Emerging Minds.

National Workforce Centre for Child Mental Health

ACT Health
Trauma informed practice training program

(PIHD0002443)

Evaluation findings: Cohort 1

Summary for ACT Health

December 2024

Emerging Minds Research and Evaluation Team

Acknowledgements

We recognise and pay respect to Aboriginal and Torres Strait Islander peoples, their Ancestors, the 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 the staff of Marymead CatholicCare 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.

This summary is prepared for ACT Health drawn from a full evaluation report on Cohort 1 also provided to ACT Health.

December 2024

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1. Background

The Trauma-Informed Practice Training Program was delivered by Emerging Minds following a request for tender from the ACT Government for suitable training providers. The program is being delivered with funding and project support from the Mental Health and Suicide Prevention Division of ACT Health and has been overseen by the department's Youth at Risk Project Steering Committee. The aim of the program has been to increase the capability of ACT Health-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 recognises the importance of organisational support in enabling and sustaining practice change among professionals. Following an expression of interest process, Marymead CatholicCare Canberra and Goulburn (MCCG) was selected as the organisation to participate as Cohort 1 of the project and 15 MCCG employees completed the program over July-October 2024.

The 16-week trauma-informed practice training program was designed and delivered by Emerging Minds to scaffold and provide a curriculum approach to support learning and application of Emerging Minds' online practice development courses. The program format aimed to support participants to translate online learning content to their own role and context by providing opportunities for group learning and discussion. The program was also designed to support an organisational culture of trauma-responsiveness across all roles and functions within MCCG.

2. Evaluation design

A mixed-methods evaluation design was used to answer key evaluation questions. This was done by seeking to identify impacts resulting from participation in the program at both the individual professional and at the organisational levels, as well as collecting insights from participants on their experiences of participating in the program. The evaluation also examined 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 of the project. Ethics approval for the evaluation was received from the Monash University Human Research Ethics Committee.

Quantitative data

All program participants (*n*=15) were invited to take part in two evaluation surveys, the first completed before the training program and the second completed post-program. Data was collected for the first evaluation survey from 3 July to 10 July 2024. A total of 12 participants (80% of program participants) completed the pre-program evaluation survey, wherein they self-reported ratings on their knowledge, confidence, practice and workplace support. The second survey aimed to understand participant perspectives of the training, and capture changes in knowledge, confidence, practice and workplace support after the training program. Of 10 participants who started the post-program evaluation survey between 16 October 2024 to 30 October 2024, four responses were

excluded from analysis due to missing data. The data from six participants (40% of program participants) who completed the post-training evaluation survey were included in the final analysis.

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 professionals representing more than 50 occupations in the health, social services and education sectors.

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.

Qualitative data

Focus groups were held with program participants 15–16 October 2024 during the final training workshop of the program. Participants were divided into three groups: (practitioners; non-practitioners/administrative; and team leaders/managers/executives). This helped enable discussion relevant to different role types and allowed some comparison and triangulation of experiences across different role types. Two Emerging Minds trainers were also interviewed to understand the design, intentions and delivery of the training program.

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

Evaluation participants

A total of 12 participants (80% of all participants) took part in the pre-program evaluation survey. Of these, eight were practitioners, two were non-practitioners, one was a team leader/manager, and one a senior manager/executive. Six participants (40% of all participants) completed the post-program evaluation survey, of which, four were practitioners, one was a non-practitioner and one a senior manager/executive.

A total of 16 people participated in focus group discussions, including 14 of the 15 training program participants and the two Emerging Minds trainers.

Focus group participants

Practitioners	7
Non-practitioners/Administrative	3
Team leaders and Executive	4
Emerging Minds trainers	2
Total	**16**

3. Evaluation findings – training program impacts

Across both quantitative and qualitative data this evaluation shows improvements in participants' post-training knowledge and confidence in trauma-informed practice skills for working with children, young people and parents. Survey and focus group data also show strong intent among participants to apply knowledge and skills from the training to their own practice contexts. In terms of practice (behaviour) change, survey data show increased use of core trauma-informed practices, while focus group data provide examples of participants already engaging in practice changes. Additionally, data indicate an increase in participants' positive perceptions of organisational support for trauma-informed practices to support the mental health of children and young people.

Although the number of post-survey responses was small (*n*=6), it represents 40% of program participants and is consistent with qualitative data on impacts of the training program.

Comparison with Emerging Minds' National Workforce Survey data provides an additional measure of program impact, with MCCG program participants scoring above the national average for all survey items across a range of trauma-informed practice competencies following completion of the training program.

3.1 Changes in knowledge about trauma-informed practices

Quantitative survey data show that prior to taking part in the training program, participants reported moderate capabilities (scores of 5–6 out of 7) in trauma-informed knowledge and understanding. After completing the training program, participants' capabilities increased between 15% and 30%. This increase placed participants as highly knowledgeable (scores of 6–7 out of 7) about the strengths and vulnerabilities that impact on children's mental health, cognitive and emotional development, and in the risks associated with adverse childhood experiences (ACEs).

