The Evaluation of the Holding Children Together Service
in Alice Springs

Holding Children Together
Prepared for Relationships Australia Northern Territory
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Artist Roseanne Ellis’ meaning attributed to the image created for the Holding Children Together Program: “This is a program we started doing for school kids around Alice Springs and the name it comes in Arrernte meaning holding children together. And what it represents is the building and the white teacher. The coolamon represents the space the children get. These circles are non-indigenous and indigenous kids. This is a indigenous worker and a non-indigenous worker, and this is the stick they use and visa versa. That’s their knowledge and they exchange their knowledge together and the circles represent the family of those children and the white one is where they come from and how their family works. It’s in a circle and it all expands. This is the program that we started.”

Image is provided to Menzies for use courtesy of Relationships Australia with the Artist's consent.
Executive summary

Introduction and methods
The Holding Children Together Service, funded by the Communities for Children initiative and the Alice Springs Transformation Plan, has been developed as an innovative service designed to fill an identified gap in therapeutic service provision for young children in Alice Springs who have experienced trauma, abuse and neglect. It does this through a unique combination of direct service delivery to children with trauma symptoms, the formation of a network of practitioners who are supported through professional development, and training and supervision informed by the latest research about the neurobiology of trauma and delivered by experts in the field. Holding Children Together has also been designed to address contextual issues in Alice Springs such as a lack of staff trained in trauma-based counselling, particularly with children, and low staff retention.

The Child Protection Research Program in the Centre for Child Development and Education at Menzies School of Health Research was contracted by Relationships Australia Northern Territory (RANT) in June 2011 to conduct an evaluation of the first twelve months of implementation of the Holding Children Together service. Holding Children Together is a collaboration between RANT and the Australian Childhood Foundation (ACF).

The evaluation considers the following research questions:

1. To what extent does the trauma-informed practice framework suit the context of service delivery in Alice Springs?
2. What impact has the training, supervision and practice panel support had on the knowledge, skills, confidence and practice of practitioners?
3. To what extent does the therapeutic model improve psychosocial outcomes for children receiving the service?

The evaluation used a mixed-method, repeated measures design incorporating interviews with practitioners, survey administration and analysis of case file information. Information was collected during two time periods; time 1 (September-October 2011) and time 2 (April-May 2012). The evaluation research design and research questions were developed in collaboration with Relationships Australia Northern Territory and Australian Childhood Foundation staff.

In February 2012 an interim evaluation report was provided to RANT regarding the initial implementation of the service between July and October 2011. This final report incorporates and builds on this information, to incorporate information collected from interviews and case audits until May of 2012 and project activity reports to June 2012.

The evaluation has been guided by a program logic which outlines the expected causal relationship between inputs, the target group, program strategies and outputs and how these are assumed to lead to short-term, medium-term and long-term outcomes, and ultimately meet the overall goals of the service. The program logic guided the analysis of evaluation data in the preliminary evaluation report, and has been further refined through analysis and interpretation in this report.
Findings
This formative evaluation of the Holding Children Together service has identified a significant impact of the service on service provision for vulnerable children in Alice Springs.

The service has demonstrated highly promising impacts on worker knowledge, skills and confidence, as well as on outcomes for children identified through practitioner-derived case reviews. Practitioners described the approach as highly relevant to the Alice Springs context, with worker support and networking providing an important defence against worker burnout and stress, as appropriate for conceptualising and responding to complex and intergenerational trauma, and through links with the Aboriginal Advisory Committee and Aboriginal practitioners as appropriate for practice with Aboriginal families. The quality of training and support provided was seen as exceeding expectations and experiences in other service settings. Broad effects of the service were noted, with the model providing a means of direct knowledge transfer through training and supervision of practitioners and through service delivery to parents, other practitioners involved, and at times to the children themselves.

The service responded to a wide and complex range of behaviours, and both client outcome reviews and interviews with practitioners identified improvements for children across the range of these behaviours. Results from the case audits generally demonstrated improvements in the goal areas identified (e.g., violence and aggression, angry outbursts, tantrums, sexualised acting out, school refusal, freezing, dissociation, sleep problems, bullying, crying). In some cases, these improvements were identified as due in part to changes in the child’s environment (e.g., leaving the home/situation in which violence was occurring), and in others resulting from direct work with children and their families. It is important to note the role of the CTT practitioners in reinforcing the need for children to be in stable environments with families, and in some cases the practitioners appeared to be the catalyst for these changes.

Practitioners noted that progress for children experiencing complex trauma was particularly notable when practitioners engaged in collaborative case planning and casework within their organisation or with other services. This was particularly relevant in promoting safe and stable environments for children (e.g., through new housing, identifying alternative carers for children). This highlights the need for all systems around the child to be a focus of therapy using a trauma-informed approach, and for systems of care which target multiple levels of the child’s environment.

Future considerations and recommendations
The evaluation highlighted several considerations for the next phase of the Holding Children Together Service; specifically quality assurance and sustainability strategies.

This evaluation has recommended that key elements of the next steps for the Holding Children Together Service should be a focus on quality assurance through clear program documentation and frameworks, review of practice against evidence standards and relevant and accurate measurement of client presentations and outcomes. It should be noted that since June 2012 the practice manual has been updated and distributed to the CTT.

Elements of sustainability that were described by participants in the evaluation included the ongoing role of ACF in training and facilitation, the inclusion of new group members, and funding to support the initiative. There was unanimous support for the initiative to continue.
Many participants in the evaluation noted the role of the ACF partner as fundamental to the process of knowledge transfer and the translation of neurobiological evidence into the complex practice setting in Alice Springs. The quality of the training, support and practice knowledge was highlighted. RANT and ACF view the service as the product of, and requiring the ongoing input of, both partner agencies. Given that members of the CTT were unaware of this partnership approach and the ongoing role of ACF in service development and delivery, this needs to be more clearly articulated to the practitioners in the CTT, and other stakeholders.

The turnover of practitioners in Alice Springs had implications for future membership and sustainability of the CTT. It was suggested that a prerequisite level of training or knowledge of the neurobiology of trauma and its application in complex practice settings could be a requirement of membership of the existing CTT.

