services snapshot of young offenders detained on sentence and remand found 63 per cent were victims of abuse, trauma or neglect (46). Another study found that each additional adverse childhood experience increased the risk of becoming a serious, chronic and violent juvenile offender by more than 35 per cent (47). The experience of detention, including lockdowns, isolation, threats from others and conflict among detainees are also likely to result in further experiences of trauma (48).
- **Young people who arrived through the Humanitarian Programme**, of whom there were 19,320 between 2010-11 and 2014-15 (49). Many of these young people and their families will have had experiences of violence directed to themselves and/or witnessed violence or deaths. They may be traumatised due to separation from family members, as well as their experiences in temporary accommodation, refugee camps, settlements and mandatory detention centres (50). Rates of PTSD among resettled refugee children and adolescents in Western countries have been found to be up to 17 per cent (51). Young people who are resettled may also face racial discrimination, which may bring both new adversity and/or may remind the young person of previous prejudice faced in their country of origin (52).
- **Young people who are homeless**. In Australia in 2017 this was estimated to be more than 26,000 young people aged 12-24 years (53). Trauma has been found to be an important factor in young peoples' pathway to homelessness (54). 97 per cent of homeless participants in one Australian study were found to have experienced more than four traumatic events (55). Few studies have assessed PTSD among people (all ages) who are experiencing homelessness. One study found 79 per cent of the sample met criteria for a lifetime diagnosis of PTSD, while 12-month prevalence was 41 per cent (56).
- **Young people in certain occupational groups such as the armed forces** (57) and **emergency services** (58). Research in the UK has found that younger recruits in the armed forces were more likely to suffer posttraumatic stress disorder, and that those from disadvantaged backgrounds were most at risk. Forces Watch, a UK group which campaigns to raise the minimum age of recruitment from 16 to 18 (in Australia recruitment age is 17) claims those who join at 16 and 17 are twice as likely to develop posttraumatic stress disorder (59). In Australia, ex-service personnel aged 18-29 years have been found to have a higher rate of suicide than men of the same age in the general population, with exposure to traumatic environments and events a key risk factor (60). Among trainee

[a] Noting that PTSD is now not included in the DSM V as an Anxiety Disorder, and now is included in a new category Trauma and Stressor-Related Disorders

paramedics, 94 per cent had been found to have directly experienced trauma, with 16 per cent meeting PTSD criteria (61).

- **LGBTIQ young people**: 61 per cent of Australian LGBTIQ young people reported verbal abuse because of homophobia and 18 per cent reported physical abuse. 24 per cent reported they had experienced verbal and physical abuse in the family home and 80 per cent experienced abuse at school (62). In a recent Australian study of over 800 transgender young people aged 14-25 years, approximately 25 per cent had been diagnosed with PTSD in their lifetime (63).
- **Aboriginal and Torres Strait Islander young people** have an increased risk of experiencing complex trauma directly or through secondary exposure (intergenerational trauma), as described in more detail in Spotlight 1.

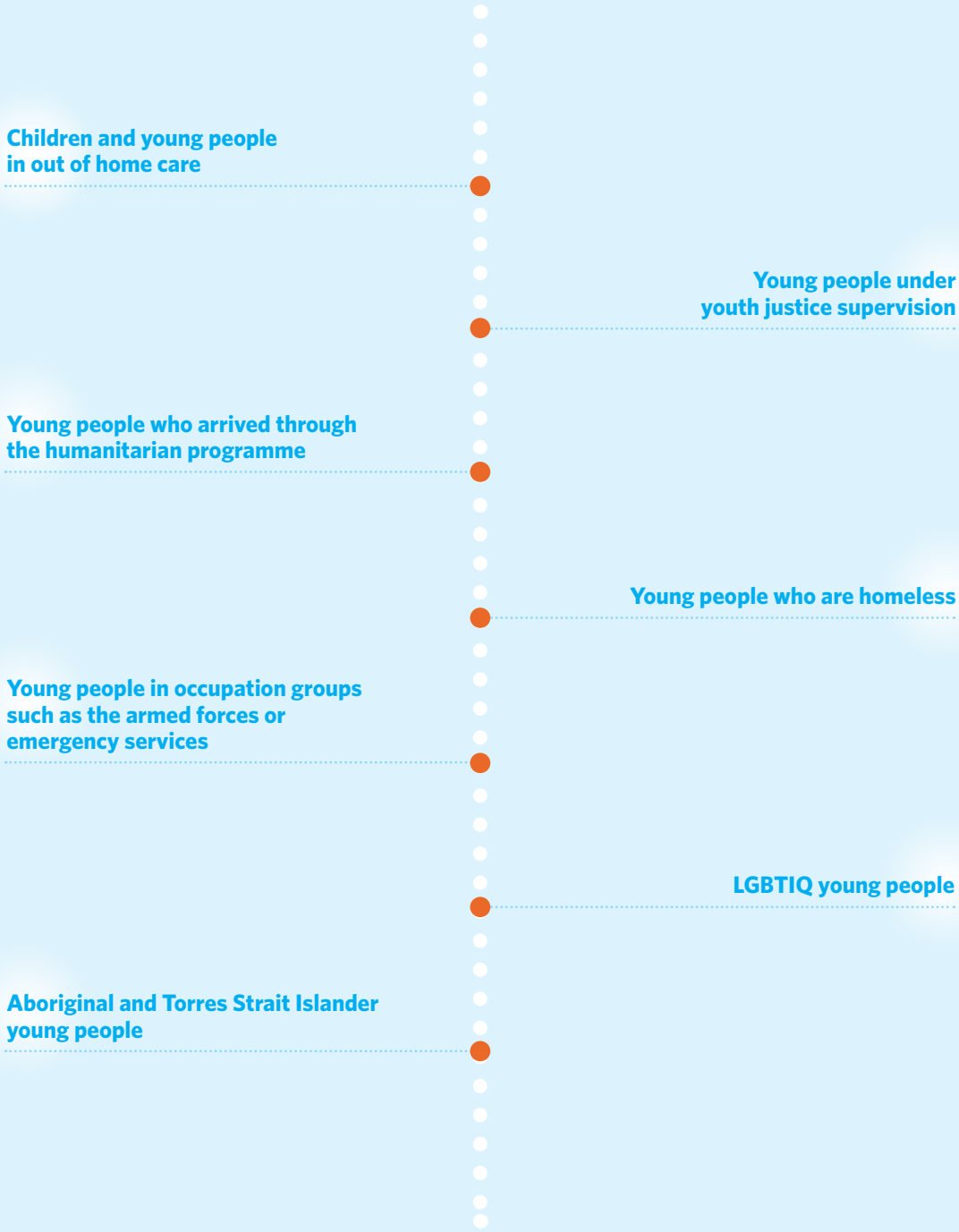
Spotlight 1: Experience of trauma among Aboriginal and Torres Strait Islander young people

Many Aboriginal and Torres Strait Islander young people are growing up in supportive families, communities and cultures, all of which lead to a strengthened sense of identity, connection and good wellbeing.

However, there are also significant numbers of Aboriginal and Torres Strait Islander young people who experience the ongoing repercussions of past government policies and a persistent high rate of separation from family and community. This has contributed to high rates of grief and trauma (including intergenerational trauma).

Historical trauma, together with current trauma, can lead to a vicious cycle of physical and mental health problems, addiction, incarceration, self-harm and suicide (64), as evidenced by Australian data and research. For example Aboriginal and Torres Strait Islander young people are 5.4 times more likely than non-Aboriginal and Torres Strait Islander young people to be hospitalised for assault and eight times as likely to have experienced substantiated abuse or neglect (65). A study of 221 Aboriginal persons in Australia (18-65 years) found over 97 per cent reported exposure to a traumatic event and 55.2 per cent met diagnostic criteria for PTSD (66). Another research project focusing on adolescents and young adults in the Kimberly region found the overall prevalence of participants who met the criteria for a PTSD diagnosis by self-report was 14 per cent for adolescents and 16 per cent for young adults (67).

Figure 2. Groups of young people in Australia with a high prevalance of trauma



SUMMARY

Experiences of trauma include single incidents, secondary exposure, prolonged or repeated events, and may be intergenerational.

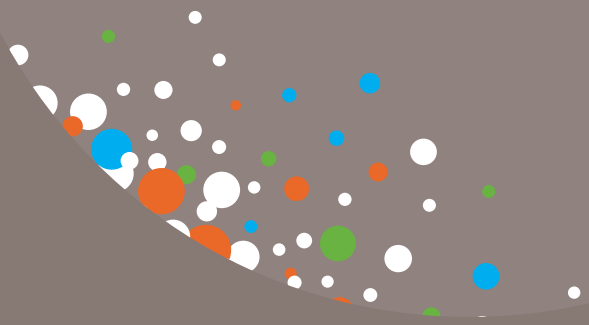
Trauma exposure can increase the risk of mental ill-health, lengthen duration of illness, compound its severity and complexity, and can impact on treatment response.

Trauma-related mental health diagnoses go beyond PTSD, and can include anxiety, depression, psychosis, personality disorders, self-harm and suicide-related behaviours, eating disorders, and comorbidity with alcohol and substance misuse.

Half to two-thirds of young people will have been exposed to at least one traumatic event by the age of 16 years.

Trauma exposure is common among particular groups such as young people in out-of-home care or under youth justice supervision, refugee young people, those experiencing homelessness, certain occupations groups (for example emergency services, armed forces and veterans) and LGBTIQ young people. Historical and current trauma has also had a serious impact on the social and emotional wellbeing of Aboriginal and Torres Strait Islander young people.

Trauma can have a devastating effect on the trajectory of a young person's life. Everything can be affected: their physical and mental health, self-worth and ability to develop healthy relationships.



Section Three

Impact of trauma

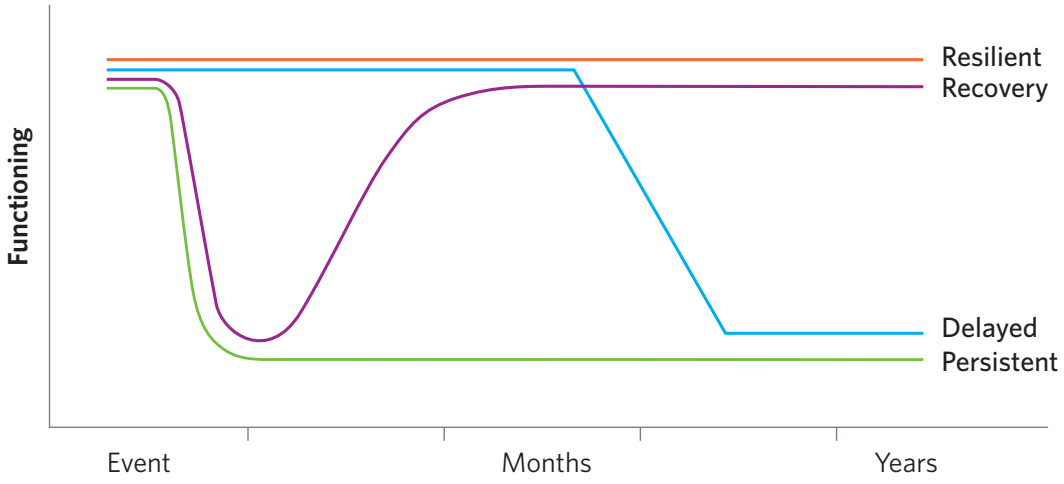
3.1 Individual impacts

Young people react in a range of different ways to a traumatic event or series of traumatic experiences (Figure 2). Many young people are resilient and will not develop further problems after their experience. Some may even find they draw additional strength and personal resources. However, for others, reactions may persist or get worse over time, or they may only first become evident much later in life (68). The effect of adverse childhood experiences can be cumulative, with a 'progression of outcomes' including an increased risk of suicide (42). The range of trauma responses are illustrated in Figure 3.

