

Trauma-informed practice training program

(PIHD0002443)

Final Evaluation Report

Summary for the Health and Community Services Directorate
ACT Government

August 2025

Emerging Minds Research and Evaluation Team

This summary report is drawn from a full final evaluation report provided to the Health and Community Services Directorate, ACT Government.

This report includes quantitative data for Cohorts 1 and 2. As qualitative data for Cohort 1 was reported extensively in the Cohort 1 report (December 2024), this report includes qualitative data for Cohort 2 only.

Acknowledgements

We recognise and pay respect to Aboriginal and Torres Strait Islander peoples, their Ancestors, and Elders past, present and future from the many different Nations and lands across this country. We acknowledge the importance of connection to Land, Waters, culture, spirituality, Ancestry, family and Community for the wellbeing of all Aboriginal and Torres Strait Islander children, young people and their families.

We thank participants in the Trauma-informed practice training program for generously contributing their time, insights and reflections to this evaluation.

We recognise the diverse lived experiences of children, young people and families. We appreciate the experiences of people whose pain and trauma require recognition and compassion. We also recognise the strengths and know-how that children and families have drawn on to navigate difficult times.

1. Background

The Trauma-informed Practice Training Program was designed and delivered by Emerging Minds following a request for tender from the ACT Government for suitable training providers. The program was delivered with funding and project support from the Mental Health and Suicide Prevention Division of the Health and Community Services Directorate and has been overseen by the Youth at Risk Project Steering Committee. The aim of the program was to increase the capability of ACT Government-funded workforces to incorporate best practice, trauma-informed approaches to better respond to the mental health and wellbeing needs of children and young people.

The project recognised the importance of organisational support in enabling and sustaining practice change among professionals. It was designed to train two distinct cohorts: a group of up to 20 professionals working in a range of different roles within a single organisation (Cohort 1); and a group of professionals who were independent learners from a range of organisations within the health and community services sectors (Cohort 2).

The 16-week training program incorporated online learning, online tutorials and face-to-face workshops. The program format aimed to support participants to translate learning content to their own roles and contexts by providing opportunities for group learning and discussion.

As part of the project's *Try, Test and Learn* approach, a series of modifications were made to the program between Cohorts 1 and 2 based on the evaluation findings for Cohort 1 and the broader recruitment strategy required for Cohort 2.

Cohort 1 completed the program from July to October 2024 and Cohort 2 completed the program between February and May 2025.

2. Program participants: Cohorts 1 and 2

Non-government organisation Marymead CatholicCare Canberra and Goulburn (MCCG) was selected to participate as Cohort 1 of the project following an EoI process. A total of 15 MCCG staff completed the training program¹. They were from a range of MCCG programs and professions including administrative officers, intake officers, psychologists, mental health outreach workers and clinical youth navigators, plus a low-intensity coach, clinical lead, acting manager, director and executive director.

¹ Full details on Cohort 1 participation are reported in *Evaluation Report: Cohort 1, December 2024*. Trauma-informed Practice Training Program Final Evaluation Report Summary | August 2025

Participants in Cohort 2 were individual learners who responded to a recruitment process conducted by the Health and Community Services Directorate. The recruitment strategy sought to encourage multiple staff members from organisations to attend to encourage reflective conversations. As a result, the majority of Cohort 2 participants attended with two or more people from their service or organisation. A total of 39 participants completed the training program in Cohort 2. Participants represented a wide range of services, organisations and sectors working with children, young people and families. They held positions across varying functions and levels of seniority (see Table 1).

Table 1. Cohort 2 participants

Employer	Number of program participants
Community sector – NGO	13
Community services	8
Private sector	7
Canberra Health Services	4
ACT Health	3
ACT Education	2
ACT Human Rights Commission	2
Total	39

3. Evaluation design

A mixed-methods evaluation design was used to answer key evaluation questions. In addition to evaluating the effectiveness of the training program, the study design collected qualitative insights from participants on their experiences of participating in the program. It also looked at barriers and facilitators that have (or may) impact on participants' ability to incorporate trauma-informed practices in their roles. Additionally, the evaluation explored participants' suggestions for improvements to the training program as part of the *Try, Test and Learn* approach.

Ethics approval for the evaluation was received from the Monash University Human Research Ethics Committee.

3.1 Quantitative data

All program participants were invited to take part in two evaluation surveys, the first completed before the training program and the second completed after the completion of the program (see Table 2).

Table 2. Survey responses by cohort

Cohort	Pre-program survey responses	Post-program survey responses
Cohort 1 <i>n</i> =15 participants at program completion	12 (80%)	6 (40%)
Cohort 2 <i>n</i> =39 participants at program completion	33 (85%)	12 (31%)

Survey results were compared against Emerging Minds’ National Workforce Survey for Child, Parent and Family Mental Health (the NWS). NWS data was last collected by Emerging Minds in 2023 via online survey responses from 3,064 respondents representing more than 50 occupations in the health, social services and education sectors.

In line with the NWS, competence was calculated within the pre- and post-program evaluation surveys using participants’ self-reported scores on a seven-point Likert scale. Scores ranged from strongly disagree (1) to strongly agree (7). Scores between 6 and 7 represented a *high* level of capability; scores of 5 to 6 represented a *moderate* capability; and scores of <5 indicated uncertainty or disagreement, and therefore represented *low* capability.

Analysis of quantitative survey data was performed within Microsoft 365 Excel (Version 2409). Means (*M*), standard deviations (*SD*) and frequencies were calculated from the data for the purposes of the analysis.

3.2 Qualitative data

Focus groups were held with program participants in October 2024 and May 2025 during the final training workshop of the program. Participants were divided into groups to enable discussion relevant to different role types and allowed some comparison and triangulation of experiences across different workforce groups. For the Cohort 1 program, a focus group was also held with two Emerging Minds trainers (see Table 3).

Discussions were recorded, transcribed and thematically analysed using NVivo software. Qualitative data were collected in the post- program survey to gather any participant suggestions on program improvements, and were also imported and analysed in NVivo.

Table 3. Focus group participants

Focus group participants	Cohort 1	Cohort 2
Practitioners	7	17 (3 focus groups)
Non-practitioners/Administrative	3	
Executives, senior managers, team leaders	4	5
Peer workforce participants		3
Project and lived experience workers and advisors		5
Emerging Minds trainers	2	
Total	16	30

4. Training program impacts

4.1 Changes in knowledge

Prior to taking part in the training program, participants across the two cohorts reported low to moderate capabilities (scores of 4-6 out of 7) in trauma-informed practice knowledge and understanding. After completing the training program, participants' capabilities increased by between 15% and 30% for Cohort 1 and between 8% and 16% for Cohort 2. These increases placed participants as highly knowledgeable (scores of 6-7 out of 7) in the strengths and vulnerabilities that impact on children's mental health, and in the risks associated with adverse childhood experiences (ACEs). In understanding the signs of optimal child development, the Cohort 1 average score increased from moderate to high capability, while Cohort 2 participants increased from low to moderate on this measure (see Table 4).

While overall increases in knowledge were greater for Cohort 1 than Cohort 2, an increase in participants' knowledge over the course of the program was notable in both cohorts.

Table 4. Knowledge in trauma-informed child mental health competencies: Baseline average v post-program average

Survey items*	Cohort	Baseline ^a		Post-program ^b		Percentage change
		<i>n</i>	<i>M</i> (<i>SD</i>)	<i>N</i>	<i>M</i> (<i>SD</i>)	%
I am knowledgeable about strengths and vulnerabilities that impact on children’s mental health	Cohort 1	12	5.00 (1.04)	6	6.50 (0.55)	30.00
	Cohort 2	33	5.24 (1.13)	12	6.08 (0.64)	16.04
I have a good understanding of the signs of optimal child (cognitive and emotional) development	Cohort 1	12	5.08 (1.31)	6	6.00 (0.89)	18.11
	Cohort 2	33	4.94 (1.10)	12	5.33 (0.75)	7.98
I am knowledgeable about the risks to children’s and young people’s mental health associated with adverse childhood experiences (ACEs)	Cohort 1	12	5.50 (1.09)	6	6.33 (0.82)	15.09
	Cohort 2	33	5.67 (1.17)	12	6.50 (0.50)	14.71

*Note: Both pre- and post-program evaluation surveys included a combination of items for all participants and items specific to each stream (practitioner, non-practitioner, manager/team leader, executive/senior manager; Appendix B: Evaluation surveys)

a Number of responses and participant average score prior to undertaking the trauma-informed practice training (Cohort 1, N=12; Cohort 2, N=33)

b Number of responses and participant average score after undertaking the trauma-informed practice training (Cohort 1, N=6; Cohort 2, N=12)

Cohort 2 provided similar feedback in focus groups to Cohort 1 regarding the knowledge they gained from program participation. Common themes were that the training provided a useful theoretical framework, that it affirmed existing practices, that it provided a shared language, and built knowledge about key trauma-informed practices such as overcoming effects of secrecy, recognising acts of protest, and building agency and strengths in children and young people.

‘I think that putting language to how to work with trauma has been really helpful.’ (Cohort 2 Practitioner focus group participant)

‘It’s validated a lot of what we already do, which is really nice.’ (Cohort 2 Practitioner focus group participant)

4.2 Changes in confidence

Survey results show an increase in confidence levels for both cohorts across all measures included in the evaluation (See Table 5). The largest increase for Cohort 1 (27%) was in confidence to assist parents to form and implement strategies aimed at mitigating the impact of adversity on children’s mental health and wellbeing. The largest increase for Cohort 2 was a 26% increase in participants’ confidence to respond to disclosures of trauma from children and young people - a similar increase to that seen in Cohort 1 (27%).

Both cohorts moved from low to moderate scores in their confidence to support Aboriginal and Torres Strait Islander children, parents and families, and to identify the strengths and vulnerabilities that impact on Aboriginal and Torres Strait Islander children’s emotional and social wellbeing. While these increases are promising, they point to a need for further strengthening participants’ skills and confidence in working with Aboriginal and Torres Strait Islander children and their families. The smallest improvement for both cohorts was in participants’ confidence to adapt their practice to interact with clients from cultural backgrounds different to their own.