A key consideration for the sustainability of the Holding Children Together Service is of course the sustainability of funding. The results of the current evaluation are promising, and suggest that sustained funding should be obtained for the service, preferably as a component of a wider “system of care” including family support and community development initiatives for vulnerable children, families and communities in Alice Springs. Sustainability of the service may be obtained by broadening the service focus (for example to be based in education and/or to focus more on a child protection population).
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Chapter One: Introduction

Background
We are now far more aware of the lifelong impact of abuse and neglect in childhood, including the impacts on the developing brain, affecting the child’s ability to regulate their own behaviour and to build trusting and trusted relationships with others (Lamont, 2010; Perry, 2009). Evidence from the field of neuroscience demonstrates that child maltreatment and exposure to “toxic” levels of stress, or to emotional and physical deprivation (i.e., child neglect), can significantly impair brain development. The associated cognitive and psychosocial impairments can lead to learning and developmental problems (poor transition to school and early drop out); externalising behaviour problems including antisocial and risk taking behaviours (substance misuse and criminal activity); and significant mental health problems (post traumatic stress disorder, anxiety, depression, suicidal ideation and behaviour) (Lamont, 2010; Northern Territory Government, 2010). Abuse in childhood has also been associated with chronic adult health conditions such as heart disease, diabetes, arthritis, bronchitis/emphysema and cancer (Northern Territory Government, 2010).

Research has shown that co-regulation of behaviour through attentive, responsive and soothing caregiving has the ability to both prevent and ameliorate stress responses in children and young people (Bath, 2008). Evidence regarding direct counselling work with children, including cognitive behavioural therapy and relational therapies, has also shown promise in areas of emotional and behavioural functioning, anxiety problems, self-harm and substance misuse (Pattison & Harris, 2006). These authors also identify a wide range of therapeutic practices which may be helpful or harmful in these areas, but which have not been evaluated through research trials.

The Board of Inquiry Report into the Child Protection System in the Northern Territory (Growing Them Strong, Together) has highlighted the significant need for therapeutic services which respond to children’s experiences of trauma, and to the intergenerational experiences of trauma. The Board of Inquiry further noted the fragmented nature of service delivery in the field of child and family services and recommended an increase in collaborative approaches to improving children’s safety and wellbeing. These issues were also recognised in a community consultation conducted by Communities for Children (C4C) which identified a service gap for therapeutic services for children who had experience interpersonal trauma in Alice Springs.

In response to this, the Holding Children Together Service was developed as an innovative service designed to fill an identified gap in therapeutic service provision for young children in Alice Springs who have experienced trauma. The result of a unique partnership between RANT and ACF, the service does this through a combination of direct service delivery to children with trauma symptoms, the formation of a network of practitioners who are supported through professional development, and training and supervision informed by the latest research about the neurobiology of trauma and delivered by experts in the field. Holding Children Together has also been designed to address contextual issues in Alice Springs such as a lack of staff trained in trauma-based counselling, particularly with children, and low staff retention.
The structure of the Holding Children Together Service involves a unique method for collaborating with other services and sharing specialist training and secondary consultation resources in a regional setting (see Figure 1).

Figure 1. Model for the Holding Children’s Together Service

The partnership between RANT and ACF has combined the skills and expertise of both organisations to develop a trauma-informed model of service delivery for the Alice Springs context. Using an adaptation of ACF’s trauma model for working with children and young people, counsellors based within RANT work with the majority of children referred to the service, with additional practitioners coming together as a Community Therapeutic Team (CTT) providing service to a small number of children on their caseload. All practitioners receive specialist training and supervision monthly from the ACF. The network training model is an innovative way of maximising and sharing resources, with non-RANT practitioners providing their counselling services to the program in return for the ACF training and supervision (see Chapter 2 for more detail). Monthly supervision sessions also provide an opportunity for peer supervision and learning which provide an opportunity to reduce practitioner isolation and address the issues of vicarious trauma associated with intensive work with clients who have experienced trauma (Jankoski, 2010; Newall & MacNeil, 2010; Palm, Polusny & Follette, 2004; Trippany, White Kress & Wilcoxon, 2004).

Only a small body of research has focused on professional development initiatives which focus on trauma-informed child and adolescent mental health. One previous workforce development evaluation which examined training related to the development of conceptual knowledge about the impact of trauma, and enhanced clinical reasoning and judgment, has demonstrated increased levels of self-efficacy in training participants, but did not measure skill acquisition or outcomes for clients (Layne et al., 2011). This evaluation report will examine these broader aspects of the Holding Children Together Service.
Purpose and structure of the report

The Child Protection Research Program in the Centre for Child Development and Education at Menzies School of Health Research was contracted by RANT in June 2011 to conduct an evaluation of the first twelve months of implementation of the Holding Children Together service.

The evaluation considers the following research questions:

1. To what extent does the trauma-informed practice framework suit the context of service delivery in Alice Springs?
2. What impact has the training, supervision and practice panel support had on the knowledge, skills, confidence and practice of practitioners?
3. To what extent does the therapeutic model improve psychosocial outcomes for children receiving the service?

In February 2012 an interim evaluation report was provided to RANT regarding the initial implementation of the service between July and October 2011. This final report incorporates and builds on this information, to incorporate information collected from interviews and case audits until May of 2012 and project activity reports to June 2012.

This interim report focused on describing project activities and outputs, whereas the focus of this report is on directly addressing the evaluation questions. Accordingly, the report is structured with an introduction that describes the background to the project and methods for the evaluation (chapter 1), a description of the Holding Children Together Service is provided in chapter 2, chapters 3-5 then explore each evaluation question, and the final chapter incorporates a conclusion and suggested next steps.

Evaluation design

The research design was approved by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research and the Central Australian Human Research Ethics Committee.

The evaluation utilises a mixed-method, repeated measures design incorporating interviews with practitioners, survey administration and analysis of case file information. Information was collected during two time periods; time 1 (September-October 2011) and time 2 (April-May 2012). The evaluation research design and research questions were developed with RANT and ACF staff.