Traumatic experiences, particularly in childhood and adolescence, can also play havoc with brain development, compromising core neural networks (69),and therefore, future cognitive functioning. There have been a number of imaging studies providing insight into the effects of childhood abuse on brain development, structure and function, with most finding evidence that maltreatment affects sensory systems and brain circuitry (70).

These brain changes can be adaptive responses to facilitate survival in an adverse situation (71). Feeling threatened in childhood, particularly from a person who is supposed to be a care giver, leaves the brain stranded between their survival reflex and attachment, diverting attention from other developmental tasks such as learning (72). This can also leave the individual in a state of high alert and more likely to be easily stressed by minor disruptions.

FIGURE 3: TRAJECTORIES OF TRAUMA (SOURCE: PHOENIX AUSTRALIA)



Potential for posttraumatic growth alongside all trajectories

For these young people, trauma can have devastating effects on the trajectory of their life. Everything can be affected: their physical and mental health and wellbeing, emotional responses, sense of self-worth, behaviours and abilities to develop healthy relationships. Along with the increased risk of developing a range of mental health conditions, discussed in the previous section, the future consequences of adverse childhood experiences have been explored in a major longitudinal research project called the ACE Study (Spotlight 2).

Spotlight 2: ACE Study

Experiences of persistent and lasting abuse and neglect during childhood and adolescence can lead to a wide range of future problems. The ACE Study is a well-regarded longitudinal investigation into the impact of childhood trauma. Participants were recruited to the study between 1995 and 1997 and have been engaged in long-term follow up across a range of health outcomes.

Ten adverse childhood experiences are measured in the study, these include:

1. Emotional abuse
2. Physical abuse
3. Sexual abuse
4. Household substance abuse
5. Household mental illness
6. Witness mother treated violently
7. Incarcerated household member
8. Parental separation or divorce
9. Emotional neglect
10. Physical neglect

Almost two-thirds of surveyed adults reported at least one ACE and more than one in five reported three or more ACEs (73). Numerous research papers published from the study since 1998 have shown clear connections between childhood trauma and later risky behaviours, illness and early death. These include that:

- There is a clear impact of adverse childhood experiences that had occurred, on average, half a century earlier on both mental and physical health: as the number of adverse experiences increased so did the risk of mental distress, depression, smoking, disability and unemployment (74).
- The ACE score had a strong graded relationship to the risk of drug initiation from early adolescence into adulthood and to problems with drug use and addiction (75).
- Individuals with six or more ACEs experienced a 20-year reduction in lifespan (76).

A range of other studies have also explored these impacts:

School incompletion and unemployment – A study involving long-term follow up of the personal economic consequences of childhood maltreatment found adults with documented histories of childhood abuse and/or neglect had lower levels of education, employment, earnings, and fewer assets as adults, compared to their peers. This study also found that there were gender differences, with women experiencing considerably poorer economic outcomes than men, including fewer years of education, lower earnings and they were less likely to have a bank account or own a vehicle (77).

Alcohol and substance use – There are a large number of studies documenting the link between the experience of trauma and substance use among adolescents. Trauma experience is both:

- **A risk factor for future substance abuse and addiction.** Studies have shown that the greater the number of adverse child experiences the more likely it will be that a person will misuse substances in adolescence and adulthood (78). One research project found that two-thirds of people who had experienced four or more adverse experiences in childhood were misusing substances, and were twice as likely to binge drink and eleven times more likely to use heroin or crack (79). The relationship appears to be particularly strong for young women (80). While many young people may use substances as a coping tool or to numb the distress of past memories (or even current events) this can have a further detrimental impact on neuro and cognitive development, lead to traumatic release of memories and/or dissociation, and increase the likelihood of lifetime addictions (9).
- **A result of drug and alcohol misuse.** For example, binge drinking or drug use can itself be a risk factor for later experiences of trauma including assaults, road accidents and overdoses. Several studies have found that for some adolescents (45–66 per cent) substance misuse occurs before exposure to a traumatic event (81, 82).

Harm to the next generation. Intergenerational trauma can be experienced by young people of parents who have not resolved their own trauma, for example through their own maladaptive or detached parenting styles (83, 84). An Australian study found that young people with trauma experiences were significantly more likely to have a parent with a history of trauma (10). Intergenerational trauma is prevalent among Aboriginal and Torres Strait Islander young people as a result of historical government policies, including the forced removal of their parents, grandparents or other relatives from their families and communities between 1910 – 1970 (approximately) (85).

Vicarious trauma can arise amongst those working within service settings where ongoing exposure to the trauma experiences of young people can result in their own trauma reactions. This is similar to secondary trauma; however, it is usually experienced through a cumulative effect, whereas secondary trauma can be experience from a single event. Throughout consultation for this report, the need to recognise and respond to the risk of vicarious trauma in the workforce was raised numerous times, with effective and regular supervision seen as a necessary workplace response to mitigate against this risk.

> “It is important to appreciate the importance of vicarious trauma and how best to safe-guard workers who are regularly exposed to the traumatic experiences of others
>
> **Service provider**

3.2 Economic impacts

Experiences of complex trauma in childhood, such as abuse and neglect, bear significant economic, as well as personal, costs. The Australian Childhood Foundation, Child Abuse Prevention Research Australia and Access Economics estimated that the cost of child abuse to the Australian community in 2007 was $10.7 billion, and as high as $30.1 billion (86).

More recently, Pegasus Economics estimated that the cost impact of child abuse (sexual, emotional and physical) to the Australian and state/territory governments could be a minimum of $6.8 billion annually, representing both government expenditure on services and systems, as well as lost tax revenue (87).

An American study through the Center for Disease Control (89) reported that the costs per child of confirmed cases of physical, sexual and verbal abuse and neglect, which child maltreatment experts say is a small percentage of what actually occurs, was:

- $32,648 in childhood health care costs
- $10,530 in adult medical costs
- $144,360 in productivity losses
- $7,728 in child welfare costs
- $6,747 in criminal justice costs
- $7,999 in special education costs.

While literature on the economic burden of PTSD and cost-benefits of treatment is sparse, what does exist indicates that PTSD is a high burden disorder which incurs higher healthcare costs than many other psychiatric disorders (88).

Single incident trauma as a result of natural disasters also carries a significant social and economic cost in Australia (including in response to mental health issues). A report by Deloitte for the Australian Business Roundtable for Disaster Resilience and Safe Communities (2016) found the economic cost of the social impact of natural disasters to be $9 billion in 2015 (90). This included the intangible costs of increased mental health issues, family violence, and alcohol consumption. For example:

- In the Queensland floods, mental health issues were the largest impact with a lifetime cost of $5.9 billion (net present value in 2015 dollars).
- In the Victorian Black Saturday bushfires, mental health care was the largest intangible cost resulting from the fires, with the lifetime cost of mental health issues estimated at more than $1 billion (net present value in 2015 dollars).

SUMMARY

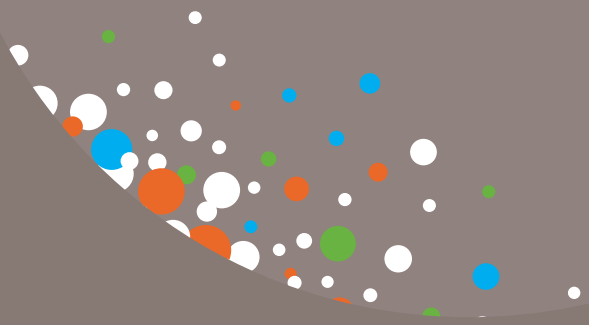
Reactions to trauma exposure vary, some young people will draw strength and resilience from an adverse or traumatic event. For many others, the negative impact of the experience/s on their mental health, physical health, and a range of other factors, may persist, get worse over time, or only become evident later in life.

An increased number and severity of adverse experiences leads to increased risk of mental distress, depression, smoking, disability and unemployment. Individuals with six or more adverse childhood experiences have been found to have a 20 year reduction in lifespan.

Unaddressed trauma can also have harmful impacts on future generations and family members, as is clearly demonstrated among Australia's young Aboriginal and Torres Strait Islander population.

There is a high cost of trauma to the Australian community, across healthcare, justice systems, family welfare, as well as lost productivity and tax revenue.

Young people fear judgement and often hide their trauma, making it difficult to quickly assess them
Service provider



Section Four

Disclosure and help-seeking

Young people who have experienced trauma face significant barriers to seeking help or disclosing the trauma. Many young people do not disclose the traumas they experience. Reasons for this include:

- Thinking they will be unable to cope with the consequences of disclosure.
- Having difficulty or not wanting to remember the trauma experience.
- Minimising or not understanding the impact the trauma is having on them.
- Feel deeply ashamed or embarrassed about the experience.

Many have difficulty verbalising their trauma for fear they won't be believed (91).

A recent study found that service providers working with traumatised young people in the US reported that the 'normalisation' of trauma was also a barrier. That is, that the intergenerational adversity and cyclical trauma experienced in some families was 'not seen as addressable or preventable but accepted as a part of life.' The authors described how the perceived 'inevitability of trauma' and scepticism on the effectiveness of services and treatment constituted a barrier for help-seeking among some young people (92).

Online forums can provide candid opinions and peer advice from young people on sensitive topics (93). For this report, we analysed comments and posts made by young people on youth mental health online forums in Australia (described in the introduction). From this process we identified that forum members had sought or recommended help from a broad range of general and trauma-specific professionals and services, which included:

- general, sexual-assault or trauma-focused counsellors or therapists (through a school, helpline or other)
- GPs
- psychiatrists (with a focus on PTSD or general)
- psychologists
- hospitals
- mental health triage services
- community mental health professionals
- food therapists
- financial educators.

When a young person did seek professional support, a broad range of medical and psychological professionals were approached, with young people reporting a broad range of both positive and negative treatment pathways.

In addition to these professionals or services, young people also disclosed trauma experiences to family, friends, and online forums. Described benefits to disclosure included:

- the importance in building trust with others and being willing to receive support
- expressing a desire for their behaviours and experiences to be understood
- the importance to treatment and determining the best course of action
- experiencing relief or freedom.

However, the online forum posts also identified multiple barriers preventing young people from disclosing trauma exposure. These included: low levels of understanding about what constitutes traumatic experience and symptoms of trauma, uncertainty and distress. For example, a low awareness of trauma created:

- difficulties in knowing how to have a conversation about trauma exposure
- uncertainty about whether their experience constituted trauma or if their symptoms were significant
- uncertainty about whether disclosing would help treatment.

Distress as a disclosure barrier included anticipating personal difficulty or distress when disclosing or wanting to protect family and friends from distress. Others reported difficulty discussing the associated symptoms or comorbidities, and fears about regretting disclosure in the future or having their experience documented. Some of these concerns were validated by negative experiences of disclosure, which resulted in additional distress, regret, or feeling that others did not know how to best respond to or support them.

> “Due to anxiety and the fear of stigma young people are challenged to be open with their story. This can lead to incorrect assessments and responses.”
>
> **Service provider**

In addition to the numerous barriers to disclosing trauma experience, young people reported diverse barriers that were specific to professional help-seeking (described in Table 2).

TABLE 2: BARRIERS DESCRIBED BY YOUNG PEOPLE TO HELP-SEEKING (INDIVIDUAL, SERVICE AND POLICY)

Self	Professionals and health services	Government
• Feeling reluctant or avoidant to seek help. • Personal financial limitations.	• A lack of trust, feeling misunderstood, or negative previous experiences with professionals. • A view that health professionals may pathologise normal reactions to distressing events. • Being placed on a waiting list, long waiting list times and a lack of availability.	• Difficulty seeking support after reaching Medicare limit. • Experiences of frustration or lack of trust with the health system. • Perceived insufficient government funding.

As some of the barriers to disclosing trauma include distress or difficulty in discussing trauma experience, and difficulty ascertaining whether symptoms are significant, an improved awareness and understanding of trauma and its effects are needed among young people. Tools or processes that reduce the distress of disclosure are also needed to support young people with trauma exposure.