Table 5. Confidence in trauma-informed child mental health competencies: Baseline average v post-program average

Survey items*	Cohort	Baseline ^a		Post-program ^b		Percentage change
		<i>n</i>	<i>M (SD)</i>	<i>n</i>	<i>M (SD)</i>	%
I feel confident assisting parents or other trusted adults to develop and use strategies that mitigate the impact of adversity on children’s mental health wellbeing	Cohort 1	9	4.33 (1.58)	4	5.50 (0.58)	26.92
	Cohort 2	24	4.79 (1.19)	10	5.30 (0.78)	10.61
I am confident in the way I respond to children and	Cohort 1	8	5.13 (0.83)	4	6.50 (0.58)	26.83

young people who disclose their experiences of trauma	Cohort 2	17	5.12 (1.13)	9	6.44 (0.68)	25.93
Within my role, I am confident in responding to children and young people that have experienced trauma and adversity	Cohort 1	12	5.17 (1.11)	6	6.50 (0.55)	25.81
	Cohort 2	31	5.35 (0.86)	12	6.00 (0.91)	12.05
I feel confident in my role to provide trauma-aware, healing informed care to Aboriginal and Torres Strait Islander children, parents and families	Cohort 1	12	4.42 (1.08)	6	5.50 (0.84)	24.53
	Cohort 2	31	4.32 (0.96)	12	5.25 (0.83)	21.46
I am confident in talking to parents about risk factors to their children's mental health	Cohort 1	9	4.67 (1.32)	4	5.75 (0.50)	23.21
	Cohort 2	24	5.08 (1.11)	10	5.80 (0.98)	14.10
I feel confident in identifying the strengths and vulnerabilities that impact on Aboriginal and Torres Strait Islander children's emotional and social wellbeing	Cohort 1	12	4.83 (0.58)	6	5.50 (0.84)	13.79
	Cohort 2	32	4.66 (1.08)	12	5.42 (0.64)	16.33
I feel confident adapting my work practices to work with families who come from social or cultural backgrounds that are dissimilar to mine	Cohort 1	12	5.75 (1.14)	6	5.83 (0.75)	1.45
	Cohort 2	32	4.94 (1.14)	12	5.25 (0.72)	6.33

*Note: Both pre- and post-program evaluation surveys included a combination of items for all participants and items specific to each stream (practitioner, non-practitioner, manager/team leader, executive/senior manager; Appendix B: Evaluation surveys)

a Number of responses and participant average score prior to undertaking the trauma-informed practice training (Cohort 1, N=12; Cohort 2, N=33)

b Number of responses and participant average score after undertaking the trauma-informed practice training (Cohort 1, N=6; Cohort 2, N=12)

In focus groups, most participants in Cohort 2 described increased confidence in their practice, including: confidence to ask more questions; confidence to respond to disclosures of trauma; feeling more confident to challenge assumptions; feeling more confident to support children’s and young people’s strengths and agency.

‘I feel more confident in the questions I’m asking young people when providing peer support ...’ (Cohort 2 Peer worker focus group participant)

‘Especially when children make disclosures and being trauma-informed about that, and also acknowledging the strengths in the child ... I do think it was beneficial, and I do think it will be brought into my practice.’ (Cohort 2 Practitioner focus group participant)

4.3 Changes in self-reported skill levels

There were high levels of self-reported improvement for both cohorts in skills specific to trauma-informed child mental health competency (see Table 6). While Cohort 2 experienced more modest improvements than Cohort 1, Cohort 2 recorded improvements of 14% to 38%. These increases were important as both cohorts reported low capabilities on almost all skill-related survey items at baseline.

There were large improvements in both Cohort 1 (39%) and Cohort 2 (38%) in having successful strategies to support children and young people navigate their feelings of self-blame and secrecy after a traumatic experience. Both cohorts rated themselves most highly on their ability to reflect on and modify their practice when responding to a child and caregiver’s sense of safety related to their experience of trauma.

Table 6. Skills in trauma-informed child mental health competencies: Baseline average v post-program average

Survey items*	Cohort	Baseline ^a		Post-program ^b		Percentage change
		<i>n</i>	<i>M</i> (SD)	<i>n</i>	<i>M</i> (SD)	%
I feel ready to provide trauma-informed mental health support to infants, children and young people following disasters or critical incidents	Cohort 1	9	4.11 (1.90)	4	5.75 (0.50)	39.86
	Cohort 2	23	3.83 (1.46)	10	4.80 (1.08)	25.45

I am able to explore with Aboriginal and Torres Strait Islander families the hope they have for their child's social and emotional wellbeing	Cohort 1	9	3.78 (1.30)	4	5.25 (0.50)	38.97
	Cohort 2	22	4.41 (1.11)	10	5.80 (1.08)	31.55
I have successful strategies for supporting children and young people to move beyond feelings of self-blame and secrecy following trauma	Cohort 1	8	4.50 (0.71)	4	6.25 (0.50)	38.89
	Cohort 2	16	4.19 (1.24)	9	5.78 (1.13)	37.98
I know how to apply a strengths-based approach that incorporates the culturally specific protective factors for Aboriginal and Torres Strait Islander families	Cohort 1	12	4.50 (1.24)	6	6.17 (0.75)	37.04
	Cohort 2	32	4.38 (0.99)	12	5.42 (1.04)	23.81
I am able to reflect on and modify my behaviours or practices in response to a child and caregiver's sense of safety related to their experience of trauma	Cohort 1	12	5.50 (1.00)	6	6.33 (0.52)	15.15
	Cohort 2	33	5.27 (0.71)	12	6.00 (0.91)	13.79

*Note: Both pre- and post-program evaluation surveys included a combination of items for all participants and items specific to each stream (practitioner, non-practitioner, manager/team leader, executive/senior manager; Appendix B: Evaluation surveys)

a Number of responses and participant average score prior to undertaking the trauma-informed practice training (Cohort 1, N=12; Cohort 2, N=33)

b Number of responses and participant average score after undertaking the trauma-informed practice training (Cohort 1, N=6; Cohort 2, N=12)

In focus groups, Cohort 2 participants expressed differing views on whether the program sufficiently equipped them with the specific trauma-informed skills they needed in their work settings. While some participants felt they had gained highly-relevant skills, others felt the skills gained were less relevant and difficult to apply to their roles (see further discussion in Section 5).

‘I’ve done training for CBT for trauma, and I run a trauma group ... but to actually sit down and do role plays, ask questions in a curious way, and focusing less on the feeling side of things, and instead the storytelling and making sense of it, I think has been great. I don't think you learn that at uni.’ (Cohort 2 Practitioner focus group participant)

‘With the strategies, there was some that I thought, “Oh yeah, I could word it like that.” That's a really good way to, even in kinship assessments.’ (Cohort 2 Practitioner focus group participant)

‘But the things I took away weren't necessarily things that I can use in my everyday... in the field working with clients.’
(Cohort 2 Practitioner focus group participant)

4.4 Impact on participants’ work practices

The translation of knowledge, confidence and skills into an individual’s work practices (behaviour change) can vary according to a person’s role, previous professional training and degree of organisational support.

In focus groups, participants identified a range of changes they were already making in the way they were working, as well as changes or improvements they would like to make in the future.

Practice changes identified	Indicative quotes
Recognising and promoting the strengths, knowledge and agency of children and young people	‘So I asked, “What do you think it says about you that you’re able to get through that time and that you’re surrounding yourself with really great people now?” And they were like, “I’m really proud of myself ...”’ (Cohort 2 Peer workforce focus group participant)
Being curious about a child and asking more questions to better understand a child’s or young person’s context and story	‘I might not have sat there in that space as long or before I would’ve been like, “Yes, yes, of course,” and then moved on. But this has made me think maybe sit with that a bit more and unpack it a bit more. And I found new things, different things come out. So that's helpful and useful.’ (Cohort 2 Practitioner focus group participant)

Slowing down and taking time to allow space for storytelling and sense making	'Being less prescriptive about the things that I absolutely want to do during a session or during the first three or four sessions.' (Cohort 2 Practitioner focus group participant)
Recognising and being more understanding of the role that trauma may play in shaping parents' and caregivers' behaviours	'I think it is helpful because we can actually apply that similar lens to the parents and sort of understand where their behaviours ... come from, from their own trauma, and then obviously adjust the way we talk to them and how we see them.' (Cohort 2 Practitioner focus group participant)
Demonstrating greater empathy, respect and understanding in case notes and other documentation	'... writing my case notes and things like that, having a better understanding of their behaviours ... and having a bit more empathy in the way I write about them, because essentially it's their story...it's something that I envision myself doing a bit more outside of this training.' (Cohort 2 Practitioner focus group participant)
Considering how practice development and education can incorporate trauma awareness across a wide range of topics	'It started to get me to think more actively about when I'm teaching a topic ... on documentation, on risk assessment on every other topic under the sun ... How can I apply all of this to make the way I teach that, and the way it's teaching someone how to do a risk assessment. For example, how do we do that in a way that perhaps might be at least more trauma-aware? How can it shift across all the areas of education?' (Cohort 2 Practice educator in Practitioner focus group)

Survey data show increases post-program in the extent that training participants were using core trauma-informed practices, including engaging parents, children and young people in discussions about mental health and social and emotional wellbeing (see Table 7). This is despite both cohorts including participants in roles with limited opportunity to directly engage with children or parents and caregivers.

Importantly, participants in both cohorts 1 and 2 increased their scores from moderate to high in terms of demonstrating trauma-informed care in their work practices with children, young people and/or parents

The extent of improvement measured on the survey's practice items were mostly smaller than improvements measured in knowledge, confidence and skills. This is to be expected as practice changes are impacted by a wider range of variables than other post-program impacts.

Table 7. Practice in trauma-informed child mental health competencies: Baseline average v post-program average

Survey items*	Cohort	Baseline ^a		Post-program ^b		Percentage change
		<i>N</i>	<i>M</i> (SD)	<i>n</i>	<i>M</i> (SD)	%
I regularly talk with parents about the impact of their own mental health or other difficulties or adversities on their parenting	Cohort 1	9	4.22 (2.11)	4	5.00 (2.16)	18.42
	Cohort 2	23	5.13 (1.70)	8	5.38 (1.93)	4.77
Within my role, I demonstrate trauma-informed care in my work practices with children, young people and/or parents	Cohort 1	12	5.83 (0.94)	6	6.67 (0.52)	14.29
	Cohort 2	32	5.31 (1.26)	12	6.25 (0.92)	17.65
I regularly talk with children and young people about their social and emotional wellbeing	Cohort 1	9	6.22 (0.83)	4	7.00 (0.00)	12.50
	Cohort 2	22	5.68 (1.33)	10	6.50 (0.50)	14.40

*Note: Both pre- and post-program evaluation surveys included a combination of items for all participants and items specific to each stream (practitioner, non-practitioner, manager/team leader, executive/senior manager; Appendix B: Evaluation surveys)

a Number of responses and participant average score prior to undertaking the trauma-informed practice training (Cohort 1, N=12; Cohort 2, N=33)

b Number of responses and participant average score after undertaking the trauma-informed practice training (Cohort 1, N=6; Cohort 2, N=12)

Encouragingly, the average survey score on participants' intent to apply learning from the training program to their work practices was high for Cohort 1 ($M=7.00$ $SD=0.00$) and Cohort 2 ($M=6.67$, $SD=0.85$).

4.5 Participants’ perceptions of organisational support

Overall, Cohort 2 reported lower levels of organisational support than Cohort 1 (see Table 8). Both before and after the training program, Cohort 2 participants reported moderate support from their organisations to promote child and youth mental health and to engage in trauma-informed practices with children and young people.

In Cohort 1, participants reported a 13% increase in access to support to manage their own mental health. However, Cohort 2 reported no change in their access to support following the training program. This finding may indicate that for Cohort 1 the organisation’s authorising environment was strengthened by participating in the program as a group, whereas for Cohort 2, individual participation did not translate into organisational changes.

By contrast, there was a small but greater increase in the level of collaboration reported for Cohort 2 (6%) than for Cohort 1 (1%). Both groups reported high levels of collaboration post-program but Cohort 1 had higher levels both pre- and post-program. The slightly higher increase in collaboration post-program for Cohort 2 may have been influenced by the opportunity to interact over the course of the training program with fellow participants from other organisations, sectors and professions.

