Developing a Trauma-Informed Therapeutic Service in the Australian Capital Territory for Children and Young People Affected by Abuse and Neglect

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Message from the Deputy Director General of Community Services Directorate

Childhood trauma is one of the nation's most important public health concerns with adverse childhood experiences being one of the strongest predictors for difficulties in life.

Research demonstrates that children in care display consistently higher rates of behavioural and other mental health problems as well as compromised cognitive and adaptive functioning than children in the general population. By the time a child has entered the care system, they may have already been exposed to multiple traumatic experiences.

In Australia, there is a growing recognition that an integrated whole of government response is required to protect children and young people from abuse and neglect. The *National Framework for Protecting Australia's Children,* endorsed by the Council of Australian Governments in 2009 and the *Closing the Gap* strategy, support this approach.

In the 2013–14 budget, the Australian Capital Territory (ACT) Government committed $3.05 million over four years to establish the Trauma Recovery Centre to support children recovering from abuse and neglect. Now known as 'Melaleuca Place' the Trauma Recovery Centre is a targeted, multi-disciplined, holistic, early intervention and prevention service, committed to supporting children and young people to heal from trauma, repair existing relationships and establish new supportive and protective networks.

Developing a Trauma-Informed Therapeutic Service in the Australian Capital Territory for Children and Young People Affected by Abuse and Neglect provides a sound foundation for the establishment of a trauma-informed therapeutic service. This paper provides an excellent resource for service providers working with vulnerable children and families and paves the way for better interagency collaboration and the development of trauma-informed services across the ACT.

Sue Chapman
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Executive Summary

A growing body of research demonstrates that adverse childhood experiences have a significant and pernicious impact through the life-span of a person. Experiences such as chaos, threat, traumatic stress, abuse and neglect, alter a developing child's brain in ways that result in enduring emotional, behavioural, cognitive, social and physical problems (Perry, 2006; cited in Webb, 2006). These effects are often observed in the child's diminished capacity to develop the new physical, social, emotional and cognitive skills necessary to become a functioning and mature adult.

Childhood trauma is one of the nation's most important public health concerns with adverse childhood experiences being one of the strongest predictors for difficulties in life including mental health problems, physical health problems, social/relational problems, poor educational and vocational outcomes, alcohol and other substance use problems, contact with the criminal justice system and lower socio-economic status. Bessel van der Kolk, an American trauma expert, asserts that 'Childhood trauma, including abuse and neglect, is probably our nation's single most important public health challenge, a challenge that has the potential to be largely resolved by appropriate prevention and intervention' (van der Kolk, 2005:2).

Across Australia, 184,284 children aged 0–17 years were the subject of child protection notifications in 2012–13 and 40,624 children were in Out of Home Care (OoHC) as at 30 June 2013 (Australian Productivity Commission, 2014). In the ACT, the most current data is from the incomplete 2013–14 year where there were 590 children and young people in OoHC as of 9 February 2014; approximately 75% aged 0–12 years, with each of these children *ipso facto* having experienced moderate to severe complex trauma. A recently finalised ACT Community Services Directorate study (2014) outlines that at 30 June 2013, 49% were under the age of two and 17% were older than 2 years and younger than 4 years giving a total of 66% under four years.

Research demonstrates that children in care display consistently higher rates of behavioural and other mental health problems as well as compromised cognitive and adaptive functioning than children in the general population. By the time a child has entered the care system, they may have already been exposed to multiple traumatic experiences including abuse, neglect, exposure to domestic violence, a family history of mental health, and drug and alcohol abuse. Children and young people whose histories have resulted in removal to foster or residential care settings, and who experience multiple changes in caregiver are unlikely to have established or maintained secure attachments with a primary caregiver. As normal development is dependent on the presence of at least one secure attachment during childhood, the consequences of this are pervasive (Schore, 2001). There is also an established link between children who suffer complex trauma and subsequent involvement in the youth justice system (ACT Human Rights Commission, 2011).

The increased use and availability of medical imaging technologies has furthered our understanding of exactly how the brain is altered following prolonged exposure to trauma and/or stress. Significantly, there is now growing evidence that persistently elevated levels of the stress hormone cortisol, can disrupt the developing architecture of the brain, including its size. This can then lead to permanent changes in brain structure and function including difficulties in learning memory and executive functioning (Shonkoff & Garner, 2011). These developments have coincided with the

emergence of new theoretical frameworks that focus on trauma-informed therapeutic approaches to working with children, and in particular focus on a child's developmental age (as opposed to chronological age) and the importance of building safe and secure relationships as a means of recovery.

As a community, we need to endeavour to prevent child maltreatment before it occurs. The Child and Family Centres based in the ACT and other universal primary prevention and early intervention services focus on this goal. However, where maltreatment has already occurred, there is growing evidence that intensive intervention as early as possible in the life of the child and in the development of the problem can help to temper the detrimental effects of abuse and neglect. In essence, there is a need for '*early intervention in the tertiary system'.* That is, the prevention of further traumatic and harmful situations for a child who has already come to the attention of statutory authorities.

This discussion paper will explore the policy context in which the Trauma Recovery Centre has been established as well as some of the literature regarding the impact of trauma on a child's physical, psychological and cognitive development. The key theories and/or frameworks being utilised by experts in this field will be examined as will the importance of understanding the cumulative impact of trauma on children in OoHC. An analysis of the trauma-informed services in Australia as well as the key aims of the Trauma Recovery Centre will be explored with reference to the OoHC data in the ACT, and will conclude this paper.

This paper highlights that a whole of government and cross sector approach is required to provide a trauma-informed, safe and nurturing environment for children and young people. Significantly, there are existing services in the ACT that provide trauma-informed therapeutic support to children and young people, such as the Child at Risk Health Unit and Canberra Rape Crisis Service. A key aim of the Trauma Recovery Centre will be to compliment these existing organisations, whilst also providing a holistic, intensive and peripatetic therapeutic service. The challenge thus lies in building a trauma-informed service system, which utilises a partnership and collaborative approach whilst also recognising the skills and expertise of individual service providers.

Background and Policy Context

In the 2013–14 budget, the ACT Government committed $3.05 million over four years to establish the Trauma Recovery Centre to support children recovering from abuse and neglect. The focus of the Trauma Recovery Centre is to provide high quality *trauma-informed* therapeutic services to children aged 0-12 who have experienced abuse and neglect and who are current clients of the statutory services. Work will be undertaken with children in the context of their care and support networks, utilising trauma and attachment informed interventions. The Trauma Recovery Centre will be situated within Early Intervention and Prevention Services in the Office for Children Youth and Family Support (OCYFS) in the Community Services Directorate.

The establishment of the Trauma Recovery Centre has occurred against a backdrop of growing recognition, both at an international and national level, that an integrated whole of government response is required to protect children and young people from abuse and neglect. The *National Framework for Protecting Australia's Children* (Framework)*,* endorsed by the Council of Australian Governments in 2009, provides the impetus for guiding service development in Australia, with three of the six outcomes reflecting the principles of the Trauma Recovery Centre:

- *Outcome 2*: Children and families access adequate support to promote safety and intervene;
- *Outcome 4*: Children who have been abused or neglected receive the support and care they need for their safety and wellbeing; and
- *Outcome 5*: Indigenous children are supported and safe in their communities.

