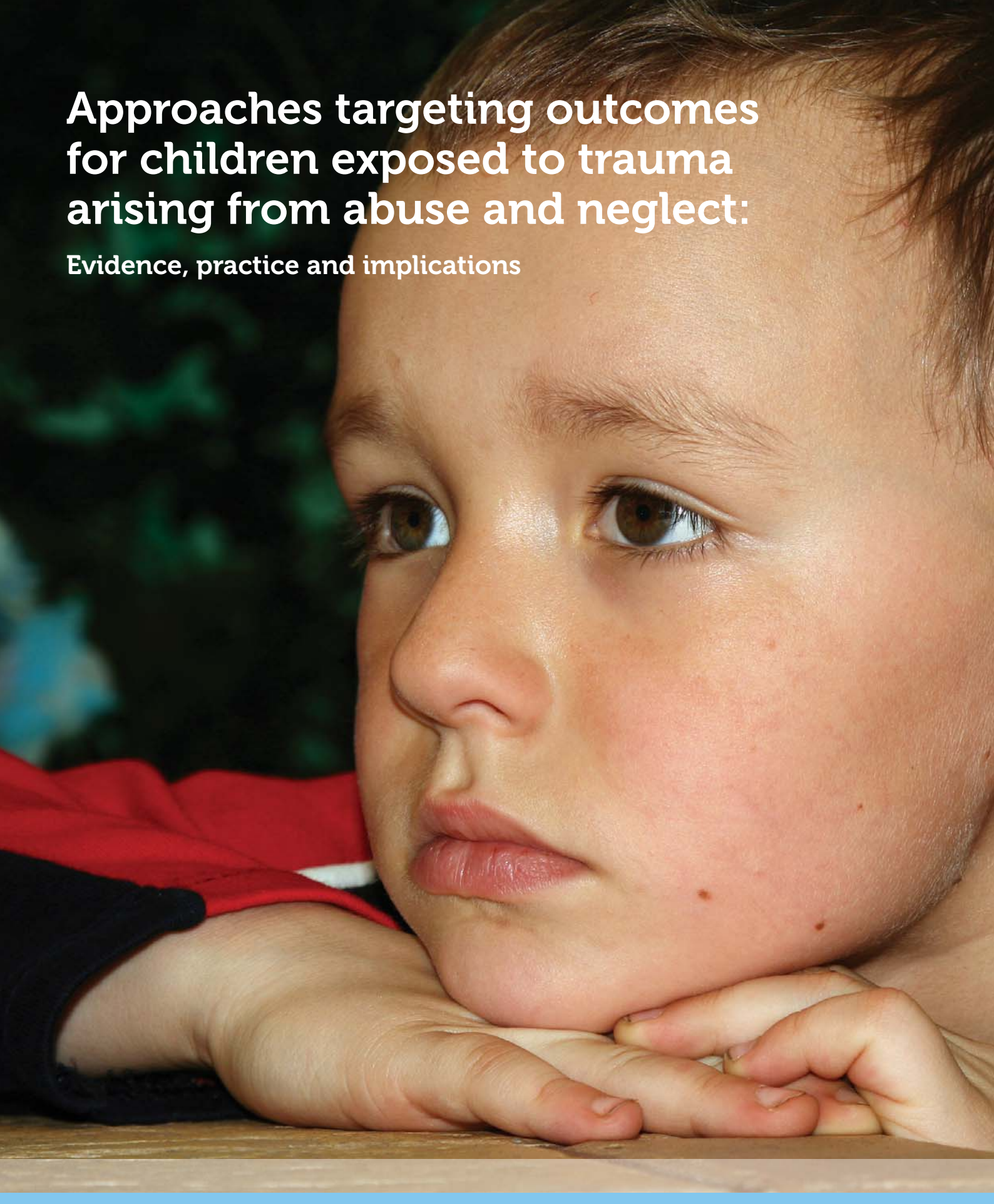

Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect:

Evidence, practice and implications

February 2014

Australian Centre for Posttraumatic Mental Health

Parenting Research Centre
raising children well

This document is the final report for the project titled *Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice and implications*. It was written as a collaborative project by the Australian Centre for Posttraumatic Mental Health and the Parenting Research Centre with funding from the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA, now the Department of Social Services).

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Executive summary

This report documents findings from an Australian Government Department of Families, Housing, Community Services, and Indigenous Affairs (FaHCSIA, now known as the Department of Social Services) funded project titled *Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice and implications.*

In recent years there has been increasing recognition by practitioners and organisational leaders within child and family service organisations that many of the children and families they serve have been exposed to traumatic life events such as abuse and neglect. This recognition has meant that many child and family service organisations have increased their focus on improving physical, psychological, emotional and social outcomes for clients who have been exposed to traumatic events. Accordingly, there appears to be greater emphasis by service providers on staff developing an awareness of the impacts of trauma on children and families, and many agencies are working towards becoming more 'trauma-informed'. What is unclear, however, is the degree to which evidence-based approaches are being used to target outcomes in children exposed to trauma associated with abuse and neglect. To address this question, this report aims to:

- identify and rate the evidence for approaches aimed at preventing and treating outcomes in children exposed to trauma through abuse and neglect
- identify the awareness and uptake of approaches that aim to address outcomes in children exposed to trauma associated with abuse and neglect across a sample of child and family services practitioners in Australia
- identify factors which influence the uptake of evidence-based approaches in the child and family services sector.

The following activities were conducted to achieve these aims:

- A Rapid Evidence Assessment (REA) to identify and rate the evidence behind approaches that target outcomes for children exposed to trauma through childhood abuse and neglect.
- An online practitioner survey to identify approaches being used currently by practitioners in the child and family services sector to address the outcomes of trauma exposure.
- Individual consultations with organisational leaders and senior managers in the child and family services sector to examine the level of awareness of evidence-based approaches and to identify factors that influence the uptake of evidence-based approaches in Australia.

It is important to acknowledge that there are many *types* of approaches that may be used to target child and family outcomes. *Types* of approaches may include sets of principles, frameworks, models, interventions, therapies, practices, programs, services or systems of care. For simplicity, we use the word 'approach' within this report to refer to all of these types of approaches, except where it is necessary to distinguish between types of approaches, in which case we have labelled them programs, service models and systems of care accordingly.

Key findings

The evidence base for approaches targeting trauma-related outcomes

The REA reviewed both the peer-reviewed and grey literature reporting on evaluations of approaches that targeted outcomes in children exposed to or at risk of experiencing repeated and/or prolonged trauma through abuse and neglect (i.e., Type II trauma exposure). Approaches were grouped according to whether they were programs, service models or systems of care, and assessed as having at least some element of trauma-informed care, trauma-specific/focused, or neither. The approaches were evaluated against criteria established for this project, with subsequent categorisation as, 'Well Supported', 'Supported', 'Promising A', 'Promising B', 'Emerging A', 'Emerging B', 'No Effect' or 'Concerning Practice'.

We found 96 approaches (63 programs, 23 service models, 10 systems of care) that had varying levels of evidence to support the improvement of outcomes for children exposed to trauma through abuse or neglect.

Of these 96 approaches, 54 were rated as having some element of trauma-informed care and/or trauma-specific/focused. We categorised 42 approaches as neither trauma-informed nor trauma-specific/focused.

Only one approach was rated as Well Supported; eight were rated as Supported; 21 were rated as Promising A; 19 were rated as Promising B; 37 were rated as Emerging A; and 10 were rated as Emerging B. There were no approaches that met criteria for No Effect or Concerning Practice. Approaches rated as Well Supported and Supported required the use of rigorous study designs (randomised controlled trials (RCTs)) and needed to demonstrate the effect (benefit) of the approach over a comparison condition at least six months after participation in the program, service or system of care had ceased. Due to the rigour of their evaluations and maintenance of effect, these approaches demonstrated a stronger evidence base for improving child and parent outcomes compared to the other 87 approaches identified in the REA.

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), which is trauma-informed and a trauma-specific/focused intervention, was the only approach that met criteria for being Well Supported. It received this rating because it showed effect in at least two RCTs, and that effect was maintained for at least 12 months after cessation. TF-CBT is a program that directly targets posttraumatic stress and related symptoms. The findings of the studies assessing the effectiveness of TF-CBT indicate that this program demonstrates effect at 12 months after program completion for the following outcomes: child Post Traumatic Stress Disorder (PTSD), child abuse-related shame, child dissociation and parent distress.

Eight approaches (five programs, two service models, one system of care) met the criteria for Supported approaches: Child-Parent Psychotherapy (CPP); Family Connections; Fourth R: Violence Prevention; Fostering Healthy Futures; Nurse Home Visiting Service; Multi-Systemic Therapy for Child Abuse and Neglect (MST-CAN); Parents Under Pressure (PUP); and Project Support. These approaches tended to draw from cognitive behavioural paradigms as well as attachment/relational and ecological paradigms. Unlike the Well Supported program, the Supported approaches did not demonstrate replication of effect (i.e., they were only evaluated in one RCT) and the benefits of the approaches were observed at a minimum of six months after participation in the program, service or system of care had ended. Supported approaches mostly

targeted outcomes relating to psychological/emotional and behavioural symptoms. Collectively, outcomes addressed by Supported approaches were: PTSD, mental health symptoms, behaviour problems, aggression, assault, dissociation, receiving mental health therapy, child maltreatment reports involving the mother as the perpetrator or the child as subject, child maltreatment reports for women experiencing domestic violence, neglect, out-of-home care placements, out-of-home care placement changes, pro-social behaviour, violent delinquency, parental depression, parental distress, parenting distress, social support, avoidance, risk for abuse, perceived inability to manage parenting and harsh parenting.

Further research is needed to determine if the benefits of Supported approaches would be seen with additional evaluations and with longer follow-up periods.

Nine of the 96 approaches included in the REA were evaluated in Australia, with none of these rated Well Supported and only one included among the Supported approaches (PUP).

Across all approaches identified in the REA, child abuse was the most frequent reason for trauma exposure (n = 47 approaches), followed by neglect (n = 37), sexual abuse (n = 36) and family violence (n = 29). Few approaches specifically targeted trauma arising from parental substance use and parental mental illness.

The majority of approaches in the REA targeted psychological, emotional and behavioural symptoms (n = 71 approaches). Some approaches targeted relationships and family functioning (n = 32), outcomes associated with risk for abuse (n = 21) and service utilisation (n = 18). There were fewer approaches that targeted child physical health and development (n = 12), educational outcomes (n = 8), and cognitive outcomes (n = 6).

Several gaps were identified in the literature:

- There was generally a lack of rigorous research trials, including few with long-term follow-up data. Furthermore, most evaluations lacked replication.
- There were a limited number of approaches with sufficient evidence to suggest that they are effective in targeting child and parent outcomes in children exposed to trauma.
- While there were several approaches that targeted outcomes associated with child abuse and neglect, there were fewer that addressed outcomes arising from family or domestic violence.
- Few approaches targeted outcomes related to child education, cognition and physical health and development.
- There was an observed evidence gap in approaches targeting infants and adolescents, with the bulk of approaches for infants at the Promising or Emerging level.
- Less than 10 per cent of identified evaluations were conducted in Australia and only two described representation from Aboriginal or Torres Strait Islanders in their sample, one of which described a very low representation[1].

Despite these limitations, there are a small number of approaches (mostly programs) with at least some evidence of effectiveness that supports their use in preventing and/or treating child and family outcomes in children exposed to trauma associated with abuse and neglect. As the

[1] Three Australian evaluations described referral pathways for Aboriginal and Torres Strait Islander children, however only two described representation of this group in their sample.

body of research develops into the future, approaches may receive more (or less) supporting evidence, which will improve the evidence base over time.

Current approaches used by practitioners across the child and family services sector in Australia

A total of 293 individuals who worked with children exposed to trauma within the child and family services sector completed an Australia-wide online survey about their practices. The survey aimed to identify the nature and extent to which evidence-based approaches were being applied by practitioners who worked with children exposed to trauma associated with abuse and neglect.

Respondents reported having high levels of contact with clients exposed to trauma. The majority of respondents indicated that assessment of trauma exposure and its impact was a priority in their work. The majority of respondents reported a high level of confidence in recognising the signs and symptoms of trauma exposure, and in delivering approaches that targeted outcomes associated with trauma exposure. The most common practices were to refer out or to link in with other services (57%), or to provide education (49%).

When asked to identify evidence-based approaches that they had delivered in the past year that aimed to address outcomes in children exposed to trauma associated with abuse and neglect, only a third of respondents reported having delivered a specific approach in the past year. **Less than *five percent of respondents*** (five out of a possible 107) identified that they delivered an approach that was identified in the REA as having sufficient evidence to be rated Well Supported or Supported. Furthermore, **less than *three percent of approaches*** (two out of a possible 79) identified as being used by respondents had sufficient evidence to be rated Well Supported or Supported, according to the results of the REA.

Decision-making and factors influencing the uptake of evidence-based approaches

Detailed consultations were conducted with a small sample of organisational leaders and senior managers (n = 9) within government and non-government organisations across Australia to examine the level of awareness and scale of uptake of evidence-based approaches in Australia.

Decisions about approaches to implement within services were generally made at an executive level, although some agencies afforded a degree of autonomy to team leaders and practitioners in this decision-making.

Organisational leaders and senior managers described a range of factors that influenced their decisions about approaches to adopt. These factors included funding, partnership opportunities, and the evidence base for approaches. Costs associated with delivery were cited as a barrier to the quality implementation of evidence-based approaches (i.e., cost to purchase, train or effectively implement an evidence-based approach).

The evidence for an approach was often considered by organisational leaders and senior managers, but the perceived importance of evidence varied. Responses reflected a range of perspectives about the relative weight or importance of scientific evidence, as well as differing perspectives on the role of research literature. Some participants reported that ‘research-based’

(contrasted with 'evidence-based') decision-making helped them to more specifically tailor their own approaches to the needs of their client population.

The importance of the evidence was often weighed up against other factors including financial considerations, time constraints, workforce experience, expertise and resources, and what is implementable.

Organisational leaders and senior managers felt that there had been an increase in recent years in the access that practitioners have to research findings, but that more support and guidance in evidence-based trauma practices and approaches was required for practitioners.

Organisational leaders and senior managers reported that there was a limited range of strategies via which practitioners were given access to evidence-based approaches and that access tended to be opportunistic rather than planned and indoctrinated into service delivery. Improving information access, ongoing professional development, training and supervision as well as organisational support from team leaders and management were seen as strategies to improve access to evidence-based approaches. There was limited evidence of systematic knowledge translation strategies that work to improve practice (e.g., competency-based training and coaching).

Although concepts such as complex trauma, trauma-informed care and evidence base were not new to those interviewed, organisational leaders and senior managers identified that the field still lacked clear definitions or understanding of each of these. There was agreement on the need for refinement of how trauma is understood in the field and that greater support could be provided to increase practitioners' knowledge. In particular, despite trauma being widely acknowledged as a potential consequence of abuse and neglect, the field currently lacks clear standardised definitions of trauma (particularly repeated/prolonged trauma or Type II trauma) and guidelines for its assessment and treatment. Senior managers and organisational leaders recognised that there was, at times, the assumption within the field that child social, emotional and behavioural difficulties were necessarily trauma-related. This was often assumed without clear assessment of trauma exposure or case formulation where child outcomes were linked to the traumatic event. An essential precursor to decisions about which programs to undertake — that is, the use of effective trauma assessment and case formulation — was not reported.

Discussion

There is a developing international evidence base for approaches, in particular programs that target psychological, emotional and behavioural outcomes associated with trauma arising from abuse and neglect. While there are several approaches that are available with good to high levels of empirical support, most approaches are only beginning to develop their evidence base. Greater attention to evaluation is required to firmly establish the approaches that were found to be Emerging and Promising in the literature.

The field acknowledged the value of appropriate assessment of trauma exposure and its outcomes, but guidelines for the assessment of trauma exposure and outcomes, and subsequent implications for intervention were limited. Effective trauma assessment and case formulation are required to improve the link between trauma exposure and trauma-related outcomes, and to improve the targeting of approaches.

The majority of practitioners:

- identified that they frequently work with children and families exposed to high levels of trauma
- were most likely to refer out or link to other services, or provide education about trauma
- tended not to use any specific approach to target outcomes associated with trauma exposure.

Where specific approaches were used, few of these were rated Well Supported or Supported as identified by our analysis of the evidence base in the REA. This suggests that approaches with the strongest evidence base according to the REA are being used by a small number of practitioners. As a result, children and families may not be receiving the most effective and potentially least harmful interventions to address outcomes of trauma associated with abuse and neglect.

There was a range of factors that both facilitated and acted as barriers to the adoption of evidence-based approaches. From the perspective of organisational leaders and senior managers, the evidence base for an approach was considered important; however, the fit of evidence-based approaches with current service models, the characteristics of the client population and staff characteristics were typically considered to be equally important.

Local innovations or adaptations of evidence-based approaches are important to acknowledge, and are at times, but not always, necessary. These innovations place greater importance on the need to evaluate to ensure that an adapted approach retains the critical components of the original approach and that the originally intended client outcomes are being achieved.

The findings of this analysis indicate that there are only a small number of approaches with evidence available to indicate that they are effective for improving outcomes for this population. While many approaches exist, few have, to date, been evaluated; thus, the use of approaches with any degree of evidence is limited. Instead, managers and practitioners are largely choosing approaches based on factors other than whether or not the program, service or system of care has evidence of effectiveness and is known to cause no harm.

Recommendations for policy and practice

This section details five key recommendations for policy makers and service providers to consider.

Recommendation 1. Improve awareness of accepted definitions of trauma and related concepts, and of evidence and related concepts.

Findings from this project suggest that currently a large proportion of the child and family service sector lacks a common definition of trauma and related concepts (e.g., Type II trauma, trauma-informed care). In addition, there was a wide range of interpretations of what constitutes evidence-based practice.

Suggested actions
Policy makers and service providers to agree upon, adopt and promote consistent and accepted definitions of trauma-specific terms to guide assessment, case formulation and service delivery.

Policy makers and service providers to agree upon, adopt and promote consistent and accepted definitions of concepts related to evidence (e.g., research-informed, evidence-based, evidence-informed).

Recommendation 2. Increase awareness, adoption and effective implementation of evidence-based approaches shown to improve outcomes associated with trauma exposure associated with abuse and neglect.

There is evidence that trauma exposure is viewed by professionals within the sector as an important concern. While it seems that many professionals are aware of the need to assess and treat the outcomes associated with trauma exposure, many professionals within the child and family service sector are not using approaches that have good evidence of effectiveness. Findings from this project indicate a gap in understanding about current best practice regarding when and how to assess for trauma exposure and outcomes (past and risk), as well as a gap in the awareness, adoption and implementation of approaches that have an evidence base. As scientific knowledge increases regarding effective approaches, policy makers and service providers must be supported to overcome challenges to the effective use of these approaches.

Suggested actions

1. Policy, service delivery and research communities to collaborate on the adoption of accepted principles of good practice against which to assess existing and innovative approaches that involve the assessment and support of children exposed to trauma.
2. Researchers and service providers to identify gold standard assessment tools and provide relevant professional training in their use. Assessment tools may differ with respect to specific population characteristics and service requirements. Training would also raise awareness of the role of trauma in abuse and neglect populations, and when/how to recognise the effects of trauma in abuse and neglect populations.
3. Increase awareness among policy makers, managers and practitioners of evidence-based approaches that target outcomes for children exposed to trauma through the effective translation of scientific evidence via appropriate dissemination and training initiatives.
4. Disseminate guidelines and protocols to help organisations select evidence-based approaches that match the needs of their clients and that suit their service characteristics including their funding models and the child/family outcomes they are working to achieve.
5. Develop a central resource area, repository or clearinghouse dedicated to trauma-specific/focused approaches and trauma-informed care in Australia. Although not all specific to trauma, similar resources in the United States include the Substance Abuse and Mental Health Services Administration, the California Evidence-Based Clearinghouse for Child Welfare, and the National Child Traumatic Stress Network. A clearinghouse where approaches are submitted and independently rated across a range of criteria has not been developed in Australia.
6. Structure funding contracts to allow services to access resources to better attend to factors that affect high quality implementation of an approach (e.g., appropriateness of the approach to the client group, delivery costs, staff competencies, training and coaching opportunities, and cultural appropriateness).

Recommendation 3. Increase use of quality assurance and quality improvement processes within child and family service organisations to allow for ongoing, built-in evaluations of service delivery.

A range of innovative and adapted approaches are being employed by professionals across the sector, which may assist in filling existing gaps in the availability of evidence-based approaches for particular client groups or for specific desired outcomes. For example, the REA revealed a significant gap in the availability of evidence-based programs suitable for Aboriginal and Torres Strait Islander families who have been exposed to trauma. However, this project found that routine or sustained evaluation of practice is uncommon, and there was little evidence of quality assurance and quality improvement processes within child and family service organisations.

Suggested actions

1. Policy makers, service providers and researchers to build the capacity of the sector to enable routine and continuous quality assurance and improvement practices that incorporate evaluations of approaches within organisations.
2. Policy makers and service providers to establish leadership to govern standards and key competencies to ensure quality assurance and quality improvement practices are enforced across government-funded agencies.

Recommendation 4. Increase independent evaluations of new or emerging approaches that are being implemented within child and family service organisations that target outcomes associated with trauma exposure.

Given the range of innovative and adapted approaches in use across the sector, ongoing research is important. In particular, research may expand the evidence base and ensure targeted supports are available for specific groups for whom, at present, evidence-based approaches are not available. Nevertheless, there was little evidence of independent evaluations of approaches being used within services across Australia, especially when an approach was new or had emerging evidence. Such independent evaluations would provide additional valuable data to support decisions by policy makers and service providers regarding the uptake or adoption of new and emerging practices.

Suggested actions

1. Encourage relationships between service providers and universities or research organisations to conduct independent or collaborative evaluations of the implementation of an approach with new or emerging evidence.

Recommendation 5. Increase the development and evaluation of approaches with and for Aboriginal and Torres Strait Islander children and families.

The REA identified a lack of locally evaluated approaches, especially those that target Aboriginal and Torres Strait Islander children and families.

Suggested actions

1. Policy makers and service providers to work with Aboriginal and Torres Strait Islander organisations and communities to develop and evaluate culturally appropriate approaches designed to target child and family outcomes of trauma associated with abuse and neglect.
2. Policy makers to provide assistance and support to encourage the development of Australian-based (or at least Australian-evaluated) evidence-based approaches suitable for Aboriginal and Torres Start Islander families.

Chapter 1: Introduction and background

In 2012, The Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA, now known as the Department of Social Services) announced its Child Aware Approaches Initiative as part of the National Framework for Protecting Australia's Children. The Child Aware Approaches Initiative aimed to improve community understanding of child abuse and neglect with the creation of new resources and research to identify what works to protect children from harm, why it works, and to help child and family support services to make use of this knowledge. This initiative particularly focused on children and young people who are exposed to child abuse and neglect, family violence, parental mental illness, and parental substance abuse.

The Australian Centre for Posttraumatic Mental Health in partnership with the Parenting Research Centre was awarded funding under the Child Aware Approaches Initiative to undertake research aimed at (1) identifying the evidence base for approaches designed to target child and family outcomes following exposure to trauma in the form of abuse and neglect, (2) determining the extent of use of these approaches within child and family service organisations in Australia, and (3) exploring the factors that influence uptake of these approaches. This report documents the methodologies, findings and key conclusions and implications arising from this project.

Scope and aims of this report

In recent years there has been increasing recognition by practitioners, senior managers and organisational leaders within child and family service organisations that many of the children and families they serve have been exposed to repeated and prolonged traumatic events. These traumatic events may include child physical, sexual and emotional abuse.

This recognition has led to child and family service organisations placing increasing attention on improving outcomes for clients who have been exposed to trauma. These outcomes may include (but not be limited to) trauma-related psychiatric symptoms such as PTSD, depression and anxiety disorders, suicidal/self-harm ideation and dissociation. They may also include (but not be limited to) behavioural disturbances and/or delays in child physical, social and emotional development associated with trauma exposure. However, despite increased attention paid to childhood trauma exposure, its causes and effects, the degree to which evidence-based approaches are being used to target outcomes associated with trauma exposure in the form of abuse and neglect is unclear. Furthermore, it is unclear how the field defines and assesses trauma exposure, and how it identifies the physical, psychological, cognitive and social outcomes that may develop as a result of trauma associated with abuse and neglect.

We acknowledge throughout this project that there are many *types* of approaches being used to target child and family outcomes. *Types* of approaches may include sets of principles, frameworks or models, interventions, therapies, practices, programs, services or systems of care. For simplicity, we use the word 'approach' within this report to refer to all of these *types* of approaches, except where it is necessary to distinguish between types of approaches, in which case we have labelled them programs, service models and systems of care accordingly.

Questions addressed by this report

This report addresses the following questions:

1. What are the evidence-based approaches relevant to child and family service organisations that target children and young people who are exposed to prolonged and repeated trauma as a consequence of child abuse and neglect, and other situations where there is an increased risk of trauma exposure such as family violence, parental mental illness and parental substance abuse?
2. What is the level of evidence for those approaches?
3. What is the awareness and uptake of evidence-based approaches that aim to address the child and family consequences of trauma exposure relevant to child and family service organisations in Australia?
4. What are the practical drivers and obstacles to the uptake of evidence-based approaches that target child outcomes after trauma exposure?
5. What are the key considerations that will assist organisations to successfully implement evidence-based approaches designed to target children exposed to trauma through abuse and neglect?

Structure of this report

The report is organised into five chapters. This chapter provides an overview of the background to this report, and includes clarification of important terminology used in the report, including definitions of child abuse and neglect, trauma (and related terminology) and evidence-based practice (and related terminology). In addition to a description of the prevalence of child abuse and neglect in Australia, Chapter 1 also provides a brief literature summary of the negative consequences for children exposed to persistent and repetitive trauma through child abuse and neglect, and a discussion of the role of trauma-specific and trauma-informed care in dealing with the negative outcomes of trauma exposure.

Chapter 2 details the methods and findings of a Rapid Evidence Assessment (REA) to review and assess the evidence for approaches that aim to prevent or treat poor child and family outcomes where children have been exposed to repeated and prolonged trauma as a consequence of physical, emotional or sexual abuse, neglect, family violence, parental mental illness or parental substance abuse.

Chapter 3 details the methods and findings of an online survey of practitioners (hereafter referred to as the 'practice survey') to identify approaches being used currently by practitioners in the child and family services sector across Australia to address the outcomes of trauma exposure.

Chapter 4 details the methods and findings of consultations with organisational leaders and senior managers regarding factors that influence the uptake of evidence-based approaches to childhood trauma exposure as a result of child abuse and neglect.

Chapter 5 provides a synthesis of major findings and key themes from the REA, the practice survey, and manager and organisational leader consultations. Implications for the implementation of evidence-based approaches are also discussed, and service delivery

considerations are provided in response to the identified needs, gaps and issues addressed in this report. Recommendations to address these gaps and issues are also made.

Background

Defining child abuse and neglect

Child abuse and neglect refers to any behaviour by parents, caregivers, or other adults or older adolescents that is considered outside the norms of conduct and involves substantial risk of causing physical or emotional harm to a child or young person.[1] These behaviours may be intentional or unintentional and can include acts of omission (i.e., neglect) and commission (i.e., abuse). Types of abuse and neglect can include physical abuse, sexual abuse, neglect and emotional maltreatment, including the witnessing of family and domestic violence.[2]

It is difficult to locate reliable statistics on the rates of child abuse and neglect among Australian children. This is due to differences in how child protection data is collected across Australian states and territories[3], as well as limitations in how national data is collected. For instance, currently available data only includes types of abuse and neglect that had been listed as the primary type, thereby reducing the effectiveness of the data to capture multiple abuse and neglect types. Reliable statistics are also affected by varied definitions of child abuse and neglect even within the same category of abuse or neglect (e.g., there is variation in the definition of child sexual abuse[4]), the undetected nature of child abuse and neglect due to non-disclosure of offences, limited understanding of child abuse by practitioners who are subject to mandatory reporting requirements[5], difficulties children may have with disclosure, and lack of evidence to substantiate some offences.[6] In addition, research investigating the prevalence of child abuse or neglect tends to report only one or two types of maltreatment, and a rigorous, nation-wide epidemiological study of the prevalence of child abuse and neglect has not yet been conducted.[5,7] Moreover, child protection data only include those cases of abuse and neglect that are detected and reported. As a result, the number of children in Australia who have experienced abuse or neglect may be underestimated, which would suggest that existing prevalence data is conservative. However, this point is debated, as there is some evidence that increased reporting of child abuse and neglect does not result in a similar increase in substantiated claims.[8,9]

According to the Australian Institute of Health and Welfare, in 2010–11 there were 237,273 reported cases of suspected abuse and neglect among Australian children, with the total number of substantiated notifications being 40,466. This amounted to 31,527 children who were abused or neglected in one calendar year.[3] Studies assessing the prevalence of childhood physical abuse in community samples of Australian adults have placed estimates at 5–10 per cent.[10] The prevalence of childhood neglect among adults is estimated to be 12 per cent.[10] Prevalence studies of emotional maltreatment among children estimate a prevalence of 6–17 per cent[10], while experiences of family violence are more common at 12–23 per cent.[10] Studies that measure the prevalence of child sexual abuse estimate the prevalence among males to be 4–8 per cent for penetrative abuse, and 12–16 per cent for non-penetrative abuse; while rates among females are 7–12 per cent for penetrative abuse and 23–36 per cent for non-penetrative abuse.[10]

Differentiating abuse and neglect

Distinctions between neglect and abuse most commonly contrast acts of omission with those of commission. Definitions of neglect tend to emphasise the failure to meet a child's basic developmental needs through acts of omission by those responsible for that child (usually a parent). Specifically, this includes the failure of the person responsible to provide needed food, clothing, shelter, medical care or supervision to the degree that the child's health, safety and wellbeing are threatened with harm.[11] In contrast, definitions of abuse are associated with acts of commission resulting in direct harm to the child[12]. Although abuse and neglect are often discussed together, and often occur with overlapping correlates[12], it is important to acknowledge that the impacts and consequences of each can be different. Furthermore, within the context of this report, we recognise that exposure to neglect or abuse may represent exposure to trauma.

Defining trauma experiences and traumatic reactions

In both the scientific literature and lay terminology, the word *trauma* often has different meanings. For the purpose of this project, we provide the following definition of trauma:

> *Trauma refers to experiences or events that by definition are out of the ordinary in terms of their overwhelming nature. They are more than merely stressful — they are also shocking, terrifying, or devastating to the survivor, resulting in profoundly upsetting feelings of terror, fear, shame, helplessness, and powerlessness.*[13]

This definition incorporates two related concepts in trauma: traumatic events and traumatic reactions, which will be explored further in the following paragraphs.

Traumatic events

Traditionally, traumatic events have been defined as the experience of actual or threatened death, serious injury or sexual violation, or exposure to the death, injury or suffering of others. In childhood trauma, this may also include witnessing these events as they occur to others (especially primary caregivers) or learning that these events occurred to a parent or primary caregiver.[14] Some have argued that such a definition of trauma lacks specificity and have therefore introduced the concept of Type I and Type II trauma.[15] Type I trauma involves a traumatic event that occurs at a particular time and place, and the duration of exposure is usually short. Traumatic events in this category include (but are not limited to) natural disasters, accidental trauma including burns and serious motor vehicle accidents, sudden death of a parent, and single incident sexual assault. Type II trauma (often referred to as complex or developmental trauma), differs from Type I trauma in that (i) the trauma is repetitive or prolonged; (ii) it may involve direct harm and/or neglect by caregivers; and (iii) it may occur at developmentally vulnerable times for a child.[16,17] Central to this concept is that exposure to this trauma occurs within an environment where escape is extremely difficult (especially when the trauma involves the primary caregiver).[18]

Trauma reactions

Many people exposed to traumatic experiences will experience a range of emotional, social and behavioural reactions. Reactions to traumatic events are traditionally described as a range of traumatic stress symptoms that include (but are not limited to), intrusive memories about the event, behavioural and emotional avoidance, high levels of arousal (such as an increased startle

response and hypervigilance), sadness or depression, anxiety and guilt.[19-21] In children, these reactions can include play that re-enacts the trauma, dreams that can evolve into nightmares about monsters or threats to self and significant others, a return to 'babyish' behaviour, extreme fearfulness, aches and pains, bedwetting, general misbehaviour, tantrums and attention seeking behaviour, or poor school performance.[22,23]

In addition to the reactions listed above, exposure to Type II traumatic events increases risk for a complex presentation of psychological, social and behavioural disturbances, including (but not limited to) emotional dysregulation (difficulty regulating emotional responses), social dysregulation (including poor early and later attachment), negative perceptions of self and the world, dissociation, self-destructive behaviours, substance abuse, difficulty trusting people, and hopelessness.[17,24,25,26]

A substantial body of research has shown that exposure to child abuse and neglect can seriously interfere with healthy development and contribute to a range of negative psychological and physical health outcomes.[27-29] Children who experience child abuse or neglect are at increased risk for delays in physical, cognitive and language development, somatic complaints, internalising and externalising problems, difficulties with early and later attachment, difficulties in emotional regulation, maladjustment to school, difficult peer relationships, social withdrawal and anti-social behaviour.[30-33] Many of these outcomes may be associated with exposure to repeated and prolonged trauma from child abuse and neglect.

Persistent trauma reactions

The degree to which reactions to traumatic events persist over time depends on a number of factors, including individual risk factors, the type of traumatic experience, and the post-trauma environment.[34] For those exposed to traumatic events, especially events that would be described as Type I traumatic events, many of the trauma reactions are transient and dissipate over time.[35] Those who are exposed to interpersonal violence are at increased risk for persistent reactions relative to traumatic events that do not involve interpersonal violence.[36,37]

There is evidence to suggest that exposure to Type II trauma increases the risk that emotional, cognitive and behavioural reactions will persist over time.[38] In a systematic review and meta-analysis of the long-term health consequences of child maltreatment, Norman and colleagues[39] found that exposure to child physical abuse, emotional abuse and neglect approximately doubled the risk of adverse mental health outcomes at a later time. Furthermore, they found evidence of a dose-response relationship between adverse health outcomes and child maltreatment, such that those experiencing more severe abuse or neglect were at greater risk of developing persistent mental disorders than those experiencing less severe maltreatment.

Compared with what is understood from the scientific literature regarding the effects of child abuse, it is more difficult to establish the cumulative effects of neglect alone because of a lack of longitudinal or population-based studies. However, research has shown that child neglect can have negative impacts on health and physical development, for example, impaired brain development[40], delays in growth or failure to thrive[41], delays in intellectual and cognitive development (e.g., poor academic performance[42], delayed or impaired language development[43]), and difficulties in emotional and psychological development (e.g., deficiencies in self-esteem[44,45] and attachment[46]) and social and behavioural development (e.g., interpersonal relationship problems[47], aggression[48]). The impacts in these areas can be inter-related, where problems in one developmental area may influence functioning in another area.

Although traumatic events and reactions may be more obviously observable as examples of abuse (e.g., witnessing or being harmed by life threatening events), the experience of one or multiple experiences of neglect (especially in severe cases), has also been shown to result in PTSD and other trauma reactions.[11,49] In addition, research indicates that experiencing neglect along with other forms of maltreatment worsens the impact.[50] Thus, it is important to consider that different forms or combinations of abuse and neglect can have differential effects, which in turn may influence the selection of an intervention approach.

The timing or age at which the prolonged trauma exposure occurs may play a role in explaining the variable impact of trauma exposure. During a child's early years, prolonged, severe or unpredictable abuse and neglect can be especially problematic, resulting in significant developmental harms. For instance, there is some evidence to suggest that brain development can be altered by abuse and neglect in early life, resulting in negative impacts on the child's physical, cognitive, emotional, and social growth.[36,51] In addition to age, the specific effects of abuse and neglect are likely to be influenced by the frequency and chronicity of traumatic event exposure, the identity of the abuser (e.g., parent or other adult), the type and severity of the abuse or neglect, and how long the abuse or neglect lasted. The presence of a dependable nurturing person in the child's life, the effect of intervention, brain plasticity and other resilience-promoting factors may also play a role in mediating the longer-term impacts of trauma associated with exposure to abuse or neglect.[36]

Defining trauma-informed care

Trauma-informed care is a term that is regularly used in the context of addressing outcomes associated with trauma exposure, however, the meaning of trauma-informed care is often unclear, and the mechanisms for change associated with use of a trauma-informed approach are not well defined.[52] Indeed, there is no consensus definition that outlines clearly the nature of trauma-informed care.[52] For this report, we have adopted the following definition of trauma-informed care:

> *Trauma-informed care refers to a framework grounded in an understanding and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. It incorporates an awareness of the impact of trauma and traumatic stress and recognition of the potential longer-term interferences to one's sense of control, safety, ability to self-regulate, sense of self, self-efficacy and interpersonal relationships.*[52]

According to the National Child Traumatic Stress Network in the USA[53], child and family service organisations that adopt a trauma-informed care framework will understand, anticipate and respond to the issues, expectations and special needs of individuals within a particular setting or service, who have been victimised. Such organisations will have programs, agencies, and service providers that: (i) routinely screen for trauma exposure and related symptoms; (ii) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (iii) make resources available to children, families, and providers about trauma exposure, its impact, and treatment; (iv) engage in efforts to strengthen resilience and protective factors of children and families impacted by and vulnerable to trauma exposure; (v) address parent and caregiver trauma and its impact on the family system; (vi) emphasise a

continuity of care and collaboration across child service systems; and (vii) maintain an environment of care for staff that addresses, minimises, and treats secondary traumatic stress, and that increases staff resilience.[54]

Note: The peak body for substance abuse and mental health in the USA, Substance Abuse and Mental Health Services Administration (SAMHSA), uses the term *trauma-informed approach.*[54] This terminology acknowledges that some sectors do not identify as 'care-giving' (e.g., criminal and juvenile justice), and thus the term *trauma-informed approach* may be more relevant for these sectors. Generally, these terms may be used interchangeably, but there may be slight differences. For the purposes of our report, we will use the term *trauma-informed care*. For information about the distinction between trauma-informed care and trauma-informed approach, refer to SAMHSA http://www.samhsa.gov/nctic/default.asp.[55]

Trauma-specific/focused interventions

Trauma-informed care is distinct from the delivery of discrete therapeutic trauma treatment, often referred to as *trauma-specific interventions*[55] or *trauma-focused interventions*. Trauma-specific/focused interventions have been developed to address traumatic experiences and their consequences for individuals or families. Trauma-specific/focused interventions directly address the impact of the trauma and its sequelae through the goals of decreasing symptoms and facilitating recovery.[56] Discrete trauma-specific/focused interventions may be offered within a trauma-informed care approach or stand alone.[52]

A note on the association between trauma and attachment

In this report it is acknowledged that a secure and stable caregiver-child relationship generally forms the foundation for a child's healthy emotional development and future secure and stable relationships. Traumatic experiences in early childhood, particularly when perpetrated by caregivers, have the potential to undermine attachments, creating a cycle of distress, alienation from sources of support, and further trauma.

Attachment plays a key role in trauma exposure for two reasons. First, abuse or neglect perpetrated by a caregiver can be a significant source of trauma, and therefore disruptive to the attachment relationship, particularly if the abuse occurs during critical times in a child's development. Second, attachment relationships play a key role in restoring a sense of safety when a potentially traumatic event has occurred. That is, in the event of trauma exposure, the establishment and maintenance of secure attachments are thought to be important to how the trauma is processed and managed. Thus, attachment relationships may be important to understanding responses to trauma. While attachment relationships may play a role as a potential mediator or outcome in the relationship between trauma exposure and child wellbeing, it should be noted, however, that for the purposes of this report, an insecure caregiver-child attachment is not regarded as a traumatic event in and of itself.

Establishing an evidence-based approach

Undoubtedly, governments, policy makers, service organisations, practitioners, researchers and advocates are committed to promoting the highest standard of care for children who are exposed to traumatic events. A great challenge in preventing and alleviating poor physical, psychological, cognitive and social outcomes in children exposed to abuse and neglect, is ensuring that care delivered across a range of support settings is both safe and effective. Without an evidence base, it is difficult to determine whether practices meet the standards of

being safe and effective, while at the same time producing the highest standard of care available.

In the literature and in practice a range of terms are often used, sometimes inappropriately, to describe the level of evidence available for approaches to prevention and treatment in child and family support intervention. Here we clarify some of the terms relevant to the current report:

Evidence-based
Evidence-based approaches incorporate research evidence with clinical decision-making, whereby practitioners, in consultation with their clients, use the best available evidence from research to choose interventions that are best suited to the needs of the client.[54] An evidence-based approach draws upon and integrates information from scientific evidence derived from systematic and empirical research. It differs from methods based on tradition, convention, rules of thumb, anecdotal evidence, or speculation.[57,58] The implementation of evidence-based approaches helps assure practitioners that they are using strategies that carry the strongest evidence for working effectively with children and families. Additionally, the use of research evidence to guide practice and develop policies in the human services has become increasingly important given limited service resources and pressures on government spending. Research and empirical evidence are therefore highly valued for their potential to improve policy and practice decisions in the child and family services sector.[59]

Evidence-informed
In contrast, *evidence-informed* approaches are those that use the current best evidence available (may not be empirical research findings) combined with the knowledge and experience of practitioners and the views and experiences of service users in the current operating environment.[60,61] Evidence-informed approaches are often used when there is a limited evidence base within a particular problem area.

Evidence
In conceptualising evidence-based and evidence-informed approaches, it becomes necessary to define what is meant by the term *evidence*.

> *Evidence refers to the forms of knowledge relevant to practice.[59] It includes research evidence (e.g., evaluations about what interventions and practices improve program outcomes, research regarding reasons for failures in treatment adherence); service monitoring and other statistical data; expert knowledge; stakeholder consultations; and program and service cost-effectiveness information.*

Research findings, knowledge from basic science, clinical knowledge, and expert opinion are all often considered to be forms of 'evidence'; however, approaches based on empirical research findings are typically more likely to result in the intended client outcomes across a range of settings and geographic locations compared with approaches based on other forms of 'evidence'.

Defining 'Approaches'

Within this report we use the term 'approach' to cover a range of *types* of approaches that may be used with children and families. *Types* of approaches may include sets of principles,

frameworks or models, interventions, therapies, practices, programs, services or systems of care. For simplicity, within this report we use the word 'approach' to refer to all of these *types* of approaches, except where it is necessary to distinguish between types of approaches, in which case we have labelled them programs, service models and systems of care accordingly. 'Practices' may be used within any of these three types of approaches. For the purposes of the current report, we have adopted the following definitions:

> *'Practices' refer to skills, strategies and/or techniques targeting prevention or treatment aimed at improving child/family/parent outcomes.*[62,63]
>
> *'Program' refers to a well-defined curriculum, set of services or interventions designed for the needs of a specific group or population.*[62] *Programs are often discrete, manualised curriculums or series of actions/tasks/behaviours designed for a particular population to meet particular outcomes, which are usually measurable*[64]*. Within a program, children, caregivers or guardians receive direct targeted education, training or support or intervention to increase their knowledge, capacity and/or skills to improve child and family outcomes.*[65]
>
> *'Service Model' refers to a suite of programs or practices delivered to a client group by an agency, organisation or service system. Services may be delivered at home (e.g., a home visiting service) or within another setting (e.g., clinic, school, community venue). NB: home visiting programs cannot always be described as 'services' or 'service models'; for instance, if they are delivered as a structured curriculum they are viewed as a program.*
>
> *'System of Care' refers to a coordinated network of community-based services and supports. It is an approach incorporating a philosophy or guiding framework that promotes program or service delivery in particular ways that prioritise the needs of children, youth and families to function better in various contexts (i.e., school, home, child protective services, peer networks).*[66]

Note. For further definitions of terms used throughout this report, the reader is referred to the Glossary in Appendix 1.

Chapter 2: Rapid Evidence Assessment

Aims of the Rapid Evidence Assessment

We conducted a Rapid Evidence Assessment (REA) of approaches that targeted or prevented poor child and family outcomes for children exposed to or at risk of exposure to prolonged or repetitive trauma as a consequence of child abuse and neglect. In addition to child abuse and neglect, we also included children who had been exposed to or were at risk of exposure to Type II trauma as a result of domestic/family violence, parental mental illness and parental substance abuse, because these were specific populations identified by the project funders (Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA, now Department of Social Services) as groups to focus on as part of their Child Aware Approaches Initiative.

This chapter outlines the methodology and findings of the REA, along with a discussion of the major conclusions and limitations of the analysis. Implications for selecting approaches identified within this REA are further explored in the General Discussion and Conclusions and Recommendations sections of this report (chapter 5).

Methodology of the Rapid Evidence Assessment

REA is a method that is increasingly being employed to systematically review the available literature on a topic. The REA methodology streamlines traditional systematic review methods to synthesise evidence within a shortened timeframe. The advantage of REA is that rigorous methods for locating, appraising and synthesising evidence from previous studies can be upheld. Also, the studies included in REAs can be described at the same level of detail that characterise systematic reviews, and results can be produced in substantially less time than required for a full systematic review. Limitations of the REA methodology mostly arise from the restricted time period, often resulting in the omission of literature such as unpublished pilot studies, difficult-to-obtain material and/or non-English language studies. A major strength, however, is that REAs can inform policy and decision makers more efficiently by synthesising the evidence in a particular area within a relatively short time and at lower cost.

Questions addressed by the Rapid Evidence Assessment

The current REA addressed the following questions:

1. What are the evidence-based approaches relevant to child and family service organisations that target children and young people who are exposed to or at risk of exposure to prolonged and repeated trauma as a consequence of child abuse and neglect, and other situations where there is an increased risk of trauma exposure such as family violence, parental mental illness, and parental substance abuse?
2. What is the level of evidence for those approaches?

Search strategy

The following search terms were used to identify papers for potential inclusion in the REA:

- children or child or infant or toddler or preschool or young person or adolescent or teenager AND

- (trauma or child abuse or child sexual abuse or child neglect or child maltreatment) OR (parental mental illness or parental substance use/abuse or family violence or domestic violence or interpersonal violence)[b] AND
- therapy or intervention or treatment or prevention or trial or practice or program OR
- trauma-informed

These search terms were selected in an attempt to identify populations or samples that predominantly encompassed children likely to have experienced Type II trauma, or, in the case of prevention approaches, children who were identified as being at specific risk for experiencing Type II trauma.

Potential documents (e.g., studies, papers, reports) for inclusion in the REA were sourced via four search methods:

1. Academic electronic databases: PsycINFO, CINAHL, ERIC, MEDLINE, PILOTS and The Cochrane Library.
2. Electronic databases containing grey literature (see Table 1 for a list of specific databases searched).
3. Government websites and websites of Australian and international child and family organisations for additional published and unpublished evaluations (see Table 2 for a list of specific websites searched).
4. Stakeholder identification of papers that were not potentially identifiable by the methods described above.

The search methods described in points 1 to 4 were employed to ensure that literature was canvassed from a diverse range of sources, including academic databases as well as grey literature. Grey literature sources and government/non-government websites were important to include, so that reports, conference proceedings, and other published and unpublished materials containing evaluations of approaches meeting inclusion criteria could be accessed for the evidence review. In the child and family services sector, the production of government or organisational reports regarding approaches targeting child abuse and neglect is commonplace, and it was considered important to include these documents in the REA. Similarly, key stakeholders in the project, such as the project Reference Group, were helpful in identifying potentially relevant papers or reports to be reviewed by the REA. In instances where specific documents were recommended by stakeholders and not identified by other specified methods, a targeted search for these documents was conducted using electronic databases, grey literature sites and the Google search engine.

[b] These terms were included in the search to ensure that family or household circumstances that may put children at high risk of exposure to maltreatment would be captured in the search, as per the project funder's specific requirements.

Table 1. Electronic databases used to source grey literature as part of the REA methodology.

Name of database website used to source literature for the REA
• OpenGrey http://www.opengrey.eu/ • Medline Plus from U.S. National Library of Medicine http://www.nlm.nih.gov/medlineplus/ • National Health Service (NHS) Evidence http://www.evidence.nhs.uk/ • Office of Scientific and Technical Information http://www.osti.gov/home/ • The New York Academy of Medicine – Grey Literature Report http://www.greylit.org/ • Government of Canada Publications http://publications.gc.ca/site/eng/home.html • Australian Government Publications http://australia.gov.au/publications • Publications USA.gov http://publications.usa.gov/USAPubs.php • Official-documents.gov.uk http://www.official-documents.gov.uk/ • British Government Publications http://www.york.ac.uk/library/publications/guides/britishgovernmentpublications

Table 2. Government and child and family service organisations used to source grey literature as part of the REA methodology.

Name of government and organisational websites used to source literature for the REA
• Child Family Community Australia – Research Practice and Policy Information Exchange http://www.aifs.gov.au/cfca/ • Australian Domestic & Family Violence Clearinghouse http://www.adfvc.unsw.edu.au/ • Canadian Child Welfare Research Portal http://cwrp.ca/ • Australian Institute of Health and Welfare http://www.aihw.gov.au/child-health-development-and-wellbeing/ • Child Welfare Information Gateway http://www.childwelfare.gov/ • World Health Organization http://search.who.int

Paper selection

Inclusion criteria

Papers were included in the review of evidence if they met **all** of the following inclusion criteria:

1. Papers dated between 1 January 2000 and 15 August 2012.
2. English language papers.
3. Papers that reported on an approach that aimed to minimise the risk for, or treat the physical, psychological/emotional, cognitive, and/or social consequences arising from exposure to repeated and/or prolonged trauma as a consequence of child physical abuse, sexual abuse, emotional abuse or neglect. Other family or household circumstances that may have exposed children to repeated and/or prolonged trauma associated with abuse or neglect, such as domestic or family violence, parental mental illness and/or parental substance abuse, were also considered for inclusion.
4. Papers that reported an empirical assessment of the impact of a relevant approach. For the purpose of this review, an empirical study was considered to be one that completed significance testing to measure the effect of the approach.
5. Empirical studies that reported changes in measures that were related to a category from the outcome framework (see Table 3).

Exclusion criteria

Papers were excluded if they met **any** of the following exclusion criteria:

1. Papers and reports not published between January 1, 2000 and August 15, 2012.
2. Non-English language papers.
3. Papers that did not report on an approach that aimed to minimise the risk for, or intervene in the physical, psychological/emotional or social consequences arising from child trauma as

defined above. For example, excluded papers under this criterion included those that described single event traumas or traumatic events that were not repeated and/or prolonged, such as a natural disaster or motor vehicle accident. Although our search yielded papers arising from war trauma and community violence, which are typically more associated with repeated and/or prolonged trauma, inclusion of these forms of traumatic events were beyond the scope of this project and were therefore excluded from the evidence review[c].

4. Papers that did not include any significance testing of the outcomes of an approach. For example, excluded papers under this criterion included qualitative papers that were purely descriptive.
5. Empirical studies that did not report on measurable changes in physical, psychological/emotional and/or social outcomes for the child. For example, excluded papers under this criterion included a parenting program where there was no measureable direct effect for the child.

Following the exclusion of papers based on a review of paper titles and abstracts, a detailed full text review of remaining papers was conducted. Those papers assessed as not meeting the inclusion criteria were excluded from the REA.

Data extraction

Data from the remaining included papers were extracted. Extracted data included information about:

- the name of the approach
- author(s) of the papers
- aims of the approach
- country where the evaluation was conducted
- ages of children targeted by the approach
- trauma type targeted by the approach
- whether the approach was prevention or intervention based
- whether the approach was a program, service model or system of care
- the extent to which the approach focused on trauma
- outcomes targeted by the approach
- design related to the evaluation of the approach
- participant characteristics of the population targeted.

Approaches that were assessed using randomised controlled trial (RCT) designs with follow-up of six months or more were subjected to additional data extraction. This additional data included information about: (i) the theory underpinning the approach, and (ii) the nature of the approach with regard to setting and delivery mode. This additional extraction procedure enabled papers of high scientific standard (i.e., RCT) to be examined in greater detail.

[c] It is unknown the extent to which children exposed to war trauma and community violence come to the attention of child protective services. We recognise the importance of these populations to informing the evidence-base for programs in children exposed to abuse generally, but as the project funder's requirements did not explicitly target these populations, associated papers were excluded from the evidence review.

Extent of focus on trauma

Within this review we categorised, where possible, approaches as having at least some element(s) of trauma-informed care or trauma-specific/focused. These terms were operationalised as follows.

- *Trauma-informed care:* A broad definition of trauma-informed care was employed. To be categorised as a trauma-informed care approach, the approach needed to demonstrate at least one of the following[53]:

  i) routinely screens for trauma exposure and related symptoms
  ii) uses culturally appropriate, evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
  iii) makes resources available to children, families and providers about trauma exposure, its impact and treatment
  iv) engages in efforts to strengthen resilience and protective factors of children and families impacted by and vulnerable to trauma exposure
  v) addresses parent and caregiver trauma and its impact on the family system
  vi) emphasises a continuity of care and collaboration across child service systems
  vii) maintains an environment of care for staff that addresses, minimises and treats secondary traumatic stress, and that increases staff resilience.

- *Trauma-specific/focused*: To be categorised as trauma-specific/focused the approach needed to directly address the impact of the trauma and its sequelae through the goals of decreasing symptoms[55]:
- *Not trauma-informed care or not trauma-focused/specific*: These approaches demonstrated neither a trauma-specific/focused nor a trauma-informed care element.

Child and family outcomes framework

A child and family outcomes framework was developed to categorise the outcomes targeted by approaches included in the REA. Here, we use the term outcome to refer to the target of the approach, rather than the benefits of the approach. This framework is aligned with previous frameworks in the child wellbeing literature[67,68], and is designed with desired outcomes for children exposed to Type II trauma through abuse and neglect in mind. The framework is also consistent with an ecological approach to examining the effects of trauma exposure on the developing child. The framework reflects the multitude of risk and protective factors as well as consequences of trauma exposure that can be targeted in prevention and intervention strategies.

The child and family outcomes framework used in this project classified relevant outcomes into seven broad domains:

1. Child physical health and development
2. Cognition
3. Educational
4. Psychological, emotional or behavioural symptoms

5. Relationships and family or social functioning
6. Service utilisation
7. Further or reduced risk for childhood abuse/maltreatment.

The outcomes framework, along with examples that fall into each of the seven core domains is shown in Table 3.

It is necessary to recognise that different approaches within the REA aim to influence different child outcomes (e.g., behaviour, confidence, emotional symptoms and substance use) and/or caregiver outcomes (e.g., parenting skills and behaviours, teacher capacity to support traumatised children). Additionally, some approaches address outcomes across a number of domains. In this REA, outcomes for all identified approaches were classed in one or more of these outcome domains. To be included for analysis in the REA, it was a prerequisite for papers to have provided evidence for at least one of the defined outcome domains described in Table 3.

Table 3. The adopted child and family outcomes framework reflecting the target outcome domains of approaches identified in the REA.

Outcome domain	Examples of outcomes within the domain
Child physical health and development	Milestone development — normal standards of growth and development Temperament and personality Physical and neurological development Safety and physical wellbeing Language
Cognition	Beliefs in safety and trust Understanding appropriate behaviours Problem-solving Attention
Educational	Indices of attendance School refusal Learning Academic performance
Psychological, emotional or behavioural symptoms	PTSD, depression, anxiety, other mental illness symptoms Traumatic grief, loss and bereavement Dissociation Affect/emotional regulation and management Coping and expression Self-esteem, self-efficacy, self-control Resilience Identity (self) and perceptions of others

Outcome domain	Examples of outcomes within the domain
	Fear Substance use Conduct problems Aggression, anger Risk-taking behaviours Sexual behaviours
Relationships and family or social functioning	Relationship between parent and child (e.g., levels of aggression) Family functioning Peer relationships Social connectedness Social competence (perception and functioning) Relationships with significant others Measures of attachment
Service utilisation	Notification to agencies Referrals to agencies Presentation to emergency department Help-seeking behaviour Out-of-home/ foster care Length of stay
Further or reduced risk for childhood abuse/maltreatment	Measures of risk for childhood abuse A measure of any construct noted to reduce the risk for childhood abuse in a paper

Evaluation of the evidence

Each included approach was assessed for the degree of evidence supporting the approach. Approaches were classified into an evidence ranking category established for this REA, with categories ranging from Well Supported (highest category) through to Concerning Practice (lowest category) (see Figure 1). The categories were established based on well-known scientific evidence grading systems in the child welfare field[54,67,69] and adapted for the purposes of this REA. Additional categories were introduced to increase discrimination between categories of evidence. For example, additional categories allowed discrimination between RCTs *with follow-up,* from RCTs *without follow-up*. Thus, the evidence grading system reflected the scientific benchmarks for empirical studies, where RCTs with long-term follow-up effects constitute a 'gold standard' category of evidence.

The evidence ranking categories used in this project to evaluate trauma approaches are presented in Figure 1. Evidence was graded from Well Supported to Concerning Practice according to specific criteria that included beneficial effect, harm and study design. Approaches rated from Well Supported through to No Effect were required to demonstrate no harmful effects. It is noted here that although the rating system adopted specifically for the current analysis is based on well-known and credible scientific rating systems used in the child welfare

sector, approaches may be assessed differently under other rating systems, depending on the criteria used by those rating systems. For instance, some rating systems emphasise conceptualisation and internal consistency of programs and practices while others do not.

The rating system adopted for this REA prioritises the review of evidence according to accepted standards of empirical research. Further, it is noted that some of the approaches rated herein may receive different ratings in other reviews, as approaches may have been evaluated in additional studies using non-trauma populations, which therefore do not meet the inclusion criteria for the current REA. Only studies that reported that an aim of the approach was to minimise the risk for, or treat the physical, psychological/emotional, cognitive, and/or social consequences arising from exposure to repeated and/or prolonged trauma as a consequence of child physical abuse, sexual abuse, emotional abuse or neglect were included in the current REA. For example, Triple P has been evaluated across a range of other non-trauma populations, and has received higher ratings than found herein[67], specifically examining the effectiveness of the program for children exposed to trauma.

Well Supported and Supported evidence categories

For an approach to reach the highest evidence rating (Well Supported), it must have been evaluated using an RCT that is widely regarded as the most rigorous evaluation design methodology. A Well Supported approach must have demonstrated beneficial effects in the intervention condition over and above a control comparison condition. The approach was also required to demonstrate maintenance of beneficial effects in the long term (at least 12 months). Finally, for an approach to be Well Supported, it was required that an additional RCT support these findings; that is, at least two RCTs demonstrating beneficial intervention with long-term maintenance of effects in at least one of those RCTs was required. Approaches that reached the Supported category were evaluated as having the rigour of the Well Supported category but without the replication (i.e., one RCT required only), and with a significant effect for at least one outcome observed at least six months following the end of the approach. Effects may or may not have been assessed beyond the six-month period.

Promising categories

For an approach to be categorised as Promising, it required one study that incorporated a control condition designed to demonstrate beneficial effects, but no replication or maintenance of effects was necessary. If the study showed benefit and was an RCT design, then the approach was classified as Promising A. Promising A approaches may have demonstrated an effect at completion of the approach or at a follow-up of less than six months (e.g., three months). If effects were not observed at six months or beyond (as required for a 'Supported' rating) it may not necessarily mean that 'no effect' was found; rather, it may mean that effects had not been assessed at later points in time. If the study had a control condition but was not a randomised design it was classified as Promising B.

Emerging categories

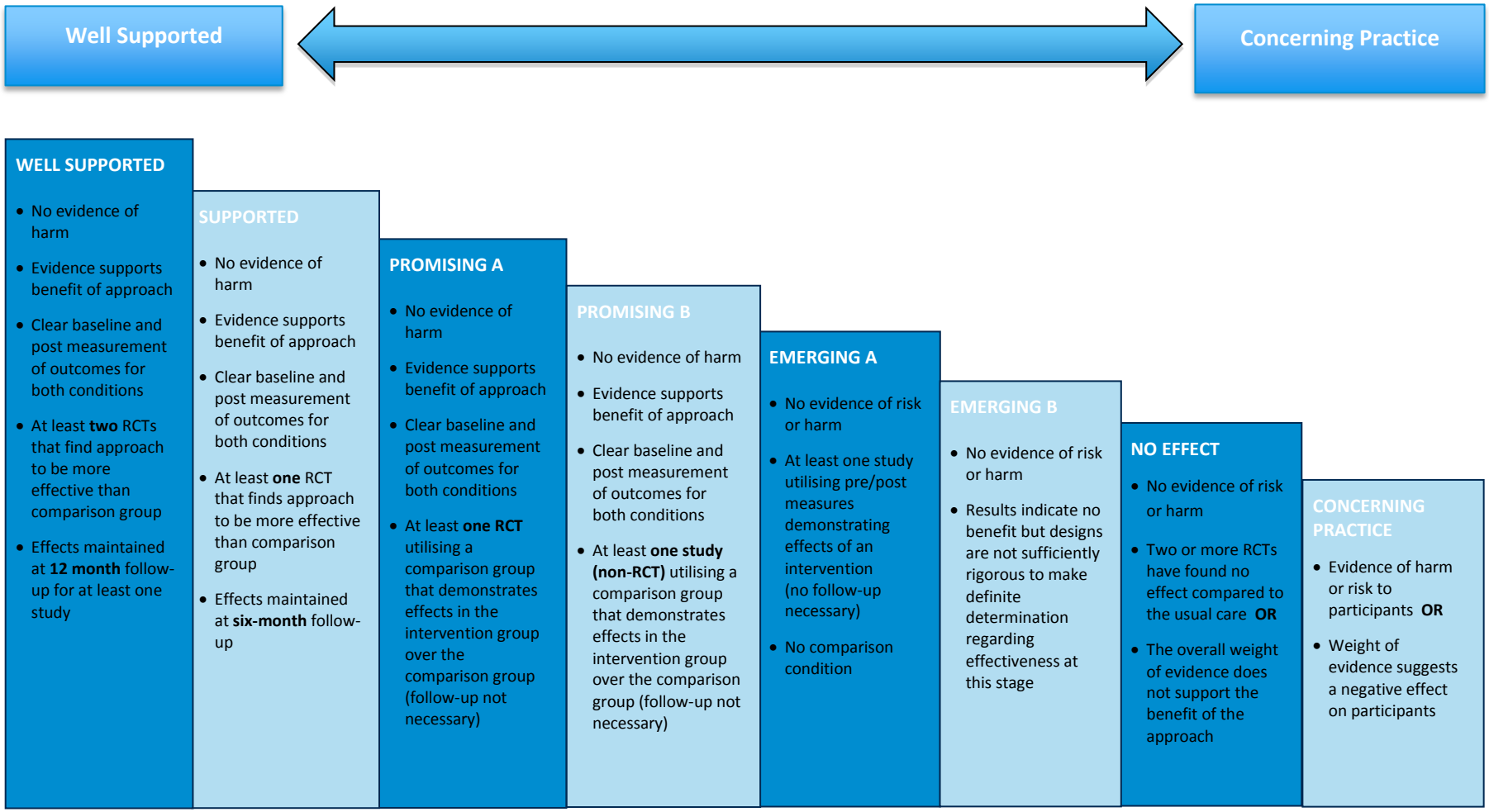
Approaches classified as Emerging received ratings of either Emerging A or Emerging B. For approaches to satisfy the Emerging A category, at least one study had to have demonstrated beneficial effects from before intervention (pre-test) to after intervention (post-test). These studies did not have control conditions and therefore did not possess the rigour of studies with a comparison group. Approaches that met the Emerging B category generally demonstrated no benefit or improved outcomes. However, as the designs used were not sufficiently rigorous (for

example, there was no element of randomisation within them or they lacked a control group), or there was insufficient replication of the findings, we could not confidently conclude that these approaches would have 'no effect' if evaluated appropriately. Future research is required to determine if they are effective or do in fact clearly demonstrate no effect.

No Effect category
Approaches were classified in the No Effect category if two or more RCT studies showed no beneficial effects. In addition, approaches could meet criteria for a rating of No Effect if the overall weight of evidence did not support the benefit of the approach.

Concerning Practice category
Approaches that demonstrated harmful effects, or where the weight of evidence suggested a negative effect on participants, were classified in the Concerning Practice category.

Figure 1. Categories of evidence used to assess approaches identified for inclusion in the REA.



Findings of the Rapid Evidence Assessment

From all sources searched, we located 137 papers reporting 133 evaluations of 96 approaches that targeted children exposed to repeated and prolonged trauma associated with child abuse, child sexual abuse, child neglect, family violence, parental mental illness and/or parental substance abuse. The disparity in numbers between papers (*n* = 137), studies (*n* = 133) and approaches (*n* = 96) is because some approaches were reported in multiple articles, some studies were reported across multiple articles, and there were also two reports that separately evaluated more than one approach.[70,71] A flow chart of identified papers is presented in Figure 2.

Combining all evidence available in the 137 REA papers, we sorted the approaches by approach type (i.e., program, service model or system of care) and rated the approaches using the categories described in Figure 1. A tally of the number of each type of approach rated in each evidence category is presented in Table 4. As no approaches were rated No Effect or Concerning Practice, these categories are not included in the table.

As shown in Table 4, there were 63 programs, 23 service models and 10 systems of care assessed in this REA. Several approaches were identified as having good evidence for preventing or reducing the impact of repetitive and/or prolonged trauma associated with child abuse and neglect and improving a range of outcomes for children. One approach met the criteria for Well Supported and eight approaches met the criteria for Supported. The bulk of approaches identified in the REA fell into the Emerging A category (*n* = 37), with several also rated as Promising A (*n* = 21), Promising B (*n* = 19) and Emerging B (*n* = 10). No approaches in this REA were rated No Effect or Concerning Practice.

Tabulated information describing each of the 96 approaches according to their approach type and evidence ranking is found in Appendix 2, Tables 1a–15b. Descriptions of the approaches reviewed in this REA are discussed in the following paragraphs.

Figure 2. A flow chart of papers identified for the REA demonstrating number of papers included and excluded and resultant total number of approaches included in REA.