Table 8. Organisational support in trauma-informed child mental health competencies: Baseline average v post-program average

Survey items*	Cohort	Baseline ^a		Post-program ^b		Percentage change
		<i>n</i>	<i>M</i> (SD)	<i>n</i>	<i>M</i> (SD)	%
I can access systems of support that can help me in my workplace to manage the impacts of my work with children, young people and families on my own mental health	Cohort 1	12	5.75 (1.36)	6	6.50 (0.84)	13.04
	Cohort 2	33	5.39 (1.41)	12	5.42 (1.75)	0.42

I feel supported in my workplace to implement culturally informed work practices to better support the social and emotional wellbeing of Aboriginal and Torres Strait Islander children, young people, parents and families	Cohort 1	12	5.42 (1.73)	6	6.00 (1.10)	10.77
	Cohort 2	33	5.21 (1.22)	12	5.75 (1.16)	10.32
The way my organisation operates enhances my capacity to operate in a trauma-informed, child-focused way	Cohort 1	12	5.83 (1.11)	6	6.17 (0.75)	5.71
	Cohort 2	32	5.16 (1.50)	12	5.50 (1.19)	6.67
I regularly collaborate with other professionals or co-workers to support child and young people's mental health	Cohort 1	12	6.08 (1.00)	6	6.17 (0.98)	1.37
	Cohort 2	32	5.72 (1.30)	12	6.08 (1.19)	6.38
My current organisation is supportive of practices to promote children's and young people's mental health	Cohort 1	12	6.50 (0.80)	6	6.33 (0.82)	-2.56
	Cohort 2	33	5.82 (1.19)	12	5.92 (0.95)	1.69

*Note: Both pre- and post-program evaluation surveys included a combination of items for all participants and items specific to each stream (practitioner, non-practitioner, manager/team leader, executive/senior manager; Appendix B: Evaluation surveys)

a Number of responses and participant average score prior to undertaking the trauma-informed practice training (Cohort 1, N=12; Cohort 2, N=33)

b Number of responses and participant average score after undertaking the trauma-informed practice training (Cohort 1, N=6; Cohort 2, N=12)

5. Challenges of a diverse cohort

Cohort 2 included a larger number and wider range of professionals than Cohort 1 and therefore a wider range of participant learning needs.

Cohort 2 participants reported that the accessible language and concepts presented in the training worked well across many of their settings. They also highlighted how the training material provided a foundational, evidence-based approach to trauma-informed practice that many participants felt complemented their existing professional practice frameworks.

However, some groups of participants found the program more relevant than others. Participants in roles that are not client-facing described difficulty with applying learning to their roles. Practitioners working in crisis response or highly time-pressured roles described finding it difficult to envisage how some practices could be translated to their settings. This included child protection, intake and assessment, outreach, and family and kinship liaison workers.

‘We are in people's lives for a short time ... and that's how it should be, so I guess building that rapport, which is so important, is really hard. I think a lot of even the roleplays in the online modules are clinicians who've seen these clients [for] like 10 weeks.’ (Cohort 2 Practitioner focus group participant)

Executive level participants felt that there was insufficient program content that applied to their roles in seeking to embed trauma-informed approaches into workforce development, policy direction and service improvement. Participants in lived experience roles experienced some pressure from drawing upon personal experiences to respond to case study discussions and reflections.

Participants doing client-facing work with greater opportunity for ongoing therapeutic contact found the program highly relevant to their roles. This included psychologists and participants in the peer workforce.

‘I think the broader approach has been really helpful for me. It doesn't tell us specifically what to say and how to respond...but it does then change the way that I do case formulation, the way that I talk to parents, and the kinds of conversations that I might choose to have inside of a session with a child or an adolescent...’ (Cohort 2 Practitioner focus group participant)

Differences in the perceived relevance of the program appear to have made it more difficult for some participants than others to translate learning into usable practices in their service settings (see Table 9).

Table 9. Perceived relevance of training program by workforce groups

More relevance	Less relevance
<ul style="list-style-type: none"> • Early career practitioners • Clinicians engaged in ongoing therapeutic practice with opportunity for longer client contact periods • Peer workforce professionals with opportunity for longer client contact periods 	<ul style="list-style-type: none"> • More experienced clinicians practising within particular theoretical and practice frameworks • Organisational and government leaders and policy professionals • Project workers • Lived experience advocates • Practitioners in crisis response roles

6. Additional outcomes for Cohort 2

While the mixed group of individual learners in Cohort 2 had its challenges, Cohort 2 participants identified additional outcomes from the training that were not as apparent in Cohort 1.

6.1 Confidence to advocate

A strong theme in Cohort 2 compared with Cohort 1 was increased advocacy confidence, with many Cohort 2 participants saying they felt better equipped to advocate for trauma-informed practices in a range of ways including:

- advocating for better care for children and young people
- advocating for organisational changes that better support people with experiences of trauma
- drawing upon their trauma-informed practice knowledge for grant submissions, workforce training and policy development.

‘...it makes me feel ... confident. And I guess stronger in fighting and advocacy for trauma-informed work and policies.’ (Cohort 2 Peer worker focus group participant)

‘... training has made me be even more confident in how important it is to continue to advocate to do things in a trauma-informed way, whether I'm advocating to my own bosses, any other government system, any other person.’ (Cohort 2 Practitioner focus group participant)

Participants highlighted that the accessible framing of trauma-informed practice gave them a language and evidence-base with which to advocate, supporting them to voice their experiences and values. This was identified as an important enabler for advocacy within their workplace, with their colleagues and in their policy context.

‘I feel like it's given us more credibility ... So it's really supporting us in that sense. It's going to be really useful.’ (Cohort 2 lived experience focus group participant)

Advocacy may have been less important for Cohort 1 participants, who attended the program with other members of their organisation including senior leaders.

6.2 Seeing trauma-informed practice as a collective responsibility

A clear theme identified in Cohort 2 focus groups was a strong sense of the need to work together to improve the trauma responsiveness of practices, organisations and systems.

Participants reported that they valued the opportunity the program provided to connect with professionals from a range of sectors with a common interest in making services for children and young people safer and more effective.

‘Isn't that reassuring that there's other people out there ... sometimes you don't see enough of those people that have the same views.’
(Cohort 2 Practitioner focus group participant)

‘I got some really great networks ... and met some really great people.’
(Cohort 2 Practitioner focus group participant)

Related to this sense of shared responsibility was also a view among many Cohort 2 participants that foundational trauma-informed practices could be utilised by a wide range of practitioners and non-practitioners. Participants saw the program content, particularly the five practice shifts, as providing guidance that could be useful across roles (with some modifications in some circumstances) in health and community services. There was a widely-held view that broad workforce training in trauma-informed practices could help improve service experiences for children and young people.

‘I think that's been a real high point on this training ... is that kind of understanding that it's not just the privatised therapy room that this work can be done in ... It's kind of like everybody's business. I think that's been a key outcome of this work. So I think that's been a really powerful thing that you don't often hear enough of, is that we mob can

do this work. And specialist trauma counsellors can do another piece of work, but there’s a whole bunch of work in the safety and stabilisation space that’s really important for everybody to be across.’
(Cohort 2 Executives focus group participant)

‘If everyone was on the same page about trauma-informed care and practice, I feel like everyone’s job would be so much easier and the outcomes would be so much better.’
(Cohort 2 Practitioner focus group participant)

These sentiments, generated by the mix of professions and organisations in Cohort 2, represent an additional positive program outcome for Cohort 2 compared with the single-organisation Cohort 1.

7. Enablers and challenges for implementing and sustaining trauma-informed practices

Qualitative data from the Cohort 2 focus groups and the post-program evaluation survey identified a range of factors that participants believed could enable or challenge their ability to incorporate and sustain more trauma-informed practices into their roles (see Table 10).

Table 10. Enablers and challenges to incorporating and sustaining trauma-informed practices

*Identified by participants in both cohorts

Level impacted	Enabling factors
Practitioner level	*Seeing what trauma-informed practice looks like
	Doing training with team member/s to discuss how it applies to your work
	*Developing a relationship with the child, young person or family
	Practice tools that are accessible in-situ for both brief and longer-term interactions
	Having the opportunity to consolidate skills through practice
	Patience and persistence
Organisation level	*Regular reflective individual supervision and group supervision
	*Team collaboration and opportunities to discuss cases with colleagues in ways that are collegiate and non-blaming
	*Senior management being knowledgeable about trauma-informed practices

	Organisation having some form of accountability in relation to its trauma-informed practices
	In private psychology practice, offering concession rates for appointments beyond the 10 Medicare-rebated appointments
	Regular lunch-time in-sessions to discuss trauma-informed practices
System level	*Having shared language to articulate and discuss trauma-informed practices
	Trauma-informed continuity of care across different service providers
	Earlier intervention to support children and young people with multi-disciplinary services
Challenges	
Practitioner level	Working in crisis response roles where there is limited time to formulate plans and establish relationships
	Statutory requirements of a role limiting ability to build trust with a child, young person or family
	Needing to get through a high volume of cases and not having time to build relationships
	Time not being made available to plan and implement new approaches
	Workforce wellbeing affected by practice and/or advocacy demands
Organisation level	Others in the organisation not believing they have a role to play in trauma-informed services
	*Lack of trauma awareness and understanding at leadership level
	*Administrative procedures and forms not being trauma-informed and difficult to change
	*Limited resources for implementing trauma-informed practices
	Lack of time and resources limiting practitioners' capacity to work with children, young people and families in a trauma-informed way
	Organisations saying or believing they're trauma-informed when that might not be the case
System level	Different languages and terminology being used across different professions
	Children or young people reaching a crisis point before getting support
	Diagnosis-driven funding dictating type and amount of support available
	Balancing legislative, criminal and relational/trauma-informed obligations and principles
	Focusing on compliance rather than relationships
	Fractured relationships between service providers
	*Insufficient services to meet demand

8. Comparison of survey data to Emerging Minds' National Workforce Survey data

Comparison with average scores from Emerging Minds' National Workforce Survey (NWS) data provides a national comparison and an additional measure of program impact.

8.1 Knowledge

Prior to the training program, participants in both cohorts self-reported scores below, or just on, the national average for their knowledge about the strengths and vulnerabilities that influence child mental health, cognitive and emotional development, and the risks of adverse childhood experiences. However, by the completion of the program, participants' knowledge had increased to levels above, or just on, the national average (Figures 1-3).

Figure 1. 'I am knowledgeable about strengths and vulnerabilities that impact on children's mental health': Baseline average and post-program average v national average

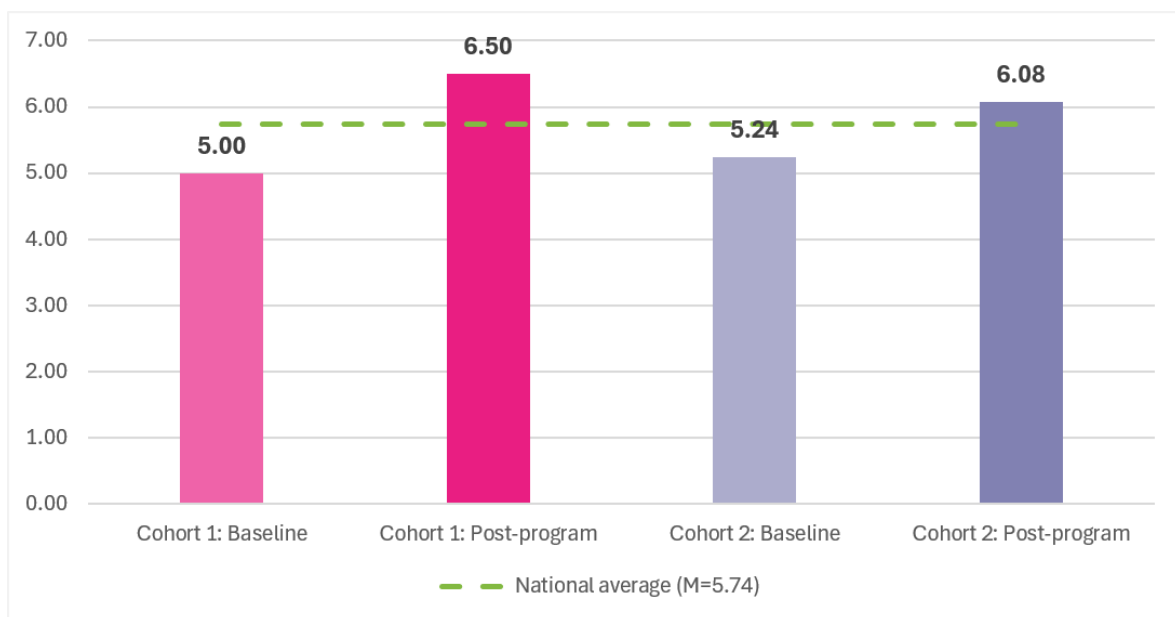


Figure 2. 'I have a good understanding of the signs of optimal child (cognitive and emotional) development': Baseline average and post-program average v national average