> “It’s very easy for single incident trauma events to ‘slip through the cracks’ when an individual present themselves to professional services because I believe that the individual may not be comfortable talking about it at all, and they might try and blame something else, or the clinician themselves may lack experience detecting trauma-related distress.”
>
> **Young person**

Given the difficulty in discussing disclosure, it is important that clinicians are aware that young people seeking help may not disclose their exposure to trauma without a trusting, ongoing therapeutic relationship. There may also be a need for a specific tool or process to disclose trauma experience while minimising the risk of distress. Largely, young people indicate that they require clinicians to respond to trauma with effective treatments, a reduction of distress, and non-judgemental and validating care without financial limitations. How this can be facilitated through system and service responses is discussed in the following section. If current abuse is disclosed, the focus of work should be in addressing the immediate safety of the young person, which may involve child protection services.

SUMMARY

Many young people do not disclose trauma experience or seek help. Reasons for this include: fear of the consequences of disclosure; not knowing how to disclose; or feeling ashamed or embarrassed.

For some young people, intergenerational or cyclical trauma prevents disclosure as it is normalised and/or considered an acceptable part of life.

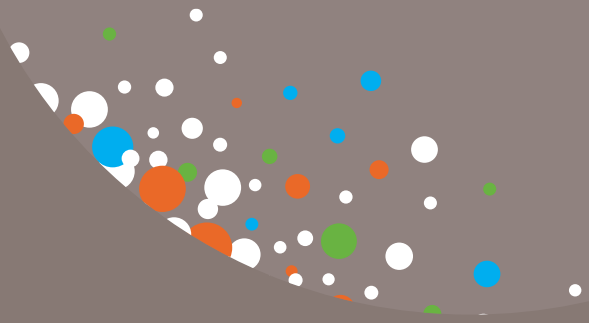
A low level of understanding about trauma and related symptoms, distress and difficulty discussing trauma were all identified as individual/personal barriers to disclosure. Increased education for young people about trauma and its impact is needed.

Multiple systemic barriers hinder professional help-seeking for trauma including personal financial limitations, a lack of trust in professionals or the health system, and a lack of service availability.

Although some young people have had their concerns validated through negative professional help-seeking experiences, young people have also identified that professional help-seeking is important to treatment and provides relief or freedom.

There appears to be a need for a tools or processes for service providers to improve trauma disclosure among young clients and to support non-judgmental, validating professional responses.

Trauma informed care provides a service environment that considers the sensitivities and needs of clients who have experienced trauma.



Section Five

Trauma-informed care

Trauma-informed care was first developed in the United States in the mid-1990s, since which time the approach has gained traction across a number of countries. In recent years, the awareness and uptake of trauma-informed approaches relevant to adolescent service organisations in Australia has been increasing.

Within Australian adolescent services, trauma exposure is viewed as an important factor relating to an adolescent's wellbeing, and there is significant awareness of the need to assess and treat the outcomes associated with trauma exposure. There is also evidence of a significant push for organisations serving adolescent populations to become trauma-informed, by establishing trauma-informed principles that underpin the service model. This push is further reflected in the significant number of formal training packages for service providers now available across the country.

5.1 What is Trauma-informed care

Trauma-informed care, sometimes referred to as trauma-informed practice or approaches, is not designed to directly ameliorate any specific symptoms related to trauma exposure but rather to provide a service environment (through policy and organisational level strategies and frameworks) that takes account of the specific needs and sensitivities of those who have experienced trauma. Generally the principles of trauma-informed care are understood to include:

- understanding its impact
- promoting safety
- ensuring cultural competence
- supporting consumer control, choice and autonomy
- sharing power and governance
- integrating care
- healing in relationships
- recovery-focused care (2).

The emphasis of trauma-informed care is on the physical, psychological and emotional safety for clients and providers. There is a significant focus on a 'do no harm' approach aiming to prevent re-traumatisation by and within services and systems (12).

> "Trauma-Informed service has a strengths based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and children and young people, and that creates opportunities for them to rebuild a sense of control and empowerment."
>
> **Service provider**

A recent book edited and published by Young Minds in the UK on addressing adversity for young people specifically (94) further distilled a trauma or adversity-informed model of service commissioning and care into six key principles:

1. **Prepared** – Prioritises addressing the causes and consequences of childhood adversity and trauma, by understanding local data and needs and bringing in effective expertise when designing responses.

2. **Aware** – Ensure service providers have a good understanding of trauma and adversity and a common framework for identifying and enquiring about trauma.
3. **Flexible** – Provide stepped-care which responds to the sub-clinical and clinical mental health impacts of trauma and develop models of care that are appropriate to young people. In particular these need to consider outreach or street triage to disengaged/disadvantaged/vulnerable young people who won't walk through the door of a service.
4. **Safe and responsible** – Prioritising early intervention, coordinated support from skilled, qualified and trustworthy professionals (who are themselves well supported) and ensuring services have policies and frameworks in place that avoid re-traumatising young people and labelling/stigmatising their behaviours.
5. **Collaborative and enhancing** – Empower young people by recognising their resources and resilience, meaningfully engaging them in decisions relating to their care and treatment and co-design service responses with them. Where possible families, peers and care givers should also be included within the treatment and recovery process.
6. **Integrated** – Support data sharing across agencies, co-commission services (even with a lead agency) to minimise transitions and pathways between service providers and provide timely referrals to expert specialist care when required.

Many service settings in Australia have adopted a trauma-informed care approach. However, there has been a need to adapt the principles to respond to the unique purposes of the service they provide and/or challenges within their service environment. This has led to an inconsistency in, and uncertainty about, how principles are translated into practice. This presents limitations in operationalising trauma-informed care to ensure fidelity, quality and the development of a stronger evidence base.

However, the multiple interpretations of trauma-informed care have left practitioners unclear about what it means for them in their practice (95).

Stakeholders consulted for this briefing (across a range of systems and services) also identified that while principles of trauma-informed care are generally understood, the translation and implementation of these principles in practice are inconsistent. They identified that the factors which have influenced this include the following:

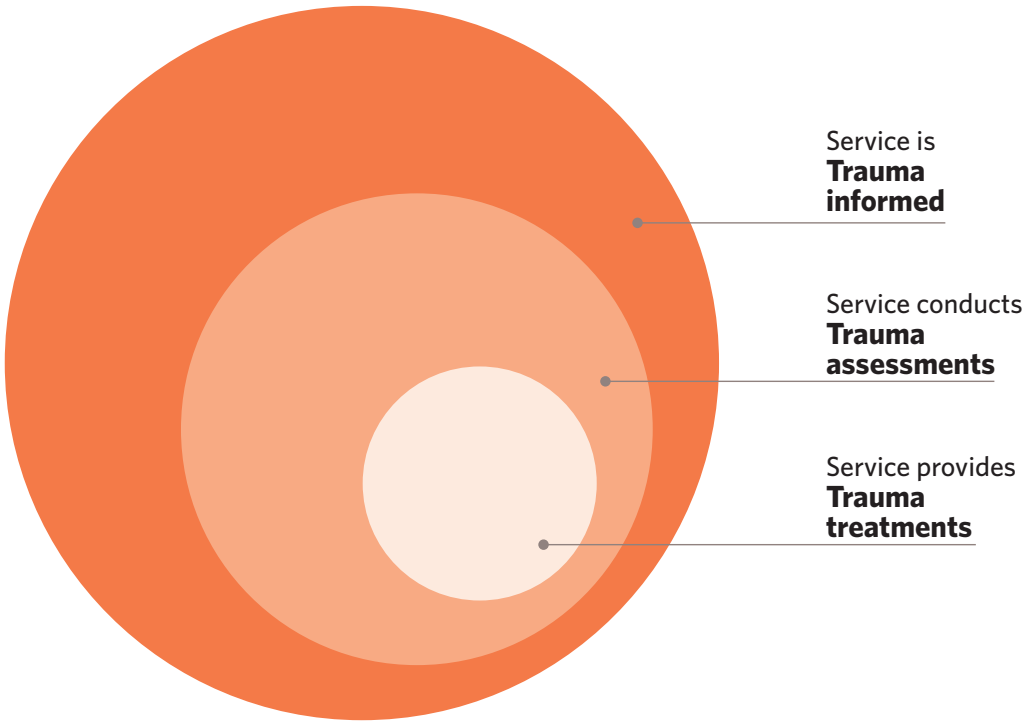
- The lack of acknowledgement in government policies on the relationship between trauma, adversity and mental health outcomes which, in turn, impacts on trauma-informed service design.
- A lack of national guidance and clear policy direction on the definition and implementation of trauma-informed care.
- That definitions of trauma-informed care in Australia often involve a Western, white and middle class conceptualisation of trauma. There is a need for all youth mental health services to increase their understanding of intergenerational trauma and cultural conceptions of trauma among Aboriginal and Torres Strait Islander and culturally diverse young people.
- The lack of widespread and consistent trauma-informed care training for both staff in youth mental health services and the gatekeepers into the system.

Even in the US where trauma-informed approaches are more established than in Australia, a systematic review of service providers' conceptualisation of trauma-informed practice across youth service settings, mental health, juvenile justice, child protection and education also identified a need for a common understanding and metric in trauma-informed care/practice (96).

5.2 Trauma-informed care in youth mental health

Within a youth mental health service environment, trauma-informed care should be only one component of an effective response which must also include trauma assessment and appropriate treatment.

FIGURE 4 – INTEGRATED TRAUMA RESPONSES IN YOUTH MENTAL HEALTH SERVICES



There has been increasing recognition by youth mental health practitioners and service managers that many young people presenting to their service have been exposed to traumatic events and/or a range of other adverse experiences. This has led to efforts to implement or modify existing approaches so that services are both aware of, and sensitive to, the potential impact of trauma and are supported by the significant number of formal trauma-informed care training packages now available across the country.

> "The physical layout of mental health units, the service delivery model and the inadequate training of staff can also at times lead to clients being re-traumatised."
>
> **Clinical consultant**

The Mental Health Coordinating Council in NSW has led a push to embed trauma-informed responses in mental health and human services in Australia. The council developed a position paper *Trauma-informed Care and Practice: Toward a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction (2)*.

They have used this work to inform subsequent advocacy for the development of a national framework and approach, as well as developing the *Trauma-Informed Care and Practice Organisational Toolkit* (TICPOT) (97). Blue Knot has also developed resources, training and networks to improve responses to complex trauma within mental health service delivery (Spotlight 3).

However, there remains a perception among some stakeholders consulted for this report, that the adoption of trauma-informed approaches in mental health services is not widespread. This perception, in part, appears to have developed due to the failure of mental health services to move beyond creating service environments that avoid re-traumatisation to ones that understand the influence of trauma experiences on the onset and symptomatic presentations of mental ill-health and ensure that these experiences and understood and integrated into treatment decisions.

> "In my experience youth mental health services do not operate from a trauma-informed perspective. Questions about trauma exposure are not routinely asked at intake and many clinicians are either not aware of or are not adequately trained in evidence-based treatment for trauma-related health disorders. Youth will often progress through the mental health system without their trauma events being acknowledged and as a result can be misdiagnosed and inappropriately treated."

Clinical consultant

Spotlight 3: Blue Knot Trauma-informed care training for mental health services

The Blue Knot Foundation has developed *Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* (discussed in more detail in Section Seven) and offers professional development (including in-house) training workshops for people working with people who have experienced trauma, with a particular focus on complex trauma and experiences of childhood abuse. Their programs range from foundational basics in trauma-informed care to specific programs to help therapeutically respond to complex trauma (72).

Recently the Blue Knot Foundation has partnered with the Mental Health Practitioners Network to support the development of specialist trauma and complex trauma networks across Australia to support interdisciplinary collaboration and professional development opportunities at a local level.

Policy context

> "There is no recognition of this issue in current (mental health) policy discourses."

