PARKERVILLE CHILDREN AND YOUTH CARE INC THERAPEUTIC TREATMENT MODEL PRACTICE MAPPING

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Pursuit of Excellence
in Responding
to Child Abuse
and Neglect, WA

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CONTENTS

ABBREVIATIONS

ACCP	Australian Centre for Child Protection, University of South Australia
ACT	Acceptance and Commitment Therapy
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BYIS	Beck Youth Inventory Scales
CALD	Culturally and Linguistically Diverse
CBCL	Child Behaviour Checklist
DBT	Dialectical Behavioural Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
FASD	Foetal Alcohol Spectrum Disorder
Parkerville CYC Inc	Parkerville Children and Youth Care Inc.
the Department	Department of Communities
MASC	Multi-actual Anxiety Scale for Children
MIST	Multi-Agency Investigation and Support Team
NMT	Neuro-sequential Model of Therapeutics
OOHC	Out of Home Care
PTSD	Post-traumatic Stress Disorder
TFS	Therapeutic Family Service
TF-CBT	Trauma Focussed Cognitive Behavioural Therapy
TSCC	Trauma Symptom Checklist for Children
TSCYC	Trauma Symptom Checklist for Young Children

OVERVIEW

The Therapeutic Family Service (TFS) at Parkerville Children and Youth Care Inc; (Parkerville CYC Inc). is a service in Western Australia that specialises in providing therapy to children and young people with trauma from abuse and neglect. Responding to the complexity of these cases, Parkerville CYC Inc operates a novel service by combining an array of therapeutic approaches and delivering a hybrid of approaches matched to symptoms. This approach also aims to be responsive to the context of children and families in the formulation of treatment approaches.

Given the ongoing challenges associated with treating multiple and complex traumas, and the limited evidence base associated with established approaches for this target group (Karatzias et al., 2019), the Australian Centre for Child Protection at the University of South Australia (ACCP) conducted a practice mapping study to document Parkerville CYC Inc's TFS practice model. The objective of this was to capture the specifics of how the model had been implemented, to better understand it's adaption to different types of children and families, and to identify its potential for informing therapeutic approaches for responding to Western Australian children and any areas for improvement or refinement that would be needed.

The study involved semi-structured interviews with thirteen staff from Parkerville CYC Inc, or previous employees of Parkerville CYC Inc that were able to provide multiple perspectives on the operation of the service. This included members of the practice leadership responsible for implementing the approach, and practice staff that delivered the approach. The study represents a particular point in time from the perspective of TFS staff who participated in the research. A detailed methodology is appended at the end of the document.

The findings of the study include:

- Client Characteristics: Participant descriptions of the diversity of the clients commonly seen in the services, particularly noting differences across sites and different referral pathways.
- Referral Pathways: The different routes by which children and families could access the service, and how the process and considerations differed by these different pathways.
- Assessment: Descriptions of how intake and assessment occurred and led into the process of formulating a treatment approach.
- Treatment Planning: How the different symptoms and contextual considerations for children and families were considered and responded to in formulating a treatment plan.
- Implementation Supports: How the service has been implemented and what supports are in place to help the model be delivered consistently and to a high standard.
- Limitations of the Model: Areas for further development and improvement identified by the participants.

Client Characteristics

Clients were mostly between the ages of 5-16, Caucasian, with large proportions of children in Out of Home Care. Participants varied in their reports of the proportion of Aboriginal children seen by the service, which seemed to be affected by service location and the predominate referral pathway. The participants reported a wide range of symptoms and noted that there is not necessarily a typical presentation. Some of the commonly reported impacts include attachment problems, anxiety, depressive symptoms, post-traumatic stress related symptoms, emotional dysregulation, dissociative type responses, sleep disturbances, toileting problems, and appetite disturbances. Trauma impacts varied according to the age of the child or young person, with young children showing more externalising behaviours and teenagers showing more self-esteem issues, mood disturbances, anxious and depressive tendencies, traumatic memory intrusions, dissociation, sleep and appetite disturbances and relational difficulties. The diversity of presentations highlighted the need for this hybrid approach to treatment.

Referral

The service relies on a triage system where the Clinical Leads assess referrals and allocate them to psychologists based on referral type, availability, skills and experience of the psychologists, and the presenting issues of the clients. The main source of referrals is the Department of Communities (the Department), which includes Out of Home Care referrals, and the Child Sexual Abuse Therapy Service (CSATs) which is funded by the Department. The service is described as being "overwhelmed with referrals" and most clients have to wait more than two weeks to see a psychologist.

Assessment

The assessment is multi-modal and aims to identify the most troubling symptoms, the aetiology of the symptoms, and match the best available treatment components for the child or young person given their developmental age and availability of caregiver support. The assessment may be completed over one, two or three sessions and involves clinical assessment interviews, psychometrics, and information from referrers. For primary school aged children, the assessment typically starts with the parent or carer prior to meeting with the child (although this is not the case for Medicare funded sessions). For adolescent clients, the psychologists typically either meet them alone first or offer the client a choice of whether they meet together with their carer or parent or whether they come into the session alone.

Treatment

The TFS therapeutic approach is a multi-modal and flexible treatment approach that is influenced by Dr. Bruce Perry's Neuro-sequential Model of Therapeutics (NMT). The psychologists are trained in some core treatment approaches, such as cognitive behavioural therapy (CBT), as well as having a range of other treatments in their toolkit to draw on. However, they also recognize the limitations of CBT in the context of abuse and neglect related trauma and tend to use a multi-modal treatment approach that includes CBT, EMDR and other interpersonal elements. This combination of approaches is understood to be structured around the NMT approach and philosophy.

Treatment plans are developed using assessment information and in collaboration with the child and the parent/carer if possible. In developing a treatment plan, the psychologists take into account factors such as trauma impacts, developmental age, and cognitive ability. For children under 5 years, the treatment approach is modified, and greater involvement of carers is considered. For children aged 10-13 years, cognitive approaches like CBT and TF-CBT are more likely to be chosen.

The participants discussed the importance of considering immediate or ongoing safety concerns in treatment planning for children and adolescents. Some client groups, such as MIST referrals, are more likely to be in concerning environments and have emotional safety concerns such as unstable placements or lack of access to attuned caregivers. Psychologists noted that safety concerns were not considered a barrier to treatment, but rather a necessary factor to consider and address prior to commencing treatment in the form of a safety plan. The lack of access to a loving and attuned caregiver was identified as one of the biggest barriers to treatment for children with abuse and neglect related trauma who are in out-of-home care placements. Where there were no attuned caregivers available, certain modalities such as dyadic work and EMDR would be excluded from the treatment plan, and in other cases, the sequencing of treatment would be adapted to focus on psychoeducation and emotional regulation components and delay trauma processing or exposure elements.

The referral pathway for TFS clients can impact the choices available for treatment, the number of funded sessions, and the stakeholders involved in negotiating a treatment plan. Clients can be referred by the Department or through a Medicare Mental Health Care Plan (MHCP). When referred by the Department, the psychologist may need to consult with the Department and negotiate the treatment plan with the District Psychologist. MHCP referrals are more prescriptive and treatment choice is influenced by the diagnosis documented in the MHCP and what Medicare will fund.

Client preference is an important aspect of evidence-informed practice when treating children who have experienced abuse or neglect-related trauma. Some psychologists described their treatment planning as collaborative with clients, while others felt their approach was to try and accommodate client preferences occasionally. The ongoing forensic and court proceedings also had an impact on how the psychologists approached treatment planning. They may not be able to proceed with an evidence-based treatment for the most pressing symptoms where there was a pending court case, and the treatment approach may be different if the client is about to go to court.

Implementation Supports

The service faces challenges in implementing this model due to the lack of official diagnosis of complex trauma in existing manuals and no single manualized approach that psychologists can implement with their clients from start to finish. To respond effectively to these challenges, the TFS program focuses on staff selection, staff training, supervision and monitoring, and evaluation as implementation strategies. Staff selection focuses on recruiting psychologists with clinical training, who can competently assess, make clinical decisions, and monitor progress. Most of the staff are new university graduates who are supported to develop trauma specialist skills with customised internal training combined with a model of intensive supervision.

To support staff to develop a broad 'tool-kit' of approaches, the TFS provides a customized internal training program with a strong emphasis on attachment theory and trauma. The TFS also supports staff to access external training in a range of different modalities, common external training being TF-CBT and EMDR. The TFS also uses a model of intensive clinical supervision to support the implementation of their model. Supervision is seen as a critical element for implementation of the therapeutic approach, with regular one-on-one, group, peer supervision, internal staff meetings and opportunities for ad hoc consultation with senior staff provided.

The TFS therapeutic model for children with abuse and neglect related trauma includes a focus on evaluation and monitoring. Participants highlighted that staff continuously review and assess progress with their clients and enter psychometric assessment results into a data management system to monitor fidelity to the approach and effectiveness aligned to service specific outcomes. However, there are some challenges in monitoring the input of assessment results in the data system with some staff not entering their psychometrics into the system affecting the ability to assess outcomes.

Limitations

Participants identified several limitations of the existing approach and how the approach had been implemented. One limitation is the lack of formalised adaption for Aboriginal and Torres Strait Islander clients. The participants highlighted that the model relied on the capacity of individuals to adapt their approach to Aboriginal children, and that staff varied in their confidence and self-reported knowledge of working with Aboriginal children and families. While providing training and practice support, participants raised the lack of resources to deliver cultural support to children and families as an issue. Participants also indicated that improvements could be made in working with Culturally and Linguistically Diverse communities. Challenges were also identified in working with children with disability, with participants suggesting they did not always have the resources to respond in a way that met client needs. Staff also reported challenges in the model of supervision, with high caseloads and tensions around receiving supervision from line managers. Other operational challenges were also highlighted, such as the heavy reliance on clinical psychologists.

INTRODUCTION

Many therapeutic services responding to trauma from child abuse and neglect are challenged by the increasingly complex and multiple traumas among the presenting population (e.g., Wolf et al., 2006). These presentations often include complex symptoms and circumstances that limit the usefulness of many of the common therapeutic approaches clinicians that are trained in. Noting the need for a more adaptive and multi-faceted approach, this report provides a summary of a novel therapeutic approach delivered by Parkerville Children and Youth Care Inc. (Parkerville CYC Inc) to children and young people affected by child abuse and neglect. The aim of this report is to document this model, how it responds to different types of clients, and possible areas of refinement and improvement.

Parkerville CYC Inc is a community services organisation in Perth, Western Australia that specialises in the treatment of trauma from child abuse and neglect. The organisation provides therapeutic services to children, young people and adults across five locations in Perth, Western Australia – Midland (Stan & Jean Perron Child Advocacy Centre), Armadale (George Jones Child Advocacy Centre), Mirrabooka, Geraldton and Northam. At the time of the research, they also operated in Bunbury in the South-West. This report provides a snapshot of the model – the clients, clinicians, therapeutic approach and implementation supports and limitations of the model – at a particular point in time (August 2020) and from the perspectives of the TFS Clinical Team.

The report provides a summary of the analysis of 13 semi-structured interviews with members of the TFS team at Parkerville CYC Inc, including 10 psychologists who were employed in the TFS at the time of the study and 3 psychologists who had left their employment in the 18 months prior to research commencing. The sample includes both managers (whom have a practice and management role) and staff psychologists. Participant quotes have been anonymised and coded as either Clinical Manager (M) or Practitioner (P).

Appendix B includes a copy of the interview schedule, which asked participants about who accesses the program, how they are referred into the program, and the process of planning and delivering treatment. Participants were asked to step out in detail the typical process from the point of first contact with the client, and to provide multiple explanations at each stage if the process differed for different types of clients.

The findings of the study include:

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More information about the project and methodology are provided in the appendices.

1. CLIENT CHARACTERISTICS AND EXPERIENCES

This section provides an outline of the key characteristics of the children and young people accessing the TFS, as described by interviewees. In the context of the interviews this information about clients, was used to prompt additional questions from participants about how the treatment process may differ for different types of participants; this section however will just summarise their description of the clients. The participants worked across different programs and sites, meaning that in some cases their descriptions of the clients are not consistent. Demographics of TFS clients between 2017-2020 are reported in Herbert et al. (2022) and are generalisable to the point in time in which the practice mapping interviews were conducted.

1.1 Basic demographic information

Age

Psychologists in the study reported seeing clients from 3 to 16 years of age. One psychologist reflected that "five is usually the youngest that we like to see" (M) with most interviewees reporting seeing clients between 5 and 16 years of age.

Ethnicity

The psychologists described the majority of TFS clients as coming from Anglo-Celtic backgrounds.