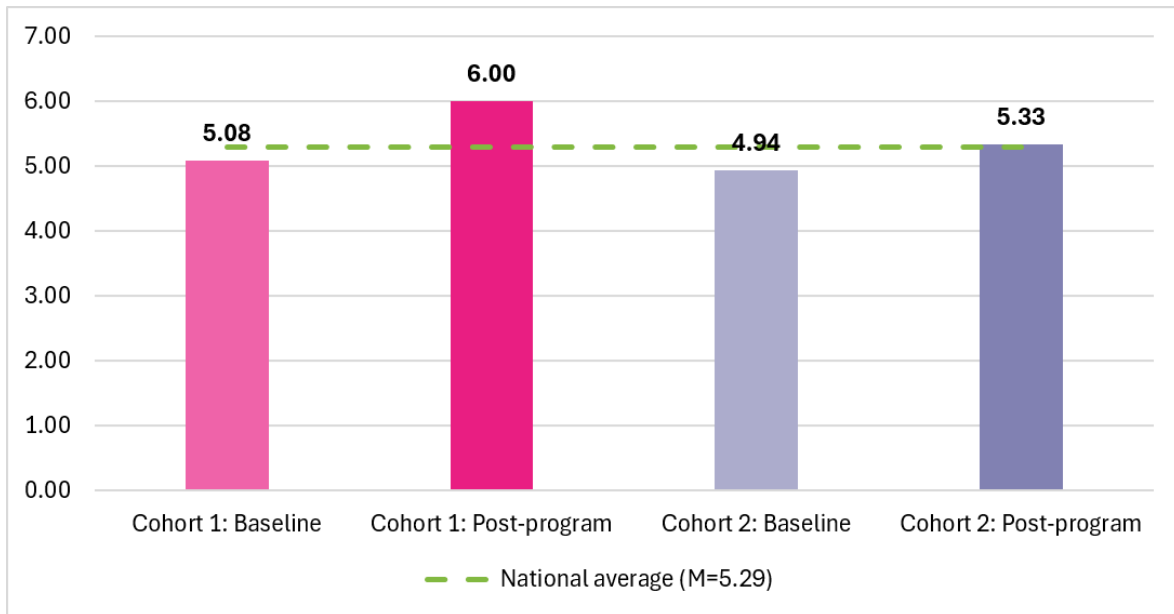
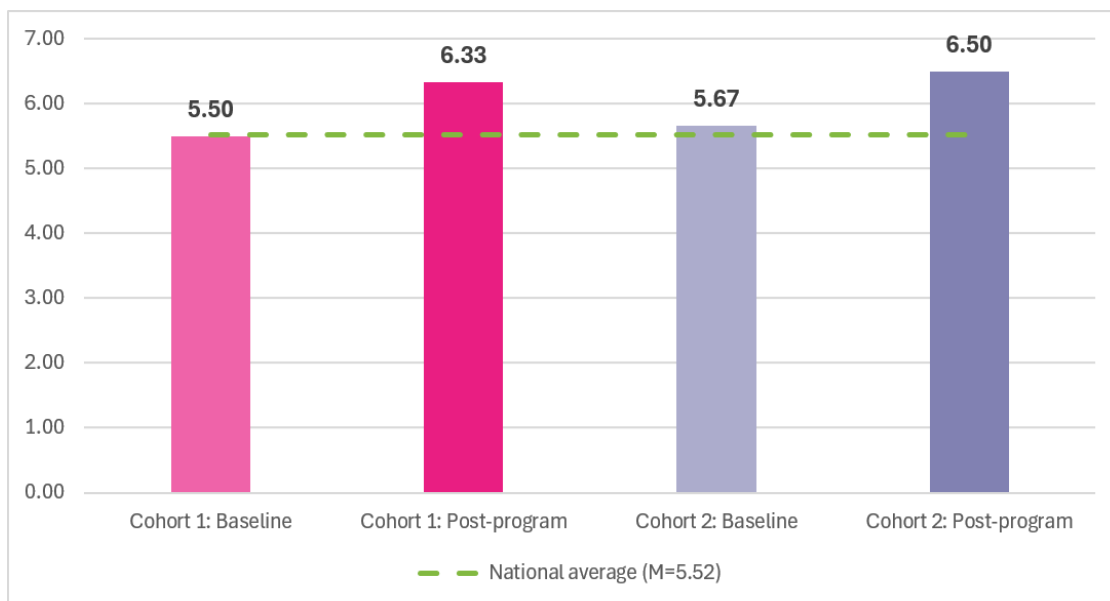


Figure 3. 'I am knowledgeable about the risks to children's and young people's mental health associated with adverse childhood experiences (ACEs)': Baseline average and post-program average v national average



8.2 Confidence

Participant confidence to engage in trauma-informed child mental health practices was often below that of the national average at baseline but increased to align with or surpass national levels post-program (Figures 4-9).

Participants reported increased levels of confidence across all survey items. However, there continues to be room for improvement in increasing practitioners' confidence to work with parents, people from diverse cultural backgrounds, and Aboriginal and Torres Strait Islander families.

Figure 4. 'I feel confident assisting parents or other trusted adults to develop and use strategies that mitigate the impact of adversity on children's mental health wellbeing': Baseline average and post-program average v national average

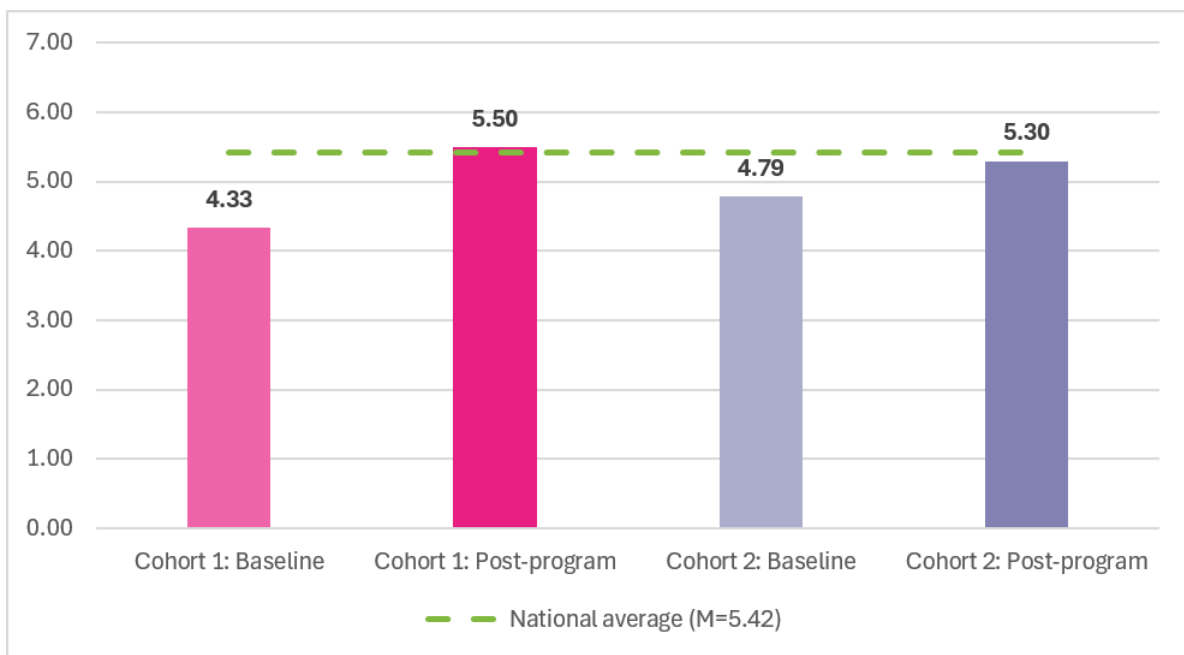


Figure 5. 'Within my role, I am confident in responding to children and young people that have experienced trauma and adversity': Baseline average and post-program average v national average

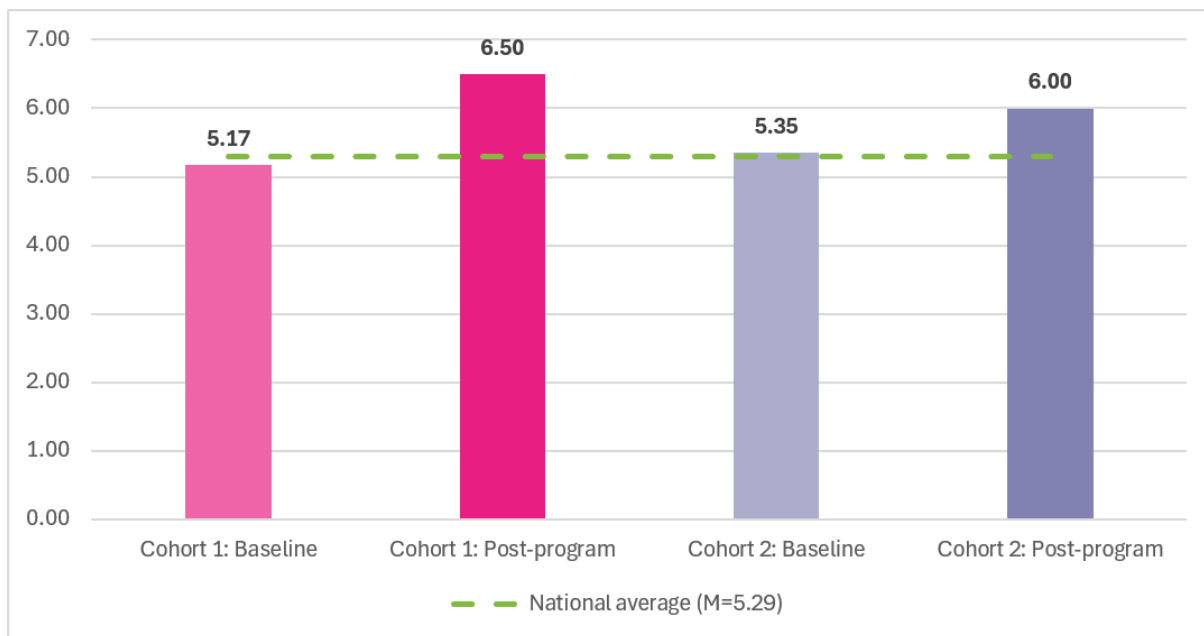


Figure 6. 'I feel confident in my role to provide trauma-aware, healing-informed care to Aboriginal and Torres Strait Islander children, parents and families': Baseline average and post-program average v national average