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

Survey items*	Baseline[a]		Post-program[b]		Percentage change
	n	*M* (SD)	*n*	*M* (SD)	%
I am knowledgeable about strengths and vulnerabilities that impact on children's mental health	12	5.00 (1.04)	6	6.50 (0.55)	30.00
I have a good understanding of the signs of optimal child	12	5.08 (1.31)	6	6.00 (0.89)	18.11

(cognitive and emotional) development					
I am knowledgeable about the risks to children's and young people's mental health associated with adverse childhood experiences (ACEs)	12	5.50 (1.09)	6	6.33 (0.82)	15.09

*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)

[a] Cohort 1 number of responses and participant average score prior to undertaking the trauma-informed practice training (*n=12*)

[b] Cohort 1 number of responses and participant average score after undertaking the trauma-informed practice training (*n*=6)

This positive change in knowledge is consistent with findings from the focus groups, in which all participants were of the view that they had increased their understanding of trauma-informed practice. Some participants had gained new knowledge about the effects of trauma on children and young people and how to recognise and respond to this in a trauma-informed way. Some participants felt they were able to identify and better articulate their existing views and practices that were trauma informed and saw potential to build on this.

> I've definitely gained a lot of knowledge … from the videos, I'm seeing approaches of psychologists and learning those practical skills within those videos. I think that was very, very valuable for me. (Practitioner focus group participant)

> I think this training has been helpful for me in that it's made me realise, I think most of the stuff that we do as psychologists is very trauma-informed ... (Practitioner focus group participant)

3.2 Changes in confidence and skill

An important outcome of the training program was that participants' confidence in their ability to provide trauma-informed care strengthened, moving participants from feeling moderately confident to highly confident.

A 27% increase in confidence was reported for participants responding to disclosures of trauma from children and young people. Confidence also rose considerably among participants to engage with parents. Participants also reported feeling more confident to work with Aboriginal and Torres Strait Islander children, parents and families by providing trauma-aware and healing-informed care.

Participants reported a minimal shift in their confidence to adapt their practice when interacting with clients from cultural backgrounds different to their own, remaining moderately confident in this capability.

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

Survey items*	Baseline[a]		Post-program[b]		Percentage change
	n	*M* (SD)	*n*	*M (SD)*	%
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	9	4.33 (1.58)	4	5.50 (0.58)	26.92
I am confident in the way I respond to children and young people who disclose their experiences of trauma	8	5.13 (0.83)	4	6.50 (0.58)	26.83
Within my role, I am confident in responding to children and young people that have experienced trauma and adversity	12	5.17 (1.11)	6	6.50 (0.55)	25.81
I feel confident in my role to provide trauma-aware, healing informed care to Aboriginal and Torres Strait Islander children, parents and families	12	4.42 (1.08)	6	5.50 (0.84)	24.53
I am confident in talking to parents about risk factors to their children's mental health	9	4.67 (1.32)	4	5.75 (0.50)	23.21
I feel confident in identifying the strengths and vulnerabilities that impact on Aboriginal and Torres Strait Islander children's emotional and social wellbeing	12	4.83 (0.58)	6	5.50 (0.84)	13.79
I feel confident adapting my work practices to work with	12	5.75 (1.14)	6	5.83 (0.75)	1.45

families who come from social or cultural backgrounds that are dissimilar to mine					

*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)

[a] Cohort 1 number of responses and participant average score prior to undertaking the trauma-informed practice training (*n=12*)

[b] Cohort 1 number of responses and participant average score after undertaking the trauma-informed practice training (*n*=6)

After completing the training program participants reported notable increases in their trauma-informed child mental health skillset. Survey data shows participants improved their ability in core trauma-informed skills including responding to a child and caregiver's sense of safety, supporting children and young people to move beyond feelings of self-blame and secrecy following trauma, and readiness to provide trauma-informed mental health support to children and young people following disasters or critical incidents. Participants also reported considerable increases in their trauma-informed skills for working with Aboriginal and Torres Strait Islander children and families.