There was some uncertainty about the proportion of Aboriginal and/or Torres Strait Islander clients, with differences in perceptions seemingly based on the type of referral pathway and the location that staff worked in. A manager reported that the TFS had a "very low" proportion of Aboriginal clients, estimating between 15 to 20 per cent of Aboriginal clients overall (M). However, some individual psychologists reported higher proportions of Aboriginal clients within their individual client load. For example, one Manager estimated, "about a quarter" of their caseload was Aboriginal children, another Practitioner reported, "40 per cent", while one Practitioner reported that "at least 50 per cent" of her case load were Aboriginal clients".

Overall, the psychologists reported few clients from culturally and linguistically diverse communities. Some of the psychologists reported having a 'couple' of clients who identified as culturally or linguistically diverse with a higher proportion generally reported in Mirrabooka than any of the other sites. As one Manager told us, culturally and linguistically diverse clients,

> *do not make a large proportion of our client cohort, but we do get referrals for CALD (culturally and linguistically diverse) clients. We get more depending on where the office location is. But anecdotally, I would say we have historically had probably higher percentages within our Mirrabooka location. There's a really high percentage of Sudanese and Vietnamese families in that area.* (M)

Disability

Managers reported that some TFS clients did have a diagnosed disability, but that these were relatively rare. It was more common for them to see developmental delay, Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Foetal Alcohol Spectrum Disorder (FASD). Mostly children and young people with disability are referred to specific disability services rather than trauma-focussed services (M). As one of the psychologists reported,

> *I haven't got a lot on my caseload that have diagnosed disabilities. I've probably had one client that's had a formal disability. But across my caseload it's not something that's common for me.* (P)

When psychologists spoke about clients with disability on their caseload, they mentioned Autism 'pops up most frequently' (M). One manager told us they see:

> *…lots of children who have a reported diagnosis of Autism. They're frequently referred and lots of the psychologists would be working with children who have a diagnosis of Autism.* (M)

> *At times, clients are diagnosed with Autism while they are in therapy and will leave therapy and be linked in with the Autism Association* (M).

ADHD and FASD, both informally and formally diagnosed were also mentioned by two Managers and one Practitioner. As one Practitioner described in her experience:

> *…often, in the referral, it will say that there's a possibility that there's this diagnosis, but for whatever reason, whether it's costs or time or the assessment hasn't been done, or maybe they're on a waitlist. So, I think, yeah, it's definitely FASD that is quite linked with a trauma background.* (P)

Undiagnosed developmental delays were observed to be more prevalent than disability.

> *We do see some kids with disabilities, but not a lot. A lot of developmental delays… not a lot of clear diagnoses of an intellectual disability, though. I think there is a real lack of capacity for the sector or the profession, probably the profession actually, to adequately interpret and diagnose kids with delays when they've had trauma, because they presented with a different profile when you look at their executive functioning and their cognitive capacity, and that's actually really – it muddies the water, and people find that very hard to actually interpret. So, a lot of those kids miss out on a diagnosis of intellectual disability because of that.* (M)

> *If clients have physical disability, one manager mentioned engaging an Occupational Therapist for help with sensory issues or gross motor delays.* (M)

Out of Home Care

As the two managers below describe, the majority of TFS clients are living in some form of out-of-home care placement:

> *Lots of children in care. That would probably be most of the clients that I see. I think for the bulk of psychs, children in care make up the largest portion. Or children at least not living with their mum or dad, biological parents.* (M)
>
> *The largest portion of my work is children who are in some sort of out-of-home care arrangement. So, in the care of the Department.* (M)

1.2 Trauma Experiences

Like other clinicians around the world, the psychologists with the TFS do not have a fit for purpose diagnosis for the kinds of experiences and diverse range of impacts they commonly treat in children exposed to abuse or neglect. They consistently described their clients as having acute, multiple, ongoing, sustained or chronic exposure to abuse or neglect that began in utero or early childhood. These experiences are more consistent with the theoretical constructs of complex trauma than Post-Traumatic Stress Disorder (PTSD).

Psychologists described seeing the “full gamut of child abuse and trauma” (M) across their caseload. The most frequent experiences mentioned were neglect, emotional abuse, physical harm including inappropriate discipline, acute or ongoing sexual abuse, family and domestic violence, exposure to parental drug use, intergenerational trauma, grief and loss, separation from their biological family, and “system dysfunction” (M) including multiple OOHC placement breakdowns. As one Practitioner described, they tend to see:

> *…a lot of neglect, a lot of physical abuse, sexual abuse. A lot of the kids have been removed from their parents’ care, exposed to DV and substance abuse. I don't know if there's one main one; maybe neglect would probably be with most of my kids.* (P)

One Manager described a ‘typical’ client in the following way:

> *The child, themselves, has normally had multiple placements, multiple types of abuse. So, when I say multiple types of abuse it's very rarely single episode trauma, it's very rarely just one type of abuse. And so it's not uncommon to get a child who's been exposed to drugs and alcohol, family violence, there's been some level of neglect and emotional abuse, and they might have come into care because they were repeatedly physically assaulted or repeatedly sexually assaulted; so that’s a really typical child.* (P)

Participants expressed that the bulk of TFS clients were experiencing complex trauma rather than PTSD, both in terms of multiple forms and incidents of trauma, and their presentations:

> *They nearly all have complex trauma.* (M)
>
> *I don't think I’ve ever seen a client who has a really specific traumatic experience, there's always been a history of long complex trauma.* (M)
>
> *There's certainly been clients I’ve had along the way that, once you do the assessment, you think wow, this really does seem to fit the PTSD criteria. They have intrusions and*

> *flashbacks. But even then, I think it's PTSD but there's still complex trauma as well, so I would say yeah, for the most part it's always just generally really clearly complex trauma.* (M)
>
> *We see all forms of abuse… and most of them have not just experienced one. It's multiple. In addition to that adverse life experiences, like placement changes and other issues like divorce and things like that, so it's never really clear-cut.* (M)
>
> *I rarely see children, adult or youth that have experienced one form of abuse. Normally it's multi-layered.* (P)

One Manager expressed frustration that despite their experience working with children with multiple or prolonged exposure to interpersonal traumas that there was still no *official* diagnosis for complex trauma.

Two Managers also identified "poverty" (M) or "financial hardship" (M) as a traumatic stressor in children's lives.

One Manager identified disconnection from culture as a traumatic experience among some of her Aboriginal clients, including a client from a remote community who she saw as 'really displaced from Country and that's a huge issue in his presentation." (M)

1.3 Trauma Impacts

Interviewees were asked about the kinds of trauma impacts they commonly observed in their clients and in response they reported a wide range of trauma presentations. One manager told us, "It's a pretty big range of different symptoms, to be honest" (M). Interviewees told us that there was not necessarily a typical presentation. For example, as one Practitioner told us, "I think they all come with their own set of complexities or different presentation" (P).

Participants mentioned the following range of impacts:

- Attachment problems, having difficulty forming relationships
- Anxiety, depressive symptoms
- Disordered mood
- Post-traumatic stress related symptoms – re-experiencing, nightmares, flashbacks, hyperarousal, avoidance
- Emotional dysregulation
- Dissociative type responses - 'often called inattention in the classroom' (M)
- Sleep disturbances, night terrors
- Toileting problems
- Appetite disturbances
- Emerging personality problems
- Poor self-concept
- Problem sexual behaviours
- Maladaptive cognitions
- Shame
- Self-harm and suicide ideation

- General behavioural conduct problems

One manager told us that children were commonly referred because of behavioural concerns that are trauma responses:

> *Our bread and butter will be kind of just naughty behaviour, not listening, being defiant. Having really big emotions. Usually, lots of difficulty at school. They've usually burned through placements because of those behaviours or those emotional outbursts. And that's usually what is written on the referral form, or sexualised behaviours, because that's what people see, that's what people have a problem with, that's what they want fixed. When you dig down into the assessment, we'll see more of the other stuff that people don't see, I guess. And that's really low self-esteem, poor self-confidence, difficulties reading emotions in other people. Kind of sitting – having tiny windows of tolerances and having difficulty remaining in those.* (M)
>
> Trauma impacts varied according to the age of the child or young person. For example, a Practitioner told us that for young children she works with:
>
>> *…it's often really quite externalising behaviours that you commonly see in kids that have experienced trauma so that might be yelling, hitting, screaming, kicking, fighting, carers will often use the words defiant or oppositional, not listening, not following instructions.* (P)

Whereas for teenagers, a participating Practitioner told us:

> *…you start to see a lot more self-esteem issues play out, a lot of more mood disturbances, a lot of anxious and depressive tendencies within their trauma symptoms as well as lot of intrusions, bit of dissociation, lots of the time as well sleep and appetite disturbances too. Relational difficulties.* (P)

2. REFERRAL PATHWAYS

The service has a complex mix of referral pathways that relies on a triage system where the Managers accept most referrals, make brief desktop-based assessments, and then allocate according to referral type, availability, skills and experience of the psychologists, and presenting issues of the clients. The model appears to be heavily reliant on this triage process to manage the complex referral pathways.

The main source of referrals is the Department of Communities (the Department). The TFS receives these referrals based on a Preferred Provider contract, where individual psychologists are also assessed for suitability of qualifications, experience, and therapeutic approach by the Department. The TFS also accepts referrals from the Multi-Agency Investigation and Support Team (MIST), a collaboration between Parkerville CYC Inc, WA Police and the Department of Communities for a joined-up response to child sexual abuse (Herbert & Bromfield, 2020). Parkerville CYC Inc's role in this response was to provide advocacy support to children and families disclosing abuse, and to provide priority access to therapy. Referrals were also received through local General Practitioners via a Mental Health Care Plan, from individuals/ families, other community service agencies and other Parkerville CYC Inc services, including its out of home care service. Similarly, funding streams also vary within this including Medicare, fee for service, Department program contracts and internal recharge to other programs within Parkerville CYC Inc.

2.1 Department referrals

When the TFS receives a referral from the Department there has usually been some correspondence between the Consultant Psychologist from the Department and one of the three Managers about the client's presenting issues. The manager then decides if they can accept the referral, for example they check to make sure the referral is suitable and to see if the goals seem achievable. At this stage they may negotiate until the clinical lead is satisfied that they can provide the required services and the Consultant Psychologist is satisfied that it will meet the Department's requirements. The manager will then provide the Department with an estimated timeframe for seeing the client, which is usually within two weeks. The Consultant Psychologist then submits the relevant paperwork, and the clinical lead reviews the information for any changes and once they have all the information they need from the Department, they allocate the client to a suitable psychologist to book the client in. The clinical lead will generally try to allocate Department referrals to the more experienced psychologists in their team.

Parkerville CYC Inc is on a Preferred Provider contract with the Department. As part of this agreement, in theory a psychologist needs to have had their first session with a Department client within two weeks of referral. A Manager described the service as currently, "overwhelmed with referrals" (M). While Department referrals are prioritised, participants told us most clients had to wait more than two weeks to see a psychologist.

2.2 Multi-Agency Investigation and Support Team (MIST) referrals

MIST referrals usually result from a forensic interview conducted by police, who are co-located with Parkerville CYC Inc at two sites (Midland, Armadale). A Child and Family Advocate is part of this process and facilitates a referral to the therapeutic service and assists with addressing any barriers to access. Prior to a referral from a Child and Family Advocate from MIST the case has generally already been discussed at one of the weekly case review meetings which operates as a multidisciplinary team meeting. At the case review, they will discuss the referral needs of certain clients and the Manager in attendance will get an early indication of what cases are coming up. If a referral needs to be made, the MIST advocate will log it through the Client Management System (CMS) as a direct referral and the case will be prioritised for treatment.

Sometimes if MIST is conducting an interview and they need a psychologist consult on the day, the advocate or the police will find a psychologist who is on the floor. That psychologist will undertake the consult and log it on the system as a referral. A senior manager described the next steps based on the psychologist's capacity as follows:

> *Then it is up to the psychologist, if they've made a good rapport with the client, and they have engaged, and they've got capacity to pick it up and they need to pick it up, then they can keep seeing the client, or it might be that they – and they'll normally talk to the client about this at the time, they'll explain that, I'm here for you today, but I don't have capacity. So, I'm going to pass you over to a friend or whatever that is. And then they'll pass them on to one of the other psychologists that has a vacancy.* (M)

2.3 Mental Health Care Plan referrals from a GP

Mental Health Care Plan (MHCP) referrals come into the TFS via a centralised system. When the TFS receives a MHCP referral, the clinical administrative staff conduct a general screen to make sure the paperwork is complete, and check that the referral is appropriate for the TFS. As Medicare clients will generally have to go on a waitlist, the clinical lead will then triage any new referrals again to make sure they are the most suitable agency to meet that person's needs. The clinical lead may follow up for further information which helps them decide if the client will be ok to sit on a waiting list. If the clinical leads find out there are additional issues such as self-harm, suicidal ideation, or harmful sexual behaviour, and if they have no capacity within the Clinical Team to allocate the client quickly, they will refer that person to another agency for acute services or urgent treatment.