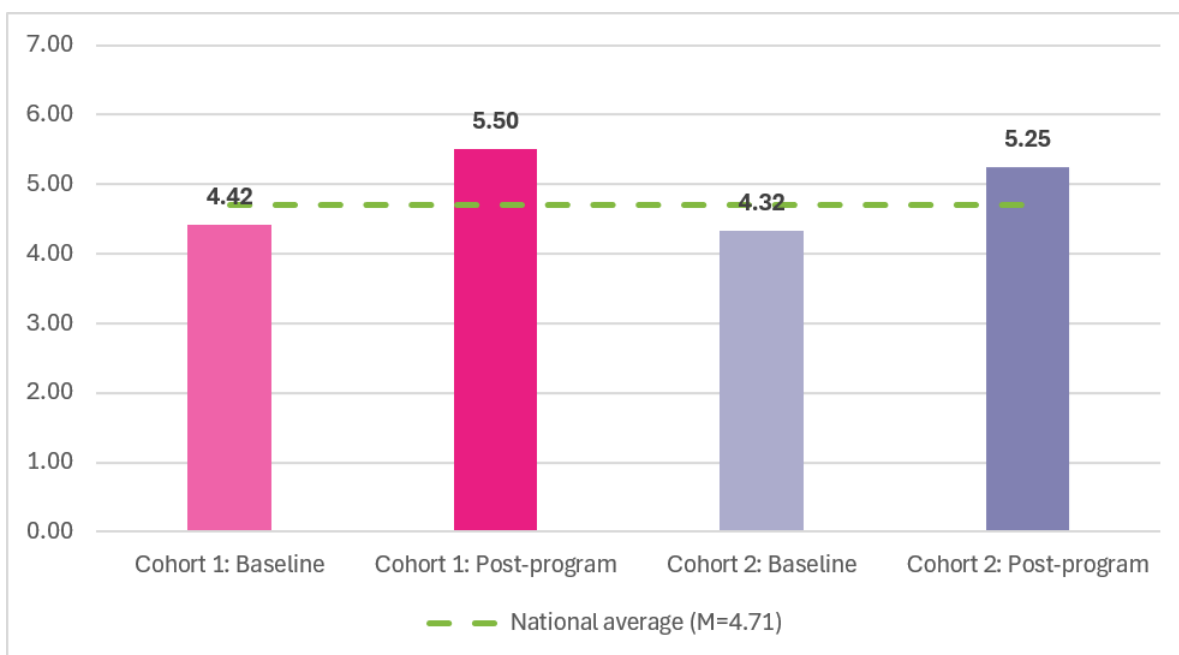


Figure 7. 'I am confident in talking to parents about risk factors to their children's mental health': Baseline average and post-program average v national average

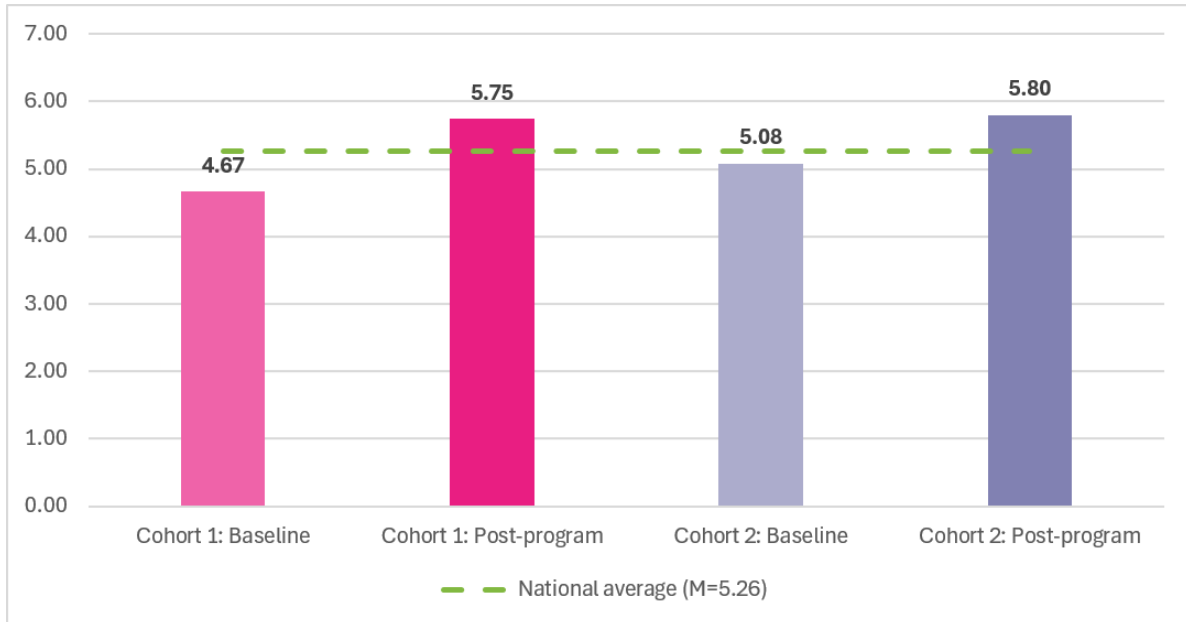


Figure 8. 'I feel confident in identifying the strengths and vulnerabilities that impact on Aboriginal and Torres Strait Island children's emotional and social wellbeing': Baseline average and post-program average v national average

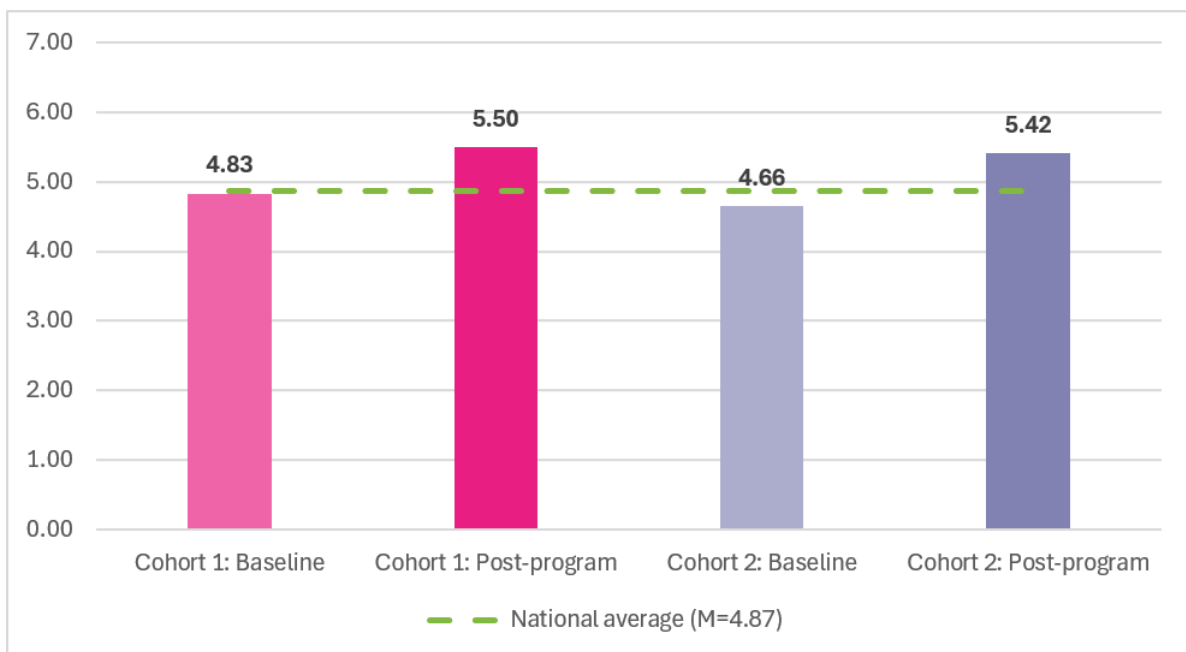
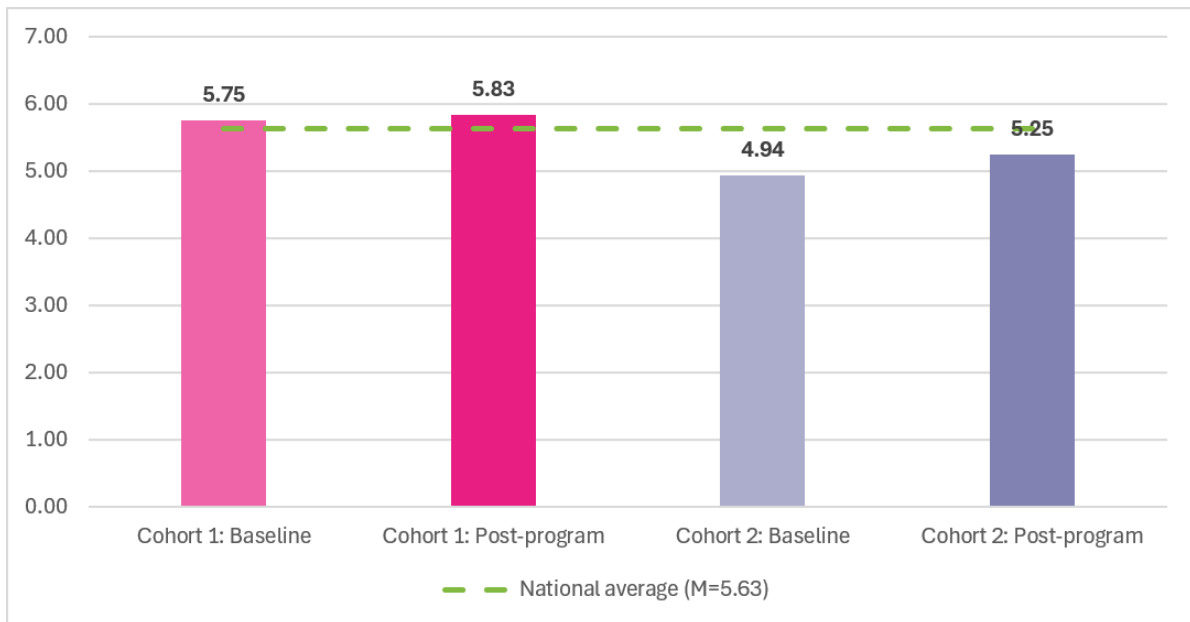


Figure 9. 'I feel confident adapting my work practices to work with families who come from social or cultural backgrounds that are dissimilar to mine': Baseline average and post-program average v national average



8.3 Skills

On survey items measuring trauma-informed skills to support the mental health and wellbeing of children and young people, participants in both cohorts 1 and 2 rated themselves below national averages prior to the training program. However, at the completion of the program, both cohorts felt better equipped across key skills and rated themselves above the national averages on all included competencies (see figures 10-13).