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

Survey items*	Baseline[a]		Post-program[b]		Percentage change
	n	*M* (SD)	*n*	*M (SD)*	%
I feel ready to provide trauma-informed mental health support to infants, children and young people following disasters or critical incidents	9	4.11 (1.90)	4	5.75 (0.50)	39.86
I am able to explore with Aboriginal and Torres Strait Islander families the hope they have for their child's social and emotional wellbeing	9	3.78 (1.30)	4	5.25 (0.50)	38.97
I have successful strategies for supporting children and young people to move beyond feelings of self-	8	4.50 (0.71)	4	6.25 (0.50)	38.89

blame and secrecy following trauma					
I know how to apply a strengths-based approach that incorporates the culturally specific protective factors for Aboriginal and Torres Strait Islander families	12	4.50 (1.24)	6	6.17 (0.75)	37.04
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	12	5.50 (1.00)	6	6.33 (0.52)	15.15

*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)

[a] Cohort 1 number of responses and participant average score prior to undertaking the trauma-informed practice training (*n=12*)

[b] Cohort 1 number of responses and participant average score after undertaking the trauma-informed practice training (*n*=6)

In focus groups, participants described varying confidence levels at the commencement of the training program, with some participants having more training and experience than others in working with people who might have experience of trauma. Consistent with the survey data, the overwhelming majority of focus group participants described an improvement in their confidence to support children, young people and families in the context of trauma. Particular skills in which participants described feeling more confident were starting conversations with children and young people about potential trauma, engaging parents, exploring child safety, and using more strengths-based and empowering language with children.

> It really sparked a little bit more knowledge and ideas as to how have those conversations with parents, how to introduce them or how to work with them from the start. (Practitioner focus group participant)

> … giving more emphasis on the child's safety these days. More questions around that … with families and with the child. Before that I was a bit hesitant to ask those questions. (Practitioner focus group participant)

Participants found the training course helpful for reaffirming and strengthening some of their existing skills as well as providing opportunities to observe new practices in action and to reflect on their past practices.

Some practitioners with training and experience in therapeutic practice frameworks felt they would have benefited from training in additional clinical skills that they believed would be useful for implementing trauma-informed clinical practices.

> I think we've spent a lot of time on formulation, I think that's been really helpful. But I guess it's more like, 'What do you do once you've got a good formulation, how do you structure this? How are we building on this?' And I think there were moments that touched on that. (Practitioner focus group participant)

3.3 Changes in work practices

In focus groups, participants identified a range of changes in the way they were working, as well as changes or improvements they would like to make in the future. Many participants identified the Five Practice Shifts used in the training as useful for guiding practice changes.

Changes identified in participants' practices	
Practice change	**Indicative quote**
General increase in engagement and discussion with children, young people and parents	'I think we've seen people start to change their practice already, in a meaningful way, from what they've learned. And it's mostly these softer skills that we're seeing.' (Team leaders/executive focus group participant)
Taking more **time to engage with parents**	'I think for me, just being a little bit more considered or just taking a little bit of extra time to listen to people in general, but more so with our contact and change over clients. Just because they're the ones that are in the position that they are and not having contact with their kids … taking that extra little bit of time to let them talk about it or make them feel a bit more comfortable and not so judged.' (Non-practitioner focus group participant)
Creating a **warm and welcoming environment**	'I'd like to set up stuff where children would feel more welcome … it'd be nice if there was some books and maybe some pencils and stuff.' (Non-practitioner focus group participant)
Increased **direct engagement with children and young people** and less reliance on parents to answer questions	'Since participating in this training I've noticed myself subconsciously focusing on moving the young person from naive to knowledgeable in an intake setting where I'm asking more direct questions towards the young person and not just

	letting the parent answer the questions for the young person.' (Practitioner focus group participant)
Greater **focus on child safety**	'Giving more emphasis on the child's safety these days. More questions around that.' (Practitioner focus group participant)
Identifying a child's or young person's **strengths and values**	'I feel like we've made some changes, even just implementing activities about values and strengths and building up that story for the young people … trying to make little changes where we can to make it a bit more of that trauma-informed approach.' (Practitioner focus group participant)

Survey data also show that program participants were engaging in trauma-informed practices to a greater extent following completion of the training program with participants reporting high scores on core measures of trauma-informed practice. Increases were recorded in the frequency with which participants talk with parents about the impacts of adversities on parenting, talking with children about their social and emotional wellbeing, and generally demonstrating trauma-informed care in working with children, young people and their families.

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

Survey items*	Baseline[a]		Post-program[b]		Percentage change
	n	*M* (SD)	*n*	*M* (SD)	%
I regularly talk with parents about the impact of their own mental health or other difficulties or adversities on their parenting	9	4.22 (2.11)	4	5.00 (2.16)	18.42
Within my role, I demonstrate trauma-informed care in my work practices with children, young people and/or parents	12	5.83 (0.94)	6	6.67 (0.52)	14.29
I regularly talk with children and young people about their	9	6.22 (0.83)	4	7.00 (0.00)	12.50

social and emotional wellbeing					

*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)

[a] Cohort 1 number of responses and participant average score prior to undertaking the trauma-informed practice training (*n=12*)

[b] Cohort 1 number of responses and participant average score after undertaking the trauma-informed practice training (*n*=6)

Not all course content was directly relevant to all participants. For example, some participants who worked with young people rather than children, found discussions around child-based case studies less relevant to their work. Other practitioners described having limited contact with parents, but still finding the training useful for when they do. Non-practitioners found the more clinical content to be outside their professional experience. However, non-practitioners found the less-clinical content highly applicable to their roles. While not all content was directly relevant to all participants, over the course of the program, most participants identified knowledge and skills that could be incorporated into their roles.