Evaluation interviews and surveys

At time 1 and time 2, practitioners in the CTT were interviewed regarding their involvement in the Holding Children Together service, this included questions regarding their practice with children and incorporation of ACF trauma theory and their experience of being part of the CTT. Interviews were of 40-80 minutes duration, and were semi-structured using open-ended questions. At time 1, 9 of the 14 Holding Children Together practitioners were interviewed (see Appendix 1 for interview schedule) and at time 2, 10 Holding Children Together practitioners were interviewed, including 8
practitioners interviewed at time 1. In this second phase, the original interview questions were adapted to further explore the themes from time 1 and the recommendations outlined in the Preliminary Evaluation Report (see Appendix 2). Informed consent was obtained by participants for their involvement in the evaluation at both time 1 and time 2.

At time 1, the Alice Springs RANT manager was also interviewed regarding the initial implementation of the service including the funding submission, recruitment and program design elements, and at time 2 an additional interview was conducted with the ACF facilitator.

Interviews were tape recorded and transcribed. Transcripts were coded using the NVIVO software program. Inter-rater reliability of coding was conducting with a 90.2% level of agreement, with disagreements resolved through discussion.

Practitioners also completed two written surveys. The first survey was used to collect demographic information and details of attendance at Holding Children Together training events (Appendix 3). In addition, a ‘Community Therapeutic Team Attitudes’ survey adapted from Horton and colleagues (2008) was administered at times 1 and 2 (see Appendix 4). The survey includes 14 positive statements such as “The purpose of the CTT is to enable clinicians to feel confident in their own practice” or “There is mutual trust between members of the CTT”. Practitioners responded using a five-point Likert scale, indicating strong agreement through to strong disagreement.

**Outcome Review Audit Form**

In May 2012 case file information for 36 children was provided by 9 CTT practitioners, including 27 cases held by RANT practitioners and 9 cases held by non-RANT CTT practitioners. Case file information was captured in the ‘Outcome Review Audit Form’ which was designed to provide a consistent framework to enable analysis of information about the needs of clients, any changes in clients’ emotional and behavioural problems and the factors contributing to client progress, extracted across case files from different organisations. The audit form also collects information about the initial assessment of children’s needs, behavioural goals and outcomes and outcomes with family, school and other networks (Appendix 5). In addition to this data extracted by practitioners from their case files, the practitioner’s also provided reflections about the role the training and support provided through involvement in the Holding Children Together Service may have played in any observed outcomes.

**Program logic**

As an initial step in the evaluation, the evaluation team and RANT staff developed a program logic to guide the evaluation and analysis (see Appendix 6). The logic was developed from program documentation and provides a visual description of the service, outlining the expected causal relationship between inputs, the target group, program strategies and outputs and how these are assumed to lead to short-term, medium-term and long-term outcomes, and ultimately meet the overall goals of the service. The program logic guided the analysis of evaluation data in the preliminary evaluation report, and has been further refined through analysis and interpretation in this report (see Chapter 6).
Chapter Two: Description of the Holding Children Together Service

Service design

‘Holding Children Together’ is a therapeutic counselling service for children aged 5-12 years of age who have experienced interpersonal trauma. Relationships Australia Northern Territory (RANT) established the service with funding received in March 2011 from the Alice Springs Transformation Plan and Communities for Children in Alice Springs from the Australian Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), with auspice from Anglicare. The need for a children’s counselling service in Alice Springs was identified through a process of community service mapping and needs analysis conducted by Anglicare and the Communities for Children Reference Group.

The service consists of the following key elements:

- The appointment of counsellors at RANT to provide direct therapeutic services to children in the target group and who are exclusively Holding Children Together counsellors;
- The establishment of a community therapeutic team of practitioners who will participate in the project;
- The appointment of the Australian Childhood Foundation (ACF) as the specialist therapeutic partner; and
- The contracting of Menzies School of Health Research to undertake an evaluation of the project.

The Holding Children Together Program is underpinned by ACF’s trauma model in working with children. Through a process of collaboration between ACF, RANT and the Aboriginal Advisory Group the model was adapted to enhance its relevance to the needs of the children, young people and families it was targeting and the context within which the service was to be provided. Within the partnership, RANT assumed overall management and coordination of the service, whilst ACF guides the clinical direction of the program. The service was launched by the Northern Territory Children’s Commissioner, Dr Howard Bath, in Alice Springs on 23rd March 2012.

A unique aspect of the program has been the formation of the Community Therapeutic Team (CTT). Formed between April and June 2011, the CTT has incorporated up to 3 staff employed by RANT (senior child practitioner and two child practitioners) and up to 12 practitioners employed by other organisations in the Alice Springs community. The CTT is coordinated by a RANT counsellor in the Holding Children Together service. Existing service networks were used to inform the selection of external counsellors to be invited into the CTT. Support was provided by those counsellors’ workplaces (Central Australian Aboriginal Congress, Tangentyere Council, Alice Springs Women’s Shelter, Anglicare, Department of Education and Training, Our Lady of the Sacred Heart Catholic School) in order to allow their involvement. Memoranda of understanding (MOUs) were negotiated between RANT and practitioners’ workplaces by August 2011, and have now been extended.
Overall, I’d have to say that I’m really impressed with the innovative way that they’ve created a team out of nothing and integrating services. There aren’t many examples – there’s a lot of great ideas and a lot of great thought about how you can integrate services but to do it successfully doesn’t happen all that often and so I think it’s a really great out-of-the-box idea that, let’s not create a team and put 10 staff on, let’s find existing resources and strengthen them and coordinate them. (R32)

Referrals to the program are received and screened by RANT, and allocated to practitioners within the service. RANT counsellors work with the majority of the children however participants from the CTT make a commitment to working with at least one child each, thus increasing the number of children able to receive services from the Holding Children Together Service. To inform their work with children, the whole CTT, including the RANT counsellors, meet monthly to receive professional supervision and support from the Australian Childhood Foundation. These meetings provide an opportunity for training, case discussions and supervision. These meetings are facilitated by a representative of the Australian Childhood Foundation.