Along with the Framework, the national *Closing the Gap* strategy also aligns with the objectives of the Trauma Recovery Centre. Endorsed by the Federal Government in 2008, the *Closing the Gap* strategy aims to reduce Indigenous disadvantage with respect to life expectancy, child mortality, access to early childhood education, educational achievement and employment outcomes (Australian Indigenous Health Infonet, 2014). The establishment of the Trauma Recovery Centre supports the building blocks 'Safe Communities' and 'Early Childhood'.

The *Review of ACT Child Protection Services* (Vardon Report) undertaken in 2004, identified a need for 'a therapeutic counselling service for children and young people with moderate to severe emotional and behavioural problems'. The Vardon Report (2004) also recommended 'that therapeutic services and placements for children and young people with high needs in the ACT be developed and piloted' (Vardon, 2004:30)*.* These recommendations were accepted by the ACT Government, and the Trauma Recovery Centre, with its key aim of providing therapeutic support to children and young people affected by trauma, directly responds to this identified need and service gap in the ACT.

The *ACT Five Year Out of Home Care Strategy* 2015–2020, will aim to ensure the adequate supply and quality of OoHC placements for children and young people in the care of the Director-General. The Trauma Recovery Centre will contribute to this aim by providing therapeutic services to assist with the reduction of complex behaviours and improve the skill of caregivers, leading to more stable placements.

Finally, the Human Services Blueprint provides another vehicle for guiding the development of the Trauma Recovery Centre. The Blueprint's vision is for a cohesive human services system in the ACT that is person-centred, strengths-based and simple. The move towards a cohesive model of service delivery and response is guided by five values and eight principles with the key aims of capacity development and integrated service delivery. The partnership approach promoted by the Trauma Recovery Centre is congruent with this shift towards an integrated approach to service delivery, offering intensive service provision for children and young people with the aim of intervening early in the life of the child and/or the problem.

Trauma Overview

"A trauma is a psychologically distressing event that is outside the range of normal childhood experience and involves a sense of intense fear, terror and helplessness" (Perry, 2002:23).

It is well documented in the literature that childhood trauma has a lasting impact on brain development and on the formation of a secure attachment between the child and their caregivers. The extent to which a child is affected by trauma is dependent on:

- The age and developmental stage of the child;
- The nature of the trauma i.e. whether it is a one-off event, a natural disaster or a persistent or evasive part of life; and
- Whether there are protective and nurturing adults to support the child during and after the traumatic event (Women's Health Goulburn North East, 2012).

Much of the literature pertaining to trauma makes a distinction between Type 1 and Type 2 Trauma. Type 1, also referred to as '*Acute Trauma'* results from exposure to a single event or situation which is overwhelming for the child, such as a bushfire, car accident or death of a parent. The presence of caring and supportive adults before, during and after the traumatic event is integral to a child's ability to make sense of such an experience (Women's Health Goulburn North East, 2012) and with supportive relationships, it is likely that children will recover from the traumatic incident, develop coping strategies as well as a degree of resilience.

Conversely, Type 2 Trauma, commonly referred to as '*Complex Trauma'* results from a child's repeated and prolonged exposure to multiple traumatic events (Bath, 2008). According to van der Kolk (2005,) these traumatic experiences are most often interpersonal in nature and occur within the child's care giving system and include physical, emotional and educational. Therefore, for children who experience persistent trauma and where adults are either the source of trauma (e.g. abusive parent) or who have a limited capacity to support the child (e.g. family violence, homelessness, parental mental health concerns), the greater the likelihood the trauma will have a lasting impact on the child's social and emotional wellbeing and development.

Child Development and the Impact of Early Trauma

Children exposed to complex trauma can experience lifelong problems that place them at risk of further difficulties, including psychiatric and addictive disorders, chronic medical illnesses and legal, vocational, and family problems. These difficulties may extend from childhood through adolescence and into adulthood (Cook et al., 2005).

Child development is commonly broken down into four stages: prenatal, early childhood (infant, toddler and preschool), middle childhood, and adolescence. At each stage of development, children have various age and stage salient tasks to achieve in order to become a fully functioning human being. Chronic maltreatment and trauma interferes with neurological development and the capacity of the brain to integrate 'sensory, emotional and cognitive information into a cohesive whole' (van der Kolk, 2005:3). This can then impact on the ability of a child to master the major tasks faced at each developmental stage, potentially leading to developmental delays or disorders (Department of Human Services, 2007).

Prenatal: During prenatal development, the unborn child needs nourishment and a safe environment in order to survive and develop. Maternal stress and heightened emotional expression can impact negatively on the unborn child as it can release stress hormones which pass through the placenta (Wolkind, 1981). It has been demonstrated through research that prenatal exposure to various substances has negative effects on prenatal development, leading to physical abnormalities, reduced birth weight and size along with language and learning delays (Dozier, Albus, Fisher & Sepulveda, 2002).

Children 0–5 years: Trauma can lead to a disturbance of general functioning (e.g. sleeping, feeding and overall irritability, or withdrawal and lack of responsiveness) as well as a possible regression of acquired fine motor skills and acquired communication skills. Exposure to trauma can manifest itself in behavioural changes, such as regressing to the behaviour of a younger child and losing previously acquired skills, increased tension, irritability, an inability to relax, increased startle response and sleeping and eating disruptions. The overall neurological impact could lead to cognitive delays and memory difficulties, loss of acquired communication skills and insecure/disorganised attachment behaviour (Department of Human Services, 2007).

Children 6–12 years: The physiological responses can be similar to those described above, but may also include the disturbance of specific skills, e.g. social skills, communication skills, the ability to interpret the emotions/behaviours of others, and the development of a poor sense of self and identity. The impact of abuse and neglect on identity formation is particularly significant, as children of this age will often believe that the abuse is their fault, that they are an inherently bad child and thus develop a negative sense of self and internal working model; which without appropriate therapeutic support may persist through adolescence and into adulthood.

Adolescents 13–19 years: In adolescents, the manifestations can be less understood, given the presence of puberty and the behavioural changes that puberty can incur. Longer term outcomes include problems in interpersonal relationships, emotional dysregulation, ongoing vulnerability to stress and impaired sense of self.

As consistently outlined in the evidence, prolonged exposure to these circumstances and overwhelming stressful events can lead to 'toxic stress', which changes the child's brain development (due to the constant flooding of cortisol and adrenalin to the brain), sensitises them to further stress, can lead to heightened activity levels and affect learning and concentration levels (Department of Human Services, 2007).

Key Theoretical Frameworks

The impact of child abuse and neglect on a child's wellbeing is complex and requires a thorough understanding of child development, attachment and trauma theory. The extent to which a child is supported by their wider ecosystem (family, school, community) is also integral to understanding the cumulative impact of child abuse and neglect on a child or young person as well as planning for recovery.

The Neurobiology of Trauma

The neurobiology of trauma builds on the aforementioned knowledge of the impact of abuse and neglect on a child's development. The brain develops in a sequential fashion from the 'bottom up', from the least (brainstem) to the most complex (limbic, cortical). Each of the four main regions of the brain (brainstem, diencephalon, limbic system and cortex) has a differing function and become fully functional at different times during childhood (Perry, 2009:242). Therefore if an impairment occurs in utero (due to exposure to alcohol for example) or in early childhood (due to trauma) this can affect the sequential development of other parts of the brain and/or lead to a range of abnormalities or deficits in function.