> I don't work with really little kids ... it still felt very relevant to me ... Probably not something I'm doing day in, day out, but definitely…a lot of tools that I feel like I can use and I'm using in my practice, so that was helpful. (Practitioner focus group participant)

3.4 Participants' perceptions of organisational support

Focus group participants identified organisational support as a key enabler of practice change, with many participants seeing benefits in the cross-organisation participation of MCCG staff in the training program.

In the baseline survey, participants reported feeling highly supported by their organisation to support the mental health and wellbeing of children and young people, with perceptions of a supportive work environment mostly increasing after the training program.

Participants reported that their organisation operates in ways that enhance trauma-informed practice capacity. They also felt supported in implementing culturally-informed work practices.

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

Survey items*	Baseline[a]		Post-program[b]		Percentage change
	n	*M* (SD)	*n*	*M* (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	12	5.75 (1.36)	6	6.50 (0.84)	13.04
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	12	5.42 (1.73)	6	6.00 (1.10)	10.77
The way my organisation operates enhances my capacity to operate in a trauma-informed, child-focused way	12	5.83 (1.11)	6	6.17 (0.75)	5.71
I regularly collaborate with other professionals or co-workers to support child and young people's mental health	12	6.08 (1.00)	6	6.17 (0.98)	1.37
My current organisation is supportive of practices to promote children's	12	6.50 (0.80)	6	6.33 (0.82)	-2.56

and young people's mental health					

*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)

[a] Cohort 1 number of responses and participant average score prior to undertaking the trauma-informed practice training (*n=12*)

[b] Cohort 1 number of responses and participant average score after undertaking the trauma-informed practice training (*n*=6)

4. Evaluation findings - Organisational learning

As part of its participation in the training program, MCCG leadership anticipated that some follow-up discussion and activity would be required at the organisational level to support staff to implement their learning, and to further embed and spread trauma-responsive care across the organisation. In focus groups, MCCG leaders described benefits for clients, staff and future development of the organisation in ensuring its programs are trauma-informed.

MCCG leaders and many practitioners felt that there were already examples of trauma-informed practice at MCCG, and that participation in the training program had helped to identify and confirm existing approaches. It also provided common frameworks, vocabulary and skills to support consistent trauma-informed practices across the organisation.

Providing trauma-informed care for all clients is embedded in the MCCG organisational strategic plan. Leaders participating in the focus group felt this provided an important mechanism for driving continuous improvement in trauma-informed competencies at the organisational level.

In the team leader/executive focus group, participants identified several goals and considerations for helping to create a trauma-informed organisation that arose (or were re-affirmed) during the training program. These were:

- Develop internal communications and messaging strategies to share trauma-informed practice knowledge and expectations across the organisation.
- Consistent use of trauma-informed language across programs, from practice interactions to language used in documentation and phone conversations.
- Consider how physical spaces could be made more welcoming, particularly for children, young people and families.
- Extend the existing supervision framework to non-clinical staff.

- Consider how further work could be done in collaboration with local Aboriginal communities to build a local cultural lens and acknowledgement of history alongside trauma-informed practice competencies.

Project partnership

MCCG executives described positive experiences in their interactions with both Emerging Minds and ACT Health in planning and delivering the training program. Executives described useful conversations with Emerging Minds about content and structure of the program. They also appreciated ongoing communication with Emerging Minds and ACT Health throughout the delivery of the program.

> [Colleague] and I had direct access to Dan and Chris and Cass, which was also really, really helpful, just to guide any of the questions that we were getting from the team, so I thought it was great. (Team leader/executive focus group participant)

Similarly, Emerging Minds described both MCCG and ACT Health as engaged and constructive partners with a high level of commitment to service quality and a genuine preparedness to explore opportunities for learning and improvement.