Once a referral is considered appropriate for the TFS, the clinical administrative staff will upload the referral into the system and liaise with the client about where they are placed on the waitlist. The clinical leads will then allocate that client from the waitlist to a suitable psychologist within the Clinical Team when one becomes available.

3. ASSESSMENT

Broadly the clinical leads highlighted the need for a detailed and thorough assessment process for this target group, highlighting the need to understand the constellation of symptoms, and their underlying causes. Also relevant to this was the context of the family and the complaint, taking into account the level of support and stability in the family, as well as the status of any ongoing criminal justice processes. The following section provides a detailed description of the TFS assessment model from the point at which a child or young person is allocated to a psychologist.

3.1 Preparing for the first meeting

For clients via a MHCP under Medicare funding, the assigned psychologist calls the parent/carer, introduces themselves and checks if the client is still interested in therapeutic services as there may have been a long time between referral and allocation. Then the psychologist makes a time to meet the carer and the child or young person. Children have to be present during all Medicare funded appointments meaning the psychologist cannot meet with a parent/ carer before meeting with the child.

For Department clients, the assigned psychologist emails the Department case manager and gets written consent for the child to engage in the service. At this time, the psychologist will also seek further information about the child and get the carer's contact details. The psychologist will call the carer and arrange to meet with the carer prior to meeting with the child.

Referrals from MIST contain only basic client details so before meeting the child, the psychologist will meet with the advocate or the detective/investigating officer for information about the case before contacting the family and arranging an appointment.

3.2 Initial Assessment Session or Sessions

The initial assessment is generally done with both the child or young person and also with a carer, if available. Assessment may be completed over one, two or three sessions (or more) and involves clinical assessment interviews (with both the child and carer), psychometrics, discussions and information from referrers and general observations. As a participating Practitioner describes, "typically over the first three sessions is where I really like to try and have my assessment completed, if not within the first or second session, I allow three generally" (P).

When the client is a primary school aged child, it was described as 'good practice' to begin this assessment with the parent or the carer prior to meeting with the child by most of the participants. Two psychologists mentioned they may need two assessment sessions with the parent/carer before seeing the child. Sometimes this is a phone call prior to meeting the child. Unless the child is a Medicare funded client, the psychologist may meet the parent/s or carer/s in person prior to having a session with the child. Medicare funding rules require the child to be present at all 10 sessions:

> *…you are not allowed to see the parent on their own for Medicare, so you would have to have the child in for every appointment. So, it changes your – I guess you've got to be a bit more creative in the way you work your assessment.* (M)

Some psychologists managed this by trying to make time in that first session to meet with the child on their own and then with the parent on their own (M).

For adolescent clients, the psychologists typically either meet them on their own first (M) or will offer the client a choice about whether they meet together with their carer/s or parent/s or whether they come into the session alone. As one manager reported, "You tend to get better engagement like that" (M). Typically, with adolescents the psychologists may only meet briefly with the parents/carers (M) but may have ongoing phone contact, for example:

> *Some of the clinicians, I think, have a bit of an age where they go oh look, if they're above that, I'll see the adolescent. I'm a bit variable with that, just because developmentally, teenagers might not be teenagers or they might prefer the carer to be there or desperately not want them, and I think that's all really important information.* (M)

> *If it's a child of 12 or above you're going to get them in to hear their perspective on what's happening for them, and then you may get the parent or caregiver in separately or with them. It just depends on the issues, and it depends on the developmental age of the child as well as their chronological age; it's a bit of a judgment call from the clinician as to do they bring the carer in first for an initial interview without the child?* (M)

Existing treatments for complex trauma usually require the participation of an attuned caregiver therefore, during the assessment period, psychologists carefully observe the dynamics between the parent or carer and the child to assess how attuned the carer is and how much support the carer can provide the child during and after treatment. Two managers described how the assessment of the relationship will then inform how they approach treatment:

> *All that time you are gauging how Mum or Dad's going, what their capacity is, how open they are, what type of parent they might be in terms of their interactions, how they have responded, and that tells you a lot around the dynamics that you're going to be working with.* (M)

> *I like to do it early on … meet with the caregiver to gauge their perspective or perception of their child's concerns, and really hear the language they're using in terms of how they're describing the issues, how they understand the function of the behaviour. You're getting a gauge there around how empathic they are around the issues, so that when you do have the child and the caregiver in the room together you have that awareness of whether you are going to have to engage in protective interrupting in terms of how that's discussed, yeah, and also to get a real clarity on, this is what therapy is about. It's not about fixing this kid, it's not about your issues with the behaviours, the things that you find challenging necessarily, you know what I mean? It's for the child and about the child, so that's important to clarify*. (M)

3.3 Building Rapport

In the first meeting, most participants reported being focused on building rapport with the child or young person, to "develop that therapeutic relationship, that engagement" (M), and to get to know "what they like, what they don't like, chatting about their families" (P). As a participating Practitioner of the TFS told us:

> *Well, once you first get the child in, the name of the game is to build a rapport with that child because if you don't build a rapport, you're not going to be anything at all and it can take you a couple of sessions to get to that point. But I'm not going to get the child to do any formal assessment until I've built that rapport.* (P)

During rapport building, psychologists discuss confidentiality and consent and introduce what therapy will look like. How they go about this in the first session depends on the age of the child. For example, if the child is really young, they may play some games while they chat. The psychologist's approach also depends on how the child is presenting and how well they are engaging; this will determine how much information they will try and get and where they might go with those conversations (P). In this way, psychologists are doing a 'little bit of assessment' (M). As one manager explains:

> *…in my rapport building, I'm getting to know them a little bit, very interested in how they talk about the members of their family and their emotional awareness. Do you know why you're coming? What do you think could be helpful? Is there anything that you would like help with? Often, they're like, 'got no idea why I'm here'. And then I'll tell them why they've been referred.* (M)

Two of the psychologists emphasised how it was critical to be collaborative and transparent with their clients, letting them know all the information that they have (P, M).

3.4 Clinical Assessment Interview

Most participants indicated that they used a structured interview to guide the initial clinical assessment that is done with the parents or carers. Using the assessment interview guide, the psychologists collect background information, childhood history of abuse and trauma, information about the pregnancy or birth if they have it, their placement history, details about their sleeping and eating, as well as any medical issues and drug and alcohol use. They collect information about the child's presenting issues, how long they have experienced these concerns, what strategies they have tried, what does and does not work for them, and any patterns that they can see (M). They complete a genogram, and identify if there are other professionals or adults that are involved, such as teachers, occupational therapists and any other relevant professionals. One psychologist told us that she also asks the child about "…other people that might be useful for me to talk to. So, psychiatrists, schools, teachers, paediatricians, previous carers. Less so biological parents" (M).

One manager described the process of doing the clinical assessment as taking a thorough case history as well as identifying the current presenting problems:

> *In the clinical interview assessment with the parent, you want to do a beginning, middle and an end. So, in terms of, the end is where they are now, so how they're functioning now. The middle is the abuse experience and what's happened. And then the beginning is actually everything that came before it. So, from an early perspective, particularly, with someone like a six- or seven-year-old, you want to know what the pregnancy was like, you want to know the early childhood, knowing things around whether they met their developmental milestones, particularly, if you're looking at things like toileting or sleeping issues, feeding issues, you want to know whether they actually reached a normal level in those areas, and then regressed, or whether they actually never attained it. So, you get a really thorough developmental history…You then look at how the child is now, so sleeping, mood, eating. You're looking for symptoms, basically, of anything.* (M)

In the clinical assessment interview, three of the psychologists discussed how they try and identify client skills, resources and strengths and then discuss what goals the child may have for therapy (M, M, P).

3.5 Psychometric Assessment

The psychologists' collect psychometric data once they have built some rapport with the child, and after they have completed their clinical interview, as one of the participating psychologists told us, "I can't think of a time I would ever do a psychometric on the first time I met a child" (P).

The TFS psychologists consistently reported using two key psychometrics in their initial assessment, the *Trauma Symptom Checklist for Children* (including the younger version, the *Trauma Symptom Checklist for Young Children*; TSCC and TSCYC) and the *Child Behaviour Checklist* (CBCL). After the TSCC/ TSCYC and the CBCL, though they may also use the Beck Youth Inventory Scales (M).

Two managers said they found it helpful to use the MASC Multi-actual Anxiety Scale for Children to, "differentiate what is the most prominent concern" (M). A Manager and a Practitioner both reported occasionally using personality measures, but as a participating psychologist reported, this was one she used less frequently, "if I think there's some additional information or something that I'm missing, I'll do that, but personality ones aren't ones that I use commonly" (P).

Psychologists said they chose the psychometric/s based on the presentation of the child and the information they collected in the clinical interview, as one manager explained:

> *I think it depends. Once you've done that clinical interview and then potentially once you've met with the child as well, you'd probably decide, based on the information you've got, what you think might be needed. If there are more depressive or anxiety symptoms really coming through, you might choose to use some of Beck Youth Inventory scales or a specific child anxiety inventory. Whereas I think a lot of the time with the kids we work with, because they've had such significant trauma histories, the trauma symptom ones give you quite a good base as an overview of a lot of different areas. So, you might start with that and potentially along the way you might use some different measures if you need to as well.* (M)

Again, depending on the presentation of the child, psychologists may start with either the *Trauma Symptom Checklist* or the *Child Behaviour Checklist*, as a participating Practitioner describes below:

> *Basically, I'll do the Trauma Symptom Checklist for young children or for children, or the CBCL, Child Behaviour Checklist. They're the main ones that I use, and it depends on the presentation. If it's a bit more vague, and there's a few more concerns, I might do the CBCL, but I find the trauma symptom checklist is quite comprehensive, and you get a good idea of functioning after that. (*P)

The psychologists have the option of excluding the sexual abuse component of the trauma symptom checklist, for example a Manager told us:

> *If there's no sexual abuse indicated and I think that might be distressing for a child to have that information there, I might not use the sexualised component of the trauma symptom checklist, I'd use the other one. But only rarely do I ever think that, though. To be honest. I can think of a couple of times where I've been like ooh, I don't want to use that.* (M)

In some cases, it is not possible to administer psychometric instruments in the first few meetings if the child or young person was too dysregulated or if they are not in a stable placement, as a Manager described:

> *…often, we're seeing children and young people who have just moved placement. So, you can't get anyone to fill in the CBCL validly, or the trauma symptoms for young children, which I find quite helpful too.* (M)

4. TREATMENT PLANNING

A key element of the TFS therapeutic model is thorough treatment planning, using assessment information and in collaboration with the child, and also with the parent/carer if that is possible. If the client has been referred from the Department, then this plan will also be discussed with the case manager. The plan may also have input from the classroom teacher or school.

The TFS therapeutic approach was described by the psychologists as a multi-modal, flexible treatment approach. The TFS approach is influenced by Dr Bruce Perry's Neuro-sequential Model of Therapeutics (NMT). NMT is not considered a modality, but rather an approach that structures the application of interventions to genuinely meet the child client's needs, described as a 'developmentally sensitive, neurobiologically informed approach to clinical work' (Perry & Hambrick, 2008, p.249). NMT is characterised by interventions/components/practices/techniques that first help develop a child's capacity for emotional regulation (e.g., repeated somatosensory activities), and the use of relational or attachment-focussed therapies and the integration of cognitive-behavioural based approaches. In the following, a Manager describes how NMT came to influence the TFS' therapeutic approach:

> *I did some work with the Neuro-sequential Model of Therapeutics and bought that model to Parkerville quite early on in our therapeutic service, so looking at kids' scattered development, so from a comprehensive assessment mode, not looking at just a presentation in a diagnostic framework but looking at where there might be deficits in certain areas, but not in others; and actually looking at how you assess that, and, therefore, how you might actually put in different types of therapies to remedy that, and looking at the different developmental levels that exist or coexist within a child*. (M)

Though only two interviewees made direct reference to NMT, interviewees consistently described using a multi-modal and flexible treatment approach to meet the child's presenting needs.