Figure 10. 'I feel ready to provide trauma-informed mental health support to infants, children and young people following disasters or critical incidents': Baseline average and post-program average v national average

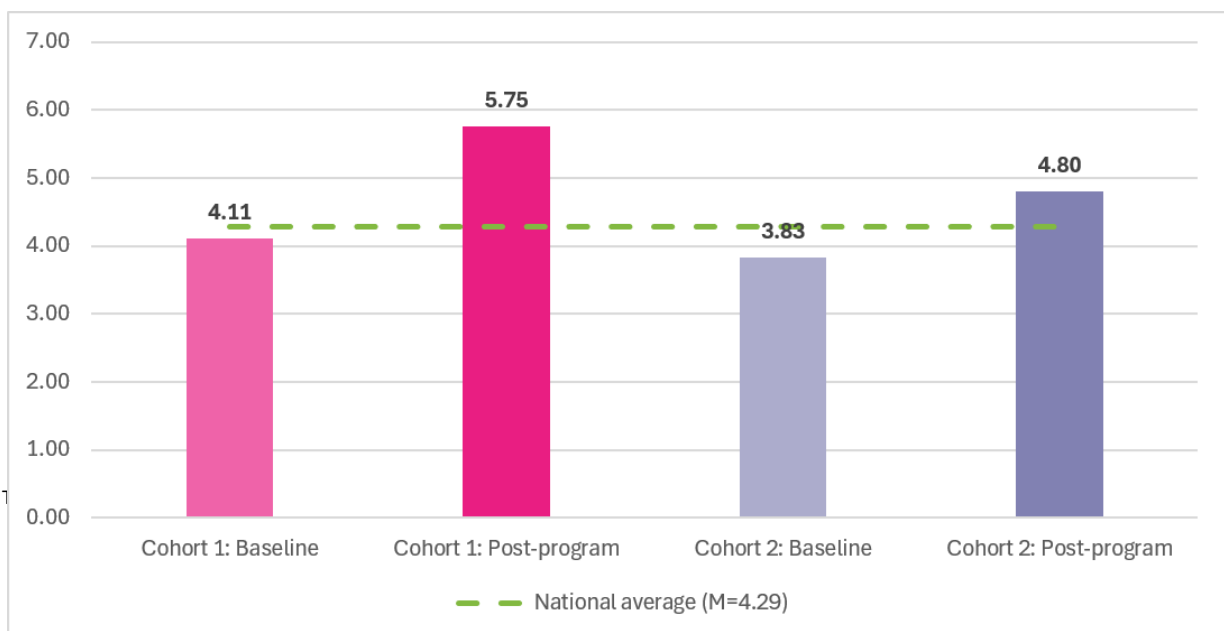


Figure 11. 'I am able to explore with Aboriginal and Torres Strait Islander families the hope they have for their child's social and emotional wellbeing': Baseline average and post-program average v national average

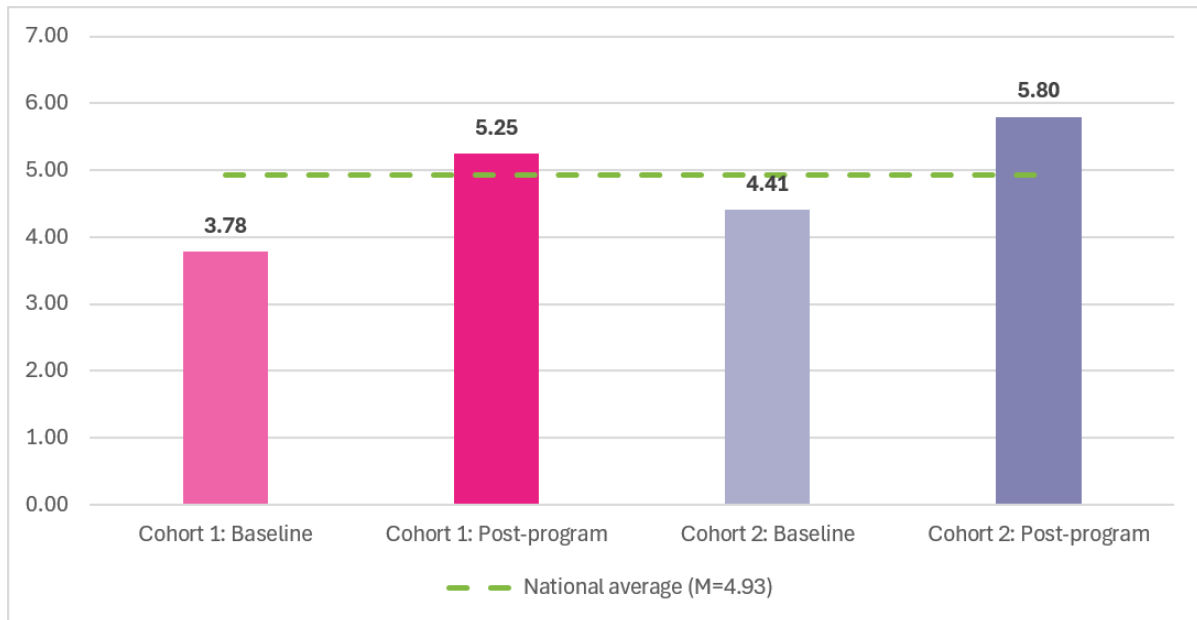


Figure 12. 'I know how to apply a strengths-based approach that incorporates the culturally specific protective factors for Aboriginal and Torres Strait Islander families': Baseline average and post-program average v national average

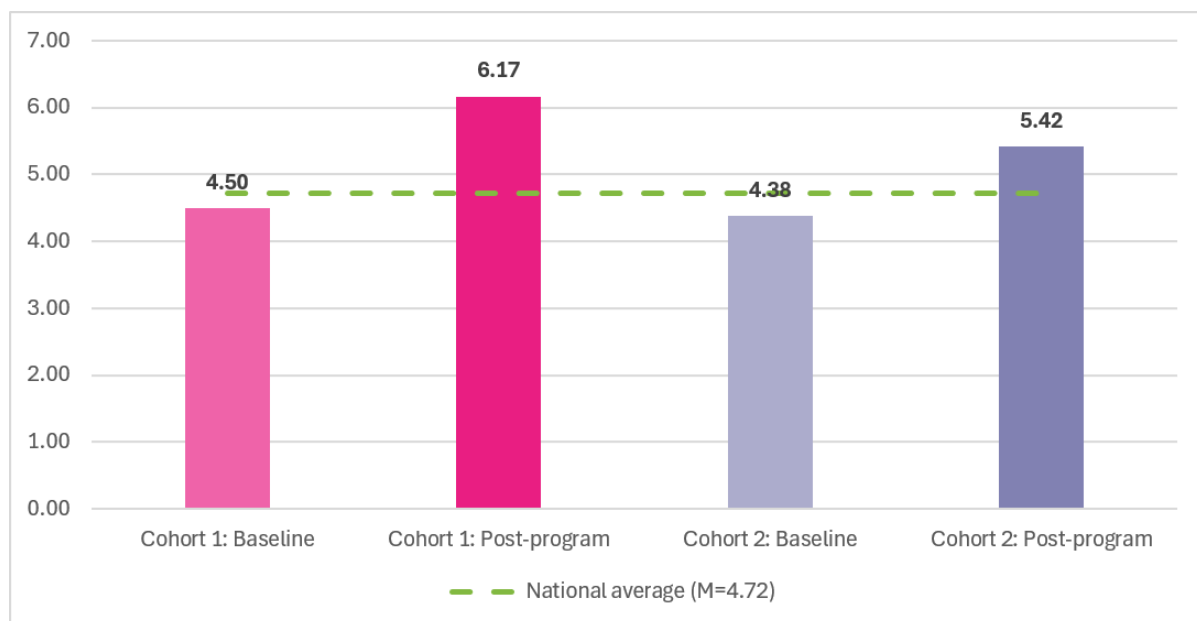
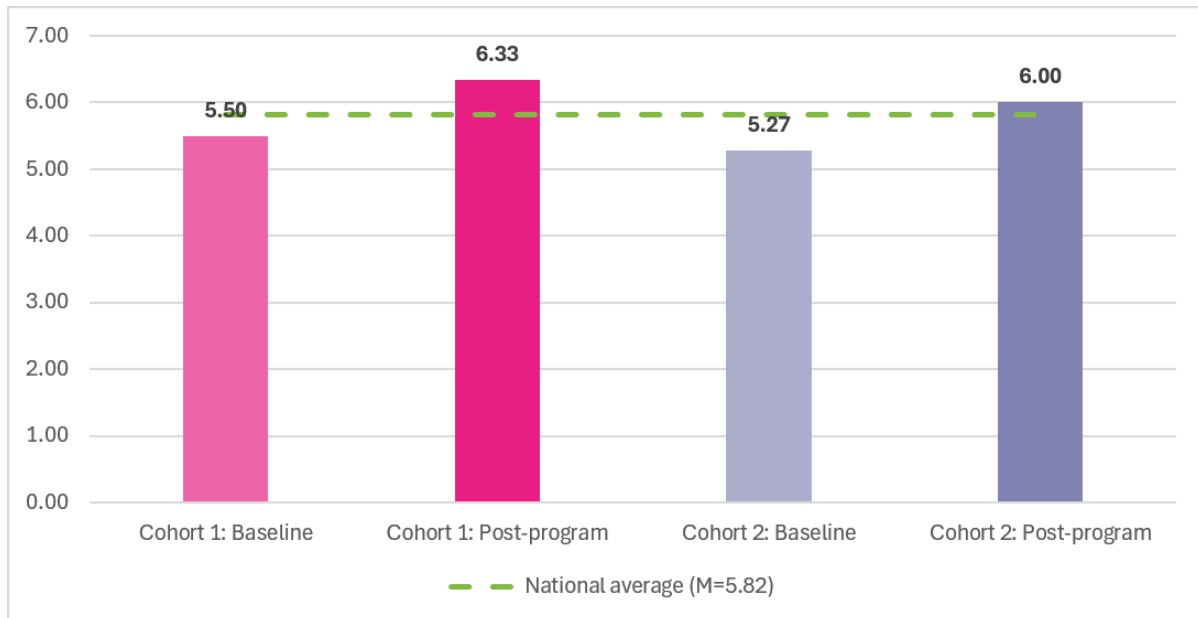


Figure 13. 'I am able to reflect on and modify my behaviours or practices in response to a child and caregiver's sense of safety related to their experience of trauma': Baseline average and post-program average v national average



8.4 Practice

By the conclusion of the training program, cohorts 1 and 2 reported that they were engaging in core trauma-informed child mental health practices at or greater than the national averages (Figures 14-16). Participants in both cohorts reported increases in the regularity with which they spoke with parents, children and young people about their mental health and wellbeing, and reported demonstrating trauma-informed care in their practice to a high level.