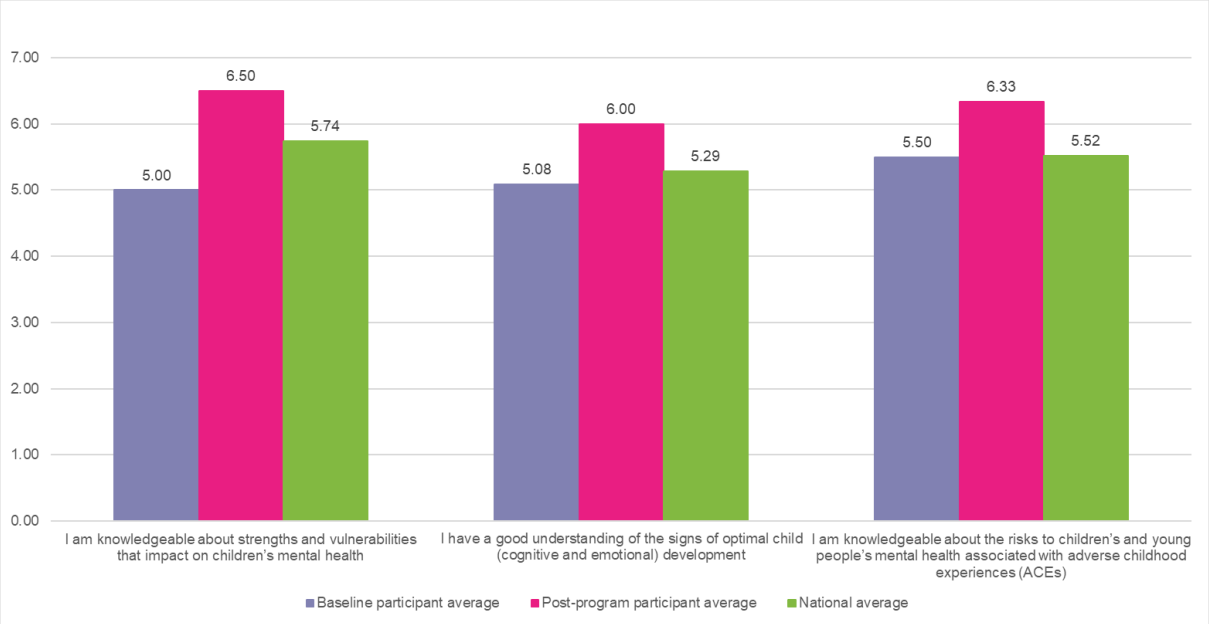
5. Comparison of MCCG survey data to Emerging Minds' National Workforce Survey data

Comparison with Emerging Minds' NWS data provides an additional measure of program impact, with MCCG participants scoring above the national average on all NWS survey items (included in the evaluation) across a range of trauma-informed practice competencies following completion of the training program.

Before completing the training program, participants' average scores fluctuated above the national average, in areas such as workplace support, but below the national average in other areas, such as supporting Aboriginal and Torres Strait Islander children and families. Following completion of the training program, participants scored above the national average on all survey items.

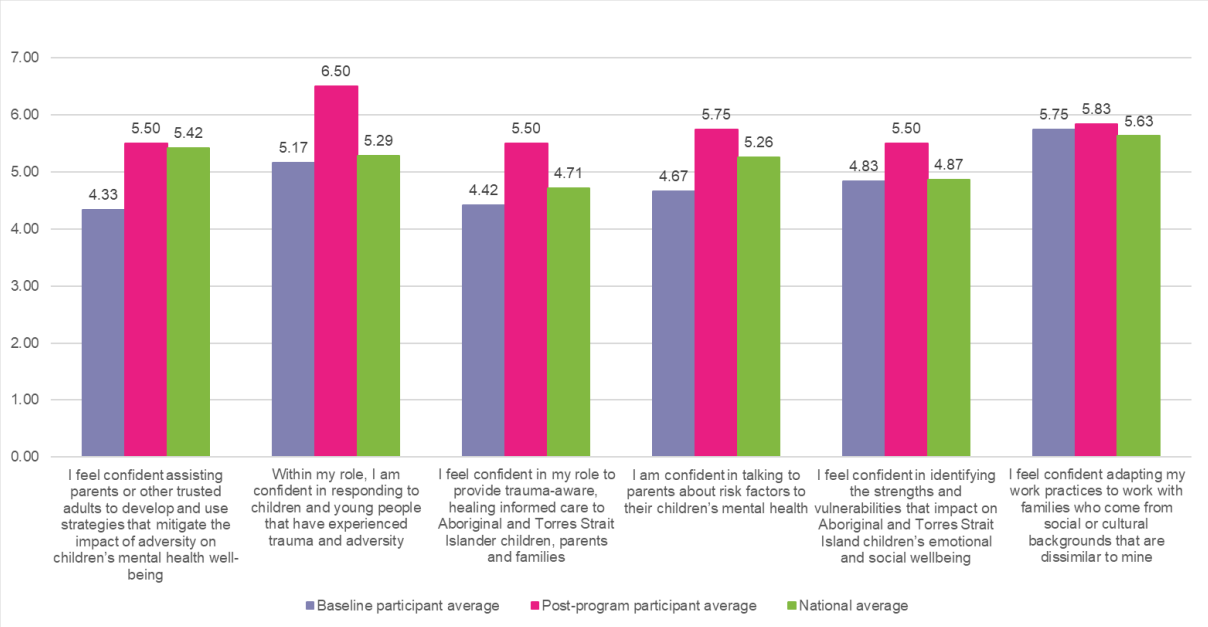
Participants shifted from having moderate levels of *knowledge* of trauma-informed competencies that scored below the national average, to having high levels of knowledge that scored >13% higher than the national average.