The literature also indicates that the 'organising, sensitive brain of an infant or young child is more malleable to an experience than a mature brain' (Perry, 2009). Therefore, any adverse or prolonged traumatic experience is likely to greatly affect the structure of an infant's brain. Conversely, it is quite feasible to assume that children can still be helped with sensitive and nurturing care-giving and positive experiences regardless of the severity and chronic nature of the maltreatment — if it is introduced early in life whilst the brain is still malleable and adaptive (Perry, 2009).

Therapeutic interventions which focus on the neurobiology of trauma, including Perry's (2009) Neurosequential Model of Therapeutics, look to implement therapeutic interventions based on the developmental age of the child. This requires a thorough assessment of a child's social, emotional and cognitive stage as well as an understanding of the age at which the trauma occurred, in order to determine the parts of the brain that are likely to have been compromised as a result of the trauma experienced.

Attachment/Trauma Theories

Attachment is a general term that describes the state and quality of an individual's emotional ties to another. Attachment theory is a theory of child development that focuses on the quality of children's early relationships with their parents or caregivers and the profound influence these have on children's social and emotional development (Evolve Therapeutic Services Framework, 2012).

Frederico, Jackson and Black (2005) postulate that a major learning from trauma theory is the understanding that those who have been traumatised are trying to survive, even if their presentation and behaviours appear contrary to this. This is evident where the child/young person experiences extreme anxiety, and then compensates for a lack of security by attempting to control all elements of their environment. Typical examples of these types of behaviours include aggression, distress in response to change and uncertainty, non-compliance, controlling behaviours with peers and family members, and defiant behaviours.

Attachment theory provides the framework for understanding the effects of early abuse, neglect, separation and loss. Each child requires the experience of a relationship with a significant parenting figure who will provide them with their first sense of self, and experience them as a worthwhile person (Hughes, 2007). This relationship also provides the child with a 'secure base', from which the child is able to safely explore the world knowing that someone is protecting them and keeping them in mind (Hoffman, Marvin , Cooper & Powell, 2006).

The way an infant/child relates to new caregivers or adult figures can be heavily influenced by how the child learnt to relate to birth parents early in life. During this early stage of development, infants and toddlers are wholly dependent on their parents to meet their physical and psychological needs. As an infant's overwhelming need is towards attachment, the infant will accommodate to the parenting style they experience (Department of Human Services, 2007). When faced with chronic stress, uncertainty, inconsistent care-giving and persistent frightening experiences, infants and young children will adapt using the body's survival mechanisms – the autonomic nervous system will become activated and switch to the freeze/fight/flight response (Department of Human Services,

2007). When the body is in this state, the brain is flooded with cortisol and adrenalin, leaving the child feeling and looking agitated or hypervigilant. Alternatively infants may display 'frozen watchfulness'.

When the first years of a child's life are characterised by experiences of loss, trauma and disruption, the child's capacity to develop secure attachment relationships as well as their capacity to later form attachments with a new carer, are significantly impacted (Golding, 2006). Interventions that are attachment focused assist parents/carers develop their understanding of the importance of attachment. For example, this may be characterised by parents/carers resisting responding to a child as the child is anticipating and instead, responding to the child in a more meaningful and attuned way. This will allow or enable the child to begin to experience a more secure attachment relationship than previously (Golding, 2008).

Systems Theory

Taking a systemic focus means that emphasis is placed on intervening with the system rather than focusing solely on the individual. Ecological and family systems theories provide a framework for understanding this type of practice. Ecological Systems Theory (Bronfenbrenner, 1979) considers a child's development within the context of the system of relationships that forms his or her environment and recognises that each part of the system impacts all other parts. Structural factors such as poverty, social isolation, and access to education and essential services are therefore considered in the application of this theory and are seen as factors that require strengthening, in order to enhance positive outcomes for a child. Any intervention therefore, needs to focus not only on the child but also supporting the child's relationship with their parents, carers, and siblings and strengthening connections to their school, community and wider service sector.

Grief and Loss

Grief and loss is an integral feature of the lives of children/young people in care. Understanding the grief and loss experienced through both loss of family of origin, and often, the multiple transitions and changes that children in care have experienced, is important in the universality of the experience. For Aboriginal and Torres Strait Islander children/young people, grief and loss is referred to as 'sorry business' that affects not only the family but the whole of the community (Evolve Therapeutic Services Framework, 2012).

Trauma-Informed Therapeutic Approaches

As our understanding of the impact of early trauma on brain development has grown, so too has the introduction of trauma-informed therapeutic approaches and practices for working with children and young people. The core principles of trauma-informed care/practice as outlined by the National Centre for Trauma Informed Care (NCTIC) include:

- Understanding trauma and its impact;

- Promoting safety;
- Ensuring cultural competence;
- Healing happens in relationships;
- Integrating care; and
- Understanding recovery is possible.

(NCTIC cited in Steele & Kuban, 2013:53)

Applying the Theory in Practice

Trauma/Attachment Focused

The effect of disrupted attachment relationships can to some extent be addressed through intensive psycho-education work with, for example, carers and teachers, so as to improve their understanding of why children/young people behave the way they do. This psycho-education aims to modify the person's response to the child/young person and assist them to respond to challenging behaviour in a manner that is informed by attachment-based principles. Psycho-educational work can occur with a variety of stakeholders at any phase of intervention, including early work focused on stabilising the systems around the child/young person. The outcome of this training is to teach the caregiver to gently lead or guide the child/young person into different ways of relating with others (Golding, 2008).

Attachment-focused therapeutic interventions such as Attachment-Focused Family Therapy (Hughes, 2007) and Dyadic Developmental Psychotherapy (Hughes, 1997) are examples of evidence-based approaches. This work is often a long-term intervention, and occurs in the context of systems having been stabilised. Parent-child or carer-child dyadic work is where the therapeutic focus is on the dynamics of the relationship between the parents or carers and the children. The emphasis of this work is on helping the parent or carer to take the initiative in developing a relationship with the child, enabling the child to directly experience the parent or carer as consistent and nurturing. Dyadic work often involves helping the adults understand their own responses through exploration of the carer's own attachment history. This type of work aims to help the parents/carers understand how the child needs them regardless of how much the child may be behaving as if he or she does not need anyone (Dozier, Stovall, Albus, & Bates, 2001).

Exploring Trauma

Addressing the trauma experienced as a consequence of an abusive or neglectful childhood is particularly difficult and challenging for any child/young person. Therefore, therapeutic interventions focused on exploring past trauma and losses cannot effectively take place until the child/young person's safety and attachment needs are met. Trauma therapeutic approaches such as psychodynamic approaches, psycho-education, life story work or family therapy are all interventions which are carefully integrated to address the 'felt' safety of the child/young person, their relational engagement or attachment needs, self regulation skills, self reflective information processing, positive affect enhancement and traumatic experience integration (van der Kolk, 2005).

Systemic Approaches

Golding (2008) identifies a framework for understanding the needs of children/young people with complex presentations. Golding's approach recognises that problems often occur simultaneously across multiple levels of functioning and across multiple systems. As a result, interventions need to be tailored to the child/young person's specific needs.