Service provider

References to trauma-informed care are included in only a small number of government mental health policy and strategic plans, and it is typically not clearly defined. The *Living Well: Strategic Plan for Mental Health in NSW 2014-2024* is perhaps the most comprehensive in its identification of the impact of trauma on mental health generally. The strategy is also the only one found by the authors of this report to define 'trauma-informed care'. The *Strategic Plan* acknowledges a need to ensure mental health services do not re-traumatise individuals and identifies a number of workforce development actions for mental health services and other systems including emergency, justice and housing services.

The COAG's *Fourth National Mental Health Plan* (98) had previously made a clear reference to developing mental health care responses for young people who have experienced trauma. In addition, the Australian Government's response to the National Mental Health Commission's *Review of Mental Health Programmes and Services* (99) outlined plans for a national workforce support initiative which would include a focus on providing early interventions for children who have experienced trauma, as well as their families.

However, the impact of trauma on mental health and wellbeing is now only identified briefly in the *Fifth National Mental Health Plan*: "Trauma is widespread among those who use mental health services. It often has lasting adverse effects, so it is critical to effectively address this issue to reduce its impact and to prevent the exposure to any further trauma within services...The provision of therapeutic responses for those affected will need to be strongly based on the best available evidence about trauma-informed care." (100).

Many stakeholders believe that, on the whole, the Fifth Plan has not adequately considered trauma within the context of mental health issues, or trauma-informed approaches within mental health service provision (the exception being the strong focus on trauma in Priority Area 4: Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention [Spotlight 4]).

Spotlight 4: Trauma-informed care and Aboriginal and Torres Strait Islander Young people

The adoption of trauma-informed care is described specifically in the context of *Priority Area 4: Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention.* It states that service models providing Aboriginal and Torres Strait Islander mental health care must include trauma-informed care with all mental health staff trained in trauma-informed principles.

The Implementation Plan for *Priority Area 4* tasks all Australian governments with 'ensur[ing] training in trauma-informed care is provided to all staff in' in public mental health services, and providing strategies to deliver this training in other mental health services that provide care to Aboriginal and Torres Strait Islander people from 2018 (100).

A culturally informed approach to trauma-informed care is critical, particularly in developing organisations' and services' capacities to understand, recognise and respond appropriately to intergenerational trauma. Given there is little data on the provision and outcomes of trauma-informed care to young people in an Aboriginal and Torres Strait Islander-specific context (101), governments have committed to establishing a clearinghouse for Aboriginal and Torres Strait Islander people that will include resources, tools and evaluations on trauma-informed care in mental health from 2018 (100).

Yarning up on trauma: Berry Street

Yarning up on Trauma draws on a holistic approach to understanding trauma and attachment for Aboriginal and Torres Strait Islander children and their communities with a focus on spiritual impacts as well as physical, emotional and social. A strong component of the program focuses on understanding trauma in the context of colonisation, the stolen generations, the ongoing disadvantage and institutional racism experienced by Aboriginal and Torres Strait Islander young people and their communities.

5.3 Trauma-informed care in other youth services and systems

Young people with experiences of trauma are likely to be in contact with a range of systems and services beyond mental health including: Education; Justice and Legal Systems; Primary or Specialist Health; Human Services such as Child Protection; Housing; Aboriginal and Torres Strait Islander Support Agencies; and Drug and Alcohol supports, among others. Sections two and three of this report have already highlighted the:

- prevalence of trauma experiences across populations of young people who would be engaged in multiple support systems and settings
- need to consider trauma in providing support and care for young people across a range of services and systems
- heightened risk of poor broader health, social and economic outcomes for young people who have experienced trauma.

The following tables 3–7 illustrate the current context, policy enablers and practical outcomes of trauma-informed care across a number of different sectors and services in contact with young people.

TABLE 3: CHILD SAFETY, OUT-OF-HOME CARE (OOHC) AND RESIDENTIAL CARE

Current context	Policy enablers	In practice
Children and young people connected to child protection and care services are likely to present with a complex range of behavioural and social issues, as well as symptomology of mental ill-health, some of which may be a consequence of having been/currently exposed to some form of trauma. Among the Australian child and family services workforce there is an increasing familiarity with the principles and key elements of 'trauma-informed care' and an understanding of the importance of recognising and understanding the impact of adverse childhood experiences within human service delivery.	There are a range of trauma-informed models endorsed and adopted across different states and territories governments. These include (but are not limited to): 1. Trauma-Informed Sanctuary Framework – see below (Residential Care – WA Govt). 2. Hope and Healing Framework for Residential Care (delivered by PeakCare – Qld Govt). 3. Therapeutic Care Framework for children and young people in statutory out-of-home care (NSW Govt). 4. Youth at risk strategy – commits to trauma-informed therapeutic supports for young people in OOHC (TAS Govt).	A review by the Parenting Research Centre and Phoenix Australia (formerly the Australian Centre for Posttraumatic Health) (2013) found those working in the child protection sector still: a) lacked clear definitions or understanding of trauma-informed care concepts, b) assumed that all behavioural issues were trauma-related, and c) lacked guidelines for assessment and treatment. Further challenges arose as community service workers and clients were often operating in very stressful and potentially dangerous settings. As a result crisis management could often be prioritised over trauma-informed responses (102).

Good practice spotlight

Berry Street Take Two program (AUS)

Take Two program is a Victoria-wide therapeutic service for children and young people who have experienced trauma and neglect. This service works intensively with children and young people as well as their carers, families and teachers to integrate child welfare services with mental health services and training. Therapeutic approaches focus on children and young people in their environment and developing a shared and enhanced understanding of the impact and effects of abuse and neglect. It has been shown to have made a significant difference in the lives of children and young people engaged in the service through three substantial evaluations. In particular the use of the Trauma Symptoms Checklist for Children (TSCC) indicated improvements over time for children and young people in areas related to trauma-related symptomatology, namely anxiety, depression, anger and posttraumatic stress (103).

Sanctuary framework

The Sanctuary Framework, developed by Bloom (2005) (104) in the US, has been adopted across a number of jurisdiction in Australia, including in the Western Australian residential care system. Large national non-government organisations (NGOs) such as MacKillop Family Services have become accredited training providers of the model. The Sanctuary Framework has been central to the development of therapeutic residential care models and provides specific components through which these settings can work toward an organisational cultural that is trauma-informed, safe and conducive to addressing trauma. Trauma-sensitive organisational structures and trauma recovery frameworks are central to the model. While the model is clear, again what is less certain is how the implementation of these components occurs across the many different service adopters in the Australian context (105).

TABLE 4: YOUTH JUSTICE

Current context	Policy enablers	In practice
Correctional settings are challenging environments to embed trauma-informed care. As described by Miller and Najavits (106) they are designed to be punitive and uncomfortable, and involve trauma triggers including body searches, discipline and restricted movement. As a result, literature is beginning to refer to the adaptation: Trauma-informed correctional care. Opportunities exist to "create a cultural shift in juvenile justice from the correctional mindset to one that embraces trauma-informed practices that support social and emotional health, successful community re-entry, and resilience, and family-oriented approaches that support youth in becoming effective adults, while still holding them accountable for their actions" (107).	Youth justice is the jurisdiction of state and territory governments, some of which have focused on rehabilitation and care. These include but are not limited to: 1. WA Youth Justice Framework 2015-18 youth justice services will address trauma-related behaviours and symptoms. 2. Qld's Youth justice policy and practice embeds trauma-informed care within the juvenile justice system, operating from the same understanding of trauma-informed practice as the Department of Communities, Child Safety and Disability Services recognising 75 per cent of clients overlap. The Australasian Juvenile Justice Administrators Principles of Youth Justice in Australia, endorsed by each jurisdiction, note the need to understand trauma within their clients broader context (108).	The Royal Commission into the Protection and Detention of Children in the Northern Territory highlighted the importance of trauma-informed care in youth justice (109) and the government recently adopted all of the Commission's recommendations. However, in Victoria, a recent Government review noted an overemphasis on responding to trauma in youth justice to address criminogenic needs (110). The report recommended the Victorian Government "establish an Expert Advisory Group to advise Justice on the extent to which a trauma-informed approach should continue to play a substantial role in the management of young offenders in the community and in custody" (p32) which the Victorian Government has accepted on principle (111).
Good practice spotlight		
Florida Department of Juvenile Justice (USA) Following the development of an Interagency Trauma-Informed Care Workgroup, the Florida Department of Juvenile Justice (FDJJ) implemented a state-wide trauma-informed care approach to youth justice. A rationale for the approach was to reduce the use of physical restraint on juvenile offenders, which may re-traumatise the young person and "may actually trigger a violent 'self-protecting' response" (112). The approach includes a resource that educates, defines 'trauma terminology', and 'can be enhanced to meet the needs of specific populations'. There is trauma-informed care training for all new staff that work directly with young people in probation and state-operated facilities. The approach also includes appointing 'Trauma Champions', a review of confinement policies and creating staff culture change (113). From 1 July 2008 to 31 March 2012, the FDJJ saw an overall 53 per cent decrease in the rate of physical restraints used on juvenile offenders (112).		

TABLE 5: YOUTH HOMELESSNESS SERVICES

Current context	Policy enablers	In practice
As described earlier in this report, trauma will often be involved in the pathway to homelessness for most young people. Many young people leave home to avoid the ongoing trauma of experiencing or witnessing abuse/interpersonal violence. The trauma-informed care principle of providing a safe service environment is particularly important and challenging for providers supporting clients of homelessness and emergency housing services. Homelessness services work with young people who face exposure to further traumatic events every day.	Government responses to homelessness have historically been developed through broader housing strategies designed to address access and affordability, without providing homelessness service framework specifics, such as the incorporation of trauma-informed care. However, the NSW Government has acknowledged trauma-informed care in the development of a new homelessness strategy (114), and the Northern Territory (NT) Government is also developing a Homelessness Strategy and Five Year Action Plan 2018-2022 which is likely to include, where appropriate, "a trauma-informed approach to care and support" (115). The Victorian Government has recently released Victoria's Homelessness and Rough Sleeping Action Plan which commits to, among other things, innovative practice incorporating trauma-informed approaches in crisis accommodation.	There still appears to be significant variance in the understanding of trauma-informed care and concerns regarding the methods of measuring the degree to which a homelessness service is operating in a trauma-informed way (116). However, an Australian study involving four homelessness service providers found all were operating consistently with the principles of trauma-informed care with a strong recognition of the need to address trauma (117). The high demand and limited housing/shelter options available often result in homelessness services needing to send individuals back into potentially traumatic environments. In 2015-16 an estimated 100,302 requests for assistance were unable to be met (118).

Good practice spotlight

Trauma and Homelessness Service Framework (AUS)

The Trauma and Homelessness Initiative (THI) is a collaboration of Phoenix Australia and four providers of services for people who are or who are at risk of being homeless: Sacred Heart Mission, Mind Australia, Inner South Community Health and VincentCare Victoria.

This collaboration developed a consensus Service Framework (117) bringing together key research findings on understandings of trauma-informed practice, particularly in the homelessness service provision context. It also identifies needs of service users and knowledge about supporting trauma recovery. The framework highlights 27 practical considerations for providing trauma-informed homelessness supports and services, across five domains:

1. Promote trauma understanding
2. Manage barriers to recovery and accessing support services
3. Establish strong relationships by managing engagement safely, providing clear boundaries, and clear role expectations
4. Provide choice, control, and predictability in providing trauma-informed care – especially in managing crises and recovery-interfering behaviours
5. Engage in ongoing service improvement and evaluation.