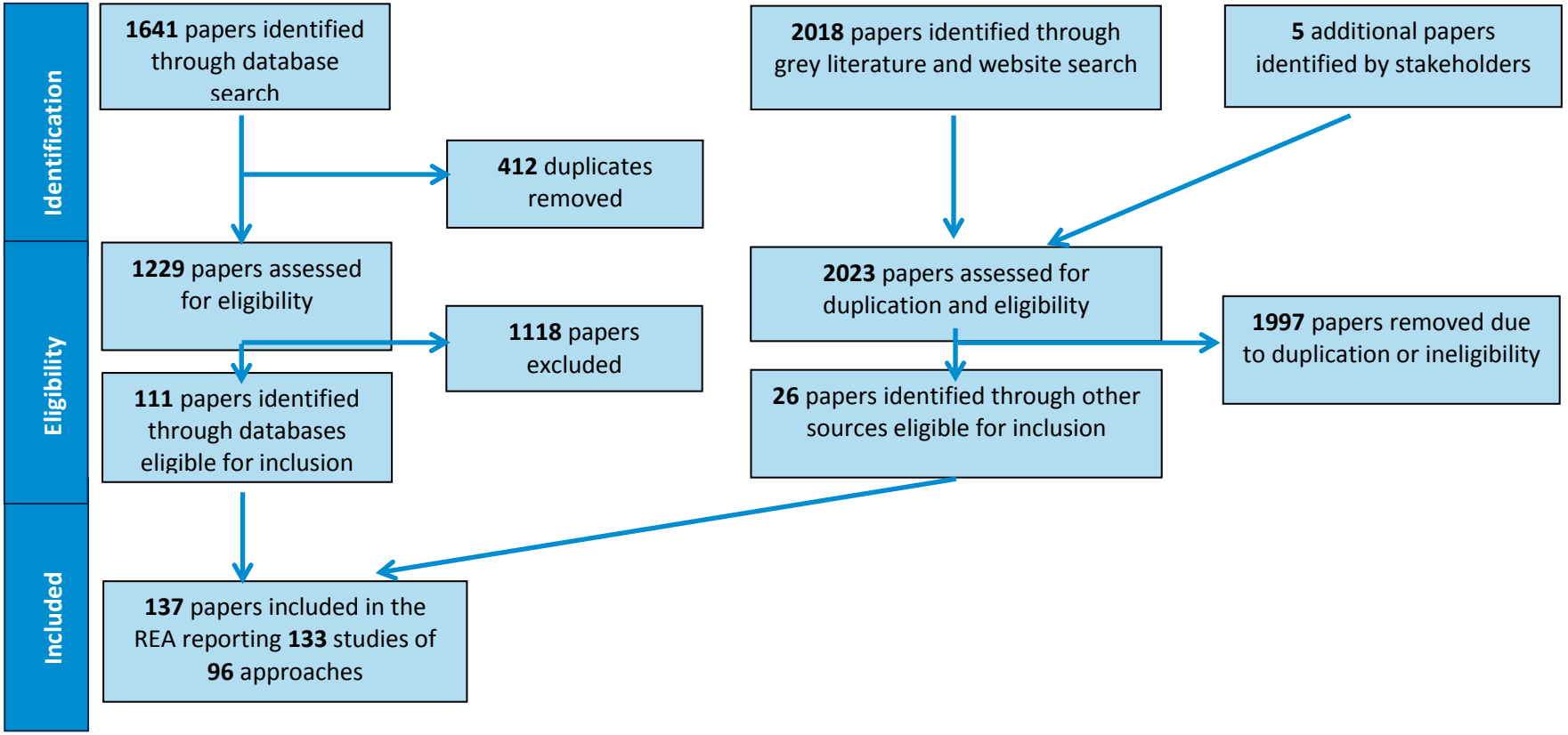


Table 4. Number of programs, service models and systems of care assessed within each evidence rating category.

Approach type	Number of approaches	Number of studies	Number of papers	Number Well Supported	Number Supported	Number Promising A	Number Promising B	Number Emerging A	Number Emerging B
Programs	63	95	98	1	5	17	8	25	7
Service models	23	26	27	0	2	2	8	8	3
Systems of care	10	12	12	0	1	2	3	4	0
Total	**96**	**133**	**137**	**1**	**8**	**21**	**19**	**37**	**10**

The approaches identified in the REA were diverse. They constituted activities including prevention work, psycho-education, skill development, case work, counselling or therapy. Some approaches took a systemic or ecological approach and sometimes involved delivery across a whole service system, while others were more individual or family-focused.

Aggregated information about the trauma types, targeted age groups and targeted outcome domains covered by each type of approach for each evidence category is provided in the paragraphs below. For the Well Supported and Supported approaches, additional information is provided including each approach's theoretical paradigm, intervention components and duration of intervention.

As some approaches were designed to address multiple trauma types, and targeted a wide range of age groups or outcome domains, the aggregated information within the evidence categories in some instances exceeds the number of approaches in that evidence category. For example, target ages were generally broken down into four groups: infancy (0–3), preschool (3–5), primary school (5–12) and adolescence (12+). Rarely did approaches limit their age range to a discrete group, so each approach may have been coded in text for more than one age range. It is also worth noting that in reporting on trauma types, we used the broad categories of child abuse, sexual abuse, neglect, domestic violence and parental mental illness. Similarly, when reviewing the different targeted trauma types, many papers described child abuse or used this keyword term to describe a range of targeted abuses (e.g., child abuse to incorporate sexual abuse, either alone or in addition to physical abuse). Where a particular trauma type was explicitly targeted by a particular approach as described in the papers, this information was recorded. Where the term child abuse or physical abuse was used in articles, they were categorised under child abuse. This implies that while an approach may target 'child abuse', it is possible that more than one abuse type was targeted by that particular approach.

Note that while approaches were assessed in terms of whether benefits were observed in targeted outcome domains, not all of the outcomes targeted within a domain demonstrated benefit. That is, approaches were rated as having benefit in a domain if at least one measure or outcome within that domain showed positive benefit to the child. This is important to recognise, as some approaches may not achieve benefits within all domains as intended.

The descriptions of approaches are organised below by degree of effectiveness, as rated in this REA. Details such as approach type and population information are then presented under subheadings.

The Well Supported program

Of the 96 approaches identified in this REA, only Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)[70,72-76] met the Well Supported criteria. This approach is a *program* that is trauma-informed and trauma-specific/focused by our definitions. It was rated Well Supported because it met the criteria of at least two RCTs, and at least one RCT had 12-month follow-up data. That is, the program was shown to be effective, the effects were maintained over time, and the findings had been replicated.

Approach evaluations

Seven studies reported in eight articles were identified that tested the effectiveness of TF-CBT. All were conducted in the USA. Four of these studies were moderate to large RCTs. Two of the RCTs and one non-RCT study had follow-up at 12 months post-intervention. Refer to Appendix 2, Tables 1a to 1d for specific details of the TF-CBT program tested in these evaluations.

Theoretical paradigm

All of the TF-CBT articles identified in this REA reported drawing from the cognitive behavioural paradigm. Trauma exposure and narrative exposure paradigms were subsumed under the general Trauma-Focused Cognitive Behavioural framework in all papers. One paper[75] reported a study that randomly allocated some participants to TF-CBT with a narrative component and others to TF-CBT without a narrative component, giving evidence to suggest the narrative component of TF-CBT was important in potentiating treatment effects, especially with child sexual abuse survivors.

Intervention components

All studies assessing a TF-CBT program administered the intervention as a time-limited intervention. Three studies, including one of the RCTs with 12-month follow-up[72,73], involved twelve 90-minute sessions, and two other studies involved eight sessions. One of the more recent studies[75] showed better efficacy with eight sessions when compared to a condition that included 16 sessions. TF-CBT programs were predominantly provided in a clinical setting. One study by Cohen and colleagues[76] found a benefit when TF-CBT was conducted over eight sessions at a community family violence shelter (contrary to a typical clinic-based setting). This was one of the RCTs with 12-month follow-up. Four studies indicated that TF-CBT was administered by a trained clinician (either a psychologist or social worker), and all papers rated fidelity of treatment highly. TF-CBT was consistently administered to the individual child in addition to the individual caregiver and the caregiver-child dyad.

Trauma type

Four studies assessing a TF-CBT program targeted childhood sexual abuse, three targeted childhood abuse and three targeted family violence. Two evaluations (three articles) were designed specifically to assess the benefit of the program with child sexual abuse clients[72-74] and one evaluation was adapted specifically to address family violence trauma.[4] There were no studies using a TF-CBT program which targeted trauma arising from neglect, parental substance abuse or parental mental illness.

Target age

The children included in these studies were aged from three to 19 years of age, with four of the seven studies targeted at children in the seven to 14-year age range. There were no studies that included infants.

Target outcome

With the exception of one study which also targeted the parent-child relationship, all seven studies focused on psychological, emotional and behavioural symptoms. No studies measured the potential benefit in outcomes associated with risk for abuse, physical abuse or service utilisation. While one study did assess the impact of TF-CBT on cognitive functioning (i.e., IQ scores), it found no significant benefit for this outcome.

Outcomes with effect at 12 months

To receive the rating of Well Supported, TF-CBT needed to demonstrate effect at 12 months after completion of the approach for at least one outcome. A significant effect was observed at 12 months for four outcomes: child PTSD[73,74], child abuse-related shame[75], child dissociation[74], and parent distress.[73]

Supported approaches

Eight of the approaches included in this REA were rated as Supported. Approaches in the Supported category met the criteria of at least one RCT with a minimum of six-month follow-up data as opposed to the two RCTs and 12-month follow-up that was required to meet the Well Supported criteria. Five of the Supported approaches were programs (Child-Parent Psychotherapy (CPP), Parents under Pressure (PUP), Project Support, Fostering Healthy Futures, Fourth R), two were service models (Family Connections, Nurse Home Visiting Service) and one was a system of care (Multi-systemic Therapy (MST-CAN)). These approaches are described in detail below. Refer to Appendix 2, Tables 2a to 2e for specific details of the five Supported programs tested in these evaluations. Refer to Appendix 2, Tables 2a, 2c, 3a–3c for further details on the Supported service models. Refer to Appendix 2, Tables 2a, 2c, 4a–4c for details of the Supported systems of care.

Child-Parent Psychotherapy (CCP) program

CPP is an intervention-focused program that had more than one study contributing to the weight of its evidence (all from the USA).[77-80] However, only one evaluation[77,78] was an RCT with six-month follow-up. According to our definitions, it is both trauma-specific/focused and trauma-informed.

CCP draws on Trauma Narrative, Ecological/Systems Theory and Attachment/Relational Theory. It is typically delivered over 50–52 sessions by psychologists in a clinical setting to child-caregiver dyads and to individual caregivers. It is manualised and has demonstrated good validity.

CPP targets children under the age of five years who have been exposed to abuse, sexual abuse, neglect, domestic or family violence and parental substance misuse. It targets psychological, emotional and behavioural symptoms and relationship and family/social functioning.

Parents under Pressure (PUP) program

PUP is a program with a focus on prevention. It is the only approach rated as Supported in this REA that has been evaluated in Australia.[81] PUP is a manualised preventive program delivered in the home to individual parents that has shown good fidelity. It did not meet our criteria for trauma-specific/focused or trauma-informed care.

The theoretical underpinnings of PUP were CBT, Attachment/Relational theory and Mindfulness. The discipline of the person delivering the program was not specified, but it had the shortest duration of the programs: typically eight to ten sessions, each lasting one to one-and-a-half hours.

PUP targets families of children aged 2–8 years who are at risk of child abuse and neglect due to problems such as parental mental illness, substance misuse, family conflict and severe financial stress. The outcomes targeted in this program are psychological, emotional and behavioural.

Project Support program

Project Support is a program with a focus on both prevention and intervention that has been evaluated in the USA.[82] It did not meet our criteria for trauma-specific/focused or trauma-informed care. It is based on CBT and Attachment/Relational theories and is delivered in the home to individual caregivers by a trained person of unspecified discipline. The program has demonstrated good fidelity. Sessions are between one and one-and-a-half hours in duration and last for up to eight months.

Project support targets children aged 3–8 years who are at risk of or exposed to child abuse, neglect or domestic/family violence. Risk of abuse and psychological, emotional and behavioural outcomes are targeted by this approach.

Fostering Healthy Futures program

Fostering Healthy Futures is a manualised program for children aged 9–11 years who are in foster care and their foster parents. It has been evaluated in the USA.[83] It is intervention-focused and meets our definition for trauma-specific/focused. This program draws on CBT and Attachment/Relational theories and is delivered on an individual and group basis in the foster home by social workers. The program is delivered in 30 individual and 30 group sessions, with a maximum session duration of four hours. This program has shown good fidelity.

Children targeted in this program have experience abuse and/or neglect and the outcomes targeted include psychological, behavioural and emotional outcomes and service utilisation.

Fourth R program

Fourth R is a prevention program evaluated in Canada that meets our definition of trauma-specific/focused[84] There was no clear theoretical framework outlined for this program in the included paper. The program has shown good fidelity.

Fourth R is a school-based program delivered by trained teachers to groups of children aged 3–8 years. The children receive 21 sessions lasting one-and-a-quarter hours. Fourth R targets violence prevention, specifically child abuse, neglect, sexual abuse and domestic violence. The outcomes targeted by this program include psychological, emotional and behavioural outcomes, relationships and family/social functioning, and educational outcomes.

Family Connections service model

Family Connections is a service model evaluated in the USA with an intervention focus.[85] It draws on Ecological/Systems Theory and does not meet our criteria for trauma-specific/focused or trauma-informed care. The service is delivered in the home to child-caregiver dyads by trained social workers in up to 40 sessions that last one-and-a-half hours each. The approach has shown good fidelity.

Children targeted in this service model are aged 5–11 years and have been exposed to neglect, domestic or family violence, parental substance misuse or parental mental illness. Outcomes targeted include risk of abuse, psychological, emotional and behavioural outcomes and service utilisation.

Nurse Home Visiting service model

This service is delivered in the home by nurses over a 30-month period to individual caregivers and has been evaluated in the USA.[86] The target children are aged 0–2 years. This service aims to prevent child abuse, sexual abuse and neglect. Service utilisation was the target outcome. The theories underpinning this service were not evident in the included paper and this did not meet our criteria for trauma-specific/focused or trauma-informed care.

Multi-systemic Therapy (MST-CAN) system of care

MST-CAN is a system of care that has been evaluated in the USA, with a focus on prevention that met our criteria for trauma-specific/focused and trauma-informed care. The theoretical underpinnings of MST-CAN are CBT and Ecological and Systems Theory.

This system of care, which has shown good fidelity, is delivered in the community and home to individual families by trained personnel for up to 16 months. It targets young people aged 10–17 years who are at risk of abuse and neglect. The outcome domains targeted are risk of abuse, psychological, emotional and behavioural outcomes, relationships, family and social functioning and service utilisation.

Narrative synthesis of the Supported approaches

The following section provides a narrative synthesis of the eight Supported approaches. These approaches have demonstrated effect in at least one RCT and the effect has maintained for at least six months following the end of participation in the program, service or system of care. While it is inadvisable to make direct comparisons across approach types due to the differences between programs, service models and systems of care, this section provides an overview of the nature of the approaches that appear to demonstrate better effect.

Approach type

Five of the Supported approaches were programs (CPP, Fostering Healthy Futures, Fourth R, PUP, Project Support), one was a system of care (MST-CAN) and two were service models (Family Connections, Nurse Home Visiting Service).

Trauma focus

Two of the Supported approaches used a trauma-specific/focused and a trauma-informed care approach (CPP, MST-CAN), two were trauma-specific/focused (Fostering Healthy Futures, Fourth R) and four were not trauma-specific/focused or trauma-informed care (PUP, Project Support, Family Connections, Nurse Home Visiting Service).

Prevention- or intervention-focused

Four of the Supported approaches were prevention-focused (PUP, Fourth R, Family Connections, Nurse Home Visiting Service) and three were intervention-focused (CPP, Fostering Healthy Futures, MST-CAN). One approach combined prevention and intervention (Project Support[82]).

Theoretical paradigm

Most of the Supported approaches were based on more than one theoretical model. Four of the Supported approaches drew on CBT as a theoretical paradigm (Fostering Healthy Futures, PUP, Project Support, MST-CAN). Four were based on Attachment/Relational Theory (CPP, Fostering Healthy Futures, PUP, Project Support) and three drew on Ecological/Systems Theory (CPP, Family

Connections, MST-CAN). One used Trauma Narrative (CPP).Two Supported approaches did not outline a clear theoretical framework (Fourth R, Nurse Home Visiting Service).

Approach components
All of the Supported approaches demonstrated good fidelity. All but the Nurse Home Visiting Service indicated that they required training for the person delivering the approach. Three approaches described interventions as being carried out by practitioners termed as 'therapists', which often included therapists, graduates, interns or paraprofessionals (PUP, Project Support, MST-CAN). Two approaches were delivered by social workers (Fostering Healthy Futures, Family Connections), one approach was delivered by psychologists (CPP), one was delivered by teachers (Fourth R) and one by nurses (Nurse Home Visiting Service).

Most of the Supported approaches were delivered in the home (Fostering Healthy Futures, PUP, Project Support, Family Connections, Nurse Home Visiting Service, MST-CAN), with one delivered in a clinical setting (CPP), one in the community (MST-CAN) and one at school (Fourth R). MST-CAN was the only Supported approach to use multiple settings.

Two of the Supported approaches employed more than one delivery mode (CPP, Fostering Healthy Futures). Four of the Supported approaches were delivered to individual caregivers (CPP, PUP, Project Support, Nurse Home Visiting Service), two were delivered to child-caregiver dyads (CPP, Family Connections), two to groups of children (Fostering Healthy Futures, Fourth R) and one to individual children (Fostering Healthy Futures). MST-CAN specified that delivery was to individual families.

The nature of programs is such that they typically have a minimum dose (i.e., number of sessions, duration of sessions, duration of program involvement) requirement. Three of the Supported approaches — all programs — were brief and specific in duration requirement: PUP required 10 sessions, each lasting one-and-a-half to two hours, and Fourth R required 21 sessions lasting one-and-a-half hours each.

Two Supported approaches that were programs took up to a year to administer but a clear number of sessions over this time period were still indicated. CPP required 50–52 sessions of one hour duration over 12 months and Fostering Healthy Futures required 30 one-and-a-half hour individual sessions and 30 two to four hour group sessions. The available information about Project Support (program) indicates that sessions were one to one-and-a-half hours long, but the number of sessions was not indicated. Participation lasted for up to eight months.

Compared to programs, greater dose variability is likely to exist for service models and systems of care, as the degree of client involvement tends to vary based on circumstances and need, and they are typically less structured and standardised than a standalone manualised program. Family Connections (service model) was similar in dose to the program mentioned above, as it was delivered over 12 to 40 sessions lasting one-and-a-half hours each. However, the variability in number of sessions in Family Connections was due to varying participant requirements.

Three of the Supported approaches did not require a specific dose for completion. Nurse Home Visiting Service (service model) indicated that session duration was 'as needed', and the service lasted up to 30 months. MST-CAN (system of care) specified a dose of up to 16 months.

Trauma types
A broad range of trauma types was covered by the Supported approaches. The general category of 'child abuse' population was included in six of the eight Supported approaches (not PUP or Family Connections). Neglect populations were also targeted by seven of the eight Supported approaches, but notably not PUP, which was the only Australian-evaluated effective approach.

Four Supported approaches targeted populations with issues of violence in the home or family (CPP, Fourth R, Project Support, Family Connections). A further three approaches targeted a sexual abuse population (CPP, Fourth R, Nurse Home Visiting Service).

Three of the Supported approaches targeted families where there were issues of parental substance misuse (CPP, PUP, Family Connections). This was the only trauma type identified in the population participating in the included evaluation of PUP, but it should be noted that the PUP parenting program has been effectively used with other non-trauma types of family populations.

Only one Supported approach was identified that targeted families where there was a parent with a mental illness, the service model Family Connections.

Target ages
We have broken child age into the following categories: infancy (0–3 years), preschool age (3–5 years), primary school age (5–12 years), and adolescence (12+ years). Most of the approaches in this REA targeted a broad age range and it was not always possible to group the approaches into discrete age categories, therefore all but one approach (service model Nurse Home Visiting Service) cross over more than one age group.

Six of the Supported approaches targeted children in the primary school years (CPP, Fourth R, PUP, Project Support, Family Connections, MST-CAN). Four approaches targeted preschool-aged children (CPP, Fourth R, PUP, Project Support), three targeted infants (CPP, PUP, Nurse Home Visiting Service) and one targeted adolescents (MST-CAN).

Target outcomes
The outcomes targeted by the Supported approaches are described below. The reader is advised to keep in mind that these outcomes are those that the approaches *aimed* to improve. All of the approaches had an effect on at least one outcome in the outcomes framework (Table 3), but the outcomes listed here are those *targeted* by the approach, not the outcomes that were actually improved as a result of the program, service model or system of care. See the next section for information on outcomes that were improved as a result of participation in these approaches.

All but one of the Supported approaches (the service model Nurse Home Visiting Service) targeted outcomes in the psychological, emotional and behavioural symptoms domain. Risk of abuse was targeted by four Supported approaches (PUP, Project Support, Family Connections, MST-CAN), as was service utilisation (Fostering Healthy Futures, Family Connections, Nurse Home Visiting Service, MST-CAN). Three approaches targeted relationships, family and social functioning (CPP, Fourth R, MST-CAN). The school-based effective program, Fourth R, was the only one to target educational outcomes.

No Supported approaches targeted outcomes in the child physical health and development or cognition domains.

Within the psychological/emotional and behavioural symptoms domain, approaches targeted a broader spectrum of outcomes (e.g., substance use, risk-taking behaviour). More varied outcomes were targeted by the approaches identified in the Supported category compared to the Well Supported category. This may be due to TF-CBT being focused specifically on the reduction of psychological symptoms and behavioural outcomes associated with experiencing prolonged and/or repeated trauma (e.g., reduction of PTSD or depression symptoms). In contrast, approaches in the Supported category tended to have less specific goals and some had a prevention focus.

Approach evaluation
CPP was evaluated in more than one study, but only one of these was an RCT with six-month maintenance data. Please note that the Family Connections study tested a nine-month version of the approach versus a three-month version and found the nine-month version to be slightly favourable, although all groups improved over time. There was no comparison against a 'no treatment' group or a different type of approach.

Seven of the Supported approaches were evaluated in the USA, one in Canada (Fourth R) and one in Australia (PUP).

Outcomes with effect at six months
Results of the RCTs testing the eight Supported approaches suggest that they have the potential to improve a range of child and parent outcomes. The REA findings suggest that, collectively, the Supported approaches had a significant improvement on the following **child** outcomes at least six months after participation in the approach ceased: PTSD, mental health symptoms, behaviour problems, aggression, assault, dissociation, receiving mental health therapy, child maltreatment reports involving the mother as the perpetrator or the child as subject, child maltreatment reports for women experiencing domestic violence, neglect, out-of-home care placements, out-of-home care placement changes, pro-social behaviour and violent delinquency. Table 5 provides a summary of the outcomes with significant improvements for children, as well as an indication of the last time point at which improvements were observed.

Findings indicate that, collectively, the following **parent** outcomes were significantly improved at least six months after involvement in the Supported approaches: depression, distress, parenting distress, social support, avoidance, child maltreatment reports involving the mother as the perpetrator or the child as subject, child maltreatment reports for women experiencing domestic violence, risk for abuse, perceived inability to manage parenting and harsh parenting. Significant improvements for parents appear in Table 6.

Table 5. Child outcomes with significant improvement at a minimum of six months after participation in a Supported approach.

Child outcomes with significant improvement	Timing of last assessment with effect	Approach
PTSD	12 months after completion	MST-CAN[87]

Child outcomes with significant improvement	Timing of last assessment with effect	Approach
Mental health symptoms	6 months after completion	Fostering Healthy Futures[83]
Behaviour problems	6 months after completion	Family Connections[85]
		CPP[80]
	12 months after completion	MST-CAN[87]
Aggression	12 months after completion	MST-CAN[87]
Assault	12 months after completion	MST-CAN[87]
Dissociation	6 months after completion	Fostering Healthy Futures[83]
	12 months after completion	MST-CAN 12 months after completion[87]
Receiving mental health therapy	6 months after completion	Fostering Healthy Futures[83]
Child maltreatment reports involving the mother as the perpetrator or the child as subject	15 years after completion	Nurse Home Visiting Service[86]
Child maltreatment reports for women experiencing domestic violence	15 years after completion	Nurse Home Visiting Service[86]
Neglect	12 months after completion	MST-CAN[87]
Out-of-home care placements	12 months after completion	MST-CAN[87]

Child outcomes with significant improvement	Timing of last assessment with effect	Approach
Out-of-home care placement changes	12 months after completion	MST-CAN[87]
Pro-social behaviour	6 months after completion	PUP[81]
Violent delinquency	Two years after completion	Fourth R Program[84]

Table 6. Parent outcomes with significant improvement at a minimum of six months after participation in Supported approaches.

Parent outcomes with significant improvement	Timing of last assessment with effect	Approach
Depression	6 months after completion	CPP[77]
Distress	8 months after completion	Project Support[82]
	12 months after completion	MST-CAN[87]
Parenting stress	6 months after completion	PUP[81]
Social support	6 months after completion	Family Connections[85]
	12 months after completion	MST-CAN[87]
Avoidance	6 months after completion	CPP[80]
Child maltreatment reports involving the mother as the perpetrator or the child as subject	15 years after completion	Nurse Home Visiting Service[86]

Parent outcomes with significant improvement	Timing of last assessment with effect	Approach
Child maltreatment reports for women experiencing domestic violence	15 years after completion	Nurse Home Visiting Service[86]
Risk for abuse	6 months after completion	PUP[81]
Perceived inability to manage parenting	8 months after completion	Project Support[82]
Harsh parenting	8 months after completion	Project Support[82]

Promising A approaches

Twenty-one Promising A approaches were identified in this REA. These approaches were evaluated in an RCT and have shown some results in favour of the program, service model or system of care. Effects were observed immediately following approach completion or within six months following cessation of participation in the approach. Outcomes may or may not have been additionally assessed beyond the six-month period.

Approach type

Seventeen Promising A approaches were programs: Attachment and Biobehavioural Catch-up Intervention (ABC), Cognitive Behavioural Therapy, Child and Family Cognitive Behavioural Therapy (CBT) for sexually abused children with PTSD, Cognitive Behavioural Intervention for Trauma in Schools (CBITS), Combined Parent-Child Cognitive Behavioural Therapy (CPC-CBT), Eye Movement Desensitisation and Reprocessing (EMDR), Infant-Parent Psychotherapy (IPP), Parent-Child Interaction Therapy (PCIT), Sanctuary Model, Seeking Safety, Short-term Attachment-based Intervention, SOS!Help for parents, Support for Students Exposed to Trauma, Trauma Affect Regulation: Guide for Education and Therapy (TARGET), Trauma Focused ARC (attachment, self-regulation & competency) Intervention Model, Trauma Focused Art Therapy Intervention, Trauma Intervention Program for Adjudicated and At-Risk Youth (SITCAP-ART), Triple P-Enhanced Group Behavioural Family Intervention for child abuse and neglect.

Two Promising A approaches were service models: (i) Child Protection Services and Family Preservation Services and (ii) Healthy Families America; and two Promising A approaches were systems of care: (i) Motivation Adaptive Skills Trauma Resolution (MASTR) and (ii) Sanctuary Model. Refer to Appendix 2, Tables 5a and 5b for specific details of the 17 Promising A programs. Refer to Appendix 2, Tables 6a and 6b for specific details of the Promising A service models. Refer to Appendix 2, Tables 7a and 7b for specific details of the Promising A systems of care.

Approach evaluations
Two Promising A approaches — both programs — were evaluated in Australia (Child and Family Cognitive Behavioural Therapy (CBT) for sexually abused children with PTSD, and Triple P-Enhanced Group Behavioural Family Intervention for child abuse and neglect).

Nine of the Promising A approaches were evaluated by a single RCT including: Child and Family Cognitive Behavioural Therapy (CBT) for sexually abused children with PTSD, Triple P-Enhanced Group Behavioural Intervention, Sanctuary Model, Seeking Safety, Short-term Attachment-based Intervention, SOS!Help for parents, Support for Students Exposed to Trauma, Trauma Focused Art Therapy Intervention, SITCAP-ART. Child Protection Services and Family Preservation Services (service model) and MASTR (system of care) were also evaluated by a single RCT. While the evaluation of MASTR involved a follow-up, the time period was three months, and therefore it did not meet the six- to 12-month period to warrant a Supported rating.

There were also a number of Promising A approaches that were tested by more than one study. ABC (program) was evaluated by two RCTs without follow-up. TARGET (program) was examined by two studies, an RCT and a large matched sample trial (not randomised). EMDR (program) was examined by three RCTs (with no follow-up), and an additional non-RCT with two-month follow-up.

Promising A approaches based on a CBT paradigm were evident within three evaluations[88-90], which included two RCTs. One had a follow-up period of less than six months. Two other Promising A programs, CPC-CBT and CBITS were notable because they were also designed with a strong emphasis on CBT theory. CPC-CBT was assessed by two studies, with one employing an RCT methodology and a three-month follow-up (therefore not appropriate for the Supported category). CBITS was assessed by four studies, one RCT with a three-month follow-up, and two non-RCTs with follow-up measures at three and six months.

Of interest is the categorisation of child and family CBT, combined parent-child CBT and CBITS in the Promising A programs category. Theoretically, these interventions are sometimes cited as pieces of evidence for the Well Supported program, TF-CBT, but they were categorised as separate interventions to TF-CBT in this report to reflect the degree of adaptation in their delivery method and/or target group.

PCIT (program) was examined by seven studies, two of which used RCT methodology. One of these had a follow-up period of one month.

Healthy Families America (service model) was evaluated by eight studies including five RCTs and three quasi-experimental studies (studies that lack random assignment to a treatment or control group), which all employed large samples for their analysis.

Trauma focus
Nine of the Promising A approaches were trauma-specific/focused (Child and Family Cognitive Behavioural Therapy (CBT) for sexually abused children, CPC-CBT, EMDR, IPP, Seeking Safety, Support for Students Exposed to Trauma, TARGET, Trauma-focused art therapy, SITCAP-ART). Five were trauma-focused/specific and used a trauma-informed care approach (CBITS, MASTR, PCIT, Trauma-focused ARC Intervention Model, Sanctuary Model). Seven approaches were not trauma-focused/specific or trauma-informed care (ABC, CBT, Short-term attachment-based intervention,

SOS! Help for Parents, Triple P, Child Protection Services and Family Preservation Services, Healthy Families).

Trauma types

In terms of trauma type, the majority of the Promising A approaches (*n* = 13) targeted child abuse (ABC, CBT, Child Protection Services and Family Preservation Services, Healthy Families America, MASTR, CPC-CBT, IPP, PCIT, Sanctuary Model, Short-term attachment-based intervention, TARGET, Trauma-focused ARC Intervention Model, Triple P). Ten targeted neglect (ABC, CBT, Child Protection Services and Family Preservation Services, EMDR, Healthy Families America, EMDR, IPP, PCIT, Sanctuary Model, Short-term attachment-based intervention, Trauma-focused ARC Intervention Model, Triple P), and nine targeted child sexual abuse (CBT, MASTR, Child and Family Cognitive Behavioural Therapy (CBT) for sexually abused children, CPC-CBT, EMDR, Sanctuary Model, Short-term attachment-based intervention, TARGET, Trauma-focused ARC Intervention Model). Six targeted family or domestic violence (CBITS, CPC-CBT, PCIT, Sanctuary Model, TARGET, Trauma-focused ARC Intervention Model), three targeted parental substance use EMDR, TARGET, Trauma-focused ARC Intervention Model, and two targeted parental mental illness (EMDR, Trauma-focused ARC Intervention Model).

Target ages

The Promising A approaches targeted a broad range of ages, with primary school-aged children targeted in nine approaches (CBITS, Child and Family Cognitive Behavioural Therapy (CBT) of sexually abused children, EMDR, PCIT, Support for Students Exposed to Trauma, Trauma-focused ARC Intervention Model, Triple P, Child Protection Services and Family Preservation Services, Healthy Families); adolescents targeted in nine approaches (CBT, CBITS, Child and Family Cognitive Behavioural Therapy (CBT) of sexually abused children, EMDR, Sanctuary Model, Seeking Safety, Support for Students Exposed to Trauma, TARGET, SITCAP-ART); and preschool-aged children targeted in seven (ABC, PCIT, Short-term attachment-based intervention, SOS! Help for Parents, Trauma-focused ARC Intervention Model, Triple P, Healthy Families), and infants in seven (ABC, IPP, PCIT, Short-term attachment-based intervention, SOS! Help for Parents, Triple P, Healthy Families). Sanctuary Model also caters for adolescents through to 20 years of age.

Target outcomes

The most common outcome domain targeted was psychological, emotional, or behavioural symptoms (*n* = 16, all Promising A approaches except for IPP, SOS! Help for Parents, Child Protection Services and Family Preservation). Relationships or family or social functioning was targeted in seven Promising A approaches (ABC, CBT, Child Protection Services and Family Preservation, IPP, Healthy Families, PCIT, Trauma-focused ARC Intervention Model); risk for childhood abuse was targeted in four (Healthy Families, SOS! Help for Parents, Trauma-focused ARC Intervention Model, Triple P); and service utilisation by three (PCIT, TARGET, Trauma-focused ARC Intervention Model). Only one approach targeted cognitive outcomes (CBT) and one targeted child physical health and development outcomes (Healthy Families). Educational outcomes were not targeted by any of the Promising A approaches.

Promising B approaches

Promising B approaches are those that were tested using a comparison group and showed some benefit over the comparison condition. However, allocation to groups was not randomised and so the design was not as rigorous as those used in evaluations in the Promising A and higher ratings. The effectiveness of these approaches is yet to be determined based on the evidence identified in

the REA. Nineteen Promising B approaches were identified in this REA. Refer to Appendix 2, Tables 8a and 8b for specific details of the eight Promising B programs tested in these evaluations. Refer to Appendix 2, Tables 9a and 9b for specific details of the Promising B service models. Refer to Appendix 2, Tables 10a and 10b for specific details of the Promising B systems of care.

Approach type

Of the 19 Promising B approaches identified in this REA, eight were programs (Canine-assisted therapy, Child Sexual Abuse Treatment Program (CSATP), Group Art Therapy for Sexual Abuse, Group therapy for sexually abused children, Imagery Rehearsal Therapy, Residential substance abuse treatment, Project SafeCare, Rythmex), eight were service models (Brighter Futures, Child-Parent Centre Program, Cottage Community Care Pilot Project (CCCPP), Minnesota Alternative Response Project, Parent Aide Program, Sexual Abuse Intervention Program (SAIP), Statewide Family Preservation and Family Support (FPFS) programs, Therapeutic Residential Care) and three were systems of care (Houston Child Advocates, Skills-based intervention program, Trauma Systems Therapy).

Approach evaluation

Two of the Promising B programs (Group therapy for sexually abused children, Project SafeCare) and one of the Promising B systems of care (Trauma Systems Therapy) were tested in more than one study, with the remaining Promising B approaches evaluated in single studies. Three of the Promising B service models were evaluated in Australia (i.e., Brighter Futures, CCCPP, Therapeutic Residential Care).

Trauma focus

Two Promising B approaches combined trauma-informed care and a trauma-specific/focused approach (Therapeutic Residential Care, Trauma Systems Therapy); five took a trauma-specific/focused approach (Canine-assisted therapy, Group Art Therapy for Sexual Abuse, Group therapy for sexually abused children, Imagery Rehearsal Therapy, Residential substance abuse treatment); and the remaining 12 were neither trauma-focused nor trauma-informed (Project SafeCare, CSATP, Rythmex, Brighter Futures, Child-Parent Centre Program, CCCPP, Minnesota Alternative Response Project, Parent Aide Program, SAIP, Statewide FPFS programs, Houston Child Advocates, Skills-based intervention program).

Trauma types

The trauma type targeted by the most (*n* = 8) Promising B approaches was child abuse (Canine-assisted therapy, CSATP, Project SafeCare, Rythmex, Brighter Futures, Minnesota Alternative Response Project, Parent Aide Program, Statewide FPFS programs). Neglect was targeted by five Promising B approaches (Project SafeCare, Rythmex, Parent Aide Program, Statewide FPFS programs, Therapeutic Residential Care) and sexual abuse was target by four (Group Art Therapy for Sexual Abuse, Imagery Rehearsal Therapy, SAIP, Statewide FPFS programs). Domestic or family violence was targeted by one approach (Brighter Futures) and no Promising B approaches targeted parental substance use or parental mental illness.

Target ages

There were six Promising B approaches that targeted infants (CSATP, Project SafeCare, Brighter Futures, CCCPP, Parent Aide Program, Statewide FPFS programs), primary school-aged children (Group Art Therapy for Sexual Abuse, Group therapy of sexually abused children, Brighter Futures, Child-Parent Centre Program, Parent Aide Program, Statewide FPFS programs) and adolescents (Group therapy of sexually abused children, Imagery Rehearsal Therapy, Residential substance abuse treatment, Brighter Futures, Statewide FPFS programs, Therapeutic Residential Care). Five Promising B approaches targeted preschool-aged children (Project SafeCare, Brighter Futures, Child-Parent Centre Program, Parent Aide Program, Statewide FPFS programs).

Target outcomes

Psychological, emotional, or behavioural symptoms were targeted by eight Promising B approaches (Group Art Therapy for Sexual Abuse, Group Therapy for sexually abused children, Imagery Rehearsal Therapy, Residential substance abuse, Rythmex, Child-Parent Centre Program, SAIP, Therapeutic Residential Care), as was the domain for relationships or family or social functioning CSATP, Group Therapy for sexually abused children, Project SafeCare, Child-Parent Centre Program, CCCPP, Parent Aide Program, SAIP, Therapeutic Residential Care). Physical health and development outcomes were targeted by seven Promising B approaches (Canine-assisted therapy, CSATP, Brighter Futures, Child-Parent Centre Program, Minnesota Alternative Response Project, Statewide FPFS programs, Therapeutic Residential Care), as was service utilisation (Project SafeCare, Brighter Futures, Child-Parent Centre Program, Minnesota Alternative Response Project, Parent Aide Program, Statewide FPFS programs). Four approaches targeted risk for abuse (Project SafeCare, Child-Parent Centre Program, Statewide FPFS programs, Therapeutic Residential Care) and three approaches targeted cognition (Canine-assisted therapy, Residential substance abuse treatment, Therapeutic Residential Care). One Promising B approach targeted education outcomes (Therapeutic Residential Care)

Emerging A approaches

The largest proportion of approaches identified in this REA fell into the Emerging A category (*n* = 37). These studies employed pre/post research designs that had no control or comparison condition and did not have follow-up assessments. Although the studies reported here indicated that participant outcomes improved, conclusions drawn from these studies are considerably less certain than those from studies using more rigorous designs. Any potential improvements observed from pre to post in the evaluations of Emerging A approaches could be due to chance, natural gains that may have otherwise been seen over time or other factors, rather than the effects of participation in the program, service model or system of care.

Approach type

Of the 37 Emerging A approaches identified in this REA, 25 were programs (A Home Within relationship-based intervention, Alterative for Families Cognitive Behavioural Therapy (AF-CBT), Circle of Parents, Circle of Security, Combined Art Therapy and CBT, Emotion-focused therapy for trauma, Equine-assisted psychotherapy, Eye movement integration therapy, Game-based cognitive behavioural therapy group program, grief and Trauma Intervention (GTI) with coping skills and trauma narrative processing, Group Intervention – Psycho-education, Group intervention (child) and group intervention (parent), Manualized Cognitive Restructuring Program, Parent-Child Attunement Therapy, Parent education about the risk of head injury after shaking infants, Parent-led, Therapist-Assisted Trauma FocusedCognitive Behavioural Therapy (PTA-TF-CBT), Play Therapy, Pragmatic Communicative Intervention, QEEG-Guided Neuro-feedback, Real

Life Heroes, Strengthening Family Coping Resources, Symboldrama, The Hope Connection, The Mothers' and Children's Group Intervention Program).

A further eight Emerging A approaches were service models (Childhood First, residential therapeutic community, Crisis Childcare Program, Cumbria Early Intervention Programs, Early intervention service – child sexual abuse, Early Intervention Programs – Gateshead, Gipuzkoa program, Louisiana Rural Trauma Services Center, Take Two, The Sunrise Project) and four were systems of care (Fairy Tale Model, Neurosequential Model of Therapeutics, Safety, Mentoring, Advocacy, Recovery and Treatment (SMART), The Child and Family Interagency Resource, Support and Training Program (Child FIRST)). Refer to Appendix 2, Tables 11a and 11b for specific details of the 25 Emerging A programs tested in these evaluations. Refer to Appendix 2, Tables 12a and 12b for specific details of the Emerging A service models tested in these evaluations. Refer to Appendix 2, Tables 13a and 13b for specific details of the Emerging A systems of care tested in these evaluations.

Approach evaluation
Of the 37 Emerging A approaches identified in the REA, one was evaluated in Australia (Take Two). Take Two is for children and young people who have experienced abuse or neglect.

Trauma focus
Seven Emerging A approaches combined a trauma-specific/focused and trauma-informed approach, 16 were trauma-specific/focused only, and 14 were neither.

Trauma type
Emerging A approaches most commonly targeted child abuse (*n* = 16), child sexual abuse (*n* = 14), neglect (*n* = 12) and family violence (*n* = 12). One approach targeted parental substance use and one targeted parental mental illness.

Target ages
The majority of the Emerging A approaches targeted children of primary school age (*n* = 17) and adolescents (*n* = 13). A further nine targeted preschool children, and six targeted infants.

Target outcomes
Most approaches in the Emerging A category targeted psychological, emotional, or behavioural symptoms (*n* = 30). The domain of relationships or family/social functioning was targeted by seven programs. Risk for childhood abuse outcomes was targeted by six programs. Child physical health and development, and education were targeted by four approaches. Cognition was targeted by two Emerging A approaches, and service utilisation by one.

Emerging B approaches

Approaches that fell into the Emerging B category showed no benefit but lacked sufficient design and/or additional studies to confidently comment on the effectiveness of the approaches tested. Firm conclusions about their effect or lack of effect could not be drawn. Research utilising more rigorous designs is required in order to make this determination. Ten Emerging B approaches were identified in this REA.

Approach type
Seven of the 10 Emerging B approaches were programs (Chapman Art Therapy Treatment Intervention (CATTI), In-patient song-writing to reduce PTSD, Koping Adolescent Group Program (KAP), Mothers and Toddlers Program, Parent support group intervention, Social Information Processing Model, Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)) and three were service models (ARS-Intensive Home Visiting, Combined TF-CBT/Psycho-educational/supportive group intervention, Healthy Start Program) and none were systems of care. Refer to Appendix 2, Tables 14a and 14b for specific details of the Emerging B programs. Refer to Appendix 2, Tables 15a and 15b for specific details of the Emerging B service models.

Approach evaluation
One Emerging B approach was evaluated in Australia (Koping Adolescent Group Program - KAP).

Trauma focus
One Emerging B approach took a combined trauma-informed care and trauma-specific/focused approach, four were trauma-specific/focused, and five were neither.

Trauma types
Three of the Emerging B approaches targeted child abuse and two targeted sexual abuse. Only one program targeted each of the remaining trauma types: neglect, family or domestic violence, parental substance use, and parental mental illness.

Target ages
Four Emerging B approaches each targeted primary school children, infants and preschool-age children. Three approaches targeted adolescents.

Target outcomes
Outcome domains targeted by approaches in the Emerging B evidence category included psychological, emotional or behavioural symptoms (*n* = 5), relationships and family/social functioning (*n* = 3), risk for childhood abuse (*n* = 2) and service utilisation (*n* = 1). No Emerging B approaches targeted the child physical health and development, education or cognition domains.

Discussion of findings from the Rapid Evidence Assessment

The aim of this REA was to identify, describe and rate the evidence for approaches for children who have been exposed to or who were at risk of exposure to repeated and/or prolonged trauma as a consequence of child abuse or neglect.

Summary of the Rapid Evidence Assessment findings

We found 96 approaches reported in 137 papers and evaluated in 133 studies. Of the 96 approaches identified, 63 were programs, 23 were service models and 10 were systems of care. Only one approach was rated as Well Supported, eight were rated Supported, 21 were Promising A, 19 were Promising B, 37 were Emerging A and 10 were Emerging B. There were no approaches rated as Concerning Practice and there were no approaches included in the No Effect category. Nine of the approaches were evaluated in Australia, with one rated Supported. Of the 96 approaches identified, over half (*n* = 54) were identified as trauma-specific/focused and/or trauma-informed care.

TF-CBT was the only approach identified in the REA that met criteria for Well Supported. To receive this rating, TF-CBT needed to demonstrate effect in at least two RCTs and for the effect to maintain for at least 12 months after program completion. Children targeted in the TF-CBT studies were aged between three and 16 years, with the majority of studies using children aged between seven and 14 years. That is, TF-CBT was mostly targeted at primary school to early adolescent age groups. TF-CBT is a trauma-informed and trauma-specific *program* that primarily targets psychological, emotional or behavioural symptoms, with clients presenting with different trauma histories. Thus, studies tended to target children with specific and overt symptoms including Post Traumatic Stress Disorder (PTSD), depression and anxiety. While TF-CBT was found to be effective for symptoms of PTSD in the child, child abuse-related shame, child dissociation and parent distress, it is less clear how effective TF-CBT would be with reactions or problems outside specific symptoms that are experienced by children exposed to abuse and neglect (e.g., physical or educational outcomes). Nonetheless, the observation that four of the seven evaluations included survivors of child sexual abuse is important because some approaches exclude this type of trauma from their treatment. Moreover, the REA findings suggest that TF-CBT has been effective in treating clients with Type II trauma, and children and families who present with complex needs.

Approaches which received a rating of Supported (*n* = 5 programs, *n* = 2 service models, *n* = 1 system of care) in the REA were varied and targeted at different levels of the health service system. Across the spectrum of approaches that were endorsed as Supported, a variety of theoretical paradigms was used both within and across approaches. Some were more oriented to prevention rather than intervention, and others separately focused on different age groups. This variability makes comparison of approaches difficult, as the specific population of a service requires consideration before identifying an approach as relevant for that service.

Approaches in the Supported category varied in the time they took to be delivered, with some delivered for up to a year and some beyond a year. Service models and systems of care tended to take longer to deliver, with all programs lasting fewer than 12 months. The longer approaches also tended to be more oriented to broad principles and were less likely to include well-defined or manualised interventions, or to be focused on establishing and/or maintaining secure caregiver-child relationships. Approaches in the Supported category tended to be administered by practitioners such as nurses, teachers or social workers already working with the population. In

most cases these studies were effectiveness studies. That is, they applied rigorous research designs to real world settings and environments, increasing the capacity to generalise the findings of these studies beyond the setting that was evaluated.

Approaches in the Supported category targeted a broad range of outcomes, however psychological, emotional and behavioural symptoms were the most frequently targeted in all Supported approaches combined. The range of outcomes targeted may reflect the wide range of poor outcomes and risk factors associated with child abuse and neglect, and therefore the multiple targets that are required in treatment. The more holistic approach, or broader aims, of the majority of Supported approaches constitutes a different approach to symptom-based interventions (such as TF-CBT), which specifically target symptoms of psychological distress. Interestingly, out of the three approach types, service models (of any rating) had the greatest variability in outcome domains targeted, with risk for abuse, child physical health and development, relationships and family/social functioning, and service utilisation targeted nearly as frequently as psychological, emotional and behavioural symptoms.

Approaches that have been rated as Well Supported and Supported in this REA (*n* = 9 out of a possible 96) have been tested using rigorous study designs, and have shown an effect on at least one relevant outcome, and the effect has maintained for at least 6 months after involvement in the program, service model or system of care has finished. In order to determine if approaches for children and families produce the desired outcomes, are more effective than no assistance or another form of support, and result in no harm, rigorous evaluations are required. Furthermore, to be more confident in the effectiveness of an approach, long-term measurement of outcomes is required so that we can see if benefits remain after the participants are no longer receiving the support/care/assistance offered by the approach. Ideally, positive results should be replicated in more than one study so that we can be sure the results were not just by chance and are observed with another group of children (a requirement of the Well Supported rating). Therefore, for the 87 approaches rated below the Supported level in this REA, additional evidence is required to determine their effectiveness.

The majority of the nine Well Supported and Supported approaches targeted the general category of child abuse and also neglect (*n* = 7 for each trauma type). Primary school-aged children were more frequently targeted (*n* = 7), as were outcomes in the psychological, emotional and behavioural symptoms domain (*n* = 8). Results of the evaluations of the Well Supported approach suggest that effects were observed for the following outcomes at 12 months after completion of the program: child PTSD, child abuse-related shame, child dissociation and parent distress. Findings also suggest that, collectively, the Supported approaches improved a range of child and parent outcomes including: PTSD, mental health symptoms, behaviour problems, aggression, assault, dissociation, receiving mental health therapy, child maltreatment reports involving the mother as the perpetrator or the child as subject, child maltreatment reports for women experiencing domestic violence, neglect, out-of-home care placements, out-of-home care placement changes, pro-social behaviour, violent delinquency, parental depression, parental distress, parenting distress, social support, avoidance, risk for abuse, perceived inability to manage parenting and harsh parenting. Note that not all Supported approaches targeted, or indeed improved, all of the abovementioned outcomes (refer to Tables 5 and 6 above for a detailed description of outcomes improved by each Supported approach).

There were 21 approaches identified in this REA that were rated Promising A (*n* = 17 programs, *n* = 2 service models, *n* = 2 system of care). These approaches showed effect when the final outcome measure was assessed at the end of the program, service model or system of care. As with the Well Supported and Supported approaches, the majority of the Promising A approaches targeted child abuse (*n* = 13) and psychological, emotional and behavioural symptoms (*n* = 16). Primary school-aged children and adolescents were targeted by the largest proportion of these approaches (*n* = 9 for each age group). The designs used in these evaluations were rigorous but lacked replication and maintenance data. We do not therefore know if the initial benefits of the approach will exist in the absence of ongoing support or intervention.

The REA identified 67 further approaches that were categorised into the rating groups Promising B, Emerging A and Emerging B. Further research using more rigorous methods is needed to determine their effectiveness. These approaches predominantly targeted the same trauma types, outcomes and age groups as the aforementioned approaches with demonstrated effect. The age group proportions targeted by Well Supported and Supported approaches versus Promising and Emerging approaches were similar, with both Well Supported/Supported and Promising/Emerging targeting primary school-aged children the most frequently, and infants least frequently (tied with adolescents in Well Supported/Supported approaches).

When target ages by approach type were considered, it was identified that primary school-aged children were the most frequently targeted across all three approach types, with adolescents tying in first place among systems of care. The age group proportions for programs revealed a similar picture as across all approach types; not surprising given that a larger number of approaches in the REA were programs. Infants were the least frequently targeted in programs and systems of care.

Just over half of the approaches in the REA explicitly identified that they were targeting trauma-related outcomes, or were approaching the population with a trauma-informed care approach. Just under half of the approaches were working within populations with high levels of trauma exposure without necessarily explicitly recognising this trauma exposure within their approach. It was certainly the case that these non-trauma approaches reported effective change in the outcomes measured in this REA; however, the degree to which they addressed outcomes directly linked to trauma exposure is unknown.

Gaps identified by the Rapid Evidence Assessment

While this REA identified many approaches that targeted outcomes associated with repeated and/or prolonged trauma exposure in child abuse and neglect populations, only nine approaches (*n* = 6 programs, *n* = 2 services models, *n* = 1 systems of care) were rated as Well Supported or Supported. The lack of long-term follow-up measures and replication studies suggests that there is room for further development within this field. It is well recognised that RCTs with long-term follow-up are difficult and costly to complete, but essential in order to determine if the approaches used with children and families are actually working, above and beyond no intervention or alternative interventions.

Working within a developmental framework that acknowledges the changing needs of children as they age, it is important to test a range of approaches within different age groups. The current REA revealed only a limited number of approaches targeting infants and adolescents that had a

Well Supported or Supported ranking. It is important that these age groups are particularly prioritised as the focus of further research.

The largest proportion of approaches, regardless of the effectiveness rating or approach type, targeted trauma associated with child abuse in general (*n* = 48 approaches), followed by neglect (*n* = 37), sexual abuse (*n* = 35) and family violence (*n* = 25). Few approaches targeted children who may be at risk of trauma exposure associated with parental substance misuse and parental mental illness. Further research is required to specifically target these groups.

In terms of outcomes targeted, the majority of approaches examined in the REA targeted psychological, emotional and behaviour symptoms (*n* = 71 approaches). While there were some approaches targeting relationships and family functioning (*n* = 32), risk for abuse (*n* = 21) and service utilisation (*n* = 18), there were fewer approaches that targeted educational outcomes (*n* = 8) and cognition (*n* = 6), and only slightly more that targeted child physical health and development (*n* = 12). This may reflect a lower perceived or actual need for children to be supported in these domains, or it may represent a gap in service provision. It may also suggest that approaches are prioritising proximal outcomes (such as behaviour) over more distal outcomes (educational outcomes).

Another clear gap in the evidence was the limited number of Australian evaluations, especially those developed explicitly for Aboriginal and Torres Strait Islander children and young people. Our REA revealed only three approaches describing pathways of referral for Aboriginal and Torres Strait Islander populations, and only two of these evaluations actually included Aboriginal and Torres Strait Islander people in the sample. Further, one of these had very low representation of Aboriginal and Torres Strait Islander people in the sample, the other evaluated a service model incorporating a statewide Aboriginal clinical team specifically tailored to meet the needs of this group.[91] Further research is required under Aboriginal and Torres Strait Islander community leadership to develop and test approaches tailored to these communities.

Limitations of the Rapid Evidence Assessment

The findings from this REA should be considered alongside its limitations. In order to make this review 'rapid', some restrictions on our methodology were necessary. These limitations included:

- the omission of potentially relevant papers that were published prior to 2000
- the omission of non-English language papers
- reference lists of included papers were not hand-searched to find other relevant studies
- studies were not critically evaluated with respect to methodological factors such as sample sizes, sample composition, randomisation procedures, quality of measures or reporting bias.

Also, in addition to restricting our search to papers written after the year 2000, our review did not include papers published after 15 August 2012, when our search was conducted. As a consequence, there will be published and unpublished literature dated after this time that is not included in this report. The implication of this is that evidence for included or additional approaches may have been missed. This evidence may have provided more information about the efficacy, effectiveness or even the potential harm of programs, service models or systems of care.

There was great variability in the types of approaches included in this REA, which makes comparison across approaches challenging, so we caution against this. We categorised approaches as either programs, service models or systems of care; however, the effectiveness

rating scheme employed was the same across all three approach types. We acknowledge that our rating scheme, which rated approaches more favourably if they used RCTs, may not have been ideal for service models or systems of care, which may be more difficult to evaluate using the same study designs as programs. Nevertheless, there were two systems of care and two service models rated as Supported according to our criteria, which therefore indicates some adherence to protocols of rigour in evaluation of these approaches (i.e., RCT demonstrating effect with six-month maintenance).

The information about approaches presented here is a summary of information presented in available papers. We have not provided specific detail on, for example, which of the target outcomes benefited from an approach. We recommend readers source the original papers if they would like to know more about a particular approach.

As occurs in many reviews, it was difficult to determine the exact details of all approaches and evaluations. These gaps in reporting within the literature present challenges on different levels. First, it can be difficult to determine the content of an approach so that it can be accurately extracted from a paper and assessed for review. This reduced clarity could impede study replication, present fidelity concerns for future implementation of an approach, and make practice decision-making challenging. An example of inadequate reporting is the use of the generic term 'therapist' to describe the person delivering the approach. Therapist is a term that may be used to describe service providers at either end of the spectrum of qualification; for instance, a qualified psychologist or a person with limited training or qualifications. Currently, there are no guidelines regarding the use of the term therapist or other similar terms (e.g., home visitor, counsellor), and when used in research papers without further description, the label is open to interpretation. In making decisions about the suitability of approaches to adopt, service providers should seek clarification from approach designers regarding qualification requirements.

Conclusion

Despite these limitations, this REA represents one of few attempts to review international evaluations of programs, service models and systems of care designed to target outcomes of repeated and/or prolonged trauma in children exposed to abuse or neglect. It provides a detailed summary of the level of evidence for approaches, and a description of these approaches (see Appendix 2). In particular, this REA highlights that there is good evidence for a small number of approaches targeting the psychological, emotional and behavioural needs of primary school-aged children who have experienced abuse. This information will aid practitioners, service providers and policy makers when making decisions about services and supports for this population.

Chapter 3: The practice survey

Aims of the practice survey

We conducted an online survey of practitioners working in the child and family support sector across Australia. Our aim was to examine the level of awareness and extent of uptake of evidence-based approaches for children exposed to repeated and/or prolonged trauma arising from abuse and neglect. This chapter describes the methodology and findings from this Australia-wide survey of practitioners, along with a discussion of the major conclusions and limitations of the survey. Implications of the findings are further explored in the General Discussion and Conclusions and Recommendations sections of this report (Chapter 5).

Methodology of the practice survey

Questions addressed by the practice survey

The practice survey aimed to address the following questions:

1. What is the level of awareness among practitioners about evidence-based approaches for children exposed to or at risk of repeated and/or prolonged trauma arising from abuse and neglect?
2. What is the extent of adoption or utilisation of evidence-based approaches among practitioners in managing clients exposed to or at risk of repeated and/or prolonged trauma arising from abuse and neglect?

Development and pilot of survey questions

Survey items were developed by the project team to collect information about approaches used by practitioners in the child and family services sector. Survey items were reviewed and approved by the project leaders and the project Reference Group prior to being piloted as an online survey by research and clinical staff at the Australian Centre for Posttraumatic Mental Health and the Parenting Research Centre.[4]

Questions in the online survey were structured within five sections:

1. *Participant screening (two items)*: These items 'screened in' practitioners who worked with children and families AND who worked with clients exposed to or at risk of exposure to traumatic events. Respondents who did not meet both criteria were 'screened out'.
2. *Practitioner and workplace characteristics (nine items)*: These items elicited demographic information about background practitioner and organisation characteristics (e.g., gender, education, professional discipline, organisation type and funding sources).
3. *Working with children who have experienced trauma (10 items)*: These items elicited information about how frequently respondents worked with children exposed to traumatic events, their level of experience, theoretical perspectives of their work, awareness of trauma-informed care, and specific strategies and techniques used when working with children exposed to traumatic experiences.

[4] The survey is available upon request from the study authors.

4. *Awareness of evidence-based approaches (two items)*: These items asked respondents about their awareness of evidence-based approaches to preventing or treating trauma in children and asked respondents to list the evidence-based approaches they were familiar with.
5. *Approaches to treat or prevent trauma responses in children (19 items)*: These items collected information about approaches respondents used in their work and included information about the model, framework or theory underpinning each approach and its key components. Questions also asked respondents to describe any training they had attended regarding approaches to their work with children exposed to trauma; whether adaptations and evaluations had been made to an approach; the types of clients who participated in the approach; delivery setting, frequency and duration of the approach; and outcomes resulting from the approach. Respondents were given the opportunity to record this information for up to three approaches.

Distribution of the practice survey

The practice survey was promoted in online newsletters and through existing practitioner networks for six weeks (from October 1 until November 9, 2012). Child and family service organisations that operate nationally and in each state and territory were also contacted directly and asked to distribute to their staff information about the project along with a link to the survey. The survey was also promoted through newsletters and email distribution lists available through the Australian Centre for Posttraumatic Mental Health and the Parenting Research Centre. A list of the networks and organisations contacted to help distribute the practice survey is provided in Appendix 3, Table 1. The project Reference Group also distributed the survey to their contacts in the child and family support sector.

Participants

Four hundred and sixty-eight child and family service practitioners responded to the survey. Of these, 416 were screened into the study. Three hundred and eighty-two completed some items beyond the two screening items, and 293 (70% of the 416 eligible respondents) completed items regarding their work with children and families who have experienced trauma. The flow of participants through the study and the number of questions completed in each section is reported in Figure 3. It is important to note that the survey was structured so that participants only completed sections that were relevant to their work and experience. Therefore, some sections were not completed by all participants and fewer participants answered questions as items became more specific (e.g., 293 participants commenced the section regarding *Awareness of evidence-based programs,* but only those respondents who indicated that they were aware of evidence-based approaches were asked to list those approaches in the following section headed *Approaches to treat or prevent trauma responses in children*).

The number of respondents who completed items varied within each section of the survey, as participants may have skipped individual questions. The range in the number of responses to items within each section is presented in Figure 3. A proportion of participants elected not to continue completing the practice survey, and participants dropped out at each stage. The majority of participants who did not complete the survey dropped out during the *Practitioner and workplace characteristics* section, before answering any questions relating to trauma. Participants were asked to provide details on up to three approaches they had used to treat or prevent trauma, but only if they had applied an approach in the last year. Participants who indicated they had not recently used an approach (62%) stopped the survey at that point.

Figure 3. Flowchart of questions completed by practice survey respondents.

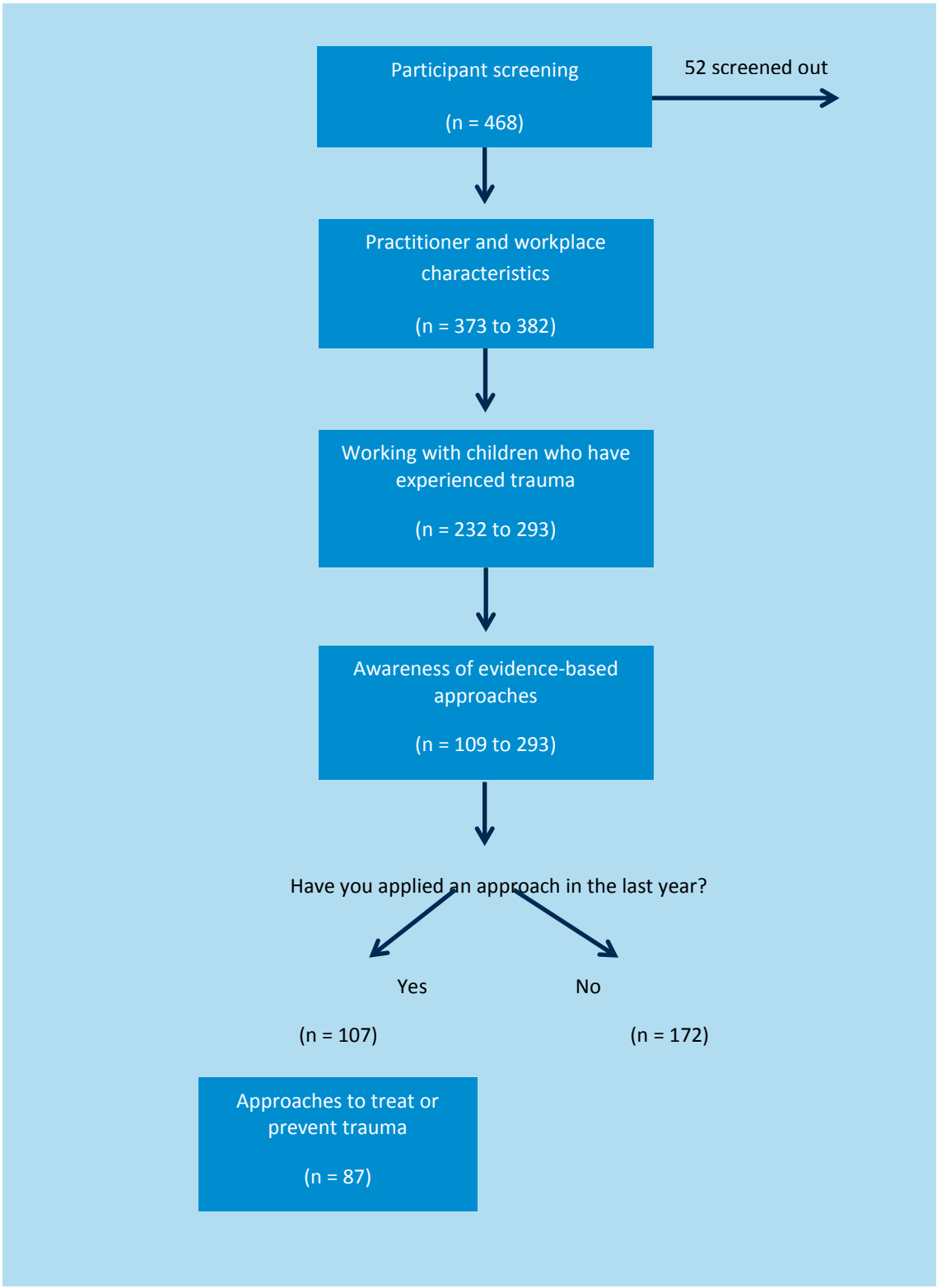


Table 7 presents a comparison of key demographics of respondents who completed the survey and those who did not complete the survey for the whole sample (Total *n* = 382). The χ^2 and *p* values indicate that the two groups did not differ on any of these individual and organisational characteristics. The 293 practitioners who provided information about their work with children and families (but did not necessarily answer questions about specific programs) are described in this report as the 'practice sample'.

Table 7. Comparison of practitioner and organisational characteristics reported by completers and non-completers.

Individual or workplace characteristic	Completers N = 257	Non-completers N = 125	χ^2	*p*
	n	*n*		
Gender (female)	229	106	0.71	.40
Education (university level)	132	67	0.17	.68
Organisation type (government)	178	83	0.09	.77
Funding (Australian Government)	114	47	1.43	.23

Note. The non-completers' sample only includes participants who provided demographic information. No information is available about the 52 participants who were screened out and the 34 who were eligible but did not answer any questions.

Findings from the practice survey

Practitioner and workplace characteristics

Practitioner characteristics

The majority of the practice sample was female (90%). Respondents came from a variety of professions including social work (30%), psychology (15%), family support (15%) and counselling (10%). Eighty-six percent of respondents reported that the highest academic qualification they had attained was undergraduate or postgraduate university level education (including Postgraduate Diploma, Masters or PhD). That is, 32% of the practice sample held undergraduate qualifications, 19% held postgraduate (Masters/PhD) qualifications, and 35% held graduate diplomas.

The most frequently reported types of services delivered as part of respondents' current roles included parenting education (77%), individual support (71%), early intervention or prevention services (61%) and in-home work (54%). Group work (49%), relationship support (46%) and crisis intervention (46%) were also commonly reported as part of respondents' current roles.

An open-ended question was used to elicit information about theoretical orientations or perspectives that most informed respondents' work with children and families. An indefinite number of responses were permitted. Participants listed 26 unique responses, not all of which

could strictly be viewed as theoretical orientations, but rather as guiding principles (e.g., person-centred or strengths-based). The most frequent responses are presented in Table 8, and included person-centred, attachment-focused, systems-focused, narrative and strengths-based.

Due to the high volume of data collected about practitioner and organisational characteristics, it was not practical to report all of these in the body of this report. The practitioner and organisational characteristics described in this chapter provide a snapshot, but a more detailed description about survey responses is presented in Appendix 3, Table 2. Similarly, detailed information about theoretical paradigms and guiding principles is also presented in Appendix 3, Table 3.

Table 8. Theoretical orientations or perspectives informing respondents' work (*n* = 189).

Theoretical orientation or perspective	Frequency cited as an influence
Person-centred	50
Attachment	47
Systems	45
Narrative	44
Strengths-based	40
Child-centred	33
Family-centred	27
Trauma-informed	24
Eclectic	21
Psychodynamic	16

Note. Responses were coded across more than one category when participants gave more than one response. Hence the frequency of theoretical orientations exceeds the number of respondents.

Workplace characteristics

The majority of practice sample respondents (69%) indicated that they worked in a non-government organisation, and 43% received some or all of their funding from the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). Organisations were most frequently described as family support services (24%), community services (21%) or child protection services (14%). When asked how best to describe their organisation's approach to service delivery, 55% of respondents identified an integrated service delivery approach, 43% identified family case management, 43% identified early intervention/prevention and 33% reported intensive intervention.

Practitioner experience with children exposed to trauma through abuse and neglect

Experience in treating clients exposed to trauma

Over half of the practice sample respondents reported that they had a moderate amount or quite a bit of experience treating children who have experienced trauma (58%), while 29% reported they had a little or no experience. The assessment of trauma and its impact was important to participants, with 90% reporting that assessment of trauma and its impact was at least a moderate priority in their everyday work.

Frequency of contact and confidence with clients exposed to trauma

The majority of the practice sample respondents (77%) had at least weekly contact with children who had experienced a potentially traumatic event such as family violence, child abuse and neglect, parent substance abuse or mental illness, while 29% had such contact more than once a day. Seventy-six percent reported they were quite or extremely confident at recognising the signs and symptoms of trauma, while 23% were a little or moderately confident. The majority of respondents (57%) reported they were moderately or quite confident delivering therapies for trauma in their usual practice, 10% were extremely confident, and 32% reported they were a little or not at all confident delivering therapies for trauma.