Working from this theoretical and conceptual framework enables multiple issues to be addressed simultaneously. For example, working directly with the carer and the child/young person's wider system (school, child protection staff and care provider) by providing education on the impact of trauma and abuse has the ability to increase each stakeholder's empathy for the child/young person and their capacity to tolerate particularly difficult behaviours. This in turn has the capacity to stabilise the child/young person's systems, allowing opportunity to forge relationships even prior to individual work commencing (Golding, 2008). Once the child/young person is then at a stage where they are feeling safe within supportive systems, they may then go on to develop personal relationships and attachments.

Trauma-Specific/Focused Interventions

Trauma-specific or trauma-focused interventions directly address the impact of trauma on a child or young person through the goals of decreasing symptoms and facilitating recovery (Fallot & Harris, 2001). A number of systematic reviews of trauma-informed approaches have been undertaken in the United States and there appears to be some consensus regarding the most appropriate and commonly used interventions for this cohort. A recent study in Australia, '*Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect: Evidence, practice and implication*s', identified and rated the evidence for approaches being utilised in Australia, which are aimed at preventing and treating outcomes in children exposed to trauma associated with abuse and neglect (Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2014:1). This study identified that Trauma-Focused Cognitive Behavioural Therapy was the only approach which met the criteria for being 'Well Supported'. Eight approaches, including Child Parent Psychotherapy and Parents Under Pressure, met the criteria for 'Supported' programs. The report concluded that while there are many approaches that exist, few have been evaluated and therefore there is little evidence available to indicate whether they are effective for improvising outcomes for this cohort (Australian Centre for Posttraumatic Mental Health et al., 2014:6).

Whilst acknowledging that there is a clear need for further analysis and evaluation of trauma-specific/focused interventions, it is still useful to explore some of the key practices and therapeutic approaches to working with children and young people who have suffered abuse and neglect. Its inclusion in this paper is not an endorsement as to effectiveness, rather an acknowledgement that these approaches are currently the most commonly utilised.

Therapeutic Interventions	Key Features of the Intervention
Trauma-Focused Cognitive Behavioural Therapy	Addresses distorted/maladaptive beliefs and attributions related to the abuse. Children are encouraged to talk about their traumatic experiences, process the experiences, overcome problematic thoughts and behaviours and develop

	effective coping and interpersonal skills (Child Welfare Information Gateway, 2012). Strong evidence base from the United States.
Neurosequential Model of Therapeutics	Focuses on understanding that violence, abuse and neglect lead to traumatic symptoms and alter the brain in ways that lead to emotional, behavioural, social, cognitive and physical difficulties (Perry, 2006:29, cited in NSW Department of Health, 2011:24). Interventions require a thorough assessment of a child's social, emotional and cognitive stage as well as an understanding of the age at which the trauma occurred, in order to determine the parts of the brain that are likely to have been compromised as a result of the trauma experienced. Relationship building, regulating emotions, and working with schools, parents and carers may occur before 'talking' therapy with the child commences.
Neurological Reparative Therapy	This is a model for treatment and not a practice; it 'provides a map for the process of repairing the brain' (Ziegler, 2011:27). It is a practical application of the new understandings of the brain and how it is affected by trauma. There are five main goals which include, to 'facilitate perceptual changes of the self, others and the child's inner working model' (Ziegler, 2011:69) and enhance the parts of the brain that process and integrate information.
Dyadic Developmental Psychotherapy	This treatment model has been developed by Dan Hughes and is an attachment-focused model of family therapy for children who have suffered abuse, neglect and multiple placements. The aim of the model is to facilitate attuned relationships between the child and caregiver as well as the therapist and child, and therapist and caregiver. The model is based on the premise that the development of a child is dependent upon and highly influenced by the nature of the parent-child relationship (Dyadic Developmental Psychotherapy, 2012).
Marte Meo Model	A developmental model which focuses on the everyday moments of life known as 'Action Moments', where a child's development takes place. The model uses video footage to allow for an analysis of a parents' and child's interaction and the child's developmental progress. The elements of a child's development that are not yet present are

	identified and parents/caregivers are given the skills to work with their child to maximise development (The Benevolent Society, 2011:48).
Multisystemic Therapy	This is a community-based, family-driven treatment for antisocial/delinquent behaviour in youth (Life Without Barriers, 2013). The aim is to improve youth and parent functioning, reduce abusive parenting behaviour, and decrease abuse and placement. It is an intensive therapeutic program that targets the natural ecology of the child or young person (i.e. family, peers, school etc). Suitable for children aged 10–17.
Attachment/Parent-Child Focused Interventions: Circles of Security – Parent/Infant Program	This is a 20 week, group-based program designed to enhance relationships between parents and their young children and aims to bring a shift from a 'disorganised attachment back to a secure attachment pattern' (The Benevolent Society, 2011:49). Parents undergo a videotaped individual attachment assessment with their child, which allows for safe feedback to parents about their relationship with their child.
Parent-Child Interactive Therapy	This intervention focuses on difficult/concerning/problematic child behaviour. Most effective for children aged 2-7. Parents learn specific skills to increase positive attention to the behaviour they want to encourage, and specific disciplinary techniques to respond to undesired behaviours. Parents receive live coaching from their therapists behind a one-way mirror via wireless ear bud, and lead the child through a series of tasks, as well as practice specific responses to both desired and undesired behaviour (Child Mind Institute, 2013).
Expressive/Sensory-Based Interventions and Therapies:	These interventions acknowledge that for many children that have experienced trauma, there are no words to assist children to communicate what has happened to them. These therapies therefore offer children opportunities to communicate without words (Steele & Kuban, 2013) and to convey their thoughts and feelings through mediums such as art, sand play, music and drama.

Art Therapy	Art Therapy is defined as the use of art media, images and the creative processes to create products which are reflections of one's own development, abilities, personality, interests, concerns and conflicts. It is a therapeutic means of reconciling emotional conflicts, managing behaviour, solving problems and reducing anxiety (Malchiodi, 2008:11).
Sand Play	Sand Play is a creative form of psychotherapy that uses a sandbox and miniatures to enable a client to explore deep layers of his/her psyche through the construction of sand pictures. These 'pictures' help a child to illustrate their psychological condition (Malchiodi, 2008:12).
Music Therapy	This form of therapy uses music to effect positive changes 'in the psychological, physical, cognitive or social functioning of individuals' (American Art Therapy Association 2007, cited in Malchiodi, 2008:11).
Drama Therapy	Requires the use of drama/theatre processes to 'achieve the therapeutic goals of symptom relief, emotional and physical integration and personal growth'. The process helps the individual to tell their story (Malchiodi, 2008: 11).
Life Story Work	Life Story Work is a collaborative approach to working with a child and involves 'unveiling the story of a child, of her family and of others who have had contact with her (Rose & Philpot, 2005). This intervention is most often used with children in care and for children who have experienced multiple placement changes. Life Story Work enables children to come to terms with the past, to understand what has happened to them and can assist with reframing a child's internal working model or negative sense of self.
Relationships-Based Work	Highlights the importance of developing strong, healing and protective relationships around a child who has experienced trauma, as well as developing strong relationships between services involved in a child's life.

Collaboration, Supportive Practice and Environment

The evidence that supports models of service delivery to meet the developmental and support needs of children and young people who have experienced trauma as result of abuse and neglect, is mostly from the United States. This evidence has been influential in regard to program development, both here in Australia, and in other countries.