TABLE 6: EDUCATION SETTINGS

Current context	Policy enablers	In practice
Numerous studies have linked trauma experiences to poor academic outcomes, including: ▪ absenteeism ▪ disruptive classroom behaviour ▪ emotional problems ▪ conduct issues. Issues of affect regulation, often resulting from abuse and taking the form of hyperarousal or dissociation, subvert one's ability to function socially and cognitively in education settings. Trauma-informed approaches within schools could mitigate against low achievement and higher risk of drop among these young people. Teachers who understand and incorporate trauma-informed care in the classroom and with carers can assist in students' recovery and educational outcomes (119).	A number of state and territory governments have developed, or endorsed, programs and resources to support a whole-of-school trauma-informed approach and/or individual teachers in responding to the behavioural and learning needs of traumatised students: 1. ACT: Social and Emotional Learning Responses (SEL). 2. Queensland: Calmer classrooms 3. NSW: R.E.W.I.R.E., a systematic, whole-of-school support model for trauma-informed and sensitive practice and care to support students and their educators. 4. Tasmania: GOOD TEACHING Trauma- Informed Practice: Including a Guide for Working with Children in Out-of-Home Care 2016	Schools are, for many young people, a setting where they spend a large part of their day. As such, they offer considerable opportunities to identify where there may be issues for a student that may require additional support. While their primary objective is to deliver education, they are also required to understand the adversity and traumatic stress which students may be dealing with in order to support regular school attendance and engagement in learning (120). However, it is difficult in the modern teaching context for teachers to provide individualised support. Increasingly, the focus of trauma-informed approaches in schools is on providing resources and approaches to teachers that can be applied uniformly across the classroom and learning environment, making them of benefit of all students.

Good practice

The Australian Childhood Foundation has led the development of two resource and training packages to enhance the capacity of schools and education providers to respond effectively to the needs of children who have experienced trauma:

- Making Space for Learning is a guide for trauma-informed practice, published in 2010, to assist schools to unlock the potential of traumatised children and young people to grow and develop at school.
- SMART (Strategies for Managing Abuse Related Trauma) was developed with Child Abuse Prevention Research Australia and the Indigenous Health Unit at Monash University. The program provides a range of resources to support integrated professional development opportunities (for education settings but also applicable to other contexts such as child protection and residential care), including knowledge and skill-building seminars and an interactive online learning package. The program was funded by the South Australian Government Department of Education and Children's Services.

TABLE 7: DRUG AND ALCOHOL SERVICES

Current context	Policy enablers	In practice
A large number of young people in contact with drug and alcohol treatment services have experienced trauma and commence and/or increase their use of these substances as a way to cope or minimise their reactions to trauma (121).	Drug and alcohol services systems have increased their knowledge and understanding of trauma-informed care although Government strategies and frameworks in Australia have to date not incorporated actions regarding trauma-informed care or practice into policy or strategies. The recent Australian National Drug Strategy 2017-2026 recognises trauma as a pathway to and consequence of drug and alcohol use, but does not make any reference to the design of a trauma-informed drug and alcohol service system, nor does the discussion paper for the draft National Alcohol Strategy 2018-2026. The Victorian Drug and Alcohol treatment principles do not include trauma-informed care for service delivery, the Western Australia Government's 2017 consultation draft Drug and Alcohol Strategy does not reference trauma-informed care, nor does the South Australian Government's Alcohol and other Drug Strategy 2017-2021.	An Australian review in 2015, reported that despite growing advocacy among experts for a trauma-informed approach to Alcohol and Other Drugs (AOD) service delivery, one which recognises the high rates of trauma among AOD clients and the need to provide safe service environments, most alcohol and other drug services were not utilising trauma-informed care (121). Trauma training is not mandatory for all alcohol and drug workers, with less than two-thirds of Australian AOD workers reporting they had received trauma training, and is inconsistent where it is received (122). In addition, secondary traumatic stress is common in AOD service staff, with nearly 20 per cent of workers surveyed in both a US study and an Australian study being impacted (122, 123).

Good practice

YoungMinds, adversity, substance use and young people (UK)

The organisation YoungMinds recently published a report on substance use, trauma and young people (9). It made a range of recommendations to embed the response to trauma and substance misuse across a range of systems (systems responses are described in more detail in Section Seven). These included:

1. embedding drug and alcohol, relationships and resilience education in all schools to build the skills of young people to make better, healthier life choices
2. building in routine enquiry about childhood adversity across Accident and Emergency Departments, urgent care, and specialist drug and alcohol services
3. focusing on working with families to break the cycle of substance use and other consequences of adverse experiences
4. developing mechanisms and pathways for interagency collaboration.

5.4 Trauma-informed care for young people: What does the evidence say?

An investigation of the evidence base supporting trauma-informed care in adolescents yielded nearly a hundred peer-reviewed studies, with approximately half of these studies published within the last two years, reflecting the increasing interest in building an evidence base supporting trauma-informed care. Eight of these published studies focused on health settings, such as psychiatric hospitals, primary care, and emergency departments (see Appendix 1).

The majority of these health setting studies were conducted in the US, with only one study being conducted on an international population. The focus of the health setting studies was at the provider-level, either addressing outcomes from or establishing the feasibility of introducing trauma-informed care. Specifically, three studies evaluated the efficacy of a trauma-informed care program, two studies aimed to establish the key principles/frameworks required for effective trauma-informed care, and the three further studies developed a psychometric measure for trauma-informed attitudes by providers, reviewed current evidence for trauma-informed care, and measured the level of trauma-informed awareness by providers, respectively.

Despite the significant number of peer-reviewed studies investigating trauma-informed care, to date there have been no empirical studies published in relation to Australian adolescents. As such, a review of Australian grey literature pertaining to trauma-informed care for young people was conducted to complement the peer-reviewed findings. This review yielded a further 13 documents (see Appendix 1). Six of these were reports relating to evaluations of trauma-informed care implementation, five were practice guides or resource sheets for practitioners, and two final documents were discussion or response papers in relation to recommendations. Five documents were from Victoria, with a single document from NSW, Queensland, and NT, respectively, and for the remaining documents the location was unspecified. Five documents addressed trauma-informed care in adolescent out-of-home settings (such as residential care or foster care), two focused on educational settings, two applied broadly across all adolescent settings, and the final three studies related to juvenile detention, mental health, and health care settings, respectively.

Summary

Current empirical and grey literature evidence indicates that researchers are building an evidence base around trauma-informed care, including evaluation studies on the effectiveness of implementing trauma-informed care in various adolescent settings (Table 3). The evidence suggests that there are a number of diverse types of programs that have been developed and implemented.

For example, a recent systematic review of implementing trauma-informed care in youth psychiatric inpatient or residential settings found five factors were instrumental in implementing trauma-informed care. These were: senior leadership commitment, sufficient staff support, amplifying the voices of patients and families, aligning policy and programming with trauma-informed principles, and using data to help motivate change (124).

However, while the peer-reviewed and grey literature findings indicate that knowledge and use of trauma-informed care has grown significantly both within Australia and internationally, there remain significant gaps in the current evidence base.

In addition, the majority of international research has focused on provider outcomes. Almost no studies evaluate whether trauma-informed program implementation leads to meaningful outcomes in the short or long-term for adolescent clients and their families, or address the cost-benefit analyses of such programs. Australian research that focuses on outcomes for adolescent clients (as well as Australian providers) is needed. Such an undertaking will require relationships between service providers and universities or research organisations that focus on collaborative evaluations of the implementation of trauma-informed approaches.

Finally, despite an international peer-reviewed evidence base rapidly growing (i.e. an increasing number of individual studies), the overall level of evidence for these approaches has not been assessed (i.e. an independent synthesis of all the current evidence, considering the quality and limitations of each study and drawing overarching conclusions regarding the evidence base).

TABLE 8: EVIDENCE SUMMARY

Expanded knowledge area	Gaps
Research is beginning to be conducted on trauma-informed care in various youth settings.	Almost no studies have evaluated whether trauma-informed program implementation leads to meaningful outcomes for young people.
A diverse range of programs has been developed and implemented, from which youth service providers have obtained positive outcomes in self-reported knowledge and skills.	Unlike the US, there is currently no central resource area, repository, or clearinghouse dedicated to trauma-informed care in Australia to consolidate trauma-informed approaches.
Emerging studies are beginning to investigate whether such programs also lead to changes in service providers' behaviours, in addition to knowledge and skills.	No studies have been published in Australian settings. Internationally there has been less focus on health settings compared to juvenile justice, educational, and out-of-home settings.
Standardised measures for service delivery outcomes for use in trauma-informed care evaluation and research are being developed and validated, significantly building the capacity to establish an evidence base.	A lack of a universally agreed approach to trauma-informed care, underpinned by empirical research, which has been adapted and trialled for use in Australian settings, across diverse populations of young people.

SUMMARY

Trauma-informed care is not designed to directly ameliorate any specific symptoms related to trauma exposure but rather to provide a service environment (through policy and organisational level strategies and frameworks) that takes account of the specific needs and sensitivities of those who have experienced trauma.

While the principles of trauma-informed care are widely understood across mental health, juvenile justice, child protection and other youth focused service systems, the approach is inconsistently operationalised (often due to differing core service goals across systems) limiting the ability to ensure its quality and develop its evidence base.

In government mental health and alcohol and other drug policies, there has been a lack of recognition regarding the role and impact of trauma and adversity. As a result, many of these services are currently not operating with a trauma-informed approach. Further, due to a lack of training on working with clients who have trauma histories, many staff are not confident to screen/assess for past/current trauma. Staff may also struggle to access organisational supports for their own experiences of vicarious trauma.

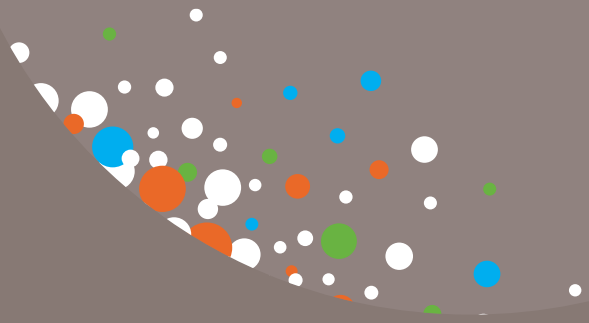
Despite a recent increase in interest in trauma-informed care for young people, most research has focused on improvements in awareness and perceived capacity and capability by providers. Significant research gaps remain, including whether trauma-informed program implementation leads to **meaningful outcomes** for young people.

There is a need in Australia to develop a central resource area, repository, or clearinghouse dedicated to trauma-informed care in Australia to consolidate trauma-informed approaches**.**

There is also a clear need for the development of standardised measures for the implementation of trauma-informed care which can enable system-wide evaluations for outcomes beyond service knowledge and skills of providers.

There is a lack of exploration of traumatic material in the lives of young people who are seen by services.

Service provider



Section Six

Trauma assessment

6.1 Mental health services

Assessment of the presence of traumatic experiences is accepted as the essential first step in any specific treatment for the effects of trauma and should be conducted with every young person who has contact with mental health services. The Australian Government's *National practice standards for the mental health workforce* requires mental health practitioners to take into account experiences of trauma at points of access to the service and to conduct and document a comprehensive, trauma-informed assessment (125).

> "In the service I work for I believe single incident traumas are generally identified at point of initial triage. Generally this will be discussed at point of entry into the service, as it may form a core feature of their presentation and why they are help-seeking."
>
> **Service provider**

Trauma assessment tools can assist youth mental health clinicians identify exposure to a traumatic event and/or symptoms of trauma (including PTSD, complex PTSD and broader symptomatology). This can reduce the potential for trauma to go unaddressed leading to poor engagement in treatment, misdiagnosis and inappropriate mental health treatment planning (126). However, there is also a risk of re-traumatising young people by requiring that they remember the specifics of their traumatic experiences without strategies to manage their distress.