Knowledge in trauma-informed child mental health competencies: Baseline average and post-program average v national average



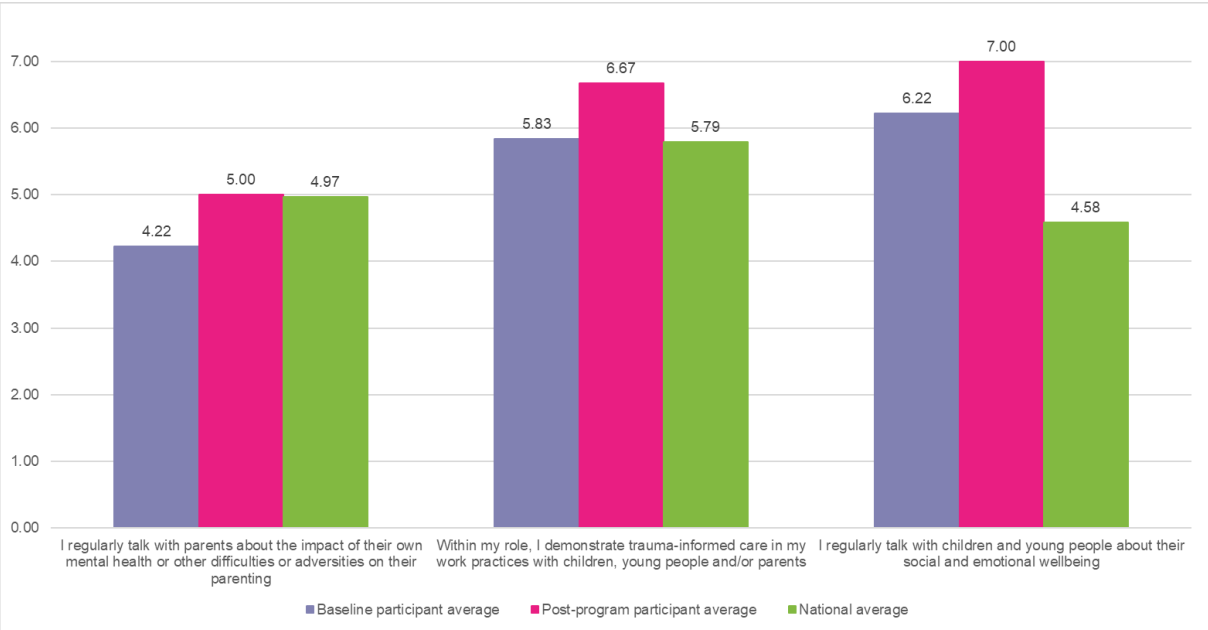
A similar trend was seen for participant *confidence*, where participants generally scored below the national average prior to the training program, but scores increased above the national average following program completion on all survey items related to participants' confidence to engage in a range of trauma-informed practices.

Confidence in trauma-informed child mental health competencies: Baseline average and post-program average v national average



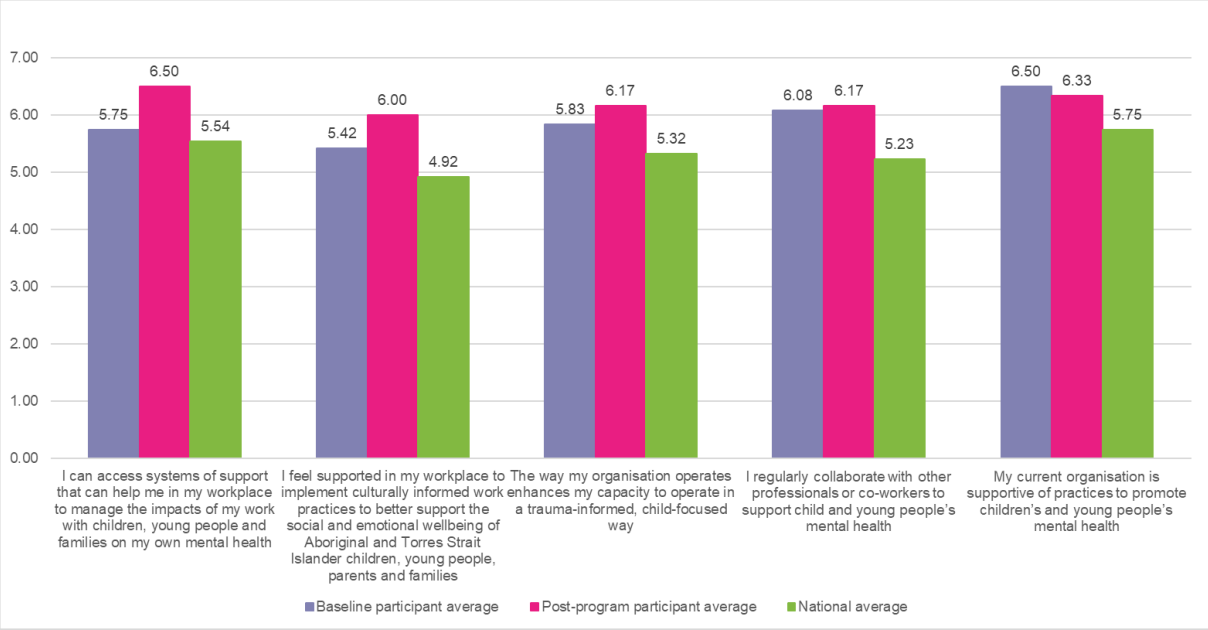
In terms of demonstrating trauma-informed care in their *practice*, program participants were at a similar level to the national workforce before the training program but scored above the national average after completion of the training program. Participants were well above the national average in engaging with children and young people about their wellbeing, and had pulled ahead of the national average in talking with parents about the impact of adversities on their parenting.