It is widely accepted that interagency collaboration and practice can achieve a coordinated response from multiple service systems, enabling timely and effective interventions. Equally, a strong focus on professional development and training enables wider sector capacity building within the service system. Finally, taking into consideration the physical environment where children and young people live (residential settings), and undertake therapeutic interventions, is an emerging field which is worth noting.

Interagency Collaboration

> "Therapeutic collaboration…has the creative potential to bring relevant helping agencies together in a way that both contains anxiety and enhances the delivery of cohesive and psychologically sound interventions. Moreover, such an approach recognises that psychic pain and trauma has the propensity to split and fragment not only victims and their families, but helping professionals and the agencies they represent: the helping process in turn falls into a state of entropy."
> (Robinson, 2004, cited in Evolve Interagency Services Manual, 2012, unpublished)

Interagency collaboration refers to the process where parties involved see different aspects of a problem and can explore their different perceptions while searching for a more integrated and holistic solution that may have been beyond the vision of the individual parties (Darlington, Feeney & Rixon, 2004). McDonald and Rosier (2011) describe collaboration as a high intensity, high commitment relationship that requires new ways of thinking, behaving and operating, and for this reason, can be highly challenging for participants. Interagency collaboration can also reduce duplication of services and allows for greater efficiency in use of public resources.

A review of the literature regarding the utilisation of services by children in foster care identified that the complexity of cohesive service implementation and integration for children in care has been due to the fragmentation between relevant agencies (Kerker and Dore, 2006, cited in Chamberlain et al., 2008). In the past, limited collaboration between key stakeholders has meant that services are delivered in an ad hoc manner without a cohesive or well organised plan. Where these circumstances exist, wariness, distrust and shifting of responsibility between stakeholders may develop and can prevent the complex needs of children, young people and their families being 'held in mind' by all involved stakeholders. In addition, what further inhibits effective collaboration is when too much stress is placed upon the system providing care; the system itself becomes chaotic and frequently reflects the internal chaotic world of the child.

What is known is that any boundaries that are created which divide statutory and therapeutic work tend to be unhelpful and unnecessary. Effective collaboration between professionals undertaking therapeutic and statutory work creates psychological environments for the client, where the client is more able to meaningfully and successfully engage in treatment programs yielding positive therapeutic outcomes (Evolve Interagency Services Manual, 2012, unpublished).

Some of the key characteristics of effective collaboration between agencies include:

- Dense interdependent connections;
- Frequent communication;
- Tactical information sharing;
- Pooled, collective resources;
- Negotiated shared goals; and
- Shared power between organisations.

(ARACY, 2010a, cited in McDonald & Rosier, 2011)

Building Sector Capacity – Professional Development and Training

Evidence suggests that underpinning most successful service interventions with this client population are highly skilled staff and carers who receive expert supervision, ongoing training and support; and strong and sustainable partnerships where key players have the necessary knowledge and also good mutual understanding (Schmied, Brownhill & Walsh, 2006). The provision of training and professional development is a vital contribution to 'capacity building' through increasing knowledge about trauma and attachment, and thereby increasing the capacity for a deeper understanding of the emotional and behavioural patterns displayed by children and young people.

Due to the intensive therapeutic interventions which often include outreach and travel with the child, systemic interventions including intervention as needed with any and all other services supporting the child (e.g. carers, parents, agencies, schools etc.), clinical supervision and ongoing professional development are necessary components of maintaining a skilled workforce. Therefore, clinicians must be supported to maintain their own health and wellbeing, avoid burnout and to access career development guidance.

Physical Environment – Creating a Trauma-Sensitive Therapeutic Space

There is a paucity of research examining how physical environments such as residential facilities and therapeutic spaces impact children and young people who have experienced trauma as a result of abuse and neglect. Some of the research reviewed suggests using soft or neutral tones and natural materials when creating therapeutic spaces instead of primary colours, although colour can be introduced to the environment.

In Australia, a collaborative project titled Beyond Building (Attiwill, 2010) has sought to examine how interior design might affect and benefit the physical and emotional wellbeing of young people who have been placed into OoHC for periods between two months and eight years. The project,

developed in partnership with Gregory Nicolau from the Australian Childhood Trauma Group, utilises second and third year students to rethink and redesign the interior environment of residential care units so as to create a more therapeutic 'healing environment' (Attiwill, 2010). The students' ideas and models of design are then presented to the Department of Human Services for consideration and some elements of these projects have directly influenced architectural design (Attiwill, 2010).

Child Protection: The Australian Context

In Australia, child protection is the responsibility of State and Territory governments. Each state and territory has their own legislative framework to protect vulnerable children who have or are at risk of suffering abuse and neglect. Each year, the Australian Institute of Health and Welfare (AIHW) releases a report entitled *Child Protection Australia*, which provides statistical analysis on state and territory child protection and support services as well as some of the key characteristics and demographics of the children who come in contact with the statutory child protection system. The report also explores statistics in relation to the prevalence of types of abuse — physical abuse, sexual abuse, emotional abuse or neglect. Data relating to child protection and OoHC is also available in the 2014 Australian Productivity Commissions' Report of Government Services (APC Report).

In 2012-13; 184,284 children aged 0–17 years were the subject of child protection notifications at a rate of 35.2 per 1000 children in Australia. Of the notifications, 40,685 were substantiated. As of 30 June 2013; 42,652 children aged 0–17 years were on care and protection orders (APC Report, 2014). Nationally, the most common type of substantiated abuse was emotional (36%), followed by neglect (31%). However, neglect was the most common type of substantiated abuse for New South Wales (NSW), Queensland, South Australia, the ACT and the Northern Territory (AIHW, 2013:11).

Total recurrent expenditure on child protection and OoHC services was approximately $3.2 billion nationally in 2012–13. This is an increase of $177.5 million (5.8%) from 2011–12 (APC Report, 2014).

Children in Out of Home Care (OoHC)

Australia's OoHC population is large and growing. It is well documented that the system is currently dealing with a population of children and young people with increasingly complex and challenging emotional and behavioural difficulties (Osborn & Bromfield, 2007). In recent years this has led to the development of a range of foster care options that incorporate a therapeutic component.

As of 30 June 2013; 40,624 children were placed in OoHC (APC Report, 2014). Of these children, 13,914 were Aboriginal and Torres Strait Islander and 26,454 were non–Aboriginal and Torres Strait Islander children. Comparably, on 30 June 2012 there were 39,621 children and young people living in OoHC placements in Australia of which 13,299 were Aboriginal and Torres Strait Islander children. Of the number of Aboriginal and Torres Strait Islander children in OoHC as of June 2013, 52.5% of Aboriginal and Torres Strait Islander children were placed with relatives/kin (APC Report, 2014).

The AIHW 2012/13 *Child Protection Australia* report has not yet been released. However as there has only been a slight increase (approximately 1000) in the number of children in OoHC from 2012 to

2013, the following age-related data, remains relevant, if only from the perspective of providing a demographic snapshot of children in care. 12,240 children were admitted to OoHC during 2011–12, of which 5,286 (43%) were less than five years old (AIHW, 2013:36). Of the total number of children in OoHC (39,621), almost one-third (32%) were aged five to nine and a similar proportion (30%) were aged 10 to 14 (AIHW, 2013: 41). The 2011–12 recurrent expenditure for children in OoHC was $1.9 billion.