Practitioners

By the commencement of the Holding Children Together service on the first of July 2011 two well qualified counsellors had been successfully employed. These counsellors have extensive experience working with Aboriginal families in Central Australia and working with children experiencing trauma. They each bring to the program highly developed counselling skills and rich experience. A new counsellor was employed 2 days per week from 9th Feb to 30 June. An Aboriginal family worker (and member of the Aboriginal Advisory Group, see below) was also employed and worked up to 8 hours per week. The RANT counsellors receive monthly specialist trauma-focused supervision from the Australian Childhood Foundation (ACF) in addition to the monthly training, case presentation and group supervision provided to the members of the CTT.

As at June 2012, the CTT included 8 practitioners from community controlled organisations, government and non-government education, and other non-government services. Of the four practitioners who had left the CTT, two had relocated interstate; one was on maternity leave and one was unable to continue due to work commitments. A waiting list has been developed for practitioners who wish to join the CTT, and it is anticipated that they will commence in the second half of 2012. New members will attend training in neurobiology (provided by ACF) to provide a standard knowledge base for the members of the group.

CTT practitioners’ professional backgrounds included psychology, counselling, social work, youth work and family therapy. The length of time that CTT practitioners had lived and worked in Alice Springs ranged from less than a year to more than 10 years, with approximately one third living in Alice Springs for less than two years. At the time of interviewing, just over half of the CTT practitioners had been in their current employment for less than a year.
Approach

Over the past few decades, the knowledge about the neurobiological impacts of trauma has burgeoned, but there have been significant gaps in the application of this knowledge in practice with children and young people (McLean, 2012; Perry, 2009). The Holding Children Together Service utilises the extensive knowledge base and experience of the Australian Childhood Foundation (ACF) to provide a framework for practice underpinned by a common understanding and language about neurobiology, specifically the neurobiology of trauma, and how relationships in children’s lives can ameliorate the effects of hardship, trauma and toxic stress in their lives.

For more than a decade, ACF have worked with agencies to translate the rapidly expanding knowledge base around neurobiology and neurobiology of trauma into a range of care settings including education and care and protection services, and have used it in their own direct therapeutic work with children. Using training, supervision and case discussions in the Holding Children Together Service, the ACF facilitator works with practitioners in the CTT to translate that knowledge base into their own practice settings and guide the clinical direction of the service.

*And there’s a wide variety of settings... You’ve got people who are from schools, who are working in health services, you know, working in community services. So it’s a range of disciplines and a range of settings, and being able to translate the knowledge base, translate a common knowledge base across all of those things and guide people in a consistent application of the knowledge.* (R40)

The approach supports practitioners to examine the degree to which children are experiencing stress, what kind of stress it is that they’re experiencing, whether that stress is associated with any level of abuse or exposure to violence or neglect, or where the dynamics in which children are living have a stressful impact on them. Practitioners develop understanding about how stress impacts on various parts of the brain and body, and understanding how the physiological responses to stress manifest socially, emotionally and behaviourally for children. The approach also includes helping practitioners identify strategies to promote more supportive relational and physical contexts for children to reduce the impact of stress and trauma on children.

*The key elements of the ACF framework I see is understanding the biophysical functions of the brain and in terms of how, over the brain’s developmental period, so for a child’s life ... if there are traumas that occur, emotional or physical or both... it interrupts the development of the brain and that therefore you could get resulting behaviour to do with changing functions or shifted functions...and that ACF looks to use that to inform what your strategies are to support kids that have experienced trauma and are now displaying problems in development or behaviour. The most interesting thing for me is the way that they do that is that I do it looking at what a theme is for a child – what you see, what’s the story, what does the theme of the entire picture of behaviour ...it then asks you once you’ve thought of a theme to devise your strategies in terms of that theme* (R30)
Integrating the approach in practice

In monthly CTT meetings practitioners are supported by ACF in the use of the model through training, supervision, case discussions, program materials and readings which support the approach.

An initial public training event, “Understanding the neurobiology of complex trauma” in July 2011 was attended by 70 attendees. This high level of participation by service providers in Alice Springs speaks to the relevance of this training for the context, and the desire for a range of practitioners to gain additional information to assist them in their practice with children and their families. In the Seminar Evaluation forms distributed by ACF at this training event participants rated how valuable the seminar was to their work from 1 (not valuable) to 5 (highly valuable). The vast majority of respondents (93.3%) reported that the event was valuable or highly valuable.

Between July and September 2011, CTT meetings focused on neurobiology theory, building a shared understanding of the trauma framework. During this time practitioners were still in the process of intake and engagement with children and families. In October 2011 the first case-presentations were introduced to the monthly CTT meetings and continue to date.

CTT meetings are now case led and use facilitated case discussions to further integrate and apply the theory base in practice with clients.

I’ve found what I’ve really liked from the case discussion, although it mightn’t be particularly structured in reviewing theory, that it really integrates the theory that we have been learning and that’s my way of learning. (R27)

The last few days, months, you know, the days each month have been with the case presentations, which has been good, but we usually start off with a bit of how are people travelling, sharing a good moment you might have had with your child, and we don’t necessarily share the challenges right there at the beginning because we’re so aware of those anyhow, so it’s really focussing on well, what is one little difference that you’ve noticed with your child. Because sometimes the changes are pretty small, so it actually helps us to think about that a bit more deliberately. (R24)

The process of group training and supervision in these meetings was described as providing consistency and some level of quality assurance in the application of theory to practice. Although as described by some respondents, there are differences in practice across the Holding Children Together service as practitioners work from different modalities, with different levels of experience, from different professional backgrounds and within different organisational and practice settings (see Chapter 4 for more discussion of this).

I think we’ve come a journey on that because I think at the beginning it wasn’t so, just because you’ve got psychologists in the room, social workers, counsellors and … people coming from different organisations which have different philosophies and different disciplines which have different philosophies and possibly quite different standpoints. So I think we’re still getting there with that. (R31)
I think the second learning is about how you bring together a fairly disparate network of people all with different skill sets and different motivations, and how you bring that group together into a team that can see itself as a team and forming itself as a team... in terms of how you bring different organisations, individuals from different organisations together into one network team. Again, it's a reasonably unique kind of opportunity. (R40)

Peer-led CTT meetings are also held between the ACF-facilitated CTT meetings, and practitioners discuss theory, cases and practical aspects of working with this client group in Alice Springs. These activities and skilled group facilitation have helped further strengthen the CTT identity as a cohesive team, building trust with each other.