Data related to the relationship between frequencies of contact with children exposed to potentially traumatic events and levels of confidence in delivering therapies for trauma is presented in Table 9. The general trend in this table suggests respondents with weekly or more frequent contact tend to be moderately to extremely confident in delivering therapies for trauma. Nevertheless, approximately 20% (*n* = 57) of the sample who had contact with trauma-exposed children at least weekly felt not at all or a little confident in delivering therapies for trauma.

Table 9. Relationship between frequency of contact and confidence in delivering therapies for trauma (*n* = 289).

Frequency of contact	Confidence delivering therapies for trauma					
	Not at all	A little	Moderately	Quite a bit	Extremely	Total
Hardly ever	5	3	6	5	0	19
Monthly	12	16	5	12	1	46
Weekly	17	24	27	30	5	103
Once a day	2	4	14	14	2	36
More than once a day	4	6	27	26	22	85
Total	40	53	79	87	30	289

Training and confidence

The majority of the practice sample (75%) reported that they had received training specific to trauma exposure in children, although it is not known what this training comprised. Prior training

was significantly associated with confidence for delivering therapies for trauma ($\chi^2(4) = 45.02$, $p < .001$). Table 10 illustrates the relationship between participation in training and confidence in delivering therapies for trauma. All participants who reported extreme confidence in delivering therapies for trauma had attended prior training specific to trauma exposure in children. No prior training was associated with lower levels of confidence.

Table 10. Frequency of respondents who had received training specific to trauma and their reported confidence delivering therapies for trauma.

	Confidence in delivering therapies for trauma					
	Not at all	A little	Moderately	Quite a bit	Extremely	Total
Participated in training specific to trauma in children (*n*)	18	34	55	79	30	216
Total (*n*)	40	53	79	87	30	289

The findings presented so far with respect to contact, experience, training and confidence provide a general snapshot of the experience of the field in working with children and families exposed to trauma. More detailed data regarding responses to questions related to the experience and confidence of respondents can be found in Appendix 3, Table 4.

Practitioner understanding of trauma in practice

Awareness and understanding of trauma-informed care

Participants were asked to indicate their knowledge of the term 'trauma-informed care'. The majority of the practice sample (66%) reported they had not heard of the term. Participants were then asked to make some comments about their understanding of trauma-informed care. Of the 98 participants (34%) who had heard of trauma-informed care, 71% mentioned the importance of understanding the impact of trauma and 41% described adapting the provision of care to consider and/or treat the effects of trauma on children. Comparatively few responses included the concepts of avoiding re-traumatisation, promoting safety and considering the vicarious effects of trauma on staff.

Participants were asked to list strategies and techniques they used to assist children who experience trauma, and how they incorporate an understanding of trauma and its impact on children and families into their practice. This part of the survey was completed by 232 participants who provided a total of 989 responses for practice strategies employed. These responses were coded into 49 thematic categories. The most frequently reported categories are presented in Table 11. A complete table outlining all 49 categories can be found in Appendix 3, Table 5.

Table 11. Strategies and techniques used to assist children who experience trauma (most frequent responses only).

Category	Frequency	Example response
Referral and linking with other services or support	133	Make appropriate referrals to assist child therapeutically, either in-house or external services. Active working relationship with enhanced maternal child health nurses. Help other people involved in the child's care/education to understand the effects of trauma on the child's development.
Education of child, family or parents	113	Attending to any educational interventions that could be shared in a developmentally appropriate way, e.g., What is physical abuse? Educating the children's carers about trauma and how this impacts on children, their behaviour and development.
Safety/routine home environment	99	Assist families to provide calm, safe structure at home and manage stress of whole family. Establishing a safe and secure environment.
Child-centred work	88	Client-centred — meeting client where they are each day, allowing choice at every opportunity.
Parenting support	87	Assisting parents in supporting their children who have experienced trauma. Debrief and discuss strategies of responding to child's behaviour with foster parents.
Art/Creative/Play Therapy	82	Creative arts in therapy — play, drama, art. Sand tray work and symbol work to allow the child to express without necessarily talking.

Practitioner awareness of evidence-based approaches

Approximately half of the practice sample (151 participants, 52%) reported that they were aware of evidence-based approaches to treat or prevent trauma in children. In an open-ended question, participants were asked to list approaches that they believed were evidence-based. One hundred and nine (37%) of the practice sample listed 157 different approaches they considered to be evidenced-based. Of the 157 approaches participants considered to be evidence-based, 48 approaches were identified by more than one respondent. Of the 157 approaches, 109 were

identified by a single respondent. A list of the 48 approaches identified by more than one respondent and those 109 identified by a single respondent, alongside information about whether and/or where the approach was located in the REA is found in Appendix 3, Table 6 and Table 7 respectively. The most frequently reported approaches (i.e., the top five, which had at least 10 respondents citing the approach) are presented in Table 12, and include the Neurosequential Model of Therapeutic Care, Trauma-Focused Cognitive Behavioural Therapy (CBT), Play Therapy, Circle of Security and Dyadic Developmental Psychotherapy. It is noted that at the time this survey was completed, Dr Bruce Perry had recently visited Australia delivering a series of workshops on the Neurosequential Model. Although the practice survey did not attempt to determine the potentially wide range of factors that may influence awareness of individual approaches, it is possible that the high frequency of respondents reporting awareness of the Neurosequential Model reflects the recency of these workshops and the popularity/preference of this approach in the Australian sector.

Table 12. Reported awareness of 'evidence-based' 'programs' to treat or prevent trauma (cited by at least 10 respondents).

Program	Frequency
Neurosequential Model of Therapeutic Care (Perry)	15
Trauma-focused CBT	14
Play Therapy	12
Circle of Security	12
Dyadic Developmental Psychotherapy	10

Specific programs currently used

We asked respondents to identify any approach they had used over the past year to treat or prevent outcomes in children exposed to trauma associated with abuse and neglect. Specific information was elicited from respondents about the theoretical paradigm, the key components, techniques and strategies within the approach, outcomes targeted by the approach and whether training or adaptation to the approach had occurred.

One hundred and seven (107) participants (38% of the practice sample) reported that they had applied a specific approach to treat or prevent outcomes in children exposed to trauma in the past year. Of these, 87 participants provided additional information about the use and delivery of these approaches. There were fifteen specific approaches that were reported by two or more respondents. Information regarding the content and delivery of these approaches as described by each respondent who mentioned the approach is presented in Tables 13a and 13b. A further 64 approaches were only mentioned by one respondent, and these are listed in Appendix 3, Table 9. The fifteen approaches identified by more than one respondent, alongside their REA rating, if applicable, are found in Appendix 3, Table 8.

Table 13a. Description of approaches currently being applied to treat or prevent trauma in children (A).

Approach	Practitioner			Client group								Format						Setting						Delivery		
	Professional Discipline	Received training in this approach	Number of times used over past year	Children	Adolescents	Parent / caregiver	Single parents	Grandparents	Teenage parents	Children with special needs	Parents with special needs	Individual	Family	Group	Telephone	Online	Self-guided	Home	Clinic	Classroom /school	Playgroup	Community Centre	Family Intervention Centre	Sessions	Frequency	Duration (of sessions)
Play therapy (*n* = 9)*	FS	✓	1	✓			✓					✓												12	weekly	1hr
	C	✓	Frame-work daily	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓				✓					up to 2 years	varies	1hr
	Psych	✓	10	✓	✓							✓							✓							
	Psych	✓	weekly	✓								✓							✓					varies	weekly	1hr
	Psych	✓	couple	✓	✓					✓		✓								✓				6-10	weekly	1hr
	C	✓	many	✓								✓							✓					12	weekly	1hr
	FS	✓	daily	✓		✓	✓					✓		✓										over 2 years		
	Psych	✓	>150	✓								✓										✓			weekly	45min
	FS	✓	6	✓								✓										✓		12	weekly	50min
Circle of Security (*n* = 8)	SW	✓	2			✓	✓				✓	✓		✓								✓		8	weekly	2hr
	SW	X	weekly	✓			✓		✓	✓	✓	✓	✓	✓				✓						∞	weekly	2hr
	Nursing	✓				✓						✓	✓	✓				✓	✓			✓		8	weekly	1-2hr
	Psych	✓				✓						✓	✓	✓				✓	✓		✓			8	weekly	
	Psych	✓	5	✓	✓	✓	✓	✓	✓	✓	✓		✓					✓	✓					8	weekly	1hr
	OT	✓	>5			✓		✓						✓								✓		8	weekly	2hr
	FS	✓	Elements daily	✓		✓	✓	✓		✓	✓			✓									✓	10	weekly	1.5hr
	SW	✓	10	✓		✓						✓		✓				✓	✓			✓		8	weekly	2hr

Approach	Practitioner			Client group								Format						Setting						Delivery		
	Professional Discipline	Received training in this approach	Number of times used over past year	Children	Adolescents	Parent / caregiver	Single parents	Grandparents	Teenage parents	Children with special needs	Parents with special needs	Individual	Family	Group	Telephone	Online	Self-guided	Home	Clinic	Classroom /school	Playgroup	Community Centre	Family Intervention Centre	Sessions	Frequency	Duration (of sessions)
Art therapy (n = 5)[1]	Art Therapist	✓	1	✓						✓				✓						✓				18	weekly	1.25hr
	Art Therapist	✓	weekly	✓		✓						✓								✓				ongoing	weekly	1hr
	Art Therapist	✓	2	✓						✓				✓						✓				10	weekly	
	FS	✓	1+	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓			✓						initial	initial	varies
	C	✓	many	✓	✓							✓		✓											weekly	1hr
Parents Under Pressure (n = 3)	Nursing	✓	3			✓	✓					✓	✓	✓				✓	✓					11	weekly	1-2hr
	Psych	✓	6			✓						✓	✓					✓	✓					12	weekly	1hr
	Psych	✓	15									✓	✓	✓				✓		✓				8	weekly	1.5hr
Angel Blankets (n = 3)	SW	✓	3	✓	✓	✓			✓	✓		✓	✓							✓		✓		6	weekly	1.5-2hr
	SW	✓	1	✓								✓											✓	8	weekly	1.5hr
	SW	✓	2	✓						✓		✓	✓										✓	9	weekly	1.5hr
Neuro-sequential Model (n = 3)	Psych	✓	mostly	✓	✓					✓		✓	✓						✓	✓				varies	weekly	0.5-1hr
	Psych	✓	every relevant case	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓		✓				
	Psych	✓	couple	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓				✓		✓				varies	daily	varies

Approach	Practitioner			Client group								Format						Setting						Delivery		
	Professional Discipline	Received training in this approach	Number of times used over past year	Children	Adolescents	Parent / caregiver	Single parents	Grandparents	Teenage parents	Children with special needs	Parents with special needs	Individual	Family	Group	Telephone	Online	Self-guided	Home	Clinic	Classroom /school	Playgroup	Community Centre	Family Intervention Centre	Sessions	Frequency	Duration (of sessions)
Mindfulness (*n* = 3)	SW + C	✓	mostly	✓	✓	✓				✓	✓	✓		✓			✓		✓					26	weekly	40min
	C	✓	50+	✓						✓		✓		✓				✓	✓	✓				18	weekly	1hr
	C	✓	∞	✓	✓							✓							✓							
CBT (*n* = 2)	Welfare	✓	a few																							
	Psych	✓	several	✓	✓	✓						✓	✓						✓					12	weekly	1hr
Trauma-focused CBT (*n* = 2)	Psych		10	✓	✓	✓						✓	✓						✓					8-16	1-2 weekly – fort-nightly	1-1.5hr
	Psych	X	1	✓	✓	✓				✓		✓							✓					12	weekly – fort-nightly	50min
Counselling (*n* = 2)	Legal	X	3	✓		✓	✓					✓	✓	✓					✓							
	SW	✓	always	✓		✓	✓	✓				✓						✓		✓				varies	fort-nightly	0.5-1hr
Therapeutic Crisis Intervention (*n* = 2)	Psych	✓	2-3 times a year			✓								✓										4 days	weekly	2 x 6hr days
	SW	✓	4		✓							✓		✓				✓								

Approach	Practitioner			Client group								Format						Setting						Delivery		
	Professional Discipline	Received training in this approach	Number of times used over past year	Children	Adolescents	Parent / caregiver	Single parents	Grandparents	Teenage parents	Children with special needs	Parents with special needs	Individual	Family	Group	Telephone	Online	Self-guided	Home	Clinic	Classroom /school	Playgroup	Community Centre	Family Intervention Centre	Sessions	Frequency	Duration (of sessions)
Parents as Teachers (n = 2)	Edu	✓	4	✓		✓	✓	✓	✓	✓	✓		✓					✓						Up to 12 months	weekly-fort-nightly	1-1.5hr
	SW	✓	8	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓						10	weekly	1.5hr
Reparative Parenting Program (*n* = 2)	SW	✓	1					✓						✓								✓		20 (10 F2F)	fort-nightly	2.5hr
	Welfare	X	1			✓								✓								✓		10	fort-nightly	2hr
Sanctuary Model (*n* = 2)	Edu	✓	daily	✓						✓		✓		✓				✓						N/A	N/A	N/A
	SW	✓																								
Seasons for Growth (*n* = 2)	Edu	✓	1	✓	✓									✓						✓				4	weekly-fort-nightly	40min – 1hr
	SW	✓	each term	✓	✓	✓	✓	✓	✓			✓	✓	✓				✓				✓	✓	8 weeks	weekly	1-2hr

Note. FS (Family Support), C (Counselling), Psych (Psychology), SW (Social Work), OT (Occupational Therapy), Edu (Teaching and Education), CBT (Cognitive Behavioural Therapy).
[1] *Three of the five art therapy programs were variations in practice reported by one participant (e.g., Individual Art Therapy, Open Art Therapy Studio and Art Therapy Group).*

** n represents the number of respondents who mentioned each approach as one they had used in the past year.*

Table 13b. Description of approaches currently being applied to treat or prevent trauma in children (B).

Approach	Explanatory theory, model or framework								Design of approach				Outcomes										
	Attachment	CBT	Mindfulness	Child / person - centred	Gestalt	Neuro-biological	Resilience	Developmental	Includes essential components	Developed in-house	Adapted by user	Evaluation by user	Child behaviour	Child physical health / safety	Child psychological wellbeing	Child cognition	School and education	Child relationships	Family wellbeing	Parenting confidence and knowledge	Parenting skills	Service use	Exposure to further risk
Play therapy				✓					✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	✓	Psycho-dynamic				✓			✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
									x	x	x	x			✓	✓		✓					
									x	x	x	x			✓			✓					
				✓					✓	x	x	x	✓	✓	✓	✓	✓	✓					✓
				✓					✓	x	x	✓	✓		✓			✓	✓				
	✓	Humanistic							✓	x	✓	x	✓	✓	✓	✓	✓	✓	✓	✓			✓
	✓							✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
				✓					✓	x	x	✓	✓	✓	✓	✓		✓					
Circle of Security	✓								✓	x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	✓								✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
									x	x	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	✓								✓	x	x	x	✓		✓			✓			✓		
	✓								x	x	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	✓								✓	✓	✓	✓						✓	✓	✓	✓		✓
	✓								✓	x	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	✓								✓	x	x	x	✓		✓			✓	✓	✓	✓		
Art therapy				✓					✓	✓	✓	✓	✓	✓	✓	✓		✓					✓

Approach	Explanatory theory, model or framework								Design of approach				Outcomes										
	Attachment	CBT	Mindfulness	Child / person - centred	Gestalt	Neuro-biological	Resilience	Developmental	Includes essential components	Developed in-house	Adapted by user	Evaluation by user	Child behaviour	Child physical health / safety	Child psychological wellbeing	Child cognition	School and education	Child relationships	Family wellbeing	Parenting confidence and knowledge	Parenting skills	Service use	Exposure to further risk
	✓			✓	✓				✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓		✓		✓
				✓	✓				✓	✓	x	✓	✓	✓	✓	✓	✓	✓					
									✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
										x	✓	x	✓		✓			✓					
Parents Under Pressure										x	✓	x	✓	✓		✓		✓	✓	✓	✓	✓	
		✓	✓						x	x	✓	x			✓			✓	✓	✓	✓		
	✓								x	x	x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Angel Blankets	✓						✓		✓	x	x	✓			✓	✓	✓	✓	✓				
							✓			x	✓	✓	✓	✓	✓	✓		✓	✓				
							✓		x	x	✓	✓	✓		✓	✓	✓	✓					
Neuro-sequential Model	✓					✓	✓		✓	x	✓	x	✓	✓	✓		✓	✓		✓			✓
						✓			x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
						✓			✓	x	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mindfulness			✓						✓		✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		✓							✓	x	✓	✓			✓								
		✓			✓				✓	x	✓	x	✓		✓	✓		✓					
CBT		x							✓	x	x	x											
		✓							✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓

Approach	Explanatory theory, model or framework								Design of approach				Outcomes									
	Attachment	CBT	Mindfulness	Child / person - centred	Gestalt	Neuro-biological	Resilience	Developmental	Includes essential components	Developed in-house	Adapted by user	Evaluation by user	Child behaviour	Child physical health / safety	Child psychological wellbeing	Child cognition	School and education	Child relationships	Family wellbeing	Parenting confidence and knowledge	Parenting skills	Service use	Exposure to further risk
Trauma-focused CBT		✓								X	✓	X	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
										X	X	X	✓	✓	✓	✓		✓	✓	✓	✓		
Counselling	Don't know									X	X	X											
	Community development and others									✓	X	✓	✓	✓	✓	✓	✓	✓					
Therapeutic Crisis Intervention									✓	X	X	X	✓		✓			✓			✓		
	CARE Model Framework									X	✓	X	✓		✓	✓							
Parents as Teachers									X	X	X	X	✓	✓				✓	✓	✓	✓	✓	✓
								✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Reparative Parenting Program	✓								X	X	X	X	✓	✓	✓		✓	✓	✓	✓	✓		✓
	✓								✓	X	X	✓	✓	✓	✓	✓	✓	✓		✓	✓		
Sanctuary Model	Safety, competence and community capacity								✓	X	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓
										✓	✓												
Seasons for Growth	Grief and loss theory								✓			X	✓	✓	✓	✓	✓	✓					
	Grief and loss theory											X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note. *Respondents needed to provide a written response for the explanatory theory, model or framework section and for the essential components column (i.e., if the respondent indicated the approach was informed by theory but did not describe that theory, the response was treated as missing data). CBT (Cognitive Behavioural Therapy).*

Discussion of findings from the practice survey

The purpose of this practice survey was to examine the awareness and uptake of evidence-based approaches for children exposed to or at risk of trauma resulting from abuse and neglect. The survey also sought to explore current approaches being used within child and family agencies across Australia to support children exposed to, or at risk of exposure to, trauma.

Summary of the practice survey findings

A large number of practitioners participated in this Australia-wide online survey. They came from a range of government and non-government agencies, many of whom receive funding from the Australian Government. Represented organisations included those that provide family support, community services and child protection services. The majority of participants provided services that included integrated service delivery, and other common approaches to service delivery included case management, individual support, parenting education and support, and prevention and early intervention services. Respondents worked with children and/or families exposed to traumatic events, with a large proportion being guided by person-centred, attachment and strengths-based paradigms in their work with families and children.

Confidence, experience and training in trauma and trauma-informed care
Most respondents had regular contact with trauma-exposed clients, with most respondents having at least weekly contact. In general, there was a moderate to high level of confidence reported by the majority of respondents in recognising the signs and symptoms of trauma and in delivering therapies for trauma. A moderate proportion (about a third), however, reported low levels of confidence in identifying trauma and in delivering trauma therapies in their usual practice. Greater confidence in providing care for children exposed to trauma appeared to be related to (1) higher frequency of contact with children who have experienced trauma, as well as to (2) prior trauma-specific training.

There were high levels of reported access and exposure to trauma-specific training, with 75% of participants having received training specific to trauma exposure in children. Importantly, training was associated with confidence in delivering interventions for trauma-exposed populations. However, given the high level of trauma exposure within the populations the sample worked with, the finding that 25% of participants had no trauma training represents an important gap.

Despite the majority of respondents having at least weekly contact with children who have experienced trauma, 20% of respondents with weekly contact reported little or no confidence in delivering any form of approach that targeted outcomes associated with trauma in their usual practice. Of course, while some practitioners may not be expected to deliver interventions in their workplaces, this may also represent a group of practitioners who have frequent contact with trauma-exposed children but who require greater clarity about effective ways of supporting their clients. Cumulatively, these findings suggest that a gap might exist within the sector in relation to confidence and training in the assessment and treatment of children experiencing or at risk of trauma as a result of child abuse and neglect.

It was interesting to note that over two-thirds of the practice sample had not heard of the concept of trauma-informed care. The other 34% mentioned the importance of understanding the impact of trauma and adapting the provision of care to consider and/or treat the effects of trauma on children. While this is consistent with the widely accepted definition of trauma-

informed care adopted for this project (see Chapter 1), fewer responses included the concepts of avoiding re-traumatisation, promoting safety and considering the vicarious effects of trauma on staff. The limited awareness of the concept of trauma-informed care among most practitioners could in part be explained by the relative newness of this framework or different understandings practitioners had around the term 'care'. For instance, in child protection the term 'care' can be synonymous with the term 'out-of-home care'. In this regard, practitioners may not have professed knowledge or use of trauma-informed care because they were not employed in an out-of-home care service or because they engaged in Therapeutic Residential Care (TRC) within an out-of-home care situation. TRC is a concept that overlaps trauma-informed care. It is an approach adopted in Australia similar to trauma-informed care, and is defined as intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. TRC is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs.[92] Given this similarity, it is possible that practitioners may be more aware of some of the principles associated with trauma-informed care, but not as an overarching framework guiding practice itself.

Approaches to supporting children exposed to trauma

The majority of respondents to the practice survey indicated that the assessment of trauma and its impact was a priority in their work. This speaks to the importance of trauma-related work for practitioners within the child and family support sector. When respondents were asked what strategies and techniques they used to assist children who experience trauma, the main practice, identified by 57% of participants, was to refer out or to link with other services. While appropriate referral may be a very appropriate action, it does raise the question of whether there are appropriate services available and whether the services to which referrals are made actually employ evidence-based approaches in the treatment of trauma.

When asked about their use of evidence-based approaches to target outcomes associated with trauma exposure associated with abuse and neglect, only a third of respondents were able to name an approach. This small number of respondents named a total of 79 approaches that they had recently delivered and which they believed were evidence-based. The number of reportedly evidence-based approaches recently used by two or more respondents totalled 15. The relatively small number of participants using approaches they understood to have an evidence base may reflect that practitioners did not see their role as one involved in the delivery of approaches. It may also reflect a deficit in knowledge of evidence-based approaches. The degree to which the actual approaches identified by practitioners did have an evidence base as identified in our REA will be discussed in the General Discussion of this report (see Chapter 5).

Limitations of the practice survey

Although two-thirds of those who were eligible (*n* = 364) did complete the online survey, almost a third did not complete the survey in its entirety. The majority of those who did not complete the survey ceased participation at the demographic questions. These completion rates are similar to other online surveys. Non-completers did not differ significantly from completers on broad demographic and organisational characteristics; therefore, we are confident that early discontinuation did not affect the observed results of the survey.

The extent to which the findings from the practice survey can be generalised to the sector as a whole is unknown because the characteristics of those employed more broadly across the sector

are not available. Moreover, a large proportion of practitioners were employed by services that received funding from the federal government. Lesser representation from state-funded child abuse and neglect services (which often encompass intervention rather than prevention services) may have impacted on the findings from this survey. Additionally, there was relatively small representation from mental health services compared with other types of services. Hence, while efforts were made to ensure the survey was promoted to as many child and family support practitioners in Australia as possible, without good information about who makes up the sector, it is difficult to be certain about the general representativeness of the present sample of practitioners. Indeed, it is noted that it is difficult to ascertain 'general representativeness' of the field given that the 'field' is diverse in itself, often incorporating multiple services and service roles (e.g., prevention, in-home services, child protective services, out-of-home care, case management/coordination, specialised intervention). Finally, although practitioners who responded to this survey reported their use of what they perceived to be evidence-based programs, we did not examine aspects of the fidelity of their practice (e.g., adherence to dose requirements and essential treatment components) to evaluate the quality of their practice.

Conclusions

It was generally acknowledged by practice survey respondents that recognising trauma and its outcomes were an important part of the work of practitioners in the field. The responses to this practice survey point to some lack of clarity within the sector about evidence-based approaches for children exposed to or at risk of trauma as a result of child abuse and neglect. While many practitioners appear to have frequent contact with children who have experienced this type of trauma, and many report reasonably high levels of confidence in supporting these children, only around a third of the sector reported using specific approaches to treat or prevent trauma in children. It is acknowledged, however, that trauma assessment and treatment may not be part of some practitioners' roles and responsibilities within this field. Nevertheless, the extent to which trauma-specific/focused approaches are employed by practitioners appears to be limited, based on the findings of this survey. The degree to which the approaches identified by practitioners as having an evidence base actually were supported in our REA will be discussed in the General Discussion of this report (see Chapter 5).

Chapter 4: Organisational leader and senior manager consultations

Aims of the consultations

We conducted in-depth semi-structured interviews with individuals identified as organisational leaders or senior managers in child and family support service delivery in Australia. Our aim was to examine the level of awareness and scale of uptake of evidence-based approaches relevant to child and family service organisations as well as identifying factors that influence the uptake of evidence-based approaches in Australia.

Questions addressed by the consultations

The organisational leader and senior manager consultations addressed the following questions:

1. Among organisational leaders and senior managers, what is the awareness and uptake of evidence-based approaches that aim to address the child and family consequences of trauma exposure relevant to child and family service organisations in Australia?
2. What are the practical drivers and obstacles to the uptake of evidence-based approaches that target child outcomes after trauma exposure?
3. What are the key considerations that will assist organisations to successfully implement evidence-based approaches designed to target children exposed to trauma through abuse and neglect?

Methodology of the consultations

A semi-structured interview was developed to collect information from organisational leaders and senior managers in the sector, including questions about organisational characteristics, awareness and adoption of evidence-based approaches, and factors that influence uptake of such approaches. The interview schedule can be found in Appendix 4. Organisational leaders and senior managers from twenty-five child and family service organisations were invited to participate in an interview, which was conducted over the telephone or face-to-face. Among the 25 organisational leaders and senior managers invited to participate, 16 did not respond and four suggested an alternative person within their agency who would be more appropriate to interview. Interviews were administered by two of the project leaders. Taped recordings were transcribed by a research assistant and thematically analysed by one of the project leaders who conducted the interviews. Evaluation reports, practice models or program materials were also reviewed if they were suggested by the interviewee.

Participants

Ten organisational leaders and senior managers from nine agencies participated in the consultations. The positions of those interviewed were generally at the CEO, Executive Manager or Director level. Most were responsible for or contributed to decisions about practice at the agency. Some were responsible for research or evaluation within their organisation.

Four Australian state-based organisations and two national organisations were represented. Many of the state-based organisations operated statewide (n = 5). All but one agency provided

services in metropolitan areas, with some also providing services in regional or rural areas (no agencies provided remote services). One agency provided services only in regional or rural areas (i.e., not in a major or capital city). One interviewee was from a government department, the remainder represented non-government organisations.

Participating agency characteristics

Client group serviced

Participating agencies served a range of target groups, including universal services such as playgroups and child care, and more targeted services such as out-of-home care and child protective services. Many agencies provided programs for out-of-home care, residential care, and foster care and a number provided programs for children not in care. Many agencies were working with multiply disadvantaged and highly vulnerable families. Vulnerability and disadvantage were related to varied circumstances including financial disadvantage, exposure to or risk of child abuse and neglect, family violence and family separation. For example, one interviewee described her organisation's program as being primarily for families where it would be 'unsafe for them to go to other services'. The majority of participating agencies took referrals from child protective services. Many agencies worked with Aboriginal and Torres Strait Islander communities. Some agencies delivered child-focused work, although most were adult-focused, or worked with caregivers (parent or foster carer) as the primary focus of intervention.

Services offered

Most agencies offered or delivered services in families' homes. Around half of the agencies offered services in group formats or through community-based services (e.g., playgroups, schools). Many described their service as providing case management and some as providing case work. A few agencies delivered clinic-based programs (e.g., in-clinic therapeutic services delivered directly to children in out-of-home care. One agency offered respite services to families. Generally, services had long-term involvement with families, although this varied from a few months to a number of years. Some agencies had specifically trained staff from helping professions (e.g., social workers, family therapy, psychologists, occupational therapists), though in general, agencies described their staff as being from varied backgrounds (e.g., education, community development).

Theoretical paradigms of agencies

The majority of agencies were described as being predominantly relational or attachment-based in perspective. A few described cognitive behavioural approaches that were used in their agency. For some agencies, cognitive behavioural approaches had been tried (i.e., workers trained) but were not deemed a good fit for their service models. Agencies were generally described as being family-centred, although one particularly noted that they viewed themselves as being child-centred. One interviewee mentioned a solution-focused philosophy, while a few mentioned strength-based approaches. A number of agencies described their agency as having 'eclectic' theoretical perspectives, using different approaches to develop their own operational framework.

Findings from the organisational leader and senior manager consultations

Decision-making processes in implementing approaches

How do organisational leaders and senior managers make decisions about the approaches they implement?

Decisions about practice approaches were usually made at the upper levels of management (CEO, Service Managers). In some smaller agencies with more ad hoc approaches to trauma work, decisions were made by workers or team leaders, or recommendations to the executive level would come from the team who worked with families. Some agencies afforded their workers a degree of autonomy in their practice choices.

Three key themes emerged in response to the question about how decisions were made about the approaches that were implemented within a service. These included:

- financial considerations
- partnership opportunities
- evidence for an approach.

Financial considerations

The majority of organisational leaders and senior managers reported that decisions were usually made based on funding requirements or where opportunities for funding were present. One agency noted that because non-government organisations often 'follow the money', different government departments in different states tended to have different requirements, resulting in diverse views of the importance of evidence. Thus, practice approaches vary substantially from state to state.

> *One of our key drivers is, 'Do we have the funding even for the research phase and development phase?' … Sometimes corporate partners might identify what's important to them on their social responsibility.*

Partnership opportunities

Current trends in practice, based on what other similar organisations were doing, was often a guiding factor in decisions around what programs to use. Furthermore, opportunities to partner with researchers or other agencies often dictated what training was offered to staff.

> *Once we establish a connection with key researchers we have an ongoing relationship with them which can be part of training. If we go into an area we are not so sure of we talk with them … We are using them for their expertise and knowledge.*

> *We are certainly trying to get the best value for our training dollar so we try and piggyback off when others are offering training.*

Evidence for an approach

Interviewees' responses to questions regarding influences on decision-making about what approaches to use usually included a discussion about the role of the evidence.

> *What guides me these days is what I know about the evidence base for that program, for example … I went on the California Evidence-Based Clearinghouse website and looked for preparation training for carers, and so there were three or four programs that were at various levels of recommendation and so I started by contacting the people that were responsible for training those programs, and that's how I guess increasingly how I'm making decisions.*

However, agencies gave varying levels of support for the importance of the evidence in their decision-making, with other factors (such as those outlined above) playing an important role. For two organisations, the evidence was not mentioned as a factor at all. The next section further discusses aspects of the use of evidence in decision-making.

Use of evidence in informing the choice of approaches

What is the extent to which evidence is used to inform which approaches are implemented?
Four main themes emerged in response to the degree to which evidence was used in determining which approaches were implemented:

- Evidence is important.
- Approaches are 'research-informed'.
- Agencies use a limited range of strategies to encourage evidence-based practice.
- The evidence base is not the only consideration.

Evidence is important
As noted above, evidence for the effectiveness of an approach was typically acknowledged as being an important consideration in adopting approaches. Some interviewees held strong views about the importance of evidence.

> *[The evidence base to a program is] absolutely fundamental. The evidence should be leading our work and we shouldn't just be putting our hand on our heart and hoping for the best.*

> *As we know through implementation science, you can't have just a couple of people banging on; you've got to embed it through the organisation. That's a longer journey about trying to make people aware of evidence-informed practices or programs and then indeed to actually implement them.*

Research-informed approaches
Many interviewees stated that research was used to inform the development of new approaches or adaptation of existing approaches, rather than necessarily adopting approaches that already had an evidence base.

> *Our work is research-based rather than evidence-based, so we would look at what the research tells us for trauma and neglect on the children and we design an intervention that relates to that rather than what necessarily has a formal gold standard.*

> *What we aimed to do [was] to develop a set of coherent practice resources … that were informed by quality research and peer-reviewed research.*

A number of interviewees who described their agency as being an evidence-based organisation noted that their agency sometimes developed their own programs based on a variety of sources of evidence including in-house experience and research.

> *Drawing on a range of different evidence, but in terms of what we've done is articulate a model — a practice approach that integrates understanding that is trauma-informed, that comes back to the importance of the relationship and forming a relationship with families and children and establishing safety through that emotional connection. [It is] developmentally- and trauma-informed.*

Strategies to encourage evidence-based practice

When asked to identify strategies employed by the agency to assist staff with efforts to implement evidence-based practices, organisational leaders and senior managers named a limited range of strategies (see Table 14). For most agencies these strategies were described as being delivered in an ad hoc way, for example, when opportunities arose and irregularly. There were a couple of exceptions, with some agencies describing a more planned approach to training plus regular supervision or coaching to encourage ongoing fidelity to a model. Some organisational leaders and senior managers were clear that their agencies were only recently starting to move toward being aware of and using evidence-based practice.

Table 14. Strategies implemented by organisations to encourage evidence-based practice.

Strategies to encourage evidence-based practice
* Support through information (e.g., provision of program materials)
* Formal or informal training
* Supervision and coaching
* Access to journal papers
* Support for workers to attend conferences
* Journal club
* Members of the Australian Research Alliance for Children and Youth, Family & Relationship Services Australia, or other clearinghouses
* Send staff to seminars/events/workshops (e.g., 2012 events delivered by Bruce Perry).

Evidence is not the only factor

Evidence was not always deemed to be the critical guiding factor influencing decision-making. A number of organisational leaders and senior managers mentioned the need to find the balance between what is evidence-based and what is implementable within their organisation. Furthermore, the client group and needs of the clients were also important considerations in the selection of approaches. Thus, where evidence was cited as important in decision-making, it did not stand alone — there were many other factors that impacted decision-making.

> *There are a whole lot of other factors — evidence is only one factor. There is also the pressure for growth. So sometimes you will take a program that you know*

doesn't work particularly well because it will give you scale to do something that does work well.

Awareness and adoption of evidence-based approaches

What is the level of awareness and scale of uptake of evidence-based approaches relevant to trauma within child and family service organisations in Australia?

There were two main themes expressed by organisational leaders and senior managers regarding the awareness and scale of uptake of evidence-based approaches suitable for children exposed to or at risk of trauma:

- Exposure of the sector to trauma information.
- Adaption of evidence-based approaches to fit client group.

Exposure of the sector to trauma information

There was a sense among organisational leaders and senior managers that the child and family sector had been exposed to a high level of information about trauma and trauma-informed practice. There was also a sense that practices around responding to the outcomes of trauma exposure were improving.

What we've done is a flooding of the field in terms of training around understanding child development and trauma … in a whole lot of different ways, [we have] tried to enable concepts that are useful in understanding trauma and child development to be really available to use [by practitioners in child protection] right through to minister's office.

We've also got a big survey that is not yet public — child and family survey, outcomes survey — that's quite big and was independently conducted … It has really good news in terms of improvement in practice from parents' perspective, from consumer perspective, changing outcomes, changing views and changing experiences of practitioners.

Adaption of evidence-based approaches to fit client group

Agencies tended not to adopt complete packages but rather used parts of programs, or adapted existing programs to meet their service contexts or client needs.

We've developed a new out-of-home care framework for foster care and residential care and that's very much informed by Bruce Perry's model around trauma. But you can't really call it trauma-informed because it doesn't have a psychologist on the team. To be truly working in that trauma framework you need those resources on tap, so we have sort of modified that.

It would be fair to say we have not found that we have been able to use a formal manualised approach as a rule. We've had training in the form of focused CBT, and more recent training in adaptation for that in relation to the bushfires, and we are certainly more able to do it for the bushfire kids, but we have pretty well struggled to consistently use a manualised approach.

While some interviewees described their agency's methods of supporting children exposed to or at risk of trauma as fairly ad hoc, most felt their agency's methods were planned and well

implemented. Some agencies had been working in the trauma field for up to ten years. Nevertheless, many interviewees saw the approach to trauma exposure and its outcomes within their agency as an area in need of refinement. Generally there was a feeling that staff could benefit from more guidance in practice models that could be applied to these families.

Rarely was evaluation discussed as part of the work that agencies undertake. Some organisational leaders and senior managers did describe methods of data collection that could be used as part of an evaluation and a description of outcomes from an approach was sometimes provided to the interviewer anecdotally. For example:

> *When we say it's working, we are seeing change in a number of placement breakdowns. It's only short-term — it's difficult to look at long-term outcomes for children in terms of their development and educational outcomes.*

At times interviewees described data collection that might feed into an evaluation, but rarely was qualitative or quantitative data analysed for changes in child or family outcomes as a result of participation in a program or service.

> *Our own measurement of our own outcomes is pretty rudimentary at this stage and it certainly wouldn't stand up to academic rigour.*
>
> *We have some feedback from families about how effective that is for them.*

A couple of interviewees talked about the evaluation of their programs or services internally or externally. For example, one agency noted that they were part of a Victorian statewide evaluation of The Circle Program, which was recently completed by La Trobe University.[93]

Note. This report (grey literature) was not available at the time of conducting the search for the REA and therefore was not included in the REA.

Practical drivers and obstacles in adoption of evidence-based approaches

What are the practical drivers and obstacles to the uptake of evidence-based trauma-informed approaches in Australia?

Influences on the uptake of evidence-based trauma-informed approaches were themed around four issues:

- Availability of relevant evidence-based approaches that fit the context of the agency or needs of the client group.
- Budgetary considerations.
- Staffing and workplace issues.
- Defining and assessing trauma.

Availability of evidence-based approaches that match context and needs of clients

The perceived absence of evidence-based approaches that could be used with particular client groups was identified as a major barrier to the uptake of evidence-based approaches. This was mentioned in particular for children in out-of-home care or those exposed to child abuse and neglect.

> *We've looked at specific programs but we are yet to be convinced that any of them have the evidence for our population. Even trauma-focused CBT, which is usually*

described as the most evidence-based program, would predominately exclude our population from their studies. There are a couple that have included multiple abuse types but they've always required a carer, for example, to be a part of it.

Budgetary considerations

The funding opportunities available to services often dictated what approaches were used. One leader noted that what traditionally gets funded tends to continue, with no pressure to access the evidence base. Cost and time to deliver an approach usually influenced decisions about what approaches to adopt within an agency. For example, one leader identified Phil Fisher's (United States of America) three-month therapeutic programs for traumatised children in out-of-home care as having a high cost that was viewed as prohibitive, which prevented them from bringing it to Australia. The Circle Program was also mentioned in relation to its fit within service delivery budgets:

We already know that it works really well but they can't afford it because this type of model requires a senior clinician with specialist training, the staff have more intense work, high caregiver payments.

Staffing and the workplace

Workforce issues common to the child and family support sector were identified as barriers to adopting and/or maintaining evidence-based approaches, including a large part-time workforce, poorly paid workers, less skilled, less qualified and less experienced workers, time-poor workers and high staff turnover.

Another barrier identified was the availability or accessibility of coaching and supervision in evidence-based approaches, as well as the role played by senior management.

I think for the supervision and coaching, the evidence-based supervision and competency-based supervision things that are actually going to support evidence-informed practice, accountability and momentary mechanisms are very important. We find with busy practitioners that they do want to do the right thing, but if they're not supported to change their practice then it won't change.

And being supported by a senior management team that supports evidence-informed practice [facilitates practice change].

Another barrier to the uptake of evidence-based approaches concerned the time-consuming nature of trying to understand the research to get a comprehensive picture of the evidence base for a particular approach.

But I think part of my frustration is not having enough time to really research all the evidence to what I like to implement in terms of training or program.

We're trying to keep abreast of the research, which is pretty hard because ten years ago when this all started you could count on two hands what research you needed to read and now it's impossible to keep up …

Defining and assessing trauma

There was much discussion about the apparent discrepancies in understanding what trauma actually is, and how it is assessed. While organisational leaders and senior managers often viewed

trauma as comprising a combination of many potentially traumatic experiences that compounded the difficulties for children, many organisational leaders and senior managers found it difficult to articulate their agency's definition of trauma.

> *I actually think that's a really hard question and I would be answering from a very personal perspective and not on behalf of the organisation. We don't have a defined definition within our organisation or shared understanding of trauma, that's not something I've ever known us to discuss or talk about.*

Consistent with the finding of variability in definitions of trauma, there was evidence from the interviews with organisational leaders and senior managers that existing models of defining trauma were not particularly relevant or helpful to understanding the impact of complex trauma resulting from experiences related to child abuse and neglect. Traditional psychological or medical diagnostic criteria for trauma-related disorders or conditions were not seen as useful in helping services to select or deliver appropriate interventions to support such children.

> *Rather than saying a lot of the evidence-based practices or even mental health lexicon of diagnoses indicates a mental health intervention, but a lot of our kids have multiple diagnoses, they have diagnoses they don't quite fit a diagnostic category because it is not a specific cluster to meet a DSM-IV criteria. When we do diagnoses we don't find it that helpful to indicate treatment. If you know, a lot of the diagnoses were developed for adults, so it's not particularly — it's not unhelpful — but it's not enough on its own.*

Organisational leaders and senior managers typically noted that their organisation's assessment framework did not always consider past trauma or risk of exposure to trauma. Commonly, if staff did ask families routinely about traumatic experiences or risk, rarely did they do anything consistent with that information. One agency was a notable exception. This non-government family support agency detailed a comprehensive assessment framework employing a range of validated measures around trauma to inform service delivery and monitor progress.

> *We would do a clinical assessment in the first six to eight weeks involving obviously the child, the child's placement, a home carer, residential care. We would attend care team meetings and often be the ones to establish them. Depending on the child we would recommend they meet weekly or fortnightly … After that six-week assessment, or during that six-week assessment, we would be working out what is the most appropriate therapeutic intervention, by us, but also by others.*

Discussion of findings from the consultations

The purpose of the organisational leader and manager consultations was to examine the factors that influenced decision-making in upper levels of organisational management about the uptake of evidence-based approaches relevant to child and family service organisations in Australia.

Summary of the consultations

Participants

Organisational leaders and senior managers from a broad cross-section of the child and family service sector were interviewed, allowing for the collation of perspectives across a range of

agencies with different types of clients, state versus national focus, varying theoretical underpinnings (although the majority were relational or attachment-focused), and offering different types and intensities of services (e.g., intensive service delivery, case management, out-of-home care, parenting and family support, child welfare focus, home and clinic-based services). However, the sample was small, and responses cannot be generalised across the sector. In particular, the sample included only one representative from a government agency, not all states and territories of Australia were represented, and only a few of the agencies identified themselves as delivering services specifically to Aboriginal and Torres Strait Islander families and communities. Nevertheless, the findings do provide insight into the factors that influence decision-making at the upper levels of organisational management across the child and family support sector, helping to inform us about drivers and barriers to the use of evidence-based approaches in trauma care across Australia.

Decision-making regarding approaches to implement

Processes around decision-making for approaches implemented within agencies were generally made at executive levels, although some agencies, especially smaller ones, afforded a degree of autonomy to team leaders and practitioners in decision-making. This has implications for how information about evidence-based approaches is translated. Information needs to be targeted to different levels of the sector, using different methods to support effective implementation of evidence-based approaches. To illustrate, given that agency-wide and top-down decisions to use evidence-based practices are probably more likely to be associated with implementation of evidence-based practices with good fidelity, evidence-based approaches should be promoted at the Executive and Manager level. However, given practitioner-level decision-making, particularly among smaller agencies, more may also need to do be done to promote evidence-based practice at that level too. Thus, different approaches to dissemination are required to achieve cross-sector coverage.

Factors influencing decisions about practices to use

Organisational leaders and senior managers in the sector described a range of factors that influenced decisions about which approaches to adopt. These factors included funding, partnership opportunities and the evidence base for approaches. It was noted that funding was often 'rolled over' without expectation to access the evidence base or to evaluate the impact of service delivery. Review of the requirements of funders for agencies to employ approaches that have an evidence base and to evaluate outcomes from service delivery is a potential policy implication of this finding.

Costs associated with program delivery were often cited as a barrier to the quality implementation of evidence-based approaches. Sometimes the cost to purchase, train or effectively implement an evidence-based approach was seen as too high. This was identified as a particular concern for community-based services. The financial benefits, however, of providing an effective evidenced-based approach also need to be considered in these service planning decisions.

Generally described as important to decision-making, the evidence for an approach was often considered, but the relative importance of evidence to decision-making was not consistently viewed by the sample. Responses regarding the use of evidence in decision-making reflected a range of perspectives about the relative weight or importance of scientific evidence about an approach, as well as differing perspectives on what role the research literature had on their

practice decisions. Some of this variation could be accounted for by different understandings of the terms 'evidence' and 'research'. The organisational leaders and senior managers interviewed for this project sometimes preferred the term 'research-based' as opposed to 'evidence-based'. They reported that this preference allowed them to be more flexible in tailoring an intervention of their own adapted to the needs of their client population. While this innovation is often needed in service delivery, these innovations are best paired with evaluation, to ensure that the adapted program leads to improved outcomes in clients.

The responses of the organisational leaders and senior managers revealed that for most, the evidence behind an approach was not the main consideration when making decisions about practice directions within their agency. The importance of the evidence was often weighed up against other factors, including financial considerations, time constraints, workforce experience, expertise and resources, and what is implementable. While these factors are all critical elements for considerations by services in the implementation of practices, they do not, in themselves, lead to good outcomes. An ineffective intervention, implemented with fidelity, will rarely lead to better outcomes for children and families. The child and family support sector may benefit from a resource that incorporates information about the effectiveness of programs, as well as information about the implementation of available approaches aimed at meeting particular needs for particular client groups. In this way the field can potentially improve its ability to respond to funding and partnership opportunities selectively.

Uptake of evidence-based approaches

There were indicators from organisational leaders and senior managers that access by practitioners to the evidence base regarding service delivery to the child and family sector had increased over recent years. This was viewed as true despite barriers to that access (e.g., limited time to become informed of the research, limited training and supervision opportunities, financial restrictions). There was also a perception among respondents that awareness of evidence-based approaches that targeted outcomes in children exposed to high levels of trauma was increasing. However, organisations may need more support to access evidence-based approaches and to implement them. Leaders felt more support and guidance was required for practitioners regarding the availability and implementation of evidence-based approaches that address trauma and its outcomes within the child abuse and neglect population.

Interviewees mentioned a limited range of strategies via which practitioners were given access to evidence-based approaches, and provision of these strategies was usually ad hoc and opportunistic rather than planned and indoctrinated. Strategies aimed at improving the uptake of evidence-based approaches centred on improving information access to ongoing professional development, training and supervision, as well as organisational support from team leaders and management. There was limited evidence of systematic knowledge translation strategies to improve practice (e.g., competency-based training and coaching). The need for more emphasis on training in evidence-based practices was further demonstrated by the observation of many organisational leaders and senior managers that there had been a lot of information (as distinct from training) about trauma over recent years. It would appear that the field has been exposed to information about the cause and effects of trauma in children (e.g., through seminars), but not widely exposed to competency-based training aimed at skill development in working with children who have experienced trauma.

Drivers and barriers to the uptake of evidence-based approaches that target trauma outcomes

Reported factors affecting the uptake of evidence-based approaches in the trauma area included awareness about and availability of approaches that fit service contexts and client needs, financial restrictions, workplace and staffing issues, and different understandings of how trauma was conceptualised.

Organisational leaders and senior managers suggested the field was unclear about what evidence-based approaches existed, indicating the value of knowledge translation mechanisms to assist learning and decision-making (e.g., an online clearinghouse or searchable database of approaches).

A range of staff and workplace issues were thought to affect uptake of evidence-based approaches, including the variable level of pre-service training or education of staff working in this sector, high staff turnover, supervision models that did not support practice development, limited support from management, and service delivery models that did not match evidence-based practices (i.e., many agencies delivered primarily case management, with a small proportion of agencies offering clinic-based therapeutic services).

It was identified that although concepts such as complex trauma, trauma-informed care and evidence-based practice were not at all new to the majority of organisational leaders, senior managers or practitioners, the field still lacked clear definitions or understanding of each of these. There was agreement among organisational leaders and senior managers that refinement about how trauma was understood in the field was required and that greater support to practitioners could be provided here. In particular, despite trauma being widely acknowledged as a potential consequence of abuse and neglect, the field currently lacked any clear standardised definitions of trauma (particularly complex/Type II trauma) or guidelines around its assessment and treatment. Many organisational leaders and senior managers felt that more could be done with regard to assessment, particularly of past trauma and risk to exposure. Good trauma assessment and case formulation were therefore seen as essential precursors to decisions about which programs and practices to undertake.

Adaptation and evaluation

It was not uncommon for services to report difficulty applying manualised approaches, nor was it uncommon for approaches to be adapted to fit around contextually specific demands. The adaptation of approaches to fit service models appeared to be common across the sector. While adaptation of existing evidence-based approaches may be valid, it cannot be assumed that the adapted version will still achieve the same outcomes for clients. Ongoing evaluation of processes and outcomes is essential in order to ensure that the approach continues to achieve positive client outcomes, is causing no harm, and that the outcomes observed are due to the practices implemented.

Evaluation of practices was not often discussed as a major element of agencies' work. Measurement of client outcomes following delivery of an approach, particularly longer-term outcome data, was limited. Thus, within this sample a gap existed in the attention given to the evaluation of practices, particularly in the presence of adaptations to existing evidence-based approaches. It is important to note that in the absence of uptake of approaches with an established evidence base, it is imperative for agencies to establish systems of accountability for good child and family outcomes.

Limitations of the consultations

Notwithstanding the limitations mentioned earlier in relation to the small sample size and potential non-representativeness of this sample of organisational leaders and senior managers, there are a few points worth considering regarding the limitations of this analysis. This report is intended to provide a general sense of views on decision-making regarding the adoption of evidence-based trauma approaches. A limitation of this was that it was not possible to explore the issues raised by organisational leaders and senior managers to a greater depth or to the point of saturation. Also, as our methodology utilised one researcher to analyse interview transcripts, cross-checking of themes by another person was precluded**.**

Conclusions

Organisational leaders and senior managers interviewed for this project reported valuing the evidence to support the use and uptake of approaches within their organisations. However, it was very clear that the evidence base of an approach was only one factor of many that influenced the uptake of approaches. Other factors such as cost, staffing profile, opportunities for training, and client profile were important considerations. Most organisations tended to adapt established approaches to fit their organisation and client group; however, there was little evaluation of whether these adapted approaches achieved expected outcomes for children and families. Finally, there was general agreement that the sector would benefit from agreed definitions of key concepts such as trauma and trauma-informed care, and further information was needed about evidence-based approaches that aimed to address the outcomes of trauma exposure.

Chapter 5: General discussion

This project aimed to link information about the evidence for approaches designed to address outcomes for children exposed to repeated and prolonged trauma as a consequence of abuse and neglect with existing knowledge and practice among Australian practitioners and leaders in the field. To do this we identified the level of research evidence for approaches that targeted child and family outcomes in children and young people who were exposed to or at high risk of exposure to Type II trauma. We also asked practitioners about their awareness and uptake of evidence-based approaches to address the child and family outcomes associated with exposure to child abuse and neglect. Finally, we examined the practical drivers and obstacles to the uptake of evidence-based approaches that targeted child and family outcomes after trauma exposure in the form of abuse and neglect. In this chapter we collate the findings from the three previous chapters and consider the findings from each of the three methodologies employed in order to summarise how these findings address the questions of interest to this project. We then discuss implications from the collective findings from this multi-method project, with emphasis on key considerations for the child and family support sector regarding the implementation of evidence-based approaches.

The evidence base identified in the Rapid Evidence Assessment

The REA examined the evidence for approaches that targeted children and young people who had experienced prolonged or repetitive trauma of an interpersonal nature (including direct abuse or neglect by caregivers). The search terms that were used in the REA were selected in an attempt to identify research samples that predominantly encompassed children likely to have experienced Type II trauma. In the case of prevention programs the review identified children who were at risk for experiencing this type of trauma. The REA identified several approaches covering a wide range of trauma exposure including child physical and emotional abuse, child sexual abuse, and family violence. The approaches were delivered across a range of environments.

Just over half of the approaches identified in the REA generally fell under the auspice of delivering either a trauma-specific/focused or trauma-informed care approach. Among the Well Supported and Supported approaches, trauma-specific/focused approaches included Trauma-Focused Cognitive Behaviour Therapy (TF-CBT), Child-Parent Psychotherapy (CPP), Fostering Healthy Futures, Fourth R Violence Prevention Program, MST-CAN. Two Supported approaches were trauma-informed care approaches: MST-CAN and CPP. Many of the approaches (*n* = 42), however, did not, according to our criteria, demonstrate a recognition of the trauma or have a trauma focus. While these approaches may have been associated with improved outcomes within this trauma-exposed population, it is not known to what degree outcomes particularly linked to trauma exposure were addressed.

The REA, which employed a rigorous methodology, identified a reasonable number of approaches, the majority of which were programs, but with varying levels of evidence to support their effectiveness. Despite the use of a relatively non-conservative evidence ranking system (e.g., Well Supported ranking required two RCTs, at least one of those with 12-month follow-up), the REA identified only one approach with a Well Supported ranking and eight with a Supported ranking. The REA found that the Well Supported approach showed positive gains at 12 months after completion of the approach for:

- child Post Traumatic Stress Disorder (PTSD)
- child abuse-related shame
- child dissociation
- parent distress.

The Supported approaches required the demonstration of effect for at least one outcome at six months after approach completion. Outcomes demonstrating effect at least six months after completion were:

- PTSD
- mental health symptoms
- behaviour problems
- aggression
- assault
- dissociation
- receiving mental health therapy
- child maltreatment reports involving the mother as the perpetrator or the child as subject
- child maltreatment reports for women experiencing domestic violence
- neglect
- out-of-home care placements
- out-of-home care placement changes
- pro-social behaviour
- violent delinquency
- parental depression
- parental distress
- parenting distress
- social support
- avoidance
- risk for abuse
- perceived inability to manage parenting
- harsh parenting.

Our REA revealed that the majority of approaches were rated as Promising or Emerging, with approximately 90% of programs and service models receiving ratings in these categories. While studies in the Promising and Emerging categories often report positive outcomes, it is important to note that the degree of certainty — that the changes reported in a given study are a result of the approach tested — declines as they move down the evidence ranking scale. For example, we have a lower level of certainty about the findings reported, and therefore the effectiveness of, approaches with a Promising A ranking relative to those with a Supported ranking because we do not know if the effects of the Promising A approach will be maintained six months after the intervention has ceased.

As a goal of effective service delivery is to ensure that children and families receive interventions that reduce their risk of exposure to trauma or that actually improve client outcomes following trauma exposure, it is critical that we have confidence that the services, practices and programs being used are effective. Further research is therefore required to continue to develop the evidence base, and to increase confidence that the approaches being used with trauma-exposed or at-risk children and families are actually effective. We acknowledge that research in this area

has its challenges — the needs of the client group are diverse, the settings in which the approaches are administered are not necessarily conducive to a rigorous research trial, and funding for research in this area is often difficult to obtain. The imperative remains, however, to grow this evidence base, and for funding bodies to prioritise research funding in this area.

Despite the limited research conducted to date, the REA identified nine approaches with evidence to support their uptake within child and family service organisations, and a further 21 that show promise.

Current use of evidence-based approaches by practitioners

In general, respondents to the practice survey identified that they had received training specific to trauma exposure in children and that they felt confident in the delivery of approaches that targeted outcomes associated with trauma exposure. However, when asked to identify either practices (i.e., strategies and techniques performed in everyday practice) or approaches they had delivered that targeted outcomes associated with trauma exposure, findings seemed to contrast with this. The main practice response was to refer out or provide education. Just over one-third (*n* = 107, 38% of survey sample) of the practice survey participants reported that they had used an approach that targeted outcomes in their trauma-exposed clients in the past year. These 107 respondents identified a total of 79 approaches that they had used, with only 15 approaches identified as being used by more than one respondent. Of the 79 approaches identified in the practice survey, only nine could be matched to approaches identified in the REA. Furthermore, only ***two*** of these approaches are included in the approaches that were rated Well Supported or Supported according to the findings of the REA. Two respondents reported having used the Well Supported program, TF-CBT, and three used the Supported program, PUP (total of five respondents). This suggests that fewer than three percent (two out of a possible 79 approaches) of the approaches being used in the past year by the surveyed practitioners had sufficient evidence in order to be rated Well Supported or Supported for meeting child and family outcomes in a trauma-exposed population. It also suggests that of the responses to this survey question, fewer than five percent (five out of a possible 107) of respondents identified that they were using approaches that were rated Well Supported or Supported according to the REA findings.

A further two respondents used the Promising A program, CBT; two respondents identified using the Promising A system of care, Sanctuary Model; and one identified using the Promising A program, PCIT. One respondent each identified that they used the Promising B approaches, Brighter Futures and Therapeutic Residential Care. Of the Emerging A approaches, three respondents used the Neurosequential Model and one respondent used the Emerging B approach, Koping.

It is noted that some approaches reported by single respondents included descriptions of a range of practices, strategies, techniques and interventions that were not identified by a title or name. Where approaches lacked a specific name, it was not possible to match them to approaches in the REA.

These data contrast with findings that the majority of practice survey respondents identified that they had received training around trauma and that they felt confident in assessing and treating outcomes associated with trauma exposure. This apparent discrepancy may be, in part, associated with how participants defined ‘training’. It may be that the training described by participants could be better described as information-giving about the impact of trauma on children, for

example, rather than skill development in the use of approaches that targeted the consequences of trauma exposure. It may also be possible that many respondents were simply unaware of approaches for trauma populations that have an evidence base. This possibility is illustrated both in the data revealing that only a third of respondents could name an approach they believed to be evidence-based, and in the observation that many of the approaches they actually used did not have an evidence base (as identified by the REA) of application with trauma-exposed populations.

It is difficult to ascertain the total number of practice survey respondents who were using evidence-based approaches due to variation in the frequency of approaches identified by individual responders. However, an estimate can be deduced by determining the percentage of evidence-based approaches from the total sample of responses. There were 16 responses that referred to an evidence-based approach out of 115 total responses. Therefore we can estimate that approximately 14% of respondents were employing evidence-based approaches in their service. These evidence-based approaches in turn varied in the level of evidence supporting the approach, as identified in the REA.

It is worth making a comment on the use of general or non-trauma-specific/focused or trauma-informed approaches by the sample. We found that many respondents were not using evidence-based approaches that had been specifically trialled on abuse and neglect populations, but rather many described general approaches (which may have an evidence base outside of abuse, neglect or trauma). While it is possible that evaluation would reveal that some of the approaches mentioned by practice survey respondents — but not located in the REA — would be beneficial to trauma-exposed populations, the current lack of evidence for these approaches in abuse and neglect samples means that we are not able to determine this. Alternatively, it is possible that some of these practices may be inert or indeed harmful, but without appropriate evaluation, this cannot be known. The potential consequence of using approaches with no supporting evidence is that they divert attention away from the use of those with good supporting evidence. Conversely, we recognise there are a number of interventions that are widely used by practitioners that have not been adequately tested, and we acknowledge that the absence of evidence does not necessarily mean that these interventions are ineffective. Nevertheless, we assert the imperative that children and families at risk or in need deserve interventions that are grounded in supporting evidence, and that the gap between evidence-based approaches and other practices should be used to help define what research is needed in the future.

To summarise key findings from the practice survey, the majority of practitioners:

- identified that they frequently work with children and families exposed to high levels of trauma
- were most likely to refer out or link to other services, or provide education about trauma
- tended not to use any specific approach to target outcomes associated with trauma exposure.

Where specific approaches were used, few of these were rated Well Supported or Supported as identified by our analysis of the evidence base in the REA. This suggests there is room to improve the uptake of evidence-based approaches in targeting outcomes from trauma associated with abuse and neglect. Notwithstanding the limited number of evaluations that have been performed, our findings suggest that approaches with evidence supporting their effectiveness as established in the REA are rarely being used by practitioners. As a consequence, children and families may not be receiving the most effective and potentially least harmful interventions to address outcomes of trauma associated with abuse and neglect.

These findings raise the important issue of roles within the child and family services sector. This report has referred to a 'field of practitioners' but the field is diverse in terms of the different roles in which practitioners are employed. For instance, practitioners in tertiary mental health have roles that often entail the goal of reducing mental health symptoms, while the roles of case managers or out-of-home care providers may not necessarily require them to use therapeutic approaches such as TF-CBT or EMDR (i.e., not all practitioners assume responsibility in the therapeutic recovery process). This could in part explain survey respondents' 'underuse' of evidence-based approaches identified in the REA. While the range of evidence-based approaches identified in the REA is varied, and thus there is some degree of choice available to practitioners, the choice of which evidence-based approach to use should be dependent on the practitioner's role within a particular service. Hence, the 'fit' between the aims of a particular evidence-based approach, the type of evidence-based approach and a practitioner's role within a service should be a driving force in the consideration of which evidence-based approach to employ.

Trauma concepts, evidence concepts and assessment

Although concepts such as 'trauma', 'trauma-informed care' and 'evidence-based' were not new to the majority of organisational leaders, senior managers and practitioners, there was a high level of variability in definitions and conceptualisations of each of these terms. There was agreement among organisational leaders and senior managers that refinement of how trauma is understood in the field was required and that practitioners could benefit from clarification in relevant terminology. Specifically, despite widespread acknowledgement that children may be exposed to high levels of trauma as a consequence of abuse and neglect, organisational leaders and senior managers identified the absence of sector-wide or even organisation-wide agreed definitions or conceptualisations of trauma. Furthermore, senior managers and organisational leaders acknowledged that the field currently lacks clear guidelines for the assessment of trauma exposure and outcomes — or implications for intervention. While a representative of one particular agency described their organisation's structured approach to the assessment of trauma, this was the exception. The general absence of guidelines for the assessment of trauma in children as noted by organisational leaders and senior managers was in contrast with the views of most respondents to the practice survey, who reported confidence in recognising the signs and symptoms of trauma. Overall, organisational leaders and senior managers were in agreement that more could be done with regard to assessment of trauma exposure, particularly of past trauma and risk of exposure.

Senior managers and organisational leaders also recognised that assumptions were frequently made within the field that child social, emotional and behavioural difficulties were necessarily trauma-related. Trauma reactions were often assumed without clear assessment of trauma exposure or case formulation. Such assumptions fail to recognise that responses to trauma are determined by many risk and resilience factors, including biological, psychological or social influences. Appropriate trauma assessment and case formulation are essential precursors to decisions about which approach to adopt within a trauma-informed framework.

Organisational adoption of evidence-based approaches

The organisational leaders and senior managers interviewed for this project highlighted the importance of using evidence to inform decisions about the uptake of approaches within their organisations. However, their definition of 'evidence' at times differed from the definition of 'evidence-based' as outlined in Chapter 1. For example, evidence about the impact of trauma

exposure on children's neurological development was often interpreted to inform practice, rather than using evidence about effective interventions to inform practice decisions. Organisational leaders and senior managers also identified that other factors contributed to their decision-making about approaches to implement. These included existing funding arrangements, service settings, and the availability and cost of training for particular programs. As with respondents to the practice survey, comments from organisational leaders and senior managers suggested that agencies often adapt or use parts of evidence-based approaches to fit their client needs.

A mismatch between their client groups and the available evidence base was often cited as a reason for adapting existing programs. Many of the organisational leaders and managers stated that the use of evidence-based approaches was also influenced by staff qualifications, experience and training, as well as challenges associated with implementing packaged programs with families with complex needs and varied levels of engagement with a service. These factors are important to acknowledge, and it is accepted that adaptations or local innovations may at times be necessary to suit the particular characteristics and needs of the client and agency. However, there was little evidence that evaluation of these innovations was occurring to ensure the desired outcomes were being achieved. This is of particular concern when the approaches selected for adaptation may have been originally developed and trialled with children and families with a particular set of complex needs.

Another factor that may impact the fit of an approach to an organisation is theory. We found that few organisational leaders and senior managers reported that their services were guided by theoretical frameworks that inform cognitive behavioural therapy, the most frequently identified theoretical foundation of REA Well Supported and Supported approaches (*n* = 6). Organisational leaders, senior managers and practice survey respondents indicated that attachment theory often guided their service provision, which was found to be the theoretical framework underlying five of the REA Supported approaches. Narrative theory also emerged as a commonly used theory in the practice survey but was less frequently found to be the basis of REA approaches with good evidence (*n* = 2).

Important considerations in the implementation of evidence-based approaches

This report has identified approaches that have been demonstrated in the empirical literature to be safe and effective at meeting outcomes for children and families exposed to trauma associated with abuse and neglect. However, if the findings from this report can generalise to the field as a whole, it would suggest that the uptake and implementation of evidence-based approaches to address child and family outcomes associated with trauma exposure within the Australian child welfare and family support sectors is low. Clearly more work is needed to address reasons for this low uptake of approaches that have evidence of being effective, to determine what should now be done to improve the evidence base for the approaches that are in use, and for improving the high quality implementation of approaches that have demonstrated effectiveness for improving outcomes for children and families exposed to or at risk of trauma. To address this final point, the following section will provide a brief overview of key implementation principles before going on to consider their application to service improvement initiatives in the context of trauma in the child and family services sector.

While the identification of evidence-based approaches can be helpful when professionals, organisations and policy makers are looking for approaches to adopt, information about the evidence supporting an approach is often necessary but not sufficient to guide the selection of

approaches for implementation within specific service contexts. To date, research systematically identifying and cataloguing effective approaches has not been matched by corresponding efforts to systematically assess the extent to which approaches are implemented, nor to evaluate the impact of implementation efforts on program outcomes.[94] This is despite strong evidence that the quality of the implementation of an approach has an impact on desired outcomes.

Implementing evidence-based approaches is complex and challenging, and previous efforts to implement evidence-based approaches in the family support and child welfare sectors have often not reached their full potential due to a variety of issues intrinsic to both the service setting and the implementation process itself.[95,96] Without addressing these systemic, organisational and individual challenges as part of a planned, purposeful and integrated implementation strategy, interventions, even effective ones, may not produce the desired effects for parents and children. Therefore, attention to **how** a program or practice is implemented is as important to child, parent and family outcomes as **what** is implemented. To ensure that the service sector is selecting and appropriately delivering approaches that are more likely to make a difference to families exposed to and experiencing trauma, both the evidence that an approach works, and the way it could be implemented to achieve good results should be considered.

A range of frameworks exists in the implementation science literature to guide effective implementation of approaches in the child and family support and welfare sectors. These frameworks highlight a range of core considerations in guiding the planning and administration of effective implementation and are presented in Table 15. These considerations include but are not limited to:

- the availability of staff with competencies matched to the skills required to implement the approach
- the capacity to deliver competency-based training that will lead staff to develop the skills and behaviours necessary for a particular approach by defining important components of the approach
- providing work-based, opportunistic and reflective consultation and coaching to staff, using implementation fidelity measures and outcome measures to inform decision-making
- using supportive and facilitative administrative systems to better integrate the program or practice into the service context.[96]

The careful selection of an approach with adequate evidence of effectiveness should be carried out within a planned, long-term implementation and maintenance process.