With respect to Aboriginal and Torres Strait Islander children and young people, on 30 June 2012, there were 13,299 Aboriginal and Torres Strait Islander children and young people in OoHC, a rate of 55.1 per 1,000 children. Nationally, the rate of Aboriginal and Torres Strait Islander children in OoHC was 10 times the rate for non-Aboriginal and Torres Strait Islander children. In all jurisdictions, the rate of Aboriginal and Torres Strait Islander children in OoHC was higher than for non-Aboriginal and Torres Strait Islander children, with rate ratios ranging from 3.4:1 in Tasmania to 15.8:1 in Victoria (AIHW, 2013:41).

As has been highlighted throughout this paper, there is an increasing body of evidence which documents the detrimental impact neglect and child abuse has on the developing brain and on the formation of secure attachments between a child and their caregiver(s).

Children involved in the child protection system are exposed to a number of situations that increase their risk of experiencing not only trauma and disrupted attachments, but also developing mental health problems. By the time a child has entered the care system, they may have already been exposed to multiple traumatic experiences including abuse, neglect, domestic violence, a family history of mental health, drug and alcohol abuse and family involvement with the criminal justice system. The ability of a child to make sense of these traumatic experiences and develop meaningful relationships or attachments that may assist them to overcome the trauma is hindered by the 'separation that is inextricably created when a child enters care and the associated loss of family, culture, community, peers and, frequently, school environments' (McLung, 2007:6). Negative outcomes can include anxiety, depression, post-traumatic stress, attachment problems, sexual behaviour problems, hyperactivity, anger and aggression, suicidal behaviour and other serious mental health issues (Briere et al., 2001; Oswald, Heil, & Goldbeck, 2010; Tilbury, Osmond, Wilson, & Clark, 2007).

As per attachment theory, the presence of caring and supportive adults is integral to a child's sense of stability and safety as well as their ability to understand and recover from a traumatic experience. Therefore, the greater the level of support and care a child can experience following a traumatic event, the greater capacity for a child to overcome the incident(s). Conversely, for children who experience persistent trauma and where adults are either the source of trauma (e.g. abusive parent) or who have a limited capacity to support the child (e.g. family violence, homelessness, parental mental health concerns), the greater the likelihood the trauma will have a lasting impact on the child's social and emotional wellbeing and development. For children in care, their experience is made even more difficult by multiple placement breakdowns, instability and/or changes which further hinder their capacity to resolve trauma. Therapeutic interventions therefore need to provide a sense of stability and safety and should 'incorporate consistency, repetition, nurturing and predictability' (DeGregorio & McLean, 2013:31).

Trauma and Aboriginal and Torres Strait Islander Children and Young People

In light of the over-representation of Aboriginal and Torres Strait Islander children and young people in OoHC, it is important to consider the needs of Aboriginal and Torres Strait Islander children when considering the application of trauma-attachment based models of intervention. Whilst trauma research specific to Indigenous Australian children is relatively new (Atkinson, 2013), the existing literature pertaining to the effects of trauma and stress on brain development must be considered when working with Aboriginal and Torres Strait Islander children and young people.

The extent to which Aboriginal and Torres Strait Islander communities, families and individuals have been affected by trauma since colonisation, is well documented. Atkinson (2013) outlines that the 'high level of distress in some Indigenous families suggests that children and adolescents are at risk of exposure to a toxic mix of trauma and life stressors'. As a result of the history of colonisation, displacement and the forced removal of children from their families as part of the stolen children generation, many Indigenous children are exposed to a milieu of traumatic life events including illness, accidents, exposure to family violence, family disintegration and financial stress (Atkinson, 2013).

It is also important to consider the fact that those parents and carers who had been forcibly removed from their own families did not have the opportunity to be parented within their own extended family and culture, and were often 'deprived of the experiences necessary to become successful parents themselves' (Healing Foundation, 2013:4). According to the Healing Foundation, this may then account for the over-representation of Aboriginal and Torres Strait Islander families coming to the attention of statutory authorities (Healing Foundation, 2013).

The limited Aboriginal and Torres Strait Islander specific trauma research that is available focuses on the need to understand and consider *intergenerational trauma*, and the possibility that many Aboriginal and Torres Strait Islander children and young people may experience trauma through direct experience or secondary exposure. With respect to secondary trauma, The Healing Foundation explores that 'secondary exposure for Aboriginal and Torres Strait Islander children and young people occurs through bearing witness to the past traumatic experiences of their family and community members as a result of colonisation, forced removals and other government policies' (Healing Foundation, 2013:3).

Therapeutic support services therefore need to take into consideration not only the trauma a child or young person may have experienced but also the extent of intergenerational trauma within the young person's family, as this may affect the type of intervention or therapeutic approach employed. As outlined by the Healing Foundation (2013:4) 'critical to healing is an emphasis on restoring, affirming and renewing a sense of pride in cultural identity, connection to country and participation in community'. Therefore, effective interventions should not only focus on, for example, therapeutic counselling for the child, but also family-based interventions such as focusing on parenting skills, supporting parents to heal from their own trauma and ensuring families have access to other culturally appropriate services.

A Shift in Focus to Trauma-Informed Services in Australia

Difficulties encountered in providing effective services for this client population has highlighted the need for a radical change in existing systems of care and models of service delivery, which currently strain to support these children and young people who have often experienced the most serious abuse and neglect and may be experiencing significant and multiple difficulties across many developmental domains. Historically, this client group has been unable to access appropriate therapeutic or clinical services that provide a specialist approach to trauma and disrupted attachment at an intensity required to meet their multiple levels of need.

The literature suggests that a combination of interagency collaboration and direct interventions for carers and children are required to meet the multifaceted needs of children in care. This 'whole of client' collaborative model has been adopted by the consortium of organisations responsible for the development of Take Two, Australia's first designated developmental therapeutic service for child protection clients who have suffered trauma, disrupted attachments and other adverse consequences as a result of serious abuse and neglect (Frederico, Jackson & Black, 2005). The Take Two program is described as a 'therapeutic clinical program with an embedded research and training component' (Frederico, Jackson & Black, 2005).

Similar to the Take Two program, the Queensland Evolve model of service includes an understanding of trauma and attachment within an ecological and developmental context (Frederico, Jackson & Black, 2005) and is aimed at supporting, assisting and improving the lives of those severely traumatised and disturbed children/young people in OoHC. Schmied, Brownhill and Walsh (2006) reviewed the available models of service delivery and interventions for children/young people with high needs in NSW. They found that positive improvements for these clients were strongly related to 'consistent, high quality and coordinated services and care which offer continuity of positive relationships and systematic therapeutic interventions' (Schmied, Brownhill and Walsh, 2006:6).

What is becoming increasingly clear is that any therapeutic approach must incorporate the broader context of the child's life and living circumstances. Contemporary treatment for children and young people should involve:

- A range of evidence-informed therapeutic interventions that are individually tailored and occur in the context of extensive collaboration; coherent theoretical frameworks with a systems-oriented trauma and attachment base;
- Comprehensive assessment frameworks including biological, psychological and social factors, which are taken into account in planning treatment and include understanding the child or young person's environment, the role that family, school and other professionals have in contributing to the child or young person's wellbeing; and
- A strong focus on relationship building in both collaborative professional practice and therapeutic practice.