Practice in trauma-informed child mental health competencies: Baseline average and post-program average v national average



Both before and after training, participants reported receiving higher support from their *organisation* than the national average, highlighting the values of MCCG and the importance of creating a supportive and authorising environment from which to build a trauma-informed organisational culture.

Organisational support in trauma-informed child mental health competencies: Baseline average and post-program average v national average



6. Enablers of implementing trauma-informed practices

Qualitative data from the focus groups and post-program survey identified seven key factors that participants identified as important to supporting improved trauma-informed practices:

- Having the opportunity to see trauma-informed practice and hear reflections on that practice.
- Developing an understanding of how trauma-informed skills can be applied in a participant's role, discipline or program.
- Organisational support.
- Supportive team collaboration.
- Having shared language to articulate trauma-informed practice.
- Supervision for staff so they can engage safely and sustainably with trauma-informed practice training and in the practice itself.
- Being able to continue and consolidate learning by continuing to access Emerging Minds Learning.

Enablers of implementing trauma-informed practices	
Enabler	**Indicative quotes**
Seeing trauma-informed practices in action and hearing practitioners reflect on their practices (both in online learning and face-to-face workshops) was clearly identified by participants as very helpful for integrating learning into their practice.	'I definitely learn like that by watching others and seeing how they have those conversations and then stealing from that, using it and trying and making my own, which I've started to kind of do in my practice a little bit more.' (Team leader/executive focus group participant) 'So I find those case studies in particular really helpful. There was one exercise … the power differences one, that I was like, "I can take that and now we'll use that."' (Practitioner focus group participant) 'I really picked up on those videos I found to be really valuable, that we watched and I thought, "Oh, I really liked the way that they said that. I would like to use that."' (Team leader/executive focus group participant) 'Having Dan and Chris talk about the way that they work. That for me was really powerful. It showed me some of the skill and the way that you can actually apply it rather than us talking about what we think we should be doing.' (Practitioner focus group participant)
Practitioners described needing to **understand how trauma-informed practices applied to their roles and settings**. In some cases participants discussed directly with the trainers how the training could be applied in their contexts, while other participants developed greater understanding of the personal relevance of the training over the course of the program.	'Initially it was a bit disconnected for me, because I was like, "Well I can't do that." I can't be having conversations about past events and things like that, because it's outside of the scope. But as we've gone into it more, I've started to understand the nuance of what trauma-informed practice is and I've taken a lot from it.' (Practitioner focus group participant) 'I think it was Dan, in a one-on-one … It was actually really, really helpful to put our work into context of what we were learning and how it could apply to what we do … We were able to find our place not being psychologists, or potentially not offering or delivering a therapeutic service in that particular context. We were able to find where we fit.' (Team leader/executive focus group participant) 'I don't speak a lot to young children. There's a lot of youth and adults that I speak to, but I do think that you can adapt all of those learnings into any conversation with anyone.' (Non-practitioner focus group participant)
Participants identified benefits in having **organisational support for trauma-informed practices**:	'The people who put their hand up to do this training really want to get everything they can out of it, so supporting the people that are trying to do it so they do get everything