Table 15. Core considerations in implementation of trauma-specific/focused or trauma-informed care approaches.

Appropriateness of approach aims and outcomes
• Is the approach based on a clearly defined theory of change? • Does the approach have clear aims? • Does the approach have clear intended outcomes that match our desired outcomes?
Targeted participants

- Is the target population of the approach identified and does it match our intended target population?
- What are the participant (child, parent, carer or family) eligibility requirements (ages of caregivers or children, type of person, diagnosis, presenting problem, gender)?

Delivery setting

- What are the delivery options (e.g., group, individual, self-administered, home-based, centre-based, residential facility)? Is there flexibility in delivery modes that suits our service context?

Costs

- What are the costs to purchase the approach?
- What are the costs to train staff in the approach?
- What are the ongoing costs associated with purchasing manuals and technical assistance (e.g., coaching and supervision of staff)?
- What are the costs to implement the approach with clients (in terms of staff time, resources to deliver, travel cost to agency, travel cost to participants, costs to participants in terms of time off work and child care)?
- Are cost-effectiveness studies available?

Accessibility

- Are the materials, trainers and experts available to provide technical assistance (i.e., training, coaching and supervision) to staff who will deliver the program or practice?
- Is the developer accessible for support during implementation of the approach?
- Does the approach come with adequate supporting documentation? For instance, are the content and methods of the approach well documented (e.g., in training courses and user manuals); are the content and methods standardised to control quality of service delivery?
- Are the content and materials suited for the professionals, children and carers we work with, in terms of comprehension of content (e.g., reading level of materials, amount of text to read or write, use of complex terminology)?
- Does the approach suit our service's access policies (e.g., 'no wrong door' principles, 'soft' entry or access points, community-based access, access in remote communities, relevance for special populations)?

Technical assistance required

- What are staff training needs (frequency, duration, location and cost)?
- What amount of ongoing technical assistance is required (including top-up training, coaching or supervision)?

Fidelity

- What are the requirements around the fidelity or quality assurance of delivery of the approach to children or carers? That is, how well do practitioners need to demonstrate use of the approach either during training or while they are working with participants (e.g., are there tests, checklists or observations that they need to perform during training; are there certain things they need to do to demonstrate to the trainers that they are using the approach correctly, such as videotaped sessions, diaries, checklists about their skills or use of the approach with clients)?
- Are there certain components that MUST be delivered to clients? That is, if they don't do 'X', they are not actually using the approach as intended.
- What are the dosage or quantity requirements for effective results (i.e., how often and for how long do clients need to receive the intervention)? Can our service meet those requirements?

Data and measurement of effectiveness

- How is progress toward goals, milestones and outcomes tracked?
- What are the requirements for data collection (i.e., what measures are recommended, how often are they to be administered, who can administer them)?
- How accessible and relevant are the developer-recommended evaluation tools (ease of access, cost, ease of administration and scoring, relevance to Australian context)?

Staff selection

- What are the necessary staff qualifications or skill requirements (i.e., who can deliver the approach)? Does our service have such staff or can our service acquire such staff?

Languages

- What languages is the approach available in, and does that match our client population?
- Is the program relevant and accessible to particular cultural and language groups (e.g., Aboriginal and Torres Strait Islander children)?

Perhaps one of the biggest challenges facing services looking to implement evidence-based approaches is managing the balance between adaption and fidelity. Indeed this was identified as a key theme in the interviews with organisational leaders and senior managers. Questions regarding the extent to which an approach should be adapted or not to fit the context must be balanced with such questions as, 'If approaches are adapted for contextual fit, how can we adapt with quality and to good effect, retaining the essential elements of the approach that contribute to its effectiveness?' Good adherence to the approach helps to ensure program fidelity and avoid possible dilution of the benefits of the approach. Nevertheless, adaptation and local innovation are sometimes necessary in order to meet emerging needs and suit specific populations. In such cases, it is important to continually monitor the extent of adaptations themselves, as well as monitoring practitioner actions and child and family outcomes to ensure relevant outcomes are still being met and that harm is not being caused. Saxe and colleagues[97] outline a useful example of a program (using Trauma Systems Therapy) that might serve as a blueprint to assist organisations to adapt and evaluate evidence-based programs.

Conclusions

The REA conducted within this project identified that there is a very limited evidence base for programs, service models and systems of care that target outcomes for children exposed to trauma associated with abuse and neglect. Where evaluations had been conducted, the majority of evidence of effectiveness was for *programs* as opposed to service models and systems of care, with primary school-age children and psychological, emotional and behavioural outcomes targeted the most frequently. Further rigorous research into the effectiveness of approaches, particularly those rated Emerging and Promising, will grow this evidence base. Few Australian-evaluated approaches were identified and there was a dearth of approaches that were evaluated with Aboriginal and Torres Strait Islander populations. Thus, the evidence base for approaches to supporting trauma-exposed children and their families is limited, and where approaches have support, the range of targeted outcomes (e.g., child behaviour, educational outcomes) and sub-populations (e.g., child age, cultural groups) is restricted.

The practice survey identified that the majority of respondents:

- identified that they frequently work with children and families exposed to high levels of trauma
- were most likely to refer out or link to other services, or provide education about trauma
- tended not to use any specific approach to target outcomes associated with trauma exposure.

Where specific approaches were used, few of these approaches were rated Well Supported or Supported in our analysis of the evidence base in the REA. This suggests that approaches with evidence to demonstrate their effectiveness according to the findings of the REA are not being used by many practitioners. As a result, children and families may not be receiving the most effective and potentially least harmful interventions to address outcomes of trauma associated with abuse and neglect.

While the view of the field of practitioners, managers and organisational leaders was clear that addressing the outcomes of exposure to repeated and prolonged trauma was important, there remains potential to improve the uptake of evidence-based approaches to address these outcomes by practitioners who work within child and family service organisations within Australia.

In view of the major findings and conclusions drawn in this report, a set of recommendations are presented in the Executive Summary that aim to address the needs and gaps or issues identified in this report. The recommendations target five areas of attention:

1. Improve awareness by policy makers and service providers of accepted definitions of trauma and related concepts.
2. Increase the awareness, adoption and effective implementation of evidence-based approaches shown to improve outcomes associated with trauma exposure associated with abuse and neglect.
3. Increase use of quality assurance and quality improvement processes within child and family service organisations to allow for ongoing, built-in evaluations of current approaches to service delivery.

4. Increase independent evaluation for new or emerging approaches that are being implemented within child and family service organisations that target outcomes associated with trauma exposure.
5. Increase the development and evaluation of approaches with and for Aboriginal and Torres Strait Islander children and families.

Child and family service organisations are placing increasing attention on improving the physical, psychological, emotional and social outcomes for clients who have been exposed to traumatic events. The practitioners, organisational leaders and senior managers interviewed for this report viewed addressing trauma and its outcomes as important in their work. Nevertheless, the existing evidence base for approaches that have demonstrated effectiveness for this population is limited, and use of evidence-based approaches by professionals working to support children and families exposed to trauma is low. An implication of these two conclusions is that trauma-affected children and families may not be receiving the best available care suitable to their needs. Opportunity exists to further develop the awareness, availability and adoption of evidence-based approaches within child and family service organisations so that child and family outcomes can be maximised and the risk of further harm minimised. This report is intended to be a resource to assist policy makers, organisational leaders, senior managers and practitioners to make informed and considered decisions about targeting outcomes for children exposed to trauma associated with abuse and neglect. As such, this report bridges knowledge about the evidence base for approaches targeting trauma arising from child abuse and neglect with information about current use of programs, service models and systems of care in the field, and decision-making around uptake of these approaches in the field.

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Appendices Book

Appendix 1

Appendix 2

Appendix 3

This document is the book of appendices for the final report for the project titled, *Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice, and implications*. This report and appendices were written as a collaborative project by the Australian Centre for Posttraumatic Mental Health and the Parenting Research Centre with funding from the Australian Government, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA, now Department of Social Services).

The Australian Centre for Posttraumatic Mental Health Inc. (ACPMH) is a not-for-profit organisation whose mission is to build and support the capability of individuals, organisations and the community to understand, prevent, reduce and recover from the adverse mental health effects of trauma. ACPMH aims to achieve its mission through specialised research, education and training, and the provision of policy and service improvement advice.

The Parenting Research Centre (PRC) is a non-profit research and development organisation with an exclusive focus on parenting. PRC are dedicated to gathering scientific knowledge of effective parenting and developing practical programs to help parents raise happy, healthy children.

Disclaimer
The material in this report, including selection of articles, summaries, and interpretations is the responsibility of the consultants, the Australian Centre for Posttraumatic Mental Health and the Parenting Research Centre, and does not necessarily reflect the views of the Australian Government. The Australian Centre for Posttraumatic Mental Health (ACPMH) and The Parenting Research Centre (PRC) do not endorse any particular approach presented here. Evidence predating the year 2000 was not considered in the rapid evidence assessment. Readers are advised to consider new evidence arising post the publication of this review when selecting and implementing approaches. The approach elements described in text and tables were obtained from the papers evaluating that approach. It is possible that approaches described here have additional elements (e.g., target other ages, target other trauma types, have additional delivery features, have different targeted outcome domains) that were not described in the included papers. It is recommended the reader source not only the papers described here, but other sources of information if they are interested in a particular approach. Other sources of information include author/approach websites, and other literature not included in the rapid evidence assessment, such as theoretical or descriptive articles that provide information about that approach.

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Table of Contents

Appendix 1: Glossary of terms

As the concepts and terms used in this report can be interpreted differently across the child and family services sector, definitions of terms adopted for this project and referred to in this report are presented below. The terms are categorised by theme and presented alphabetically under each theme.

Theme or term	Definition
Abuse and neglect terms	
Child abuse	The maltreatment of a child spanning four broad categories of neglect, emotional abuse, sexual abuse, and physical abuse[1].
Child maltreatment (collectively referred to as child abuse and neglect)	Any non-accidental behaviour by parents, caregivers, other adults or older adolescents that is outside the norms of conduct and entails a substantial risk of causing physical or emotional harm to a child or young person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e., neglect) and commission (i.e., abuse). Commonly divided into four subtypes: ▪ physical abuse ▪ sexual abuse ▪ neglect ▪ emotional maltreatment (including the witnessing of family and domestic violence)[2].
Child neglect	Occurs when a child's basic needs, such as their developmental, emotional and physical wellbeing and safety, have not been met. Chronic neglect is when this occurs in an entrenched and multi-level pattern of experience for the child and family[3].
Domestic and family violence	Domestic violence occurs when one partner in a relationship attempts by physical or psychological means to dominate and control the other. It is generally understood as gendered violence, and is an abuse of power within a relationship (heterosexual and homosexual) or after separation. In the large majority of cases the offender is male and the victim female. Children and young people are profoundly affected by domestic violence, both as witnesses and as victims. Issues of power and control are central to the definition[4]. Family violence is often used in conjunction with domestic violence and is a term is preferred by some communities (e.g., indigenous), where incidents of violence are not always about intimate partner abuse. 'Family' covers a diverse range of ties of mutual obligation and support, and perpetrators and victims of family violence can include, for example, aunts, uncles, cousins and children of previous relationships[4].

Theme or term	Definition
Mental health and trauma terms	
Acute trauma exposure (also known as single event or Type I trauma)	Exposure to a traumatic event that occurs at a particular time and place and is usually short-lived. Acute traumatic events include natural disasters, terrorist attacks, serious accidents, single episodes of physical or sexual assault, gang-related violence in the community, school shootings or sudden or violent loss of a loved one[5].
Chronic trauma exposure	Exposure to trauma which occurs repeatedly over long periods of time. These experiences can result in a range of responses, including intense feelings of fear, loss of trust in others, decreased sense of personal safety, guilt, and shame. They can also adversely impact the social, emotional and cognitive development of the child. Chronic traumatic situations include some forms of physical abuse, long-standing sexual abuse, domestic violence, war and other forms of political violence[5].
Mental illness/disorder	As defined by the Department of Health and Aging, a clinically recognisable set of symptoms (relating to mood, thought, or cognition or behaviour) that is associated with distress and interference with functions (that is, impairments leading to activity limitations or participation restrictions)[6]. Mental illnesses include: dementia, delirium and other organic mental disorders; schizophrenia, bipolar disorder and other related psychotic disorders that are characterised by hallucinations, delusions, thought disorders, behaviour disturbances; mood disorders such as depression; anxiety disorders; substance use disorders; and personality disorders that are characterised by enduring patterns of behaviour that are inflexible and maladaptive and cause distress or interference with functions[7].
Posttraumatic stress disorder (PTSD)	A set of reactions that develop in people who have experienced or witnessed an event which threatened their life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. Symptoms that meet DSM IV criteria around three clusters of symptoms including re-living the traumatic event, being overly alert or wound up, avoiding reminders of the event and feeling emotionally numb[7].
Repeated event trauma	The simultaneous, multiple or sequential occurrence of traumatic events. In this project, repeated traumatic events often occur within the context of child abuse and neglect[5].

Theme or term	Definition
Mental health and trauma terms cont.	
Single event trauma (also known as acute trauma or Type I trauma)	Exposure to a traumatic event that occurs at a particular time and place and is usually short-lived. Kinds of acute traumatic events include natural disasters, terrorist attacks, serious accidents, single episodes of physical or sexual assault, gang-related violence in the community, school shootings or sudden or violent loss of a loved one[5].
Substance abuse	A maladaptive pattern of substance use leading to clinically significant impairment or distress manifested by recurrent substance use resulting in a failure to fulfil major roles at work, school, or home. Substance abuse also refers to recurrent substance use in situations where it is physically hazardous and/or related to legal problems and/or continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance[8].
Traumatic event	An event which threatens a person's life or safety, or that of others around them. There is a range of events that fall in this category such as motor vehicle accidents, war and natural disasters[9]. This project focused on children's' exposure to repeated traumatic events, where the traumatic event was defined as the experience of child abuse, child sexual abuse, child neglect, domestic/family violence, parental substance abuse and/or parental mental illness. It is recognised that these are distinct from single trauma events in that exposure to these events is often repeated and chronic. It is also recognised that these events are not always experienced as 'traumatic', and as such can be recognised as 'potentially traumatic events'.
Trauma-Informed Care (TIC)	A framework grounded in an understanding and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. The awareness of the impact of trauma and recognition of its potential longer term interferences to one's sense of control, safety, ability to self-regulate, sense of self, self-efficacy and interpersonal relationships[10]. The TIC framework in this project is used in reference to chronic or repeated experiences of traumatic events.
Trauma reactions	Physical and psychological reactions that develop following the experience or witnessing of an event which threatened a person's life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. In children, trauma reactions can present in repetitive play, frightening dreams, specific trauma enactments, regressed behaviours, lowered school performance, social, emotional and behavioural difficulties, and physical ailments[11].

Theme or term	Definition
Mental health and trauma terms cont.	
Trauma reactions	Physical and psychological reactions that develop following the experience or witnessing of an event which threatened a person's life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. In children, trauma reactions can present in repetitive play, frightening dreams, specific trauma enactments, regressed behaviours, lowered school performance, social, emotional and behavioural difficulties, and physical ailments[11].
Type I trauma	Exposure to a traumatic event that occurs at a particular time and place and is usually short-lived. Acute traumatic events include natural disasters, terrorist attacks, serious accidents, single episodes of physical or sexual assault, gang-related violence in the community, school shootings or sudden or violent loss of a loved one[5].
Type II trauma	Experience of events that are of an interpersonal, prolonged and/or repeated nature (e.g. child abuse, neglect, witnessing violence). Effects of Type II traumatic events can be pervasive and long-lasting. Type II trauma that occurs in childhood, and that involves direct harm and/or neglect by caregivers, often occurs at developmentally vulnerable times for the child, and can give rise to complex psychological, social and behavioural problems in adulthood. Type II trauma is often contrasted with Type I trauma, which refers to a single occurrences of a traumatic event[5].
Child and Family Support Sector-related terms	
Approach	A set of principles aimed at guiding overall service delivery or individual practice[12]. In this project, we have used the term approach to encompass sets of principles, frameworks, models, interventions, therapies, practices, systems of care, programs, as well as services.
Caregiver	Biological relative or non-biological person performing the roles and responsibilities of parenting[13].
Child	A person up to the age or equal to 18 years[14].

Theme or term	Definition
Child and Family Support Sector-related terms cont.	
Out of home care (OOHC)	The care of children and young people up to 18 years who are unable to live with their families (often due to child abuse and neglect). It involves the placement of a child or young person with alternate caregivers on a short or long-term basis. There are four main types of out-of-home care[15]: ▪ *foster care:* where care is provided in the private home of a substitute family who receives payment that is intended to cover the child's living expenses ▪ *kinship care:* where the caregiver is a family member or a person with a pre-existing relationship with the child ▪ *residential care:* where placement is in a residential building whose purpose is to provide placement for children and where there is paid staff. This includes facilities where there are rostered staff, a live-in carer and where staff are off-site (e.g., a lead tenant or supported residence arrangement). ▪ *permanent care*: a child is placed into the permanent care of an existing foster carer or kinship carer through the Family Court
Practices	Approaches, skills, strategies and/or techniques targeting prevention or treatment aimed at improving child/family/parent outcomes[16,17].
Program	A well-defined curriculum, set of services or interventions designed for the needs of a specific group or population[16]. Programs are often discrete, manualised curriculums or series of actions/tasks/behaviours designed for a particular population to meet particular outcomes, which are usually measurable[18]. Within a program children, caregivers, guardians (i.e., group or population) receive direct targeted education, training or support or intervention to increase their knowledge, capacity, skills to improve child and family outcomes[9]. For the purpose of this project, we have grouped therapeutic interventions with programs.
Service Model	A suite of approaches, programs or practices delivered to a client group by an agency, organisation or service system. Services may be delivered at home (e.g., home visiting service) or within another setting, however home visiting programs are not always 'services' or 'service models'; for instance, if they are delivered as a structured curriculum (program).
System of care	A coordinated network of community-based services and supports. It is an approach incorporating a philosophy or guiding framework that promotes program delivery in ways that prioritise the needs of the children, youth and families to function better in various contexts (i.e., school, home, child protection, peers)[19].
Therapeutic/treatment interventions	A particular technique or set of interventions usually delivered by a single practitioner aimed at improving a set of well-defined outcomes (e.g., reduction in posttraumatic symptoms) for a child or family [20]. Can be manualised and outcomes for client are usually measureable.

Theme or term	Definition
Scientific or evidence-related terms	
Effective	Approaches for which there is measureable and statistically significant improvement in child, parent or family outcomes as a result of the approach (or combination of approaches) compared to a no-treatment or other-treatment comparison group, that is demonstrated in a randomised controlled trial (RCT) with at least 6-month follow-up assessment.
Evidence	Forms of knowledge relevant to practice which may include research evidence, service monitoring and other statistical data; expert knowledge; stakeholder consultations; and program and service cost-effectiveness information.
Evidence-based practices	Approaches to prevention or treatment that are validated by some form of documented scientific evidence (including but not limited to controlled clinical studies). Ideally, evidence-based practices should be responsive to families' cultural backgrounds, community values, and individual preferences[21].
Evidence-based programs	A defined curriculum or set of practices that, when implemented with fidelity as a whole, has been validated by some form of scientific evidence. Ideally, evidence-based programs should be responsive to families' cultural backgrounds, community values, and individual preferences[21].
Evidence-informed practices	Refers to programs and practices that use current best evidence available (may not be empirical research findings) combined with the knowledge and experience of practitioners and the views of service users[21].
Outcome	A measureable change or benefit. The target at which change is intended. An outcome is a specific benefit that occurs to participants of a program. It is generally phrased in terms of the changes in knowledge, skills, attitudes, behaviour, condition or status that are expected to occur in the participants as a result of implementing the program[22].
Randomised controlled trial (RCT)	A research protocol in which the study participants, after assessment for eligibility and recruitment, are randomly allocated to receive the intervention or an alternative treatment [23] (often a no-treatment control condition, for example, wait list or treatment as usual) before the study begins.
Research informed practices or programs	Practices or programs which use forms of research (as opposed to 'direct evidence' per se) to guide them. For example, research that investigates risk and protective factors to identify those factors that could be targeted by an intervention.

Appendix 2: Summaries of Programs, Service Models and Systems of Care identified in the Rapid Evidence Assessment

Table 1a. Summary of the studies evaluating the Well Supported program (TF-CBT)

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
Puccia, Redding, Brown, Gwynne, Hirsh, Hoffmann, & Morrison (2012) [24]	Sig. improvements were made with respect to re-experiencing & avoidance as well, with 14 clients in the normal range for re-experiencing & 20 clients in the normal range for avoidance. Less sig. improvements are made for arousal, with 19 clinical at baseline & eight normal at completion.	Psycho-education, parenting skills, cognitive coping & processing, trauma narrative, conjoint child-parent sessions, safety skills & a safety plan.	Intervention	Clinic	Trained Clinician	Individual caregiver; Individual child; Individual caregiver-child dyads	1 x 8 sessions	-
Grasso, Joselow, Marquez, & Webb (2011) [25]	Child had higher PTSD symptom severity relative to sample, & had greater reduction of symptoms at post-treatment & follow up (non-sig. test). Child had lower internalizing (non-sig.) & externalising (sig.) behaviour at pre-treatment, scores were maintained at post-treatment & follow up, whereas comparison group behaviour not maintained at follow up.	Psycho-education & development of a trauma narrative (TN) & cognitive/ emotional processing of event based on Emotional Processing Theory (EPT). TN development stimulates child's fear network, activates trauma memory & facilitates learned inhibition of fear response & cognitive re-structuring.	Intervention	Home	Psychologist	Individual caregiver-child dyads	1 x 12-16wks	-
Cohen, Deblinger, Mannarino, & Steer (2004) [26]	TF-CBT was more effective than CCT on all measures of MH & child/ parent behaviour at post-treatment (incl. Child: PTSD subscales, behaviour, depression, attributes/ perceptions, interpersonal trust, shame. Caregiver: parenting practices, support & emotional reactions.	TF-CBT: is informed by effective treatments for adult PTSD & non-PTSD child anxiety disorders, plus cognitive & learning theories about dev. of PTSD in children. CCT: Establishes a trusting r/s which is self-affirming, empowering & validating for parent & child. Aimed at restoring trust within dyad following child sexual abuse.	Intervention	Community	Psychologist; Social worker; Counsellor	Individual caregiver-child dyads	1 x 12wks mean:10/11 Individual sessions (x9) & dyad sessions (x3).	RCT included dyads who attended a minimum of 3 weeks
Deblinger, Mannarino, Cohen, & Steer (2006) [27]	Greater reduction of PTSD symptoms & shame in children & reduced parental distress in TF-CBT compared to CCT. Multiple traumas (90% of sample), & child depression positively related to total PTSD symptoms at post-intervention in CCT group (not TF-CBT).	TF-CBT is a structured treatment approach, education & coping skills to children & parents process traumatic experiences in individual & combined sessions. CCT is a supportive, client centred approach that establishes trusting & empowering therapeutic r/s. CBT & Client-centred/ strengths based.	Intervention	Other	Psychologist	Individual caregiver-child dyads	1 x 12 sessions, once a week.	Study included participants who only attended 3 out of 12 sessions.
Cohen, Mannarino, & Knudsen	Intent to treat: TF-CBT had sig. greater treatment outcomes than NST for all MH domains (Depression, anxiety, sexual prob.) &	TF-CBT components specifically target conditioned fear responses & cognitive errors which contribute to symptom	Intervention	Clinic	Psychologist	Individual caregiver-child dyads	1 x 12wks.	-

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
(2005) [28]	behaviour (Internal & social, but not externalising). Treatment completers: TF-CBT had sig. greater improvement on all MH domains at 6-mths, & PTSD & Dissociation at 12-mths. Behaviour approached sig. (p=0.6) at both 6/12mth follow up.	development & maintenance in depression & anxiety. NST is a prototypical supportive, empowerment therapy.						
Deblinger, Mannarino, Cohen, Runyon, & Steer (2011) [29]	N.S. differences: (Child: sexual behaviours, depression, shame & ability to identify abusive situations; Parent: Depression); 1. Sig. less Child fear & general anxiety in 8 Yes TN compared to 8 No TN. 2. Sig. less child externalising behaviours in 16 No TN (possibly due to more parenting focus) than 8/16 Yes TN. 3. Sig. reduced PTSD (one symptom) in 16 sessions compared to 8 session groups. 4. Sig. parent practices in 16 No TN compared to 8/16 Yes TN. Sig parenting emotional reaction (to abuse) in 8 Yes TN than 8 No TN.	Psycho-education & parenting, relaxation, affect modulation, cognitive coping, in vivo exposure, conjoint parent child sessions, enhancing safety & future development, & trauma narrative (Yes TN OR No TN).	Both	Clinic	Psychologist; Social worker; Counsellor	Individual caregiver-child dyads	90 minutes of TF-CBT with or without (Yes/No TN) x 8 or 16weeks.	
Cohen, Mannarino, & Lyengar (2011) [30]	TF-CBT was sig. more effective than CCT on all measures of Child MH (total PTSD, PTSD reaction, anxiety), child behaviours & TF-CBT had sig. less reports of adverse events. N.S. for child cognition (intelligence) & depression.	TF-CBT: 1. Safety component, 2. TN not past trauma, rather sharing child's IPV experiences, mother's IPV awareness & maladaptive cognitions. 3. Not child's mastery of past trauma reminders, rather optimize the child's ability to discriminate between real danger & generalized fears.	Both	Community	Social worker	Individual caregiver-child dyads	45min session for both child & parent TF-CBT or TAU (CCT) x 8wks.	-
Weiner, Schneider, & Lyon (2009) [31]	African American youth & White youth experienced sig. reductions in “Traumatic Stress Symptoms” & “Behavioural/Emotional Needs” & sig. increase in “Strengths.” White youth experienced sig. reductions in risk behaviours & problems with functioning.	Individual sessions with caregiver (psycho-educational focused on parenting skills) & individual sessions with the child (focused on relaxation, affect modulation, cognitions).	Intervention	Clinic	Trained clinician	Individual caregiver, Individual child	1 x 12-20wks.	-

Note: The TF-CBT program is categorised by author in this table. TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; PTSD = Post-Traumatic Stress Disorder: RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings.

Table 1b. Summary of the Well Supported program (TF-CBT)

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To alleviate symptoms of posttraumatic stress as a result of witnessing domestic violence. Trauma-focused CBT used as part of overarching model of care in this Children's Initiative	Not specified	Puccia, Redding, Brown, Gwynne, Hirsh, Hoffmann, & Morrison (2012) [24]	USA	Family violence	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=22	No comparison group	a. Yes b. No c. N/A d. N/A
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To reduce symptoms related to trauma.	Not specified	Grasso, Joselow, Marquez, & Webb (2011) [25]	USA	Family violence	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: 6/9/12mths	n=1	n=65	a. Yes b. No c. N/A d. N/A
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To reduce posttraumatic stress & related emotional/ behavioural problems (including depression, behaviour problems, abuse-specific distress, shame & dysfunction abuse attributions).	8 - 14	Cohen, Deblinger, Mannarino, & Steer (2004) [26]	USA	Child abuse; Child sexual abuse; Family violence; Other	Other	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: Yes Control: Child-Centred Therapy (CCT) for PTSD Follow up: None	n=115	n=91	a. Yes. TF-CBT is sig. more effective than CCT to reduce child mental health problems (PTSD, shame), normal child development & relationship with significant others (parent mental health, trust). b. No c. N/A d. N/A
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To reduce symptoms of posttraumatic stress after sexual abuse & other related emotional/ behavioural problems	8 - 14	Deblinger, Mannarino, Cohen, & Steer (2006) [27]	USA	Child abuse; Child sexual abuse; Family violence, Other	Other	Child physical; Psychological/ emotional or behavioural symptoms; Relationships & family or social	RCT: Yes Control: non-directive supportive therapy (NST) and CCT	Combined sample n=183 (child) M/F= not specified	See total in previous cell	a. Yes b. No (yet possible concern re: possible faster pace/ structure of TF-CBT). c. Yes d. 6/12mths

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	(including depression, behaviour problems, abuse-specific distress, shame & dysfunction abuse attributions).						functioning	Follow up: 6/12mths			
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To decrease trauma avoidance, hyper-arousal & maladaptive cognitions in children exposed to Interpersonal violence.	8 - 15	Cohen, Mannarino, & Knudsen (2005) [28]	USA	Child abuse; Child sexual abuse	Other	Child physical; Psychological/ emotional or behavioural symptoms	RCT: Yes Control: NST for PRSD following sexual abuse Follow up: 6/12mths	Combined sample n=82 F=56; M=26 Means (NST= 10.8; TF-CBT=11.4)	See total in previous cell	a. Yes b. No c. Yes maintained d. 6/12mths
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To treat PTSD in sexually abused children. Aim to investigate efficacy of how much general (CBT) & exposure treatment (TN) is optimal for children w/ PTSD.	4 - 11	Deblinger, Mannarino, Cohen, Runyon, & Steer (2011) [29]	USA	Child abuse; Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: Yes Control groups: (8 No Trauma Narrative (TN); 8 Yes TN; 16 No TN; 16 Yes TN) Follow up: None	Combined sample n=210 (n=52-54 per group). F=128; M=82 mean: 7.7	See totals in previous cell	a. Yes (8 Yes TN TF-CBT most efficacious for parent & child). Non-sig. for risk of abuse. b. No c. N/A d. N/A Duration: 8 or 16wks.
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To decrease trauma avoidance, hyper-arousal, & maladaptive cognitions in children exposed to Interpersonal violence.	7 - 14	Cohen, Mannarino, & Lyengar (2011) [30]	USA	Child abuse; Child sexual abuse; Family violence; Parental substance use; Parental mental illness	Ethnicity; Other	Cognition; Psychological/ emotional or behavioural symptoms; risk for childhood abuse	RCT: Yes Control: CCT (TAU) Follow up: None	n=64 F=35; M=29	n=60 F=28; M=32	a. Yes; only cognition was non-sig. (IQ) b. No c. N/A d. N/A
Trauma-	To decrease	3 - 16	Weiner,	USA	Not specified	Other	Psychological/	RCT: No	n=35	No	a. No; sig. for specific

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Focussed Cognitive Behaviour Therapy (TF-CBT)	physiological arousal & improve wellbeing; improve identification & management of feelings; improve parent child communication, enhance social skills.		Schneider, & Lyon (2009) [31]				emotional or behavioural symptoms	Pre/post treatment measure Follow up: None	F=17; M=18 Mean:8.4	comparison group	measures for one racial group) b. No c. N/A d. N/A

Note: TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; PTSD = Post-Traumatic Stress Disorder: RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = Statistically non-significant findings; Sig. = Statistically significant findings. a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 1c. Summary of the Well Supported program (TF-CBT) by targeted age, theory, trauma type and outcome domain

Approach name	Authors & year	Age	Approach theory								Intervention	Prevention	Trauma type							Outcome domain						
			CBT	Trauma narrative	Trauma exposure	Ecological/systems	Attachment/Relational	Neuro-biological	Mindfulness	Psycho-dynamic			Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
TF-CBT: Trauma-focused Cognitive behavioural therapy	Puccia, … & Morrison (2012) [24]	4-19	✓	✓	✓											✓						✓				
	Grasso, … & Webb (2011) [25]	11	✓	✓	✓						✓		✓			✓						✓				
	Cohen, … & Steer (2004) [26S]	8-14	✓	✓	✓						✓			✓								✓	✓			
	Deblinger, … & Steer (2006) [27S]	8-14	✓	✓	✓						✓			✓								✓				
	Cohen, … & Knudsen (2005) [28]	8-14	✓	✓	✓						✓			✓								✓				
	Deblinger, … & Steer (2011) [29]	4-11	✓	✓	✓						✓		✓	✓								✓				
	Cohen, … & Lyengar (2005)	7-14	✓	✓	✓						✓		✓	✓		✓			✓			✓				
	Weiner,… & Lyon (2009) [31*]	3-16	✓	✓	✓														✓			✓				
Total studies			**7**	**7**	**7**	**0**	**0**	**0**	**0**	**0**	**5**	**0**	**3**	**4**	**0**	**3**	**0**	**0**	**2**	**0**	**0**	**7**	**1**	**0**	**0**	**0**

Note. The three studies highlighted were RCT's with 12 month follow up period. PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning; [S] = These articles report on the same study; * = This study showed TF-CBT had no effect for participants generally, although significant findings of benefit were found for specific groups in the sample.

Table 1d. Summary of the Well Supported program (TF-CBT) by approach elements, setting and delivery mode

Approach name	Authors & year	Elements			Setting				Delivered by						Delivered to				
		Dose	Training	Program fidelity	Clinic	Community	Home	School	Psychologist	Social worker	Counsellor	Teacher	Nurse	Unspecified professional, paraprofessional	Individual child	Individual caregiver	Child-caregiver dyad	Individual families	Groups of children
TF-CBT: Trauma-focused Cognitive behavioural therapy	Puccia, … & Morrison (2012) [24]	8 x session	✓	✓	✓									✓	✓	✓	✓		
	Grasso, … & Webb (2011) [25]	12-16 x 1.5hr		✓	✓				✓						✓	✓	✓		
	Cohen, … & Steer (2004) [26S]	12 x 1.5hr	✓	✓	✓				✓	✓					✓	✓	✓		
	Deblinger, … & Steer (2006) [27S]	12 x 1.5hr	✓	✓	✓				✓	✓					✓	✓	✓		
	Cohen, … & Knudsen (2005) [28]	12 x 1.5hr	✓	✓	✓				✓	✓					✓	✓	✓		
	Deblinger, … & Steer (2011) [29]	8/16 x 1.5hr	✓	✓	✓				✓	✓					✓	✓	✓		
	Cohen, … & Lyengar (2011) [30]	8 x 1.5hr	✓	✓		✓									✓	✓	✓		
	Weiner,… & Lyon (2009) [31]	12-20 weeks	✓	✓	✓									✓	✓	✓	✓		
Total studies			**6**	**7**	**7**	**1**	**0**	**0**	**5**	**4**	**0**	**0**	**0**	**2**	**7**	**7**	**7**	**0**	**0**

Note. The three studies highlighted in pink were RCTs with 12 month follow up period. PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning; and [S] = These articles report on the same study.

Table 2a. Summary of the studies evaluating the Supported approaches

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or Intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
Ippen, Harris, Van Horn, & Lieberman (2011) [32]	CHILD - a sig. time by treatment effect was found for the intervention (intention to treat & completers) for child PTSD. No sig. reduction in PTSD for comparison children. High-risk children (more than 4 traumatic events) in intervention group showed greater reductions in PTSD. Sig. time by intervention effect for child depression & child behaviour, & maintained only for those with 4+ traumatic events. MOTHER - sig. reduction in maternal PTSD for intervention group regardless of number of events, for comparison group with fewer events, but not for comparison group with 4+ events. For maternal depression, sig. reductions were found for the intervention group but not the comparison group. This was maintained for intervention completers but not the intention to treat group. When analysed by number of events, a sig. reduction in maternal depression was found for the intervention group regardless of number of events & for the comparison group with fewer events, but not the comparison group with 4+ events.	Content: Previously described. Theory: Infant-parent psychotherapy (Fraiberg) & attachment theory (Bowlby).	Both	Other	Psychologist	Individual caregiver-child dyads	1hr x 50weeks	Population - referred for treatment due to child behaviour. Setting not indicated. Trauma - separation from perpetrating father.
Lieberman, van Horn, & Ippen (2005) [33]	CPP was the only group that had sig. efficacy as an intervention in reducing children's total behaviour problems, traumatic stress symptoms, & diagnostic status. There was a trend towards sig. for TAU, & a sig. effect for CPP in reducing mother's general distress. Mother's PTSD symptoms reduced over time, but non-sig. between groups.	Content: psychodynamic formulations, attachment theory, social learning & cognitive behavioural theory, & ecological models as each contributes understanding about the impact, predictors, & mediators of marital violence on children's psychological functioning.	Intervention	Community	Psychologist	Individual caregiver-child dyads	CCP: 1hr x 50weeks TAU: 0.5hr phone call x 1/4weeks plus contact when needed.	-
Cicchetti, Rogosch, & Toth (2006) [34]	Infants in the maltreatment groups had sig.ly higher rates of disorganized attachment than infants in the NC group. At post intervention follow-up at age 26-mths, children in the IPP groups demonstrated substantial increases in secure attachment, whereas increases in secure attachment were not found for the CS & NC groups.	In IPP, the patient is not the mother or the infant, but rather it is the relationship between the mother & her baby.	Intervention	Clinic	Other	Individual caregiver-child dyads	Weekly for 1yr	-
Toth, Maughan,	Children in the PPP intervention evidenced more of a decline in maladaptive maternal	Within the therapeutic sessions, the clinician strives to alter the relationship	Intervention	Clinic	Other	Individual caregiver-	52 x 1hr	-

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or Intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
Manly, Spagnola, & Cicchetti (2002) [35]	representations over time than Control children & displayed a greater decrease in negative self-representations than control children. Also, the mother–child relationship expectations of PPP children became more positive over the course of the intervention, as compared to control participants.	between mother & child. Toward this end, clinicians must attend to both the interactional & the representational levels as they are manifested during the therapy sessions. Attachment theory.				child dyads		
Lieberman, Ippen, & Van Horn (2006) [36]	Child behaviour & mothers distress was significantly reduced compared with the control group with effects maintained over 6mths	Theory: psychodynamic formulations, attachment theory, social learning & cognitive behavioural theory, & ecological models as each contributes understanding about the impact, predictors, & mediators of marital violence on children's psychological functioning.	Intervention	Community	Psychologist	Individual caregiver-child dyads	50 x 1hr	-
Weiner, Schneider, & Lyon (2009) [31]	For CPP, African American youth experienced improvement in every CANS domain. Biracial youth experienced sig. improvements in Traumatic Stress Symptoms, Strengths, Behavioural/emotional needs, & Risk Behaviours. Hispanic youth experienced sig. improvement in Traumatic Stress Symptoms, Life Domain Functioning, & Behavioural Emotional Needs. White youth improved sig. in Life Domain Functioning.	CPP is designed for children ages birth to 6. The treatment focuses on decreasing traumatic stress responses, learning difficulties, & relationship problems in infants & young children exposed to violence by improving the quality of parent–child relationships.	Intervention	Clinic	Other	Individual caregiver-child dyads	Weekly for 1yr	-
DePanfilis & Dubowitz (2005) [37]	Positive changes in protective factors (sig. parenting attitudes & social support; non-sig. for parenting competence); diminished risk factors (parent depression & stress); improved child safety & child behaviour over time. Non-sig. differences on any measures between FC3 & FC9 groups.	Content: Individual family support, Community outreach, tailored interventions, helping alliance, empowerment, strengths-based, cultural competence, developmental appropriateness, & outcome-driven service plans. Theory: social ecology (Brofenbrenner).	Prevention	Home	Social worker; Other	Individual caregiver-child dyads	1wk x 3mths mean:17hrs; or 1wk x 9mths mean:31hrs	*Original RCT incl. group intervention, but compliance was too low: caregivers, 32% attendance
Taussig & Colhane (2010) [38]	Time 2: No group differences on mental health symptoms. Intervention group scored higher on quality of life measure. Groups did not differ on self- or caregiver-reported use of mental health services or psychotropic medication. Time 3: Intervention group scored lower on mental health symptoms. Intervention group	Skills groups Content: Emotion recognition, perspective taking, problem solving, anger management, cultural identity, change & loss, healthy relationships, peer pressure, abuse prevention, & future orientation. Theory: CBT & Process-orientation Mentoring Content: To create positive	Intervention	Home	Trained clinician; Other	Groups of children; Individual child	Skills group: 1.5hrs x 30wks Mentoring 2-4hrs a wk.	Skills Group: 8-10 children, 2 facilitators

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or Intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
	reported fewer symptoms of dissociation. The intervention group were less likely to report receiving recent mental health therapy.	relationships, help children receive appropriate services, apply skills learnt to real world settings, engage children in extracurricular activities, help foster positive future orientation. Theory: None specified.						
Crooks, Scott, Ellis, & Wolfe (2011) [39]	The program had a buffering impact for maltreated youth for delinquent peer interactions at post-intervention.	Content: Skill development: 1. Personal safety in relationships; 2. Sexual health; & 3. Substance use.	Prevention	School	Teacher	Groups of children	75 mins x 21sessions.	-
Eckenrode, Ganzel, Henderson, Smith, Olds, Powers, …, & Sidora (2000) [40]	Families receiving Home visitation during pregnancy & infancy had sig. fewer child maltreatment reports involving the mother as perpetrator or the study child as subject than families not receiving Home visitation. The number of maltreatment reports for mothers who received Home visitation during pregnancy only was not different from the control group. For mothers who received visits through the child's second birthday, the treatment effect decreased as the level of domestic violence increased.	Content: During Home visits, the nurses promoted 3 aspects of maternal functioning: health-related behaviours during pregnancy & the early years of the child's life, the care parents provide to their children, & maternal life-course development (family planning, educational achievement, & participation in the work force). Visits were held once every other week during pregnancy, once a week for the first 6 weeks postpartum, & then on a diminishing schedule until the children reached age 2yrs. Theory: Unspecified.	Prevention	Home	Nurse	Individual caregiver	Nurses completed an average of 9 (range:0-16) visits during the mother's pregnancy & 23 (range:0-59) visits with child aged birth to 2yrs.	-
Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew (2010) [41]	Sig. improvement in Youth Mental Health symptoms, parenting psychiatric distress, maltreatment in parenting behaviour, out of Home (placement) factors, & improved natural support for parents compared to control. Non-sig. service utilisation (CPS reports), though there were reduced no.'s of report in MST-CAN group.	Theory: Social ecological conceptualization of behaviour, the physical abuse of youth has been linked to modifiable factors pertaining to the individual youth, parent & family systems. MST: address nature of serious clinical problems (adaptions can be used for serious emotional disturbance, sex offending, chronic illness). Home-based model to overcome barriers to service access, integrating evidence-based interventions & QA framework.	Both	Community	Counsellor; other	Individual families	MST-CAN: daily or 1-2 weekly (as needed) for up to 16mths, plus 24/7 crisis support.	Standard MST-CAN is 4-6-mths only.
Dawe & Harnett (2007) [42]	Risk for abuse: TAU group increased risk, Brief intervention & PUP had sig. reductions. Relationship: Parent stress (decrease)/ Child behaviour Prob. (decrease), child pro-social	Content: Comprehensive needs assessment & case formulation to establish targets for change. Brief intervention was two sessions of	Prevention	Home	Other	Individual caregiver	1x 10-12wks	Note: For all groups some participants remained high

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or Intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
	(increase): PUP was only sig. group. Change from High risk to Low risk: PUP (36%) & Brief Intervention (17%). Change (worsening) from Low risk to High risk in TAU (42%).	parenting education. Theory: Case formulation, change models.						risk: PUP (36%), Brief (56%) & TAU (37%).
Jouriles, McDonald, Rosenfield, Norwood, Spiller, Stephens, …, & Ehrensaft (2010) [43]	For Parenting Support compared to control: Sig. improvement over time & sig. more rapid impact on perceived inability to parent & reduced harsh parenting. Sig rapid observed ineffective parenting, but no difference over time. Sig. reduction in psychological distress found in parenting support, not in control. No sig. effects found in control group over time.	Content: Designed to decrease coercive patterns of aggressive discipline & increase positive parenting, by: 1. teaching mother's child management skills; 2. providing instrumental & emotional support to mothers. A very intensive, hands-on approach.	Both	Home	Counsellor; Other	Individual families	Project Support: 1 x a week for 8mths. Mean: 22.1 TAU: 0-18 sessions +	Note: TAU (counselling, plus psycho-education or educational support).

Note: The Supported programs are categorised by author in this table. TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 2b. Summary of Supported programs

Name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Child-Parent Psycho-therapy (CPP)	To enhance parental capacity to provide safety & developmentally appropriate caregiving to their child/ children.	3 - 5	Ippen, Harris, Van Horn, & Lieberman (2011) [44]	USA	Child abuse, Neglect; Child sexual abuse; Family violence; Parental substance use; Parental mental illness; Other	Other	Child physical; Relationships & family or social functioning	RCT: Yes Control: 1mth case management & community service referral. Follow-up: 6mths	n=75 (child) F=39; M=36 mean:4.1 n=75 (mother) f=75; M=0 mean:31.5 n=27 (dyads)	See totals in previous cell	a. Yes b. No c. Yes d. 6mths
Child-Parent Psycho-therapy (CPP)	To foster child mental health by promoting a relational process, in which increased maternal responsiveness to the child's developmental needs strengthens the child's trust in the mother's capacity to provide protective care.	3 - 5	Lieberman, van Horn, & Ippen (2005) [33]	USA	Child abuse; Child sexual abuse; Family violence	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Case management plus TAU Follow up: None	n=36 (dyad)	n=29 (dyad)	a. Yes b. No c. N/A d. N/A
Child-Parent Psycho-therapy (CPP)	To foster positive child development, improved parent-child interaction, & decrease child maltreatment.	3 - 5	Toth, Maughan, Manly, Spagnola, & Cicchetti (2002) [35]	USA	Child abuse; Child sexual abuse; Neglect	Other	Relationships & family or social functioning; Psychological/ emotional or behavioural symptoms	RCT: Yes Controls: TAU & community sample Follow up: None	n=31 (family)	TAU: n=33 (family) Community: n=43 (family)	a. Yes b. No c. N/A d. N/A
Child-Parent Psycho-therapy (CPP)	To foster child mental health by promoting a relational process in which increased maternal responsiveness to the child's developmental needs strengthens the child's trust in the mother's capacity to provide protective care.	3 - 5	Lieberman, Ippen, & Van Horn (2006) [36]	USA	Family Violence; Child abuse; Child sexual abuse	Other	Psychological/emotional or behavioural symptoms	RCT: Yes Follow up Study: Lieberman, Van Horn & Ippen (2005)	See Lieberman, Van Horn & Ippen (2005)	See Lieberman, Van Horn & Ippen (2005)	a. N/A b. No c. Yes d. 6mths

Name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Child-Parent Psycho-therapy (CPP)	To decrease traumatic stress responses, learning difficulties & relationship problems in infants & young children exposed to violence by improving the quality of parent–child relationships.	0 - 6	Weiner, Schneider, & Lyon (2009) [31]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=33 F=21; M=12 Mean:3.8	No control group	a. Non-sig. overall (sig. for racial groups on some measures) b. No c. N/A d. N/A
Fostering Healthy Futures	To provide skills groups & mentoring.	9 - 11	Taussig & Colhane (2010) [38]	USA	Child abuse; Neglect	Foster care	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Wait-list Follow up: 6mths	n=77	n=79	a. Yes (Sig. on quality of life measure); Non-sig. between groups at end of intervention, but sig. diff at 6mths post intervention b. No c. Yes d. 6-mths
Fourth R: A school-based violence prevention program	To provide knowledge, awareness & skill development for personal safety in relationships, sexual health, & substance use. To reduce conflict & risk behaviours.	14 - 15	Crooks, Scott, Ellis, & Wolfe (2011) [39]	Canada	Neglect	Ethnicity; Other	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: Control: TAU Standard curriculum Follow-up: 2.5yrs	n=865 F=493; M=372 14-15yrs	n= 655 F=327; M=328 14-15yrs	a. Yes b. No c. Yes d. 2.5yrs Duration: 21 sessions
Parents Under Pressure (PUP)	To provide comprehensive needs assessment & case formulation to establish targets for change.	2 - 8	Dawe & Harnett (2007) [42]	Australia	Child abuse; Neglect	Other	Relationships & family or social functioning; risk for childhood abuse	RCT: Yes Controls: TAU & Brief intervention Follow up: 3/6mths	n=22 (family)	n=20 (Brief Intervention); n=19 (TAU) (family)	a. Yes b. No c. Yes d. 3/6mths Duration: 1x 10-12wks.
Project Support	To reduce child conduct problems among families departing from domestic violence shelters.	3 - 8	Jouriles, McDonald, Rosenfield, Norwood, Spiller, Stephens, …,	USA	Family violence; Other	Other	Psychological/ emotional or behavioural symptoms; Relationships & family or social	RCT: Yes Control: TAU Follow-up: 8mths	n=17 (child)	n=18 (child)	a. Yes b. No c. Yes d. 8mths

Name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
			& Ehrensaft (2010) [43]				functioning; Service utilisation				

Note: TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy. a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 2c. Summary of Supported approaches by theory

Approach name	Authors & year	Approach theory								Intervention	Prevention
		CBT	Trauma narrative	Trauma exposure	Ecological/systems	Attachment/ Relational	Neurobiological	Mindfulness	Psycho-dynamic		
Approach type: Programs											
CPP: Child-Parent Psychotherapy	Ippen, … & Lieberman (2011) [32S]		✓		✓	✓				✓	
	Lieberman, … & Ippen (2005) [33S]		✓		✓	✓				✓	
	Cicchetti, … & Toth (2006) [34]		✓		✓	✓				✓	
	Toth, … & Cicchetti (2002) [35]		✓		✓	✓				✓	
	Lieberman, … & Van Horn (2006) [36S]		✓		✓	✓				✓	
	Weiner, … & Lyon (2009) [31]		✓		✓	✓				✓	
Fostering Healthy Futures	Taussig & Colhane (2010) [38]	✓				✓				✓	
Fourth R: violence prevention	Crooks, … & Wolfe (2011) [39]	Not reported/applicable									✓
PUP: Parents under Pressure	Dawe & Harnett (2007) [42]	✓				✓		✓			✓
Project Support	Jouriles, … & Ehrensaft (2010) [43]	✓				✓				✓	✓
Total programs		**3**	**1**	**0**	**1**	**4**	**0**	**1**	**0**	**3**	**3**
Approach Type: Service Models											
Family Connections	DePanfilis & Dubowitz (2005) [37]				✓						✓
Nurse Home Visiting Service	Eckenrode, … & Sidora (2000) [40]	Not reported/applicable									✓
Total service models		**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**2**
Approach Type: Systems of Care											
MST-CAN: multi-systemic therapy	Swenson, … & Mayhew (2010) [41]	✓			✓					✓	
Total systems of care		**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**

Note: CBT = Cognitive Behaviour Therapy; [S] These three articles reported on the same study and this was the only CPP study that was an RCT with 6 months follow-up.

Table 2d. Summary of Supported programs by approach elements, setting and delivery mode

Approach name	Authors & year	Elements			Setting				Delivered by						Delivered to				
		Dose	Training	Program fidelity	Clinic	Community	Home	School	Psychologist	Social worker	Counsellor	Teacher	Nurse	Unspecified professional, paraprofessional	Individual child	Individual caregiver	Child-caregiver dyad	Individual families	Groups of children
CPP: Child-Parent Psychotherapy	Ippen, … & Lieberman (2011) [44S]	50 x 1hr	M	✓	✓				✓							✓	✓		
	Lieberman, … & Ippen (2005) [33S]	50 x 1hr	M	✓	✓				✓							✓	✓		
	Cicchetti, … & Toth (2006) [34]	52 sessions	M	✓	✓									✓			✓		
	Toth, … & Cicchetti (2002) [35]	52 x 1hr	M	✓	✓									✓			✓		
	Lieberman, … & Van Horn (2006) [36S]	50 x 1hr	M	✓		✓			✓								✓		
	Weiner, … & Lyon (2009) [31]	52 sessions	M	✓	✓									✓			✓		
Fostering Healthy Futures	Taussig & Colhane (2010) [38]	30 x 1.5hr / 30 x 2-4hr	M	✓			✓			✓				✓	✓				✓
Fourth R: violence prevention	Crooks, … & Wolfe (2011) [39]	21 x 1.25hr	✓	✓				✓				✓							✓
PUP: Parents under Pressure	Dawe & Harnett (2007) [42]	10 x 1.5-2hr	✓	✓			✓							✓		✓			
Project Support	Jouriles, … & Ehrensaft (2010) [43]	1-1.5hrs; up to 8mths[1]	✓	✓			✓							✓		✓			
Total			**5**	**5**	**1**	**1**	**3**	**1**	**1**	**1**	**0**	**1**	**0**	**4**	**1**	**3**	**1**	**0**	**2**

NOTE: [1] = as needed/ unspecified time spent in sessions. M = Manualised program (refers to the study noting that therapists followed intervention protocols via the use of a session based written manual. In these articles there was no notation of therapist training as per the description above). [S] These three articles reported on the same study and this was the only CPP study that was an RCT with 6 months follow-up. Fidelity – refers to the study monitoring the adherence of therapists to the intervention protocol (i.e., such as supervision, or reviewing of video or audiotapes of sessions). Training – refers to the study noting that therapists were provided specific training of the intervention protocol.

Table 2e. Summary of Supported programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific\focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
CPP: Child-Parent Psychotherapy	Ippen, … & Lieberman (2011) [44S]	3-5	TS/F TIC		✓	✓	✓	✓	✓					✓				
	Lieberman, … & Ippen (2005) [33S]	3-5				✓	✓		✓					✓				
	Cicchetti, … & Toth (2006) [34]	1-3			✓		✓								✓			
	Toth, … & Cicchetti (2002) [35]	3-5			✓	✓	✓							✓	✓			
	Lieberman, … & Van Horn (2006) [31S]	3-5			✓	✓		✓						✓				
	Weiner, … & Lyon (2009) [33]	0-6									✓			✓				
Fostering Healthy Futures	Taussig & Colhane (2010) [37]	9-11[B]	TS/F		✓		✓							✓			✓	
Fourth R: violence prevention	Crooks, … & Wolfe (2011) [39]	3-8	TS/F		✓	✓	✓	✓						✓	✓	✓		
PUP: Parents under Pressure	Dawe & Harnett (2007) [32]	2-8[A]		✓					✓			✓		✓				
Project Support	Jouriles, … & Ehrensaft (2010) [35]	3-8			✓		✓	✓				✓		✓				
Total programs				**1**	**4**	**2**	**4**	**3**	**2**	**0**	**1**	**2**	**0**	**5**	**2**	**1**	**1**	**0**

Note: [A]= At risk; [B]= Fostercare; SMU = Substance misuse; TS/F = Trauma specific/ focused; TIC = Trauma informed care; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning. [S] These three articles reported on the same study and this was the only CPP study that was an RCT with 6 months follow-up.

Table 3a. Summary of Supported service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Family Connections (3- or 9-mth intervention) with/ without group intervention	To increase protective factors (parenting, family & social support) & decrease risk (stress/ parental depression) for abuse in inner-city families.	5 - 11	DePanfilis & Dubowitz (2005) [37]	USA	Neglect; Family violence; Parental substance use; Parental mental illness; Other	Ethnicity	Psychological/ emotional or behavioural symptoms; Service utilisation; Risk for childhood abuse	RCT: Yes Controls: FC 3-mth or FC Follow-up: 6 & 9mths	Combined samples n=154 (parent); n=473 (child) 0-20yrs	See totals in previous cell.	a. Yes b. No c. Yes d. 6mths
Nurse Home visiting service	To prevent child abuse, neglect or maltreatment.	1 - 2	Eckenrode, Ganzel, Henderson, Smith, Olds, Powers, …, & Sidora (2000) [40]	USA	Other	At risk families	Service utilisation	RCT: Yes Control: TAU (T1: pregnancy visits) & (T1: infant-age) Follow-up: 15yrs	T1 n=100 (mother) T2 n= 116 (mother)	n=184 (mother)	a. Yes (at Time 2 only) b. No c. Yes d. 15yrs

Note: TAU = Treatment As Usual; RCT = Randomised Controlled Trial; T = time; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 3b. Summary of Supported service models by program elements, setting and delivery mode

Approach name	Authors & year	Elements			Setting				Delivered by						Delivered to				
		Dose	Training	Program fidelity	Clinic	Community	Home	School	Psychologist	Social worker	Counsellor	Teacher	Nurse	Unspecified professional, paraprofessional	Individual child	Individual caregiver	Child-caregiver dyad	Individual families	Groups of children
Family Connections	DePanfilis & Dubowitz (2005) [37]	12/40 x 1.5hr	✓	✓			✓			✓							✓		
Nurse Home visiting service	Eckenrode, … & Sidora (2000) [40]	Up to 30mths[1]		✓			✓						✓			✓			
Total service models			**1**	**2**	**0**	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**1**	**1**	**0**	**0**

NOTE: [1] = as needed/ unspecified time spent in sessions. Note: Direct comparison between programs in this table is should be avoided because they take a number of forms constituted under the term program (e.g., trauma specific interventions, systems of care). Fidelity – refers to the study monitoring the adherence of therapists to the intervention protocol (i.e., such as supervision, or reviewing of video or audiotapes of sessions). Training – refers to the study noting that therapists were provided specific training of the intervention protocol.

Table 3c. Summary of Supported service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Family Connections	DePanfilis & Dubowitz (2005) [37]	5-11[E]					✓	✓	✓	✓	✓	✓		✓			✓	
Nurse Home Visiting Service	Eckenrode, … & Sidora (2000) [40]	0-2[A]			✓	✓	✓										✓	
Total service models				**0**	**1**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**0**	**1**	**0**	**0**	**2**	**0**

Note: [E] = Ethnicity; [A]= At risk; TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 4a. Summary of Supported systems of care

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Multisystemic Therapy for Child Abuse & Neglect (MST-CAN)	To improve youth & parent functioning, reduce abusive parenting behaviour, & decrease abuse & placement.	10 - 17	Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew (2010) [41]	USA	Child abuse; Neglect	Other	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning; Service utilisation	RCT: Yes Control: Enhanced Outpatient treatment (TAU) Follow up: 2/ 4/10/16mths	n=45	n=45	a. Yes b. No c. Yes d. Months: 2, 4, 10, 16

Note: TF = Trauma specific or trauma focused but not trauma informed; TIC = Trauma informed care; RCT = Randomised Controlled Trial; F = Female; M = Male; n= no. of participants in sample; TAU = Treatment As Usual; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 4b. Summary of Supported systems of care by program elements, setting and delivery mode

Approach name	Authors & year	Elements			Setting				Delivered by						Delivered to				
		Dose	Training	Program fidelity	Clinic	Community	Home	School	Psychologist	Social worker	Counsellor	Teacher	Nurse	Unspecified professional, paraprofessional	Individual child	Individual caregiver	Child-caregiver dyad	Individual families	Groups of children
MST-CAN: multi-systemic therapy	Swenson, … & Mayhew (2010) [41]	Up to 16mths[1]	✓	✓		✓	✓							✓				✓	
Total systems of care			**1**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**

NOTE: [1] = as needed/ unspecified time spent in sessions. M = Manualised program (refers to the study noting that therapists followed intervention protocols via the use of a session based written manual. In these articles there was no notation of therapist training as per the description above). Note: Direct comparison between programs in this table is should be avoided because they take a number of forms constituted under the term program (e.g., trauma specific interventions, systems of care). Fidelity – refers to the study monitoring the adherence of therapists to the intervention protocol (i.e., such as supervision, or reviewing of video or audiotapes of sessions). Training – refers to the study noting that therapists were provided specific training of the intervention protocol.

Table 4c. Summary of Supported systems of care by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
MST-CAN: multi-systemic therapy	Swenson, … & Mayhew (2010)[41]	10-17	TS/F TIC		✓		✓					✓		✓	✓		✓	
Total systems of care				**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**1**	**0**	**1**	**0**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning.