> *I feel like I tend to work in combination, and I tend to be a bit fluid between different modalities, particularly with kids…With kids though, you're responding to their presentation that day as well… I feel like you have to be flexible and fluid.* (M)

> *So, it's quite an eclectic approach, and I may go into a session expecting to have a particular focus and they might throw a curveball at me that then I've got to kind of work within the moment. It may be there's been a relational breakdown and that's where their focus is at and so, okay, so we need a – this is important to you right now. So, you have this overarching goal and direction you're taking but there are little deviations along the way I think.* (P)

To provide a multi-modal treatment approach and to be flexible in meeting the children's therapeutic and developmental needs at different stages throughout treatment, the psychologists are trained in some core treatment approaches as well as having a range of other treatments in their toolkit to draw on. For example, all the interviewees were originally trained in cognitive behavioural approaches with some interviewees describing themselves as "CBT-oriented" (M). A strong focus on CBT is consistent with Psychology Undergraduate and Masters qualifications, as one Manager described, “Given my Masters training, it was very CBT-based. So, I come from quite a CBT framework” (M). Although many of the clinicians described themselves as CBT oriented, they tended to qualify this by making it clear that their current work required a ‘multi-modal treatment approach’:

> *…with complex trauma, that’s not enough. So, you have to kind of adapt that a little bit…probably in practice, I tend to use CBT and EMDR and some kind of more interpersonal elements as well, within – as a kind of multimodal treatment approach.* (M)

> *So that I would say, CBT in general is probably my main framework but yeah, bits and pieces of other things when it’s needed.* (M)

All of the psychologists are trained in more than one modality. Twelve of the thirteen participants are trained in TF-CBT and unsurprisingly participants tended to describe TF-CBT as the most common treatment choice “the TF-CBT model works for most” (M). There are 10 psychologists trained in EMDR, 9 psychologists reported having CBT training and 6 trained in Acceptance and Commitment Therapy (ACT). The following table shows the range of treatments or programs that TFS psychologists reported being trained in, as well as the number of staff who reported having been trained in any given modality or program.

Table 1: Number of participants trained in each modality or program

Treatment or Program	**Number of Participants**
Trauma Focussed Cognitive Behavioural Therapy (TF-CBT)	12
Eye Movement Desensitisation and Repossessing (EMDR)	10
Cognitive Behavioural Therapy (CBT)	9
Acceptance and Commitment Therapy (ACT)	6
Imagery rescripting	4
Dyadic Developmental Psychology	4
Dialectical Behaviour Therapy (DBT)	3
Schema therapy	3
Interpersonal therapy	2
Circle of Security	2
Process oriented therapy	1
Mindfulness	1
Behavioural analysis	1
Solutions focussed-brief therapy	1
Emotion focused therapy	1
Protective Behaviours	1

In developing a treatment plan, the psychologists indicated they consider a wide range of factors. These factors are described in more detail in the sections below.

4.1 Trauma impacts

Participants used assessment data to identify which trauma impacts – what the TFS psychologists refer to as symptoms – are causing the most problems for the child or young person. These most pressing symptoms are then prioritised in treatment planning. For example, if emotional regulation is the main goal, participants told us they would use a "pretty standard TF-CBT model" (P). If the impacts are attachment related, they start with, "rapport building and emotional regulation and then quickly move on" (P). In another example, if there are conduct or behavioural issues, they may avoid using a trauma exposure component, but focus on behaviour change and attachment.

4.2 Developmental age and cognitive ability

The psychologists consistently indicated that the chronological and developmental age of the child was something they factored into treatment choice. As a participating Practitioner explained, "Age is probably a huge factor in terms of what modality I might use".

Children 5 years and under

For young clients, practitioners described modifying treatment approaches, for example a participating practitioner explained they would not use all the components of TF-CBT for children who were five or under and may combine some TF-CBT components with other approaches:

> *I'm not going to use straight forward, TF-CBT with a kid who's five, that doesn't have any understanding of their thoughts or their feelings, and all of that stuff. But I will definitely use bits of it in conjunction with maybe some attachment focussed strategies.* (P)

In working with very young children, the psychologists find that treatment plans need to factor in greater involvement of carers (where attuned carers were available):

> *So, for two or three, and then we work with the parents, rather than the kids.* (M)

> *Five is usually the youngest that we like to see, but depending on referral and particular details, you could get referrals that are younger than that. You're working a lot with the parent in that instance*. (M)

> *So a three or four, five (year old) I'll often involve the carer in sessions because an hour a week maybe, they're around so much more so intervention might heavily involve them, and that might be more around helping, teaching them the same strategies that the child is learning so that they can use them in the home so that there's a common language, so there's some consistency in what's been utilised…I would need to make sure that the carer didn't have their own stuff sort of going on and that they were going to be able to support the child and follow my lead in sessions so that they weren't going to do anymore harm to that relationship with the child too.* (P)

> *I have had a three-year-old client every now and then, but that's really challenging and that's usually carer-based work, like dyadic work.* (P)

Another practitioner told us that her treatment plans with young children often involved delivering the intervention to the parent so they could help the child, for example, "instead of teaching the child the relaxation strategy, it might be more teaching the parent how to help the child with that relaxation strategy" (P).

Children aged 10 to 13 years

As children got older, the psychologists were more likely to choose cognitive approaches like CBT and TF-CBT. A manager explained that it was around 10, 11, 12 that clients move through a significant threshold where cognitive approaches can be incorporated into a treatment plan:

> *I've had a number of kids that I've worked with over a long period of time, where they kind of move through that development and the case study I talked through was one of them, you get them at kind of six, seven, eight. And you might see them across time and they cross that kind of 10, 11, 12-year-old threshold. And you get this [unclear] development then, where trauma-focussed CBT and I guess more of those cognitively based talk therapies that involve CBT-based therapies and have a level of viewing the world that changes then, usually. And they do better.* (M)

> *And then, obviously, as they progress and hopefully, their cognitive capacity is a little bit more developed, you can do more cognitive work and with an adolescent, that can be quite good. I don't find the younger kids that works particularly well, most of the time.* (M)

Adolescents

Psychologists told us that different kinds of symptoms start to emerge in adolescent clients which affect treatment choice:

> *Teenagers you start to see a lot more self-esteem- issues start play out, a lot of more mood disturbances, a lot of anxious and depressive tendences within their trauma symptoms as well as well as lot of intrusions, bit of dissociation, lots of the time as well sleep and appetite disturbances too…relational difficulties is also really quite common for teenagers I work with as well. (P)*

4.3 Immediate or ongoing safety concerns

Immediate or ongoing safety concerns was an important factor to be considered in treatment planning. One manager reported that while, "the majority of our clients are not in unsafe environments… there are those occasions when stuff pops up" (M). Some client groups, for example MIST referrals, were seen as more likely to be in, "concerning environments", particularly if the disclosure is recent and there is, "something that needs to change" to make that child safe (MCP5). Emotional safety concerns such as being in an unstable placement or having no attuned caregiver were reported as ‘common’ and ‘frequent’ (M), and destabilising circumstances were ‘typical’ (M) for their clients. As a Manager explains, flexibility in the treatment plan was important in order to respond to safety concerns:

> *I feel like you’ve always got that overarching treatment plan, but what you find is that significant issues, like this is a good case example of significant issues popping up over that time that need to be responded to. Self-harm, suicide ideation, her mum’s passing away and her placement changed. You can’t ignore those. But that’s so typical of this client population of adverse life experiences happening that muddy the water a little bit. (M)*

Safety concerns were not considered a barrier to treatment *per se*, with no practitioners reporting they would stop or withdraw treatment for a child just because they were in an unsafe or unstable situation as illustrated in the quotes below:

> *I don't think it would be helpful to just discontinue therapy when there are safety issues because then you’re losing that safeguard… It's just you change what it is that you're focusing on in that moment.* (P)
>
> *…them being at risk doesn’t exclude them from this service.* (M)
>
> *I can’t think of many situations where we would stop treatment completely.* (P)

Instead, practitioners would first consider if the assessment showed the client was, “…still experiencing ongoing trauma or stress” (P), including any immediate risks such as suicide ideation, self-harm, ongoing family and domestic violence, and ongoing exposure to a perpetrator. Consistent with phased based therapeutic approaches, in the TFS therapeutic approach safety concerns were unanimously addressed as the “number one issue” (M) prior to treatment commencing in the form of a safety plan, “doing some harm minimisation” (M) and “restoring safety” (M). For example:

> *If a young person is having thoughts of suicide, self-harm, that kind of thing, again, you’re really needing to address that, focus on that, resource that as much as you can before you’re going to go into specific trauma intervention.* (M)

In these cases, the psychologists routinely excluded EMDR as a treatment option, and if TF-CBT was otherwise indicated, the psychologists would then factor safety risks into the sequencing of particular treatment components. In general, there was some consensus that where there were safety concerns there should be a slower pace of treatment, a longer period for stabilisation with more time spent on emotional regulation and psycho-education components, and the delay of trauma processing or exposure components:

> *We would also be a bit gentler and probably take a longer approach if there was more complex mental health because that's got a higher risk, particularly, where there's – it’s more your bipolar type presentations*. (M)

> *If we’ve got a child who is highly vulnerable to suicidal ideation or they’ve had previous suicide attempts, you would probably take a slower approach to any type of exposure work.* (M)
>
> *We put some kind of buffers around them, to allow them to then do therapy, if that’s indicated. For some of these kids, it’s just not the right time and they need some initial work to reduce their risk to themselves and they might need a mentor or they might be needing stabilisation in their placement and then they come back to therapy. Because therapy’s really hard and it can be really distressing and if you’re not in the right place, then all you take on saying look, I’m seeing them for therapy, I’m seeing on the condition that we’re stabilising them to get them to a place where they can do some work on their trauma.* (M)
>
> *While the child or young person might be really vulnerable and has a lot of welfare needs and child protection issues; you almost in some ways need that to stabilise before you’d want to come in with therapy.* (M)

The practitioners also refine their safety planning on a “case by case basis” (P) depending on specific scenarios. For example, where there is a risk of self-harm one junior psychologist explained TFS’s strict safety protocols:

> *If it's a suicide risk, then we have a safety plan that we have to go through with the client. We have to do a risk assessment. Then after all that, we do our own internal incident report for any of those issues, so what happened, how I responded, the plans for the future, and then that goes through a managerial approval process.* (P)

If the initial assessment or any subsequent session identified the child as having ongoing exposure to a person responsible for harm, the practitioners may need to first “…intervene directly to address that with a parent or carer or to speak with the case manager” (P), “…report to the Department, and debrief with my supervisor, make sure I’ve followed the correct procedure” (P).

Critically, the presence of danger in the child’s life would change the practitioner’s interpretation of the presenting symptoms as coping mechanisms that the client still needs, to keep themselves safe in an unsafe environment. In this case, as the examples below highlight, the practitioner needs to weigh up the evidence-based approaches for resolving the symptoms against the safety implications of turning off a child’s ‘early warning systems’ with a treatment plan involving any exposure therapies, such as EMDR or TF-CBT:

> *If a child is still being hyper-vigilant and they're a little bit on alert and there are still current safety concerns, it actually makes a lot of sense. We wouldn’t even expect that [these symptoms] would reduce even with treatment if the other stuff is not being addressed. So, it would be very unhelpful to try to look at them as unhelpful coping strategies when they're very adaptive in that context.* (P)

> *Some therapy will actually make the child more vulnerable. "I'll give you an example of a case. We had a young girl who had been sexually abused by her brother, but, actually, the problem that she still – she had PTSD, she had quite classic PTSD, actually. And it was complex in nature because she'd actually been exposed to family domestic violence and physical assaults of her brother. Her PTSD symptoms in terms of the classical things that were bothering her that were causing nightmares and flashbacks and general distress and triggering, actually had nothing to do with sexual abuse. It was actually all to do with the physical abuse that she witnessed and the exposure to family violence, but she still lived in that environment. So if we did exposure therapy, because, essentially, in exposure therapy, you are removing some of the triggering, so you're telling her brain, don't worry, you're in safe situation, and there's no need to be triggered, and you're turning off that alarm system if you like. Her alarm system needs to be on because it's really important for her that her alarm system is still on and is still sensitive, because when Dad starts drinking, and that's a cue, she does need to be more alert. She does need to be more protective. So we had to have – and I was the supervisor in this case, we had to have lengthy discussions around, we know this is the best evidence based practice for this kid, and this would actually resolve a lot of those trauma experiences for her that were really impacting on her, but by doing that, she then actually becomes far more vulnerable and was highly likely not to respond in the required way to keep herself safe in that situation where she absolutely was exposed to family violence. Yeah. So that's a really clear example where the risk, there's a massive risk there, and so we could not do that type of therapy.* (M)

The question of what is safe enough in the context of complex trauma was something that many of the Managers discussed in their interviews. Some managers, were not sure if the way they currently sequence treatment to delay or avoid trauma processing until clients are completely stable was working well for clients. They mentioned that some clients may, "…never get stable" (M) and "…do not have a caregiver who is responsive and supportive" (M) and may therefore not experience the benefits of trauma processing. While recognising the risks, a Manager wondered whether a better threshold for trauma processing might be 'stable enough':

> *…particularly EMDR, you want to know that they're not going to be completely overcome. Like you're taking the lid off their trauma. You're dragging it out. You don't want them to jump off the bridge. You don't want them to start self-harming again, but I guess, you know, I think a lot of that has to do with our own fear in terms of doing harm than it is for the client's wellbeing. I think a lot of the time, we could probably have proceeded with them being a little bit less stable. And some of these clients never get stable and they would have been fine – or they will be fine. You know, they've been fine to now. Like, they're still alive, they're getting through your therapy door.* (M)