Trauma-Informed Therapeutic Services 1

There has been an increase in the establishment of trauma-informed therapeutic services across Australia over the past 15 years. This appears consistent with the availability and prevalence of international research regarding the impact of trauma on childhood development and our understanding of how a trauma-informed service system can assist children to overcome their adverse experiences.

Models of care which allow for intensive, flexible and varied treatment interventions ranging from individual work to dyadic, family or group sessions are being adopted more widely in an effort to promote a therapeutic wrap-around environment. Interventions are targeted not only towards children and young people but extend to carers, biological parents, youth workers, teachers/school staff, and other professionals involved in the child's or young person's care. A key element is effective stakeholder communication via coordinating regular stakeholder meetings, where the key support people for a child or young person (including, where appropriate, the young person themselves) develop and review the interagency care plan.

The following organisations are well established in the field of trauma-informed service provision with a number of these services providing support to children and families across several states. Some of these services operate on a 'closed referral system' whereby referrals are only received from the child protection or statutory/judicial bodies of their respective states. Other services have an 'open referral system', which allows them to receive referrals from statutory services as well as other government agencies, human services or community sector organisations.

Closed referral services

Take Two — Victoria

Take Two is a state-wide therapeutic program for children and young people, aged 0–18 years who are clients of the child protection system in Victoria. Established in 2004, Take Two provides therapeutic interventions for children who have suffered trauma, abuse, neglect and disrupted attachments and with a focus on the child within their environment. These interventions are informed by developmental, attachment and trauma theories and are underpinned by an ecological systems perspective.

This service operates in partnership with Berry Street, Austin Child and Adolescent Mental Health Service, La Trobe University and the Mindful Centre for Training and Research in Developmental Health. In addition to the provision of therapeutic services, Take Two also aims to build sector capacity, through professional development and training opportunities to improve the system that provides care to children and young people in Victoria (Frederico, Jackson, & Black, 2010).

Evolve Interagency Services (Evolve) — Queensland

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[1] It is not within the scope of this paper to explore all services in Australia who are providing trauma-informed therapeutic support to children. The services included in this paper are examples from each state and/or services with whom the Trauma Recovery Centre Project Officers have had direct contact.

Evolve provides therapeutic and behaviour support services for children and young people 0–18 on child protection orders and in OoHC who have severe and complex psychological and behavioural problems. Evolve was established in 2005 as a collaborative partnership between the Department of Communities, Child Safety and Disability Services, Queensland Health, and the Department of Education, Training and Employment. The key focus of this interagency collaboration is to provide planned and coordinated therapeutic supports to children and young people in OoHC, aimed at improving their emotional wellbeing and the development of skills to enhance participation in school and in the community.

Therapeutic and behavioural support services are delivered through the following:

- *Evolve Therapeutic Services* provide specialist intensive mental health therapeutic interventions for children and young people on interim or finalised child protection orders in OoHC, with severe and complex mental health support needs. Referrals are only received from Child Safety and the service aims to provide a mental health therapeutic response via a multidisciplinary team of consultant child psychiatrists, clinicians and professional development coordinators. Interventions are intensive, medium to long term and have a theoretical focus on trauma and attachment—similar to that of Take Two—and focus on engaging with not only the child, but the wider service system as well as enhancing the capacity of the child's support network to better meet their developmental needs (Evolve Therapeutic Services, 2012).
- *Evolve Behaviour Support Services* provide positive behaviour support services through a multidisciplinary team of psychologists, speech and language pathologists and occupational therapists.

Child Protection Counselling Service — NSW

NSW Health established the Physical Abuse and Neglect of Children Services (PANOC), following the Wood Royal Commission in 1997. In 2006 this service changed to Child Protection Counselling Services (CPCS). CPCS provides a 'specialist, tertiary level counselling response to children experiencing the health and related consequences of serious and substantiated violence, abuse and neglect' (NSW Department of Health, 2011:3).

CPCS also has a role in providing services to the offending family members if they are willing to engage with the service. In order for a child to receive a service from CPS, the abuse must be substantiated. As a result, only Joint Investigation Response Teams within Community Services and The Children's Court of NSW can refer to CPCS (NSW Department of Health, 2011:3). Interventions are generally medium to long term due to the serious nature of problems experienced by children and the service provides training activities to health staff as well as community education and awareness with respect to child abuse, neglect and trauma.

Dalwood Spilstead — NSW (Northern Beaches)

The Dalwood Spilstead Service provides multidisciplinary health, education and therapeutic support services for vulnerable families, who are in stress or experiencing difficulties in the care/parenting of

their children (0–9 years). This is a voluntary early intervention model of service delivery based on an understanding of neurobiological development. All services for both parents and children are located on the one site, which allows for both enhanced engagement with families and case coordination.

Referrals are only received from NSW Family and Community Services Department. Services include early intervention therapeutic pre-school, infant-supported play groups, child therapy, parent/child interaction therapies and parent education programs. Dalwood Spilstead utilises Perry's Neurosequential Model of Therapy as an overarching framework guiding service provision (Dalwood Children's Services, 2012).

Open referral services

Australian Childhood Foundation — Australia Wide

The Australian Childhood Foundation (ACF) is a not-for-profit organisation that provides therapeutic support to children and families affected by abuse, neglect and family violence. ACF provides services across Australia including specialist counselling, therapeutic care (training to foster carers and residential care staff who support children affected by trauma), community and professional education, child abuse prevention programs, parenting education seminars, advocacy and research (ACF, 2013). The ACF also provides the only nationally recognised and accredited Vocational Graduate Certificate in Developmental Trauma. In the ACT, ACF provides a therapeutic foster care program, 'On Track' in partnership with Barnados as well as training to kinship carers.

The Australian Childhood Trauma Group — Victoria-based and Australia Wide

The Australian Childhood Trauma Group (ACT Group) provides support services to government agencies, non-government organisations, schools and individuals including consultations, training, counselling, assessment and program reviews. The ACT Group specialise in trauma, abuse, attachment, brain development, therapeutic treatment plans, behaviour management and professional development. The team at ACT Group consists of qualified psychologists, psychiatrists, social workers, allied health professionals and education consultants (The Australian Childhood Trauma Group, 2013).

Parkerville Children and Youth Care — Western Australia

The Parkerville Trauma Assessment and Treatment Service provide individual counselling and group work to children, young people, families and carers. In-depth assessments are provided for each client and treatment strategies include cognitive behavioural therapy (including relaxation training, cognitive re-processing and exposure therapy), psycho-education, applied behaviour, analysis, motivational interviewing and skills training (Parkerville, 2013).

Parkerville Children and Youth Care have also recently established the George Jones Child Advocacy Centre. This centre is a place where several professionals including 'doctors, police, child protection workers, psychologists, and child and family advocates form a multi-disciplinary team to provide services to care for all the needs of a child or young person who has been abused, and their family' (Parkerville, 2013).

ACT for Kids — Queensland

ACT for Kids is a charitable organisation providing free long-term and intensive therapeutic support to children and young people who have suffered abuse and neglect. The intensive therapy program has a multidisciplinary team including psychologists, speech therapists, occupational therapists and early education specialists and provides intensive support to young children.

The service includes the use of a sensory and a larger play room where children can develop fine motor skills. There is no time limit on interventions. In addition to the intensive therapy program, an early education 'Kindy' program is also provided. ACT for Kids accepts referrals primarily from the Department of Communities, Child Safety and Disability Services. However, there is some funding available for children who have not been referred by government (ACT For Kids, 2013).