I would say that it had moved from the place where it was [the ACF facilitator’s] group, it's almost a place where it's the group’s group. (R21)

We're pretty close. Yeah, we’re pretty good but, and the trust is built, which is really useful. (R31)

Program materials
RANT and ACF developed a service description outlining the vision, structure, principles and expected outcomes for children involved in the program. This document also outlines the theoretical base behind the ACF trauma model.

It’s not a therapeutic model that says, okay, on session 1 you do this, session 2 you do this, session 3 you do that. Overall what it’s trying to do is say how do you understand the way that living in environments, in relationships that are constantly, you know, that are full of experiences of toxic stress on a child’s life, how does living in that manifest itself for a child and what can you do about it, and getting to some deeper understanding than the general response which is around reacting to behaviour in kids, reacting to the behaviour of adults. (R40)

ACF worked together with RANT staff to develop the following forms for use within the service. These, while available, are not required to be used and practitioners may use their own organisation’s forms and procedures.

- MOU form,
- referral forms,
- intake forms,
- informed consent for assessment,
- informed consent for sharing information,
- parent engagement letter,
- counselling plan report,
- practice panel outcome report,
- counselling review report, and
- counselling closure summary.
The interim evaluation report highlighted the importance of assessment materials in order to assess outcomes for children in the service. In some cases, practitioners are using the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001) and developmental assessments, while other practitioners have not used such measures because they have not been considered relevant for the child’s presenting problems, or because administration of the tools may be hampered by language barriers or the movement of family members to other communities. For the purpose of this evaluation the ‘Case Review Audit Form’ was also developed to attempt to get a consistent, although retrospective, assessment of client progress (Appendix 5). More will be discussed about these tools in later chapters.

During this initial funding period, the service has been in a developmental phase and now that the model has been consolidated through this process, resources such as a program manual and other associated case materials are being developed, which will be imperative to underpin the sustainability of this approach in service contexts which include high turnover of staff.

**Recommendation**

1. Consolidate program materials including training materials, assessments and other documentation into a Holding Children Together service manual which can be updated as required

**Cultural input into the design of the service**

The Holding Children Together service has expressed a commitment to ensuring the service works in a way which is appropriate for all children and families in the service, and to paying particular attention to considering the needs of Aboriginal clients. To this end, RANT, with ACF, formed an Aboriginal Advisory Group, which has six Aboriginal members chosen for their involvement in therapeutic practice, including traditional healing. The group are directly consulted about the service model and individual practice considerations and are also able to identify other appropriate contacts for advice or collaboration in the community to broaden the base for cultural input into the service. The first meeting of the Aboriginal Advisory Group was held in October 2011.

*I guess [the role of the Aboriginal Advisory Group] was really as it says to advise on those cultural issues in terms of how we apply the knowledge from ACF within this context and I know some of the other practitioners are particularly working with much more marginalised kids and family groups, translating the concepts, even conceptualising. Again, that translating of what we’ve conceptualised into their set area. (R27)*

While in some cases the Advisory Group were able to provide advice that could be used directly by practitioners, in other cases the role of the Aboriginal Advisory Group and its availability to members of the broader CTT were not known.

*I’ve certainly used the Aboriginal Advisory Board in some fairly high risk situations for kids with DCF [the statutory child protection department]. So I’ve got an advice individually through a few of them and gone to DCF with the Board’s recommendations. (R26)*
It think it’s really great they’re on board, I really approve of the... and I’m not sure what they do, I’m not sure what they advise so I think it’s good but they haven’t come into any discussion with us. (R22)

Yeah, if they’re the advisory on the model of what’s being used, if they’re not the advisory on that and they’re not an information source for workers, then what exactly role do they play? I’m very unclear on that... (R30)

Recommendation

2. Regularly update members of the CTT about the terms of reference and role of the Aboriginal Advisory Group, and their activities associated with the Holding Children Together Service

Where possible, members of the CTT also work regularly with Aboriginal colleagues from within their own organisation or from other organisations to improve connections with families, promote relationship building and to ensure common understanding and accurate assessment.

Well that’s the great thing about having an Aboriginal Support Worker on the team. They can have conversations and connect with families in a way that I can’t. [The Aboriginal support worker] does a great job of actually brokering our programs connection. I definitely see it as crucial to my role to up-skill [the Aboriginal support worker] because she’s the one who can actually drive a lot more of the real change than I can. I can do some of the specific things and help with the logic of the program and to help with the child therapy. But to have her doing that with the parents and talking to the parents and using some of the language and the ideas, she can explain them to Aboriginal families in a way that I can’t (R32)

Service delivery

The Holding Children Together Service has demonstrated a capacity to meet a demand in Alice Springs for supporting traumatised children and children living in high stress environments. The service has maintained its client case load of 36-40 clients since our preliminary report. As at 6th June 2012, 47 cases had been accepted and there were an additional 21 formal inquiries which were referred on as the service was at capacity. The June 2012 six month funding report identified that nine cases had been closed, two because counselling had been completed, one was referred to DCF and six cases were closed before review due to the child unexpectedly leaving Alice Springs.

Of the 47 cases, 19 clients were from Town Camps and 28 clients were from Alice Springs more generally. As described, RANT-based counsellors carry higher case loads for the Holding Children Together Service than do other practitioners in the CTT, with approximately three quarters of the cases allocated to RANT practitioners.

All children accepted into the program have been between 5 and 12 years of age (57% female), with the vast majority of children being Aboriginal (at June 2012, 90% of the 40 clients were Aboriginal). The review of case files presented a range of reasons for referral. In some cases referrals included
known instances of a traumatic event, including exposure to family violence including homelessness as a result of violence, disclosure of sexual abuse or the loss of a parent or carer. In many cases externalising behaviours had raised concerns and led to a referral, including physical aggression, signs of frustration and anger, high levels of arousal and inability to regulate arousal, disruptive classroom behaviours and bullying. Other concerns included internalising signs such as withdrawal and lack of emotional expression or literacy as well as low school attendance, poor health and other signs of neglect. In many instances living conditions were noted in the reason for referral as factors influencing the child’s experience of trauma and emotional safety including living in very overcrowded conditions exposure to violence, substance misuse and caregivers experiencing mental illness.