> *Some intervention might really cause them to become extremely dysregulated. You don't want to like – the hard thing is…sometimes the treatment is the thing that helps them not become incredibly dysregulated. So, you've got to weigh that up. What is enough safety that I can do this?* (M)

A third manager reflected on the frequency of which their clients were in unsafe or unstable situations. That manager observed that sequencing of treatment in this context actually means there was a lot of time spent ‘holding’ safety for clients rather than doing therapeutic work and whether this was a necessary part of a complex trauma treatment model:

> *To be perfectly honest with you, it's probably a question of whether you're doing therapeutic work necessarily. If a child's in a really unsafe situation, are you really doing therapy with them? Or are you trying to advocate or see what can be done and provide them a safe place of experience, and maybe that could be therapeutic in a sense. But I think you get a lot of – and whether it's someone in a safe unsafe situation or just a kid who's going through lots of changes and isn't settled, you tend to end up in this zone of a supportive therapy for your times, which I think for the clinical psychologist in particular is hard to handle.* (M)

Depending on the definition of therapeutic work, the psychologists may frame what they are doing in terms of delivering therapeutic components such as psychoeducation, emotional regulation, and others may either be doing something different or framing what they are doing in this period as ‘supportive counselling’. A fourth manager reflected some ambiguity in the definition of what was a therapeutic intervention and what wasn’t, giving an example of one of their clients in out of home care:

> *We’re going to continue therapy for a supportive intervention or supportive counselling because that relationship that’s been built is actually really important to that young person, or it’s a protective factor currently to maintain that relationship. You’re not actually pursing an intervention*. (M)

4.4 Availability of an attuned caregiver

Children need access to at least one caregiver that is generally attuned to their needs and emotions. In recognition of this basic need for a safe caregiver, many therapeutic modalities (for example dyadic work, EMDR, TF-CBT) require an attuned caregiver as a prerequisite to treatment. Therefore, there are considerable practice challenges in delivering therapeutic services to children with abuse and neglect related trauma who are in OOHC placements or who otherwise do not have access to a loving and attuned caregiver in their lives. One manager identified children having no attuned care giver available as one of the biggest barriers to treatment:

> *We've got a few really great long-term primary carers at Parkerville and the kids attach to them and you can work with them and that's great. But unfortunately, it certainly doesn't seem to be really common, and you have got a lot of kids where they just change placement so much that they might be in a placement with a primary carer or a foster carer now. They don't know that carer well enough that that carer has been involved because they haven't really connected with them yet. So that I think is probably one of the biggest barriers in these populations.* (M)

The psychologists recognised that in many ways you were not likely to have an ideal therapeutic context when you are working with abuse or neglect related trauma, as one manager told us,

> *You might have a different carer every time a child comes to see you. It is really tricky for the kid to be in a place where they're having different carers all the time and then they come to therapy and it's always a different person bringing them, or sometimes it's just different Department workers dropping them off and picking them up. That I think is really not the ideal therapy scenario.* (M)

Where there was no attuned caregiver available the practitioners described a couple of different treatment options. The practitioners may need to exclude certain modalities from their treatment plan altogether, even if that was otherwise the best treatment available. For example, one manager explained:

> *Like dyadic work you would never do unless the caregiver was – even if it was a stable placement, if the caregiver were not appropriate for dyadic work, you'd never stick them in a room together and try and do dyadic work. So that just wouldn't be a treatment option for that child, even though that might be the best treatment option.* (M)

> *If there is no supportive caregiver you wouldn't do EMDR…EMDR poses a risk if they don't have (a supportive caregiver) – because of the way the processing works. They're continuously processing in the hours and days after the exposure. So, if the risk is too great in the home environment in terms of the lack of caregiver attunement or support, then you wouldn't do it.* (M)

> *How stable their placement is makes a really big difference for me, even making decisions. I'd be far more likely to tackle trauma processing when the child is in a stable placement than one who's not. I don't think I'd even consider it in many cases.* (M)

In other cases, the practitioners may make a treatment choice, but then adapt the sequencing for children who do not have access to an attuned caregiver. First, practitioners consistently told us they would delay trauma processing or exposure elements:

> *Maybe, they're in an environment where they don't have a particularly robust care system around them, you wouldn't want to go too hard and fast with your exposure, because it can cause distress, and it will cause distress, because they then might not have the coping strategies enough to actually hold them outside of session. And if they don't have the care group outside of session, then the risk is too great*. (M)

Second, while they delayed trauma processing, the practitioners would focus on other elements of treatment, for example spending more time on psycho-education and emotional regulation components:

> *So, if there's been huge change and their parent has just left and that was their primary carer, they might not be anywhere near ready to work on the trauma. I'm helping them to*

> *regulate and then to reconnect and create a relationship that is quite safe and stable with this new carer.* (P)

Others described having a break in therapy and moving into:

> *…a bit of a supportive counselling phase for a while where you're just checking in with them and validating and reassuring and reframing and monitoring and doing all of that kind of stuff to hold them, I guess.* (M)

In some cases, it was not a matter of waiting for a placement to stabilise, but of a child who was not likely to have a supportive caregiver in their life. In those cases, they would "focus on building up the child's independence and resilience" because that is "going to be their lot in life as a child, which is really sad". (M)

4.5 Referral pathway

TFS clients are referred for treatment via several different pathways which impact on the choices available for treatment, the number of funded sessions and the stakeholders involved in negotiating a treatment plan. As a participating psychologist explained, "compared with normal clinical work" in the TFS when you are formulating a treatment plan, "you have a lot more input from other agencies" (P).

Department referrals

If the client is referred by the Department, the practitioner will need to consult with the Department and may need to negotiate the treatment plan with the District Psychologist. As a participating practitioner told us, the Department will "often have their recommendations or thoughts on what the best modality or the best approach would be". They continued that "occasionally" the Department may prescribe the treatment on the referral documents, for example, "they want you to do dyadic work", but in general the practitioners were able to come up with what they thought 'the best approach is' and then negotiate with the Department.

MHCP referrals

For Medicare funded clients, treatment choice is influenced by what the GP has documented in the Mental Health Care Plan and what Medicare will fund under its prescribed list of modalities:

> *…as a psychologist you need to be treating the diagnosis on the Mental Health Care Plan (sic). You're bound by that, and you're bound by Medicare as to the type of treatment that you can provide, so it's quite prescriptive in what you can actually do as well.* (M)

There did appear to be room for negotiation and recognition of the assessment completed by the psychologist in making changes to the Mental Health Care Plan, as a Manager explained:

> *…you have a look at what the doctor's diagnosed. If it's totally different to what is going on, you write back to them and say, "I'm going to treat this, because this is the presenting issue for these reasons.* (M)

4.6 Length of treatment time

The referral pathway determines how many sessions the psychologist is funded to work with the client and consequently the treatments that can be safe and effective for that length of engagement. For example, clients who are referred on a Mental Health Care Plan are funded for 10 sessions[1]. This means a psychologist cannot ordinarily complete a manualised 12-week program like TF-CBT with their Medicare-funded clients. This is despite TF-CBT being an evidence-based treatment for PTSD and being a Medicare approved treatment. As two managers explained:

> *You've only got 10 sessions and you're in January, you're not going to get another 10 and most of the clients can't fund privately. So, they can only have those 10 sessions. So, you have to factor that in when you're deciding what you're going to do.* (M)

> *You need to be thinking about what can I do that is safe for this client, helpful for this client, treating their symptoms, but is doable within 10 sessions and in the context of all these other factors that they might be experiencing, which is normally the case.* (M)

Generally, 10 sessions were not enough for clients with abuse or neglect-related trauma. As a participating psychologist told us, for Medicare clients:

> *Even where they have a trauma background, I probably wouldn't go down the road of using full TFCBT, or EMDR because of the number of sessions that they might have available to them. If we got halfway through processing and they didn't have any more sessions that would be extremely unethical and horrible*. (P)

For their Medicare clients, the psychologists approach treatment as an 'episode of care' (M) rather than an intervention from start to finish. In their treatment planning, they need to consider what can be reasonably achieved within each episode of care and how they might extend the length of therapy within the constraints of the Medicare funding rules:

> *When you've got complex trauma and children who are still exposed to FDV, still living with the perpetrator of their sexual abuse, still have parents with substance use issues, non-consistent attendance, poverty, they're the factors that we're working with. So I think it's a lot harder to do that in 10 sessions. But you can make – I think of it as like a – this episode of care. So what do I want them to get out of this episode of care? And you are talking with them about how they re-refer at the end of that and you do that before the end of treatment. So you think like great, so this episode of care, I could teach them these skills and help them work out if they're not safe as the first instance, help them talk through that kind of thing and how to keep themselves safe. Because that needs to be met before you can do anything else. So sometimes, that becomes a lot of that stabilisation stuff that you are doing to begin with. But they might get that in this episode of care and*

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[1] This was at the time of interview. Later, this period was extended to 20 weeks during the COVID-19 pandemic.

> *then next time they come back, and they've already got those skills and then you can focus on other things and then, they might come back again. Or they might have started halfway through the year, so you get 10 sessions and then you get another 10 at the beginning of next year, so you get 20, kind of block. And then, you can make some really good progress in there.* (M)
>
> *With a Mental Health Care Plan you have to consider what's realistic within the time frame, so it might be for the first initial presentation it might be - we're going to build up your emotional regulation and coping strategies, and then next year if you want to come back you've got that foundation and maybe we can do some trauma processing work and this would be the modalities we could use.* (P)

4.7 Client preference

Children who have experienced abuse or neglect related trauma may have experienced feelings of powerlessness or had their agency or choices denied. Empowering clients, or caregivers, if children are very young, to be active participants in decision making is an important element of helping children restore their sense of agency. A key element of evidence-informed practice is the consideration of client preferences alongside available evidence and practitioner expertise. For example, some clients may have a strong preference not to talk about what they have experienced, or may not be able to recall the experience, and this may impact treatment choice. As one Manager explained, "they may not want to talk about it, may not be able to talk about it, particularly if abuse occurred in early childhood" (M). In this case, the Manager offered EMDR as a treatment option.

Several psychologists described their treatment planning as collaborative, taking into account client preferences along the way. For example, a participating practitioner made several references to engaging clients through collaborative decision making around treatment:

> *But I guess, yeah, I like to do that sort of really collaboratively with the clients so that we're both on the same page, we're being transparent about what's happening and what we're going to be working on moving forward, because if they're not interested then it's not going to work…I like to collaboratively kind of develop goals with my clients as well because I think that there's no point in doing intervention and only working on what I think is important, if there's no buy in from them.* (P)

For the practitioner quoted below, being able to provide psychoeducation and share information about the treatment options with carers was an important element in supporting client choice in treatment planning:

> *…a collaborative approach … I consult with what others think if I need to, or I give them information. Like, for a parent, they're a lay person, you'd give them that psychoeducation around that and usually they're like, yep, I trust you.* (P)

> *Yeah, so I've had clients where I've gone to attempt EMDR and it's been a big no-no or I've given them the idea of it and they've gone, "No." So trying to give them the education around it and then they can have that choice in controlling it, which is fine.* (P)

Others felt their approach was to try and accommodate client preferences if they arose, but generally did not try and elicit client preferences. In response to being asked how much client preferences were taken into account in treatment planning, one manager responded:

> *Look, to be honest, I don't think that does that often. I'm being completely honest. Because if a client had a particular preference, I certainly would consider that. But I guess, because working with children and young people, I don't know that they're given much of an option. I always talk with them about what we're going to be doing. That certainly changes – their preferences certainly change the style in which you engage them. So like, if you've got – but I don't know if that would change your modality because of their preference. Yeah, I mean, I guess it would actually. If they had a strong preference that their carer wasn't in the sessions, I would never force that upon them.* (M)

4.8 Ongoing Forensic and Court Proceedings

The practitioners also interface with police investigators and some of their clients may be waiting to provide evidence in court. This had an impact on how they approach treatment planning. As one Manager told us:

> *If they're about to go to court, your treatment might be a bit different". Another manager described how they might not be able to proceed with an evidence-based treatment for the most pressing symptoms while a court case was pending.* (M)
>
> *You might have a child with really intrusive symptoms, so you think we've got to do that [EMDR], but of course then I've got one who's presenting like that but has an ongoing court case. So that then influences whether we can go with EMDR or not, unfortunately.* (M)

While the main consideration is to avoid trauma processing modalities and components, psychologists can still proceed with other therapeutic components so that clients are supported during what can be a protracted court process:

> *Yeah, I liaise with them a lot in terms of where they're at, what it's looking like in terms of whether the person might be pleading guilty or not guilty, where we're at in the court case if you had a hearing at court, if they mentioned having entered the plea, sometimes it can be two years before that process is finished. I've had clients where it's been a lot of support and a lot of all of the other components of TF-CBT, or before we've actually then been able to get to a point where we've been able to do any sort of processing work because of that barrier, so that's a huge factor too.* (P)

4.9 Skill and experience

Treatment plans are often developed in combination with the practitioner and the manager. The more inexperienced the staff member is the more likely their treatment plans will be developed in supervision. The manager takes, "…the level of experience of the Psychologist and their capacity to synthesise all the information" (M) into account when they are developing the treatment plans with staff, emphasising the complexity of the work and the need for intensive supervision. As one Manager described:

> *The more junior psychologists–- or the ones doing registrations–- all their cases will come up in supervision for review, and then the modalities are reviewed and discussed then.* (M)

5. IMPLEMENTATION SUPPORTS

Along with understanding the approach being delivered, the interviews were also concerned with how the approach was being implemented, particularly what systems and supports were in place for consistent delivery of the approach across sites and psychologists. The following examines the implementation supports according to Fixsen et al.'s (2005) key components of successful implementation - staff selection, staff training, supervision and monitoring and evaluation, which framed the questions presented to participants.