Mobile Outreach Service Plus (Northern Territory)

The Mobile Outreach Service Plus provides 'culturally safe counselling and support for Aboriginal children and their families and communities in remote Northern Territory who are experiencing trauma associated with any form of child abuse and neglect'. The service is available for children aged 0–17 years and includes 'preventative and therapeutic interventions' (Atkinson, 2013:4). A second key focus of the service is community education and professional development sessions. The Mobile Outreach Service visits 30 remote communities and will support communities on demand/with referral.

Cara House — Centre for Resiliency and Recovery NSW (Inner West)

Cara House offers therapeutic counselling for the effects of sexual abuse, physical assault and for the impact of childhood neglect and domestic violence. Adult survivors are seen as part of the service and counselling is also provided to children who are using violent or sexually abusive behaviours. Therapeutic interventions are for a minimum of one year. Therapeutic and psycho-educational group programs for children, parents and carers are also provided as well as 'carer coaching'. Pet therapy is also utilised. Referrals are received from Community Services, Medicare Local, Victims Services and the Attorney Generals Department (Cara House, 2013).

ACT: The Trauma Recovery Centre

As outlined, the aforementioned services focus on children and young people who are clients of child protection statutory services; being the primary referral source. Similarly, in the ACT, the Trauma Recovery Centre will provide therapeutic support to children aged 0–12 who are clients of the OCYFS statutory services. The centre will:

- Provide services aimed at facilitating healing, recovery and positive life outcomes for children and young people recovering from abuse and neglect;
- Provide evidence-informed intensive therapeutic services for children and young people who are clients of OCYFS statutory services;
- Lead a trauma-informed, collaborative and flexible approach to service delivery; and
- Enhance the capacity of the child's support network and the wider service system to better meet their developmental needs.

As part of the development of the Trauma Recovery Centre, a service mapping exercise was undertaken to review the accessibility and availability of existing therapeutic support services for children and young people in the ACT. This exercise has highlighted that the ACT does currently have

a range of existing services that provide trauma-informed therapeutic support to children and young people. Of note are the Child at Risk Health Unit, Relationships Australia and Canberra Rape Crisis Centre. It is anticipated that these trauma-informed services will allow for opportunities for partnerships and interagency collaboration.

However, whilst there are trauma-informed services in the ACT, the service mapping exercise also highlighted that the Trauma Recovery Centre has an integral role to play in the provision of therapeutic services to children. Notably, it will be the only therapeutic service in the ACT specifically for children aged 0–12 and the focus on sole referrals from the statutory services (Care and Protection Services and Youth Justice) is unique. The centre will also offer a service to children and young people who are experiencing placement instability/placement moves; at present there appears no service that offers a therapeutic and long term intervention to young people experiencing placement instability and/or persistent and multiple placement changes. Furthermore, the Trauma Recovery Centre is a peripatetic service and will therefore provide a flexible approach to service delivery.

In line with the rest of Australia, the OoHC data in the ACT highlights the need for a therapeutic service that focuses on children in care who have experienced trauma as a result of abuse and neglect, and is culturally sensitive. On 30 June 2012, there were 566 children and young people in OoHC, of which 17 children were under one; 120 children were aged one to four; 184 children aged five to nine and 157 children aged 10–14. The 2011–12 recurrent expenditure on children in OoHC in the ACT was $26 million (AIHW, 2013). Just over half (52%) of the children exiting care after 12 months or more had experienced three or more placement moves. For those exiting care after less than one year, 19% had lived in three or more placements and about 40% of children admitted to care were under the age of five years.

The Trauma Recovery Centre's focus on children aged 0–12 is supported by this data insofar as a significant majority of children in the care of the Director General in the ACT are under 12 years of age. Additionally, a recent ACT Community Services Directorate *Child Profiling Study* (2014) has further highlighted these numbers — as of 30 June 2013, 66% of the children who came into care were under the age of four and 49% under the age of two. The purpose of the *Child Profiling Study* was to gain a population measure of all children and young people in OoHC with respect to their current levels of need and the complexity of their behaviours. Using a Complexity Assessment Tool, the children and young people in this study (476) were assessed and categorised as having either a Minor (Level 1), Moderate (Level 2), Significant (Level 3) or Extreme (Level 4) level of need. Of note, 80% of children in the study had minor level of needs, whilst 20% fell into the moderate, significant and extreme levels of need categories. There were more children in the extreme behaviour category as opposed to the next level down, the significant level. Therefore, there were more children exhibiting extremely complex behaviours that required very intensive interventions and needed additional assistance to support their placements, than those with significantly complex needs (Community Services Directorate, *Child Profiling Study*, 2014:10). It is likely based on this level of need, that the Trauma Recovery Centre will see many of the children who fall into the significant and extreme levels of needs, although referrals will be coordinated by Care and Protection Services.

With respect to Aboriginal and Torres Strait Islander children and young people, of the 566 children in OoHC in the ACT (as of 30 June 2012), 134 were Aboriginal and Torres Strait Islander, which is the

highest rate ratio (13.8%) of entry to care between Aboriginal and Torres Strait Islander and non Indigenous children of any State/Territory in Australia (Parenting Research Centre, 2013:12). The *Child Profiling Study* has provided more recent information regarding the representation of Aboriginal and Torres Strait Islander Children in OoHC. At the time of the assessment (June 2013) Aboriginal and Torres Strait Islander children and young people made up 28.4% of the OoHC population. There were double the number of Aboriginal and Torres Strait Islander males (90) than Aboriginal and Torres Strait Islander females (45) in the care system and Aboriginal and Torres Strait Islander males made up 34.9% of the male population and Aboriginal and Torres Strait Islander females make up 20.6% of the female population. The study also highlighted that Aboriginal and Torres Strait Islander children are more likely than non-Aboriginal and Torres Strait Islander children to have a level of need above minor (27% to 17%). Aboriginal and Torres Strait Islander males are almost twice as likely to have a higher level of need (32%) than both Aboriginal and Torres Strait Islander females (16%) and non-Aboriginal and Torres Strait Islander males (17%) (Community Services Directorate, *Child Profiling Study*, 2014:7).

Future Directions

The research clearly articulates that the earlier in life an intervention is applied, the greater the chance of recovery. Conversely, the older the child and/or the longer the history of abuse or exposure to trauma, the more difficult it is for the individual to recover (McClung, 2007:38). Recovery will not occur whilst the trauma is still continuing for the child, therefore children and young people need to feel safe and secure and enjoy the presence of supportive and loving relationships in order for healing to take place.

The ACT Trauma Recovery Centre will seek to provide children and young people with the therapeutic support required to heal from their traumatic experiences and achieve optimal development. In addition, and in line with the literature which highlights the importance of an eco-systemic and collaborative approach, the centre will work to build a trauma-informed system or 'village' around the child to further facilitate recovery.

In order for this to be achieved however, the existing services in the ACT must work together and commit to the understanding (and a key service principle) that supporting a child to heal from trauma, repair existing relationships and develop new healthy and supportive relationships is a shared responsibility, and requires the long term support and commitment of *all* caring adults in a child's life. As consistently identified in the literature, without a trauma-informed, integrated and coherent service response, children will continue to experience difficulties with developing the physical, social, emotional and cognitive skills necessary to become an adaptive, mature adult.

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