Practitioners within the CTT noted that for some clients they are provided with limited information about the child’s history, including possible previous traumatic experiences, which can make therapeutic planning difficult.

And, you know, what is the history and it’s all very all over the place and I don’t know what’s going on for this kid but, so I would work in a neurobiology way and I am with her, but I don’t have the story that helps you kind of guide that stuff. (R26)

It is important to note that initially the Holding Children Together Service was not designed to receive referrals from children who were the subject of court orders regarding child protection matters. This was to avoid service overlap with the DCF therapeutic service for child protection clients. In our interim evaluation report we noted several observations made by practitioners regarding this exclusion criteria, and that notifications were being made to the Department of Children and Families (DCF) post-intake into the Holding Children Together Service and therefore presented the potential for clients to have open protection cases. It was decided that as a relationship had been established with these children, they should remain clients of the Holding Children Together service rather than being referred back to DCF therapeutic services. More will be discussed about the potential of the service in working with open child protection cases in Chapter 5.

The service has been responsible for a very high level of service delivery during its operation. The June 2012 activity report identified that 393 individual therapeutic sessions had been conducted with children. Of the outreach sessions which were not held in the clinic, 58 were held in town camps and 55 were held in Alice Springs more generally.

The service allows for flexibility in working with children. In general practitioners spent at least an hour a week with each child. Therapeutic time spent with children was in some cases an hour spent in a counselling room, using various therapeutic modalities (e.g., sand-tray therapy, play therapy or somatic techniques). Other practitioners spent time with the child in the classroom or school playground, observing school-based behaviours and assisting the child and teacher with therapeutic strategies. Practitioners work directly with teachers to develop classroom strategies which support the child and also support the teacher. To assist with school attendance practitioners have worked with children while transporting them to and from school. The service has demonstrated very strong engagement with the education sector. For example, in the 6 months between January-June 2012, CTT practitioners held 78 meetings with teachers, 21 with principals, 25 with special needs teachers, and 3 with Aboriginal education workers.
The Holding Children Together service works with other people who play a role in supporting children’s social and emotional wellbeing including family members including siblings, peers, teachers and other workers (e.g., family support workers, child protection workers). In addition to individual time spent with children additional therapeutic conversations are undertaken with family members and carers, to conduct assessment, discuss strategies for supporting children in the family and at school and proving emotional support to the parent. In addition practitioners provide advocacy and psycho-education with other services, including Department of Children and Families (DCF) and attend case meetings with other agencies involved in the children and families’ lives. The June 2012 activity report identified practitioners had held 147 family sessions and visits; an additional 30 sessions had involved work with clients and their siblings and 16 sessions had involved peer groups.

Work with children generally occurs on a weekly basis, however, family mobility can impact on this. In many cases practitioners reported periods of suspended service delivery where families had spent time ‘out bush’ in a remote community for a period of weeks or where the child had moved to live with alternative family members either for long or short-term period. Some practitioners also reported that movement within town, between housing or to emergency accommodation, and sometimes a lack of telephone contact affected the ability to meet with children and families on a weekly basis. Where children attended school, this became a valuable place of engagement to be able to work consistently with children when home-life was less stable. School also provided this forum for families whose capacity for engagement were less stable.

**Broader service initiatives**

In addition to the program development, service delivery and professional development activities delivered as core components of the Holding Children Together model, the service has been able to extend its activities and reach of the service through a range of additional initiatives. This is in addition to CTT staff being able to apply the knowledge and skills developed as part of their involvement in the CTT, to other clients beyond those engaged as part of the Holding Children Together service.

> I guess the point that I raised earlier that this - the learning for me for this is not just specific to CTT in the clients that I’ve seen there or even young people that I see that are even beyond the program, but the learning, it’s been so critical in all of the people that I see and the conceptualising generally has been really so invaluable and I can’t - I don’t think that even if we were working in Victoria or working on the East Coast somewhere that we would have exposure to this level of training and supervision. So I feel very fortunate and lucky to have been involved (R27).

Working with the Aboriginal Advisory Group RANT and ACF have been able to extend the service to develop a training program called ‘Tracking the Lines of Trauma – Healing from the Inside Out’ for Aboriginal workers. This has been funded through the Australian Government Child Aware Approaches initiative and will occur in the second half of 2012.
We’ve talked with our Aboriginal Advisory Group, and in talking that through with them we’ve identified about six key Aboriginal workers who have had some exposure to the training already, or who are well placed to have input into what that sort of training would look like. We’ve really only got time and money to run one lot of training so we thought we would actually train up those indigenous people more so that - almost like a train the trainer thing. (R24)

O’Loughlin (2009) has written of the need for teaching approaches which recognise and adapt themselves to the behavioural manifestations of intergenerational trauma experiences for Indigenous peoples. Similarly, the Holding Children Together service has identified the high demand for trauma-informed practice with children in Alice Springs, and a number of practitioners in the CTT have noted that many school classrooms may have students who demonstrate behaviours which are a response to trauma and chronic stress. To this end, RANT and ACF organised training events for schools in Central Australia using ACF’s ‘Making Space for Learning, Trauma informed practice in schools’ approach. The following events were held:

- 74 people attended the training in Alice on 16th February 2012.
- 40 people attended the training at Santa Teresa community on 17th February 2012
- Our Lady of the Sacred Heart College held the training as a professional development day for all of their staff.
- 14 staff from Yipirinya attended a professional development session run by the Senior Practitioner

The role of the Holding Children Together Service in informing trauma-informed school environments is also explored in later chapters.
Chapter 3. To what extent does the trauma-informed practice framework suit the context of service delivery in Alice Springs?

To explore this evaluation question, we asked members of the CTT to describe the Alice Springs context and of particular relevance for Alice Springs was to consider the suitability of the Holding Children Together service for contexts in which there is high staff turnover, a high proportion of Aboriginal clients, clients experiencing intergenerational trauma and stress, and for children who are still living in very stressful environments.