5.1 Staff selection

The TFS therapeutic model is delivered by psychologists, including a mix of registered and clinical psychologists, as well as clinical psychologist registrars. There are no counsellors employed in the TFS team and it was common for participants to reflect that their clients often needed supportive counselling for long periods in between periods of active clinical intervention.

The psychologists felt it was important to recruit psychologists with the clinical training to consider the evidence, to competently assess, to make clinical decisions, and to continuously monitor progress:

> *I think it's really important that people are clinically trained, that people do have at least a psychology background because you've got more awareness of evidence-based practice and to be able to use psychometrics and assess it properly as well.* (P)

Two clinical leads felt that this work was best suited to experienced psychologists, reflecting that in an ideal world, the service would recruit psychologists with a diverse range of training and accreditation in different approaches and a background working with different types of populations. A broad range of experiences and skills were presented as the ideal.

> *If you have more tools, if you've done different trainings, if you have more things to draw on, then you're able to be flexible.* (M)

> *You have to be able to assess the client adequately. You have to be able to see the connections. To be able to assess a client adequately, you have to know what causes what and why, and how it all fits together. And I do think there's a huge amount of that, that just comes from experience, like, the volume of cases and the exposure to it.* (M)

However, the psychologists who took part in the study, were relatively young with most psychologists in their late 20s and early 30s. A core group of staff are new university graduates. As one Manager reported, "we get a lot of new grads" (M). As a result, the psychologists are recruited into TFS with a firm grounding in cognitive and behavioural approaches attained in their university training, but not usually with specialist trauma training. Subsequently the TFS therapeutic model requires staff to be supported to develop trauma specialist skills with customised internal training combined with a model of intensive supervision.

The managers recognised that there is a "particular way of working" in the TFS team and in the past, it has not worked well to recruit experienced psychologists that also bring with them too many "preconceived ideas" (M). The TFS selects psychologists who are ready to learn and where managers can "…teach them in a way that's really specific to this work" (M) rather than more experienced psychologists who may be, "ingrained in a particular type of working and may be less flexible to change" (M).

Other managers reiterated the importance of flexibility as an attribute they are looking for when selecting psychologists and a critical factor in being able to deliver a multi-modal therapeutic intervention:

> *You need to be adaptable as a therapist. So, you have to be able to go into a session and be completely attuned to the child to pick up on their cues and where they're at. And you have to be prepared to throw whatever you had planned out the window if need be, but you need to know when to do that and when not to, so you have to be willing and open and dynamic to do that, which not all therapists are.* (M)

Flexibility was consistently mentioned as an important attribute of psychologists delivering this type of trauma intervention:

> *Flexibility is like one of the main things.* (M)
>
> *I think flexibility, an eclectic approach, being able to acknowledge there is not one modality necessarily that will fit every single presentation.* (P)
>
> *…definitely flexibility and adaptability, I think are huge*. (P)
>
> *…competency, flexibility, adaptability, openness and vulnerability.* (P)

Other prominent attributes staff described as important qualities for psychologists delivering a multi-modal approach, included, an understanding of the evidence base, enjoying working with children, being passionate, empathetic and assertive on behalf of your clients, having good communication skills, being self-reflective, able to sustain hope and engage in self-care:

> *The kind of people that work for this organisation, they tend to be completely invested, passionate, nurturing people*. (P)
>
> *Empathy. A sense of humour is important. Having hope, because you can work with clients where there's not a lot of hope. You've got to like children…So apart from everything that you require to be a clinical psychologist, you have to enjoy children… you have to like being with children, you have to be respectful of children.* (P)
>
> *This is''t particularly scientific, but I think you need someone who really likes kids and who wants to work with kids and enjoys that. Because otherwise ther''s hard work, so you need to enjoy working with kids in the first place.* (P)

> *I think good communication skills because you've got to do a lot of consultation and liaison, I think that's super important as well as self-care, I think that's pretty important too.* (P)
>
> *Self-reflective capacity as well. There are psychs who don't have that*. (P)
>
> *You need to be really reflective of your practice and relational, working relationally with the clients.* (P)
>
> *Having a sense of playfulness and being open, non-judgemental… playful, accepting, empathic and curious.* (P)

5.2 Staff training

Implementation of the TFS therapeutic model requires substantial investment in training staff who leave university with a strong background in cognitive and behavioural approaches but need to quickly build up a 'tool kit' of modalities, approaches and techniques in order to work with the specific symptomatology they could be presented with in any given session:

> *It's also important to have a really good tool belt or a tool box with lots of different strategies and modalities that you can use because no modality fits all, you have to be quite flexible, and as much as I've said earlier you might start with CBT, but then you might need to move to counselling or you might need to use more humanistic or psychodynamic approaches and you need to move around quite a bit depending on the client and I think it's important to have training so that you do have a skillset across those different modalities*. (P)
>
> *You have to be flexible, have your toolbox ready and see what hits you in that session.* (P)

Training is also important in supporting Practtioners to deliver therapeutic services in a consistent way, as a participating practitioner commented, "…most of us are probably trained in the same or similar kind of interventions". Building on the knowledge psychologists gain as part of their university studies and to ensure consistency across the therapeutic team, TFS provides a customised internal training program with a strong emphasis on attachment theory and the emerging insights on trauma generated in neuroscience. Participants mentioned having completed the following internal training programs during their time with the TFS:

- Impact of trauma on neurobiology
- Impact of trauma on the adolescent brain
- Attachment theory
- Cultural safety
- Safeguarding children
- Family and Domestic Violence
- Responding to sexualised behaviour
- How to respond to disclosures
- Report Writing

The TFS also supports staff to access external training in a range of different modalities to build up their 'tool kit' over time. The most common external training interviewees reported having completed were the two most well supported complex trauma interventions - TF-CBT and EMDR.

5.3 Supervision and coaching

The TFS used a model of intensive clinical supervision to support the implementation of their model. A Manager described the following features of their supervision model:

- A high proportion of clinical psychologist managers, who are able to supervise, and also to fulfil the requirements of registration supervision
- Each psychologist, regardless of seniority, has a designated supervisor
- All psychologists have
  - A primary and secondary supervisor
  - one-on-one supervision for one hour a week or held fortnightly in a block
  - group supervision every couple of months where there is sometimes an invited guest speaker
  - peer supervision and peer consultation
  - internal staff meetings
  - opportunities for ad hoc consultation with senior staff if problems arise
- New psychologists have all their cases reviewed until the supervisor is satisfied they are applying the right modalities and approaches to their clients.

Clinical leads and practitioners described supervision as a critical element for implementation of the therapeutic approach:

> *You absolutely need supervision. And when I say supervision, I mean you need excellent clinical supervision, more than what – you need someone with more experience knowledge and skills than what you have. Having supervision just because someone's a trained supervisor is not enough. You actually need someone with the technical skills as well, in your discipline to do that.* (M)

> *I think it probably is just purely the supervision we have applied. So because we all get fortnightly supervision and that impacts us all. When I came to Parkerville I came from a completely different area, so I've never worked with Child Protection before and I just had no clue. And so having that regular supervision, you can be like, 'Holy moly, all this stuff, what am I supposed to do?' And talk through, and your supervisor is obviously more experienced and saying, 'Look, from what you're saying, it sounds you're in this bit of a stuck place and it sounds like the Department needs to know this or maybe you need to liaise.' So it comes from that supervision and then, over time, you obviously become more confident and develop those skills.* (M)

> *You can't do this unless you can, actually, adequately assess a kid and a family and bring in all the knowledge into a synthesised view of the child. Then you actually have to have an*

> *understanding of how different symptoms might interact with each other. And not in a – you have to have enough broad knowledge to know, and then you have to know what might be an evidence-based practice for different things, so what would I do if the kid had a really low mood?* (M)

> *I think if you didn't have that (supervision), you would feel like you were kind of out in the middle of the ocean without a life raft, just bopping around and just paddling and trying to survive*. (P)

Five clinical leads participated in the study (included in the group referred to as Managers to protect participant anonumity in a small sample). They have smaller client caseloads and spend the bulk of their time supervising staff psychologists, "talking through their treatment plans" (M), "ensuring consistency in how the psychologists perform assessments" (M), and reviewing their reports, "When you first start with the program, all of your reports are reviewed by your supervisor until they feel that you are at a standard that they no longer need to be reviewed". (M)

From the perspective of one of the Managers, the TFS invests a lot of time and resources into supervising clinical staff:

> *I think about when I went through, like my supervisors would watch my videos and give me kind of minute-by-minute information about questions I should have asked and what I should have done. And that's how I learnt. And that's how we try and teach them, but it's a lot of time and effort.* (M)

Practitioners shared this perspective, describing the supervision model as both intensive and also of high quality. For example, a participating practitioner told us:

> *Regardless of what was going on managerial or political, or any of that sort of stuff, I actually had really, really high-quality supervisors and the thing that Parkerville, provided me with was excellent supervision, intense supervision, and regular supervision and I always had somebody on the end the phone, which was really what was needed in that position*. (P)

When asked what organisational supports were necessary to support consistent decision making for implementing this model of treatment, 12 of the 13 interviewees told us that high quality supervision was the main thing that allowed the team to deliver such a complex treatment approach with a high level of consistency:

> *We have quite a good supervision frequency here and so we have frequent supervision where we are talking about our more complex cases…we have that really frequent supervision where we, one, are held accountable to what we're doing, but two, have the option to kind of bounce those ideas off of our supervisor*. (P)

> *I think that we're quite consistent given our processes of supervision and peer supervision training, internal training.* (M)

> *So, I think having clinical supervision and also processes in place, like for the way people go about things. Like when you do an assessment, when you write a report, who reviews that report depending on how trained you are.* (M)
>
> *That consistent supervision, clinical supervision, from a supervisor; I think that we've done that really well, I believe.* (M)

5.4 Evaluation and Monitoring

Evaluation and monitoring were described as key features of the therapeutic approach. The practitioners continually review and assess progress with their clients and are required to enter psychometric assessment results into a data management system so that the organisation can monitor fidelity to the approach and effectiveness according to specific outcomes.

Engaging in continuous assessment with their clients was part of the evaluation process, for example:

> *’'I'm always assessing, even every session.* (M)
>
> *Your assessment continues really subtly as you interweave stuff over the next couple of sessions.* (M)
>
> *The assessment process is ongoing, is what I feel. It is something that's always being readjusted, you're always readjusting your understanding of that child.* (P)

Continuous monitoring and evaluation was described as important in maintaining the necessary flexibility within the treatment plan to address changes – treatment progress, times when strategies were not working or when new concerns came to the fore. The need to be prepared to perform subsequent assessments and review treatment plans was dependent on emerging pressing issues and disclosure of additional information:

> *So, you reassess and you're like okay, this is now – at the beginning, we thought we were going to be working on this, but it's six weeks in and your carer's now telling me that you are no longer sleeping, or you are engaging in risky sexual practices. And then, that becomes – so you're kind of looking at like, what's the most pressing of the issues? So, you still have that original treatment plan in mind, which might be to process trauma. But you tackle that issue and you switch modalities as a kind of like, more kind of concrete decision, I guess.* (M)
>
> *You see more of them as the sessions go on. I get a better read on them. I might vary my modality, like if I'm doing a lot of talking and I'm getting nothing, then we'll play games or do drawing, and you get more stuff out of them. They get distracted and they talk to you more. But I think you've kind of got your initial assessment and then you're constantly kind of reviewing that as you get more and more information, in my head.* (M)

In practice, the managers were facing some challenges in monitoring the input of assessment results in their data system with some staff not entering their psychometrics into the system affecting their ability to assess outcomes:

> *Particularly, like the use of psychometrics and things like that. The fact that lots of them are not there. And you know, I mean, [my Manager] has kind of just been talking to me a little bit about some of the issues and you know, like for one of our ex-clinicians, there was really no psychometrics on her file and I supervised her registration, I supervised her post that. She's a good clinician. She has good judgement, good assessment, gets good outcomes. And that really surprised me, that she didn't have any of that on her files.* (M)

6. LIMITATIONS OF THE MODEL

The interviews highlighted some limitations with the model's capacity to respond to the needs of diverse client groups, some challenges in the model of supervision as well as some other operational challenges.