Table 5a. Summary of Promising A programs

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Attachment & Bio-behavioural Catch up Intervention (ABC)	To decrease frightening behaviour & to enhance nurturing/ sensitive care for parents identified as at risk for neglecting young children & at risk of developing a disorganized attachment style.	0 - 2.5	Bernard, Dozier, Bick, Lewis-Morrarty, Lindhiem, & Carlson (2012) [45]	USA	Neglect	Ethnicity; Other	Relationships & family or social functioning	RCT: Yes Control: ABC without parental sensitivity Follow up: None	n=60 (dyads) F=26; M=34 Combined sample: (mean:10mth range:2-21)	n=60 (dyads) F=25; M=35	a. Yes b. No c. N/A d. N/A Note: Control group= removed components re: parental sensitivity.
Attachment & Bio-behavioural Catch up Intervention (ABC)	To help parents/ caregivers reinterpret behavioural cues in children who fail to elicit nurturance & decrease caregiver discomfort in providing nurturance.	0 - 5	Sprang (2009) [46]	USA	Child abuse; Neglect	Foster care	Psychological/emotional or behavioural symptoms; Relationships & family or social functioning	RCT: Yes Control: Waitlist (support groups) Follow up: None	n=26 (dyads)	n=27 (dyads)	a. Yes b. No c. N/A d. N/A
Cognitive Behavioural Therapy (CBT)	To address aggressive tendencies by teaching coping skills, effective prob. solving & replace maladaptive schemas. Teach new ways to deal with stressful social encounters.	12 - 16	LeSure-Lester (2002) [47]	USA	Child abuse; Neglect	Residential care; Ethnicity	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: Yes Control (52wks indirect) Follow up: None	n=6 f=0; m=6	n=6 F=0; M=6	a. Yes b. No c. N/A d. N/A
Cognitive Behaviour Therapy	To examine psychosocial functioning after disclosure of sexual abuse history using gender-specific CBT. A holistic intervention (i.e., structured personal journal, creative expression, empowerment, role-playing) to address health, mental health, substance abuse, & family issues.	12 - 17	Arnold, Kirk, Roberts, Griffith, Meadows, & Julian (2003) [48]	USA	Child sexual abuse	Residential care; Ethnicity; Juvenile offenders; Substance abusers	Cognition; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: no Pre/ Post treatment measures Follow up: None	n=41 F=41; M=0	No comparison group	a. Yes all domains sig. Mixed findings for relationships (sig. for problems with father & school; non-sig. for problems with mother & with friends). b. No c. N/A d. N/A
Cognitive	To reduce trauma	10-16	Morsette,	USA	Not	Ethnicity	Psychological/	RCT: No	n=43	No comparison	a. Yes

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Behavioural Intervention for Trauma in Schools (CBITS)	symptoms.		van den Pol, Schuldberg, Swaney, & Stolle (2012) [49]		specified		emotional or behavioural symptoms	Control: Pre/post treatment measures Follow up: 3yr (limited)	F=24; M=19 mean:12.7	group	b. No c. N/A d. 3yr measure of program acceptability/ appropriateness.
Cognitive Behavioural Intervention for Trauma in Schools (CBITS)	To reduce symptoms of PTSD & depression in children who have been exposed to violence.	11-15	Stein, Jaycox, Kataoka, Wong, Tu, Elliot, & Fink (2002) [50]	USA	Family violence; Other	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Delayed treatment Follow up: 3mths	n=61	n=65	a. Yes b. No c. No d. 3mth (control group at end of treatment).
Cognitive Behavioural Intervention for Trauma in Schools (CBITS)	To reduce symptoms of PTSD & depression in children who have been exposed to violence.	11-15	Goodkind, LaNoue, & Milford (2010) [51]	USA	Family violence; Other	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: No Control: Delayed treatment Follow up: 3/6mths	n=23 F=16; M=7 mean:13.4	n=23 F=16; M=7 mean: 13.4	a. Yes b. No c. Yes (depression & anxiety) non-sig. (PTSD & avoidance) d. 6mths
Cognitive Behavioural Intervention for Trauma in Schools (CBITS)	To reduce symptoms of PTSD & depression in children who have been exposed to violence.	11-15	Kataoka, Stein, Jaycox, Wong, Escudero, Tu, …, & Fink (2003) [52]	USA	Family violence; Other	Ethnicity	Psychological/emotional or behavioural symptoms	RCT: No Control: Delayed treatment Follow up: 3mths	n=152 F=92; M=90 mean:11.5	n=47 F=22; M=25 mean:11.2	a. Yes b. No c. No d. 3mths
Child & Family Cognitive Behavioural Therapy (CBT) for sexually abused children	To use psycho-education, coping skills, relaxation, behaviour, rehearsal, assertive behaviour, graded exposure, relapse prevention, problem sharing, abuse-discussion, child behaviour manage, parental coping to reduce PTSD symptoms.	5 - 17	King, Tonge, Mullen, Myerson, Heyne, Rollings, …, & Ollendick (2000) [53]	Australia	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Controls: 2 treatment & Waitlist (WLC) Follow up: 3mths	Combined samples: n=36 F=24; M=11 mean:11.5	WLC: n=12	a. Yes for treatment versus control; non-sig. between treatment conditions b. No c. Yes d. 3mth
Combined Parent-Child Cognitive	To address the complex needs of the parent who engages in physically	Not specified	Runyon, Deblinger, and	USA	Child abuse, Family	Caregiver offenders; Other	Psychological/ emotional or behavioural	RCT: No Control: Pre/post	n=21 (child) n=24 (parent)	No comparison group	a. Yes b. No c. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Behavioural Therapy (CPC-CBT)	abusive behaviour & the traumatized child.		Schroeder (2009) [54]		Violence, Child sexual abuse		symptoms	treatment measures Follow up: None			d. N/A
Combined Parent-Child Cognitive Behavioural Therapy (CPC-CBT)	To address the complex needs of the parent who engages in physically abusive behaviour & the traumatized child.	Not specified	Runyon, Deblinger, & Steer (2010) [55]	USA	Child abuse	Caregiver offenders; Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Parent-only CBT Follow up: 3mths	n=34 (child) n= 24 (parent)	n= 26 (child) n=20 (parent)	a. Yes (PTSD; equally internalising & externalising child behaviour). b. No c. Yes d. 3mths
Eye Movement Desensitization & Reprocessing (EMDR)	To reduce PTSD symptoms in sexually abused children.	12 - 13	Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi (2004) [56]	Iran	Child sexual abuse	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Alternate (CBT) Follow up: None	n=7 (child) f=7; M=0	n=7 (child) F=7; M=0	a. Yes b. No c. N/A d. N/A
Eye Movement Desensitization & Reprocessing (EMDR)	To treat children with conduct disorder.	10 - 16	Soberman, Greenwald, & Rule (2002) [57]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Control: TAU without EMDR Follow up: 2mths	n=14	n=15	a. Yes b. No c. Yes d. 2mths
Eye Movement Desensitization & Reprocessing (EMDR)	To compare the effects of EMDR with a waiting list condition (WLC) in RCT for children suffering from PTSD elicited by various traumatic events.	6 - 16	Ahmad, Larsson & Sundelin-Wahlsten (2007) [58]	Sweden	Child sexual abuse; Neglect, parental substance use; Parental mental illness, Other	Foster Care; Ethnicity; Caregiver offenders; Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: No treatment Follow up: None	n=16 F=10; M=7 range:6-15 mean:9.6	n=17 F=10; M=6 range:6-16 mean:10.3	a. Yes b. No c. N/A d. N/A
Eye Movement Desensitization & Reprocessing (EMDR)	To test the treatment effect size of a special protocol for EMDR used in treatment of children with PTSD.	6 - 16	Ahmad & Sundelin-Wahlsten (2008) [59]	Sweden	Child sexual abuse; Neglect: Parental substanc	Foster care; Ethnicity; Caregiver offenders; Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control (half had 2mth delayed treatment) Follow up:	n=33 F=20; M=13 Mean:9.6 range:5–15	n=16-17	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
					e use; Parental mental illness			None			
Infant-Parent Psychotherapy (IPP)	IPP: To focus on mother's interactional history & its effect on her representation on relationship to infant. PPI: To focus on current behaviour utilizing intervention skills (parent-skills oriented).	1-1	Cicchetti, Rogosch, & Toth (2006) [34]	USA	Child abuse; Neglect	Ethnicity; Other	Relationships & family or social functioning	RCT: Yes Controls: TAU & Psycho-educational Parenting Intervention (PPI) Follow up: None (1.2yr post-intervention)	n=137 infant (TAU; IPP; PPI) F=77; M=60 mean:1.1	n=52 infant (normative control: low income) F=24; M=28 mean1.1	a. Yes (but equally for both groups). b. No c. N/A d. N/A
Parent-Child Interaction Therapy (PCIT)	To assist parents to maintain consistent limits, to ignore minor disruptive behaviours, to manage their own emotions during negative interactions, to identify effective time-out strategies, & to implement strategies effectively & judiciously.	2.5 - 7	Thomas & Zimmer-Gembeck (2011) [60]	Australia	Child abuse; Neglect	At risk families	Relationships & family or social functioning; Psychological/ emotional or behavioural symptoms	RCT: Yes Controls: Wait List (12wks) & Treatment completion Follow up: 1mth	n=99 (family)	n=51 (family)	a. Yes (parent-child interactions; stress; behaviour) ; Non-sig (child abuse potential)* b. No c. Yes d. 1mth *Note: one measure found evidence for reduced 'child abuse potential' but this could not be compared with the wait-list due to the study design
Parent-Child Interaction Therapy (PCIT)	To offer a parent training program that helps parents address children's behaviour problems. Stage 1: Relationship enhancement phase (child-directed interaction; CDI), & Stage 2: discipline phase	2 - 10	Galanter, Self-Brown, Valente, Dorsey, Whitaker, Bertuglia-Haley, & Prieto (2012)	USA	Child abuse; Neglect	Ethnicity; Other; Caregiver offenders	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=83 F=73; M=10	No control group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	(parent-directed interaction; PDI).		[61]								
Parent-Child Interaction Therapy (PCIT)	To enhance the parent–child relationship through the use of play therapy that incorporates both parent & child within the treatment session as well as the use of live coaching.	Not specified	Pearl (2008) [62]	USA	Family violence	At risk families	Psychological/emotional or behavioural symptoms	RCT: No Case Study Follow up: 7mths	n=1 (mother & 3yr old child)	No control group	a. Yes b. No c. Yes d. 7mths
Parent-Child Interaction Therapy (PCIT)	To enhance the parent–child relationship through the use of play therapy that incorporates both parent & child within the treatment session as well as the use of live coaching.	Not specified	Pearl, Thieken, Olafson, Boat, Connelly, Barnes, & Putnam (2012) [63]	USA	Not specified	At risk families	Psychological/emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=53 (family) F=24; M=59 mean:5.4	No control group	a. Yes b. No c. N/A d. N/A
Parent-Child Interaction Therapy (PCIT)	To prevent child abuse by improving parent-child interaction skills & discipline skills.	4 - 12	Hakman, Chaffin, Funderburk & Silovsky (2009) [64]	USA	Child abuse	At risk families	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=22 (dyads) parents: (F=77%, M=23% mean:32.0) Child: (F= 36%, M=64% mean:7.0)	No comparison group	a. Yes b. No c. N/A d. N/A
Parent-Child Interaction Therapy (PCIT)	To teach parents very specific but very limited set of parenting skills. To teach risk factors for engaging in physically abusive behaviours clearly extend beyond parenting & include broad parental & familial factors.	2-12	Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, …, & Bonner (2004) [65]	USA	Child abuse	Caregiver offenders	Service utilisation	RCT: Yes Controls : TAU & enhanced individual PCIT Follow up: None	n=110 (dyads)	See total in previous cell	a. Yes b. No c. N/A d. N/A
Parent-Child Interaction Therapy (PCIT)	To reduce the presenting clinical problems of young children.	2-7	McNeil, Hershell, Gurwitch, & Clemens-Mowrer (2005) [66]	USA	Child abuse; Neglect	Foster care	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=33 (dyads) mean:5.2	No comparison group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Short-term attachment-based intervention	To change risk outcomes for children of maltreating families.	1 - 5	Moss, Dubois-Comtois, Cyr, Tarabulsy, St-Laurent, & Bernier (2011) [67]	Canada	Child abuse; Child sexual abuse; Neglect	Other	Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: Yes Control: TAU Follow up: None	n=35 (family) mean:3.3	n=32 (family) mean:3.4	a. No (psychological, except for older aged children); Yes (risk for childhood abuse). b. No c. N/A d. N/A
Seeking Safety (SS)	To target current posttraumatic stress disorder & substance use disorder concurrently.	13 - 18	Najavits, Gallop, & Weiss (2006) [68]	USA	Not specified	Substance abusers	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: TAU Follow up: 3mths	n=18 F=18; M=0	n=15 F=15; M=0	a. Yes b. No c. Yes (but not across all measures). d. 3mths
SOS! Helps for parents	To provide a preventive intervention to mothers of young children.	2 - 6	Oveisi, Ardabili, Dadds, Majdzadeh, Mohammadkhani, Rad, & Shahrivar (2010) [69]	Iran	Other	Other	Risk for childhood abuse	RCT: Yes Control: No treatment Follow up: 2mths	n=136	n=136	a. Yes b. No c. Yes d. 2mths
Support for Students Exposed to Trauma	To reduce post-traumatic & depressive symptoms & improve functioning in middle school youth who have been exposed to traumatic events.	Not specified	Jaycox, Langley, Stein, Wong, Sharma, Scott, & Schonlau (2009) [70]	USA	Other	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Waitlist Follow up: None	n=39 (child) F=21; M=18 mean:11.4yrs	n=37 (child) F=18; M=19 Mean: 11.5yrs	a. Yes b. No c. N/A d. N/A
Trauma Affect Regulation: Guide for Education & Therapy (TARGET)	To reduce PTSD symptoms & improve emotional regulation in delinquent female youths.	13 - 18	Ford, Steinberg, Hawke, Levine, & Zhang (2012) [71]	USA	Child abuse; Child sexual abuse; Family violence; Parental substance use	Juvenile offenders	Psychological/ emotional or behavioural symptoms	RCT: Yes Control : TAU (enhanced) Follow up: None	n=33	n=26	a. Yes (PTSD & affect regulation); Non-sig. (anger domain TAU better) b. No c. N/A d. N/A
Trauma	To teach youths who	13 - 18	Ford &	USA	Not	Juvenile	Service utilisation	RCT: No	n=197	n=197	a. Yes (other -

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Affect Regulation: Guide for Education & Therapy (TARGET)	behave problematically to better manage their emotions, thoughts, & behaviour.		Hawke (2012) [72]		specified	offenders		Control: Matched sample (gender & age) Follow up: None			incidents within the facility); Non-sig. (service utilisation), b. No c. N/A d. N/A
Trauma-focused ARC (attachment, Self-regulation & competency) Intervention Model	To provide clinical illustration & associated outcomes from the first naturalistic program evaluation of the ARC model applied to young children impacted by complex trauma exposure & maladaptation.	3 - 12	Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Evans, …, & Blaustein (2011) [73]	USA	Child abuse; Child sexual abuse: Neglect; Family violence; Parental substance use; Parental mental illness; Other	Foster care; Ethnicity	Child physical; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning; Service utilisation	RCT: No Control: Non-completer Follow up: None (comments about later service utilisation)	n=21	n=24	a. Yes b. No c. Yes (service utilisation only) d. Not specified
Trauma focused art therapy intervention	To reduce trauma symptoms.	Not specified	Lyshak-Stelzer, Singer, Patricia, & Chemtob (2007) [74]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: TAU Follow up: None	n=14 mean:14.8	n=15 mean:15.1	a. Yes b. No c. N/A d. N/A
Trauma Intervention Program for Adjudicated & At-Risk Youth (SITCAP-ART)	To diminish terror in exposed individuals & facilitate feelings of safety using sensory-based therapeutic activities & CBT.	13 - 18	Raider, Steele, Delillo-Storey, Jacobs, & Kuban (2008) [75]	USA	Not specified	Other	Psychological/emotional or behavioural symptoms	RCT: Yes Control: Waitlist Follow up: None	n=13 range:15-18	n=10 range:15-18	a. Yes b. No c. N/A d. N/A
Triple P - Enhanced Group Behavioural Family	To improve parent/child interactions to reduce the risks for child maltreatment.	2 - 7	Sanders, Pidgeon, Gravestock, Connors, Brown, &	Australia	Child abuse; Neglect	Caregiver offenders; Other	Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: Yes Control: Triple P – Standard Group Behavioural	n=50 (parent) mean: 34.2 (parent) mean:2.4	n=48 (parent) mean: 33.3 (parent) mean:1.9	a. Yes b. No c. No (improvements were maintained

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Intervention			Young (2004) [76]					Family Intervention (TAU) Follow up: 6mths	(child)	(child)	but group differences attenuated). d. 6mths

Note: TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 5b. Summary of Promising A programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific\focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Attachment and Biobehavioural Catchup Intervention (ABC)	Bernard, … & Carlson (2012) [45]	0-2.5					✓								✓			
	Sprang (2009) [46]	0-5			✓		✓							✓	✓			
Cognitive Behavioural Therapy (CBT)	LeSure-Lester (2002) [47]	12-16			✓		✓							✓	✓			
	Arnold, … & Julian (2003) [48]	12-17				✓								✓	✓			✓
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Morsette, … & Stolle (2012) [49]	Not specified	TS/F TIC		Not specified									✓				
	Stein, … & Fink (2002) [50]	11-15						✓			✓			✓				
	Goodkind, … & Milford (2010) [51]	11-15						✓			✓			✓				
	Kataoka, … & Fink (2003) [52]	11-15						✓			✓			✓				
Child & Family Cognitive Behavioural Therapy (CBT) for sexually abused children	King, , … & Ollendick (2000) [53]	5-17	TS/F	✓		✓								✓				
Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)	Runyon, … & Schroeder (2009) [54]	Not specified	TS/F		✓									✓				
	Runyon, … & Steer (2010) [61]	Not specified			✓	✓		✓						✓				
Eye Movement Desensitization & Reprocessing (EMDR)	Jaberghaderi, … & Dolatabadi (2004) [56]	12-13	TS/F			✓								✓				
	Soberman, … & Rule (2002) [57]	10-16			Not specified									✓				
	Ahmad, … & Sundelin-Wahlsten (2007) [58]	6-16				✓	✓		✓	✓	✓			✓				
	Ahmad & Sundelin-Wahlsten (2008) [59]	6-16				✓	✓		✓	✓				✓				
Infant-Parent Psychotherapy (IPP)	Cicchetti, … & Toth (2006) [34]	1-1	TS/F		✓		✓								✓			
Parent-Child Interaction Therapy (PCIT)	Thomas & Zimmer-Gembeck (2011) [60]	2-12	TS/F TIC		✓		✓							✓	✓			
	Galanter, … & Prieto (2012) [61]	2-12			✓		✓								✓				
	Pearl (2008) [62]	2-12						✓						✓				
	Pearl, … & Putnam (2012) [63]	2-12			Not specified									✓	✓			
	Hakman, … & Silovsky (2009) [64]	2-12			✓										✓			
	Chaffin, … & Bonner (2004) [65]	2-12			✓												✓	

Approach name	Authors & year	Age	Trauma-specific\focused Trauma-informed care	Australia	Trauma type: Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Outcome domain: Risk for abuse	Physical	PEBS¹	RFSF²	Educational	Service utilisation	Cognition
	McNeil, … & Clemens-Mowrer (2005) [66]	2-7			✓		✓							✓				
Short-term attachment-based intervention	Moss, … & Bernier (2011) [67]	1-5			✓	✓	✓							✓				
Seeking Safety (SS)	Najavits, … & Weiss (2006) [68]	13-18	TS/F		Not specified									✓				
SOS! Helps for parents	Oveisi, … & Shahrivar (2010) [69]	2-6									✓	✓						
Support for Students Exposed to Trauma	Jaycox, … & Schonlau (2009) [70]	mean:11.5	TS/F								✓			✓				
Trauma Affect Regulation: Guide for Education and Therapy (TARGET)	Ford, … & Zhang (2012) [47,71 47,71 47,71] 47,71 48,72 48,72 {Ford, 2012}	13-18	TS/F		✓	✓		✓	✓					✓				
	Ford & Hawke (2012) [72]	13-18			Not specified												✓	
Trauma-focused ARC (attachment, Self-regulation & competency) Intervention Model	Arvidson, … & Blaustein (2011) [73]	3-12	TS/F TIC		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	
Trauma focused art therapy intervention	Lyshak-Stelzer, … & Chemtob (2007) [74]	Not specified	TS/F		Not specified									✓				
Trauma Intervention Program for Adjudicated and At-Risk Youth (SITCAP-ART)	Raider, … & Kuban (2008) [75]	13-18	TS/F		Not specified									✓				
Triple P - Enhanced Group Behavioural Family Intervention	Sanders, … & Young (2004) [76]	2-7		✓	✓		✓					✓		✓				
Total programs				**2**	**9**	**7**	**8**	**5**	**3**	**2**	**5**	**3**	**0**	**15**	**5**	**0**	**3**	**1**

Note: TS/F = Trauma-specific/ focused; TIC = Trauma-informed care; SMU = Substance misuse; MI = Mental illness; PEBS¹= Psychological/ emotional or behavioural symptoms; RFSF²= Relationships & family/ social functioning.

Table 6a. Summary of Promising A service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Child protection services (CPS) concurrent with family preservation services (FPS)	To combine family preservation services with child protection services to minimise use of out-of-Home placements.	Not specified	Walton (2001) [77]	USA	Child abuse; Neglect	Other	Service utilisation; Relationships & family or social functioning	RCT: Yes Control: TAU (post-treatment only) Follow up: None	n=97 (family) mean:8.0	n=111 (family)	a. Yes b. No c. N/A d. N/A
Healthy Families America	To promote positive parenting, enhance child health & development, & prevent child maltreatment (America)	0 - 7	Cullen, Ownbey, & Ownbey (2010) [78]	USA	Neglect	At risk families	Relationships & family or social functioning; Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=116	See total in previous cell.	a. Yes b. No c. N/A d. N/A
Healthy Families America	To decrease the occurrence of abuse & neglect among high-risk families & specifically target 95% of children with no substantiated child abuse/ neglect (Alaska)	0 - 2	Gessner (2008) [79]	USA	Child abuse; Neglect	At risk families	Child physical; Service utilisation	RCT: No Design: retrospective cohort Follow up: None	n=985	See total in previous cell.	a. No b. No c. N/A d. N/A
Healthy Families America	To prevent child maltreatment by promoting positive parenting & child health & development (Alaska)	0 - 5	Duggan, Caldera, Rodriguez, Burrell, Rohde, & Crowne (2007) [80]	USA	Other	At risk families	Service utilisation; Risk for childhood abuse	RCT: Yes Control: TAU Follow up: None	n=162 (family)	n=163 (Family)	a. Yes (for one measure of risk for abuse). No (for other measures of abuse & service utilise). b. No c. N/A d. N/A
Healthy Families America	To promote positive parenting, enhance child health & development, & prevent child abuse & neglect (Arizona)	0 - 5	LeCroy & Krysik (2011) [81]	USA	Child abuse; Neglect	At risk families	Relationships & family or social functioning	RCT: Yes Control: Child development Follow up: 6- & 12mths	n=97	n=98	a. Yes b. No c. No d. 6 or 12mths
Healthy Families America	To use screening & assessment to identify families at-risk of child	0 - 5	Duggan, McFarlane, Fuddy, Burrell,	USA	Child abuse; Neglect	At risk families	Child physical; Relationships & family or social	RCT: Yes Controls: Main & Testing (n=45)	n=395	n=290	a. Yes b. No c. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	abuse & neglect. Then home visit identified at-risk families (Hawaii)		Higman, Windham, & Sia (2004) [82]				functioning	Follow up: None			d. N/A Note: Data at 12mth, 24mth & 36mth for regression analysis)
Healthy Families America	To promote parenting competencies in the early formative years of the child's life to best influence positive development & enhance mothers' habitual parenting practices (New York)	0 - 5	Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene (2010) [83]	USA	Child abuse; Neglect	At risk families	Relationships & family or social functioning	RCT: Yes Control: Not stated Follow up: None	n=255 (mother) mean: 3.1 (child)	n=267 (mother) mean: 3.1 (child)	a. Yes (positive parenting & negative parenting for HPO subgroup); non-sig. (negative parenting). b. No c. N/A d. N/A
Healthy Families America	To promote positive parenting skills & parent-child interaction, prevent child abuse & neglect, support optimal prenatal care, & child health & development; & improve parent's self-sufficiency (New York)	0 - 5	DuMont, Mitchell-Herzfeld, Greene, Lee, Lowenfels, Rodriguez, & Dorabawila (2008) [84]	USA	Other	At risk families	Child physical; Service utilisation	RCT: Yes Control: group given info & referral to other appropriate services in the Community Follow-up: 2yrs (in Study 1 only)	n=478 (mother) (including prevention subgroup: n=170; psychological vulnerable subgroup: n=122)	n=493 (mother)	Study 1: Overall a. No; b. No; c. No; d. 2yrs Study 2: Prevention group a. Yes (at 2yrs) b. No; c. N/A; d. N/A Study 3: Vulnerable Grp a. Yes (at 2yrs) b. No; c. N/A; d. N/A Note: randomisation was pre-natal.

Note: RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy. a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 6b. Summary of Promising A service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-focused/specific Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Child protection services (CPS) concurrent with family preservation services (FPS)	Walton (2001) [77]	mean: 8yrs			✓		✓								✓		✓	
Healthy Families America	Gessner (2008) [79]	0-2			✓		✓						✓				✓	
	Duggan, … & Crowne (2007) [80]	0-5									✓	✓					✓	
	Cullen, … & Ownbey (2010) [78]	0-7					✓							✓	✓			
	LeCroy & Krysik (2011) [81]	0-5			✓		✓								✓			
	Duggan, … & Sia (2004) [82]	0-5			✓		✓						✓		✓			
	Rodriguez, … & Greene (2010) [83]	0-5			✓		✓								✓			
	DuMont, … & Dorabawila (2008) [84]	0-5									✓		✓				✓	
Total service models				**0**	**2**	**0**	**2**	**0**	**0**	**0**	**1**	**1**	**1**	**1**	**2**	**0**	**2**	**0**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 7a. Summary of Promising A systems of care

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Motivation–adaptive skills–trauma resolution (MASTR) with eye movement desensitization & reprocessing (EMDR)	To reduce trauma symptoms & behavioural problems in traumatised youth with conduct problems in youth protective services.	Not specified	Farkas, Cyr, Lebeau, & Lemay (2010) [85]	Canada	Child abuse; Child sexual abuse; Other	Residential care	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: TAU Follow-up: 3mths	n=19 (child) F=14; M=5 mean:14.3	n=21 (child) F=11; M=10 mean:14.9	a. Yes b. No c. Yes d. 3mths
Sanctuary Model	To use a trauma-focused model to address the special needs of youth with serious emotional disturbances & histories of maltreatment &/or exposure to domestic & community violence.	12 - 20	Rivard, Bloom, McCorkle, & Abramovitz (2005) [86]	USA	Not specified	Residential care	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Standard Residential Services Follow up: 3/6mths	No detail	n=158 F=58; M=100 mean:15.0	a. Yes b. No c. Yes d. 6mths

Note: RCT = Randomised Controlled Trial; F = Female; M = Male; n= no. of participants in sample; TAU = Treatment As Usual; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 7b. Summary of Promising A systems of care by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Motivation–Adaptive Skills–Trauma Resolution (MASTR) with Eye Movement Desensitization & Reprocessing	Farkas, … & Lemay (2010) [85]	Not specified	TS/F TIC		✓	✓					✓			✓				
Sanctuary Model	Rivard, … & Abramovitz (2005) [86]	12-20[D]	TS/F TIC		✓	✓	✓	✓						✓				
Total systems of care				**0**	**2**	**2**	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**2**	**0**	**0**	**0**	**0**

Note: [D]= Residential care; TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning.

Table 8a. Summary of Promising B programs

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Canine assisted therapy	To reduce psychological distress associated with trauma.	Not specified	Hamama, Hamama-Raz, Dagan, Greenfeld, Rubinstein, & Ben-Ezra (2011) [87]	Israel	Child abuse; Child sexual abuse	Other	Psychological/emotional or behavioural symptoms	RCT: No Control: TAU Follow up: None	n=9 (child) F=9; M=0 mean: 15.3	n=9 (child) F=9; M=0 mean:14.5	a. Yes b. No c. N/A d. N/A
Child Sexual Abuse Treatment Program (CSATP; Giarretto model)	To examine program effectiveness on vulnerability (self-esteem/ depressive affect) & problem behaviours reported by adults.	0 - 16	Bagley & LaChance (2000) [88]	Canada	Child sexual abuse	Caregiver offenders	Educational; Psychological/ emotional or behavioural symptoms	RCT: No Control: Untreated Follow up: None	(n=27) mean: 11.2	(n=30) Mean: 11.8	a. Yes b. No c. N/A d. Post measures taken 2yrs after commencing therapy
Group Art Therapy	To reduce depression, anxiety, sexual trauma & low self-esteem among sexually abused girls.	8 - 11	Pretorius & Pfeifer (2010) [89]	South Africa	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Controls: 2 intervention & 2 non-intervention Follow up: None	n=6 (for intervention / non-intervention groups)	n=6 & n=7	a. Yes b. No c. N/A d. N/A
Group therapy for sexually abused children	To reduce internalizing & externalizing behaviour problems & posttraumatic stress symptoms; to foster positive self-esteem; to help children recognize & express their feelings; to help children identify their personal coping resources to manage the aftermaths of CSA; to reduce sense of social isolation & shame by fostering exchanges & supportive relationships with other child victims of abuse; to foster positive parent–child relationship; & to prevent re-victimization.	6 - 12	Hebert & Tourigny (2010) [90]	Canada	Child sexual abuse	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: No Control: TAU Follow up: None	n=51 F=38; M=13	N=39 F=34, M=5	a. Yes b. No c. N/A d. N/A
Group therapy for	To evaluate a group therapy program for sexually abused	13 - 17	Tourigny, Herbert,	Canada	Child sexual	Other	Psychological/ emotional or	RCT: No Control: No	n=27 F=27; M=0	n=15 F=15; M=0	a. Yes; non-sig. (somatic,

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
sexually abused teenage girls	teenage girls.		Daigneault, & Simoneau (2005) [91]		abuse		behavioural symptoms; Relationships & family or social functioning	treatment. Follow up: None	mean:14.8	mean:14.3	delinquency, aggression) b. No c. N/A d. N/A
Group therapy for sexually abused teenage girls	To evaluate group therapy for sexually abused teenage girls (Open groups & Closed Groups).	13 - 17	Tourigny & Hebert (2007) [92]	Canada	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms;	RCT: No Control: untreated Follow up: None	(n=27) F=27; M=0 mean:14.8	(n=15) F=15; M-0 Mean: 14.3	a. Yes b. No c. N/A d. N/A
Imagery Rehearsal Therapy	To reduce sleep complaints related to PTSD & reduce the impact & occurrence of distressing chronic nightmares.	13 - 18	Krakow, Sanoval, Schrader, Keuhne, McBride, Yau, & Tandberg (2001) [93]	USA	Child sexual abuse	Substance abusers	Psychological/ emotional or behavioural symptoms	RCT: No Control: No intervention Follow up: None	(At baseline n=30) n=9 F=9; M=0 range:13-18	n=10 F=10; M=0 range:13-18	a. Mixed Yes (nightmares only); non-sig. (PTSD & sleep measures) b. No c. N/A d. N/A
Outpatient & Residential treatment for adolescent	To reduce substance use.	13 - 18	Funk, McDermeit, Godley, & Adams (2003) [94]	USA	Not specified	Juvenile offenders	Psychological/ emotional or behavioural symptoms	RCT: No Controls: Residential & Outpatient modalities Follow up: None	n=114 F=27; M=87	n=73 F=19; M=54	a. Yes (residential preferred with history of high levels of trauma); non-sig. (both modalities equal for low trauma histories). b. No c. N/A d. N/A
Project SafeCare	To improve parenting skills & reduce future occurrences of abuse & neglect.	0 - 5	Gershater-Molko, Lutzker, & Wesch (2002) [95]	USA	Child abuse	Caregiver offenders	Service utilisation	RCT: No Control: TAU Follow up: 24mths	n=41	n=41 (matched by child age)	a. Yes b. No c. Yes d. 24mths Note: TAU = Family Preservation program
Project SafeCare	To decrease child maltreatment & prevent the removal of children, by improving parental knowledge of child development, changing parental attitudes towards their children, improving home environment, & linking	0 - 5	Gershater-Molko, Lutzker, & Wesch (2003) [96]	USA	Child abuse, Neglect	Caregiver offenders, Other	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=70	No comparison group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	parents to community resources.										
Project SafeCare	To increase parenting skills, child & infant health, home safety, & parent/ child bonding.	0 - 5	Damashek, Bard, & Hecht (2012) [97]	USA	Child abuse, Neglect	Ethnicity	Service utilisation, Risk for childhood abuse	RCT: No Control: TAU Follow up: None	Combined sample: n=1,305 (parent: F=80%) range:0-12	See total in previous cell.	a. Yes b. No c. N/A d. N/A
Rythmex	To use rhythmic exercises to improve the cognitive function & behaviour of maltreated children.	6 - 11	Goldshtrom, Korman, Goldshtrom, & Bendavid (2011) [98]	USA	Child abuse, Neglect	Residential care	Psychological/ emotional or behavioural symptoms; Cognition	RCT: No Control: TAU Follow up: 12mths	n=23 (child) F=13; M=10 mean:8.5	n=14 (child) F=6; M=8 mean:8.5	a. Yes b. No c. Yes d. 12mths

Note: RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 8b. Summary of Promising B programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Canine assisted therapy	Hamama, … & Ben-Ezra (2011) [87]	Not specified	TS/F		✓								✓					✓
Child Sexual Abuse Treatment Program (CSATP)	Bagley & LaChance (2000) [88]	0-16			✓								✓		✓			
Group Art Therapy for Sexual Abuse	Pretorius & Pfeifer (2010) [89]	8-11	TS/F			✓								✓				
Group therapy for sexually abused children	Hebert & Tourigny (2010) [90]	6-12	TS/F			✓								✓	✓			
	Tourigny, … & Simoneau (2005) [91]	13-17				✓								✓				
	Tourigny & Hebert (2007) [92]	13-17				✓								✓				
Imagery Rehearsal Therapy	Krakow, … & Tandberg (2001) [93]	13-18	TS/F			✓								✓				
Residential substance abuse treatment	Funk, … & Adams (2003) [94]	13-18	TS/F		Not specified									✓				✓
Project SafeCare	Gershater-Molko, … & Wesch (2002) [95]	0-5			✓												✓	
	Gershater-Molko, … & Wesch (2003) [96]	0-5			✓		✓								✓			
	Damashek, … & Hecht (2012) [97]	0-5			✓		✓					✓					✓	
Rythmex	Goldshtrom, … & Bendavid (2011) [98]	Not specified			✓		✓							✓				
Total programs				**0**	**4**	**3**	**2**	**0**	**0**	**0**	**0**	**1**	**2**	**4**	**3**	**0**	**1**	**2**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 9a. Summary of Promising B service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Brighter Futures	To assess the effectiveness of a child protection prevention program that is targeted at vulnerable families with children at risk of abuse &/or neglect.	0 - 18	Hilferty &…Katz (2010) [99]	Australia	Family Violence; Child abuse	Caregiver offenders; Other	Child physical; Service utilisation	RCT: No Control & Pre/post treatment Follow up: 12mths	n=4170 (child)	n=2462 (child)	*Harm Reports: a. Yes (pre/post); Non-sig. (comparison group better than intervention. However when families completed intervention program the outcome were better than the comparison group). b. No c. Yes (for parents who completed intervention). d. 12mths. *Out of Home Care: a. Yes; b. No; c. N/A; d. N/A *Child Behaviour: a. Yes (no control) b. No; c. N/A; d. N/A *Child Development: a. No; b. No; c. N/A; d. N/A
Child-Parent Centres	To examine the effectiveness of a family-school partnership model used in prevention programming.	3 - 9	Reynolds & Robertson (2003) [100]	USA	Not specified	Other	Service utilisation; Risk for childhood abuse	RCT: No Control: Full day kindergarten Follow up: None	n=989	n=550	a. Yes b. No c. N/A d. N/A
Child-Parents Centres	To provide educational & family support services to eligible children.	3 - 9	Mersky, Topitzes, & Reynolds (2011) [101]	USA	Other	At risk families	Child physical; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Control: TAU Follow up: None	n=989 (child)	n=550 (child)	a. Yes b. No c. N/A d. N/A
Cottage Community Care Pilot Project (CCCPP)	To directly address factors in first-time families that are associated with child maltreatment.	15 – 35 mothers	Kelleher (2004) [102]	Australia	Other	At risk families	Relationships & family or social functioning	RCT: No Control: Signed up to program but not waitlist & Follow up: None	n=25 (mother) F=25; M=0 48% aged <19yrs	n=14 (mother) F=14; M=0 57% aged <19yrs	a. Yes b. No c. No d. NA

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Minnesota Alternative Response Project	To assist families reported for child abuse & neglect to child protection services.	Not specified	Loman & Siegel (2005) [103]	USA	Child abuse	Caregiver offenders	Child physical; Service utilisation	RCT: No Control: Untreated Follow up: 1yr	n=2,860 (families)	n=1,305 (families)	a. Yes b. No c. Yes d. 1yr
Parent Aide Program	To break the cycle of child abuse though the provision of in-Home services, free of charge, to families in Dallas County, referred by CPS.	0 - 12	Harder (2005) [104]	USA	Child abuse, Neglect	Other	Relationships & family or social functioning, Service utilisation	RCT: No Controls: Program Refusers & Drop outs Follow up: None	Completers: N=46 (parent) mean:28.3 F=96% mean:4.4 (child)	Drop outs: n=88 (parent mean:26.1 F=97%). mean:3.5 (child) Refusers: n=112 (parent mean:26.8) Mean:4.8 (child)	a. Yes b. No c. N/A d. N/A
Sexual Abuse Intervention Program (SAIP)	Not indicated.	Not specified	Holland, Gorey, & Lindsay (2004) [105]	Canada	Child sexual abuse	Residential care; Ethnicity	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Comparison: TAU Follow up: None	n=10 (child)	n=56 (child)	a. Yes b. No c. No d. N/A
State-wide Family Preservation & Family Support (FPFS) programs	8 programs: Healthy Families America (HFA) & Parents-as Teachers (Home visits); Basic Needs (practical assistance); Nurturing (education); Parent Mentoring; Parent Education Centre; Agency Collaborative (case management).	0 - 18	Chaffin, Bonner, & Hill (2001) [106]	USA	Child abuse; Child sexual abuse; Neglect	Ethnicity; Caregiver offenders; Other; Teenage pregnancy	Child physical; Service utilisation; Risk for childhood abuse	RCT: No Control: Treatment non-completers Follow up: Up to 3yrs	n=1601 (family) F=1462; M=139	No comparison group	a. Yes (Child physical/ service utilisation) Basic Needs & Parent Mentoring were most effective, especially for high risk parents). No (Risk for abuse) non-sig. for programs types. b. No c. No d. 3yrs max, median:1.6yrs
Therapeutic Residential Care	To support independent/ adult living (12-17yrs); or restore family connections were possible (11-14yrs); or	Varies across pilots: 0 - 14; 9 - 12	Sullivan, Faircloth, McNair, Southern, Brann,	Australia	Neglect,	Residential care	Child physical; Cognition; Educational, Psychologica	RCT: No Control (Out-of-Home Care,	n=38 F=25 ; M=13 range: 5-16	n=16 F=8; M=8 median:13.0 (18mths pre-program	a. Non-sig. compared to control. Yes sig. for Pre/post comparison for conduct problems (entry to follow up). Pre-entry compared to Entry sig. (pro-social behaviours & impact of difficulties;

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	offer placement with ATSI kinship (0-14yrs); or develop Community & education linkages (13-15yrs).	11-17	Starbuck, …, & Ribarow (2011) [107]				l/ emotional or behavioural symptoms; Relationships & family or social functioning	OoHC). Follow up: 2yrs	median :15.0	matched demographic /time in care)	totals HoNOSCA & SDQ). b. No c. Yes, but non-sig. for all but conduct. d. 2yrs

Note: TAU = Treatment As Usual; RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 9b. Summary of Promising B service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Brighter Futures	Hilferty ...& Katz (2010) [99]	0-18		✓	✓			✓					✓				✓	
Child-Parent Centre Program	Reynolds & Robertson (2003) [100S]	3-9			Not specified							✓					✓	
	Mersky, … & Reynolds (2011) [101S]	3-9									✓		✓	✓	✓			
Cottage Community Care Pilot Project (CCCPP)	Kelleher (2004) [102]	1-3		✓							✓				✓			
Minnesota Alternative Response Project	Loman & Siegel (2005) [103]	Not specified			✓								✓				✓	
Parent Aide Program	Harder (2005) [104]	0-12			✓		✓								✓		✓	
Sexual Abuse Intervention Program (SAIP)	Holland, … & Lindsay (2004) [105]	Not specified				✓								✓	✓			
State-wide Family Preservation and Family Support (FPFS) programs	Chaffin, … & Hill (2001) [106]	0-18			✓	✓	✓					✓	✓				✓	
Therapeutic Residential Care	Sullivan, … & Ribarow (2011) [107]	11-17	TS/F TIC	✓			✓				✓	✓	✓	✓	✓	✓		✓
Total service models				**3**	**4**	**2**	**3**	**1**	**0**	**0**	**3**	**3**	**5**	**3**	**5**	**1**	**5**	**1**

Note: [S] = These two articles reported on the same study; TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 10a. Summary of Promising B systems of care

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Houston Child Advocates	To find safe, loving, permanent homes for abused & neglected children.	0 - 18	Waxman, Houston, Profilet, & Sanchez (2009) [108]	USA	Child abuse; Neglect	Foster care; Residential care	Relationships & family or social functioning; Psychological/ emotional or behavioural symptoms; Service utilisation	RCT: No Control: Protective custody*. Follow up: 1/2/3yrs	n=327 F=161; M=167	n=254 F=124; M=130	a. Yes b. No c. Yes (only family communication 2yrs) d. 2yrs Note: *matched: gender/ age/ abuse type
Trauma Systems Therapy	To assess the fit between child's emotional regulation capacities & adequacy of the social environment & system of care to help the child. Therapy is based on assessment to offer a variety of treatment modules designed for severe problems in children's environments.	Not specified	Saxe, Ellis, Fogler, Hansen, & Sorkin (2005) [109]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=82 F=34; M=48 mean:11.2	No comparison group	a. Yes b. No c. N/A d. N/A
Trauma Systems Therapy	To meet the multiple socio-ecological needs of children with histories of trauma exposure.	Not specified	Saxe, Ellis, Fogler, & Navalta (2012) [110]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Control: TAU Follow up: None	n=10	n=10	a. Yes b. No c. N/A d. N/A
Skills-Based Intervention	To promote children's resilience, increase their knowledge about safety & safety planning, & increase their intrapersonal skills & competencies.	5 - 10	Noether, Brown, Finkelstein, Russell, VandeMark, Morris, & Graeber (2007) [111]	USA	Family violence; Parental substance use, Parental mental illness	Other	Psychological/ emotional or behavioural symptoms	RCT: No Control: TAU Follow up: 6/12mths	n=115 (mother)	n=138 (mother)	a. Yes b. No c. Yes d. 1yr

Note: RCT = Randomised Controlled Trial; F = Female; M = Male; n= no. of participants in sample; TAU = Treatment As Usual; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 10b. Summary of Promising B systems of care by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Houston Child Advocates	Waxman, … & Sanchez (2009) [108]	0-18			✓		✓							✓	✓		✓	
Skills-based intervention program	Noether, … & Graeber (2007) [111]	5-10						✓	✓	✓				✓				
Trauma Systems Therapy	Saxe, … & Sorkin (2005) [109]	Not specified	TS/F TIC		Not specified									✓				
	Saxe, … & Navalta (2012) [110]	Not specified			Not specified									✓				
Total systems of care				**0**	**1**	**0**	**1**	**1**	**1**	**1**	**0**	**0**	**0**	**3**	**1**	**0**	**1**	**0**

Note: TS/F = Trauma-specific/ focused; TIC = Trauma-informed care; SMU = Substance misuse; PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning.

Table 11a. Summary of Emerging A programs

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
A Home Within – A relationship-based intervention	To prioritize children's needs of community, stability, & permanency in attachment to healthy adult(s). Long-term psychoanalytically-orientated therapy including play therapy.	5 - 11	Clausen, Ruff, Von Wiederhold, & Heineman (2012) [112]	USA	Neglect	Foster care	Educational; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=20 F=6; M=14	No comparison group	a. Yes (school, anxiety, sleep, dissociative, depression & Peer relationships). Non-sig. (conduct, learning, anger, psychosis, eating, self-injury, substance use, family). b. No c. N/A d. N/A Duration: 0.5-7.4yrs (mean: 3.4yrs)
Alternatives for Families: Cognitive behavioural Therapy (AF-CBT)	To improve the relationships between children & caregivers in families involved in physical coercion/force & chronic conflict/hostility.	3 - 17	Kolko, Iselin, & Gully (2011) [113]	USA	Child abuse; Child sexual abuse; Neglect; Family violence	Ethnicity; Disability	Child Physical; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=46 F=25; M=27 mean:9.1	No comparison group	a. Yes b. No c. N/A d. N/A
Circle of Parents	To use a mutual self-help support group model as a means of preventing child abuse & neglect & strengthening families.	Not specified	Falconer, Haskett, McDaniels, Dirkes, & Siegel (2008) [114]	USA	Other	Other	Relationships & family or social functioning	RCT: No Pre/post treatment measures in four states Follow up: None	Parents : n=118 (Florida) N=101 (Minnesota) n=564 (Washington) n=89 (Nth Carolina)	No comparison group	a. Yes b. No c. N/A d. N/A
Circle of Security	To reduce the risk of insecure attachment	Not specified	Hoffman, Marvin, Cooper & Powell (2006) [115]	USA	Other	At risk families	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=65 (caregivers), n=65 (children), F=35, M=30	No comparison group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Combined Art Therapy & Cognitive Behavioural Therapy	To reduce post traumatic symptoms in victims of childhood sexual abuse.	8 - 17	Pifalo (2002) [116]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=13	No comparison group	a. Yes (anxiety, PTSD); non-sig. (depression). b. No c. N/A d. N/A
Combined Art Therapy & Cognitive Behavioural Therapy	To Reduce post traumatic symptoms in victims of childhood sexual abuse.	Not specified	Pifalo (2006) [117]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=41	No comparison group	a. Yes b. No c. N/A d. N/A
Emotion-focused therapy for trauma	To focus on exploring trauma-related feelings & meanings, constructing more adaptive meaning, & resolving issues with particular perpetrators of abuse & neglect.	Not specified	Mundorf & Paivio (2011) [118]	Canada	Child abuse; Child sexual abuse; Neglect	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=37	No comparison group	a. Yes b. No c. N/A d. N/A
Equine-assisted psycho-therapy	To encourage client insight through horse interactions/ examples. Horses have characteristics like humans, & they respond to non-verbal human behaviours through interaction.	Not specified	Schultz, Remnick-Barlow, & Robbins (2007) [119]	USA	Family violence; Child abuse; Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=63 F=26 (mean:10.1) M=37 (mean:11.5)	No comparison group	a. Yes (abuse/neglect), non-sig. (sexual abuse, family violence). b. No c. N/A d. N/A
Eye movement integration therapy	To support the overcoming of childhood trauma.	14 – 16	Struwig & van Breda (2012) [120]	South Africa	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=12	No comparison group	a. Yes b. No c. N/A d. N/A
Game-based cognitive-behavioural therapy	To improve internalizing symptoms, externalizing behaviours, sexually inappropriate behaviours, social skills deficits, self-esteem problems, & knowledge of healthy	Not specified	Misurell, Springer, & Tryon (2011) [121]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=48 F=30; m=18 mean: 7.3	No comparison group	a. Yes (anxiety, sexually inappropriate behaviour); non-sig (depression & post trauma symptoms). b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	sexuality & self-protection skills.										
Gipuzkoa program	To provide specialised/ individualised case management, psycho-education & therapy to caregiver & child.	0 – 18	de Paúl & Arruabarrena (2003) [122]	Spain	Child abuse; Neglect	Residential care	Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: No Pre/post treatment measures Follow up: None	n=133 (family); n=289 (child)	No comparison group	a. Yes b. No c. N/A d. N/A Duration: 15-17 sessions A home-based treatment for a maximum of 2yrs.
Grief & Trauma Intervention (GTI) with coping skills & TN processing	To improve symptoms of PTSD.	Not specified	Salloum & Overstreet (2012) [123]	USA	Child abuse; Family violence; Other	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: GTI with coping skills only Follow up: 3/12mths	n=39	n=33	a. Yes (but equally across groups). b. No c. Yes (but equally across groups). d. 12mths
Group Intervention: Psycho-education	To reduce levels of depression, anxiety & trauma symptoms among incarcerated the female juvenile offenders	Not specified	Pomeroy, Green, & Kiam (2001) [124]	USA	Child abuse; Child sexual abuse; Neglect; Family violence	Juvenile offenders	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=15 mean:51.9	No comparison group	a. Yes (depression, trauma), No (anxiety). b. No c. N/A d. N/A
Group intervention (child) & group intervention (parent)	To address posttraumatic stress issues in children by creating a safe & trusting therapeutic environment that enables expression of thoughts & feelings, and sharing of experiences. To focus on relationship building between the parent & child and promote positive discipline practices.	6 – 12	MacMillan & Harpur (2003) [125]	Canada	Family violence	Other	Psychological/emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=47 (child) F=23; M=24 means: child 9yrs; parent: 37yrs	No comparison group	a. Yes (psychological/ behavioural measures) b. No c. N/A d. N/A
Manualized cognitive restructuring	To reduce symptoms of posttraumatic stress.	13 – 18	Rosenberg, Jankowski,	USA	Not specified	Other	Psychological/emotional or behavioural	RCT: No Pre/post treatment	n=12 F=9; M=3 mean:16.0	No comparison group	a. Yes b. No c. Yes

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
program			Fortuna, Rosenberg, & Mueser (2011) [126]				symptoms	measures Follow up: 3mths			d. 3mths
Parent-Child Attunement Therapy	To strengthen caregivers r/s with children & learning of appropriate child-management techniques.	1-2.5	Dombrowski, Timmer, Blacker, & Urquiza (2005) [127]	USA	Child abuse, Neglect	Other	Relationships and family or social functioning, Risk for childhood abuse	RCT: No Control: Pre/post treatment measures Follow up: None	n=1 M=1 23 mths	No comparison group	a. No b. No c. N/A d. N/A
Parent education about the risk of head injury after shaking infants	To prevent child abuse/ head injuries caused by caregivers shaking infants & reduce medical costs for treatment & loss of life.	0 – 1	Dias, Smith, DeGuehery, Mazur, Li, & Shaffer (2005) [128]	USA	Child abuse	Other	Risk for childhood abuse	RCT: No Control: Community norms Follow up: None	n=65,205 (parent) signed forms: F=96%; M=76% range:0-3	Population-level (statistics): Previous 6yrs of data	a. Yes b. No c. N/A d. N/A Duration: <1hr.
Parent-led, Clinician-Assisted Trauma Focused - Cognitive Behavioural Therapy (PTA-TF-CBT)	To improve PTSD symptoms.	3 – 7	Salloum & Storch (2011) [129]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=1	No comparison group	a. Yes b. No c. N/A d. N/A
Play therapy	To produce positive changes in sexually abused children's traumatic symptoms.	Not specified	ReYes & Asbrand (2005) [130]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=18 F=13; M=5 mean:11.0	No comparison group	a. Yes b. No c. N/A d. N/A
Pragmatic-communicative intervention	To encourage adults to solve interpersonal problems by enhancing communication and skills (conversational language, requests, narrative skills & abstract	8 - 12	Manso, Sanchez, Alonso, & Romero (2012) [131]	Spain	Child abuse; Neglect	Residential care	Cognition	RCT: No Pre/post treatment measures Follow up: None	n=21	No comparison group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	& figurative language).										
QEEG-guided neuro-feedback	To teach children to self-regulate brain rhythmicity.	6 - 12	Huang-Storms, Bodenhamer, Davis, & Dunn (2006) [132]	USA	Child abuse; Neglect	Residential care	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	N=20 (child) F=9; M=11 mean:10.4 range:6-15.5	No comparison group	a. Yes b. No c. N/A d. N/A
Real Life Heroes	To build the skills & interpersonal resources needed to re-integrate painful memories & reduce affect dis-regulation following trauma.	8 - 15	Kagan, Amber, Hornik, Kratz, & Suzannah (2008) [133]	USA	Child abuse, neglect; Family violence, Other	Residential care; Foster care; Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=41 (child) F=17; M=24 mean:10.5	No comparison group	a. Yes b. No c. N/A d. NA
Strengthening Family Coping Resources	To establish within the family unit: routine, structure, connectedness, safety, resource seeking, co-regulation & crisis management, positive affect, memories & meaning.	1 - 12	Kiser, Donohue, Hodgkinson, Medoff, & Black (2010) [134]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/ post treatment measures Follow up: None	n=36 (child) M/F= not specified	No comparison group	a. Yes b. No c. N/A d. N/A Duration: 2hr x 14-15wks Small group delivery.
Symbol-drama	To reduce symptoms of dissociation & posttraumatic stress by the psycho-therapeutic use of imagery.	Not specified	Nilsson & Wadsby (2010) [135]	Sweden	Child abuse; Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=15 F=13; M=2	No comparison group	a. Yes b. No c. N/A d. N/A
The Hope Connection	To address the developmental areas of: attachment, sensory processing, & pro-social behaviour.	4 - 12	Purvis & Cross (2007) [136]	USA	Child abuse; Neglect	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=12 F=2; M=10	No comparison group	a. Yes b. No c. N/A d. N/A Duration: 5wk day camp
The Mothers' & Children's Group	To address the needs of abused mothers & their children who have	Not specified	Sullivan, Egan, & Gooch	USA	Family violence	Other	Psychological/ emotional or	RCT: No Pre/post treatment	n=46 (mother) n=79	No comparison group	a. Yes b. No c. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Intervention Program	witnessed violence.		(2004) [137]				behavioural symptoms	measures Follow up: None	(child)		d. N/A Duration: 1 x 9wks

Note: TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; PTSD = Post-Traumatic Stress Disorder: RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = Statistically non-significant findings; Sig. = Statistically significant findings. a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 11b. Summary of Emerging A programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
'A Home Within' relationship-based intervention	Clausen, … & Heineman (2012) [112]	5-11					✓				✓			✓	✓	✓		
Alternatives for Families: Cognitive behavioural Therapy (AF-CBT)	Kolko, … & Gully (2011) [113]	3-17	TS/F TIC		✓	✓	✓	✓					✓	✓	✓			
Circle of Parents	Falconer, … & Siegel (2008) [114]	Not specified				✓					✓				✓			
Circle of Security	Hoffman, … & Powell (2006) [115]	Not specified									✓				✓			
Combined Art Therapy & CBT	Pifalo (2002) [116]	8-17	TS/F			✓								✓				
	Pifalo (2006) [117]	Not specified				✓								✓				
Emotion-focused therapy for trauma	Mundorf & Paivio (2011) [118]	Not specified	TS/F		✓	✓	✓							✓				
Equine-assisted psychotherapy	Schultz … & Robbins (2007) [119],	Not specified			✓	✓		✓						✓				
Eye movement integration therapy	Struwig & van Breda (2012) [120]	14-16	TS/F								✓			✓				
Game-based cognitive-behavioral therapy group program	Misurell … & Tryon (2011) [121]	Not specified	TS/F			✓								✓				
Grief and Trauma Intervention (GTI) with coping skills and trauma narrative processing	Salloum & Overstreet (2012) [123]	Not specified	TS/F			✓		✓			✓			✓				
Group Intervention - Psychoeducation	Pomeroy, … & Kiam (2001) [124]	Not specified	TS/F		✓	✓	✓	✓						✓				
Group intervention (child) & group intervention (parent)	MacMillan & Harpur (2003) [125]	6-12	TS/F TIC					✓						✓				
Manualized Cognitive Restructuring Program	Rosenberg, … & Mueser (2011) [126]	13-18	TS/F								✓			✓				
Parent-Child Attunement Therapy	Dombrowski, … & Urquiza (2005) [127]	1-2.5			✓		✓					✓			✓			
Parent education about the risk of head injury after shaking infants	Dias, … & Shaffer (2005) [128]	0-1			✓							✓						
Parent-led, Therapist-Assisted Trauma Focused - Cognitive Behavioural Therapy (PTA-TF-CBT)	Salloum & Storch (2011) [129]	3-7	TS/F								✓			✓				
Play Therapy	Reyes & Asbrand (2005) [130]	Not specified	TS/F			✓								✓				
Pragmatic Communicative Intervention	Manso, … & Romero (2012) [131]	8-12			✓		✓											✓

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
QEEG-Guided Neuro-feedback	Huang-Storms, … & Dunn (2006) [132]	6-11.5	TS/F		✓		✓							✓	✓			
Real Life Heroes	Kagan, … & Suzannah (2008) [133]	8-15	TS/F TIC		✓		✓	✓			✓			✓				
Strengthening Family Coping Resources	Kiser, … & Black (2010) [134]	1-12	TS/F								✓			✓				
Symboldrama	Nilsson & Wadsby (2010) [135]	Not specified	TS/F		✓	✓								✓				
The Hope Connection	Purvis & Cross (2007) [136]	4-12			✓		✓							✓				
The Mothers' & Children's Group Intervention Program	Sullivan, … & Gooch (2004) [137]	Not specified	TS/F					✓						✓				
Total programs				**0**	**11**	**10**	**9**	**7**	**0**	**0**	**9**	**2**	**1**	**19**	**6**	**1**	**0**	**1**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 12a. Summary of Emerging A service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Childhood First, residential therapeutic Community	To use Integrated Systemic Therapy, (IST) in a residential treatment setting to reduce the symptoms of children who have experienced severe early life trauma & have emotional/ behavioural difficulties.	13 - 18	Carter (2011) [138]	UK	Not specified	Residential care	Educational	RCT: No Pre/post treatment measures Follow up: 15-20yrs	n=8 (single interview); n= not specified (group interview)	Population level data (statistics) for looked after children	a. Yes b. No c. Yes d. 15-20yrs
Crisis Childcare Program	To provide emergency caregiving respite & counselling to stressed parents who are at risk of maltreating their children, with the aim of reducing reports of child abuse or neglect.	Not specified	Cowen (2001) [139]	USA	Other	Ethnicity; Other	Risk for childhood abuse	RCT: No Pre/post treatment measures compared to national stats. Follow up: None	n=159 (family) n=269 (child) range:0-3	Population-level data (statistics)	a. Yes b. No c. N/A d. N/A
Cumbria Early Intervention Programs	To improve wellbeing of domestic violence survivors & their children, & increase perpetrator accountability for their behaviour.	5 - 17	Donovan, Griffiths & Groves (2010) [140]	UK	Family violence	At risk families	Child physical; Psychological/ emotional or behavioural symptoms; Risk for childhood abuse, Other	RCT: No Pre/post treatment measures Follow up: None	303 (mother) 56 (child) mean:10.0	No comparison group	a. Yes b. No c. Yes d. N/A
Early Intervention Programs - Gateshead	To improve wellbeing of domestic violence survivors & their children, & increase perpetrator accountability for their behaviour	5 - 17	Donovan, Griffiths & Groves (2010) [140]	UK	Family violence	At risk families	Child Physical; Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: No Pre/post treatment measures Follow up: None	n=340 (mother) n=57 (child) mean:8.0	No comparison group	a. Yes b. No c. Yes d. N/A
Early intervention service - child sexual abuse	To provide education to non-abusing parents about child sexual abuse (i.e., grooming & outcomes). To help parents empathise with their child. To provide reinforcement of competent parenting & advice on	Not specified	Forbes, Duffy, Mok, & Lemvig (2003) [141]	Scotland	Child sexual abuse	Caregiver offenders	Psychological/ emotional or behavioural symptoms; Other	RCT: No Pre/post treatment measures Follow up: 3mths	n=39 (parent) F=30; M=9) n=31 (child) F=23; M=8 mean:9.0 range:4-14	No comparison group	a. Yes b. No c. No d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	management of child difficulties.										
Louisiana Rural Trauma Services Centre	To reduce the symptoms of trauma by modifying trauma-focused cognitive behavioural therapy in school-based rural mental health services.	Not specified	Hansel, Osofsky, Costa, Kronenberg, & Selby (2010) [142]	USA	Child abuse; Child sexual abuse; Neglect; Family violence; Other	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=115 (child) F=55; M=60 mean:14.0	No comparison group	a. Yes b. No c. N/A d. N/A
Take Two	To provide a high quality clinical programme & to contribute to service system improvement.	8- 16	Jackson, Frederico, Tanti, & Black (2009) [143]	Australia	Child abuse; Neglect	Other	Child physical; Cognition; Educational; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	Sample 1: n=49 (child) F=20; M=29 mean:11.8 Sample 2: n=28 (child) F=11; M=17 mean:11.6	No comparison group	a. Yes b. No c. N/A d. N/A
The Sunrise Project	To use Rogerian style CBT therapy for adolescents & therapeutic play for younger children, with age-appropriate psycho-education.	0 - 18	Barker & Place (2005) [144]	UK	Child abuse; Child sexual abuse	Caregiver offenders	Educational; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=67 F=40; M=27 mean:9.2 range 4-18	No comparison group	a. Yes (for measures of antisocial, somatic, emotional & family life/ relationships). b. No c. N/A d. N/A

Note: CBT = Cognitive Behaviour Therapy; TAU = Treatment As Usual; RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 12b. Summary of Emerging A service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Childhood First, residential therapeutic community	Carter (2011) [138]	13-18									✓					✓		
Crisis Childcare Program	Cowen (2001) [139]	Not specified									✓	✓						
Cumbria Early Intervention Programs	Donovan, … & Groves (2010) [140]	5-17						✓				✓	✓	✓				
Early intervention service - child sexual abuse	Forbes, … & Lemvig (2003) [141]	Not specified	TS/F TIC		✓									✓				
Early Intervention Programs - Gateshead	Donovan, … & Groves (2010) [140]	5-17						✓				✓	✓	✓				
Gipuzkoa program	de Paúl & Arruabarrena (2003) [122]	0-18				✓	✓					✓		✓				
Louisiana Rural Trauma Services Center	Hansel, … & Selby (2010) [142]	Not specified	TS/F TIC		✓	✓	✓	✓			✓			✓				
Take Two	Jackson, … & Black (2009) [143]	8-16	TS/F TIC	✓	✓		✓						✓	✓	✓	✓		✓
The Sunrise Project	Barker & Place (2005) [144]	0-18			✓	✓								✓	✓	✓		
Total service models				**1**	**4**	**3**	**3**	**3**	**0**	**0**	**3**	**4**	**3**	**7**	**2**	**3**	**0**	**1**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 13a. Summary of Emerging A systems of care

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Fairy Tale model	To use trauma-informed methods to provide safety & stability, and provide a supportive setting to improve behaviours via relationship, coaching, punishment, & reinforcement.	13 – 18	Greenwald, Siradas, Schmitt, Reslan, Fierle, & Sande (2012) [145]	USA	Not specified	Residential care	Psychological/emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=53 range:10-21	No comparison group	a. Yes b. No c. N/A d. N/A
Fairy Tale model	To reduce symptoms of PTSD by eliminating or mitigating a wide range of presenting problems. To empower parents to support children's treatment and improve access & engagement with impoverished youth & families.	4 - 19	Becker, Greenwald, & Mitchell (2011) [146]	USA	Not specified; Other	Ethnicity	Psychological/emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=59 F=20; M=39 range;4-19 mean:11.2	No comparison group	a. Yes (PTSD); non-sig. for FES measure of relationships. b. No c. N/A d. N/A
Neuro-sequential Model of Therapeutics	To provide therapeutic & educational efforts in a sequential manner that replicates neural organization & development. Therapeutic interventions must have adequate patterns & frequency of experiences that will activate & influence the areas of the brain that are mediating the dysfunction.	Not specified	Barfield, Dobson, Gaskill, & Perry (2012) [147]	USA	Child abuse; Family violence; Parental substance use; Parental mental illness	Other	Psychological/emotional or behavioural symptoms	RCT: No Study 1: Pre/post treatment measures Study 2: Children are own controls Follow up: None	Study 1: n=13 (child) Study 2: n=15 (child)		Study 1: a. Yes (with non-sig. for parent ratings). b. No c. N/A d. N/A Study 2: a. Yes (with non-sig. for emotional regulation & parent ratings). b. No c. N/A d. N/A
Safety, Mentoring, Advocacy, Recovery, & Treatment (SMART)	To integrate individual, family, & group therapy in a strengths-based, problem-focused treatment model targeting problematic sexual	3 - 11	Offermann, Johnson, Johnson-Brooks, & Belcher (2008) [148]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: 6mths	n=62 F=22; M=40 mean:8.3	No comparison group	a. Yes b. No c. Yes d. 6mths

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	behaviours.										
The Child & Family Interagency Resource, Support & Training Program (Child FIRST)	To offer a comprehensive needs assessment & personalised service planning & care coordination to enhance the caregiver-child relationship.	0 - 5	Crusto, Lowell, Paulicin, Reynolds, Feinn, Friedman, & Kaufman (2008) [149]	USA	Family violence	Other	Psychological/ emotional or behavioural symptoms; Service utilisation; Risk for childhood abuse	RCT: No Pre/ Post treatment measures Follow up: None	n=82 F=36; M=46	No comparison group	a. Yes b. No c. N/A d. N/A Duration: mean:7.5mths

Note: TF = Trauma specific or trauma focused but not trauma informed; TIC = Trauma informed care; RCT = Randomised Controlled Trial; F = Female; M = Male; n= no. of participants in sample; TAU = Treatment As Usual; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 13b. Summary of Emerging A systems of care by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Fairy Tale Model	Greenwald, … & Sande (2012) [145]	13-18	TS/F TIC								✓			✓				
	Becker, … & Mitchell (2011) [146]	4-19									✓			✓	✓			
Neurosequential Model of Therapeutics	Barfield, … & Perry (2012) [147]	Not specified	TS/F		✓			✓	✓	✓				✓				
Safety, Mentoring, Advocacy, Recovery, & Treatment (SMART)	Offermann, … & Belcher (2008) [148]	3-11	TS/F			✓								✓				
The Child & Family Interagency Resource, Support & Training Program (Child FIRST)	Crusto, … & Kaufman (2008) [149]	0-5	TS/F TIC					✓				✓		✓			✓	
Total systems of care				**0**	**1**	**1**	**0**	**2**	**1**	**1**	**1**	**1**	**0**	**4**	**1**	**0**	**1**	**0**

Note TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning.

Table 14a. Summary of Emerging B programs

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Designs	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Chapman Art Therapy Treatment Intervention (CATTI)	To use a trauma resolution method in hospitals for incident specific, medical trauma for child to sequentially relate & cognitively comprehend the traumatic event.	7 – 17	Chapman, Morabito, Ladakakos, Schreier, & Knudson (2001) [150]	USA	Other	Ethnicity; Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: TAU Follow up: 1wk & 1mth (Post-treatment)	n=31 Combined sample: (F=21%; M=71% mean:10.7)	n=27	a. No b. No c. No d. 1mth Duration: 1 x 1hr Note: Pre/post treatment care and adjustment for min 24hr hospital stay.
In-patient song-writing to reduce PTSD symptoms	To develop an in-patient song writing procedure that is more effective at PTSD symptom reduction than listening to recreational music.	9 – 11	Coulter (2000) [151]	USA	Child abuse; Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=9 F=4; M=5 range:9-17	No control group	a. No b. No c. N/A d. N/A Duration: 1 x 8 sessions (song writing x4, music listening x4).
Koping Adolescent Group Program (KAP)	To increase mental health literacy, connectedness with peers, emotional adjustment & increase repertoire of coping skills.	12 – 18	Fraser & Pakenham (2008) [152]	Australia	Parental mental illness	Other	Psychological/ emotional or behavioural symptoms; relationships & family or social functioning	RCT: No Control: Waitlist Follow up: 2mths	n=27 (child) F=16; M=11 mean:13.4	n=17 (child) F=11;M=6 mean:13.2	a. No b. No c. N/A d. N/A
Mothers & Toddlers Program	To use an attachment-based parenting method for mothers in substance use treatment targeting their ability to care for their children.	0 – 3	Suchman, DeCoste, Castiglioni, McMahon, Rounsaville, & MaYes (2010) [153]	USA	Parental substance use	Other	Relationships & family or social functioning	RCT: No Control: Psycho-education group Follow up: None	n=23	n=24	a. No b. No c. N/A d. N/A
Parent support group intervention	To focus on parenting (i.e., empathy, discipline) & discuss DV; to offer emotional & practical support for issues of safety, child custody & legal proceedings.	3 – 12	Basu, Malone, Levendosky, & Dubay (2009) [154]	USA	Family violence; Other	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: Yes Controls: Access services (no treatment) & Early	n=9 (mother) n=5 (child)	No treatment: n=15 (mother) n=11 (child).	a. No (non sig. mother & child, small sample). b. No c. No d. 6mths

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Designs	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	Separately children discuss DV, aim to reduce feelings of shame & master behaviours during conflict.							termination (<5 sessions) Follow up: 3/6mths		Early termination: n=12 (mother), n=5 (child).	Duration: 1 x 10wks.
Social Information Processing Model	To provide a cognitive adjustment program for parental attitudes toward child rearing to reduce the potential for child physical abuse.	1 – 6	Sawasdipanich, Srisuphan, Yenbut, Tiansawad, & Humphreys (2010) [155]	Thailand	Child abuse	Other	Risk for childhood abuse	RCT: Yes Control: TAU plus psycho-education Follow up: None	n = 56	n=70	a. No b. No c. N/A d. N/A
Structured Psycho-therapy for Adolescents Responding to Chronic Stress (SPARCS)	To enhance adolescents' ability to cope more effectively in the moment through mindfulness, & to create connections & meaning. Program uses mindfulness & interpersonal skills from Dialectical Behaviour Therapy: problem-solving skills, enhancing social support & planning for the future.	13 - 21	Weiner, Schneider, & Lyon (2009) [31]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=65 F=32; M=33 mean:3.7	No comparison group	a. Yes (sig. on a few measures, but only for African/American participants. b. No c. N/A d. N/A

Note: RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 14b. Summary of Emerging B programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Chapman Art Therapy Treatment Intervention (CATTI)	Chapman, … & Knudson (2001) [150]	7-17	TS/F								✓			✓				
In-patient song-writing to reduce PTSD symptoms	Coulter (2000) [151]	9-11	TS/F		✓	✓								✓				
Koping Adolescent Group Program (KAP)	Fraser & Packenham (2008) [152]	12-18		✓						✓				✓	✓			
Mothers & Toddlers Program	Suchman, … & Mayes (2010) [153]	0-3							✓						✓			
Parent support group intervention	Basu, … & Dubay (2009) [154]	3-12	TS/F					✓			✓			✓				
Social Information Processing Model	Sawasdipanich, … & Humphreys (2010) [155]	1-6			✓							✓						
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	Weiner, … & Lyon (2009) [31]	13-21	TS/F TIC		Not specified									✓				
Total programs				**1**	**2**	**1**	**0**	**1**	**1**	**1**	**2**	**1**	**0**	**5**	**2**	**0**	**0**	**0**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 15a. Summary of Emerging B service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
ARS: Intensive home visiting	To use a Family Care Plan to set goals for family progress to address family needs, support parent-child relationships & offer social support.	0 – 5	Conley & Berrick (2010) [156]	USA	Child abuse; Child sexual abuse; Neglect; Other	Ethnicity	Service utilisation	RCT: No Control: No treatment group Follow up: None	n=134 F=63; M=71	n=511 F=229; M=282	a. No b. No c. N/A d. N/A Duration: 9-12mths
Combined TFCBT/ psycho-educational/ supportive group intervention	To reduce parental post-traumatic stress symptoms (in non-offending parents of childhood sexual abuse), & to improve family functioning.	5 – 15	Hernandez, Ruble, Rockmore, McKay, Messam, Harris, & Hope (2009) [157]	USA	Child sexual abuse	Other	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	N= Not specified Females only	No comparison group	a. No b. No c. N/A d. N/A
Healthy Start Program (HSP)	To prevent child abuse by improving family functioning & parenting behaviour.	0 - 5	Duggan, Fuddy, Burrell, Higman, MacFarlane, Windham, & Sia (2004) [158]	USA	Other	At risk families	Risk for childhood abuse	RCT: Yes Control: No treatment Follow up: None	n=373 (family)	n=270 (family)	a. No b. No c. N/A d. No (data is available for 1-3yrs follow up but regression modelling was used).