Several experts and practitioners consulted in the development of this report identified inadequate assessment of trauma by youth mental health services. A number of reasons for this were suggested, including:

- Fear of opening 'Pandora's box' (95) and a reluctance to inquire or screen for experiences of trauma, due to actual or perceived lack of capacity to respond therapeutically.
- That asking about trauma could re-traumatise or trigger psychological distress (whereas failing to ask actually risks further stigmatisation and shaming of the abuse).
- The lack of a clinically validated youth specific (12-25 years) trauma assessment tool and/or time to train in and understand appropriate assessment tools.
- A belief that treatment for trauma is something that should be provided separately to the mental health care being provided, and is, therefore, out of the remit of the clinicians role.
- Issues of disclosure where the young person: is reluctant to discuss the experience; does not identify the experience as traumatic; and/or feels stigma and shame regarding the experience.

A number of clinical trauma assessment tools have been developed and validated for child and adolescent populations. The *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* (2013) identified that some of the strongest validated tools include: the *Trauma Symptom Checklist for Children (TSCC)* for 8-16 year olds and the *Child PTSD Symptom Scale (CPSS)* for 8-18 year olds, both designed to be completed by the young person. However, the authors of this report were unable to find a test validated for young people across the 12-25 year age span. Tools which screen for complex trauma in this age group (as opposed to a PTSD assessment) also appear to be needed.

> "Many services still do not screen for complex trauma, and staff are not trained and or supported to work with clients who have experienced complex trauma. For many they still see mental health issues and trauma as distinct issues, rather than facets of a person's life experiences."
>
> **Psychologist**

Further, issues with meeting diagnostic thresholds were flagged in a report on adversity and youth mental health by the UK organisation YoungMinds (UK). They recognised that many young people (presenting with risk-taking, harming or behavioural issues) were currently missing out on critical trauma responses in the mental health system as their level of mental ill-health did not reach a threshold of diagnosis. The report called for guaranteed access to mental health services for young people with a history of trauma and/or adversity (127).

6.2 Screening across other services and systems

Trauma screening and assessment are also important outside a clinical environment/ behavioural health services and are often conducted across a range of health, justice, education, housing and human service settings. However, there is a risk that, particularly for young people with complex trauma histories who are more likely to be in contact with numerous support services and systems, they will be screened for trauma multiple times, using multiple screening instruments. This is discussed further in Section 8 on the need for systems responses to trauma among young people.

The following is a brief summary the types of trauma assessments undertaken across a small selection of other settings/youth population groups.

Youth justice clients

As described by the American National Child Traumatic Stress Network, trauma assessment and screening can be performed across a range of contact points and functions of the justice system. This includes diversionary staff, detention staff, court staff and probation officers, all of whom should understand the importance of identifying trauma exposure in this population. Ideally, at each point of the system these staff would then have access to appropriate assessment tools as well as referral processes through which qualified mental health professionals can then undertake a more formal assessment, facilitate evidence-based trauma treatment where required, and undertake mental health evaluations (128).

Needs and risk assessment protocols and procedures are standard practice in juvenile justice systems across Australia, such as the Victorian Offending Needs Indicator for Youth and Youth Justice Risk/Needs Assessment (Qld/ NSW). However, it is unclear whether these tools alone are adequate to identify the experience and impact of trauma backgrounds in young people in contact with the justice system.

The identification of appropriate assessment tools is particularly complex. These tools need to consider the skill level of the person conducting the assessment, immediate risk management for staff and young people, the appropriateness for the young person based on their emotional state, the time and cost involved, and the purpose of the assessment at that point. For example is the purpose to guide clinical care or just provide an initial screen?

The Australian Capital Territory (ACT) Children's Commissioner released a discussion paper, which among other areas, asked for comment on what the most suitable clinical screening and assessment tools would be across various settings in the youth justice system. The final report noted that the Commissioners did not receive any comments in response to this question, suggesting that there may be a need for further research and knowledge translation in this area (129).

In primary care

Clinical tools for screening and assessing for trauma among young people presenting to primary care services (e.g. GPs and headspace centres) are often not practical to administer in the consultation time available. However, clinically appropriate processes to assess for adverse childhood events are needed in these settings so as to provide appropriate referrals and/or tailor interventions (130). A recent systematic review of trauma assessment tools and their appropriateness for children and adolescents with histories of complex trauma found that current measures require further validation (131). Due to adverse childhood experiences being associated with negative health consequences, one systematic review concluded that nurse practitioners in primary care settings should incorporate a routine assessment of the patient's childhood history in order to provide appropriate care (132).

In refugee populations

Assessing for trauma among refugee (and non-English speaking/or first language) young people has additional challenges. A study of computer-based screening of trauma in unaccompanied young people seeking asylum using touch screens and sound-files in native language found that this was a well-received, practical and valid tool, regardless of reading and writing ability (133). Technology, therefore, may provide effective and acceptable screening tools for young people with low literacy or from diverse cultures.

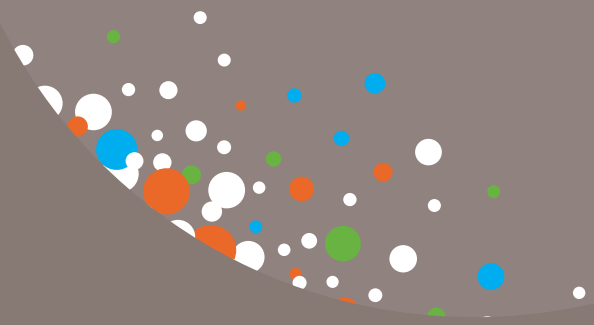
SUMMARY

A number of clinical trauma assessment tools have been validated with child and adolescent populations, but clinically validated tools for 12-25 year olds are still needed.

Several experts and practitioners identified that there is an inadequate assessment of trauma in youth mental health services, citing a reluctance to inquire due to a lack of capacity to respond, concerns about re-traumatising young people, a lack of availability and training in assessment tools, a belief that trauma treatment should be provided separately, and issues relating to disclosure.

As identification of trauma exposure is necessary to tailor clinical interventions, there is a need for trauma screening and assessment tools to be appropriate for the age group, validated across multiple contexts, and of practical utility in a range of clinical and non-clinical settings.

Beyond PTSD diagnoses, treatment for trauma is a contested area in the literature.



Section Seven

Trauma treatment

Within Australian youth mental health services there is a growing awareness of the need to treat the outcomes associated with trauma exposure. While there are recommended evidence-based treatment approaches for PTSD, services appear to be restricted in their capacity and capability to deliver these effectively across all trauma-related presentations.

Since 2013, several dozen trials have been published that have significantly expanded the evidence base for trauma-focused treatment in young people. Broadly, these new studies have focused on expanding three areas of knowledge while highlighting ongoing gaps (Table 8).

In summary, although a significant number of high quality studies have been published that expand the current evidence base for trauma-focused treatments in adolescents, the recommendations made by the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* (2013) remain the recommended practice for Australian providers until a new update is made.

However, beyond PTSD diagnoses, treatment for trauma is a contested area in the literature. There is very little published research evidence available for the treatment of the broader, more complex outcomes of severe trauma. Where studies exist, the results may not be applicable to populations broader than the sub-set of participants involved in the study. Further studies are generally restricted to children and adolescents, with limited literature on what works for young people and young adults between the ages of 18 and 25 years.

It is also important to note that the literature scan undertaken for this report did not include outcomes of treatment directed to *broader mental health diagnoses* where trauma was a contributing factor. For example, it did not include evidence for the efficacy of Dialectical Behaviour Therapy (DBT) for the treatment of Borderline Personality Disorder (where trauma has been shown to have a causal relationship, and where trauma-related symptomology may also be improved as a result of this treatment).

TABLE 9 – TRAUMA TREATMENT EVIDENCE REVIEW

Expanded knowledge area	Ongoing gaps
The evidence base for trauma-focused cognitive behavioural therapy (TF-CBT) by trialling the effectiveness of TF-CBT in a broad range of trauma types, adolescent populations, and settings.	There were no treatment trials found relating to complex PTSD in adolescents and young people.
Evaluations of the effectiveness of new treatments or modalities in improving trauma symptoms in adolescents, such as web-based programs. This area of research has developed due to the finding in recent years that a significant minority of individuals fail to respond to traditional treatments.	The absence of treatment trials investigating the efficacy of eye movement desensitisation and reprocessing (EMDR) in adolescents. Although the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder recommend the use of EMDR in adults with PTSD, the evidence base in 2013 was insufficient to support such a recommendation in adolescents. The literature search yielded only one study investigating EMDR in adolescents since 2013.
Evidence investigating early intervention in the acute stages of trauma in adolescents. Such endeavours have significant application particularly in mass traumas such as natural disasters or terrorism-related events.	Studies for effective youth mental health (12-25 years) interventions are lacking, with most of the literature focused on either treatment for children and adolescents or for adults.

Evidence-based treatment for PTSD

In 2013, the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* (the Guidelines) were published, which, for the first time, provided recommendations for children and adolescents. **Specifically, the Guidelines recommended developmentally appropriate Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), with the inclusion of parents/caregivers in the therapy process** (88). Core components of TF-CBT include: the detailed retelling of the experience of the trauma (exposure), identifying and correcting faulty beliefs about the trauma such as "it's my fault" (cognitive restructuring) and psycho-education about the effects of trauma (134). TF-CBT treatments vary in duration but are generally between 12-16 sessions for 60-90 minutes per session.

Evidence-based treatment for complex PTSD (C-PTSD)

Although C-PTSD is not currently a distinct diagnosis, it is increasingly referred to in the literature with varying levels of support. Some argue that it requires a treatment approach beyond what is currently delivered for PTSD. Although there is some contention (135), many experts recommend a phase-based approach to the treatment of complex trauma, which generally involves the components of TF-CBT but includes a prior phase that prepares the young person to engage with the trauma and manage any distress that may result.

The phase-based approach requires a longer duration of treatment than TF-CBT, often more than 20 sessions. The Blue Knot Foundation's *Practice Guidelines for Treatment of Complex Trauma* endorse the use of this approach (12). Also, as the Gatehouse Centre described to the Royal Commission into Institutional Responses to Child Sexual Abuse, children who have disclosed abuse and worked through the process of assessment and therapy may well have to undergo this process a second, third and fourth time as they become young adults, as the impact of the trauma will re-emerge in different ways at different ages and stages of their development. This may require that they revisit the abuse therapeutically more than once.

Family involvement

Evidence-based interventions for children and adolescents with PTSD, complex PTSD and broader trauma-related disorders place an emphasis on including the family in trauma treatment (88, 136), whereas adult models focus on the individual. Best practice for 18-25-year-olds is currently unknown, but they would usually be treated using an adult model.

Issues identified by mental health service providers and clinicians

Much of the evidence available for trauma treatment is most applicable to PTSD or single incident trauma and not C-PTSD, or the broader effects of trauma. Stakeholders consulted in the development of this paper identified:

- Inadequate diagnostic frameworks and criteria available for young people who have experiences of complex or intergenerational trauma. Complex trauma presents with clinical characteristics that transcend current diagnostic criteria for PTSD (as described in the DSM 5).
- They were using a number of other treatment approaches not recommended in the Guidelines, but where they believed these treatments were effective, such as EMDR, creative therapies, animal therapies, motivational interviewing, Dialectical Behavioural Therapy (particularly where trauma co-presents with Borderline Personality Disorder) and mindfulness. Many of these interventions are also described by young people in their treatment experiences (Spotlight 5).
- Concerns with a diagnostic emphasis and treatment of symptoms, rather than identifying the underlying situation or circumstances, being incompatible with trauma-informed care.

> “If trauma-informed practice is about ‘what happened’ (rather) than ‘what’s wrong with you’ (then) the focus on diagnosis and labelling (particularly with children and young people) strikes me as being at odds with trauma-informed practice.”

Psychologist

- The need to better understand and consider the role of online and Tele-Health service provision in the context of trauma-related mental health issues.
- The limited number of public mental health practitioners, even in specialist mental health systems, who have the specialised training to deliver evidence-based trauma-specific treatments.
- The limited number of Medicare Benefits Schedule (MBS) sessions available through MBS (Better Access) Initiative are insufficient to deliver evidence-based trauma interventions such as TF-CBT (recommended over 12-16 sessions for 60-90 minutes), let alone additional sessions required for complex trauma.