6.1 More support needed for working with Aboriginal children and families

Overall participants indicated that the service did not have clear processes and procedures for ensuring the needs of Aboriginal children and young people were understood and addressed. Some practitioners indicated that they would like additional and more specific training and support for working alongside Aboriginal and Torres Strait Islander children and their families.

It was unclear how many Aboriginal children or young people the therapeutic team was working with, and this makes it difficult for the organisation to understand who the model works well for. One Manager reported the proportion of Aboriginal to non-Indigenous clients as low overall (M). However, at the individual level, some staff had reported 50 per cent of their caseload as Aboriginal clients. One Manager reported that the number of Aboriginal clients, "has increased over the years" (M). While Parkerville CYC Inc does collect demographic data, at the time of the interviews one Manager reflected that they do not always have the capacity to use that data to inform service delivery – "we haven't really studied that or done anything with that for the bulk of our services" (M).

There were varying degrees of knowledge and awareness of the needs of Aboriginal children who were disconnected from culture. For example, one Manager stated:
~~that Aboriginal children and their families may experience specific forms of complex trauma due to the impacts of colonisation and may need access to cultural healing approaches as a result. For example, one Clinical Lead demonstrated a lack of understanding of the impacts of colonisation on identity and belonging when she reflected that~~:

> *A lot of the Aboriginal kids that we do see, and I know this is probably very – people would argue with it, but a lot of the kids that we see, they are very white, Western, from here. They might be Noongar kids, but they are not connected to culture very much at all for whatever reason, and they respond okay to our style of therapy.* (M)

By contrast, a second Manager reflected on the critical therapeutic importance of Aboriginal children having their cultural needs met, she said:

> *It's important. It's tricky though, I've got the one from [remote Aboriginal community] and I have liaised with [Parkerville Aboriginal Practice Leader] and the Aboriginal Practice Leader at the Department about his treatment– in every single one of my reports, I've acknowledged this child is not getting their cultural needs met. They're not getting them met in therapy at all, but I'm not proposing to do that. But they're not getting them met in general. And it's like my foremost recommendation. I was looking back at the last two reports, like you guys need to think about how to address for this young man, he's a teenager. Really burgeoning on adulthood and no connection to Country almost. And*

> *really far away from home and it's always like this huge issue that emerges. But we've acknowledged it a lot, I guess, and I ask him a lot of questions about it, I guess, to get to know what he thinks about staff and about his culture and how it works working with me, with me not being Aboriginal. So really, like, to talk with him about that. He's quite comfortable with me and we'll talk about stuff, but mainly my role, I guess, is to look at how he can get that need met and advocate for him to get that need met in an appropriate way and it hasn't happened. There's like, one Aboriginal man that he knows, so that's about it, yeah.* (M)

Participants identified lack of adequate training and supports in place as impacting their capacity to recognise and meet the cultural needs of Aboriginal children. There was also reflection on the lack of shared lived experience of non-Aboriginal practitioners working with Aboriginal children and young people.

Several staff mentioned accessing Parkerville CYC Inc's Aboriginal Practice Leader. Staff also had access to Cultural Safety training, however one manager described this training as very broad when she felt she needed psychology specific cultural training, for example she said that in the training, they:

> *…talk generally around history and experience and having empathy for that collective trauma and that kind of thing, which is absolutely relevant, but it's like what I really feel is needed is really concrete things to consider when you're engaging an Indigenous client. Really practical, navigating that kind of thing. Psych specific is probably one aspect that's really key, I don't know if there's that anywhere but, again, just navigating engagement, that kind of thing.* (MCP5)

At the time of the research Parkerville CYC Inc did not employ any Aboriginal psychologists or counsellors on the TFS team and as the quote below illustrates, some of the staff identified a lack of shared lived experience as a barrier to the model working well with Aboriginal clients:

> *I think there's a lot about the culture that's very, very different to what my culture is, and I think that the challenges are that I still come from my own levels and expect that family have the same expectations or upbringing. I think there's such a connection to land and community and sense of belonging that is really, really important and often can be overlooked in our work because we're still just coming at it from — well, I'm a white woman and so I'm still coming from that perspective sometimes. So I try to hold it in mind all the time but that's difficult to really get a sense of what that means. Then when I'm working in a rural community like Northam, there's really different ways of living because it's a small community or the local areas where people come from to the office, [unclear] expectations around letting children be out at night roaming a little bit more independently and then coming back home, which is very, very different I guess even from the urban culture.* (Practitioner)

At the time of the interviews, participant responses demonstrate several opportunities for Parkerville CYC Inc TFS staff to better meet the cultural needs of Aboriginal children and young people engaged with the service. A shared understanding of the proportion of Aboriginal clients engaged with the service and the implications of this for the practice model were clear implications. As was the need for practice specific workforce development that includes the impacts of colonisation as a specific form of trauma for which children need access to cultural healing. In addition to consultation with Parkerville CYC Inc's Aboriginal Practice Leader, there is an opportunity for the organisation to consider how it might incorporate components of cultural healing into service responses, this could be achieved in a number of ways such as engagement of Aboriginal practitioners in the TFS, partnering with or referral to ACCOs who can provide cultural healing, and/or engaging with Elders.

6.2 More support needed for working with children and families from cultural and linguistically diverse communities

Staff also highlighted the need to adapt the model or work in partnership with organisations representing culturally and linguistically diverse communities so the TFS team could engage better with children and families from culturally and linguistically diverse communities. In some sites, culturally and linguistically diverse clients are 'rare', as one psychologist put it, "I've very rarely had a different kind of culture, like very rarely" (P). In this context, psychologists may not have opportunities to develop their experience and awareness of cultural safety for a wide variety of cultural groups.

For example one psychologist thought that ethnicity was not a relevant issue for her in her practice, saying:

> *Like it's probably something that hasn't so — salient to me…I guess it's a bit like going to a party, and kind of going is there a particular culture that stands out to you? Actually no, not really, you know what I mean? It's not something salient to me, no.* (P)

In contrast one manager was aware of a need for better access to interpreters in their work. For example, one manager told us:

> *We've had a couple of refugee families referred there and there's been some real difficulties with language barriers and trying to help those people engage in a way that's meaningful and appropriate for them, without an interpreter necessarily available.* (M)

The same manager also reflected on the need for the Department to provide greater support for some culturally and linguistically diverse families to attend therapy:

> *And also, like a father – this is one of example of this, father trying to learn English. So attending school all the time to try and learn English, so he can get a job to look after his family, but also trying to bring – I think there was like four of the same family. Four children who had recently been reunified with that family in for therapy. And like, the Department – there was a lack of foresight there about how this family would even like, make that work. I think any family would find that really hard to have four different children attending four different appointments with mother and father who don't speak*

> *English very well. Have minimal English skills. In MIST, we come up – like, I guess with people from different cultural backgrounds, which can be challenging. Like, we had a German family and that was pretty tricky.* (M)

At the time of the interviews, it appeared that some cultural awareness training may be needed to support the application of the model with children from culturally and linguistically diverse communities.

6.3 More support needed for working with children with intellectual disability

Practice challenges emerged in applying the model with clients with intellectual disability. One manager also queried whether their service was the right fit for children with trauma and an ASD diagnosis, saying:

> *Sometimes, I don't think that it's necessarily that we're the most appropriate service, even if they do have trauma. And we're kind of working to try and work that out. When they have got trauma and they do also have autism, are we the best service? Maybe. But what are we going to upskill the staff members in, so they can work really effectively with that?* (M)

A second manager raised a similar challenge for service provision and a gap in what's available for children with trauma and intellectual disability. Traditionally, disability services are not resourced to address trauma and TFS psychologists are not resourced to work specifically with disability:

> *So, one of my clients at the moment has an intellectual disability, but a severe trauma history as well, so it depends I think on what they need is more a disability focus for this particular client. I even had a case of it yesterday and it's trying to figure out – you might have disability services coming but they're very behaviourally-based in their approaches and that might not necessarily fit this trauma needs. So where it's not appropriate, we do refer out because we try to say, 'Look, that's obviously not the area we specialise in.' But there are definitely times where the overlap is, you can't avoid it unfortunately.* (M)

Where possible, practitioners tried to bridge this gap by working closely with disability service providers and providing trauma training. For example, one manager told us about a client with intellectual disability who had been placed in a disability-specific residential placement. The carers in the residential home had disability-specific training but:

> *None of them had ever had trauma training. I've arranged a carer session for next week, and hopefully the majority of the carers will come and we'll do all of that together and work through trauma to give them that sort of lens. So if you've got carers who are willing, that's always the ideal.* (M)

6.4 Challenges in supervision

The TFS model relies on intensive clinical supervision. While staff found the intensive model of supervision to be very helpful, some mentioned their case load was so high that there was not enough time to discuss all their cases, as a participating practitioner described:

> *It also means that you don't get to discuss your case load, and there can be some quite higher risk children that would really need discussing but there's just not enough time to speak about everyone.* (P)

A manager reported that the growth in the team had made it harder for them to maintain the intense supervision over time without additional resources:

> *As a much smaller team, we had less people on board to supervise and oversee and they saw less clients. You often did talk about most of the clients that they would be seeing and they would be bringing more to you, because there was less to discuss. And they might – and we had paper files, but they would bring their paper files, you would get stuff out, you would look. There was a lot more oversight.* (M)

Staff also mentioned there was a tension in the supervision model whereby they were receiving supervision from someone who was their line manager:

> *So, I get supervision from someone who is also my team leader, which can present with some challenges because they're also the one who performs the performance management.* (P)
>
> *I think I've had this discussion with a few people and with management as well around sometimes some people might be worried to be open to supervision because of the issues around line management, so that's your line and your supervisor so maybe a little bit blurry around that.* (P)

6.5 Other operational challenges

Staff highlighted some operational limitations with regards to the heavy reliance on clinical supervision, mentoring and on the job training, trauma expertise of a few distributed to support the many, and reliance on a clinical administrative team and triage process that draws upon both clinical and administration efforts to manage the complex referral and funding mix.

7. Conclusion

Responding effectively to children with complex trauma is challenging and an understanding of and experience working effectively with complex trauma, is not common in the existing workforce and service system. The Royal Commission into Institutional Responses to Child Sexual Abuse (2017) found that, in Australia, there was insufficient workforce capacity to respond to the needs of survivors of abuse. The field of trauma research is rapidly developing with new insights emerging from developments in neuroscience. There is also no official diagnosis of complex trauma in the existing manuals and no single manualised approach that psychologists can implement with their clients from start to finish. Existing evidence-based practices for PTSD need to be modified for the realities of complex trauma (e.g., working with children who do not have access to an attuned caregiver, are currently not in safe living arrangements or experience repeat victimisation throughout treatment).

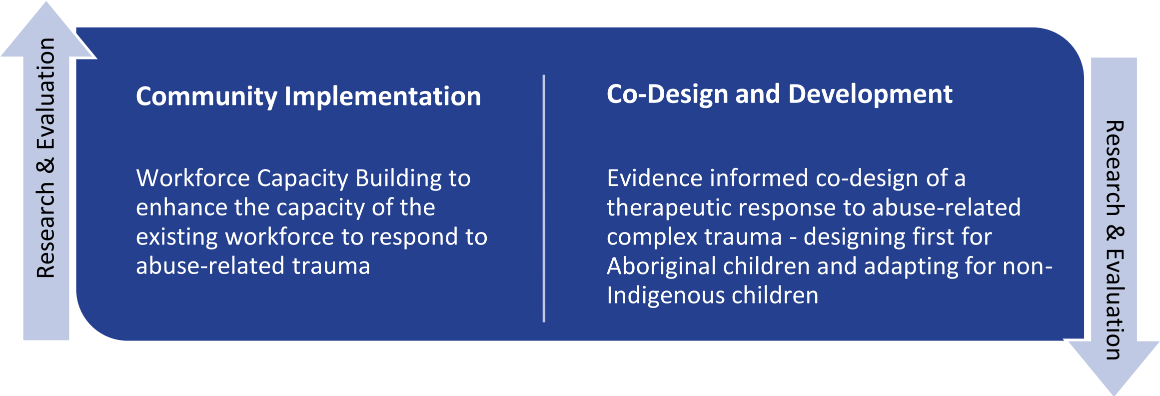
This report outlines how Parkerville CYC Inc TFS delivered (at the time of interviews) their multi-modal treatment approach to children that overwhelmingly present with multiple and complex traumas and symptomology. The model responds to a diverse range of circumstances and issues through a consultative assessment process that seeks to formulate a treatment response acknowledging the context, and matching treatment modalities to symptoms. Primarily this involves TF-CBT, but with additional therapeutic approaches to address other pertinent symptoms. In considering the treatment approach, participants primarily talked about considerations for treatment planning, identifying the range of factors that went into developing the treatment plan.