Note: CBT = Cognitive Behaviour Therapy; TAU = Treatment As Usual; RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 15b. Summary of Emerging B service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
ARS - Intensive Home Visiting	Conley & Berrick (2010) [156]	0-5			✓	✓	✓				✓						✓	
Combined TFCBT/ psychoeducational/ supportive group intervention	Hernandez, … & Hope (2009) [157]	Not specified	TS/F			✓									✓			
Healthy Start Program (HSP)	Duggan, … & Sia (2004) [82]	0-5									✓	✓						
Total service models				**0**	**1**	**2**	**1**	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**1**	**0**	**1**	**0**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Appendix 3: Practice survey

Table 1. Networks, associations and organisations contacted to disseminate project information and practice survey

Dissemination and promotion contacts	
Networks, associations and newsletters	**Targeted organisations**
Association of Children's Welfare Agencies (ACWA)	Anglican Diocese of Brisbane (QLD)
Association for the Welfare of Children in Hospital - Western Australia	Anglicare (National)
Association for the Wellbeing of Children in Healthcare (AWCH)	Barnardos Australia (NSW)
Australian Association of Social Workers (AASW)	BoysTown (QLD)
Australian Children's Foundation (ACF)	The Benevolent Society (NSW)
Australian Child & Adolescent Trauma, Loss & Grief Network (ACATLGN)	Berry Street (VIC)
Australian Institute of Family Studies (AIFS)	CatholicCare (NSW)
Australian Research Alliance for Children and Youth (ARACY)	Centacare (National)
Child Family Community Australia (CFCA)	Child Protection, DHS
Children's Healthcare Australasia	Children's Protection Society (VIC)
Children of Parents with a Mental Illness (COPMI)	Communicare (WA)
Family Relationship Services Australia	Connections Child Youth and Family Services (VIC)
Family Support Services Association of Tasmania (FSSA)	Gateway Community Health (VIC)
Murdoch Childrens Research Institute (MCRI)	Good Beginnings Australia (National)
NSW Family Services/Fams	Mallee Family Care Inc. (VIC)
Parenting Research Centre (PRC) corporate newsletter	Menzies School of Health Research (NT)
Peak Care QLD	Mission Australia (National)
Queensland Commission for Children and Young People	Relationships Australia (National)
Royal Children's Hospital (RCH) professional newsletter	Red Cross
Young People and Child Guardian's (CCYCG)	Salvation Army
Women's Information and Referral Exchange (WIRE)	The Smith Family (National)
	St Giles (TAS)
	UnitingCare (National)
	Wanslea Family Services (WA)
	Youth and Family Focus (TAS)

Table 2. Participant and organisational characteristics reported by the respondents to the trauma Practice Survey

	Total Sample *N*=468			Practice Sample [b] *N*=293	
	n (%)	Missing *n* (%)	Missing *n* (adj[a])	*n (%)*	Missing *n* (%)
Gender		30 (7%)	5 (1%)		3 (1%)
Male	42 (11%)			28 (10%)	
Female	335 (89%)			262 (90%)	
Education		25 (6%)	0		1 (<1%)
High school	4 (1%)			3 (1%)	
Tafe	31 (8%)			21 (7%)	
University (undergraduate)	129 (34%)			93 (32%)	
Graduate Diploma	127 (33%)			103 (35%)	
University (masters/phd)	70 (18%)			54 (19%)	
Other	21 (6%)			17 (6%)	
Organisation Type		29 (7%)	4 (1%)		2 (1%)
Government	117 (31%)			90 (31%)	
Non-Government	261 (69%)			201 (69%)	
Funding		29 (7%)	4 (1%)		2 (1%)
Sole FaHCSIA	36 (10%)			30 (10%)	
Partially FaHCSIA	125 (33%)			95 (33%)	
Non-FaHCSIA	158 (42%)			116 (40%)	
Not sure	59 (16%)			49 (17%)	

	Total Sample *N*=468			Practice Sample [b] *N*=293	
	n (%)	Missing *n* (%)	Missing *n* (adj[a])	*N (%)*	Missing *n* (%)
Organisation description		27 (7%)	2 (1%)		2 (1%)
Family Support	97 (26%)			71 (24%)	
Community Services	84 (22%)			62 (21%)	
Education	17 (5%)			15 (5%)	
Hospital/Medical	31 (8%)			21 (7%)	
MCH	16 (4%)			15 (5%)	
Child Protection	50 (13%)			40 (14%)	
Disability Support	15 (4%)			9 (3%)	
Other	70 (18%)			58 (20%)	
Current Position		31 (8%)	6 (2%)		3 (1%)
Family care/support worker	48 (13%)			40 (14%)	
Social worker	49 (13%)			32 (11%)	
Allied health	46 (12%)			39 (13%)	
Manager	53 (14%)			36 (13%)	
Team leader	58 (15%)			47 (16%)	
Case manager	46 (12%)			35 (12%)	
Other	76 (20%)			60 (21%)	

	Total Sample *N*=468			Practice Sample [b] *N*=293	
	n (%)	Missing *n* (%)	Missing *n* (adj[a])	*n (%)*	Missing *n* (%)
Professional Discipline		29 (7%)	4 (1%)		2 (1%)
Family support	57 (15%)			43 (15%)	
Psychology	55 (15%)			43 (15%)	
Social work	113 (30%)			86 (30%)	
Welfare	37 (10%)			24 (8%)	
Teaching	28 (7%)			21 (7%)	
Counselling	31 (8%)			28 (10%)	
Speech pathology	5 (1%)			5 (2%)	
Occupational therapy	7 (2%)			6 (2%)	
Nursing	13 (4%)			10 (3%)	
Other	32 (8%)			24 (8%)	
Services and Programs		9(2%)			6(2%)
Early intervention or preventative services	235 (63%)			176 (61%)	
Crisis intervention	173 (46%)			132 (46%)	
Parenting education	278 (75%)			220 (77%)	
Relationship support	169 (45%)			133 (46%)	
Family law services	21 (6%)			14 (5%)	
Group work	189 (51%)			141 (49%)	
Individual work	270 (72%)			205 (71%)	
In-home work	198 (53%)			154 (54%)	

	Total Sample *N*=468			Practice Sample [b] *N*=293	
	n (%)	Missing *n* (%)	Missing *n* (adj[a])	*n (%)*	Missing *n* (%)
Clinic work	88 (24%)			72 (25%)	
Telephone service delivery	93 (25%)			72 (25%)	
Brokerage and referral	152 (41%)			116 (40%)	
Other	61 (16%)			51 (18%)	
Organisation Service Model		8(2%)			5(2%)
Integrated service delivery	207 (55%)			157 (55%)	
Community development	85 (23%)			66 (23%)	
Adult focused care	11 (3%)			8 (3%)	
Family case management	158 (42%)			125 (43%)	
Long term care	43 (12%)			32 (11%)	
Intensive intervention	119 (32%)			94 (33%)	
In-home care	42 (11%)			33 (12%)	
Out of home care (e.g. foster and residential care)	76 (20%)			61 (21%)	
Early intervention or prevention	161 (43%)			124 (43%)	
Other	34 (9%)			28 (10%)	

Note. [a] Missing values adjusted to exclude participants who did not complete any questions in Section 1 (dropped out after screening)

[b] Practice Sample includes participants who answered questions about their practice with children at risk of or exposed to trauma (provided information about working with trauma).

Table 3. Theoretical orientation or perspective reported by respondents to the Practice Survey

Category	Frequency	Example response
Person-centred	50	Person centred
Attachment	47	A combination of current thinking and research involving psychodynamic, attachment and neuroscience theories and frameworks
Systemic	45	A systemic approach understanding the trauma in the context of intergenerational influence. Also from the NMT/attachment training
Narrative	44	Narrative, emotion focused, attachment, feminist object relations
Strengths-based	40	Child-centred, person-centred, narrative, strengths-based
Child-centred	33	Child centred practice
Family-centred	27	Family & systemic therapy and eclectic
Trauma-informed	24	Draw on systemic, trauma-informed and other related theories as needed
Eclectic	21	I have a diverse and eclectic theoretical approach including psychodynamic, play therapy, family therapy, systems theory, person/child centred, developmental and feminist approaches
Psychodynamic	16	Psychodynamic and person centred
Developmental	15	Attachment and developmental theories
Psychosocial	15	Psychosocial, relational, systemic
Solutions-focused	14	Narrative therapy, Brief solution focussed therapy
Systems	13	An integrated approach utilising systems theory, strengths based, narrative and person centred approaches
Relational	13	Child centred, systemic, narrative, psychodynamic, relational
Behavioural	11	Person centred and behavioural with a focus on actions and reactions
Cognitive Behaviour Therapy (CBT)	11	Cognitive-behaviour therapy
Neuroscience	9	Bruce Perry's neuroscience approach to trauma

Category	Frequency	Example response
Play Therapy	7	Play based therapy for children
Grief and Loss	6	Attachment, Family & Systems , Grief & Loss, Child Development & Trauma
Resilience	5	Client centred, trauma informed, strengths based, resilience-building
Acceptance and Commitment Therapy (ACT)	5	Eclectic, systems, attachment, relational, ACT, RFT, narrative, trauma sensitive
Feminism	5	Narrative, emotion focused, attachment, feminist object relations
Humanistic	4	An integrated model of humanistic and psychotherapeutic; Person-centred, Attachment Theory, Object Relations, Gestalt
Crisis Intervention	3	Therapeutic Crisis Intervention
Ecological	3	Systemic, strengths based, attachment theory, ecological, narrative, feminist ideology, psychosocial, person centred

Table 4. Frequency distributions of responses to questions relating to respondent confidence and experience

						Total
	Hardly Ever	Monthly	Weekly	Once a Day	More than Once a Day	
How frequently do you have contact with children who have experienced a potentially traumatic event?	19	46	105	36	85	291
	Not at all	A little	Moderately	Quite a bit	Extremely	
How confident are you in recognising the signs and symptoms of trauma?	1	12	55	150	73	291
To what extent is the assessment of trauma and its impact is a priority in everyday work?	7	22	57	100	103	289
How comfortable are you discussing difficult or frightening experiences with children and families?	3	25	54	125	81	288
How much experience do you have in treating children who have experienced trauma?	19	55	74	91	47	286
How confident are you in delivering therapies for trauma in your usual practice?	40	53	79	87	30	289

Table 5. The 49 categories used to describe the 989 strategies and techniques used in everyday practice to target outcomes in children exposed to abuse and neglect

Category	Frequency	Example response
Referral and linking with other services/support	133	Active working relationship with enhanced maternal child health nurses Help other people involved in the child's care/education to understand the effects of trauma on the child's development Make appropriate referrals to assist child therapeutically either in house or external services
Education of child, family, parents	113	Attending to any educational interventions that could be shared in a developmentally appropriate way e.g. What is physical abuse Educating the children's carers around trauma and how this impact on children, their behaviour and development
Safety/Routine Home Environment	99	Assist families to provide calm, safe, structure at home and look after stress of whole family. Establishing a safe and secure environment
Child centred work	88	Client centred - meeting client where they are at each day - allowing choice at every opportunity
Parenting support	87	Assisting parents in supporting their children who have experienced trauma Debrief and discuss strategies of responding to child's behaviour with foster parents
Art/Creative/Play Therapy	82	Creative arts in therapy- play, drama, art Sand tray work and symbol work to allow the child to express without necessarily talking
Family work (including parent-child relationship)	71	Assess families and children to gain a better understanding of the trauma experienced Encouraging enhancement of parent/carer/child relationships

Category	Frequency	Example response
Supporting and interacting with the client/building relationship/rapport	58	Be a consistent, caring and secure base for parents and children Engagement in dialogue/rapport building/structuring a safe place to reflect
Acknowledging and exploring feelings and abilities	42	Acknowledging skills/ abilities of family members Normalising the clients feelings and reactions
Teaching skills/strategies	38	Communication skills/strategies to use Preventive strategies to reduce stress and risk (like managing the environment , routine and structure and building rapport), co-regulation strategies and intervention strategies to help deescalate the child
Assessment	37	Assess families and children to get a better understanding of the trauma experience Identify that a child has had trauma
Supporting expression (verbal and non-verbal communication)	36	Be available to talk and support Communication with the child's family members Expression through non-verbal means Give them a space to express their feeling and emotions using a variety of tools
Addressing and understanding behavioural issues	30	Behaviour management strategies due to trauma Talking with the parents about understanding children's behavioural response
Relaxation strategies	29	Body awareness/mindfulness/breathing/ safe place (EMDR) Creating safety, support and self-care including relaxation and positive self-talk strategies to manage triggers and stress
Narrative Strategies	28	Narrative discussions through art Life story work
Specific interventions/therapies/theories	27	Therapeutic intervention as required Brain stem interventions-patterned repetitive activity

Category	Frequency	Example response
Working with schools	23	Build capacity of schools to support the behaviour of students who have experienced trauma Connecting them with the school guidance counsellor
Developmentally tailored care	22	Age/developmentally appropriate honesty and information Talk to caregivers about the impact of trauma on development
Specific strategies	22	Bear cards/strength cards Bioenergetics and encouraging exercises in kids
Open questions/Active Listening	21	Build trust and rapport by applying listening skills Open questions and listening with skills and heart
Group work	18	Conduct regular group work activities for children to help them understand their past Group meetings to discuss domestic violence and the effects on children
Other	14	Example not provided
Counselling	13	Counselling for individual students and groups of students Relationship building-co regulation of affect in counselling sessions
Strengths based work	13	Helping the client identify strengths on their part that have helped them survive or cope with the trauma Strengths based work that build up individuals strengths and uses these to assist them to move on
Individual work	13	Individual counselling Specific risk assessment, safety planning and casework with individual children in families

Category	Frequency	Example response
Reduce negative impacts	13	In collaboration with parents draft a Case Plan to address underlying problems within the home to minimise dangers/risk factors. Working with parental mental illness/ trauma to reduce impact on child
Support emotion regulation	12	Affect regulation training Support with emotional regulation
Trainings for practitioners	11	Commitment to ongoing training with a trauma-attachment focus for direct service delivery staff and for carers. Keeping up to date with trauma training and new programs that might be able to assist families.
Encouragement	10	Example not provided due to low proportion of responses
Advocacy	9	Example not provided due to low proportion of responses
Home supports	9	Example not provided due to low proportion of responses
Modelling behaviour/ Role modelling	9	Example not provided due to low proportion of responses
Self-awareness	8	Example not provided due to low proportion of responses
Assisting with resources	6	Example not provided due to low proportion of responses
Emotional	6	Example not provided due to low proportion of responses
Structure of session	6	Example not provided due to low proportion of responses
Building resilience	5	Example not provided due to low proportion of responses
Casework	5	Example not provided due to low proportion of responses
Relational activities	5	Example not provided due to low proportion of responses
Management/ review/ monitor	5	Example not provided due to low proportion of responses

Category	Frequency	Example response
Boundaries	4	Example not provided due to low proportion of responses
Empowerment	4	Example not provided due to low proportion of responses
Reflection	4	Example not provided due to low proportion of responses
Goal setting	4	Example not provided due to low proportion of responses
Allow self-determination/ choices	3	Example not provided due to low proportion of responses
Engagement	3	Example not provided due to low proportion of responses
Cognitive processes	3	Example not provided due to low proportion of responses
Visualisations	2	Example not provided due to low proportion of responses

Table 6. Respondent's reported awareness of evidence-based approaches to treat or prevent trauma in children exposed to trauma through abuse and neglect, as reported by more than one respondent

Reported evidence-based approaches (multiple respondents; n = 48 approaches)								
Approach	**Frequency**	**REA rating**	**Approach**	**Frequency**	**REA rating**	**Approach**	**Frequency**	**REA rating**
Neurosequential Model (Bruce Perry)	15	EA	Sanctuary Model	6	PA	Acceptance and Commitment Therapy	4	N/A
Trauma-focused CBT	14	WS	Narrative Therapy	5	N/A[3]	Psych Education/ Information	3	N/A
Play Therapy	12	N/A[1]	Tuning into Kids	5	N/A	Triple P	3	N/A
Circle of Security	12	N/A	Peek-a-Boo Club (Wendy Bunstan, RCH)	5	N/A	Life Story Work	3	N/A[5]
Dyadic Developmental Psychotherapy	10	N/A	Mindfulness	5	N/A	CARE	3	N/A
Australian Childhood Foundation (ACF)	10	N/A	Attachment, self-regulation & competency (ARC)	5	PA	Early Identification & Referral	3	N/A
Art Therapy	8	N/A[2]	Psychotherapy	4	N/A	Sandplay Therapy	3	N/A
Cognitive Behavioural Therapy (CBT)	8	PA	Counselling	4	N/A	PARKAS	3	N/A
Therapeutic Crisis Intervention (TCI)	7	N/A	Take Two - Berry Street	4	EA[4]	Music Therapy	3	N/A[6]
Parent-child interaction therapy (PCIT)	7	PA	Eye Movement Desensitisation Reprocessing (EMDR)	4	PA	Marte Meo	3	N/A

See all notes on the two next pages.

Reported evidence-based approaches (multiple respondents; n = 48 approaches)								
Approach	**Frequency**	**REA rating**	**Approach**	**Frequency**	**REA rating**	**Approach**	**Frequency**	**REA rating**
Angel Blankets	3	N/A	Headspace	2	N/A	Tree of Life - Dulwich Centre	2	N/A
Neurofeedback	2	EA	Emotion focused therapy	2	EA	TARGET (Julian Ford)	2	PA
PANOC	2	N/A	DV services	2	N/A	Reparative Parenting Program	2	N/A
Therapeutic Residential Care	2	PB	Dialectic Behavioural Therapy	2	N/A	Incredible Years	2	N/A
Motivational interviewing	2	N/A	Multi-Systemic Therapy (MST)	2	S	Evolve	2	N/A
Helping out families program	2	N/A	Van der Kolk	2	N/A	Animal Therapy	2	N/A[7]

Note: N/A means approaches not identified by the REA.

[1] Play Therapy was not classified as being identified in the REA as it was not known whether this program mirrored that of programs utilising play identified in the REA. “Play Therapy” identified in the REA received an EA rating.

[2] Art Therapy was not classified as being identified in the REA as it was not known whether this approach mirrored that of approaches utilising art identified in the REA. Note. “Chapman Art Therapy Treatment Intervention” identified in the REA received an EB rating. “Combined art therapy and cognitive behavioural therapy as a program also identified in the REA received an EA rating. “Group Art Therapy” received a PA rating in the REA. “Combined art therapy and cognitive behavioural therapy” as a program also identified in the REA received an EA rating.

[3]Narrative therapy described in this table was not classified as being identified in the REA, as narrative therapy as a standalone approach was not identified in the REA. “TF-CBT with the narrative component” was rated WS in the REA. “Grief and trauma intervention”, which comprised trauma narrative processing, was identified in the REA as EA. It should be noted that narrative exposure therapies were identified in the REA as effective approaches in war populations but these were excluded due to war populations being beyond the scope of this project. Standalone narrative therapy was not identified in the REA for populations of abuse and neglect.

[4] Take Two incorporates a range of specific interventions, as well as Neurosequential Model of Therapeutics as an overarching approach.

[5]Triple P was rated N/A as it was not known whether this program was referring to the Triple P - Enhanced Group Behavioural Family Intervention identified in the REA. Triple P - Enhanced Group Behavioural Family Intervention is an adaptation of Triple P, which is an adaptation specifically designed for parents to reduce the risks for child maltreatment. Enhanced Triple P received a PA rating in the REA.

[6]Life story work was kept independent of narrative therapy as it was not known whether components of life story work mirrored that of narrative therapy.

[7] Music therapy was not classified as being identified in the REA as it was not known whether this approach mirrored that of approaches utilising music identified in the REA. The one approach identified in the REA with a music component was “In patient Song Writing (distinct from music therapy), which received an EB rating in the REA”

[8]Animal Therapy was not classified as being identified in the REA as it was not known whether this approach mirrored that of approaches utilising animals identified in the REA.” Equine assisted therapy” was identified in the REA as EA.

Well Supported approaches that practitioners are aware of: n=1 (TF-CBT); Supported approaches that practitioners are aware of: n=1 (MST); Promising A approaches that practitioners are aware of: n=6 (CBT, PCIT, EMDR, TARGET, ARC, Sanctuary); Promising B approaches that practitioners are aware of: n=1 (Therapeutic Residential Care); Emerging A approaches that practitioners are aware of: n= 4 (Neurosequential Model, Take Two, Neurofeedback, Emotion focused therapy); Emerging B approaches that practitioners are aware of: n=0; No effect approaches that practitioners are aware of: n=0; Concerning Practice approaches that practitioners are aware of: n=0; N/A: n= 35; Total: 48 approaches.

Table 7. Respondent's reports of awareness of evidence-based approaches to treat or prevent trauma in children exposed to trauma through abuse and neglect, as reported by a single respondent

Reported evidence-based 'programs' (single respondents; n = 109 approaches)							
Approach	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**
123 magic behaviour management course	N/A	DHS	N/A	Drug and alcohol sessions for families - education & support	N/A	Health advise - cooperative food sources	N/A
Anything by Dan Siegal	N/A	Drama Therapy	N/A	Family focused therapy	N/A	Home visiting program	S
Attachment Therapies	N/A	Drug and alcohol sessions for families - education & support	N/A	Family intervention to assist natural families	N/A	Homebuilders child Protection Intervention Program	N/A
Banana splits	N/A						
Bereavement Counselling	N/A	DV programs for children who have experienced DV but at the time of entering into the program they are not in DV. (i.e., KIDS CAN Coffs Harbour)	N/A	Family Mediation Centres (POP Programmes)	N/A	Hornsby Child & Family Adolescent Mental Health	N/A
Berry Street (Take two)	EA			Family Pathways programmes	N/A	Horses Helping out Humans Program	N/A
Bravehearts	N/A			Family Play Therapy/ Filial Therapy	N/A	I'm currently do research on knowledge guided practice within out of home care, as there is none known in QLD	N/A
Bubs @ the Hub	N/A						
Calmer classrooms program (Melb)	N/A	Emotional Release through symbol work	N/A	FIST -Feeling Is Thinking	N/A		
CAMHS	N/A	Equine Assisted Therapy EAGALA	EA	Flexibly Sequential Play Therapy (FSPT) developed by Paris Goodyear-Brown	N/A	Individualised programs within the service I work	N/A
CASA	N/A	Experiential therapy	N/A				
Catholic Care	N/A	Expressive Therapy	N/A	Dyadic developmental psychotherapy – for disorganised attachment	N/A	Infant Mental Health programs	N/A
Circle programme OzChild Home Based Care	N/A					Instruction in Relaxation/ Anxiety management techniques for individual trauma triggers	N/A
Clayfield therapy	N/A	DHS	N/A	Family focused therapy	N/A		
Community support groups	N/A	Drama Therapy	N/A				

Total approaches: n=109. Well Supported: n=0, Supported: n=2 (Home Visiting Service, PUP), Promising A: n=0, Promising B: n=1 (Trauma Systems Therapy), Emerging A: n=2 (Berry Street, Equine Assisted Therapy), Emerging B: n=0, No effect: n=0, Concerning Practice: n=0. N/A: n=104; N/A means approaches not identified by the REA.

Table 7. Continued: Respondent's reports of awareness of evidence-based approaches to treat or prevent trauma in children exposed to trauma through abuse and neglect, as reported by a single respondent

Reported evidence-based 'programs' (single respondents; n = 109 approaches)							
Approach	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**
Integrative Treatment of Complex Trauma for Children - John Briere	N/A	Horses Helping out Humans Program	N/A	Long term psychodynamic treatments	N/A	Provide financial support/ debt advise	N/A
J Mitchell Case study in Attempted reform in out of home care: A Preliminary Examination of the Circle Therapeutic Foster Care Program, Victoria. Master thesis Monash University.	N/A	Long term psychodynamic treatments	N/A	Me and my Mum (for children from DV)	N/A	PTSD in young people post MVA's - Justin Kennardy at al research project	N/A
Jannawi Family Centre	N/A	Me and my Mum (for children from DV)	N/A	MEND domestic violence awareness program for perpetrators	N/A	Rage Program	N/A
Just For Kids	N/A	MEND domestic violence awareness program for perpetrators	N/A	Neurological Reparative Therapy (Dave Ziegler)	N/A	Resilience Framework	N/A
Jungle tracks - refuge children	N/A	Neurological Reparative Therapy (Dave Ziegler)	N/A	New Street & Rural New Street	N/A	Safe from the start	N/A
Kids Create Tomorrow (Bensoc)	N/A	New Street & Rural New Street	N/A	Pat Ogden body work	N/A	Seasons for growth program	N/A
Kinesiology	N/A	Non punitive - therapeutic based	N/A	Person Centred Psychotherapy	N/A	Seeing red program	N/A
Leapin Lizards (our organisation has recently offered this program)	N/A	North Carolina Family Assessment Scale	N/A	Pet Therapy	N/A	Sensory Attachment Intervention (Eadaoin Bhreathnach)	N/A
Lifeworks	N/A	PACT	N/A	Pre-natal and post natal support for young mothers	N/A	Sensory integration theory	N/A
Light house Foundation	N/A	Paradise kids	N/A	Breakfast clubs in schools	N/A	Sensory Modulation (Tina Champagne)	N/A
		Parents as Teachers Program	N/A	Give mental health advise	N/A	Sensory programmes	N/A
		Parents Under Pressure (PUP)	S	Provide a sense of safety & hope	N/A	Sexualised Behaviour Strategies	N/A
						SFCR	N/A

Table 7 Continued: Respondent's reports of awareness of evidence-based approaches to treat or prevent trauma in children exposed to trauma through abuse and neglect, as reported by a single respondent

Reported evidence-based 'programs' (single respondents; n = 109 approaches)							
Approach	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**
Shaping Brains	N/A	Supported play groups	N/A	Three pillars of trauma informed care (Bath)	N/A	Wait Watch and Wonder	N/A
Somatic Experiencing	N/A	Systemic Work with child safety, education, Govt. & non-Govt. services	N/A	Transpersonal Art Therapy	N/A	Working systemically with stakeholders	N/A
Special camps	N/A	Tavistock clinic	N/A	Trauma and recovery	N/A	Wrapped in Angels	N/A
St George/ Sutherland Building Resilience in Children Project	N/A	The Bridge Anger Management	N/A	Trauma informed	N/A	www.childtrauma.org	N/A
Story telling	N/A	Therapeutic Daycare/Preschools	N/A	Trauma informed counselling	N/A	Yarning up on trauma	N/A
Strength Based Practice	N/A	Theraplay TTI	N/A	Trauma systems therapy	PB	Yoga based programs (Bessel Van Der Kolk)	N/A
Supported counselling	N/A			Trusting environment	N/A	Using a Neurobiology lens to work with Trauma	N/A
				Using a Neurobiology lens to work with Trauma	N/A		

Table 8. Frequency of approaches currently used to treat or prevent trauma in children exposed to abuse and neglect reported by more than one respondent (n = 15)

Approach	Frequency	REA ranking
Play therapy	9	N/A*
Circle of Security	8	N/A
Art therapy	5	N/A*
Parents Under Pressure (PUP)	3	Supported
Angel Blankets	3	N/A
Mindfulness	3	N/A
Neurosequential Model of Therapeutics (NMT)	3	Emerging A
Cognitive Behavioural Therapy (CBT)	2	Promising A
Trauma Focused CBT (TF-CBT)	2	Well Supported
Counselling	2	N/A
Therapeutic Crisis Intervention	2	N/A
Parents as Teachers	2	N/A
Reparative Parenting Program	2	N/A
Sanctuary Model	2	Promising A
Seasons for Growth	2	N/A

*Note. It is unknown whether the Art therapy and Play therapy approaches currently being utilised by respondents mirrored the Play therapy and Art therapy programs identified in the REA. Thus, N/A was applied to Play therapy and Art therapy in this table. Readers are advised to refer to the original papers if they wish to compare Play therapy and Art therapy with those identified in the REA. N/A means approaches not identified by the REA.

Table 9. Descriptions of approaches currently used to treat or prevent trauma, as reported by a single respondent

Reported evidence-based approach (single respondent, n = 64)							
Approach	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**
123 Magic	N/A	Family Liaison Workers	N/A	On Fire	N/A	Strengthening Families	N/A
Babies in Refuge	N/A	Family Mediation	N/A	Parenting Circles	N/A	Support to Foster Carers	N/A
Brighter Futures	PB	FIST - Feeling IS Thinking	N/A	Parenting Workshop	N/A	Supported Playgroup	N/A
Calmer Classrooms	N/A	HCSSS	N/A	Parents Early Education Program (PEEP)	N/A	Therapeutic Residential Care	PB
CAMHS	N/A	Home Visiting Program	S	PARKAS	N/A	Touching Rules and Protective Behaviours Programs	N/A
Child & Family program	N/A	Impact of Trauma	N/A	PCIT	PA	Training Staff	N/A
COMPI	N/A	Infant Massage Instruction	N/A	Photo Elicitation	N/A	Transforming Care Training	N/A
C-Star	N/A	Journey of a Lifetime	N/A	POP Programme	N/A	Trauma and the Brain	N/A
Dan Hughes	N/A	Just For Kids	N/A	Post Natal Depression Group Program	N/A	Trauma Counselling	N/A
Dan Siegel's Attachment Practices	N/A	Liana Lowenstein's Resource for bereaved children	N/A	Koping (KAP)	EB	Trauma in the Classroom	N/A
Emotion Coaching	N/A	Life Story Work	N/A	Referral	N/A	Triple P	N/A
Emotion Regulation	N/A	Marte Meo	N/A	Sandplay	N/A	Triple R	N/A
Expressive Therapy & Sandplay	N/A	Mental Health Nurse	N/A	Solution Focused Brief Intervention	N/A		
Family Counselling	N/A	Motivational interviewing	N/A	StarGazers	N/A		

See Notes on the next page.

Approaches that were described (but not specifically named)	REA rating
Ensuring all stakeholders are well informed in trauma, attachment and neurobiology of trauma, create a stable placement to ensure safety, work closely with natural families and young person to create hope. A combination of techniques to support a child.	N/A
The benefit of quality early years education for children at risk of abuse and neglect.	N/A
We provide care to young people who have experienced abuse or neglect - which could be referred to as a traumatic experience. Research tells us that young people do well when they are able to trust the adults around them. We build an environment of consistent adults to build trust (key person) provide a nurturing environment by putting in clear boundaries, advocating for the young person's needs and by doing life story work with them to establish a bonding relationship which they can look back on when they are adults.	N/A
We are developing our own resource to use with aboriginal women to explore the effects of violence on children. The resource has been developed by strong women in the communities we work.	N/A
Focus is on building a healing relationship.	N/A
Integrative treatment of complex trauma for children.	N/A
It is more of an intervention base, in using care teams to develop long term plans for particular children and families.	N/A
Plan to engage with Creative Interventions with Traumatized Children + Breaking the Silence (Cathy Malchiodi)	N/A
Secure attachment and support for emotional co-regulation.	N/A
Self-regulating activity, learning how to manage situations that cause anxiety.	N/A

Well Supported: n=0; Supported: n=1 (Home Visiting Service); Promising A: n=1(PCIT); Promising B: n=2 (Brighter futures, Therapeutic Residential Care); Emerging A: n=0; Emerging B: n=1 (KAP); No effect: n=0; Concerning practice: n=0; N/A means approaches not identified by the REA.

[1] Nurse Home Visiting Service was rated as Supported in the REA and there were other approaches that described home visiting services and programs. As we could not be sure “Home Visiting Program” described here matched any of those described in the REA, the Home Visiting Program approach was given an N/A.

Appendix 4: Interview guide for organisational leader and senior manager consultations

[Ask bolded questions and use unbolded text as further prompts if required. Ask for more information or clarification if required]

General Service delivery questions:

What is your position and role within the organisation?

Please describe your organisation in terms of who you aim to assist and what you aim to achieve.

Client types/target population (who, where, ages, sub-groups):

Aims/outcomes:

Staff training/disciplines:

Government/NGO:

Theoretical or philosophical orientation:

Please describe your organisation in terms of how you typically work with clients.

Service model/Modes of service delivery (community-based, home-based, individual, family, group, child, parent, group, long or short-term, casework, case management) :

What types of services or programs are provided by the organisation?

- Early intervention or preventative services
- Crisis intervention
- Parenting education
- Relationship support
- Family law services
- Group work
- Individual work
- In home work
- In clinic work
- Telephone service delivery
- Other:_____

Names of specific programs delivered or therapeutic approaches used:

Decisions about practices to use:

This next set of questions asks about your organisation' approaches to making decisions about what practices or programs to use.

Who makes decisions about what training or programs are adopted in your organisation?

How do you (or senior management) make decisions about training for staff or practices and programs to use within your service?

Look at evidence-based practices?

Opportunities that arise?

Current trends?

What sorts of things influence your decisions about what programs or practices to adopt at your agency?

Practical drivers for the uptake of EBP (e.g., availability, time, cost to purchase, train or deliver, relevance to clients, appropriateness to aims/outcomes of service, support available from developers, delivery setting/mode, complexity, availability of manual/support materials, training availability/time, dosage requirements, data collection requirements, staff availability, languages).

Obstacles to the uptake of EBP (as above).

How relevant is the evidence-base behind a program, to the decisions made by your organisation to adopt a program or practice?

What (if any) supports does your organisation provide to assist with efforts to implement EBPs?

- ☐ Agency sponsored EBP trainings or in-services
- ☐ Conferences, workshops, or seminars focusing on EBP
- ☐ Guest speakers presenting about EBP
- ☐ EBP specific supervision and/or general guidance from administrators
- ☐ Continuing education and/or grand rounds focused on EBP
- ☐ Internal research and/or evaluation which has provided data regarding EBP
- ☐ EBP training materials or journals
- ☐ Time off or funding for individual training/education in EBP
- ☐ Financial incentives to use EBP[2]

Trauma-specific questions:

Now I want to find out about what your organisation does specifically in the area of trauma. So here I'm talking about child and family exposure to traumatic experiences associated with child abuse (physical, emotional and sexual), domestic violence, child neglect, parental substance abuse and parental mental illness.

Does this service/organisation work with children or families who have been exposed to or are at risk of exposure to these types of trauma?

What is your organisation's understanding of what Trauma is? It's definition? What can it include or exclude?

Do you use diagnostic frameworks for identifying trauma? Please describe.

What, if any, community resources are you aware of for children and families who have been exposed to trauma?

Would you say that the approach or strategies of your organisation to trauma for children, families and staff was planned and well implemented or more ad hoc and used intermittently?

What makes you say that?

Policies and procedures in place? E.g., routinely ask about previous trauma?

Clinical practice manuals?

Screening for trauma as routine in client assessment?

Staff training maintained?

Staff supervision/coaching maintained?

In general, what types of therapeutic approaches or models of care does your organisation use when working with children and families exposed to trauma or at risk of exposure to trauma?

What are the key components of the programs, practices or approaches used? Can you describe what workers do with clients?

Cognitive-behavioural techniques?

Behavioural therapy?

Interpersonal therapies?

Parenting programs or interventions?

Parent-child relationship interventions?

Mindfulness techniques?

Play or art based therapies?

What services, practices or programs do you provide for children/families that have been exposed to or are at risk of trauma?

For each program/practice identified, ask the following:

For Program 1: (write name or brief description, including whether established program/practice or created in-house)

Can you please describe the practice or program's content?

Describe the model/theoretical approach that the practice or program is based on.

Describe the key components, techniques or strategies that you use in this practice or program?

Have you adapted the practice or program from somewhere else?

How have you adapted it?

Why have you made these changes?

How are you ensuring fidelity to critical components of original program/practice?

How are you ensuring desired outcomes of original program still met?

Have staff ever participated in training for this practice or program?

Why are you using this practice or program within your service?

What setting is this practice or program provided in?

- ☐ Home
- ☐ Clinic
- ☐ Playgroup
- ☐ Classroom
- ☐ Metropolitan
- ☐ Rural
- ☐ Remote
- ☐ Other: _____

How is this practice or program delivered to families?

- ☐ Individual
- ☐ Group
- ☐ Telephone
- ☐ Family
- ☐ Short-term
- ☐ Long-term
- ☐ Single session

Frequency of sessions?

Duration of sessions?

Please describe the target groups of families you deliver this practice or program to.

- ☐ Children
- ☐ Adolescent
- ☐ Parent
- ☐ Stepfamilies
- ☐ Single parents
- ☐ Grandparents
- ☐ Disabilities/special needs - child/adolescent
- ☐ Disabilities/special needs - parent
- ☐ Teenage parents
- ☐ Child abuse and neglect (including physical, sexual and emotional abuse)
- ☐ Substance dependence and abuse
- ☐ Health/mental health issues
- ☐ Family/domestic violence issues
- ☐ Communication difficulties
- ☐ Relationship issues
- ☐ Child behaviour difficulties
- ☐ Other: _____

What are the intended outcomes of the practice or program?

For Child

- ☐ Physical health & development
- ☐ Psych/emotional wellbeing (int or ext)
- ☐ Cognition
- ☐ School & Educational
- ☐ Social

For parent or family

- ☐ Relationships & social functioning
- ☐ Service use
- ☐ Environmental risk
- ☐ Other:

Are you evaluating the effectiveness of this practice or program?

☐ Yes No ☐

How are you evaluating this program?

Publicly available? Where?

How is the program working? What sorts of outcomes are you seeing from it?

What evidence do you have of this?

[repeat set of questions for each program they identified.]

Thanks for your time. Any questions?

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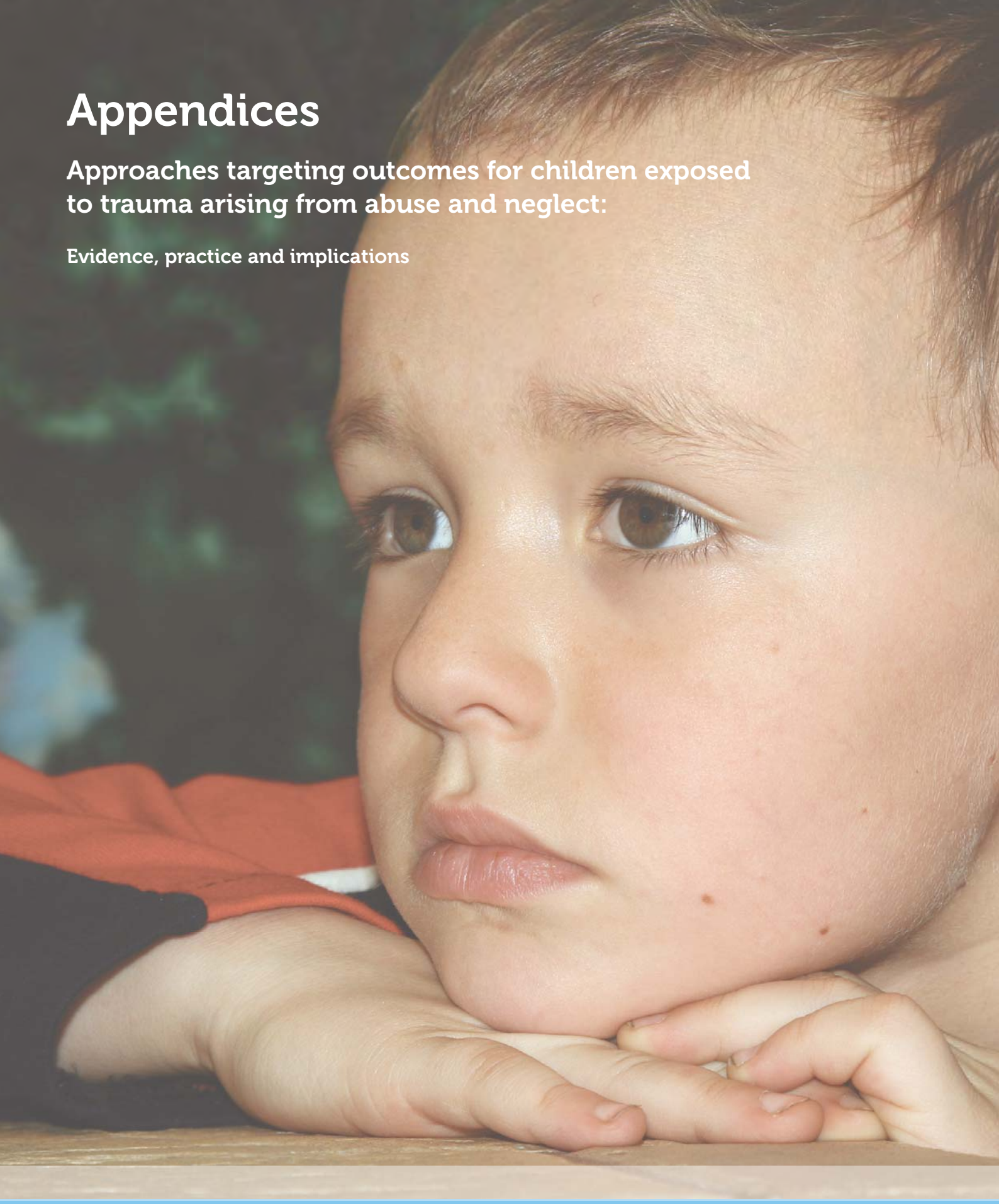
Appendices

Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect:

Evidence, practice and implications



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This document is the book of appendices for the final report for the project titled, *Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice, and implications*. This report and appendices were written as a collaborative project by the Australian Centre for Posttraumatic Mental Health and the Parenting Research Centre with funding from the Australian Government, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA, now Department of Social Services).

The Australian Centre for Posttraumatic Mental Health Inc. (ACPMH) is a not-for-profit organisation whose mission is to build and support the capability of individuals, organisations and the community to understand, prevent, reduce and recover from the adverse mental health effects of trauma. ACPMH aims to achieve its mission through specialised research, education and training, and the provision of policy and service improvement advice.

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Appendix 1: Glossary of terms

As the concepts and terms used in this report can be interpreted differently across the child and family services sector, definitions of terms adopted for this project and referred to in this report are presented below. The terms are categorised by theme and presented alphabetically under each theme.

Theme or term	Definition
Abuse and neglect terms	
Child abuse	The maltreatment of a child spanning four broad categories of neglect, emotional abuse, sexual abuse, and physical abuse[1].
Child maltreatment (collectively referred to as child abuse and neglect)	Any non-accidental behaviour by parents, caregivers, other adults or older adolescents that is outside the norms of conduct and entails a substantial risk of causing physical or emotional harm to a child or young person. Such behaviours may be intentional or unintentional and can include acts of omission (i.e., neglect) and commission (i.e., abuse). Commonly divided into four subtypes: ▪ physical abuse ▪ sexual abuse ▪ neglect ▪ emotional maltreatment (including the witnessing of family and domestic violence)[2].
Child neglect	Occurs when a child's basic needs, such as their developmental, emotional and physical wellbeing and safety, have not been met. Chronic neglect is when this occurs in an entrenched and multi-level pattern of experience for the child and family[3].
Domestic and family violence	Domestic violence occurs when one partner in a relationship attempts by physical or psychological means to dominate and control the other. It is generally understood as gendered violence, and is an abuse of power within a relationship (heterosexual and homosexual) or after separation. In the large majority of cases the offender is male and the victim female. Children and young people are profoundly affected by domestic violence, both as witnesses and as victims. Issues of power and control are central to the definition[4]. Family violence is often used in conjunction with domestic violence and is a term is preferred by some communities (e.g., indigenous), where incidents of violence are not always about intimate partner abuse. 'Family' covers a diverse range of ties of mutual obligation and support, and perpetrators and victims of family violence can include, for example, aunts, uncles, cousins and children of previous relationships[4].

Theme or term	Definition
Mental health and trauma terms	
Acute trauma exposure (also known as single event or Type I trauma)	Exposure to a traumatic event that occurs at a particular time and place and is usually short-lived. Acute traumatic events include natural disasters, terrorist attacks, serious accidents, single episodes of physical or sexual assault, gang-related violence in the community, school shootings or sudden or violent loss of a loved one[5].
Chronic trauma exposure	Exposure to trauma which occurs repeatedly over long periods of time. These experiences can result in a range of responses, including intense feelings of fear, loss of trust in others, decreased sense of personal safety, guilt, and shame. They can also adversely impact the social, emotional and cognitive development of the child. Chronic traumatic situations include some forms of physical abuse, long-standing sexual abuse, domestic violence, war and other forms of political violence[5].
Mental illness/disorder	As defined by the Department of Health and Aging, a clinically recognisable set of symptoms (relating to mood, thought, or cognition or behaviour) that is associated with distress and interference with functions (that is, impairments leading to activity limitations or participation restrictions)[6]. Mental illnesses include: dementia, delirium and other organic mental disorders; schizophrenia, bipolar disorder and other related psychotic disorders that are characterised by hallucinations, delusions, thought disorders, behaviour disturbances; mood disorders such as depression; anxiety disorders; substance use disorders; and personality disorders that are characterised by enduring patterns of behaviour that are inflexible and maladaptive and cause distress or interference with functions[7].
Posttraumatic stress disorder (PTSD)	A set of reactions that develop in people who have experienced or witnessed an event which threatened their life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. Symptoms that meet DSM IV criteria around three clusters of symptoms including re-living the traumatic event, being overly alert or wound up, avoiding reminders of the event and feeling emotionally numb[7].
Repeated event trauma	The simultaneous, multiple or sequential occurrence of traumatic events. In this project, repeated traumatic events often occur within the context of child abuse and neglect[5].

Theme or term	Definition
Mental health and trauma terms cont.	
Single event trauma (also known as acute trauma or Type I trauma)	Exposure to a traumatic event that occurs at a particular time and place and is usually short-lived. Kinds of acute traumatic events include natural disasters, terrorist attacks, serious accidents, single episodes of physical or sexual assault, gang-related violence in the community, school shootings or sudden or violent loss of a loved one[5].
Substance abuse	A maladaptive pattern of substance use leading to clinically significant impairment or distress manifested by recurrent substance use resulting in a failure to fulfil major roles at work, school, or home. Substance abuse also refers to recurrent substance use in situations where it is physically hazardous and/or related to legal problems and/or continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance[8].
Traumatic event	An event which threatens a person's life or safety, or that of others around them. There is a range of events that fall in this category such as motor vehicle accidents, war and natural disasters[9]. This project focused on children's' exposure to repeated traumatic events, where the traumatic event was defined as the experience of child abuse, child sexual abuse, child neglect, domestic/family violence, parental substance abuse and/or parental mental illness. It is recognised that these are distinct from single trauma events in that exposure to these events is often repeated and chronic. It is also recognised that these events are not always experienced as 'traumatic', and as such can be recognised as 'potentially traumatic events'.
Trauma-Informed Care (TIC)	A framework grounded in an understanding and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. The awareness of the impact of trauma and recognition of its potential longer term interferences to one's sense of control, safety, ability to self-regulate, sense of self, self-efficacy and interpersonal relationships[10]. The TIC framework in this project is used in reference to chronic or repeated experiences of traumatic events.
Trauma reactions	Physical and psychological reactions that develop following the experience or witnessing of an event which threatened a person's life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. In children, trauma reactions can present in repetitive play, frightening dreams, specific trauma enactments, regressed behaviours, lowered school performance, social, emotional and behavioural difficulties, and physical ailments[11].

Theme or term	Definition
Mental health and trauma terms cont.	
Trauma reactions	Physical and psychological reactions that develop following the experience or witnessing of an event which threatened a person's life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror. In children, trauma reactions can present in repetitive play, frightening dreams, specific trauma enactments, regressed behaviours, lowered school performance, social, emotional and behavioural difficulties, and physical ailments[11].
Type I trauma	Exposure to a traumatic event that occurs at a particular time and place and is usually short-lived. Acute traumatic events include natural disasters, terrorist attacks, serious accidents, single episodes of physical or sexual assault, gang-related violence in the community, school shootings or sudden or violent loss of a loved one[5].
Type II trauma	Experience of events that are of an interpersonal, prolonged and/or repeated nature (e.g. child abuse, neglect, witnessing violence). Effects of Type II traumatic events can be pervasive and long-lasting. Type II trauma that occurs in childhood, and that involves direct harm and/or neglect by caregivers, often occurs at developmentally vulnerable times for the child, and can give rise to complex psychological, social and behavioural problems in adulthood. Type II trauma is often contrasted with Type I trauma, which refers to a single occurrences of a traumatic event[5].
Child and Family Support Sector-related terms	
Approach	A set of principles aimed at guiding overall service delivery or individual practice[12]. In this project, we have used the term approach to encompass sets of principles, frameworks, models, interventions, therapies, practices, systems of care, programs, as well as services.
Caregiver	Biological relative or non-biological person performing the roles and responsibilities of parenting[13].
Child	A person up to the age or equal to 18 years[14].

Theme or term	Definition
Child and Family Support Sector-related terms cont.	
Out of home care (OOHC)	The care of children and young people up to 18 years who are unable to live with their families (often due to child abuse and neglect). It involves the placement of a child or young person with alternate caregivers on a short or long-term basis. There are four main types of out-of-home care[15]: ▪ *foster care:* where care is provided in the private home of a substitute family who receives payment that is intended to cover the child's living expenses ▪ *kinship care:* where the caregiver is a family member or a person with a pre-existing relationship with the child ▪ *residential care:* where placement is in a residential building whose purpose is to provide placement for children and where there is paid staff. This includes facilities where there are rostered staff, a live-in carer and where staff are off-site (e.g., a lead tenant or supported residence arrangement). ▪ *permanent care*: a child is placed into the permanent care of an existing foster carer or kinship carer through the Family Court
Practices	Approaches, skills, strategies and/or techniques targeting prevention or treatment aimed at improving child/family/parent outcomes[16,17].
Program	A well-defined curriculum, set of services or interventions designed for the needs of a specific group or population[16]. Programs are often discrete, manualised curriculums or series of actions/tasks/behaviours designed for a particular population to meet particular outcomes, which are usually measurable[18]. Within a program children, caregivers, guardians (i.e., group or population) receive direct targeted education, training or support or intervention to increase their knowledge, capacity, skills to improve child and family outcomes[9]. For the purpose of this project, we have grouped therapeutic interventions with programs.
Service Model	A suite of approaches, programs or practices delivered to a client group by an agency, organisation or service system. Services may be delivered at home (e.g., home visiting service) or within another setting, however home visiting programs are not always 'services' or 'service models'; for instance, if they are delivered as a structured curriculum (program).
System of care	A coordinated network of community-based services and supports. It is an approach incorporating a philosophy or guiding framework that promotes program delivery in ways that prioritise the needs of the children, youth and families to function better in various contexts (i.e., school, home, child protection, peers)[19].
Therapeutic/treatment interventions	A particular technique or set of interventions usually delivered by a single practitioner aimed at improving a set of well-defined outcomes (e.g., reduction in posttraumatic symptoms) for a child or family [20]. Can be manualised and outcomes for client are usually measureable.

Theme or term	Definition
Scientific or evidence-related terms	
Effective	Approaches for which there is measureable and statistically significant improvement in child, parent or family outcomes as a result of the approach (or combination of approaches) compared to a no-treatment or other-treatment comparison group, that is demonstrated in a randomised controlled trial (RCT) with at least 6-month follow-up assessment.
Evidence	Forms of knowledge relevant to practice which may include research evidence, service monitoring and other statistical data; expert knowledge; stakeholder consultations; and program and service cost-effectiveness information.
Evidence-based practices	Approaches to prevention or treatment that are validated by some form of documented scientific evidence (including but not limited to controlled clinical studies). Ideally, evidence-based practices should be responsive to families' cultural backgrounds, community values, and individual preferences[21].
Evidence-based programs	A defined curriculum or set of practices that, when implemented with fidelity as a whole, has been validated by some form of scientific evidence. Ideally, evidence-based programs should be responsive to families' cultural backgrounds, community values, and individual preferences[21].
Evidence-informed practices	Refers to programs and practices that use current best evidence available (may not be empirical research findings) combined with the knowledge and experience of practitioners and the views of service users[21].
Outcome	A measureable change or benefit. The target at which change is intended. An outcome is a specific benefit that occurs to participants of a program. It is generally phrased in terms of the changes in knowledge, skills, attitudes, behaviour, condition or status that are expected to occur in the participants as a result of implementing the program[22].
Randomised controlled trial (RCT)	A research protocol in which the study participants, after assessment for eligibility and recruitment, are randomly allocated to receive the intervention or an alternative treatment [23] (often a no-treatment control condition, for example, wait list or treatment as usual) before the study begins.
Research informed practices or programs	Practices or programs which use forms of research (as opposed to 'direct evidence' per se) to guide them. For example, research that investigates risk and protective factors to identify those factors that could be targeted by an intervention.

Appendix 2: Summaries of Programs, Service Models and Systems of Care identified in the Rapid Evidence Assessment

Table 1a. Summary of the studies evaluating the Well Supported program (TF-CBT)

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
Puccia, Redding, Brown, Gwynne, Hirsh, Hoffmann, & Morrison (2012) [24]	Sig. improvements were made with respect to re-experiencing & avoidance as well, with 14 clients in the normal range for re-experiencing & 20 clients in the normal range for avoidance. Less sig. improvements are made for arousal, with 19 clinical at baseline & eight normal at completion.	Psycho-education, parenting skills, cognitive coping & processing, trauma narrative, conjoint child-parent sessions, safety skills & a safety plan.	Intervention	Clinic	Trained Clinician	Individual caregiver; Individual child; Individual caregiver-child dyads	1 x 8 sessions	-
Grasso, Joselow, Marquez, & Webb (2011) [25]	Child had higher PTSD symptom severity relative to sample, & had greater reduction of symptoms at post-treatment & follow up (non-sig. test). Child had lower internalizing (non-sig.) & externalising (sig.) behaviour at pre-treatment, scores were maintained at post-treatment & follow up, whereas comparison group behaviour not maintained at follow up.	Psycho-education & development of a trauma narrative (TN) & cognitive/ emotional processing of event based on Emotional Processing Theory (EPT). TN development stimulates child's fear network, activates trauma memory & facilitates learned inhibition of fear response & cognitive re-structuring.	Intervention	Home	Psychologist	Individual caregiver-child dyads	1 x 12-16wks	-
Cohen, Deblinger, Mannarino, & Steer (2004) [26]	TF-CBT was more effective than CCT on all measures of MH & child/ parent behaviour at post-treatment (incl. Child: PTSD subscales, behaviour, depression, attributes/ perceptions, interpersonal trust, shame. Caregiver: parenting practices, support & emotional reactions.	TF-CBT: is informed by effective treatments for adult PTSD & non-PTSD child anxiety disorders, plus cognitive & learning theories about dev. of PTSD in children. CCT: Establishes a trusting r/s which is self-affirming, empowering & validating for parent & child. Aimed at restoring trust within dyad following child sexual abuse.	Intervention	Community	Psychologist; Social worker; Counsellor	Individual caregiver-child dyads	1 x 12wks mean:10/11 Individual sessions (x9) & dyad sessions (x3).	RCT included dyads who attended a minimum of 3 weeks
Deblinger, Mannarino, Cohen, & Steer (2006) [27]	Greater reduction of PTSD symptoms & shame in children & reduced parental distress in TF-CBT compared to CCT. Multiple traumas (90% of sample), & child depression positively related to total PTSD symptoms at post-intervention in CCT group (not TF-CBT).	TF-CBT is a structured treatment approach, education & coping skills to children & parents process traumatic experiences in individual & combined sessions. CCT is a supportive, client centred approach that establishes trusting & empowering therapeutic r/s. CBT & Client-centred/ strengths based.	Intervention	Other	Psychologist	Individual caregiver-child dyads	1 x 12 sessions, once a week.	Study included participants who only attended 3 out of 12 sessions.
Cohen, Mannarino, & Knudsen	Intent to treat: TF-CBT had sig. greater treatment outcomes than NST for all MH domains (Depression, anxiety, sexual prob.) &	TF-CBT components specifically target conditioned fear responses & cognitive errors which contribute to symptom	Intervention	Clinic	Psychologist	Individual caregiver-child dyads	1 x 12wks.	-

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
(2005) [28]	behaviour (Internal & social, but not externalising). Treatment completers: TF-CBT had sig. greater improvement on all MH domains at 6-mths, & PTSD & Dissociation at 12-mths. Behaviour approached sig. (p=0.6) at both 6/12mth follow up.	development & maintenance in depression & anxiety. NST is a prototypical supportive, empowerment therapy.						
Deblinger, Mannarino, Cohen, Runyon, & Steer (2011) [29]	N.S. differences: (Child: sexual behaviours, depression, shame & ability to identify abusive situations; Parent: Depression); 1. Sig. less Child fear & general anxiety in 8 Yes TN compared to 8 No TN. 2. Sig. less child externalising behaviours in 16 No TN (possibly due to more parenting focus) than 8/16 Yes TN. 3. Sig. reduced PTSD (one symptom) in 16 sessions compared to 8 session groups. 4. Sig. parent practices in 16 No TN compared to 8/16 Yes TN. Sig parenting emotional reaction (to abuse) in 8 Yes TN than 8 No TN.	Psycho-education & parenting, relaxation, affect modulation, cognitive coping, in vivo exposure, conjoint parent child sessions, enhancing safety & future development, & trauma narrative (Yes TN OR No TN).	Both	Clinic	Psychologist; Social worker; Counsellor	Individual caregiver-child dyads	90 minutes of TF-CBT with or without (Yes/No TN) x 8 or 16weeks.	
Cohen, Mannarino, & Lyengar (2011) [30]	TF-CBT was sig. more effective than CCT on all measures of Child MH (total PTSD, PTSD reaction, anxiety), child behaviours & TF-CBT had sig. less reports of adverse events. N.S. for child cognition (intelligence) & depression.	TF-CBT: 1. Safety component, 2. TN not past trauma, rather sharing child's IPV experiences, mother's IPV awareness & maladaptive cognitions. 3. Not child's mastery of past trauma reminders, rather optimize the child's ability to discriminate between real danger & generalized fears.	Both	Community	Social worker	Individual caregiver-child dyads	45min session for both child & parent TF-CBT or TAU (CCT) x 8wks.	-
Weiner, Schneider, & Lyon (2009) [31]	African American youth & White youth experienced sig. reductions in “Traumatic Stress Symptoms” & “Behavioural/Emotional Needs” & sig. increase in “Strengths.” White youth experienced sig. reductions in risk behaviours & problems with functioning.	Individual sessions with caregiver (psycho-educational focused on parenting skills) & individual sessions with the child (focused on relaxation, affect modulation, cognitions).	Intervention	Clinic	Trained clinician	Individual caregiver, Individual child	1 x 12-20wks.	-

Note: The TF-CBT program is categorised by author in this table. TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; PTSD = Post-Traumatic Stress Disorder: RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings.

Table 1b. Summary of the Well Supported program (TF-CBT)

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To alleviate symptoms of posttraumatic stress as a result of witnessing domestic violence. Trauma-focused CBT used as part of overarching model of care in this Children's Initiative	Not specified	Puccia, Redding, Brown, Gwynne, Hirsh, Hoffmann, & Morrison (2012) [24]	USA	Family violence	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=22	No comparison group	a. Yes b. No c. N/A d. N/A
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To reduce symptoms related to trauma.	Not specified	Grasso, Joselow, Marquez, & Webb (2011) [25]	USA	Family violence	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: 6/9/12mths	n=1	n=65	a. Yes b. No c. N/A d. N/A
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To reduce posttraumatic stress & related emotional/ behavioural problems (including depression, behaviour problems, abuse-specific distress, shame & dysfunction abuse attributions).	8 - 14	Cohen, Deblinger, Mannarino, & Steer (2004) [26]	USA	Child abuse; Child sexual abuse; Family violence; Other	Other	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: Yes Control: Child-Centred Therapy (CCT) for PTSD Follow up: None	n=115	n=91	a. Yes. TF-CBT is sig. more effective than CCT to reduce child mental health problems (PTSD, shame), normal child development & relationship with significant others (parent mental health, trust). b. No c. N/A d. N/A
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To reduce symptoms of posttraumatic stress after sexual abuse & other related emotional/ behavioural problems	8 - 14	Deblinger, Mannarino, Cohen, & Steer (2006) [27]	USA	Child abuse; Child sexual abuse; Family violence, Other	Other	Child physical; Psychological/ emotional or behavioural symptoms; Relationships & family or social	RCT: Yes Control: non-directive supportive therapy (NST) and CCT	Combined sample n=183 (child) M/F= not specified	See total in previous cell	a. Yes b. No (yet possible concern re: possible faster pace/ structure of TF-CBT). c. Yes d. 6/12mths

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	(including depression, behaviour problems, abuse-specific distress, shame & dysfunction abuse attributions).						functioning	Follow up: 6/12mths			
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To decrease trauma avoidance, hyper-arousal & maladaptive cognitions in children exposed to Interpersonal violence.	8 - 15	Cohen, Mannarino, & Knudsen (2005) [28]	USA	Child abuse; Child sexual abuse	Other	Child physical; Psychological/ emotional or behavioural symptoms	RCT: Yes Control: NST for PRSD following sexual abuse Follow up: 6/12mths	Combined sample n=82 F=56; M=26 Means (NST= 10.8; TF-CBT=11.4)	See total in previous cell	a. Yes b. No c. Yes maintained d. 6/12mths
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To treat PTSD in sexually abused children. Aim to investigate efficacy of how much general (CBT) & exposure treatment (TN) is optimal for children w/ PTSD.	4 - 11	Deblinger, Mannarino, Cohen, Runyon, & Steer (2011) [29]	USA	Child abuse; Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: Yes Control groups: (8 No Trauma Narrative (TN); 8 Yes TN; 16 No TN; 16 Yes TN) Follow up: None	Combined sample n=210 (n=52-54 per group). F=128; M=82 mean: 7.7	See totals in previous cell	a. Yes (8 Yes TN TF-CBT most efficacious for parent & child). Non-sig. for risk of abuse. b. No c. N/A d. N/A Duration: 8 or 16wks.
Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT)	To decrease trauma avoidance, hyper-arousal, & maladaptive cognitions in children exposed to Interpersonal violence.	7 - 14	Cohen, Mannarino, & Lyengar (2011) [30]	USA	Child abuse; Child sexual abuse; Family violence; Parental substance use; Parental mental illness	Ethnicity; Other	Cognition; Psychological/ emotional or behavioural symptoms; risk for childhood abuse	RCT: Yes Control: CCT (TAU) Follow up: None	n=64 F=35; M=29	n=60 F=28; M=32	a. Yes; only cognition was non-sig. (IQ) b. No c. N/A d. N/A
Trauma-	To decrease	3 - 16	Weiner,	USA	Not specified	Other	Psychological/	RCT: No	n=35	No	a. No; sig. for specific

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Focussed Cognitive Behaviour Therapy (TF-CBT)	physiological arousal & improve wellbeing; improve identification & management of feelings; improve parent child communication, enhance social skills.		Schneider, & Lyon (2009) [31]				emotional or behavioural symptoms	Pre/post treatment measure Follow up: None	F=17; M=18 Mean:8.4	comparison group	measures for one racial group) b. No c. N/A d. N/A

Note: TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; PTSD = Post-Traumatic Stress Disorder: RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = Statistically non-significant findings; Sig. = Statistically significant findings. a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 1c. Summary of the Well Supported program (TF-CBT) by targeted age, theory, trauma type and outcome domain

Approach name	Authors & year	Age	Approach theory								Intervention	Prevention	Trauma type							Outcome domain						
			CBT	Trauma narrative	Trauma exposure	Ecological/systems	Attachment/Relational	Neuro-biological	Mindfulness	Psycho-dynamic			Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
TF-CBT: Trauma-focused Cognitive behavioural therapy	Puccia, … & Morrison (2012) [24]	4-19	✓	✓	✓											✓						✓				
	Grasso, … & Webb (2011) [25]	11	✓	✓	✓						✓		✓			✓						✓				
	Cohen, … & Steer (2004) [26S]	8-14	✓	✓	✓						✓			✓								✓	✓			
	Deblinger, … & Steer (2006) [27S]	8-14	✓	✓	✓						✓			✓								✓				
	Cohen, … & Knudsen (2005) [28]	8-14	✓	✓	✓						✓			✓								✓				
	Deblinger, … & Steer (2011) [29]	4-11	✓	✓	✓						✓		✓	✓								✓				
	Cohen, … & Lyengar (2005)	7-14	✓	✓	✓						✓		✓	✓		✓			✓			✓				
	Weiner,… & Lyon (2009) [31*]	3-16	✓	✓	✓														✓			✓				
Total studies			**7**	**7**	**7**	**0**	**0**	**0**	**0**	**0**	**5**	**0**	**3**	**4**	**0**	**3**	**0**	**0**	**2**	**0**	**0**	**7**	**1**	**0**	**0**	**0**

Note. The three studies highlighted were RCT's with 12 month follow up period. PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning; [S] = These articles report on the same study; * = This study showed TF-CBT had no effect for participants generally, although significant findings of benefit were found for specific groups in the sample.

Table 1d. Summary of the Well Supported program (TF-CBT) by approach elements, setting and delivery mode

Approach name	Authors & year	Elements			Setting				Delivered by						Delivered to				
		Dose	Training	Program fidelity	Clinic	Community	Home	School	Psychologist	Social worker	Counsellor	Teacher	Nurse	Unspecified professional, paraprofessional	Individual child	Individual caregiver	Child-caregiver dyad	Individual families	Groups of children
TF-CBT: Trauma-focused Cognitive behavioural therapy	Puccia, … & Morrison (2012) [24]	8 x session	✓	✓	✓									✓	✓	✓	✓		
	Grasso, … & Webb (2011) [25]	12-16 x 1.5hr		✓	✓				✓						✓	✓	✓		
	Cohen, … & Steer (2004) [26S]	12 x 1.5hr	✓	✓	✓				✓	✓					✓	✓	✓		
	Deblinger, … & Steer (2006) [27S]	12 x 1.5hr	✓	✓	✓				✓	✓					✓	✓	✓		
	Cohen, … & Knudsen (2005) [28]	12 x 1.5hr	✓	✓	✓				✓	✓					✓	✓	✓		
	Deblinger, … & Steer (2011) [29]	8/16 x 1.5hr	✓	✓	✓				✓	✓					✓	✓	✓		
	Cohen, … & Lyengar (2011) [30]	8 x 1.5hr	✓	✓		✓									✓	✓	✓		
	Weiner,… & Lyon (2009) [31]	12-20 weeks	✓	✓	✓									✓	✓	✓	✓		
Total studies			**6**	**7**	**7**	**1**	**0**	**0**	**5**	**4**	**0**	**0**	**0**	**2**	**7**	**7**	**7**	**0**	**0**

Note. The three studies highlighted in pink were RCTs with 12 month follow up period. PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning; and [S] = These articles report on the same study.