Figure 14. 'I regularly talk with parents about the impact of their own mental health or other difficulties or adversities on their parenting': Baseline average and post-program average v national average

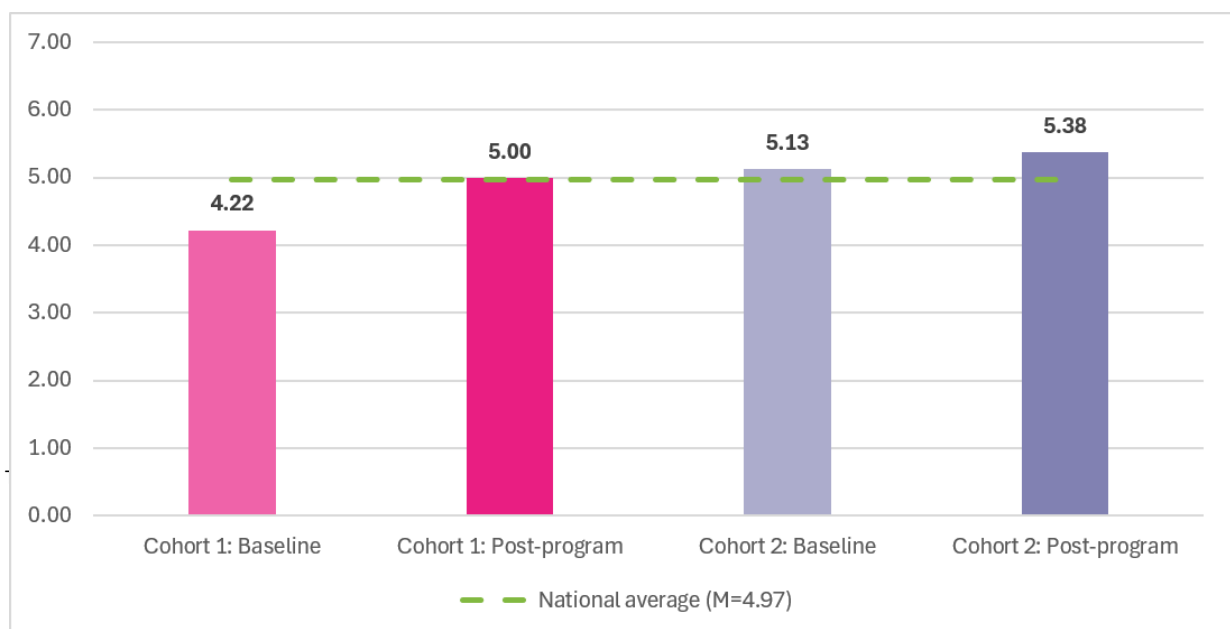


Figure 15. 'Within my role, I demonstrate trauma-informed care in my work practices with children, young people and/or parents': Baseline average and post-program average v national average

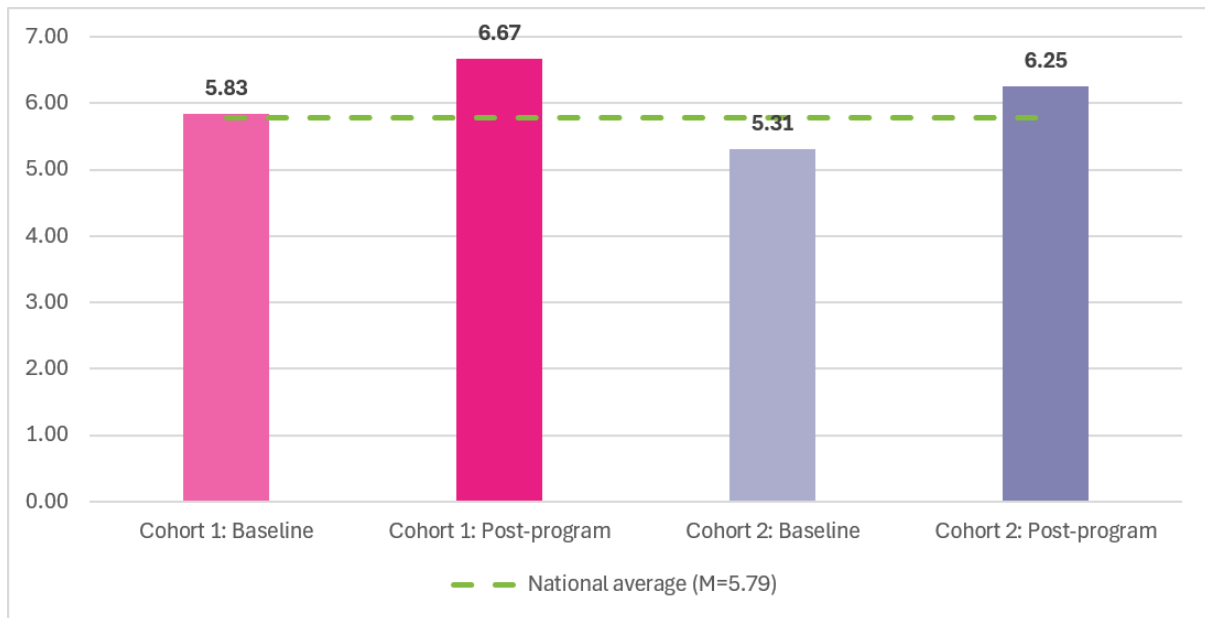
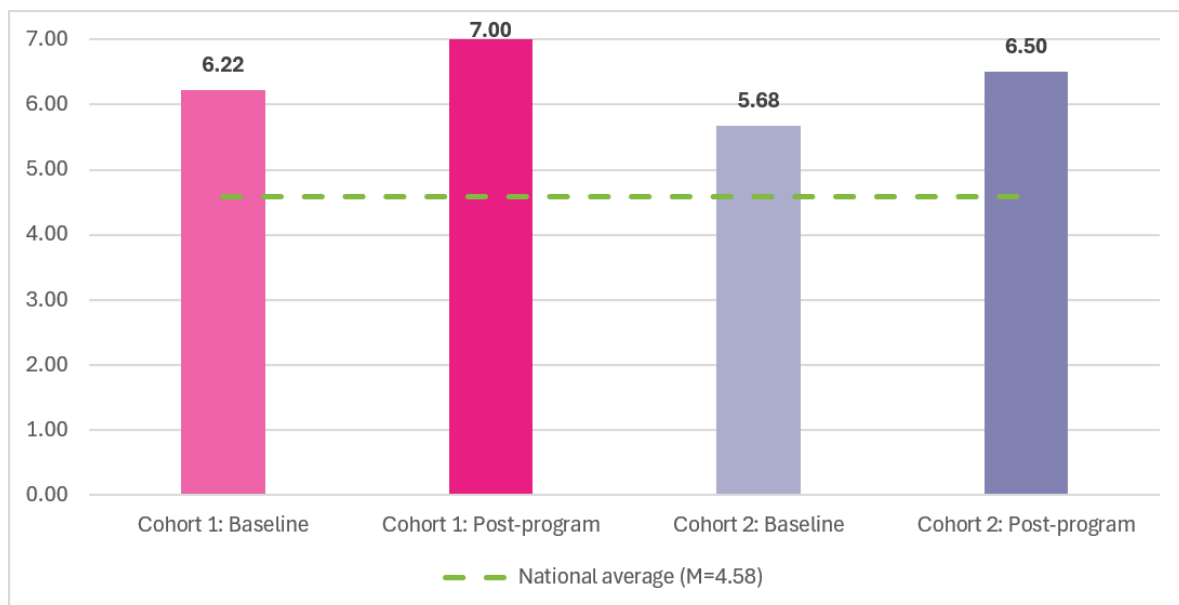


Figure 16. 'I regularly talk with children and young people about their social and emotional wellbeing': Baseline average and post-program average v national average



8.5 Perceived organisational support

Cohort 1 participants reported high levels of organisational support both before and after the training program. In contrast, participants in Cohort 2 reported levels of organisational support that fluctuated below and just above national averages before the training program, with modest improvements by the end of the program (see figures 17-21).

Access to systems of support to help participants manage the impact of their work on their mental health remained below the national average for Cohort 2, even after the program had concluded.

The difference in results between the two cohorts appears to point to the importance of an organisational approach to trauma-informed practice training that fosters a supportive work environment from which to build a trauma-informed organisational culture.

Both cohorts reported higher-than-average levels of professional collaboration both before and after the training program.

Figure 17. 'I can access systems of support that can help me in my workplace to manage the impacts of my work with children, young people and families on my own mental health': Baseline average and post-program average v national average

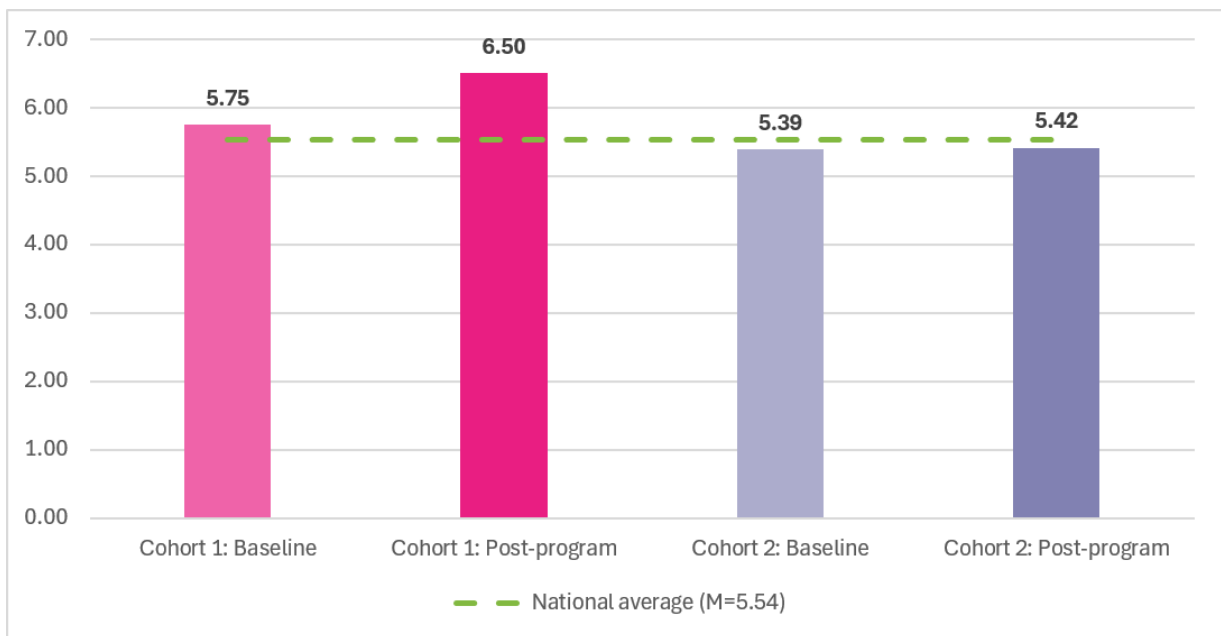


Figure 18. 'I feel supported in my workplace to implement culturally informed work practices to better support the social and emotional wellbeing of Aboriginal and Torres Strait Islander children, young people, parents and families': Baseline average and post-program average v national average

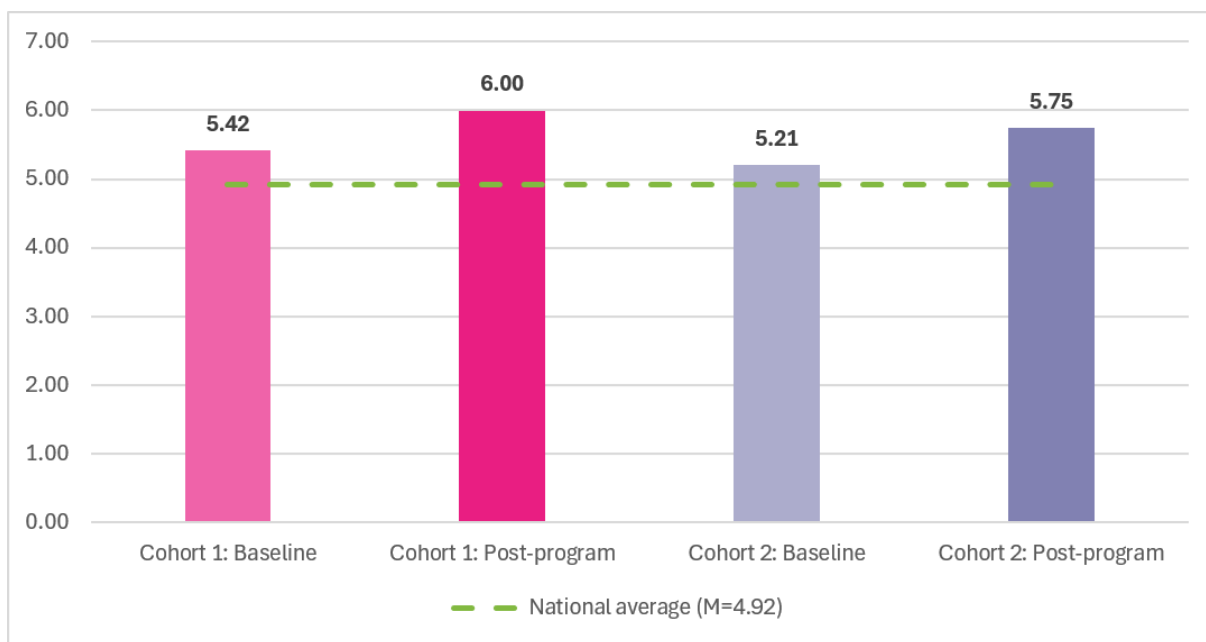


Figure 19. 'The way my organisation operates enhances my capacity to operate in a trauma-informed, child-focused way': Baseline average and post-program average v national average