1. Supporting staff members who volunteered to do the training. 2. Facilitating shared learning and consistent use of skills across the organisation. 3. Helping to implement structural improvements. 4. Recognising the importance of non-clinical roles in a trauma-informed organisation.	that they can out of it is important.' (Practitioner focus group participant) 'This unity of shared skills and experience and learning at different levels has been really, really valuable.' (Team leader/executive focus group participant) 'I think one advantage of having managers in the training is we're all on the same page, so that's quite helpful. So we're having those conversations, we're making changes as we go and they're willing to make changes. They're offering a lot of resources for us to make changes, which is helpful.' (Practitioner focus group participant) 'I think it's really, really, really lovely that Emerging Minds have actually considered people that aren't clinical … people on the front line in administration roles, intake roles, reception roles, whatever. We are the ones that hear a lot.' (Non-practitioner focus group participant)
Team collaboration and opportunities to discuss cases with colleagues were seen as important to support participants to make and sustain practice improvements.	'Collaboration … enthusiasm from the team to constantly improve …' (Participant survey response) 'It'd be really nice to meet up as a team every so often and go, "How are we going with that? What can we keep changing?" Because I think that's something that will fall off once we finish this training. And maybe having some goals and some targets to work towards. Obviously, change takes a long time to implement. And I think most people lose traction once training's finished … I think that would help.' (Practitioner focus group participant)
Having **common language to identify and discuss trauma-informed practices** was seen as important for reflecting upon and developing individual and team practices.	'I think it's great when everyone's speaking the same language. So, we've been lucky enough to have the majority of our team here … so that we can reflect on what we've learned together and use that same language too, when we're in supervision or team meetings.' (Team leader/executive focus group participant)
Supervision for all roles including intake and administrative roles to support practitioners and non-practitioners to engage in trauma-informed practice.	'We found in the first probably month or so, once the online training commenced, was that especially for our non-clinical [workers], a couple of my managers had reached out and said, "Are we going to be able to get a little bit of supervision for our non-clinical staff going through this training?" Which we hadn't even considered. And it's because commencing that training, a lot of feelings, emotions, potential historic concerns came up for everyone in general. But for non-clinical [workers], they didn't know how to hold this space. But in saying that, then as well, we also had this expectation that clinical can just

	hold anything that comes their way because they're clinical, they know how to deal with this. Whereas we have actually found that no, that's not the case. They need just as much supervision.' (Team leader/executive focus group participant)
Many participants felt that **continued access to Emerging Minds Learning** would help them to revisit, consolidate and continue learning.	'Because I know in supervision we'll set goals on things we want to focus on. And that could be something that I'm going to ... an hour a week or whatever, I'm going to continue the learning.' (Practitioner focus group participant)

7. Challenges to implementing more trauma-informed practices

Participants identified the design and funded scope of programs as factors limiting the extent to which some practitioners felt they could engage in trauma-informed practices. Participants described constraints such as lack of funded time to engage with clients and families, and limitations on the clients a program is designed and funded to support.

Despite programmatic constraints, practitioners also described ways they were providing trauma-informed support to both children/young people and parents when possible.

Challenges to implementing more trauma-informed practices	
Challenge	**Indicative quote**
Program scope and funding **doesn't allow time for conversations with parents.**	'We get paid to work with the youth specifically … but sometimes the parents aren't always on board with the treatment approach and sometimes they might be reinforcing potentially negative things ... I think it can be quite hard to navigate that space when we don't have any time to actually talk to the parent. It has to happen. We basically make time … I would really love to do some specific training on working with parents.' (Practitioner focus group participant)
Program scope and funding **limit the number and length of sessions** required for engaging in more trauma-informed work.	'A lot of what we do is very trauma-informed, but I think it's the things like having the time, having the scope, so we're constrained in funding in terms of how many sessions we have and how long those sessions can be.' (Practitioner focus group participant)
Gaps in Level 3 of the stepped-care model for one program means there are **limited referral options** for some clients.	'So we're moderate to severe … CAMHS is severe … there's just that gap of long-term work, chronic work that's not super severe and critical that falls through the gap really. And so, we can give them 18 sessions. But I mean … when we've got those clients [that need longer term support] you're going to be a drop in the ocean.' (Practitioner focus group participant)

Making administrative changes to support trauma-informed interactions such as changes to intake and self-referral forms **takes time and organisational commitment.**	'The forms have to be approved by our UK software database company which can take up to six months.' (Non-practitioner focus group participant)
Lack of budget to make physical changes to spaces.	'A budget would be nice.' (Non-practitioner focus group participant)

8. Suggested program refinements and improvements

Program participants and Emerging Minds trainers identified potential program refinements for consideration for Cohort 2 of the project, including:

- More instructional content in early online tutorials to prepare participants for contributing their own practice reflections in subsequent tutorials.
- Spending more time on understanding the existing professional frameworks that might be informing practitioners' practices.
- Working with clinicians to demonstrate how trauma-informed skills can be integrated into clinicians' existing practice frameworks and applied across the assessment, formulation and implementation stages of care.
- Using small groups for some case study discussions so that participants can discuss cases of varying degrees of complexity depending on their roles and experience.
- Ensuring participants are aware of organisational supports available to them if they experience strong emotional reactions as a result of participating in the program.

(More detail on participants' experiences of participating in the training program are included in the complete Cohort 1 Evaluation Report submitted to ACT Health.)

9. Conclusion

In sum, the Trauma-Informed Practice Training Program has resulted in significantly positive impacts for the MCCG cohort of both practitioners and non-practitioners, and useful learnings for Cohort 2 of the project.

The openness of participants and project partners to the Try, Test and Learn approach has led to constructive reflections and shared learnings about effective methods for building capability in practitioners and non-practitioners in trauma-informed practices when working with children, young people and families.