Participants outlined the implementation supports in place for the implementation of the approach, which primarily relied on recruiting psychologists with a diverse range of therapeutic approaches and experiences, training, supervision and coaching, and monitoring of treatment progress through psychometric instruments.

In terms of areas for improvement in the approach, participants indicated that they would like additional support in responding to Aboriginal children and families, and families from culturally and linguistically diverse communities, particularly as the current model relies on individual practitioner knowledge and skill. Participants also highlighted the need for more support for working with children with disability, and that this was fairly common across the clients referred to TFS. Increased access to supervision and practice support was also highlighted as important to improving the quality and consistency of the service.

APPENDIX A: PROJECT BACKGROUND

The PERCAN initiative was developed in 2019 via seed funding from Lotterywest in Western Australia. It is a joint project between Parkerville CYC Inc and ACCP to support the WA Community Services Sector build capacity and enhance responses to responding to complex trauma from child abuse and neglect.



Community Implementation

Workforce Capacity Building to enhance the capacity of the existing workforce to respond to abuse-related trauma

Co-Design and Development

Evidence informed co-design of a therapeutic response to abuse-related complex trauma - designing first for Aboriginal children and adapting for non-Indigenous children

It is within this second stream of work '**Co-Design and Development'** that this current review sits.

Co-Design and Development: Therapeutic Responses for Children with Abuse-Related Complex Trauma

The Therapeutic Responses for Children with Abuse-Related Complex Trauma Project addresses the international paucity of evidence-based complex trauma treatment models. Critically it addresses the need for responses designed for the Australian service delivery context (including regional and remote areas). The project is made up of multiple research projects. *Ngarluma, Jaru and Gooniyandi* woman, Professor Victoria Hovane is the Chief Investigator of an Aboriginal-led and evidence-informed co-design project in partnership with Yorgum Healing Services for Noongar children and their families in Perth, WA. The co-design centres Noongar knowledge of complex trauma and healing to co-design a therapeutic response for Noongar children and their families experiencing complex trauma. This first phase of the co-design project is scheduled for completion in 2022.

The anticipated outcomes of the grant are a co-designed therapeutic model for responding to complex trauma for Aboriginal children and a model for non-Indigenous children particularised and ready for trial and testing. In addition, the grant has funded several evidence and clinical reviews of existing treatments for PTSD to assess their applicability to children experiencing complex trauma. This review of Parkerville CYC Inc's TFS therapeutic treatment model forms a part of this project as it seeks to understand a therapeutic practice model that has been developed for children and young people with complex trauma.

APPENDIX B: RESEARCH DESIGN

In August 2020, Dr Sharni Chan undertook a practice mapping exercise to document the TFS therapeutic approach to the treatment of abuse and neglect related trauma in children.

Aims

The aim of this research was to document Parkerville CYC Inc's TFS therapeutic practice approach with children experiencing abuse or neglect related trauma symptoms. The research was to provide a snapshot of the therapeutic approach at a particular point in time (August 2020) with a view to informing the larger body of work under PERCAN as discussed above in the Project Background.

Research Questions

There were four general areas of enquiry.

1. **Who are the clients of Parkerville CYC Inc's therapeutic services**?
    - What are client characteristics and presentation?
    - Who are they referred by?
    - What funding stream(s) enable their service provision?
2. **What does the Parkerville CYC Inc practice approach look like from referral to closure**?
    - What is the assessment and treatment planning approach?
    - What are the components that make up the Parkerville practice approach?
        - Does the Parkerville practice approach draw upon existing practice models/approaches? If so, which ones and how?
        - How are these components similar or different to components in other evidence-based treatments/models/approaches being used with children with complex trauma? (secondary analysis using a priori coding frame developed from literature)
        - What components are used for which symptoms, which children?
    - How frequently would Parkerville clinicians treat children/young people who are living in unsafe situations?
        - Do practitioners adapt their approach when safety concerns are identified, and if so how?
    - How do Practitioners assess clients and make decisions around treatment, sequencing, frequency and duration?
    - How do Ps monitor progress and make decisions around treatment completion?
3. **What are the individual and organisational requirements to implement the approach**?
    - What P skills/capabilities/experience are needed to implement this approach?
    - What kind of supervision, professional development and organisational supports are required to support this approach?
4. **What are the systemic challenges/supports for the approach**?

Methodology

As the aim of the research was to examine the range of ways the model was articulated and collect in-depth accounts of everyday experiences of implementing the practice approach, we employed a qualitative methodology for data collection and analysis. Researchers were specifically instructed to examine the model without reference to literature or practice guidelines.

Dr Sharni Chan and Dr James Hebert conducted individual qualitative interviews with 10 psychologists who were employed on the TFS team at the time of the study and 3 psychologists who had left the TFS within the 18 months prior to the research commencing.

Interviews were semi-structured to ensure consistency as well as allow some flexibility for interviewees to contribute additional information and perspectives according to their individual experiences. Interviews were between 60 minutes and two hours with the majority of interviews taking 90 minutes.

Interviews were conducted via zoom, according to the University of South Australia's (UniSA) Covid Safety Protocols, audio recorded and professionally transcribed.

Participants

Sharni and James interviewed five clinical leads (Managers), five staff psychologists and three ex-TFS psychologists who had left the TFS team within the preceding 18 months and were still practicing psychologists. Interviewing recently departed employees has the advantage of gaining perspectives from staff whose experience of the model is fresh and who may have had the opportunity to reflect on the model in comparison to their current approach or model.

We interviewed clinical leads to identify if there was a consistent approach articulated across the leadership team and then map out what this approach looked like from referral to treatment. We interviewed non-managers to identify if this approach was replicated by staff down the chain and to identify the factors that facilitated implementation with a high degree of fidelity.

All participants were female, non-Indigenous and tertiary educated.

Interviewee	Total number
Clincal Leads – Clinical Psychologist Managers	5
Psychologists and registrars	5
Ex-Parkerville CYC Inc Psychologists	3

Recruitment

Interviewees were recruited via 'arms reach'. The Chief Investigator emailed the Clinical Director of the TFS with an invitation to participate in research and provided participant information forms. The Clinical Director forwarded this email to all clinical staff who provide therapeutic treatment to children as part of the TFS and to recent ex-employees. Psychologists could then contact the project team directly to ask questions or to volunteer their participation without the Clinical Director or other managers knowing who had opted in and who had declined.

We invited 21 currently employed Parkerville CYC Inc psychologists and 6 recent ex-employees of Parkerville CYC Inc to participate in the study. Ten psychologists who were employed in the TFS team at the time of the study and 3 recent ex-employees participated in the study.

Coding and Analysis

Sharni and James coded de-identified transcripts in NVivo12 according to a coding framework.

Sharni analysed the transcripts to report descriptive data based on client characteristics and understand the range and variety of clinical practices. This information was used to identify whether there was a consistent model or approach to therapeutic treatment, the factors that supported implementation of the approach and practice challenges.

Ethics Approval

This study has ethics approval from the University of South Australia Human Research Ethics Committee. Application number: 203058.

Interview Schedule

About the clinician	
Can you tell me a bit about your current/recent role at Parkerville CYC Inc?	Position/role Urban, regional or remote or combination Part-time/full-time Ongoing, fixed-term, casual, contractor other
Can you tell me a bit about your qualifications and professional training?	What is your highest qualification? Any other qualifications in the last 5 years/most recent qualification? Are there particular modalities you are trained in? Are there particular modalities or approaches you prefer? Or a theoretical orientation? How does this influence the way you work?
How long have you been practicing as a psychologist?	And how long at Parkerville? Or How long were you employed at Parkerville? When did you leave Parkerville?
About the children and young people	
Can you tell me about the particular client group you work with at Parkerville CYC Inc?	For example: At Parkerville, do you work with a particular age group or range? What are the kind of trauma experiences and symptoms you most commonly see in the children/young people you work with? Do you work with children/young people in OOHC? Do you work with • children/young people who have disability? • children/young people from culturally and linguistically diverse communities? • Aboriginal and or Torres Strait Islander children/young people?

What are the different referral or funding pathways for children coming into treatment at Parkerville CYC Inc?	
Assessment	
Once a child or young person is referred to Parkerville CYC Inc, what happens next?	Who typically attends the first meeting/s? What typically happens in the first meeting? When is assessment done? What assessment tools do you use? Is it always the same tools or does this vary? How long does assessment take?
Treatment choice	
Once you complete the initial assessment, what happens next?	How do you develop a treatment plan? Do you tend to use a single modality or components-based approach? What are the kinds of things that influence your treatment choice/options? For example: • client preferences • treatment guidelines/manuals • evidence-based criteria • referral/funding pathway • symptoms • past and current trauma experiences • developmental age • disability • cultural safety • safety issues Who is involved in this decision making? • Parents/carers • Child/young person • Supervisors

	• Team • Other agencies How do you know when a complex trauma response is indicated (rather than a PTSD response)?
Treatment components	
If you use a components approach, what are the different components that you use? Example components: Psychoeducation, Parenting Skills, Relaxation, Affective Modulation, Cognitive Processing, Trauma Narrative, In Vivo Desensitization, Conjoint parent-child sessions, Enhancing safety and social skills, EMDR, CBT	What components do you tend to use for which symptoms? What do you find works best for which symptoms, which children?
Sequencing	
What influences the way you sequence the different components?	For example: • Client preferences • Developmental age • Trauma experiences • Treatment manuals/guidelines • Assessments • Safety concerns • Additional disclosures What are some of the challenges you find in sequencing treatment components? How do you know when to move on from one component to another or return to a previous component?

Safety	
What do you do in the course of assessment or treatment if you find out that your client is unsafe? E.g living with FDV, parental substance abuse, exposed to harmful sexual behaviour in OOHC etc	Do you do any advocacy or service coordination work to mitigate the safety concerns, and if so, what? Do you adapt the treatment approach? If so, how? Are there some safety concerns/circumstances where treatment could not commence or continue? How common is it for you to identify safety concerns during assessment or treatment?
Parents/carers/systems	
Do you work with parents or other caregivers during treatment?	If no, why? OR If yes: How do you identify which people in the child's network to work with? How do you incorporate parents or carers? How do you approach issues of intergenerational trauma in treatment? Do you provide or facilitate a therapeutic response to parents or carers? How do you adapt the treatment approach if there is no available caregiver? How does having no available caregiver impact the treatment? How do you find having no available caregiver impacts on treatment outcomes?
Are there aspects of the treatment plan that require action for anyone else in the child's network, e.g. school, residential care home?	If so, what does this comprise? What are the challenges and supports for working within the child's network? If not, why?

Dose, duration	
How many sessions do you have with a child/young person?	How frequent are the sessions? Over how many weeks, months? What influences the intensity and length of treatment? - Funding - Assessment of progress - Other In your experience, is there an optimum or an average length and intensity of treatment?
Subsequent assessment or review	
How do you assess treatment progress and how do reviews intersect with the treatment plan?	Do you assess progress and goals during treatment? When? (triggers or changes in circumstances, regular intervals)? What tools do you use to assess progress? What are some of the challenges of assessing progress with this particular client group? How do you use the outcomes of progress review? (eg adjusting treatment plan)
Completion, discharge and re-referral	
And when is treatment complete?	What does the completion of treatment look like? How is the decision to end treatment made? Who is involved in the decision making? Do you have clients come back for further treatment after completing treatment?
Ok just changing the topic here…	
About the clinicians	
In your experience, what do you think are the most essential skills and capabilities for a psychologist to have when working with children with trauma as a consequence of abuse or neglect?	

About the organisational supports	
What organisational supports do you need to work well with children with trauma as a consequence of abuse or neglect?	Do you receive regular supervision and, professional development? Do you receive any specific cultural training or professional development? Do you receive cultural mentoring? Are there strategies for preventing/managing vicarious trauma that you are aware of? Use? Does your caseload allow you enough time to work well?
Basic demographic questions	
Before we wrap up today, can I ask you a few demographic questions?	Can I ask your age? [ABS age categories] What gender do you identify with? What is your ethnic or cultural background? Any languages other than English (including Auslan)?
Close	
Any questions or anything you wanted to go back and expand on? Anything that I haven't asked that you wanted to tell me? Interviewer to explain the next steps. Double check they know how to find the information about withdrawing from the study, contacts for more information, wellbeing information, and contact details for UniSA HREC if they have any concerns about the research.	

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