I think the first thing is there are the same problems but they’re contextualised in different ways (R21)

I think it could transfer anywhere. I think just basically it’s a very sound model, (R23)

Alice Springs has a unique mix of residents. You get people from all over Australia living here, some for short term, some have been here long term obviously. You get Indigenous people who have been living in town for quite some time; you get traditional Indigenous people who come in from out bush, who stay or don’t stay. You get your Americans who are here as part of the Defence Force, so the actual residents in Alice Springs is quite a mixture. (R23)

Working context

Participants described the working context in Alice Springs as providing challenges and opportunities. Despite high levels of staff turnover which could make networking and relationship building difficult, there was a high level of skilled professionals and a rich web of service delivery that would not necessarily be found in settings of a similar size in other parts of Australia.

People just don’t stay for long enough, that’s probably one of the difficulties that the networks are always changing… (R28)

...And just those relationships and that commonality that we have with being practitioners in Alice Springs... So I suppose connections, and the other one would be the networking opportunities. And I think we do have a lot of resources and we do have a lot of very skilled practitioners. I’m not sure if you took a 30,000 vision in a city of suburbs that you would actually have the services that we have here in Alice Springs. (R28)
Several practitioners noted that working in a complex environment such as Alice Springs allowed them to develop professionally and to engage in transformative practice with clients. The size of Alice Springs also provided a context supportive of integrated service delivery.

_I think as a clinician or a practitioner, Alice Springs gives you a very rich population to work within. There’s a lot of really good work that can be done here if you are a good practitioner in an area of need here. To be a child focused psychologist, if you’re working somewhere else you might not see the high – the same clinical presentations in Alice Springs. In Alice Springs you see quite a high ratio of those clinical presentations that relate quite a lot to trauma or to high levels of stress. I think it’s a rich place to be. There is scope to do really amazing work because we can do these integrated approaches._

(R32)

While some participants described Alice Springs as being resource rich, staff turnover, short term funding opportunities and complex practice environments produced a context in which clients were fatigued with changes in practitioners and inconsistencies in practice, and a lack of sustainability in service development and delivery. Vicarious traumatisation (Palm, Polusny & Follette, 2004) was noted as a potential risk to practitioners in this environment.

_In the professional context which is also another part I think for the clients is that there is massive client fatigue to do with the huge turnover of staff, ‘I’m leaving’, and clients having to continually re-educate staff because you need cultural competence to work here and it’s also always based on relationships and when there’s so much transience in the staff it weakens a lot of consistency in any work you do – it means that that contextual knowledge is constantly lost by people that build it up...The needs of communities and families and kids and everything else I just said, is that that sparks the staff turnover in a way, like, levels of disillusionment and then the contextual knowledge is gone again and then it’s pretty crap situation because no programs will get off the ground. The other thing I think about Alice Springs people need to know is that in terms of NGO work it’s very – the character is not for anything to be funded more than three years and it’s normally one year – it definitely affects how you work._

(R30)

_I think part of the support is, especially working as part of the CTT, and you know, the case management type meetings we have with all the different organisations, all the workers, you can see all the workers are exhausted and all the workers are over committed and all the workers are great people who are really trying to do their best, so there is that sense of, yes, we’re all here doing a really tough job and even though part of me would really like to see a lot more support go into workers, because I think we still lose such a lot of people, because the burnout rate is still really high, so that vicarious trauma aspect for workers I think is huge here._

(R24)

_The social environment does impact on you personally and obviously on clients as well. So there’s that interaction of how it impacts you personally, how it impacts them and the two coming together. So, I guess the higher chance of vicarious trauma for a practitioner through the work but through just being in the community as well._

(R27)
Lewis and colleagues (1988) have identified that practitioners who do not have a formal practice structure including supervision and opportunities for regular peer interaction are more likely than other practitioners to experience stress and burnout. The role of peer consultation groups such as the CTT provide an opportunity for practitioners to develop professionally, maintain practice standards and receive emotional support (Lewis et al., 1988). This was reflected by the practitioners in this evaluation, and was seen as an advantage over practice in other settings.

_I think we hold a lot, so I think to be able to sit there and kind of unravel a bit of what we’re holding and get some input and I think often, you know, people, you know, the professionalism in the group can often, there can be something pinpointed I think that’s quite poignant and quite useful._ (R26)

_If I was working in a team somewhere, you wouldn’t really have the opportunity to have somebody like [the ACF facilitator] come and work with us._ (R28)

Consistent with the literature regarding the benefits of supervision for practitioners working with clients who have experienced trauma (Sommer & Cox, 2005), several practitioners in this evaluation reflected that the Community Therapeutic Team group supervision environment provided multiple perspectives on practice, and collaborative guidance and support. These benefits of the initiative were viewed as highly relevant to the Alice Springs professional context.

_Peer group supervision, we’re doing quite a lot of that, and I enjoy that. That’s really good. Getting a lot of different people’s perspectives...I think it’s important not to be isolated in this work with children, is what I’m saying, especially this group which is 100% trauma, ongoing trauma that they’re living, interpersonally stored trauma, that it’s really important as a practitioner not to be isolated. And the group of people being bigger than two or three is great too, like having eight to 12 is great too, because you’ve got a whole range of styles and ways and us coming together on the same page about values and philosophy but still being diverse practitioners, like it’s quite a flexible model. It’s good. It’s really good._ (R31)

_And I think every modality has offered something into the room. The counsellors, social workers or psychologists have all contributed things that have made me think around what I’m doing and I think that’s probably the most beneficial thing from the whole process is that I’m challenged professionally and held collegially. It’s those two things that, when I came to Alice, that I sensed were missing. So I think we are well held in that environment._ (R21)
Aboriginal clients and intergenerational trauma and stress

The Holding Children Together Service has recognised the need for the service to incorporate Aboriginal world views and to work in ways which recognise the role of culture in healing for children. The establishment of the Aboriginal Advisory Group and the extension of the service to Aboriginal practitioners (as described in chapter 2) reflect this approach to working with Aboriginal clients. This is consistent with a growing body of literature advocating for two-way approaches which combine aspects of western knowledge systems and Aboriginal knowledge systems to provide culturally appropriate mental health intervention with Indigenous communities (Subia BigFoot & Schmidt, 2010; Westerman, 1997). These approaches must incorporate cultural beliefs and norms regarding such issues as health and wellness, mental health, spirituality, sexuality, gender roles, parenting practices, and intimate and social relationships. These approaches also aim to address system and service barriers to accessing mental health services experienced by Aboriginal people by embedding “elements of cultural and clinical competence within practice” through cultural supervision, consultation and collaboration (Westerman, 2004).