Table 2a. Summary of the studies evaluating the Supported approaches

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or Intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
Ippen, Harris, Van Horn, & Lieberman (2011) [32]	CHILD - a sig. time by treatment effect was found for the intervention (intention to treat & completers) for child PTSD. No sig. reduction in PTSD for comparison children. High-risk children (more than 4 traumatic events) in intervention group showed greater reductions in PTSD. Sig. time by intervention effect for child depression & child behaviour, & maintained only for those with 4+ traumatic events. MOTHER - sig. reduction in maternal PTSD for intervention group regardless of number of events, for comparison group with fewer events, but not for comparison group with 4+ events. For maternal depression, sig. reductions were found for the intervention group but not the comparison group. This was maintained for intervention completers but not the intention to treat group. When analysed by number of events, a sig. reduction in maternal depression was found for the intervention group regardless of number of events & for the comparison group with fewer events, but not the comparison group with 4+ events.	Content: Previously described. Theory: Infant-parent psychotherapy (Fraiberg) & attachment theory (Bowlby).	Both	Other	Psychologist	Individual caregiver-child dyads	1hr x 50weeks	Population - referred for treatment due to child behaviour. Setting not indicated. Trauma - separation from perpetrating father.
Lieberman, van Horn, & Ippen (2005) [33]	CPP was the only group that had sig. efficacy as an intervention in reducing children's total behaviour problems, traumatic stress symptoms, & diagnostic status. There was a trend towards sig. for TAU, & a sig. effect for CPP in reducing mother's general distress. Mother's PTSD symptoms reduced over time, but non-sig. between groups.	Content: psychodynamic formulations, attachment theory, social learning & cognitive behavioural theory, & ecological models as each contributes understanding about the impact, predictors, & mediators of marital violence on children's psychological functioning.	Intervention	Community	Psychologist	Individual caregiver-child dyads	CCP: 1hr x 50weeks TAU: 0.5hr phone call x 1/4weeks plus contact when needed.	-
Cicchetti, Rogosch, & Toth (2006) [34]	Infants in the maltreatment groups had sig.ly higher rates of disorganized attachment than infants in the NC group. At post intervention follow-up at age 26-mths, children in the IPP groups demonstrated substantial increases in secure attachment, whereas increases in secure attachment were not found for the CS & NC groups.	In IPP, the patient is not the mother or the infant, but rather it is the relationship between the mother & her baby.	Intervention	Clinic	Other	Individual caregiver-child dyads	Weekly for 1yr	-
Toth, Maughan,	Children in the PPP intervention evidenced more of a decline in maladaptive maternal	Within the therapeutic sessions, the clinician strives to alter the relationship	Intervention	Clinic	Other	Individual caregiver-	52 x 1hr	-

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or Intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
Manly, Spagnola, & Cicchetti (2002) [35]	representations over time than Control children & displayed a greater decrease in negative self-representations than control children. Also, the mother–child relationship expectations of PPP children became more positive over the course of the intervention, as compared to control participants.	between mother & child. Toward this end, clinicians must attend to both the interactional & the representational levels as they are manifested during the therapy sessions. Attachment theory.				child dyads		
Lieberman, Ippen, & Van Horn (2006) [36]	Child behaviour & mothers distress was significantly reduced compared with the control group with effects maintained over 6mths	Theory: psychodynamic formulations, attachment theory, social learning & cognitive behavioural theory, & ecological models as each contributes understanding about the impact, predictors, & mediators of marital violence on children's psychological functioning.	Intervention	Community	Psychologist	Individual caregiver-child dyads	50 x 1hr	-
Weiner, Schneider, & Lyon (2009) [31]	For CPP, African American youth experienced improvement in every CANS domain. Biracial youth experienced sig. improvements in Traumatic Stress Symptoms, Strengths, Behavioural/emotional needs, & Risk Behaviours. Hispanic youth experienced sig. improvement in Traumatic Stress Symptoms, Life Domain Functioning, & Behavioural Emotional Needs. White youth improved sig. in Life Domain Functioning.	CPP is designed for children ages birth to 6. The treatment focuses on decreasing traumatic stress responses, learning difficulties, & relationship problems in infants & young children exposed to violence by improving the quality of parent–child relationships.	Intervention	Clinic	Other	Individual caregiver-child dyads	Weekly for 1yr	-
DePanfilis & Dubowitz (2005) [37]	Positive changes in protective factors (sig. parenting attitudes & social support; non-sig. for parenting competence); diminished risk factors (parent depression & stress); improved child safety & child behaviour over time. Non-sig. differences on any measures between FC3 & FC9 groups.	Content: Individual family support, Community outreach, tailored interventions, helping alliance, empowerment, strengths-based, cultural competence, developmental appropriateness, & outcome-driven service plans. Theory: social ecology (Brofenbrenner).	Prevention	Home	Social worker; Other	Individual caregiver-child dyads	1wk x 3mths mean:17hrs; or 1wk x 9mths mean:31hrs	*Original RCT incl. group intervention, but compliance was too low: caregivers, 32% attendance
Taussig & Colhane (2010) [38]	Time 2: No group differences on mental health symptoms. Intervention group scored higher on quality of life measure. Groups did not differ on self- or caregiver-reported use of mental health services or psychotropic medication. Time 3: Intervention group scored lower on mental health symptoms. Intervention group	Skills groups Content: Emotion recognition, perspective taking, problem solving, anger management, cultural identity, change & loss, healthy relationships, peer pressure, abuse prevention, & future orientation. Theory: CBT & Process-orientation Mentoring Content: To create positive	Intervention	Home	Trained clinician; Other	Groups of children; Individual child	Skills group: 1.5hrs x 30wks Mentoring 2-4hrs a wk.	Skills Group: 8-10 children, 2 facilitators

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or Intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
	reported fewer symptoms of dissociation. The intervention group were less likely to report receiving recent mental health therapy.	relationships, help children receive appropriate services, apply skills learnt to real world settings, engage children in extracurricular activities, help foster positive future orientation. Theory: None specified.						
Crooks, Scott, Ellis, & Wolfe (2011) [39]	The program had a buffering impact for maltreated youth for delinquent peer interactions at post-intervention.	Content: Skill development: 1. Personal safety in relationships; 2. Sexual health; & 3. Substance use.	Prevention	School	Teacher	Groups of children	75 mins x 21sessions.	-
Eckenrode, Ganzel, Henderson, Smith, Olds, Powers, …, & Sidora (2000) [40]	Families receiving Home visitation during pregnancy & infancy had sig. fewer child maltreatment reports involving the mother as perpetrator or the study child as subject than families not receiving Home visitation. The number of maltreatment reports for mothers who received Home visitation during pregnancy only was not different from the control group. For mothers who received visits through the child's second birthday, the treatment effect decreased as the level of domestic violence increased.	Content: During Home visits, the nurses promoted 3 aspects of maternal functioning: health-related behaviours during pregnancy & the early years of the child's life, the care parents provide to their children, & maternal life-course development (family planning, educational achievement, & participation in the work force). Visits were held once every other week during pregnancy, once a week for the first 6 weeks postpartum, & then on a diminishing schedule until the children reached age 2yrs. Theory: Unspecified.	Prevention	Home	Nurse	Individual caregiver	Nurses completed an average of 9 (range:0-16) visits during the mother's pregnancy & 23 (range:0-59) visits with child aged birth to 2yrs.	-
Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew (2010) [41]	Sig. improvement in Youth Mental Health symptoms, parenting psychiatric distress, maltreatment in parenting behaviour, out of Home (placement) factors, & improved natural support for parents compared to control. Non-sig. service utilisation (CPS reports), though there were reduced no.'s of report in MST-CAN group.	Theory: Social ecological conceptualization of behaviour, the physical abuse of youth has been linked to modifiable factors pertaining to the individual youth, parent & family systems. MST: address nature of serious clinical problems (adaptions can be used for serious emotional disturbance, sex offending, chronic illness). Home-based model to overcome barriers to service access, integrating evidence-based interventions & QA framework.	Both	Community	Counsellor; other	Individual families	MST-CAN: daily or 1-2 weekly (as needed) for up to 16mths, plus 24/7 crisis support.	Standard MST-CAN is 4-6-mths only.
Dawe & Harnett (2007) [42]	Risk for abuse: TAU group increased risk, Brief intervention & PUP had sig. reductions. Relationship: Parent stress (decrease)/ Child behaviour Prob. (decrease), child pro-social	Content: Comprehensive needs assessment & case formulation to establish targets for change. Brief intervention was two sessions of	Prevention	Home	Other	Individual caregiver	1x 10-12wks	Note: For all groups some participants remained high

Authors & years	Detailed description of main findings	Intervention content/theory	Prevention or Intervention	Setting	Delivered by	Delivered to	Frequency & duration of session	Notes
	(increase): PUP was only sig. group. Change from High risk to Low risk: PUP (36%) & Brief Intervention (17%). Change (worsening) from Low risk to High risk in TAU (42%).	parenting education. Theory: Case formulation, change models.						risk: PUP (36%), Brief (56%) & TAU (37%).
Jouriles, McDonald, Rosenfield, Norwood, Spiller, Stephens, …, & Ehrensaft (2010) [43]	For Parenting Support compared to control: Sig. improvement over time & sig. more rapid impact on perceived inability to parent & reduced harsh parenting. Sig rapid observed ineffective parenting, but no difference over time. Sig. reduction in psychological distress found in parenting support, not in control. No sig. effects found in control group over time.	Content: Designed to decrease coercive patterns of aggressive discipline & increase positive parenting, by: 1. teaching mother's child management skills; 2. providing instrumental & emotional support to mothers. A very intensive, hands-on approach.	Both	Home	Counsellor; Other	Individual families	Project Support: 1 x a week for 8mths. Mean: 22.1 TAU: 0-18 sessions +	Note: TAU (counselling, plus psycho-education or educational support).

Note: The Supported programs are categorised by author in this table. TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 2b. Summary of Supported programs

Name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Child-Parent Psycho-therapy (CPP)	To enhance parental capacity to provide safety & developmentally appropriate caregiving to their child/ children.	3 - 5	Ippen, Harris, Van Horn, & Lieberman (2011) [44]	USA	Child abuse, Neglect; Child sexual abuse; Family violence; Parental substance use; Parental mental illness; Other	Other	Child physical; Relationships & family or social functioning	RCT: Yes Control: 1mth case management & community service referral. Follow-up: 6mths	n=75 (child) F=39; M=36 mean:4.1 n=75 (mother) f=75; M=0 mean:31.5 n=27 (dyads)	See totals in previous cell	a. Yes b. No c. Yes d. 6mths
Child-Parent Psycho-therapy (CPP)	To foster child mental health by promoting a relational process, in which increased maternal responsiveness to the child's developmental needs strengthens the child's trust in the mother's capacity to provide protective care.	3 - 5	Lieberman, van Horn, & Ippen (2005) [33]	USA	Child abuse; Child sexual abuse; Family violence	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Case management plus TAU Follow up: None	n=36 (dyad)	n=29 (dyad)	a. Yes b. No c. N/A d. N/A
Child-Parent Psycho-therapy (CPP)	To foster positive child development, improved parent-child interaction, & decrease child maltreatment.	3 - 5	Toth, Maughan, Manly, Spagnola, & Cicchetti (2002) [35]	USA	Child abuse; Child sexual abuse; Neglect	Other	Relationships & family or social functioning; Psychological/ emotional or behavioural symptoms	RCT: Yes Controls: TAU & community sample Follow up: None	n=31 (family)	TAU: n=33 (family) Community: n=43 (family)	a. Yes b. No c. N/A d. N/A
Child-Parent Psycho-therapy (CPP)	To foster child mental health by promoting a relational process in which increased maternal responsiveness to the child's developmental needs strengthens the child's trust in the mother's capacity to provide protective care.	3 - 5	Lieberman, Ippen, & Van Horn (2006) [36]	USA	Family Violence; Child abuse; Child sexual abuse	Other	Psychological/emotional or behavioural symptoms	RCT: Yes Follow up Study: Lieberman, Van Horn & Ippen (2005)	See Lieberman, Van Horn & Ippen (2005)	See Lieberman, Van Horn & Ippen (2005)	a. N/A b. No c. Yes d. 6mths

Name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Child-Parent Psycho-therapy (CPP)	To decrease traumatic stress responses, learning difficulties & relationship problems in infants & young children exposed to violence by improving the quality of parent–child relationships.	0 - 6	Weiner, Schneider, & Lyon (2009) [31]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=33 F=21; M=12 Mean:3.8	No control group	a. Non-sig. overall (sig. for racial groups on some measures) b. No c. N/A d. N/A
Fostering Healthy Futures	To provide skills groups & mentoring.	9 - 11	Taussig & Colhane (2010) [38]	USA	Child abuse; Neglect	Foster care	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Wait-list Follow up: 6mths	n=77	n=79	a. Yes (Sig. on quality of life measure); Non-sig. between groups at end of intervention, but sig. diff at 6mths post intervention b. No c. Yes d. 6-mths
Fourth R: A school-based violence prevention program	To provide knowledge, awareness & skill development for personal safety in relationships, sexual health, & substance use. To reduce conflict & risk behaviours.	14 - 15	Crooks, Scott, Ellis, & Wolfe (2011) [39]	Canada	Neglect	Ethnicity; Other	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: Control: TAU Standard curriculum Follow-up: 2.5yrs	n=865 F=493; M=372 14-15yrs	n= 655 F=327; M=328 14-15yrs	a. Yes b. No c. Yes d. 2.5yrs Duration: 21 sessions
Parents Under Pressure (PUP)	To provide comprehensive needs assessment & case formulation to establish targets for change.	2 - 8	Dawe & Harnett (2007) [42]	Australia	Child abuse; Neglect	Other	Relationships & family or social functioning; risk for childhood abuse	RCT: Yes Controls: TAU & Brief intervention Follow up: 3/6mths	n=22 (family)	n=20 (Brief Intervention); n=19 (TAU) (family)	a. Yes b. No c. Yes d. 3/6mths Duration: 1x 10-12wks.
Project Support	To reduce child conduct problems among families departing from domestic violence shelters.	3 - 8	Jouriles, McDonald, Rosenfield, Norwood, Spiller, Stephens, …,	USA	Family violence; Other	Other	Psychological/ emotional or behavioural symptoms; Relationships & family or social	RCT: Yes Control: TAU Follow-up: 8mths	n=17 (child)	n=18 (child)	a. Yes b. No c. Yes d. 8mths

Name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
			& Ehrensaft (2010) [43]				functioning; Service utilisation				

Note: TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy. a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 2c. Summary of Supported approaches by theory

Approach name	Authors & year	Approach theory								Intervention	Prevention
		CBT	Trauma narrative	Trauma exposure	Ecological/systems	Attachment/ Relational	Neurobiological	Mindfulness	Psycho-dynamic		
Approach type: Programs											
CPP: Child-Parent Psychotherapy	Ippen, … & Lieberman (2011) [32S]		✓		✓	✓				✓	
	Lieberman, … & Ippen (2005) [33S]		✓		✓	✓				✓	
	Cicchetti, … & Toth (2006) [34]		✓		✓	✓				✓	
	Toth, … & Cicchetti (2002) [35]		✓		✓	✓				✓	
	Lieberman, … & Van Horn (2006) [36S]		✓		✓	✓				✓	
	Weiner, … & Lyon (2009) [31]		✓		✓	✓				✓	
Fostering Healthy Futures	Taussig & Colhane (2010) [38]	✓				✓				✓	
Fourth R: violence prevention	Crooks, … & Wolfe (2011) [39]	Not reported/applicable									✓
PUP: Parents under Pressure	Dawe & Harnett (2007) [42]	✓				✓		✓			✓
Project Support	Jouriles, … & Ehrensaft (2010) [43]	✓				✓				✓	✓
Total programs		**3**	**1**	**0**	**1**	**4**	**0**	**1**	**0**	**3**	**3**
Approach Type: Service Models											
Family Connections	DePanfilis & Dubowitz (2005) [37]				✓						✓
Nurse Home Visiting Service	Eckenrode, … & Sidora (2000) [40]	Not reported/applicable									✓
Total service models		**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**2**
Approach Type: Systems of Care											
MST-CAN: multi-systemic therapy	Swenson, … & Mayhew (2010) [41]	✓			✓					✓	
Total systems of care		**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**

Note: CBT = Cognitive Behaviour Therapy; [S] These three articles reported on the same study and this was the only CPP study that was an RCT with 6 months follow-up.

Table 2d. Summary of Supported programs by approach elements, setting and delivery mode

Approach name	Authors & year	Elements			Setting				Delivered by						Delivered to				
		Dose	Training	Program fidelity	Clinic	Community	Home	School	Psychologist	Social worker	Counsellor	Teacher	Nurse	Unspecified professional, paraprofessional	Individual child	Individual caregiver	Child-caregiver dyad	Individual families	Groups of children
CPP: Child-Parent Psychotherapy	Ippen, … & Lieberman (2011) [44S]	50 x 1hr	M	✓	✓				✓							✓	✓		
	Lieberman, … & Ippen (2005) [33S]	50 x 1hr	M	✓	✓				✓							✓	✓		
	Cicchetti, … & Toth (2006) [34]	52 sessions	M	✓	✓									✓			✓		
	Toth, … & Cicchetti (2002) [35]	52 x 1hr	M	✓	✓									✓			✓		
	Lieberman, … & Van Horn (2006) [36S]	50 x 1hr	M	✓		✓			✓								✓		
	Weiner, … & Lyon (2009) [31]	52 sessions	M	✓	✓									✓			✓		
Fostering Healthy Futures	Taussig & Colhane (2010) [38]	30 x 1.5hr / 30 x 2-4hr	M	✓			✓			✓				✓	✓				✓
Fourth R: violence prevention	Crooks, … & Wolfe (2011) [39]	21 x 1.25hr	✓	✓				✓				✓							✓
PUP: Parents under Pressure	Dawe & Harnett (2007) [42]	10 x 1.5-2hr	✓	✓			✓							✓		✓			
Project Support	Jouriles, … & Ehrensaft (2010) [43]	1-1.5hrs; up to 8mths[1]	✓	✓			✓							✓		✓			
Total			**5**	**5**	**1**	**1**	**3**	**1**	**1**	**1**	**0**	**1**	**0**	**4**	**1**	**3**	**1**	**0**	**2**

NOTE: [1] = as needed/ unspecified time spent in sessions. M = Manualised program (refers to the study noting that therapists followed intervention protocols via the use of a session based written manual. In these articles there was no notation of therapist training as per the description above). [S] These three articles reported on the same study and this was the only CPP study that was an RCT with 6 months follow-up. Fidelity – refers to the study monitoring the adherence of therapists to the intervention protocol (i.e., such as supervision, or reviewing of video or audiotapes of sessions). Training – refers to the study noting that therapists were provided specific training of the intervention protocol.

Table 2e. Summary of Supported programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific\focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
CPP: Child-Parent Psychotherapy	Ippen, … & Lieberman (2011) [44S]	3-5	TS/F TIC		✓	✓	✓	✓	✓					✓				
	Lieberman, … & Ippen (2005) [33S]	3-5				✓	✓		✓					✓				
	Cicchetti, … & Toth (2006) [34]	1-3			✓		✓								✓			
	Toth, … & Cicchetti (2002) [35]	3-5			✓	✓	✓							✓	✓			
	Lieberman, … & Van Horn (2006) [31S]	3-5			✓	✓		✓						✓				
	Weiner, … & Lyon (2009) [33]	0-6									✓			✓				
Fostering Healthy Futures	Taussig & Colhane (2010) [37]	9-11[B]	TS/F		✓		✓							✓			✓	
Fourth R: violence prevention	Crooks, … & Wolfe (2011) [39]	3-8	TS/F		✓	✓	✓	✓						✓	✓	✓		
PUP: Parents under Pressure	Dawe & Harnett (2007) [32]	2-8[A]		✓					✓			✓		✓				
Project Support	Jouriles, … & Ehrensaft (2010) [35]	3-8			✓		✓	✓				✓		✓				
Total programs				**1**	**4**	**2**	**4**	**3**	**2**	**0**	**1**	**2**	**0**	**5**	**2**	**1**	**1**	**0**

Note: [A]= At risk; [B]= Fostercare; SMU = Substance misuse; TS/F = Trauma specific/ focused; TIC = Trauma informed care; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning. [S] These three articles reported on the same study and this was the only CPP study that was an RCT with 6 months follow-up.

Table 3a. Summary of Supported service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Family Connections (3- or 9-mth intervention) with/ without group intervention	To increase protective factors (parenting, family & social support) & decrease risk (stress/ parental depression) for abuse in inner-city families.	5 - 11	DePanfilis & Dubowitz (2005) [37]	USA	Neglect; Family violence; Parental substance use; Parental mental illness; Other	Ethnicity	Psychological/ emotional or behavioural symptoms; Service utilisation; Risk for childhood abuse	RCT: Yes Controls: FC 3-mth or FC Follow-up: 6 & 9mths	Combined samples n=154 (parent); n=473 (child) 0-20yrs	See totals in previous cell.	a. Yes b. No c. Yes d. 6mths
Nurse Home visiting service	To prevent child abuse, neglect or maltreatment.	1 - 2	Eckenrode, Ganzel, Henderson, Smith, Olds, Powers, …, & Sidora (2000) [40]	USA	Other	At risk families	Service utilisation	RCT: Yes Control: TAU (T1: pregnancy visits) & (T1: infant-age) Follow-up: 15yrs	T1 n=100 (mother) T2 n= 116 (mother)	n=184 (mother)	a. Yes (at Time 2 only) b. No c. Yes d. 15yrs

Note: TAU = Treatment As Usual; RCT = Randomised Controlled Trial; T = time; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 3b. Summary of Supported service models by program elements, setting and delivery mode

Approach name	Authors & year	Elements			Setting				Delivered by						Delivered to				
		Dose	Training	Program fidelity	Clinic	Community	Home	School	Psychologist	Social worker	Counsellor	Teacher	Nurse	Unspecified professional, paraprofessional	Individual child	Individual caregiver	Child-caregiver dyad	Individual families	Groups of children
Family Connections	DePanfilis & Dubowitz (2005) [37]	12/40 x 1.5hr	✓	✓			✓			✓							✓		
Nurse Home visiting service	Eckenrode, … & Sidora (2000) [40]	Up to 30mths[1]		✓			✓						✓			✓			
Total service models			**1**	**2**	**0**	**0**	**2**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**1**	**1**	**0**	**0**

NOTE: [1] = as needed/ unspecified time spent in sessions. Note: Direct comparison between programs in this table is should be avoided because they take a number of forms constituted under the term program (e.g., trauma specific interventions, systems of care). Fidelity – refers to the study monitoring the adherence of therapists to the intervention protocol (i.e., such as supervision, or reviewing of video or audiotapes of sessions). Training – refers to the study noting that therapists were provided specific training of the intervention protocol.

Table 3c. Summary of Supported service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Family Connections	DePanfilis & Dubowitz (2005) [37]	5-11[E]					✓	✓	✓	✓	✓	✓		✓			✓	
Nurse Home Visiting Service	Eckenrode, … & Sidora (2000) [40]	0-2[A]			✓	✓	✓										✓	
Total service models				**0**	**1**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**0**	**1**	**0**	**0**	**2**	**0**

Note: [E] = Ethnicity; [A]= At risk; TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 4a. Summary of Supported systems of care

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Multisystemic Therapy for Child Abuse & Neglect (MST-CAN)	To improve youth & parent functioning, reduce abusive parenting behaviour, & decrease abuse & placement.	10 - 17	Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew (2010) [41]	USA	Child abuse; Neglect	Other	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning; Service utilisation	RCT: Yes Control: Enhanced Outpatient treatment (TAU) Follow up: 2/ 4/10/16mths	n=45	n=45	a. Yes b. No c. Yes d. Months: 2, 4, 10, 16

Note: TF = Trauma specific or trauma focused but not trauma informed; TIC = Trauma informed care; RCT = Randomised Controlled Trial; F = Female; M = Male; n= no. of participants in sample; TAU = Treatment As Usual; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 4b. Summary of Supported systems of care by program elements, setting and delivery mode

Approach name	Authors & year	Elements			Setting				Delivered by						Delivered to				
		Dose	Training	Program fidelity	Clinic	Community	Home	School	Psychologist	Social worker	Counsellor	Teacher	Nurse	Unspecified professional, paraprofessional	Individual child	Individual caregiver	Child-caregiver dyad	Individual families	Groups of children
MST-CAN: multi-systemic therapy	Swenson, … & Mayhew (2010) [41]	Up to 16mths[1]	✓	✓		✓	✓							✓				✓	
Total systems of care			**1**	**1**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**

NOTE: [1] = as needed/ unspecified time spent in sessions. M = Manualised program (refers to the study noting that therapists followed intervention protocols via the use of a session based written manual. In these articles there was no notation of therapist training as per the description above). Note: Direct comparison between programs in this table is should be avoided because they take a number of forms constituted under the term program (e.g., trauma specific interventions, systems of care). Fidelity – refers to the study monitoring the adherence of therapists to the intervention protocol (i.e., such as supervision, or reviewing of video or audiotapes of sessions). Training – refers to the study noting that therapists were provided specific training of the intervention protocol.

Table 4c. Summary of Supported systems of care by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
MST-CAN: multi-systemic therapy	Swenson, … & Mayhew (2010)[41]	10-17	TS/F TIC		✓		✓					✓		✓	✓		✓	
Total systems of care				**0**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**1**	**1**	**0**	**1**	**0**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning.

Table 5a. Summary of Promising A programs

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Attachment & Bio-behavioural Catch up Intervention (ABC)	To decrease frightening behaviour & to enhance nurturing/ sensitive care for parents identified as at risk for neglecting young children & at risk of developing a disorganized attachment style.	0 - 2.5	Bernard, Dozier, Bick, Lewis-Morrarty, Lindhiem, & Carlson (2012) [45]	USA	Neglect	Ethnicity; Other	Relationships & family or social functioning	RCT: Yes Control: ABC without parental sensitivity Follow up: None	n=60 (dyads) F=26; M=34 Combined sample: (mean:10mth range:2-21)	n=60 (dyads) F=25; M=35	a. Yes b. No c. N/A d. N/A Note: Control group= removed components re: parental sensitivity.
Attachment & Bio-behavioural Catch up Intervention (ABC)	To help parents/ caregivers reinterpret behavioural cues in children who fail to elicit nurturance & decrease caregiver discomfort in providing nurturance.	0 - 5	Sprang (2009) [46]	USA	Child abuse; Neglect	Foster care	Psychological/emotional or behavioural symptoms; Relationships & family or social functioning	RCT: Yes Control: Waitlist (support groups) Follow up: None	n=26 (dyads)	n=27 (dyads)	a. Yes b. No c. N/A d. N/A
Cognitive Behavioural Therapy (CBT)	To address aggressive tendencies by teaching coping skills, effective prob. solving & replace maladaptive schemas. Teach new ways to deal with stressful social encounters.	12 - 16	LeSure-Lester (2002) [47]	USA	Child abuse; Neglect	Residential care; Ethnicity	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: Yes Control (52wks indirect) Follow up: None	n=6 f=0; m=6	n=6 F=0; M=6	a. Yes b. No c. N/A d. N/A
Cognitive Behaviour Therapy	To examine psychosocial functioning after disclosure of sexual abuse history using gender-specific CBT. A holistic intervention (i.e., structured personal journal, creative expression, empowerment, role-playing) to address health, mental health, substance abuse, & family issues.	12 - 17	Arnold, Kirk, Roberts, Griffith, Meadows, & Julian (2003) [48]	USA	Child sexual abuse	Residential care; Ethnicity; Juvenile offenders; Substance abusers	Cognition; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: no Pre/ Post treatment measures Follow up: None	n=41 F=41; M=0	No comparison group	a. Yes all domains sig. Mixed findings for relationships (sig. for problems with father & school; non-sig. for problems with mother & with friends). b. No c. N/A d. N/A
Cognitive	To reduce trauma	10-16	Morsette,	USA	Not	Ethnicity	Psychological/	RCT: No	n=43	No comparison	a. Yes

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Behavioural Intervention for Trauma in Schools (CBITS)	symptoms.		van den Pol, Schuldberg, Swaney, & Stolle (2012) [49]		specified		emotional or behavioural symptoms	Control: Pre/post treatment measures Follow up: 3yr (limited)	F=24; M=19 mean:12.7	group	b. No c. N/A d. 3yr measure of program acceptability/ appropriateness.
Cognitive Behavioural Intervention for Trauma in Schools (CBITS)	To reduce symptoms of PTSD & depression in children who have been exposed to violence.	11-15	Stein, Jaycox, Kataoka, Wong, Tu, Elliot, & Fink (2002) [50]	USA	Family violence; Other	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Delayed treatment Follow up: 3mths	n=61	n=65	a. Yes b. No c. No d. 3mth (control group at end of treatment).
Cognitive Behavioural Intervention for Trauma in Schools (CBITS)	To reduce symptoms of PTSD & depression in children who have been exposed to violence.	11-15	Goodkind, LaNoue, & Milford (2010) [51]	USA	Family violence; Other	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: No Control: Delayed treatment Follow up: 3/6mths	n=23 F=16; M=7 mean:13.4	n=23 F=16; M=7 mean: 13.4	a. Yes b. No c. Yes (depression & anxiety) non-sig. (PTSD & avoidance) d. 6mths
Cognitive Behavioural Intervention for Trauma in Schools (CBITS)	To reduce symptoms of PTSD & depression in children who have been exposed to violence.	11-15	Kataoka, Stein, Jaycox, Wong, Escudero, Tu, …, & Fink (2003) [52]	USA	Family violence; Other	Ethnicity	Psychological/emotional or behavioural symptoms	RCT: No Control: Delayed treatment Follow up: 3mths	n=152 F=92; M=90 mean:11.5	n=47 F=22; M=25 mean:11.2	a. Yes b. No c. No d. 3mths
Child & Family Cognitive Behavioural Therapy (CBT) for sexually abused children	To use psycho-education, coping skills, relaxation, behaviour, rehearsal, assertive behaviour, graded exposure, relapse prevention, problem sharing, abuse-discussion, child behaviour manage, parental coping to reduce PTSD symptoms.	5 - 17	King, Tonge, Mullen, Myerson, Heyne, Rollings, …, & Ollendick (2000) [53]	Australia	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Controls: 2 treatment & Waitlist (WLC) Follow up: 3mths	Combined samples: n=36 F=24; M=11 mean:11.5	WLC: n=12	a. Yes for treatment versus control; non-sig. between treatment conditions b. No c. Yes d. 3mth
Combined Parent-Child Cognitive	To address the complex needs of the parent who engages in physically	Not specified	Runyon, Deblinger, and	USA	Child abuse, Family	Caregiver offenders; Other	Psychological/ emotional or behavioural	RCT: No Control: Pre/post	n=21 (child) n=24 (parent)	No comparison group	a. Yes b. No c. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Behavioural Therapy (CPC-CBT)	abusive behaviour & the traumatized child.		Schroeder (2009) [54]		Violence, Child sexual abuse		symptoms	treatment measures Follow up: None			d. N/A
Combined Parent-Child Cognitive Behavioural Therapy (CPC-CBT)	To address the complex needs of the parent who engages in physically abusive behaviour & the traumatized child.	Not specified	Runyon, Deblinger, & Steer (2010) [55]	USA	Child abuse	Caregiver offenders; Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Parent-only CBT Follow up: 3mths	n=34 (child) n= 24 (parent)	n= 26 (child) n=20 (parent)	a. Yes (PTSD; equally internalising & externalising child behaviour). b. No c. Yes d. 3mths
Eye Movement Desensitization & Reprocessing (EMDR)	To reduce PTSD symptoms in sexually abused children.	12 - 13	Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi (2004) [56]	Iran	Child sexual abuse	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Alternate (CBT) Follow up: None	n=7 (child) f=7; M=0	n=7 (child) F=7; M=0	a. Yes b. No c. N/A d. N/A
Eye Movement Desensitization & Reprocessing (EMDR)	To treat children with conduct disorder.	10 - 16	Soberman, Greenwald, & Rule (2002) [57]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Control: TAU without EMDR Follow up: 2mths	n=14	n=15	a. Yes b. No c. Yes d. 2mths
Eye Movement Desensitization & Reprocessing (EMDR)	To compare the effects of EMDR with a waiting list condition (WLC) in RCT for children suffering from PTSD elicited by various traumatic events.	6 - 16	Ahmad, Larsson & Sundelin-Wahlsten (2007) [58]	Sweden	Child sexual abuse; Neglect, parental substance use; Parental mental illness, Other	Foster Care; Ethnicity; Caregiver offenders; Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: No treatment Follow up: None	n=16 F=10; M=7 range:6-15 mean:9.6	n=17 F=10; M=6 range:6-16 mean:10.3	a. Yes b. No c. N/A d. N/A
Eye Movement Desensitization & Reprocessing (EMDR)	To test the treatment effect size of a special protocol for EMDR used in treatment of children with PTSD.	6 - 16	Ahmad & Sundelin-Wahlsten (2008) [59]	Sweden	Child sexual abuse; Neglect: Parental substanc	Foster care; Ethnicity; Caregiver offenders; Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control (half had 2mth delayed treatment) Follow up:	n=33 F=20; M=13 Mean:9.6 range:5–15	n=16-17	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
					e use; Parental mental illness			None			
Infant-Parent Psychotherapy (IPP)	IPP: To focus on mother's interactional history & its effect on her representation on relationship to infant. PPI: To focus on current behaviour utilizing intervention skills (parent-skills oriented).	1-1	Cicchetti, Rogosch, & Toth (2006) [34]	USA	Child abuse; Neglect	Ethnicity; Other	Relationships & family or social functioning	RCT: Yes Controls: TAU & Psycho-educational Parenting Intervention (PPI) Follow up: None (1.2yr post-intervention)	n=137 infant (TAU; IPP; PPI) F=77; M=60 mean:1.1	n=52 infant (normative control: low income) F=24; M=28 mean1.1	a. Yes (but equally for both groups). b. No c. N/A d. N/A
Parent-Child Interaction Therapy (PCIT)	To assist parents to maintain consistent limits, to ignore minor disruptive behaviours, to manage their own emotions during negative interactions, to identify effective time-out strategies, & to implement strategies effectively & judiciously.	2.5 - 7	Thomas & Zimmer-Gembeck (2011) [60]	Australia	Child abuse; Neglect	At risk families	Relationships & family or social functioning; Psychological/ emotional or behavioural symptoms	RCT: Yes Controls: Wait List (12wks) & Treatment completion Follow up: 1mth	n=99 (family)	n=51 (family)	a. Yes (parent-child interactions; stress; behaviour) ; Non-sig (child abuse potential)* b. No c. Yes d. 1mth *Note: one measure found evidence for reduced 'child abuse potential' but this could not be compared with the wait-list due to the study design
Parent-Child Interaction Therapy (PCIT)	To offer a parent training program that helps parents address children's behaviour problems. Stage 1: Relationship enhancement phase (child-directed interaction; CDI), & Stage 2: discipline phase	2 - 10	Galanter, Self-Brown, Valente, Dorsey, Whitaker, Bertuglia-Haley, & Prieto (2012)	USA	Child abuse; Neglect	Ethnicity; Other; Caregiver offenders	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=83 F=73; M=10	No control group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	(parent-directed interaction; PDI).		[61]								
Parent-Child Interaction Therapy (PCIT)	To enhance the parent–child relationship through the use of play therapy that incorporates both parent & child within the treatment session as well as the use of live coaching.	Not specified	Pearl (2008) [62]	USA	Family violence	At risk families	Psychological/emotional or behavioural symptoms	RCT: No Case Study Follow up: 7mths	n=1 (mother & 3yr old child)	No control group	a. Yes b. No c. Yes d. 7mths
Parent-Child Interaction Therapy (PCIT)	To enhance the parent–child relationship through the use of play therapy that incorporates both parent & child within the treatment session as well as the use of live coaching.	Not specified	Pearl, Thieken, Olafson, Boat, Connelly, Barnes, & Putnam (2012) [63]	USA	Not specified	At risk families	Psychological/emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=53 (family) F=24; M=59 mean:5.4	No control group	a. Yes b. No c. N/A d. N/A
Parent-Child Interaction Therapy (PCIT)	To prevent child abuse by improving parent-child interaction skills & discipline skills.	4 - 12	Hakman, Chaffin, Funderburk & Silovsky (2009) [64]	USA	Child abuse	At risk families	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=22 (dyads) parents: (F=77%, M=23% mean:32.0) Child: (F= 36%, M=64% mean:7.0)	No comparison group	a. Yes b. No c. N/A d. N/A
Parent-Child Interaction Therapy (PCIT)	To teach parents very specific but very limited set of parenting skills. To teach risk factors for engaging in physically abusive behaviours clearly extend beyond parenting & include broad parental & familial factors.	2-12	Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, …, & Bonner (2004) [65]	USA	Child abuse	Caregiver offenders	Service utilisation	RCT: Yes Controls : TAU & enhanced individual PCIT Follow up: None	n=110 (dyads)	See total in previous cell	a. Yes b. No c. N/A d. N/A
Parent-Child Interaction Therapy (PCIT)	To reduce the presenting clinical problems of young children.	2-7	McNeil, Hershell, Gurwitch, & Clemens-Mowrer (2005) [66]	USA	Child abuse; Neglect	Foster care	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=33 (dyads) mean:5.2	No comparison group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Short-term attachment-based intervention	To change risk outcomes for children of maltreating families.	1 - 5	Moss, Dubois-Comtois, Cyr, Tarabulsy, St-Laurent, & Bernier (2011) [67]	Canada	Child abuse; Child sexual abuse; Neglect	Other	Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: Yes Control: TAU Follow up: None	n=35 (family) mean:3.3	n=32 (family) mean:3.4	a. No (psychological, except for older aged children); Yes (risk for childhood abuse). b. No c. N/A d. N/A
Seeking Safety (SS)	To target current posttraumatic stress disorder & substance use disorder concurrently.	13 - 18	Najavits, Gallop, & Weiss (2006) [68]	USA	Not specified	Substance abusers	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: TAU Follow up: 3mths	n=18 F=18; M=0	n=15 F=15; M=0	a. Yes b. No c. Yes (but not across all measures). d. 3mths
SOS! Helps for parents	To provide a preventive intervention to mothers of young children.	2 - 6	Oveisi, Ardabili, Dadds, Majdzadeh, Mohammadkhani, Rad, & Shahrivar (2010) [69]	Iran	Other	Other	Risk for childhood abuse	RCT: Yes Control: No treatment Follow up: 2mths	n=136	n=136	a. Yes b. No c. Yes d. 2mths
Support for Students Exposed to Trauma	To reduce post-traumatic & depressive symptoms & improve functioning in middle school youth who have been exposed to traumatic events.	Not specified	Jaycox, Langley, Stein, Wong, Sharma, Scott, & Schonlau (2009) [70]	USA	Other	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Waitlist Follow up: None	n=39 (child) F=21; M=18 mean:11.4yrs	n=37 (child) F=18; M=19 Mean: 11.5yrs	a. Yes b. No c. N/A d. N/A
Trauma Affect Regulation: Guide for Education & Therapy (TARGET)	To reduce PTSD symptoms & improve emotional regulation in delinquent female youths.	13 - 18	Ford, Steinberg, Hawke, Levine, & Zhang (2012) [71]	USA	Child abuse; Child sexual abuse; Family violence; Parental substance use	Juvenile offenders	Psychological/ emotional or behavioural symptoms	RCT: Yes Control : TAU (enhanced) Follow up: None	n=33	n=26	a. Yes (PTSD & affect regulation); Non-sig. (anger domain TAU better) b. No c. N/A d. N/A
Trauma	To teach youths who	13 - 18	Ford &	USA	Not	Juvenile	Service utilisation	RCT: No	n=197	n=197	a. Yes (other -

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Affect Regulation: Guide for Education & Therapy (TARGET)	behave problematically to better manage their emotions, thoughts, & behaviour.		Hawke (2012) [72]		specified	offenders		Control: Matched sample (gender & age) Follow up: None			incidents within the facility); Non-sig. (service utilisation), b. No c. N/A d. N/A
Trauma-focused ARC (attachment, Self-regulation & competency) Intervention Model	To provide clinical illustration & associated outcomes from the first naturalistic program evaluation of the ARC model applied to young children impacted by complex trauma exposure & maladaptation.	3 - 12	Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Evans, …, & Blaustein (2011) [73]	USA	Child abuse; Child sexual abuse: Neglect; Family violence; Parental substance use; Parental mental illness; Other	Foster care; Ethnicity	Child physical; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning; Service utilisation	RCT: No Control: Non-completer Follow up: None (comments about later service utilisation)	n=21	n=24	a. Yes b. No c. Yes (service utilisation only) d. Not specified
Trauma focused art therapy intervention	To reduce trauma symptoms.	Not specified	Lyshak-Stelzer, Singer, Patricia, & Chemtob (2007) [74]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: TAU Follow up: None	n=14 mean:14.8	n=15 mean:15.1	a. Yes b. No c. N/A d. N/A
Trauma Intervention Program for Adjudicated & At-Risk Youth (SITCAP-ART)	To diminish terror in exposed individuals & facilitate feelings of safety using sensory-based therapeutic activities & CBT.	13 - 18	Raider, Steele, Delillo-Storey, Jacobs, & Kuban (2008) [75]	USA	Not specified	Other	Psychological/emotional or behavioural symptoms	RCT: Yes Control: Waitlist Follow up: None	n=13 range:15-18	n=10 range:15-18	a. Yes b. No c. N/A d. N/A
Triple P - Enhanced Group Behavioural Family	To improve parent/child interactions to reduce the risks for child maltreatment.	2 - 7	Sanders, Pidgeon, Gravestock, Connors, Brown, &	Australia	Child abuse; Neglect	Caregiver offenders; Other	Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: Yes Control: Triple P – Standard Group Behavioural	n=50 (parent) mean: 34.2 (parent) mean:2.4	n=48 (parent) mean: 33.3 (parent) mean:1.9	a. Yes b. No c. No (improvements were maintained

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Intervention			Young (2004) [76]					Family Intervention (TAU) Follow up: 6mths	(child)	(child)	but group differences attenuated). d. 6mths

Note: TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 5b. Summary of Promising A programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific\focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Attachment and Biobehavioural Catchup Intervention (ABC)	Bernard, … & Carlson (2012) [45]	0-2.5					✓								✓			
	Sprang (2009) [46]	0-5			✓		✓							✓	✓			
Cognitive Behavioural Therapy (CBT)	LeSure-Lester (2002) [47]	12-16			✓		✓							✓	✓			
	Arnold, … & Julian (2003) [48]	12-17				✓								✓	✓			✓
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	Morsette, … & Stolle (2012) [49]	Not specified	TS/F TIC		Not specified									✓				
	Stein, … & Fink (2002) [50]	11-15						✓			✓			✓				
	Goodkind, … & Milford (2010) [51]	11-15						✓			✓			✓				
	Kataoka, … & Fink (2003) [52]	11-15						✓			✓			✓				
Child & Family Cognitive Behavioural Therapy (CBT) for sexually abused children	King, , … & Ollendick (2000) [53]	5-17	TS/F	✓		✓								✓				
Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)	Runyon, … & Schroeder (2009) [54]	Not specified	TS/F		✓									✓				
	Runyon, … & Steer (2010) [61]	Not specified			✓	✓		✓						✓				
Eye Movement Desensitization & Reprocessing (EMDR)	Jaberghaderi, … & Dolatabadi (2004) [56]	12-13	TS/F			✓								✓				
	Soberman, … & Rule (2002) [57]	10-16			Not specified									✓				
	Ahmad, … & Sundelin-Wahlsten (2007) [58]	6-16				✓	✓		✓	✓	✓			✓				
	Ahmad & Sundelin-Wahlsten (2008) [59]	6-16				✓	✓		✓	✓				✓				
Infant-Parent Psychotherapy (IPP)	Cicchetti, … & Toth (2006) [34]	1-1	TS/F		✓		✓								✓			
Parent-Child Interaction Therapy (PCIT)	Thomas & Zimmer-Gembeck (2011) [60]	2-12	TS/F TIC		✓		✓							✓	✓			
	Galanter, … & Prieto (2012) [61]	2-12			✓		✓								✓				
	Pearl (2008) [62]	2-12						✓						✓				
	Pearl, … & Putnam (2012) [63]	2-12			Not specified									✓	✓			
	Hakman, … & Silovsky (2009) [64]	2-12			✓										✓			
	Chaffin, … & Bonner (2004) [65]	2-12			✓												✓	

Approach name	Authors & year	Age	Trauma-specific\focused Trauma-informed care	Australia	Trauma type: Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Outcome domain: Risk for abuse	Physical	PEBS¹	RFSF²	Educational	Service utilisation	Cognition
	McNeil, … & Clemens-Mowrer (2005) [66]	2-7			✓		✓							✓				
Short-term attachment-based intervention	Moss, … & Bernier (2011) [67]	1-5			✓	✓	✓							✓				
Seeking Safety (SS)	Najavits, … & Weiss (2006) [68]	13-18	TS/F		Not specified									✓				
SOS! Helps for parents	Oveisi, … & Shahrivar (2010) [69]	2-6									✓	✓						
Support for Students Exposed to Trauma	Jaycox, … & Schonlau (2009) [70]	mean:11.5	TS/F								✓			✓				
Trauma Affect Regulation: Guide for Education and Therapy (TARGET)	Ford, … & Zhang (2012) [47,71 47,71 47,71] 47,71 48,72 48,72 {Ford, 2012}	13-18	TS/F		✓	✓		✓	✓					✓				
	Ford & Hawke (2012) [72]	13-18			Not specified												✓	
Trauma-focused ARC (attachment, Self-regulation & competency) Intervention Model	Arvidson, … & Blaustein (2011) [73]	3-12	TS/F TIC		✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	
Trauma focused art therapy intervention	Lyshak-Stelzer, … & Chemtob (2007) [74]	Not specified	TS/F		Not specified									✓				
Trauma Intervention Program for Adjudicated and At-Risk Youth (SITCAP-ART)	Raider, … & Kuban (2008) [75]	13-18	TS/F		Not specified									✓				
Triple P - Enhanced Group Behavioural Family Intervention	Sanders, … & Young (2004) [76]	2-7		✓	✓		✓					✓		✓				
Total programs				**2**	**9**	**7**	**8**	**5**	**3**	**2**	**5**	**3**	**0**	**15**	**5**	**0**	**3**	**1**

Note: TS/F = Trauma-specific/ focused; TIC = Trauma-informed care; SMU = Substance misuse; MI = Mental illness; PEBS¹= Psychological/ emotional or behavioural symptoms; RFSF²= Relationships & family/ social functioning.

Table 6a. Summary of Promising A service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Child protection services (CPS) concurrent with family preservation services (FPS)	To combine family preservation services with child protection services to minimise use of out-of-Home placements.	Not specified	Walton (2001) [77]	USA	Child abuse; Neglect	Other	Service utilisation; Relationships & family or social functioning	RCT: Yes Control: TAU (post-treatment only) Follow up: None	n=97 (family) mean:8.0	n=111 (family)	a. Yes b. No c. N/A d. N/A
Healthy Families America	To promote positive parenting, enhance child health & development, & prevent child maltreatment (America)	0 - 7	Cullen, Ownbey, & Ownbey (2010) [78]	USA	Neglect	At risk families	Relationships & family or social functioning; Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=116	See total in previous cell.	a. Yes b. No c. N/A d. N/A
Healthy Families America	To decrease the occurrence of abuse & neglect among high-risk families & specifically target 95% of children with no substantiated child abuse/ neglect (Alaska)	0 - 2	Gessner (2008) [79]	USA	Child abuse; Neglect	At risk families	Child physical; Service utilisation	RCT: No Design: retrospective cohort Follow up: None	n=985	See total in previous cell.	a. No b. No c. N/A d. N/A
Healthy Families America	To prevent child maltreatment by promoting positive parenting & child health & development (Alaska)	0 - 5	Duggan, Caldera, Rodriguez, Burrell, Rohde, & Crowne (2007) [80]	USA	Other	At risk families	Service utilisation; Risk for childhood abuse	RCT: Yes Control: TAU Follow up: None	n=162 (family)	n=163 (Family)	a. Yes (for one measure of risk for abuse). No (for other measures of abuse & service utilise). b. No c. N/A d. N/A
Healthy Families America	To promote positive parenting, enhance child health & development, & prevent child abuse & neglect (Arizona)	0 - 5	LeCroy & Krysik (2011) [81]	USA	Child abuse; Neglect	At risk families	Relationships & family or social functioning	RCT: Yes Control: Child development Follow up: 6- & 12mths	n=97	n=98	a. Yes b. No c. No d. 6 or 12mths
Healthy Families America	To use screening & assessment to identify families at-risk of child	0 - 5	Duggan, McFarlane, Fuddy, Burrell,	USA	Child abuse; Neglect	At risk families	Child physical; Relationships & family or social	RCT: Yes Controls: Main & Testing (n=45)	n=395	n=290	a. Yes b. No c. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	abuse & neglect. Then home visit identified at-risk families (Hawaii)		Higman, Windham, & Sia (2004) [82]				functioning	Follow up: None			d. N/A Note: Data at 12mth, 24mth & 36mth for regression analysis)
Healthy Families America	To promote parenting competencies in the early formative years of the child's life to best influence positive development & enhance mothers' habitual parenting practices (New York)	0 - 5	Rodriguez, Dumont, Mitchell-Herzfeld, Walden, & Greene (2010) [83]	USA	Child abuse; Neglect	At risk families	Relationships & family or social functioning	RCT: Yes Control: Not stated Follow up: None	n=255 (mother) mean: 3.1 (child)	n=267 (mother) mean: 3.1 (child)	a. Yes (positive parenting & negative parenting for HPO subgroup); non-sig. (negative parenting). b. No c. N/A d. N/A
Healthy Families America	To promote positive parenting skills & parent-child interaction, prevent child abuse & neglect, support optimal prenatal care, & child health & development; & improve parent's self-sufficiency (New York)	0 - 5	DuMont, Mitchell-Herzfeld, Greene, Lee, Lowenfels, Rodriguez, & Dorabawila (2008) [84]	USA	Other	At risk families	Child physical; Service utilisation	RCT: Yes Control: group given info & referral to other appropriate services in the Community Follow-up: 2yrs (in Study 1 only)	n=478 (mother) (including prevention subgroup: n=170; psychological vulnerable subgroup: n=122)	n=493 (mother)	Study 1: Overall a. No; b. No; c. No; d. 2yrs Study 2: Prevention group a. Yes (at 2yrs) b. No; c. N/A; d. N/A Study 3: Vulnerable Grp a. Yes (at 2yrs) b. No; c. N/A; d. N/A Note: randomisation was pre-natal.

Note: RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy. a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 6b. Summary of Promising A service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-focused/specific Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Child protection services (CPS) concurrent with family preservation services (FPS)	Walton (2001) [77]	mean: 8yrs			✓		✓								✓		✓	
Healthy Families America	Gessner (2008) [79]	0-2			✓		✓						✓				✓	
	Duggan, … & Crowne (2007) [80]	0-5									✓	✓					✓	
	Cullen, … & Ownbey (2010) [78]	0-7					✓							✓	✓			
	LeCroy & Krysik (2011) [81]	0-5			✓		✓								✓			
	Duggan, … & Sia (2004) [82]	0-5			✓		✓						✓		✓			
	Rodriguez, … & Greene (2010) [83]	0-5			✓		✓								✓			
	DuMont, … & Dorabawila (2008) [84]	0-5									✓		✓				✓	
Total service models				**0**	**2**	**0**	**2**	**0**	**0**	**0**	**1**	**1**	**1**	**1**	**2**	**0**	**2**	**0**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 7a. Summary of Promising A systems of care

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Motivation–adaptive skills–trauma resolution (MASTR) with eye movement desensitization & reprocessing (EMDR)	To reduce trauma symptoms & behavioural problems in traumatised youth with conduct problems in youth protective services.	Not specified	Farkas, Cyr, Lebeau, & Lemay (2010) [85]	Canada	Child abuse; Child sexual abuse; Other	Residential care	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: TAU Follow-up: 3mths	n=19 (child) F=14; M=5 mean:14.3	n=21 (child) F=11; M=10 mean:14.9	a. Yes b. No c. Yes d. 3mths
Sanctuary Model	To use a trauma-focused model to address the special needs of youth with serious emotional disturbances & histories of maltreatment &/or exposure to domestic & community violence.	12 - 20	Rivard, Bloom, McCorkle, & Abramovitz (2005) [86]	USA	Not specified	Residential care	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: Standard Residential Services Follow up: 3/6mths	No detail	n=158 F=58; M=100 mean:15.0	a. Yes b. No c. Yes d. 6mths

Note: RCT = Randomised Controlled Trial; F = Female; M = Male; n= no. of participants in sample; TAU = Treatment As Usual; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 7b. Summary of Promising A systems of care by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Motivation–Adaptive Skills–Trauma Resolution (MASTR) with Eye Movement Desensitization & Reprocessing	Farkas, … & Lemay (2010) [85]	Not specified	TS/F TIC		✓	✓					✓			✓				
Sanctuary Model	Rivard, … & Abramovitz (2005) [86]	12-20[D]	TS/F TIC		✓	✓	✓	✓						✓				
Total systems of care				**0**	**2**	**2**	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**2**	**0**	**0**	**0**	**0**

Note: [D]= Residential care; TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning.

Table 8a. Summary of Promising B programs

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Canine assisted therapy	To reduce psychological distress associated with trauma.	Not specified	Hamama, Hamama-Raz, Dagan, Greenfeld, Rubinstein, & Ben-Ezra (2011) [87]	Israel	Child abuse; Child sexual abuse	Other	Psychological/emotional or behavioural symptoms	RCT: No Control: TAU Follow up: None	n=9 (child) F=9; M=0 mean: 15.3	n=9 (child) F=9; M=0 mean:14.5	a. Yes b. No c. N/A d. N/A
Child Sexual Abuse Treatment Program (CSATP; Giarretto model)	To examine program effectiveness on vulnerability (self-esteem/ depressive affect) & problem behaviours reported by adults.	0 - 16	Bagley & LaChance (2000) [88]	Canada	Child sexual abuse	Caregiver offenders	Educational; Psychological/ emotional or behavioural symptoms	RCT: No Control: Untreated Follow up: None	(n=27) mean: 11.2	(n=30) Mean: 11.8	a. Yes b. No c. N/A d. Post measures taken 2yrs after commencing therapy
Group Art Therapy	To reduce depression, anxiety, sexual trauma & low self-esteem among sexually abused girls.	8 - 11	Pretorius & Pfeifer (2010) [89]	South Africa	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Controls: 2 intervention & 2 non-intervention Follow up: None	n=6 (for intervention / non-intervention groups)	n=6 & n=7	a. Yes b. No c. N/A d. N/A
Group therapy for sexually abused children	To reduce internalizing & externalizing behaviour problems & posttraumatic stress symptoms; to foster positive self-esteem; to help children recognize & express their feelings; to help children identify their personal coping resources to manage the aftermaths of CSA; to reduce sense of social isolation & shame by fostering exchanges & supportive relationships with other child victims of abuse; to foster positive parent–child relationship; & to prevent re-victimization.	6 - 12	Hebert & Tourigny (2010) [90]	Canada	Child sexual abuse	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: No Control: TAU Follow up: None	n=51 F=38; M=13	N=39 F=34, M=5	a. Yes b. No c. N/A d. N/A
Group therapy for	To evaluate a group therapy program for sexually abused	13 - 17	Tourigny, Herbert,	Canada	Child sexual	Other	Psychological/ emotional or	RCT: No Control: No	n=27 F=27; M=0	n=15 F=15; M=0	a. Yes; non-sig. (somatic,

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
sexually abused teenage girls	teenage girls.		Daigneault, & Simoneau (2005) [91]		abuse		behavioural symptoms; Relationships & family or social functioning	treatment. Follow up: None	mean:14.8	mean:14.3	delinquency, aggression) b. No c. N/A d. N/A
Group therapy for sexually abused teenage girls	To evaluate group therapy for sexually abused teenage girls (Open groups & Closed Groups).	13 - 17	Tourigny & Hebert (2007) [92]	Canada	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms;	RCT: No Control: untreated Follow up: None	(n=27) F=27; M=0 mean:14.8	(n=15) F=15; M-0 Mean: 14.3	a. Yes b. No c. N/A d. N/A
Imagery Rehearsal Therapy	To reduce sleep complaints related to PTSD & reduce the impact & occurrence of distressing chronic nightmares.	13 - 18	Krakow, Sanoval, Schrader, Keuhne, McBride, Yau, & Tandberg (2001) [93]	USA	Child sexual abuse	Substance abusers	Psychological/ emotional or behavioural symptoms	RCT: No Control: No intervention Follow up: None	(At baseline n=30) n=9 F=9; M=0 range:13-18	n=10 F=10; M=0 range:13-18	a. Mixed Yes (nightmares only); non-sig. (PTSD & sleep measures) b. No c. N/A d. N/A
Outpatient & Residential treatment for adolescent	To reduce substance use.	13 - 18	Funk, McDermeit, Godley, & Adams (2003) [94]	USA	Not specified	Juvenile offenders	Psychological/ emotional or behavioural symptoms	RCT: No Controls: Residential & Outpatient modalities Follow up: None	n=114 F=27; M=87	n=73 F=19; M=54	a. Yes (residential preferred with history of high levels of trauma); non-sig. (both modalities equal for low trauma histories). b. No c. N/A d. N/A
Project SafeCare	To improve parenting skills & reduce future occurrences of abuse & neglect.	0 - 5	Gershater-Molko, Lutzker, & Wesch (2002) [95]	USA	Child abuse	Caregiver offenders	Service utilisation	RCT: No Control: TAU Follow up: 24mths	n=41	n=41 (matched by child age)	a. Yes b. No c. Yes d. 24mths Note: TAU = Family Preservation program
Project SafeCare	To decrease child maltreatment & prevent the removal of children, by improving parental knowledge of child development, changing parental attitudes towards their children, improving home environment, & linking	0 - 5	Gershater-Molko, Lutzker, & Wesch (2003) [96]	USA	Child abuse, Neglect	Caregiver offenders, Other	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=70	No comparison group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	parents to community resources.										
Project SafeCare	To increase parenting skills, child & infant health, home safety, & parent/ child bonding.	0 - 5	Damashek, Bard, & Hecht (2012) [97]	USA	Child abuse, Neglect	Ethnicity	Service utilisation, Risk for childhood abuse	RCT: No Control: TAU Follow up: None	Combined sample: n=1,305 (parent: F=80%) range:0-12	See total in previous cell.	a. Yes b. No c. N/A d. N/A
Rythmex	To use rhythmic exercises to improve the cognitive function & behaviour of maltreated children.	6 - 11	Goldshtrom, Korman, Goldshtrom, & Bendavid (2011) [98]	USA	Child abuse, Neglect	Residential care	Psychological/ emotional or behavioural symptoms; Cognition	RCT: No Control: TAU Follow up: 12mths	n=23 (child) F=13; M=10 mean:8.5	n=14 (child) F=6; M=8 mean:8.5	a. Yes b. No c. Yes d. 12mths

Note: RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 8b. Summary of Promising B programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Canine assisted therapy	Hamama, … & Ben-Ezra (2011) [87]	Not specified	TS/F		✓								✓					✓
Child Sexual Abuse Treatment Program (CSATP)	Bagley & LaChance (2000) [88]	0-16			✓								✓		✓			
Group Art Therapy for Sexual Abuse	Pretorius & Pfeifer (2010) [89]	8-11	TS/F			✓								✓				
Group therapy for sexually abused children	Hebert & Tourigny (2010) [90]	6-12	TS/F			✓								✓	✓			
	Tourigny, … & Simoneau (2005) [91]	13-17				✓								✓				
	Tourigny & Hebert (2007) [92]	13-17				✓								✓				
Imagery Rehearsal Therapy	Krakow, … & Tandberg (2001) [93]	13-18	TS/F			✓								✓				
Residential substance abuse treatment	Funk, … & Adams (2003) [94]	13-18	TS/F		Not specified									✓				✓
Project SafeCare	Gershater-Molko, … & Wesch (2002) [95]	0-5			✓												✓	
	Gershater-Molko, … & Wesch (2003) [96]	0-5			✓		✓								✓			
	Damashek, … & Hecht (2012) [97]	0-5			✓		✓					✓					✓	
Rythmex	Goldshtrom, … & Bendavid (2011) [98]	Not specified			✓		✓							✓				
Total programs				**0**	**4**	**3**	**2**	**0**	**0**	**0**	**0**	**1**	**2**	**4**	**3**	**0**	**1**	**2**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 9a. Summary of Promising B service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Brighter Futures	To assess the effectiveness of a child protection prevention program that is targeted at vulnerable families with children at risk of abuse &/or neglect.	0 - 18	Hilferty &…Katz (2010) [99]	Australia	Family Violence; Child abuse	Caregiver offenders; Other	Child physical; Service utilisation	RCT: No Control & Pre/post treatment Follow up: 12mths	n=4170 (child)	n=2462 (child)	*Harm Reports: a. Yes (pre/post); Non-sig. (comparison group better than intervention. However when families completed intervention program the outcome were better than the comparison group). b. No c. Yes (for parents who completed intervention). d. 12mths. *Out of Home Care: a. Yes; b. No; c. N/A; d. N/A *Child Behaviour: a. Yes (no control) b. No; c. N/A; d. N/A *Child Development: a. No; b. No; c. N/A; d. N/A
Child-Parent Centres	To examine the effectiveness of a family-school partnership model used in prevention programming.	3 - 9	Reynolds & Robertson (2003) [100]	USA	Not specified	Other	Service utilisation; Risk for childhood abuse	RCT: No Control: Full day kindergarten Follow up: None	n=989	n=550	a. Yes b. No c. N/A d. N/A
Child-Parents Centres	To provide educational & family support services to eligible children.	3 - 9	Mersky, Topitzes, & Reynolds (2011) [101]	USA	Other	At risk families	Child physical; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Control: TAU Follow up: None	n=989 (child)	n=550 (child)	a. Yes b. No c. N/A d. N/A
Cottage Community Care Pilot Project (CCCPP)	To directly address factors in first-time families that are associated with child maltreatment.	15 – 35 mothers	Kelleher (2004) [102]	Australia	Other	At risk families	Relationships & family or social functioning	RCT: No Control: Signed up to program but not waitlist & Follow up: None	n=25 (mother) F=25; M=0 48% aged <19yrs	n=14 (mother) F=14; M=0 57% aged <19yrs	a. Yes b. No c. No d. NA

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Minnesota Alternative Response Project	To assist families reported for child abuse & neglect to child protection services.	Not specified	Loman & Siegel (2005) [103]	USA	Child abuse	Caregiver offenders	Child physical; Service utilisation	RCT: No Control: Untreated Follow up: 1yr	n=2,860 (families)	n=1,305 (families)	a. Yes b. No c. Yes d. 1yr
Parent Aide Program	To break the cycle of child abuse though the provision of in-Home services, free of charge, to families in Dallas County, referred by CPS.	0 - 12	Harder (2005) [104]	USA	Child abuse, Neglect	Other	Relationships & family or social functioning, Service utilisation	RCT: No Controls: Program Refusers & Drop outs Follow up: None	Completers: N=46 (parent) mean:28.3 F=96% mean:4.4 (child)	Drop outs: n=88 (parent mean:26.1 F=97%). mean:3.5 (child) Refusers: n=112 (parent mean:26.8) Mean:4.8 (child)	a. Yes b. No c. N/A d. N/A
Sexual Abuse Intervention Program (SAIP)	Not indicated.	Not specified	Holland, Gorey, & Lindsay (2004) [105]	Canada	Child sexual abuse	Residential care; Ethnicity	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Comparison: TAU Follow up: None	n=10 (child)	n=56 (child)	a. Yes b. No c. No d. N/A
State-wide Family Preservation & Family Support (FPFS) programs	8 programs: Healthy Families America (HFA) & Parents-as Teachers (Home visits); Basic Needs (practical assistance); Nurturing (education); Parent Mentoring; Parent Education Centre; Agency Collaborative (case management).	0 - 18	Chaffin, Bonner, & Hill (2001) [106]	USA	Child abuse; Child sexual abuse; Neglect	Ethnicity; Caregiver offenders; Other; Teenage pregnancy	Child physical; Service utilisation; Risk for childhood abuse	RCT: No Control: Treatment non-completers Follow up: Up to 3yrs	n=1601 (family) F=1462; M=139	No comparison group	a. Yes (Child physical/ service utilisation) Basic Needs & Parent Mentoring were most effective, especially for high risk parents). No (Risk for abuse) non-sig. for programs types. b. No c. No d. 3yrs max, median:1.6yrs
Therapeutic Residential Care	To support independent/ adult living (12-17yrs); or restore family connections were possible (11-14yrs); or	Varies across pilots: 0 - 14; 9 - 12	Sullivan, Faircloth, McNair, Southern, Brann,	Australia	Neglect,	Residential care	Child physical; Cognition; Educational, Psychologica	RCT: No Control (Out-of-Home Care,	n=38 F=25 ; M=13 range: 5-16	n=16 F=8; M=8 median:13.0 (18mths pre-program	a. Non-sig. compared to control. Yes sig. for Pre/post comparison for conduct problems (entry to follow up). Pre-entry compared to Entry sig. (pro-social behaviours & impact of difficulties;

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	offer placement with ATSI kinship (0-14yrs); or develop Community & education linkages (13-15yrs).	11-17	Starbuck, …, & Ribarow (2011) [107]				l/ emotional or behavioural symptoms; Relationships & family or social functioning	OoHC). Follow up: 2yrs	median :15.0	matched demographic /time in care)	totals HoNOSCA & SDQ). b. No c. Yes, but non-sig. for all but conduct. d. 2yrs

Note: TAU = Treatment As Usual; RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 9b. Summary of Promising B service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Brighter Futures	Hilferty ...& Katz (2010) [99]	0-18		✓	✓			✓					✓				✓	
Child-Parent Centre Program	Reynolds & Robertson (2003) [100S]	3-9			Not specified							✓					✓	
	Mersky, … & Reynolds (2011) [101S]	3-9									✓		✓	✓	✓			
Cottage Community Care Pilot Project (CCCPP)	Kelleher (2004) [102]	1-3		✓							✓				✓			
Minnesota Alternative Response Project	Loman & Siegel (2005) [103]	Not specified			✓								✓				✓	
Parent Aide Program	Harder (2005) [104]	0-12			✓		✓								✓		✓	
Sexual Abuse Intervention Program (SAIP)	Holland, … & Lindsay (2004) [105]	Not specified				✓								✓	✓			
State-wide Family Preservation and Family Support (FPFS) programs	Chaffin, … & Hill (2001) [106]	0-18			✓	✓	✓					✓	✓				✓	
Therapeutic Residential Care	Sullivan, … & Ribarow (2011) [107]	11-17	TS/F TIC	✓			✓				✓	✓	✓	✓	✓	✓		✓
Total service models				**3**	**4**	**2**	**3**	**1**	**0**	**0**	**3**	**3**	**5**	**3**	**5**	**1**	**5**	**1**

Note: [S] = These two articles reported on the same study; TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 10a. Summary of Promising B systems of care

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Houston Child Advocates	To find safe, loving, permanent homes for abused & neglected children.	0 - 18	Waxman, Houston, Profilet, & Sanchez (2009) [108]	USA	Child abuse; Neglect	Foster care; Residential care	Relationships & family or social functioning; Psychological/ emotional or behavioural symptoms; Service utilisation	RCT: No Control: Protective custody*. Follow up: 1/2/3yrs	n=327 F=161; M=167	n=254 F=124; M=130	a. Yes b. No c. Yes (only family communication 2yrs) d. 2yrs Note: *matched: gender/ age/ abuse type
Trauma Systems Therapy	To assess the fit between child's emotional regulation capacities & adequacy of the social environment & system of care to help the child. Therapy is based on assessment to offer a variety of treatment modules designed for severe problems in children's environments.	Not specified	Saxe, Ellis, Fogler, Hansen, & Sorkin (2005) [109]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=82 F=34; M=48 mean:11.2	No comparison group	a. Yes b. No c. N/A d. N/A
Trauma Systems Therapy	To meet the multiple socio-ecological needs of children with histories of trauma exposure.	Not specified	Saxe, Ellis, Fogler, & Navalta (2012) [110]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Control: TAU Follow up: None	n=10	n=10	a. Yes b. No c. N/A d. N/A
Skills-Based Intervention	To promote children's resilience, increase their knowledge about safety & safety planning, & increase their intrapersonal skills & competencies.	5 - 10	Noether, Brown, Finkelstein, Russell, VandeMark, Morris, & Graeber (2007) [111]	USA	Family violence; Parental substance use, Parental mental illness	Other	Psychological/ emotional or behavioural symptoms	RCT: No Control: TAU Follow up: 6/12mths	n=115 (mother)	n=138 (mother)	a. Yes b. No c. Yes d. 1yr

Note: RCT = Randomised Controlled Trial; F = Female; M = Male; n= no. of participants in sample; TAU = Treatment As Usual; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 10b. Summary of Promising B systems of care by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Houston Child Advocates	Waxman, … & Sanchez (2009) [108]	0-18			✓		✓							✓	✓		✓	
Skills-based intervention program	Noether, … & Graeber (2007) [111]	5-10						✓	✓	✓				✓				
Trauma Systems Therapy	Saxe, … & Sorkin (2005) [109]	Not specified	TS/F TIC		Not specified									✓				
	Saxe, … & Navalta (2012) [110]	Not specified			Not specified									✓				
Total systems of care				**0**	**1**	**0**	**1**	**1**	**1**	**1**	**0**	**0**	**0**	**3**	**1**	**0**	**1**	**0**

Note: TS/F = Trauma-specific/ focused; TIC = Trauma-informed care; SMU = Substance misuse; PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning.