> “As with complex trauma in children and youth, intergenerational trauma in children and youth appears to be only effectively identified and treated by a limited number of public mental health teams and practitioners.”

Service provider

At least one PHN in Australia has utilised the Australian Government’s funding for Youth Severe mental health presentations to supplement the Better Access session limit with additional psychological, family and outreach support sessions for young people who have experienced trauma. These include:

- South East Melbourne PHN has funded headspace Frankston to pilot outreach services, Emotional Regulation and Impulse Control (ERIC) model and single session family consults for young people aged 12-25 years who have complex Post-Traumatic Stress Disorder (PTSD) and/or severe depression and who are resistant to treatment.
- North Queensland PHN, in responding to the needs of young people in Mackay, has identified the need for a trauma informed program for young people aged 12-25 with multi-model service delivery (individual therapy, group programs and family therapy).

Spotlight 5: Young people's experiences of trauma treatment

In the online forum posts analysed through the Orygen project, young people identified that they experienced a range of mental ill-health that they understood to be comorbid with, or caused by, trauma exposure or PTSD, including depression, anxiety, psychosis and alcohol use.

Young people who engaged with treatment received support through exposure therapy, EMDR, medication, catharsis therapy, or support over a helpline.

Treatment experiences appeared to vary considerably. The benefits of formal treatment that young people experienced, or expected to experience, included:

- Improved coping skills.
- Receiving input.
- Knowledge, encouragement and support.
- A better understanding of disassociation, strategies for processing emotions.
- An understanding that the positives of treatment outweighed the negatives.

However, some young people expressed that treatment was a difficult experience and felt disillusioned by setbacks or slow progress due to:

- Perceived insensitivity or negative attitudes from health professionals.
- Associated financial costs.
- Feeling that professionals were unwilling to ask about trauma or inexperienced with mental ill-health.
- Experiencing power imbalances when seeking support.

Some young people with negative healthcare experiences did not return, and/or felt distressed about their disclosure.

SUMMARY

Beyond PTSD, there are few studies that focus on trauma treatment. There is a need for trials that examine treatment with young people, specifically in the treatment of complex PTSD, novel treatments such as EMDR and Cognitive Processing Therapy, and treatments where trauma was a contributing factor to a broader presentation.

Stakeholders identified current issues such as inadequate diagnostic frameworks and criteria for young people with complex trauma, a limited number of appropriate mental health practitioners, and an insufficient number of MBS Better Access sessions for the support needed.

Although some young people reported negative experiences receiving professional support, other young people were engaged in a number of different treatments and received beneficial care.

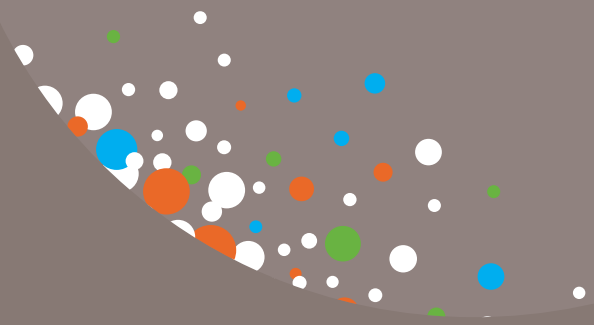
Accredited advanced training for mental health professionals is needed to increase the number of clinicians and service providers who are skilled in trauma treatment, leading to reduced waiting list times, increased availability and appropriate treatment.

A targeted primary mental health care funding package is required to remove personal finances as a barrier to treatment for experiences of trauma. Some PHNs in Australia are already utilising the Youth Severe funding to increase support for young people with trauma-related mental health issues.

More research is needed to build the evidence base for novel trauma treatments for young people (including the potential for online interventions and family involvement in treatment approaches for young people aged 18-25 years).

A `merry go round' of unintegrated care risks re-traumatisation and compounding of unrecognised trauma.

Kezelman and Stavropoulos, 2012



Section Eight

A 'systems approach' to young people and trauma

Human and social support systems in Australia have been moving toward a 'trauma-informed paradigm' that has been more fully realised in the US (137). Nationally (12) and internationally (126) it has been recognised that the multifaceted needs of people with trauma experiences require responses across a number of services and systems (not just mental health). This approach is not dissimilar to the systems models of suicide prevention which are being developed and trialled across Australia and internationally (Spotlight 6).

Trauma-informed care (discussed in detail in Section 5) has provided a model through which, increasingly, individual Australian service settings have made efforts to embed a response to trauma across all levels and functions of the organisation, including leadership, management, service delivery, environments, policies and procedures.

However, Australia is a long way off having the national and jurisdictional leadership, policies, frameworks, work force and service infrastructure to achieve a 'systems approach' to trauma. This would require: a) a system-level recognition and a consistent understanding of the prevalence and impact of trauma across a person's life; and b) the integrated and coordinated delivery of care and supports across human services, justice, education providers and mental health services, to enable multiple issues to be addressed simultaneously (138).

The recent Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) described the current challenges for our service systems, in particular, their capacity to respond to the needs of individuals with complex trauma experiences who are involved in, or move in and out of, multiple services. These include child safety, justice, homelessness, mental health, drug and alcohol, and refugee/newly arrived services as already identified throughout this report. The Royal Commission also identified other social services such as Centrelink, financial aid and legal services (1).

As the final report found:

> "A system-wide response is needed to address all aspects of victims' and survivors' wellbeing, which may include financial, legal, medical, psychological, spiritual and other forms of assistance. We are of the view that, to be responsive to victims' and survivors' interconnected needs and promote healing and recovery, the service system should be trauma-informed and have an understanding of institutional child sexual abuse. Services within an effective system are collaborative, available, accessible, acceptable and high quality. Aboriginal and Torres Strait Islander healing approaches are part of a trauma-informed service system."

While the focus of the Royal Commission was the victims and survivors of institutional child abuse (current and historical), the authors of this report believe the same considerations and approach should be applied to all individuals who have been exposed to, or have experienced, significant trauma.

In Australia, system responses to trauma have been implemented when entire communities have experienced a major traumatic incident or natural disaster. Examples include the responses to the 2009 Victorian Black Saturday bushfires and 2010-11 Queensland floods. In recognising the collective traumatic impact and high likelihood of secondary/intergenerational trauma resulting from these events, the state and federal governments mobilised support across a range of systems with the view that this would provide holistic responses, including psychological supports, financial services, housing services and legal supports.

Spotlight 6: Systems approaches in suicide prevention

Systems responses, recognising the need for coordinated multi-level, multi-service interventions, have been developed in suicide prevention with evidence-based models such as the European Alliance Against Depression (139) and the Black Dog framework (currently being rolled out in numerous regions across Australia).

These models require the collective implementation of a range of evidence-based interventions within a community to reduce suicide risk in the population. These include: training of GPs, responsible media reporting, means restriction, school-based prevention programs, workplace programs, and access to mental health care and treatment (140). The critical factor of these approaches is that they are delivered through multiple services and systems in the community. While there is strong evidence to support the efficacy of each individual intervention/component, bringing them all together has been shown to result in stronger outcomes.

8.1 Core elements for a 'systems approach'

The elements of a systems approach to trauma have been articulated by both the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States and the Mental Health Coordinating Council of NSW in Australia (Table 5).

TABLE 5: SYSTEMS MODEL ELEMENTS

SAMHSA (USA)	Mental Health Coordinating Council (NSW, AUSTRALIA)
The SAMHSA has articulated the key levels of action required to achieve real systems change in trauma responses (141). This can be applied to an individual system, or in a more sophisticated approach led by a cross-government or inter-portfolio commitment spanning across a number of health and human services systems.	The Mental Health Coordinating Council (MHCC) described the key elements that are required across all service systems (with a focus on human services and mental health) so as to meet the needs of individuals with experiences of trauma (2). This was an Australian adaptation of a similar set of criteria for building trauma-informed mental health service systems developed and continually updated by the National Association of State Mental Health Program Directors (NASMHPD) in the US (142).
▪ Governance and leadership. ▪ Policy. ▪ Physical environment. ▪ Engagement and involvement. ▪ Cross-sector collaboration. ▪ Screening, assessment and treatment. ▪ Training and workforce development. ▪ Progress monitoring and quality assurance. ▪ Financing. ▪ Evaluation.	▪ Trauma function and focus in Australian state mental health departments. ▪ National Government trauma policy. ▪ Prioritise recruitment to the workforce of those with training in trauma. ▪ Workforce orientation, training, support, competencies relating to trauma. ▪ Undergraduate (pre-service) education and training. ▪ Consumer involvement in trauma-informed practice and implementation. ▪ Funding of trauma-informed system development and evidence-based treatment (and access to public funded care). ▪ Practice guidelines for children and adults. ▪ Policies, procedures, rules and regulations to support access to trauma treatment, develop trauma-informed services and avoid re-traumatisation. ▪ Local/regional needs assessment, research, evaluation and data collection. ▪ Trauma screening and assessment for all adults and children seeking clinical care. ▪ Trauma-informed services and service systems. ▪ Trauma-specific services and treatment.

8.2 Current challenges in an Australian context

Lack of policy direction, mandate and funding

The MHCC has called for a clear policy position from the Australian and jurisdictional governments prioritising trauma in mental health policies and frameworks and making a commitment to support trauma-informed service systems (2). As discussed in Section Five, our review of mental health policies across governments in Australia found, at best, an acknowledgement of trauma in the pathway to mental ill-health without describing clear actions and activities for implementing effective and evidence-based trauma responses within mental health services and systems.

Inconsistent translation of trauma-informed approaches into practice

One of the clearest challenges for system-wide approaches has been the inconsistencies in the understanding of trauma-informed care,

particularly in regards to its implementation (also discussed in Section 5). For example, one study looking at the conceptualisation of trauma-informed practice across mental health, juvenile justice, child welfare and education providers found that service providers in particular were concerned that each system had their own conceptualisation and understanding of trauma-informed practice, and that even individual practitioners had different definitions (96).

A discussion paper on trauma-informed approaches prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse identified that while, broadly, there was a shared understanding about the principles and purpose of trauma-informed care, the understanding on how to operationalise and translate this into practice was not consistent (95). This was partly a result of a divergent purposes across systems. Some, such as justice settings, by their very nature "work against the principles of trauma-informed care" (p39). The ever increasing number of models and approaches, resources, training packages and toolkits may also be contributing to a lack of clarity and consistency in implementing trauma-informed approaches.

Lack of common assessment frameworks

The authors of this report were unable to identify a common assessment tool utilised in youth-focused (12-25 years) services to screen or rapidly assess for trauma. In the UK, the Government had previously prescribed a Common Assessment Framework through its former 'Every Child Matters' policy, which helped agencies identify children's needs and any adversities experienced in a consistent way. Even though they are no longer required through government policy, Common Assessment Frameworks are still reported to be routinely utilised by a number of local authorities (94).

Workforce issues

There remains workforce challenges across a number of systems working with vulnerable and/or traumatised young people. This includes both the recruitment and retention of qualified and experienced staff in child protection, juvenile justice, mental health and youth/social work related services. One of the challenges of developing 'trauma literacy' in these workforces is in the significant turnover of staff, and the expense involved in organisations continually providing professional development for new staff. Building compulsory units of trauma literacy into pre-service education across a range of job functions, such as health, mental health, justice, education and social work is one opportunity to ensure that there is consistency in trauma knowledge and skills, at least upon entry into the workforce.

8.3 Cross-sector collaboration/integration at the regional level

Cross-sector collaboration is a key component of SAMHSA's systems approach to trauma, and 'Cross System Collaboration' approaches for young people who have experienced trauma have been further developed through regional projects in the US (143).

The siloed nature of health and human services delivery in Australia, along with limited resources and capacity and competition for policy prioritisation and funding has presented many road blocks to services working together in a collaborative way.