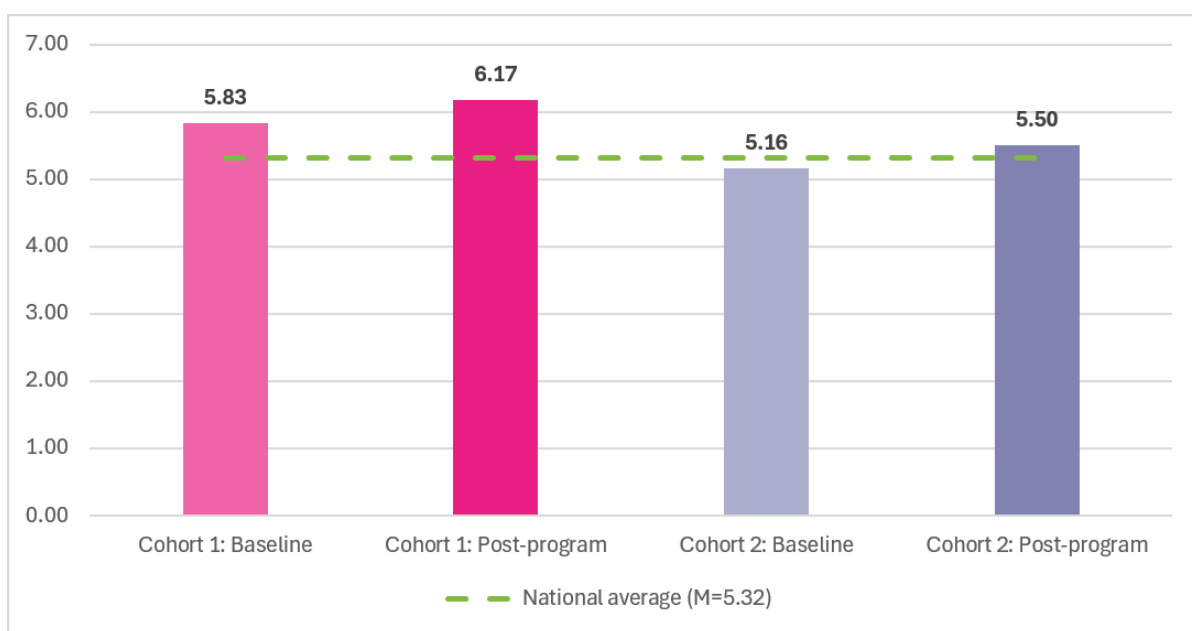


Figure 20. ‘I regularly collaborate with other professionals or co-workers to support child and young people’s mental health’: Baseline average and post-program average v national average

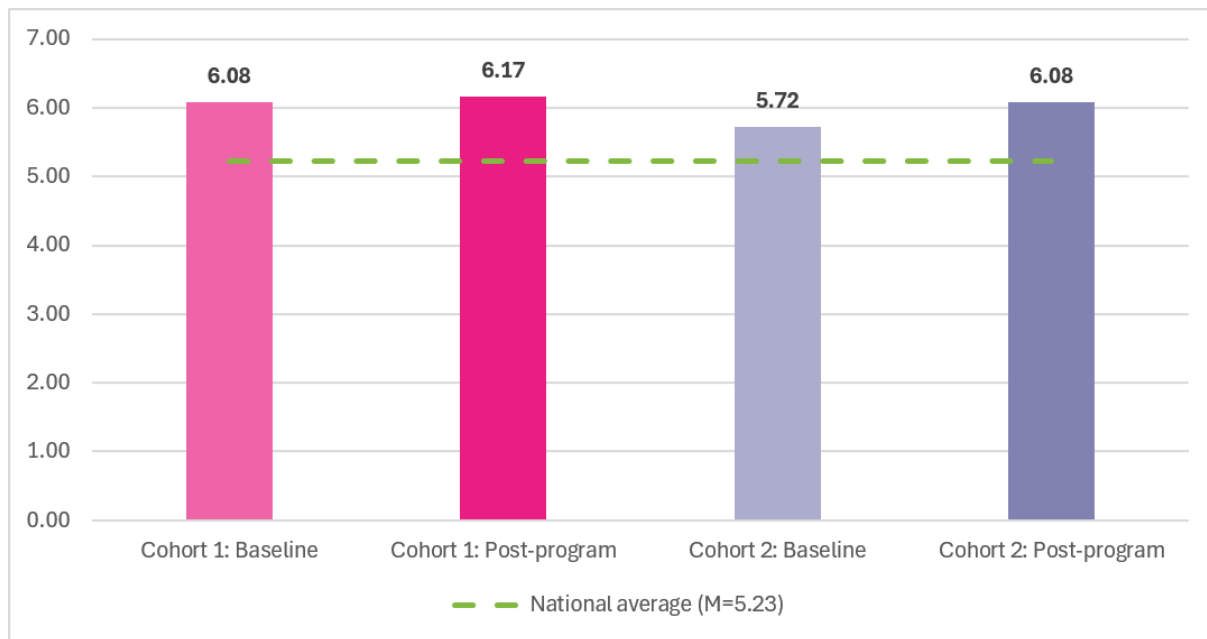
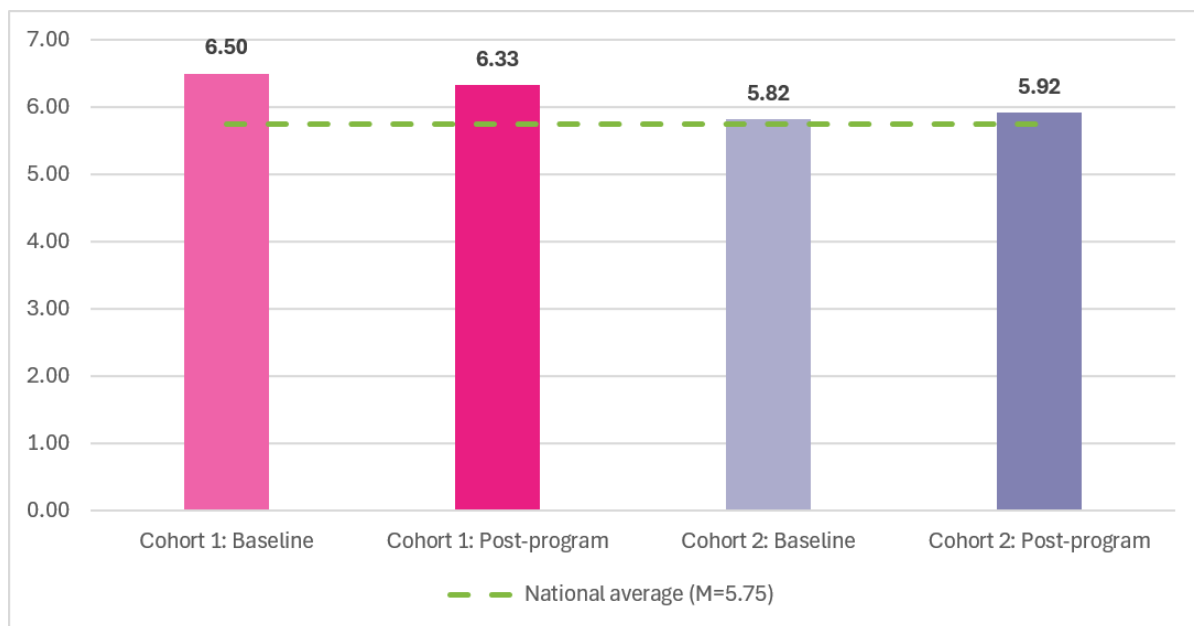


Figure 21. ‘My current organisation is supportive of practices to promote children’s and young people’s mental health’: Baseline average and post-program average v national average



9. Conclusions

Both quantitative and qualitative evaluation data demonstrated positive impacts on cohorts 1 and 2 following completion of the Trauma-informed Practice Training Program.

Survey data measured improvements in participants' knowledge, confidence, skills and trauma-informed practices when working with children and young people, with favourable results across all these impact areas when compared with national averages.

Qualitative data provide details of participants increasing their skill in relational practice, agency building, storytelling and sense-making, responding to disclosures of trauma and addressing the effects of secrecy. Many participants described trauma-informed changes to their practices.

Improvements were measured in participants' capability to work with parents, Aboriginal and Torres Strait Islander families, and culturally diverse families, but there is opportunity for further strengthening in these areas of competence.

Cohort 2 of independent learners reported lower organisational support for trauma-informed and child mental health practices than the single-organisation Cohort 1, highlighting the benefits of an organisational approach to professional development for creating an authorizing environment for practice improvement.

The diversity of Cohort 2 brought the additional challenge of meeting a wider range of professional development needs. While some participants in particular roles found the learning difficult to apply in their positions, there was agreement among participants that the training provided a widely-applicable foundational theoretical model for trauma-informed practice with children and young people, a shared language to enable professional collaboration, and reinforcement or development of existing skillsets.

Cohort 2 participants described additional outcomes from the training, including increased knowledge and confidence to advocate for trauma-informed practices and policies in their workplaces, and a recognition of a collective responsibility for improving services for children and young people with experience of adversity and trauma. These would seem to be positive workforce attributes for promoting sector-wide trauma-informed care.

The *Try, Test and Learn* approach of this program has driven a strong improvement focus by the Health and Community Services Directorate and Emerging Minds, with program modifications between Cohorts 1 and 2 improving important aspects of participants' learning experiences resulting in complimentary responses from participants.

10. Recommendations for consideration

1. Continue to provide common training program content for all program participants to support shared foundational learning in knowledge and skills and the development of common language alongside opportunities for cross-disciplinary learning.
2. Include more tailored content and learning strategies – including case studies, small group discussions and facilitated reflection opportunities - for specific workforce groups.
3. For practitioners working in high-pressure settings, increase focus on skills that can be used in crisis situations, when there is limited engagement, or when there is a statutory component to the interaction (i.e. risk of harm or suicidality).

These practitioners also expressed a need for practice tools such as tips and quick guides for use in situations where an urgent response is required.

4. Provide more opportunities for executive level participants to engage in facilitated sessions on implementing trauma-informed principles and practices at organisational and structural levels. This could include relevant content on implementation science.

Executive level participants may also benefit from a more condensed program.

5. Consider the inclusion of advanced clinical skills content for experienced practitioners qualified in a particular modality of practice looking to incorporate trauma-informed approaches into existing practice frameworks.
6. Further consultation with lived experience advocates/advisors on learning objectives and facilitation approaches that would support increased understanding among all participants of lived experiences of trauma, while limiting any burden on lived experience participants when sharing personal stories.
7. Further training to support practitioners in working with Aboriginal and Torres Strait Islander families and families from culturally diverse backgrounds.
8. Given the range of professions within the trauma response workforce, add an explicit learning outcome for the program on the translation of trauma-informed practices into diverse therapeutic and non-therapeutic settings to help ensure broad relevance for the program.