Table 11a. Summary of Emerging A programs

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
A Home Within – A relationship-based intervention	To prioritize children's needs of community, stability, & permanency in attachment to healthy adult(s). Long-term psychoanalytically-orientated therapy including play therapy.	5 - 11	Clausen, Ruff, Von Wiederhold, & Heineman (2012) [112]	USA	Neglect	Foster care	Educational; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=20 F=6; M=14	No comparison group	a. Yes (school, anxiety, sleep, dissociative, depression & Peer relationships). Non-sig. (conduct, learning, anger, psychosis, eating, self-injury, substance use, family). b. No c. N/A d. N/A Duration: 0.5-7.4yrs (mean: 3.4yrs)
Alternatives for Families: Cognitive behavioural Therapy (AF-CBT)	To improve the relationships between children & caregivers in families involved in physical coercion/force & chronic conflict/hostility.	3 - 17	Kolko, Iselin, & Gully (2011) [113]	USA	Child abuse; Child sexual abuse; Neglect; Family violence	Ethnicity; Disability	Child Physical; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=46 F=25; M=27 mean:9.1	No comparison group	a. Yes b. No c. N/A d. N/A
Circle of Parents	To use a mutual self-help support group model as a means of preventing child abuse & neglect & strengthening families.	Not specified	Falconer, Haskett, McDaniels, Dirkes, & Siegel (2008) [114]	USA	Other	Other	Relationships & family or social functioning	RCT: No Pre/post treatment measures in four states Follow up: None	Parents : n=118 (Florida) N=101 (Minnesota) n=564 (Washington) n=89 (Nth Carolina)	No comparison group	a. Yes b. No c. N/A d. N/A
Circle of Security	To reduce the risk of insecure attachment	Not specified	Hoffman, Marvin, Cooper & Powell (2006) [115]	USA	Other	At risk families	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=65 (caregivers), n=65 (children), F=35, M=30	No comparison group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Combined Art Therapy & Cognitive Behavioural Therapy	To reduce post traumatic symptoms in victims of childhood sexual abuse.	8 - 17	Pifalo (2002) [116]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=13	No comparison group	a. Yes (anxiety, PTSD); non-sig. (depression). b. No c. N/A d. N/A
Combined Art Therapy & Cognitive Behavioural Therapy	To Reduce post traumatic symptoms in victims of childhood sexual abuse.	Not specified	Pifalo (2006) [117]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=41	No comparison group	a. Yes b. No c. N/A d. N/A
Emotion-focused therapy for trauma	To focus on exploring trauma-related feelings & meanings, constructing more adaptive meaning, & resolving issues with particular perpetrators of abuse & neglect.	Not specified	Mundorf & Paivio (2011) [118]	Canada	Child abuse; Child sexual abuse; Neglect	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=37	No comparison group	a. Yes b. No c. N/A d. N/A
Equine-assisted psycho-therapy	To encourage client insight through horse interactions/ examples. Horses have characteristics like humans, & they respond to non-verbal human behaviours through interaction.	Not specified	Schultz, Remnick-Barlow, & Robbins (2007) [119]	USA	Family violence; Child abuse; Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=63 F=26 (mean:10.1) M=37 (mean:11.5)	No comparison group	a. Yes (abuse/neglect), non-sig. (sexual abuse, family violence). b. No c. N/A d. N/A
Eye movement integration therapy	To support the overcoming of childhood trauma.	14 – 16	Struwig & van Breda (2012) [120]	South Africa	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=12	No comparison group	a. Yes b. No c. N/A d. N/A
Game-based cognitive-behavioural therapy	To improve internalizing symptoms, externalizing behaviours, sexually inappropriate behaviours, social skills deficits, self-esteem problems, & knowledge of healthy	Not specified	Misurell, Springer, & Tryon (2011) [121]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=48 F=30; m=18 mean: 7.3	No comparison group	a. Yes (anxiety, sexually inappropriate behaviour); non-sig (depression & post trauma symptoms). b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	sexuality & self-protection skills.										
Gipuzkoa program	To provide specialised/ individualised case management, psycho-education & therapy to caregiver & child.	0 – 18	de Paúl & Arruabarrena (2003) [122]	Spain	Child abuse; Neglect	Residential care	Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: No Pre/post treatment measures Follow up: None	n=133 (family); n=289 (child)	No comparison group	a. Yes b. No c. N/A d. N/A Duration: 15-17 sessions A home-based treatment for a maximum of 2yrs.
Grief & Trauma Intervention (GTI) with coping skills & TN processing	To improve symptoms of PTSD.	Not specified	Salloum & Overstreet (2012) [123]	USA	Child abuse; Family violence; Other	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: GTI with coping skills only Follow up: 3/12mths	n=39	n=33	a. Yes (but equally across groups). b. No c. Yes (but equally across groups). d. 12mths
Group Intervention: Psycho-education	To reduce levels of depression, anxiety & trauma symptoms among incarcerated the female juvenile offenders	Not specified	Pomeroy, Green, & Kiam (2001) [124]	USA	Child abuse; Child sexual abuse; Neglect; Family violence	Juvenile offenders	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=15 mean:51.9	No comparison group	a. Yes (depression, trauma), No (anxiety). b. No c. N/A d. N/A
Group intervention (child) & group intervention (parent)	To address posttraumatic stress issues in children by creating a safe & trusting therapeutic environment that enables expression of thoughts & feelings, and sharing of experiences. To focus on relationship building between the parent & child and promote positive discipline practices.	6 – 12	MacMillan & Harpur (2003) [125]	Canada	Family violence	Other	Psychological/emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=47 (child) F=23; M=24 means: child 9yrs; parent: 37yrs	No comparison group	a. Yes (psychological/ behavioural measures) b. No c. N/A d. N/A
Manualized cognitive restructuring	To reduce symptoms of posttraumatic stress.	13 – 18	Rosenberg, Jankowski,	USA	Not specified	Other	Psychological/emotional or behavioural	RCT: No Pre/post treatment	n=12 F=9; M=3 mean:16.0	No comparison group	a. Yes b. No c. Yes

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
program			Fortuna, Rosenberg, & Mueser (2011) [126]				symptoms	measures Follow up: 3mths			d. 3mths
Parent-Child Attunement Therapy	To strengthen caregivers r/s with children & learning of appropriate child-management techniques.	1-2.5	Dombrowski, Timmer, Blacker, & Urquiza (2005) [127]	USA	Child abuse, Neglect	Other	Relationships and family or social functioning, Risk for childhood abuse	RCT: No Control: Pre/post treatment measures Follow up: None	n=1 M=1 23 mths	No comparison group	a. No b. No c. N/A d. N/A
Parent education about the risk of head injury after shaking infants	To prevent child abuse/ head injuries caused by caregivers shaking infants & reduce medical costs for treatment & loss of life.	0 – 1	Dias, Smith, DeGuehery, Mazur, Li, & Shaffer (2005) [128]	USA	Child abuse	Other	Risk for childhood abuse	RCT: No Control: Community norms Follow up: None	n=65,205 (parent) signed forms: F=96%; M=76% range:0-3	Population-level (statistics): Previous 6yrs of data	a. Yes b. No c. N/A d. N/A Duration: <1hr.
Parent-led, Clinician-Assisted Trauma Focused - Cognitive Behavioural Therapy (PTA-TF-CBT)	To improve PTSD symptoms.	3 – 7	Salloum & Storch (2011) [129]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=1	No comparison group	a. Yes b. No c. N/A d. N/A
Play therapy	To produce positive changes in sexually abused children's traumatic symptoms.	Not specified	ReYes & Asbrand (2005) [130]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=18 F=13; M=5 mean:11.0	No comparison group	a. Yes b. No c. N/A d. N/A
Pragmatic-communicative intervention	To encourage adults to solve interpersonal problems by enhancing communication and skills (conversational language, requests, narrative skills & abstract	8 - 12	Manso, Sanchez, Alonso, & Romero (2012) [131]	Spain	Child abuse; Neglect	Residential care	Cognition	RCT: No Pre/post treatment measures Follow up: None	n=21	No comparison group	a. Yes b. No c. N/A d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	& figurative language).										
QEEG-guided neuro-feedback	To teach children to self-regulate brain rhythmicity.	6 - 12	Huang-Storms, Bodenhamer, Davis, & Dunn (2006) [132]	USA	Child abuse; Neglect	Residential care	Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	N=20 (child) F=9; M=11 mean:10.4 range:6-15.5	No comparison group	a. Yes b. No c. N/A d. N/A
Real Life Heroes	To build the skills & interpersonal resources needed to re-integrate painful memories & reduce affect dis-regulation following trauma.	8 - 15	Kagan, Amber, Hornik, Kratz, & Suzannah (2008) [133]	USA	Child abuse, neglect; Family violence, Other	Residential care; Foster care; Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=41 (child) F=17; M=24 mean:10.5	No comparison group	a. Yes b. No c. N/A d. NA
Strengthening Family Coping Resources	To establish within the family unit: routine, structure, connectedness, safety, resource seeking, co-regulation & crisis management, positive affect, memories & meaning.	1 - 12	Kiser, Donohue, Hodgkinson, Medoff, & Black (2010) [134]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/ post treatment measures Follow up: None	n=36 (child) M/F= not specified	No comparison group	a. Yes b. No c. N/A d. N/A Duration: 2hr x 14-15wks Small group delivery.
Symbol-drama	To reduce symptoms of dissociation & posttraumatic stress by the psycho-therapeutic use of imagery.	Not specified	Nilsson & Wadsby (2010) [135]	Sweden	Child abuse; Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=15 F=13; M=2	No comparison group	a. Yes b. No c. N/A d. N/A
The Hope Connection	To address the developmental areas of: attachment, sensory processing, & pro-social behaviour.	4 - 12	Purvis & Cross (2007) [136]	USA	Child abuse; Neglect	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=12 F=2; M=10	No comparison group	a. Yes b. No c. N/A d. N/A Duration: 5wk day camp
The Mothers' & Children's Group	To address the needs of abused mothers & their children who have	Not specified	Sullivan, Egan, & Gooch	USA	Family violence	Other	Psychological/ emotional or	RCT: No Pre/post treatment	n=46 (mother) n=79	No comparison group	a. Yes b. No c. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Intervention Program	witnessed violence.		(2004) [137]				behavioural symptoms	measures Follow up: None	(child)		d. N/A Duration: 1 x 9wks

Note: TF-CBT = Trauma focussed Cognitive Behaviour Therapy; CCT = Child-Centred Therapy; PTSD = Post-Traumatic Stress Disorder: RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = Statistically non-significant findings; Sig. = Statistically significant findings. a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 11b. Summary of Emerging A programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
'A Home Within' relationship-based intervention	Clausen, … & Heineman (2012) [112]	5-11					✓				✓			✓	✓	✓		
Alternatives for Families: Cognitive behavioural Therapy (AF-CBT)	Kolko, … & Gully (2011) [113]	3-17	TS/F TIC		✓	✓	✓	✓					✓	✓	✓			
Circle of Parents	Falconer, … & Siegel (2008) [114]	Not specified				✓					✓				✓			
Circle of Security	Hoffman, … & Powell (2006) [115]	Not specified									✓				✓			
Combined Art Therapy & CBT	Pifalo (2002) [116]	8-17	TS/F			✓								✓				
	Pifalo (2006) [117]	Not specified				✓								✓				
Emotion-focused therapy for trauma	Mundorf & Paivio (2011) [118]	Not specified	TS/F		✓	✓	✓							✓				
Equine-assisted psychotherapy	Schultz … & Robbins (2007) [119],	Not specified			✓	✓		✓						✓				
Eye movement integration therapy	Struwig & van Breda (2012) [120]	14-16	TS/F								✓			✓				
Game-based cognitive-behavioral therapy group program	Misurell … & Tryon (2011) [121]	Not specified	TS/F			✓								✓				
Grief and Trauma Intervention (GTI) with coping skills and trauma narrative processing	Salloum & Overstreet (2012) [123]	Not specified	TS/F			✓		✓			✓			✓				
Group Intervention - Psychoeducation	Pomeroy, … & Kiam (2001) [124]	Not specified	TS/F		✓	✓	✓	✓						✓				
Group intervention (child) & group intervention (parent)	MacMillan & Harpur (2003) [125]	6-12	TS/F TIC					✓						✓				
Manualized Cognitive Restructuring Program	Rosenberg, … & Mueser (2011) [126]	13-18	TS/F								✓			✓				
Parent-Child Attunement Therapy	Dombrowski, … & Urquiza (2005) [127]	1-2.5			✓		✓					✓			✓			
Parent education about the risk of head injury after shaking infants	Dias, … & Shaffer (2005) [128]	0-1			✓							✓						
Parent-led, Therapist-Assisted Trauma Focused - Cognitive Behavioural Therapy (PTA-TF-CBT)	Salloum & Storch (2011) [129]	3-7	TS/F								✓			✓				
Play Therapy	Reyes & Asbrand (2005) [130]	Not specified	TS/F			✓								✓				
Pragmatic Communicative Intervention	Manso, … & Romero (2012) [131]	8-12			✓		✓											✓

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
QEEG-Guided Neuro-feedback	Huang-Storms, … & Dunn (2006) [132]	6-11.5	TS/F		✓		✓							✓	✓			
Real Life Heroes	Kagan, … & Suzannah (2008) [133]	8-15	TS/F TIC		✓		✓	✓			✓			✓				
Strengthening Family Coping Resources	Kiser, … & Black (2010) [134]	1-12	TS/F								✓			✓				
Symboldrama	Nilsson & Wadsby (2010) [135]	Not specified	TS/F		✓	✓								✓				
The Hope Connection	Purvis & Cross (2007) [136]	4-12			✓		✓							✓				
The Mothers' & Children's Group Intervention Program	Sullivan, … & Gooch (2004) [137]	Not specified	TS/F					✓						✓				
Total programs				**0**	**11**	**10**	**9**	**7**	**0**	**0**	**9**	**2**	**1**	**19**	**6**	**1**	**0**	**1**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 12a. Summary of Emerging A service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Childhood First, residential therapeutic Community	To use Integrated Systemic Therapy, (IST) in a residential treatment setting to reduce the symptoms of children who have experienced severe early life trauma & have emotional/ behavioural difficulties.	13 - 18	Carter (2011) [138]	UK	Not specified	Residential care	Educational	RCT: No Pre/post treatment measures Follow up: 15-20yrs	n=8 (single interview); n= not specified (group interview)	Population level data (statistics) for looked after children	a. Yes b. No c. Yes d. 15-20yrs
Crisis Childcare Program	To provide emergency caregiving respite & counselling to stressed parents who are at risk of maltreating their children, with the aim of reducing reports of child abuse or neglect.	Not specified	Cowen (2001) [139]	USA	Other	Ethnicity; Other	Risk for childhood abuse	RCT: No Pre/post treatment measures compared to national stats. Follow up: None	n=159 (family) n=269 (child) range:0-3	Population-level data (statistics)	a. Yes b. No c. N/A d. N/A
Cumbria Early Intervention Programs	To improve wellbeing of domestic violence survivors & their children, & increase perpetrator accountability for their behaviour.	5 - 17	Donovan, Griffiths & Groves (2010) [140]	UK	Family violence	At risk families	Child physical; Psychological/ emotional or behavioural symptoms; Risk for childhood abuse, Other	RCT: No Pre/post treatment measures Follow up: None	303 (mother) 56 (child) mean:10.0	No comparison group	a. Yes b. No c. Yes d. N/A
Early Intervention Programs - Gateshead	To improve wellbeing of domestic violence survivors & their children, & increase perpetrator accountability for their behaviour	5 - 17	Donovan, Griffiths & Groves (2010) [140]	UK	Family violence	At risk families	Child Physical; Psychological/ emotional or behavioural symptoms; Risk for childhood abuse	RCT: No Pre/post treatment measures Follow up: None	n=340 (mother) n=57 (child) mean:8.0	No comparison group	a. Yes b. No c. Yes d. N/A
Early intervention service - child sexual abuse	To provide education to non-abusing parents about child sexual abuse (i.e., grooming & outcomes). To help parents empathise with their child. To provide reinforcement of competent parenting & advice on	Not specified	Forbes, Duffy, Mok, & Lemvig (2003) [141]	Scotland	Child sexual abuse	Caregiver offenders	Psychological/ emotional or behavioural symptoms; Other	RCT: No Pre/post treatment measures Follow up: 3mths	n=39 (parent) F=30; M=9) n=31 (child) F=23; M=8 mean:9.0 range:4-14	No comparison group	a. Yes b. No c. No d. N/A

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	management of child difficulties.										
Louisiana Rural Trauma Services Centre	To reduce the symptoms of trauma by modifying trauma-focused cognitive behavioural therapy in school-based rural mental health services.	Not specified	Hansel, Osofsky, Costa, Kronenberg, & Selby (2010) [142]	USA	Child abuse; Child sexual abuse; Neglect; Family violence; Other	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=115 (child) F=55; M=60 mean:14.0	No comparison group	a. Yes b. No c. N/A d. N/A
Take Two	To provide a high quality clinical programme & to contribute to service system improvement.	8- 16	Jackson, Frederico, Tanti, & Black (2009) [143]	Australia	Child abuse; Neglect	Other	Child physical; Cognition; Educational; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	Sample 1: n=49 (child) F=20; M=29 mean:11.8 Sample 2: n=28 (child) F=11; M=17 mean:11.6	No comparison group	a. Yes b. No c. N/A d. N/A
The Sunrise Project	To use Rogerian style CBT therapy for adolescents & therapeutic play for younger children, with age-appropriate psycho-education.	0 - 18	Barker & Place (2005) [144]	UK	Child abuse; Child sexual abuse	Caregiver offenders	Educational; Psychological/ emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=67 F=40; M=27 mean:9.2 range 4-18	No comparison group	a. Yes (for measures of antisocial, somatic, emotional & family life/ relationships). b. No c. N/A d. N/A

Note: CBT = Cognitive Behaviour Therapy; TAU = Treatment As Usual; RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 12b. Summary of Emerging A service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Childhood First, residential therapeutic community	Carter (2011) [138]	13-18									✓					✓		
Crisis Childcare Program	Cowen (2001) [139]	Not specified									✓	✓						
Cumbria Early Intervention Programs	Donovan, … & Groves (2010) [140]	5-17						✓				✓	✓	✓				
Early intervention service - child sexual abuse	Forbes, … & Lemvig (2003) [141]	Not specified	TS/F TIC		✓									✓				
Early Intervention Programs - Gateshead	Donovan, … & Groves (2010) [140]	5-17						✓				✓	✓	✓				
Gipuzkoa program	de Paúl & Arruabarrena (2003) [122]	0-18				✓	✓					✓		✓				
Louisiana Rural Trauma Services Center	Hansel, … & Selby (2010) [142]	Not specified	TS/F TIC		✓	✓	✓	✓			✓			✓				
Take Two	Jackson, … & Black (2009) [143]	8-16	TS/F TIC	✓	✓		✓						✓	✓	✓	✓		✓
The Sunrise Project	Barker & Place (2005) [144]	0-18			✓	✓								✓	✓	✓		
Total service models				**1**	**4**	**3**	**3**	**3**	**0**	**0**	**3**	**4**	**3**	**7**	**2**	**3**	**0**	**1**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 13a. Summary of Emerging A systems of care

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Fairy Tale model	To use trauma-informed methods to provide safety & stability, and provide a supportive setting to improve behaviours via relationship, coaching, punishment, & reinforcement.	13 – 18	Greenwald, Siradas, Schmitt, Reslan, Fierle, & Sande (2012) [145]	USA	Not specified	Residential care	Psychological/emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=53 range:10-21	No comparison group	a. Yes b. No c. N/A d. N/A
Fairy Tale model	To reduce symptoms of PTSD by eliminating or mitigating a wide range of presenting problems. To empower parents to support children's treatment and improve access & engagement with impoverished youth & families.	4 - 19	Becker, Greenwald, & Mitchell (2011) [146]	USA	Not specified; Other	Ethnicity	Psychological/emotional or behavioural symptoms; Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	n=59 F=20; M=39 range;4-19 mean:11.2	No comparison group	a. Yes (PTSD); non-sig. for FES measure of relationships. b. No c. N/A d. N/A
Neuro-sequential Model of Therapeutics	To provide therapeutic & educational efforts in a sequential manner that replicates neural organization & development. Therapeutic interventions must have adequate patterns & frequency of experiences that will activate & influence the areas of the brain that are mediating the dysfunction.	Not specified	Barfield, Dobson, Gaskill, & Perry (2012) [147]	USA	Child abuse; Family violence; Parental substance use; Parental mental illness	Other	Psychological/emotional or behavioural symptoms	RCT: No Study 1: Pre/post treatment measures Study 2: Children are own controls Follow up: None	Study 1: n=13 (child) Study 2: n=15 (child)		Study 1: a. Yes (with non-sig. for parent ratings). b. No c. N/A d. N/A Study 2: a. Yes (with non-sig. for emotional regulation & parent ratings). b. No c. N/A d. N/A
Safety, Mentoring, Advocacy, Recovery, & Treatment (SMART)	To integrate individual, family, & group therapy in a strengths-based, problem-focused treatment model targeting problematic sexual	3 - 11	Offermann, Johnson, Johnson-Brooks, & Belcher (2008) [148]	USA	Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: 6mths	n=62 F=22; M=40 mean:8.3	No comparison group	a. Yes b. No c. Yes d. 6mths

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	behaviours.										
The Child & Family Interagency Resource, Support & Training Program (Child FIRST)	To offer a comprehensive needs assessment & personalised service planning & care coordination to enhance the caregiver-child relationship.	0 - 5	Crusto, Lowell, Paulicin, Reynolds, Feinn, Friedman, & Kaufman (2008) [149]	USA	Family violence	Other	Psychological/ emotional or behavioural symptoms; Service utilisation; Risk for childhood abuse	RCT: No Pre/ Post treatment measures Follow up: None	n=82 F=36; M=46	No comparison group	a. Yes b. No c. N/A d. N/A Duration: mean:7.5mths

Note: TF = Trauma specific or trauma focused but not trauma informed; TIC = Trauma informed care; RCT = Randomised Controlled Trial; F = Female; M = Male; n= no. of participants in sample; TAU = Treatment As Usual; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 13b. Summary of Emerging A systems of care by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Fairy Tale Model	Greenwald, … & Sande (2012) [145]	13-18	TS/F TIC								✓			✓				
	Becker, … & Mitchell (2011) [146]	4-19									✓			✓	✓			
Neurosequential Model of Therapeutics	Barfield, … & Perry (2012) [147]	Not specified	TS/F		✓			✓	✓	✓				✓				
Safety, Mentoring, Advocacy, Recovery, & Treatment (SMART)	Offermann, … & Belcher (2008) [148]	3-11	TS/F			✓								✓				
The Child & Family Interagency Resource, Support & Training Program (Child FIRST)	Crusto, … & Kaufman (2008) [149]	0-5	TS/F TIC					✓				✓		✓			✓	
Total systems of care				**0**	**1**	**1**	**0**	**2**	**1**	**1**	**1**	**1**	**0**	**4**	**1**	**0**	**1**	**0**

Note TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; PEBS = Psychological, Emotional and Behavioural Symptoms; RFSF = Relationships, Family and Social Functioning.

Table 14a. Summary of Emerging B programs

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Designs	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
Chapman Art Therapy Treatment Intervention (CATTI)	To use a trauma resolution method in hospitals for incident specific, medical trauma for child to sequentially relate & cognitively comprehend the traumatic event.	7 – 17	Chapman, Morabito, Ladakakos, Schreier, & Knudson (2001) [150]	USA	Other	Ethnicity; Other	Psychological/ emotional or behavioural symptoms	RCT: Yes Control: TAU Follow up: 1wk & 1mth (Post-treatment)	n=31 Combined sample: (F=21%; M=71% mean:10.7)	n=27	a. No b. No c. No d. 1mth Duration: 1 x 1hr Note: Pre/post treatment care and adjustment for min 24hr hospital stay.
In-patient song-writing to reduce PTSD symptoms	To develop an in-patient song writing procedure that is more effective at PTSD symptom reduction than listening to recreational music.	9 – 11	Coulter (2000) [151]	USA	Child abuse; Child sexual abuse	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=9 F=4; M=5 range:9-17	No control group	a. No b. No c. N/A d. N/A Duration: 1 x 8 sessions (song writing x4, music listening x4).
Koping Adolescent Group Program (KAP)	To increase mental health literacy, connectedness with peers, emotional adjustment & increase repertoire of coping skills.	12 – 18	Fraser & Pakenham (2008) [152]	Australia	Parental mental illness	Other	Psychological/ emotional or behavioural symptoms; relationships & family or social functioning	RCT: No Control: Waitlist Follow up: 2mths	n=27 (child) F=16; M=11 mean:13.4	n=17 (child) F=11;M=6 mean:13.2	a. No b. No c. N/A d. N/A
Mothers & Toddlers Program	To use an attachment-based parenting method for mothers in substance use treatment targeting their ability to care for their children.	0 – 3	Suchman, DeCoste, Castiglioni, McMahon, Rounsaville, & MaYes (2010) [153]	USA	Parental substance use	Other	Relationships & family or social functioning	RCT: No Control: Psycho-education group Follow up: None	n=23	n=24	a. No b. No c. N/A d. N/A
Parent support group intervention	To focus on parenting (i.e., empathy, discipline) & discuss DV; to offer emotional & practical support for issues of safety, child custody & legal proceedings.	3 – 12	Basu, Malone, Levendosky, & Dubay (2009) [154]	USA	Family violence; Other	Ethnicity	Psychological/ emotional or behavioural symptoms	RCT: Yes Controls: Access services (no treatment) & Early	n=9 (mother) n=5 (child)	No treatment: n=15 (mother) n=11 (child).	a. No (non sig. mother & child, small sample). b. No c. No d. 6mths

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Designs	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
	Separately children discuss DV, aim to reduce feelings of shame & master behaviours during conflict.							termination (<5 sessions) Follow up: 3/6mths		Early termination: n=12 (mother), n=5 (child).	Duration: 1 x 10wks.
Social Information Processing Model	To provide a cognitive adjustment program for parental attitudes toward child rearing to reduce the potential for child physical abuse.	1 – 6	Sawasdipanich, Srisuphan, Yenbut, Tiansawad, & Humphreys (2010) [155]	Thailand	Child abuse	Other	Risk for childhood abuse	RCT: Yes Control: TAU plus psycho-education Follow up: None	n = 56	n=70	a. No b. No c. N/A d. N/A
Structured Psycho-therapy for Adolescents Responding to Chronic Stress (SPARCS)	To enhance adolescents' ability to cope more effectively in the moment through mindfulness, & to create connections & meaning. Program uses mindfulness & interpersonal skills from Dialectical Behaviour Therapy: problem-solving skills, enhancing social support & planning for the future.	13 - 21	Weiner, Schneider, & Lyon (2009) [31]	USA	Not specified	Other	Psychological/ emotional or behavioural symptoms	RCT: No Pre/post treatment measures Follow up: None	n=65 F=32; M=33 mean:3.7	No comparison group	a. Yes (sig. on a few measures, but only for African/American participants. b. No c. N/A d. N/A

Note: RCT = Randomised Controlled Trial; TN = Trauma Narrative; F = Female; M = Male; n= no. of participants in sample; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; TAU = Treatment As Usual; CPP = Child-Parent Psychotherapy; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 14b. Summary of Emerging B programs by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
Chapman Art Therapy Treatment Intervention (CATTI)	Chapman, … & Knudson (2001) [150]	7-17	TS/F								✓			✓				
In-patient song-writing to reduce PTSD symptoms	Coulter (2000) [151]	9-11	TS/F		✓	✓								✓				
Koping Adolescent Group Program (KAP)	Fraser & Packenham (2008) [152]	12-18		✓						✓				✓	✓			
Mothers & Toddlers Program	Suchman, … & Mayes (2010) [153]	0-3							✓						✓			
Parent support group intervention	Basu, … & Dubay (2009) [154]	3-12	TS/F					✓			✓			✓				
Social Information Processing Model	Sawasdipanich, … & Humphreys (2010) [155]	1-6			✓							✓						
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	Weiner, … & Lyon (2009) [31]	13-21	TS/F TIC		Not specified									✓				
Total programs				**1**	**2**	**1**	**0**	**1**	**1**	**1**	**2**	**1**	**0**	**5**	**2**	**0**	**0**	**0**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Table 15a. Summary of Emerging B service models

Approach name	Aims	Age range	Authors & years	Country	Trauma types	Population	Outcome domains	Design	Participants		Summary of main findings [a-d]
									Intervention	Comparison	
ARS: Intensive home visiting	To use a Family Care Plan to set goals for family progress to address family needs, support parent-child relationships & offer social support.	0 – 5	Conley & Berrick (2010) [156]	USA	Child abuse; Child sexual abuse; Neglect; Other	Ethnicity	Service utilisation	RCT: No Control: No treatment group Follow up: None	n=134 F=63; M=71	n=511 F=229; M=282	a. No b. No c. N/A d. N/A Duration: 9-12mths
Combined TFCBT/ psycho-educational/ supportive group intervention	To reduce parental post-traumatic stress symptoms (in non-offending parents of childhood sexual abuse), & to improve family functioning.	5 – 15	Hernandez, Ruble, Rockmore, McKay, Messam, Harris, & Hope (2009) [157]	USA	Child sexual abuse	Other	Relationships & family or social functioning	RCT: No Pre/post treatment measures Follow up: None	N= Not specified Females only	No comparison group	a. No b. No c. N/A d. N/A
Healthy Start Program (HSP)	To prevent child abuse by improving family functioning & parenting behaviour.	0 - 5	Duggan, Fuddy, Burrell, Higman, MacFarlane, Windham, & Sia (2004) [158]	USA	Other	At risk families	Risk for childhood abuse	RCT: Yes Control: No treatment Follow up: None	n=373 (family)	n=270 (family)	a. No b. No c. N/A d. No (data is available for 1-3yrs follow up but regression modelling was used).

Note: CBT = Cognitive Behaviour Therapy; TAU = Treatment As Usual; RCT = Randomised Controlled Trial; Non-sig. = statistically non-significant findings; Sig. = statistically significant findings; F = Female; M = Male; n= no. of participants in sample; a-d = a. Summary of significant findings; b. Harm reported; c. Significant findings at follow up; d. Duration of follow up.

Table 15b. Summary of Emerging B service models by targeted age, trauma type and outcome domain

Approach name	Authors & year	Age	Trauma-specific/focused Trauma-informed care	Australia	Trauma type							Outcome domain						
					Child abuse	Sexual abuse	Neglect	Violence	Parent SMU	Parent MI	Other	Risk for abuse	Physical	PEBS[1]	RFSF[2]	Educational	Service utilisation	Cognition
ARS - Intensive Home Visiting	Conley & Berrick (2010) [156]	0-5			✓	✓	✓				✓						✓	
Combined TFCBT/ psychoeducational/ supportive group intervention	Hernandez, … & Hope (2009) [157]	Not specified	TS/F			✓									✓			
Healthy Start Program (HSP)	Duggan, … & Sia (2004) [82]	0-5									✓	✓						
Total service models				**0**	**1**	**2**	**1**	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**1**	**0**	**1**	**0**

Note: TS/F = Trauma specific/ focused; TIC = Trauma informed care; SMU = Substance misuse; MI = Mental illness; PEBS[1]= Psychological/ emotional or behavioural symptoms; RFSF[2]= Relationships & family/ social functioning.

Appendix 3: Practice survey

Table 1. Networks, associations and organisations contacted to disseminate project information and practice survey

Dissemination and promotion contacts	
Networks, associations and newsletters	**Targeted organisations**
Association of Children's Welfare Agencies (ACWA)	Anglican Diocese of Brisbane (QLD)
Association for the Welfare of Children in Hospital - Western Australia	Anglicare (National)
Association for the Wellbeing of Children in Healthcare (AWCH)	Barnardos Australia (NSW)
Australian Association of Social Workers (AASW)	BoysTown (QLD)
Australian Children's Foundation (ACF)	The Benevolent Society (NSW)
Australian Child & Adolescent Trauma, Loss & Grief Network (ACATLGN)	Berry Street (VIC)
Australian Institute of Family Studies (AIFS)	CatholicCare (NSW)
Australian Research Alliance for Children and Youth (ARACY)	Centacare (National)
Child Family Community Australia (CFCA)	Child Protection, DHS
Children's Healthcare Australasia	Children's Protection Society (VIC)
Children of Parents with a Mental Illness (COPMI)	Communicare (WA)
Family Relationship Services Australia	Connections Child Youth and Family Services (VIC)
Family Support Services Association of Tasmania (FSSA)	Gateway Community Health (VIC)
Murdoch Childrens Research Institute (MCRI)	Good Beginnings Australia (National)
NSW Family Services/Fams	Mallee Family Care Inc. (VIC)
Parenting Research Centre (PRC) corporate newsletter	Menzies School of Health Research (NT)
Peak Care QLD	Mission Australia (National)
Queensland Commission for Children and Young People	Relationships Australia (National)
Royal Children's Hospital (RCH) professional newsletter	Red Cross
Young People and Child Guardian's (CCYCG)	Salvation Army
Women's Information and Referral Exchange (WIRE)	The Smith Family (National)
	St Giles (TAS)
	UnitingCare (National)
	Wanslea Family Services (WA)
	Youth and Family Focus (TAS)

Table 2. Participant and organisational characteristics reported by the respondents to the trauma Practice Survey

	Total Sample *N*=468			Practice Sample [b] *N*=293	
	n (%)	Missing *n* (%)	Missing *n* (adj[a])	*n (%)*	Missing *n* (%)
Gender		30 (7%)	5 (1%)		3 (1%)
Male	42 (11%)			28 (10%)	
Female	335 (89%)			262 (90%)	
Education		25 (6%)	0		1 (<1%)
High school	4 (1%)			3 (1%)	
Tafe	31 (8%)			21 (7%)	
University (undergraduate)	129 (34%)			93 (32%)	
Graduate Diploma	127 (33%)			103 (35%)	
University (masters/phd)	70 (18%)			54 (19%)	
Other	21 (6%)			17 (6%)	
Organisation Type		29 (7%)	4 (1%)		2 (1%)
Government	117 (31%)			90 (31%)	
Non-Government	261 (69%)			201 (69%)	
Funding		29 (7%)	4 (1%)		2 (1%)
Sole FaHCSIA	36 (10%)			30 (10%)	
Partially FaHCSIA	125 (33%)			95 (33%)	
Non-FaHCSIA	158 (42%)			116 (40%)	
Not sure	59 (16%)			49 (17%)	

	Total Sample *N*=468			Practice Sample [b] *N*=293	
	n (%)	Missing *n* (%)	Missing *n* (adj[a])	*N (%)*	Missing *n* (%)
Organisation description		27 (7%)	2 (1%)		2 (1%)
Family Support	97 (26%)			71 (24%)	
Community Services	84 (22%)			62 (21%)	
Education	17 (5%)			15 (5%)	
Hospital/Medical	31 (8%)			21 (7%)	
MCH	16 (4%)			15 (5%)	
Child Protection	50 (13%)			40 (14%)	
Disability Support	15 (4%)			9 (3%)	
Other	70 (18%)			58 (20%)	
Current Position		31 (8%)	6 (2%)		3 (1%)
Family care/support worker	48 (13%)			40 (14%)	
Social worker	49 (13%)			32 (11%)	
Allied health	46 (12%)			39 (13%)	
Manager	53 (14%)			36 (13%)	
Team leader	58 (15%)			47 (16%)	
Case manager	46 (12%)			35 (12%)	
Other	76 (20%)			60 (21%)	

	Total Sample *N*=468			Practice Sample [b] *N*=293	
	n (%)	Missing *n* (%)	Missing *n* (adj[a])	*n (%)*	Missing *n* (%)
Professional Discipline		29 (7%)	4 (1%)		2 (1%)
Family support	57 (15%)			43 (15%)	
Psychology	55 (15%)			43 (15%)	
Social work	113 (30%)			86 (30%)	
Welfare	37 (10%)			24 (8%)	
Teaching	28 (7%)			21 (7%)	
Counselling	31 (8%)			28 (10%)	
Speech pathology	5 (1%)			5 (2%)	
Occupational therapy	7 (2%)			6 (2%)	
Nursing	13 (4%)			10 (3%)	
Other	32 (8%)			24 (8%)	
Services and Programs		9(2%)			6(2%)
Early intervention or preventative services	235 (63%)			176 (61%)	
Crisis intervention	173 (46%)			132 (46%)	
Parenting education	278 (75%)			220 (77%)	
Relationship support	169 (45%)			133 (46%)	
Family law services	21 (6%)			14 (5%)	
Group work	189 (51%)			141 (49%)	
Individual work	270 (72%)			205 (71%)	
In-home work	198 (53%)			154 (54%)	

	Total Sample *N*=468			Practice Sample [b] *N*=293	
	n (%)	Missing *n* (%)	Missing *n* (adj[a])	*n (%)*	Missing *n* (%)
Clinic work	88 (24%)			72 (25%)	
Telephone service delivery	93 (25%)			72 (25%)	
Brokerage and referral	152 (41%)			116 (40%)	
Other	61 (16%)			51 (18%)	
Organisation Service Model		8(2%)			5(2%)
Integrated service delivery	207 (55%)			157 (55%)	
Community development	85 (23%)			66 (23%)	
Adult focused care	11 (3%)			8 (3%)	
Family case management	158 (42%)			125 (43%)	
Long term care	43 (12%)			32 (11%)	
Intensive intervention	119 (32%)			94 (33%)	
In-home care	42 (11%)			33 (12%)	
Out of home care (e.g. foster and residential care)	76 (20%)			61 (21%)	
Early intervention or prevention	161 (43%)			124 (43%)	
Other	34 (9%)			28 (10%)	

Note. [a] Missing values adjusted to exclude participants who did not complete any questions in Section 1 (dropped out after screening)

[b] Practice Sample includes participants who answered questions about their practice with children at risk of or exposed to trauma (provided information about working with trauma).

Table 3. Theoretical orientation or perspective reported by respondents to the Practice Survey

Category	Frequency	Example response
Person-centred	50	Person centred
Attachment	47	A combination of current thinking and research involving psychodynamic, attachment and neuroscience theories and frameworks
Systemic	45	A systemic approach understanding the trauma in the context of intergenerational influence. Also from the NMT/attachment training
Narrative	44	Narrative, emotion focused, attachment, feminist object relations
Strengths-based	40	Child-centred, person-centred, narrative, strengths-based
Child-centred	33	Child centred practice
Family-centred	27	Family & systemic therapy and eclectic
Trauma-informed	24	Draw on systemic, trauma-informed and other related theories as needed
Eclectic	21	I have a diverse and eclectic theoretical approach including psychodynamic, play therapy, family therapy, systems theory, person/child centred, developmental and feminist approaches
Psychodynamic	16	Psychodynamic and person centred
Developmental	15	Attachment and developmental theories
Psychosocial	15	Psychosocial, relational, systemic
Solutions-focused	14	Narrative therapy, Brief solution focussed therapy
Systems	13	An integrated approach utilising systems theory, strengths based, narrative and person centred approaches
Relational	13	Child centred, systemic, narrative, psychodynamic, relational
Behavioural	11	Person centred and behavioural with a focus on actions and reactions
Cognitive Behaviour Therapy (CBT)	11	Cognitive-behaviour therapy
Neuroscience	9	Bruce Perry's neuroscience approach to trauma

Category	Frequency	Example response
Play Therapy	7	Play based therapy for children
Grief and Loss	6	Attachment, Family & Systems , Grief & Loss, Child Development & Trauma
Resilience	5	Client centred, trauma informed, strengths based, resilience-building
Acceptance and Commitment Therapy (ACT)	5	Eclectic, systems, attachment, relational, ACT, RFT, narrative, trauma sensitive
Feminism	5	Narrative, emotion focused, attachment, feminist object relations
Humanistic	4	An integrated model of humanistic and psychotherapeutic; Person-centred, Attachment Theory, Object Relations, Gestalt
Crisis Intervention	3	Therapeutic Crisis Intervention
Ecological	3	Systemic, strengths based, attachment theory, ecological, narrative, feminist ideology, psychosocial, person centred

Table 4. Frequency distributions of responses to questions relating to respondent confidence and experience

						Total
	Hardly Ever	Monthly	Weekly	Once a Day	More than Once a Day	
How frequently do you have contact with children who have experienced a potentially traumatic event?	19	46	105	36	85	291
	Not at all	A little	Moderately	Quite a bit	Extremely	
How confident are you in recognising the signs and symptoms of trauma?	1	12	55	150	73	291
To what extent is the assessment of trauma and its impact is a priority in everyday work?	7	22	57	100	103	289
How comfortable are you discussing difficult or frightening experiences with children and families?	3	25	54	125	81	288
How much experience do you have in treating children who have experienced trauma?	19	55	74	91	47	286
How confident are you in delivering therapies for trauma in your usual practice?	40	53	79	87	30	289

Table 5. The 49 categories used to describe the 989 strategies and techniques used in everyday practice to target outcomes in children exposed to abuse and neglect

Category	Frequency	Example response
Referral and linking with other services/support	133	Active working relationship with enhanced maternal child health nurses Help other people involved in the child's care/education to understand the effects of trauma on the child's development Make appropriate referrals to assist child therapeutically either in house or external services
Education of child, family, parents	113	Attending to any educational interventions that could be shared in a developmentally appropriate way e.g. What is physical abuse Educating the children's carers around trauma and how this impact on children, their behaviour and development
Safety/Routine Home Environment	99	Assist families to provide calm, safe, structure at home and look after stress of whole family. Establishing a safe and secure environment
Child centred work	88	Client centred - meeting client where they are at each day - allowing choice at every opportunity
Parenting support	87	Assisting parents in supporting their children who have experienced trauma Debrief and discuss strategies of responding to child's behaviour with foster parents
Art/Creative/Play Therapy	82	Creative arts in therapy- play, drama, art Sand tray work and symbol work to allow the child to express without necessarily talking
Family work (including parent-child relationship)	71	Assess families and children to gain a better understanding of the trauma experienced Encouraging enhancement of parent/carer/child relationships

Category	Frequency	Example response
Supporting and interacting with the client/building relationship/rapport	58	Be a consistent, caring and secure base for parents and children Engagement in dialogue/rapport building/structuring a safe place to reflect
Acknowledging and exploring feelings and abilities	42	Acknowledging skills/ abilities of family members Normalising the clients feelings and reactions
Teaching skills/strategies	38	Communication skills/strategies to use Preventive strategies to reduce stress and risk (like managing the environment , routine and structure and building rapport), co-regulation strategies and intervention strategies to help deescalate the child
Assessment	37	Assess families and children to get a better understanding of the trauma experience Identify that a child has had trauma
Supporting expression (verbal and non-verbal communication)	36	Be available to talk and support Communication with the child's family members Expression through non-verbal means Give them a space to express their feeling and emotions using a variety of tools
Addressing and understanding behavioural issues	30	Behaviour management strategies due to trauma Talking with the parents about understanding children's behavioural response
Relaxation strategies	29	Body awareness/mindfulness/breathing/ safe place (EMDR) Creating safety, support and self-care including relaxation and positive self-talk strategies to manage triggers and stress
Narrative Strategies	28	Narrative discussions through art Life story work
Specific interventions/therapies/theories	27	Therapeutic intervention as required Brain stem interventions-patterned repetitive activity

Category	Frequency	Example response
Working with schools	23	Build capacity of schools to support the behaviour of students who have experienced trauma Connecting them with the school guidance counsellor
Developmentally tailored care	22	Age/developmentally appropriate honesty and information Talk to caregivers about the impact of trauma on development
Specific strategies	22	Bear cards/strength cards Bioenergetics and encouraging exercises in kids
Open questions/Active Listening	21	Build trust and rapport by applying listening skills Open questions and listening with skills and heart
Group work	18	Conduct regular group work activities for children to help them understand their past Group meetings to discuss domestic violence and the effects on children
Other	14	Example not provided
Counselling	13	Counselling for individual students and groups of students Relationship building-co regulation of affect in counselling sessions
Strengths based work	13	Helping the client identify strengths on their part that have helped them survive or cope with the trauma Strengths based work that build up individuals strengths and uses these to assist them to move on
Individual work	13	Individual counselling Specific risk assessment, safety planning and casework with individual children in families

Category	Frequency	Example response
Reduce negative impacts	13	In collaboration with parents draft a Case Plan to address underlying problems within the home to minimise dangers/risk factors. Working with parental mental illness/ trauma to reduce impact on child
Support emotion regulation	12	Affect regulation training Support with emotional regulation
Trainings for practitioners	11	Commitment to ongoing training with a trauma-attachment focus for direct service delivery staff and for carers. Keeping up to date with trauma training and new programs that might be able to assist families.
Encouragement	10	Example not provided due to low proportion of responses
Advocacy	9	Example not provided due to low proportion of responses
Home supports	9	Example not provided due to low proportion of responses
Modelling behaviour/ Role modelling	9	Example not provided due to low proportion of responses
Self-awareness	8	Example not provided due to low proportion of responses
Assisting with resources	6	Example not provided due to low proportion of responses
Emotional	6	Example not provided due to low proportion of responses
Structure of session	6	Example not provided due to low proportion of responses
Building resilience	5	Example not provided due to low proportion of responses
Casework	5	Example not provided due to low proportion of responses
Relational activities	5	Example not provided due to low proportion of responses
Management/ review/ monitor	5	Example not provided due to low proportion of responses

Category	Frequency	Example response
Boundaries	4	Example not provided due to low proportion of responses
Empowerment	4	Example not provided due to low proportion of responses
Reflection	4	Example not provided due to low proportion of responses
Goal setting	4	Example not provided due to low proportion of responses
Allow self-determination/ choices	3	Example not provided due to low proportion of responses
Engagement	3	Example not provided due to low proportion of responses
Cognitive processes	3	Example not provided due to low proportion of responses
Visualisations	2	Example not provided due to low proportion of responses

Table 6. Respondent's reported awareness of evidence-based approaches to treat or prevent trauma in children exposed to trauma through abuse and neglect, as reported by more than one respondent

Reported evidence-based approaches (multiple respondents; n = 48 approaches)								
Approach	**Frequency**	**REA rating**	**Approach**	**Frequency**	**REA rating**	**Approach**	**Frequency**	**REA rating**
Neurosequential Model (Bruce Perry)	15	EA	Sanctuary Model	6	PA	Acceptance and Commitment Therapy	4	N/A
Trauma-focused CBT	14	WS	Narrative Therapy	5	N/A[3]	Psych Education/ Information	3	N/A
Play Therapy	12	N/A[1]	Tuning into Kids	5	N/A	Triple P	3	N/A
Circle of Security	12	N/A	Peek-a-Boo Club (Wendy Bunstan, RCH)	5	N/A	Life Story Work	3	N/A[5]
Dyadic Developmental Psychotherapy	10	N/A	Mindfulness	5	N/A	CARE	3	N/A
Australian Childhood Foundation (ACF)	10	N/A	Attachment, self-regulation & competency (ARC)	5	PA	Early Identification & Referral	3	N/A
Art Therapy	8	N/A[2]	Psychotherapy	4	N/A	Sandplay Therapy	3	N/A
Cognitive Behavioural Therapy (CBT)	8	PA	Counselling	4	N/A	PARKAS	3	N/A
Therapeutic Crisis Intervention (TCI)	7	N/A	Take Two - Berry Street	4	EA[4]	Music Therapy	3	N/A[6]
Parent-child interaction therapy (PCIT)	7	PA	Eye Movement Desensitisation Reprocessing (EMDR)	4	PA	Marte Meo	3	N/A

See all notes on the two next pages.

Reported evidence-based approaches (multiple respondents; n = 48 approaches)								
Approach	**Frequency**	**REA rating**	**Approach**	**Frequency**	**REA rating**	**Approach**	**Frequency**	**REA rating**
Angel Blankets	3	N/A	Headspace	2	N/A	Tree of Life - Dulwich Centre	2	N/A
Neurofeedback	2	EA	Emotion focused therapy	2	EA	TARGET (Julian Ford)	2	PA
PANOC	2	N/A	DV services	2	N/A	Reparative Parenting Program	2	N/A
Therapeutic Residential Care	2	PB	Dialectic Behavioural Therapy	2	N/A	Incredible Years	2	N/A
Motivational interviewing	2	N/A	Multi-Systemic Therapy (MST)	2	S	Evolve	2	N/A
Helping out families program	2	N/A	Van der Kolk	2	N/A	Animal Therapy	2	N/A[7]

Note: N/A means approaches not identified by the REA.

[1] Play Therapy was not classified as being identified in the REA as it was not known whether this program mirrored that of programs utilising play identified in the REA. “Play Therapy” identified in the REA received an EA rating.

[2] Art Therapy was not classified as being identified in the REA as it was not known whether this approach mirrored that of approaches utilising art identified in the REA. Note. “Chapman Art Therapy Treatment Intervention” identified in the REA received an EB rating. “Combined art therapy and cognitive behavioural therapy as a program also identified in the REA received an EA rating. “Group Art Therapy” received a PA rating in the REA. “Combined art therapy and cognitive behavioural therapy” as a program also identified in the REA received an EA rating.

[3]Narrative therapy described in this table was not classified as being identified in the REA, as narrative therapy as a standalone approach was not identified in the REA. “TF-CBT with the narrative component” was rated WS in the REA. “Grief and trauma intervention”, which comprised trauma narrative processing, was identified in the REA as EA. It should be noted that narrative exposure therapies were identified in the REA as effective approaches in war populations but these were excluded due to war populations being beyond the scope of this project. Standalone narrative therapy was not identified in the REA for populations of abuse and neglect.

[4] Take Two incorporates a range of specific interventions, as well as Neurosequential Model of Therapeutics as an overarching approach.

[5]Triple P was rated N/A as it was not known whether this program was referring to the Triple P - Enhanced Group Behavioural Family Intervention identified in the REA. Triple P - Enhanced Group Behavioural Family Intervention is an adaptation of Triple P, which is an adaptation specifically designed for parents to reduce the risks for child maltreatment. Enhanced Triple P received a PA rating in the REA.

[6]Life story work was kept independent of narrative therapy as it was not known whether components of life story work mirrored that of narrative therapy.

[7] Music therapy was not classified as being identified in the REA as it was not known whether this approach mirrored that of approaches utilising music identified in the REA. The one approach identified in the REA with a music component was “In patient Song Writing (distinct from music therapy), which received an EB rating in the REA”

[8]Animal Therapy was not classified as being identified in the REA as it was not known whether this approach mirrored that of approaches utilising animals identified in the REA.” Equine assisted therapy” was identified in the REA as EA.

Well Supported approaches that practitioners are aware of: n=1 (TF-CBT); Supported approaches that practitioners are aware of: n=1 (MST); Promising A approaches that practitioners are aware of: n=6 (CBT, PCIT, EMDR, TARGET, ARC, Sanctuary); Promising B approaches that practitioners are aware of: n=1 (Therapeutic Residential Care); Emerging A approaches that practitioners are aware of: n= 4 (Neurosequential Model, Take Two, Neurofeedback, Emotion focused therapy); Emerging B approaches that practitioners are aware of: n=0; No effect approaches that practitioners are aware of: n=0; Concerning Practice approaches that practitioners are aware of: n=0; N/A: n= 35; Total: 48 approaches.

Table 7. Respondent's reports of awareness of evidence-based approaches to treat or prevent trauma in children exposed to trauma through abuse and neglect, as reported by a single respondent

Reported evidence-based 'programs' (single respondents; n = 109 approaches)							
Approach	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**
123 magic behaviour management course	N/A	DHS	N/A	Drug and alcohol sessions for families - education & support	N/A	Health advise - cooperative food sources	N/A
Anything by Dan Siegal	N/A	Drama Therapy	N/A	Family focused therapy	N/A	Home visiting program	S
Attachment Therapies	N/A	Drug and alcohol sessions for families - education & support	N/A	Family intervention to assist natural families	N/A	Homebuilders child Protection Intervention Program	N/A
Banana splits	N/A						
Bereavement Counselling	N/A	DV programs for children who have experienced DV but at the time of entering into the program they are not in DV. (i.e., KIDS CAN Coffs Harbour)	N/A	Family Mediation Centres (POP Programmes)	N/A	Hornsby Child & Family Adolescent Mental Health	N/A
Berry Street (Take two)	EA			Family Pathways programmes	N/A	Horses Helping out Humans Program	N/A
Bravehearts	N/A			Family Play Therapy/ Filial Therapy	N/A	I'm currently do research on knowledge guided practice within out of home care, as there is none known in QLD	N/A
Bubs @ the Hub	N/A						
Calmer classrooms program (Melb)	N/A	Emotional Release through symbol work	N/A	FIST -Feeling Is Thinking	N/A		
CAMHS	N/A	Equine Assisted Therapy EAGALA	EA	Flexibly Sequential Play Therapy (FSPT) developed by Paris Goodyear-Brown	N/A	Individualised programs within the service I work	N/A
CASA	N/A	Experiential therapy	N/A				
Catholic Care	N/A	Expressive Therapy	N/A	Dyadic developmental psychotherapy – for disorganised attachment	N/A	Infant Mental Health programs	N/A
Circle programme OzChild Home Based Care	N/A					Instruction in Relaxation/ Anxiety management techniques for individual trauma triggers	N/A
Clayfield therapy	N/A	DHS	N/A	Family focused therapy	N/A		
Community support groups	N/A	Drama Therapy	N/A				

Total approaches: n=109. Well Supported: n=0, Supported: n=2 (Home Visiting Service, PUP), Promising A: n=0, Promising B: n=1 (Trauma Systems Therapy), Emerging A: n=2 (Berry Street, Equine Assisted Therapy), Emerging B: n=0, No effect: n=0, Concerning Practice: n=0. N/A: n=104; N/A means approaches not identified by the REA.

Table 7. Continued: Respondent's reports of awareness of evidence-based approaches to treat or prevent trauma in children exposed to trauma through abuse and neglect, as reported by a single respondent

Reported evidence-based 'programs' (single respondents; n = 109 approaches)							
Approach	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**
Integrative Treatment of Complex Trauma for Children - John Briere	N/A	Horses Helping out Humans Program	N/A	Long term psychodynamic treatments	N/A	Provide financial support/ debt advise	N/A
J Mitchell Case study in Attempted reform in out of home care: A Preliminary Examination of the Circle Therapeutic Foster Care Program, Victoria. Master thesis Monash University.	N/A	Long term psychodynamic treatments	N/A	Me and my Mum (for children from DV)	N/A	PTSD in young people post MVA's - Justin Kennardy at al research project	N/A
Jannawi Family Centre	N/A	Me and my Mum (for children from DV)	N/A	MEND domestic violence awareness program for perpetrators	N/A	Rage Program	N/A
Just For Kids	N/A	MEND domestic violence awareness program for perpetrators	N/A	Neurological Reparative Therapy (Dave Ziegler)	N/A	Resilience Framework	N/A
Jungle tracks - refuge children	N/A	Neurological Reparative Therapy (Dave Ziegler)	N/A	New Street & Rural New Street	N/A	Safe from the start	N/A
Kids Create Tomorrow (Bensoc)	N/A	New Street & Rural New Street	N/A	Pat Ogden body work	N/A	Seasons for growth program	N/A
Kinesiology	N/A	Non punitive - therapeutic based	N/A	Person Centred Psychotherapy	N/A	Seeing red program	N/A
Leapin Lizards (our organisation has recently offered this program)	N/A	North Carolina Family Assessment Scale	N/A	Pet Therapy	N/A	Sensory Attachment Intervention (Eadaoin Bhreathnach)	N/A
Lifeworks	N/A	PACT	N/A	Pre-natal and post natal support for young mothers	N/A	Sensory integration theory	N/A
Light house Foundation	N/A	Paradise kids	N/A	Breakfast clubs in schools	N/A	Sensory Modulation (Tina Champagne)	N/A
		Parents as Teachers Program	N/A	Give mental health advise	N/A	Sensory programmes	N/A
		Parents Under Pressure (PUP)	S	Provide a sense of safety & hope	N/A	Sexualised Behaviour Strategies	N/A
						SFCR	N/A

Table 7 Continued: Respondent's reports of awareness of evidence-based approaches to treat or prevent trauma in children exposed to trauma through abuse and neglect, as reported by a single respondent

Reported evidence-based 'programs' (single respondents; n = 109 approaches)							
Approach	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**
Shaping Brains	N/A	Supported play groups	N/A	Three pillars of trauma informed care (Bath)	N/A	Wait Watch and Wonder	N/A
Somatic Experiencing	N/A	Systemic Work with child safety, education, Govt. & non-Govt. services	N/A	Transpersonal Art Therapy	N/A	Working systemically with stakeholders	N/A
Special camps	N/A	Tavistock clinic	N/A	Trauma and recovery	N/A	Wrapped in Angels	N/A
St George/ Sutherland Building Resilience in Children Project	N/A	The Bridge Anger Management	N/A	Trauma informed	N/A	www.childtrauma.org	N/A
Story telling	N/A	Therapeutic Daycare/Preschools	N/A	Trauma informed counselling	N/A	Yarning up on trauma	N/A
Strength Based Practice	N/A	Theraplay TTI	N/A	Trauma systems therapy	PB	Yoga based programs (Bessel Van Der Kolk)	N/A
Supported counselling	N/A			Trusting environment	N/A	Using a Neurobiology lens to work with Trauma	N/A
				Using a Neurobiology lens to work with Trauma	N/A		

Table 8. Frequency of approaches currently used to treat or prevent trauma in children exposed to abuse and neglect reported by more than one respondent (n = 15)

Approach	Frequency	REA ranking
Play therapy	9	N/A*
Circle of Security	8	N/A
Art therapy	5	N/A*
Parents Under Pressure (PUP)	3	Supported
Angel Blankets	3	N/A
Mindfulness	3	N/A
Neurosequential Model of Therapeutics (NMT)	3	Emerging A
Cognitive Behavioural Therapy (CBT)	2	Promising A
Trauma Focused CBT (TF-CBT)	2	Well Supported
Counselling	2	N/A
Therapeutic Crisis Intervention	2	N/A
Parents as Teachers	2	N/A
Reparative Parenting Program	2	N/A
Sanctuary Model	2	Promising A
Seasons for Growth	2	N/A

*Note. It is unknown whether the Art therapy and Play therapy approaches currently being utilised by respondents mirrored the Play therapy and Art therapy programs identified in the REA. Thus, N/A was applied to Play therapy and Art therapy in this table. Readers are advised to refer to the original papers if they wish to compare Play therapy and Art therapy with those identified in the REA. N/A means approaches not identified by the REA.

Table 9. Descriptions of approaches currently used to treat or prevent trauma, as reported by a single respondent

Reported evidence-based approach (single respondent, n = 64)							
Approach	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**	**Approach**	**REA rating**
123 Magic	N/A	Family Liaison Workers	N/A	On Fire	N/A	Strengthening Families	N/A
Babies in Refuge	N/A	Family Mediation	N/A	Parenting Circles	N/A	Support to Foster Carers	N/A
Brighter Futures	PB	FIST - Feeling IS Thinking	N/A	Parenting Workshop	N/A	Supported Playgroup	N/A
Calmer Classrooms	N/A	HCSSS	N/A	Parents Early Education Program (PEEP)	N/A	Therapeutic Residential Care	PB
CAMHS	N/A	Home Visiting Program	S	PARKAS	N/A	Touching Rules and Protective Behaviours Programs	N/A
Child & Family program	N/A	Impact of Trauma	N/A	PCIT	PA	Training Staff	N/A
COMPI	N/A	Infant Massage Instruction	N/A	Photo Elicitation	N/A	Transforming Care Training	N/A
C-Star	N/A	Journey of a Lifetime	N/A	POP Programme	N/A	Trauma and the Brain	N/A
Dan Hughes	N/A	Just For Kids	N/A	Post Natal Depression Group Program	N/A	Trauma Counselling	N/A
Dan Siegel's Attachment Practices	N/A	Liana Lowenstein's Resource for bereaved children	N/A	Koping (KAP)	EB	Trauma in the Classroom	N/A
Emotion Coaching	N/A	Life Story Work	N/A	Referral	N/A	Triple P	N/A
Emotion Regulation	N/A	Marte Meo	N/A	Sandplay	N/A	Triple R	N/A
Expressive Therapy & Sandplay	N/A	Mental Health Nurse	N/A	Solution Focused Brief Intervention	N/A		
Family Counselling	N/A	Motivational interviewing	N/A	StarGazers	N/A		

See Notes on the next page.

Approaches that were described (but not specifically named)	REA rating
Ensuring all stakeholders are well informed in trauma, attachment and neurobiology of trauma, create a stable placement to ensure safety, work closely with natural families and young person to create hope. A combination of techniques to support a child.	N/A
The benefit of quality early years education for children at risk of abuse and neglect.	N/A
We provide care to young people who have experienced abuse or neglect - which could be referred to as a traumatic experience. Research tells us that young people do well when they are able to trust the adults around them. We build an environment of consistent adults to build trust (key person) provide a nurturing environment by putting in clear boundaries, advocating for the young person's needs and by doing life story work with them to establish a bonding relationship which they can look back on when they are adults.	N/A
We are developing our own resource to use with aboriginal women to explore the effects of violence on children. The resource has been developed by strong women in the communities we work.	N/A
Focus is on building a healing relationship.	N/A
Integrative treatment of complex trauma for children.	N/A
It is more of an intervention base, in using care teams to develop long term plans for particular children and families.	N/A
Plan to engage with Creative Interventions with Traumatized Children + Breaking the Silence (Cathy Malchiodi)	N/A
Secure attachment and support for emotional co-regulation.	N/A
Self-regulating activity, learning how to manage situations that cause anxiety.	N/A

Well Supported: n=0; Supported: n=1 (Home Visiting Service); Promising A: n=1(PCIT); Promising B: n=2 (Brighter futures, Therapeutic Residential Care); Emerging A: n=0; Emerging B: n=1 (KAP); No effect: n=0; Concerning practice: n=0; N/A means approaches not identified by the REA.

[1] Nurse Home Visiting Service was rated as Supported in the REA and there were other approaches that described home visiting services and programs. As we could not be sure “Home Visiting Program” described here matched any of those described in the REA, the Home Visiting Program approach was given an N/A.

Appendix 4: Interview guide for organisational leader and senior manager consultations

[Ask bolded questions and use unbolded text as further prompts if required. Ask for more information or clarification if required]

General Service delivery questions:

What is your position and role within the organisation?

Please describe your organisation in terms of who you aim to assist and what you aim to achieve.

Client types/target population (who, where, ages, sub-groups):

Aims/outcomes:

Staff training/disciplines:

Government/NGO:

Theoretical or philosophical orientation:

Please describe your organisation in terms of how you typically work with clients.

Service model/Modes of service delivery (community-based, home-based, individual, family, group, child, parent, group, long or short-term, casework, case management) :

What types of services or programs are provided by the organisation?

- Early intervention or preventative services
- Crisis intervention
- Parenting education
- Relationship support
- Family law services
- Group work
- Individual work
- In home work
- In clinic work
- Telephone service delivery
- Other:_____

Names of specific programs delivered or therapeutic approaches used:

Decisions about practices to use:

This next set of questions asks about your organisation' approaches to making decisions about what practices or programs to use.

Who makes decisions about what training or programs are adopted in your organisation?

How do you (or senior management) make decisions about training for staff or practices and programs to use within your service?

Look at evidence-based practices?

Opportunities that arise?

Current trends?

What sorts of things influence your decisions about what programs or practices to adopt at your agency?

Practical drivers for the uptake of EBP (e.g., availability, time, cost to purchase, train or deliver, relevance to clients, appropriateness to aims/outcomes of service, support available from developers, delivery setting/mode, complexity, availability of manual/support materials, training availability/time, dosage requirements, data collection requirements, staff availability, languages).

Obstacles to the uptake of EBP (as above).

How relevant is the evidence-base behind a program, to the decisions made by your organisation to adopt a program or practice?

What (if any) supports does your organisation provide to assist with efforts to implement EBPs?

- ☐ Agency sponsored EBP trainings or in-services
- ☐ Conferences, workshops, or seminars focusing on EBP
- ☐ Guest speakers presenting about EBP
- ☐ EBP specific supervision and/or general guidance from administrators
- ☐ Continuing education and/or grand rounds focused on EBP
- ☐ Internal research and/or evaluation which has provided data regarding EBP
- ☐ EBP training materials or journals
- ☐ Time off or funding for individual training/education in EBP
- ☐ Financial incentives to use EBP[2]

Trauma-specific questions:

Now I want to find out about what your organisation does specifically in the area of trauma. So here I'm talking about child and family exposure to traumatic experiences associated with child abuse (physical, emotional and sexual), domestic violence, child neglect, parental substance abuse and parental mental illness.

Does this service/organisation work with children or families who have been exposed to or are at risk of exposure to these types of trauma?

What is your organisation's understanding of what Trauma is? It's definition? What can it include or exclude?

Do you use diagnostic frameworks for identifying trauma? Please describe.

What, if any, community resources are you aware of for children and families who have been exposed to trauma?

Would you say that the approach or strategies of your organisation to trauma for children, families and staff was planned and well implemented or more ad hoc and used intermittently?

What makes you say that?

Policies and procedures in place? E.g., routinely ask about previous trauma?

Clinical practice manuals?

Screening for trauma as routine in client assessment?

Staff training maintained?

Staff supervision/coaching maintained?

In general, what types of therapeutic approaches or models of care does your organisation use when working with children and families exposed to trauma or at risk of exposure to trauma?

What are the key components of the programs, practices or approaches used? Can you describe what workers do with clients?

Cognitive-behavioural techniques?

Behavioural therapy?

Interpersonal therapies?

Parenting programs or interventions?

Parent-child relationship interventions?

Mindfulness techniques?

Play or art based therapies?

What services, practices or programs do you provide for children/families that have been exposed to or are at risk of trauma?

For each program/practice identified, ask the following:

For Program 1: (write name or brief description, including whether established program/practice or created in-house)

Can you please describe the practice or program's content?

Describe the model/theoretical approach that the practice or program is based on.

Describe the key components, techniques or strategies that you use in this practice or program?

Have you adapted the practice or program from somewhere else?

How have you adapted it?

Why have you made these changes?

How are you ensuring fidelity to critical components of original program/practice?

How are you ensuring desired outcomes of original program still met?

Have staff ever participated in training for this practice or program?

Why are you using this practice or program within your service?

What setting is this practice or program provided in?

- ☐ Home
- ☐ Clinic
- ☐ Playgroup
- ☐ Classroom
- ☐ Metropolitan
- ☐ Rural
- ☐ Remote
- ☐ Other: _____

How is this practice or program delivered to families?

- ☐ Individual
- ☐ Group
- ☐ Telephone
- ☐ Family
- ☐ Short-term
- ☐ Long-term
- ☐ Single session

Frequency of sessions?

Duration of sessions?

Please describe the target groups of families you deliver this practice or program to.

- ☐ Children
- ☐ Adolescent
- ☐ Parent
- ☐ Stepfamilies
- ☐ Single parents
- ☐ Grandparents
- ☐ Disabilities/special needs - child/adolescent
- ☐ Disabilities/special needs - parent
- ☐ Teenage parents
- ☐ Child abuse and neglect (including physical, sexual and emotional abuse)
- ☐ Substance dependence and abuse
- ☐ Health/mental health issues
- ☐ Family/domestic violence issues
- ☐ Communication difficulties
- ☐ Relationship issues
- ☐ Child behaviour difficulties
- ☐ Other: _____

What are the intended outcomes of the practice or program?

For Child

- ☐ Physical health & development
- ☐ Psych/emotional wellbeing (int or ext)
- ☐ Cognition
- ☐ School & Educational
- ☐ Social

For parent or family

- ☐ Relationships & social functioning
- ☐ Service use
- ☐ Environmental risk
- ☐ Other:

Are you evaluating the effectiveness of this practice or program?

☐ Yes No ☐

How are you evaluating this program?

Publicly available? Where?

How is the program working? What sorts of outcomes are you seeing from it?

What evidence do you have of this?

[repeat set of questions for each program they identified.]

Thanks for your time. Any questions?

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