As identified through experiences in the UK, without systems collaborating together, there is "no effective way to share, and flag, evidence of young people's and familial involvement, so that professionals could see if levels of adversity or symptomology were escalating" (144).

In Australia, Kezelman and Stavropoulos (12) described that currently "a `merry go round' of unintegrated care risks re-traumatisation and compounding of unrecognised trauma". The lived experience of this failure to integrate and coordinate care has been clearly articulated by young people in the UK:

> "Stop asking me to repeat myself" – it's a hard thing for me to talk about, and if it's going to help me I'd rather you told the right professional so that I don't have to.

> "Don't pass me from person to person" – I have to start from scratch each time. I don't want to be thrown between services, and it's going to screw with my recovery.

From Young Minds, Addressing Adversity Chapter 7 (145)

The National Child Traumatic Stress Network in the US published a paper on collaborative cross system responses which identified key strategies to address these challenges:

- That service/systems acknowledge the core connection to other existing services/systems.
- Systems must cultivate relationships with each other which can best serve the interests of the young person that they are all working with.
- Systems and services must formalise a commitment to partner and collaborate, for example through formal agreements/MOUs (143).

In their extensive work on adversity among young people in the UK over recent years, YoungMinds has frequently identified the need to establish interagency collaboration to ensure all of the young person's needs are being addressed. Responses should be positioned in the context of the adversity that has been experienced and its impact on the range of health and social outcomes (9, 94, 127).

> "Creating and sustaining a local transformation priority of adversity and trauma-informed care requires us to bring together the different ways in which local agencies recognise and identify adversity, trauma and related mental health needs."
>
> **From Young Minds, Addressing Adversity, Chapter 6 (94)**

One example of a whole of government approach to vulnerable young people, many of who will have experienced trauma, is the Tasmanian Government's *Youth at risk strategy* (146). While addressing trauma experienced by young people is only one part of this strategy, it does provide a policy platform through which the government can fund and develop training, resources and regional governance arrangements in such a way that collaboration is optimised.

For example, through this strategy the Tasmanian Government will consider cross-sectoral training opportunities that will enhance consistency across the youth service sector and will look at targeting areas of greatest need. This could include engaging key stakeholder groups across the government and non-government sector and partnering with universities and technical and further education (TAFE) institutions, to ensure graduates entering professions within the youth sector are adequately skilled in areas such as trauma-informed care.

Opportunities for cross-sector collaboration can also be developed and driven at the local/regional level, as described in the Spotlight 7 below. Commissioning of health and mental health services in Australia at a regional level through the PHNs also provide an opportunity to build cross-system collaboration into funding agreements and regional priorities.

Spotlight 7: Cross-sector development of an youth early intervention platform – The Geelong Project

An example of an early intervention platform for improving outcomes for vulnerable young people who were at high risk of entering homelessness, justice, mental health, and substance abuse or protective services is The Geelong Project. While not specifically focused on trauma, it is likely many of the young people involved in this project will have a trauma history or be currently experiencing trauma.

This project developed (among others):

- Formal partnerships with local secondary schools.
- Formalised agreements and integrated work plans with partnering community service agencies, health providers, peak bodies and universities to build an integrated early intervention platform.
- Cross-sectoral training.
- An online platform through with cross-sector collaboration and information sharing can occur.

An interim evaluation of the project has found a decline in young people presenting to local specialist homelessness services, reduction in early school leaving and improvements in home situations.

SUMMARY

A systems approach to trauma requires further development in Australia to respond to the needs of individuals with complex trauma experiences who are involved in, or move in and out of, multiple services.

Australian systems level responses are hindered through:

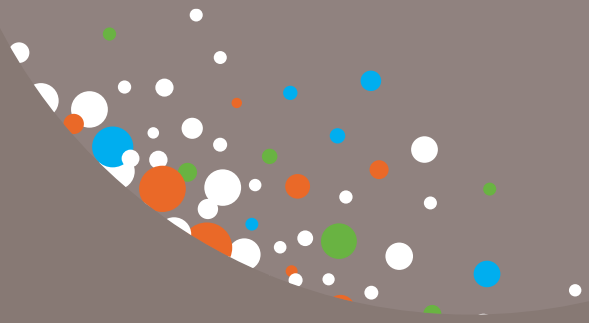
- Lack of government leadership and policy.
- Inconsistent understanding on implementation of trauma-informed approaches across and even within systems.
- Workforce issues.
- Lack of targeted funding which supports systems to work together with a shared understanding and meet the holistic needs of what is often a shared client group.

The result is a 'merry go round' of service presentations and representations experienced by a very vulnerable group of young people, and potentially a traumatising experience of the services system.

Innovative and regionally responsive mechanisms for cross-sector collaboration for young people experiencing heightened risk and vulnerability (more often than not as a result of trauma experiences) have been developed in Australia and internationally. These approaches have demonstrated improved outcomes for these young people, including in education and housing security.

The focus really needs to shift away from establishing the evidence base on the link between trauma and mental health...toward service change.

Psychologist



Section Nine

Discussion and conclusion

A number of key implications have been identified through this report for consideration in the future development of trauma responses across youth mental health and other youth focused policies, services and systems. These are summarised below. Please refer to the front of this document for the final set of recommendations.

> "I believe the focus really needs to shift away from establishing the evidence base on the link between trauma and mental health issues as this has been established, toward service change. Services are crying out for information, support and training in this area, but providers who have this expertise are being defunded, with the risk being that this expertise and knowledge is lost and funding goes into doing it all again, rather than moving things forward and actually implementing change."
>
> **Psychologist**

9.1 Government policies

Current mental health policies do not adequately describe or emphasise the extent of exposure to trauma among young people, the impact of trauma and adversities on mental health and wellbeing, or explicit direction on the need for trauma-informed responses to be embedded in youth mental health interventions and services. While the Fourth National Mental Health Plan had made considerable gains in improving the policy response, the Fifth National Mental Health and Suicide Prevention Plan took a step back in its acknowledgement and response to trauma outside of Aboriginal and Torres Strait Islander people and communities.

The authors of this report strongly support the MHCC recommendations for a policy position from the Australian and jurisdictional governments prioritising trauma in mental health policies and frameworks and making a commitment to support trauma-informed service systems.

Where the need for trauma-informed care is described across a range of other youth focused policies and strategies there is, in almost all instances, a lack of direction on the implementation of this approach that needs to be urgently addressed. This includes detail such as the training, resources and investment required to support the development of trauma-informed services.

Further, there is a need to consolidate an understanding of trauma and its impacts, how it is identified and develop a framework for implementing and measuring trauma-informed care across systems and for particular population groups of vulnerable young people. This will require a substantial reform of public policy, service system design and workforce development coordinated across a range of relevant policy portfolios and across all levels of government.

9.2 Service planners

Youth mental health

The development of youth-friendly and focused models of mental health care, such as headspace, has well-positioned these services to operate according to principles identified within trauma-

informed care models. However, improvements are urgently needed in the assessment and treatment of trauma-related disorders within these services. In particular, there is a need for youth mental health services more broadly to stop conceptualising 'trauma' and 'mental health' as distinct and different treatment approaches and services.

Many youth mental health service providers also appear to be hindered in their capacity to provide the adequate treatment response for trauma. Sessions available through the MBS (Better Access) Initiative were considered to be inadequate. The required number and duration of sessions of evidence-based treatment approaches such as TF-CBT is 12-16 sessions. Given the additional sessions that may be required in establishing trust and addressing barriers for a young person to disclose a traumatic experience, the current limit of ten sessions appears to be inadequate.

An alternative targeted trauma care package could be provided by utilising a range of mental health funding options including, Better Access, the Australian Government's Youth Severe mental health funding through the PHNs and the ATAPS. For example, ATAPS Tier 2 initiatives have previously included a targeted trauma response for the 2009 Victorian victims. The *Bushfire Initiative* has been subsequently rolled out to other bushfire affected areas such as the Blue Mountains, NSW (2013) where persisting symptoms of mental illness resulted from trauma and loss (147).

Broader youth systems

It has also been noted that populations with complex needs (including those described in Section 2.3) are at very high risk of falling through the gaps of service delivery systems due to a lack of service coordination and integration (148). There is an understanding that true trauma-informed care is only possible through a systems approach, where all services and systems involved in a young person's life are trauma-informed and working collaboratively. It is important to strengthen the capacity of youth mental health services to work in connection with other systems including education, human and social services and youth justice and provide continuity of service and consistent approach for young people as they move between various youth service systems.

Funding is required to support the development of cross-system integration with a focus on formalising partnerships between key service providers and stakeholders, building platforms for information sharing and cross-sectoral training opportunities. Given the bilateral nature of the national and jurisdictional government action required, one mechanism for providing this funding involves the establishment of a National Partnership Agreement for responding to young people with histories or experiences of trauma.

9.3 Workforce

Youth mental health

Support and training appears to be required for clinicians to feel comfortable in assessing for trauma and integrating responses within treatment. This relates to trauma-related diagnoses and for broader presentations of mental ill-health including anxiety, depression, eating disorders, psychosis, drug and alcohol and personality disorders. This should be supported through:

- Development of youth-specific trauma assessment tools and training (to achieve the Australian Government's National Mental Health Workforce Standards).
- Prioritisation of training and upskilling by individual services and professional associations.
- Regional sector development activities commissioned by PHNs and other government incentives provided to youth mental health services to address barriers to training.

> "Training in psychological trauma (assessment, awareness of developmental impacts and treatment) needs to begin at undergraduate university level for all disciplines involved in mental health service delivery, be a core subject at postgraduate level and be a compulsory PE activity for maintaining registration. All mental health professionals should be trained/endorsed in at least one evidence-based treatment for trauma-related mental health problems."
>
> **Clinical consultant**

In addition, there appears to be a lack of trained clinicians who specialise in trauma-specific treatments for young people. There is a need to better understand the extent and nature of this workforce shortage through the mental health needs assessments being undertaking by the 31 PHNs.

Finally, there is a need to develop an accreditation program for advanced practice in trauma therapy which includes opportunities for training, ongoing supervision and regular upskilling. The authors of this report are aware that, in 2018, the Department of Health released a tender for "a systematic review of the evidence for the effective treatment of complex trauma and workforce support activities based on the findings of this systematic review and a directory of the mental health professionals that practice trauma-informed care." This is a timely piece of work and it is important that it incorporates findings specific to different population groups, including young people.

Broader youth systems

There are now a significant number of formal training packages for service providers on trauma-informed care available across Australia. However, there is a need to ensure consistency in approaches to trauma and engage widespread participation in this training. For services working with young people, the training provided should also be designed and delivered in a way that represents the experiences and needs of young people specifically. Involving young people in the design and delivery of this training should be considered.

It should also be culturally sensitive and appropriate, responding to different constructs and experiences of trauma and mental health among culturally and linguistically diverse (CALD) young people and families, as well as Aboriginal and Torres Strait Islander young people.

> "An individual's appraisals, reactions and expressions of distress in response to potentially stressful and traumatic events may be, in part, culturally determined."
>
> **Service provider**

To build the capacity of all systems to respond more appropriately and effectively to trauma in young people there is a need for consistent pre-service training across professional disciplines which are likely to come in contact with young people who have trauma histories. This includes mental health and health services, as well as social services (social workers, youth workers) and justice/corrections.

9.4 Research

Finally, a paucity of research into appropriate and effective trauma assessment (and the gateways into mental health care) and treatments for broader, more complex outcomes of severe trauma is a significant stumbling block for all Australian governments to more effectively target their services and investments.

In addition, there is no universally agreed approach to trauma-informed care underpinned by empirical research that has been adapted and tested for use both within Australian settings and across diverse populations of young people. The authors of this report believe a central resource clearinghouse on trauma would assist government and service providers to consolidate and update practice based on existing and rapidly emerging evidence for trauma-informed approaches and treatments across different populations and age-groups.

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