There’s been a lot of discussion around, not just training content, but Aboriginal world view and what trust means and what love means and what partner means and all those... and I think it’s extremely valid in the sense that we don’t communicate well, white fellas and black fellas, I don’t believe very well and I think there’s a whole kind of conceptual thing around what words mean that could be really helpful. (R26)

as you translate it, you need to translate it in a way that’s not just culturally sensitive and relevant, but actually pays respect to the significance of what relationships mean for Aboriginal children, because relationships have different dimensions for Aboriginal kids. (R40)

O’Loughlin (2009) has spoken of the need for practice with Indigenous peoples to be derived from an understanding of the socio-historical basis of collective traumatic responses to colonisation, dispossession, racism and the decimation of traditional lifestyles. He argues that without this lens, behaviours which are actually collective trauma responses (e.g., petrol sniffing, drug and alcohol addiction, family violence and suicide) will be seen as pathologies of the individual and will be responded to as such. Authors have also argued that healing from the effects of intergenerational trauma experiences require the incorporation of traditional healing practices within practice frameworks and that the indicators of intergenerational and collective trauma , and therapeutic responses to these indicators operate at the level of the individual, the family, the community and the nation (Krieg, 2009; Menzies, 2008; O’Loughlin, 2009). Figure 2 below taken from Menzies (2008, p.45) presents a conceptual model which incorporates the indicators of intergenerational trauma at these different levels for Canadian Aboriginal populations. This conceptualisation was mirrored by the comments of practitioners in the CTT during this evaluation.
The parents are experiencing stress and had some sort of trauma themselves so they don’t necessarily know that they’re doing the right or wrong thing, they’re treating their child probably in the same way they were treated. (R32)

In terms of clients I would say the context is a massive shortage of housing issues which means huge overcrowding issues in houses and with the overcrowding issues, flow-on effects of hygiene problems, it’s like cleaning up after 30 people who have had a party at your house every night, every morning, that morning after; separately to that, as I said low socioeconomic status, so the majority of my clients are on Centrelink, the majority – and it would be close to 90% of my clients don’t read or write English – I would say close to 95% of my clients speak English as a second or third language, so that means that employment – like I’m saying they’re all on Centrelink – but employment is quite difficult if you can’t read and write and count, so that’s definitely part of the context, is this closed shop in terms of financial independence. There’s significant issues of, as I’ve said, probably child removal due to neglect or substance misuse or violence and they’re all connected across families, so by families I would say - I’m calling a family say six or seven different family groups that are all one family - so across say that many, not
saying every immediate family has a child removed but across a family grouping odds are there would definitely be one removal, so that is definitely part of the context, is the heavy involvement of child protection and that has its own trauma. It’s a very strong part of the context here is that people’s importance in Aboriginal culture and, not ceremony, but ways of choosing ways of behaviour in terms of interacting with family members, interacting with services, making choices about criminal justice stuff, or child protection stuff, the context here is that people will not make those choices based on punitive measures from those paradigms and will be more likely to make them based on cultural obligations and what they should do the Aboriginal way. (R30)

I know the town camps, or [that particular] town camp is a very traumatised town camp as it is; there’s a whole generation of men missing out there because they’re all in prison; they’re in prison for alcohol offences, violence offences, all of those kind of things. (R33)

I think every single Aboriginal person has intergenerational trauma, I think they carry shame, I think they carry a huge thing of lack of self-esteem, they carry racism every day. It’s in every kid that I work with. (R26)

The ability of the Holding Children Together model to provide practitioners and clients with a collective understanding of the impact of historical and contemporary trauma and stress on current behaviour was seen as particularly useful. O’Loughlin (2009) emphasises that the development of a collective narrative that explains and acknowledges the impact of trauma and loss, and which also provides a hope-oriented future worldview is essential for healing.

So there’s a kind of common reference point, a common language that people can talk about in Alice, that’s based on neurobiology. I think that’s helpful to the community as a whole. (R40)

Within the CTT, practitioners spoke of the usefulness of the concept of stress, as distinct from the notion of intergenerational trauma, as a universal concept to explain both parents’ and children’s reactions to their environments and experiences. This conceptualisation of behaviour as a reaction to stress was seen to be highly useful in case conceptualisation and treatment planning, and was also seen by some practitioners as less extreme and less value-laden than the concept of trauma, which helped in the engagement of family members in the child’s treatment plan.

I guess there certainly is the fact that the mother has a mental health issue would mean that there’s stress – I don’t know if you’d call it trauma – but there is stress that is experienced by all members of that family. The grandmother would appear to be the least affected by – I wouldn’t look at her and say she’s someone who has experienced lots of trauma in her life but what she is doing now is managing the stress of looking after two children basically, but I wouldn’t call it intergenerational trauma, whereas I can certainly see that in many of the other cases that I work on as part of my job, yeah. (R23)

I think the important distinction that we’ve made in our program is that not all kids you work with are necessarily traumatised. The risk is, with using that framework, that you
start treating all children you’re using that framework on as traumatised and they’re not. In the environment that we work in, we don’t want to start labelling kids as traumatised so I think a nicer way to explain that is that there is a continuum of stressful experiences that children are exposed to when they come from crowded houses, when they come from conditions of poverty. So in this cohort we have high levels of stress. That stress might be acute, it might be chronic. That might mean that some children experience high levels of trauma, it might mean that they experience regular levels of trauma. The good thing is the framework still applies because they talk about that trauma being on a continuum of stress... The experience of stress explains all of those different things. It’s quite a universal mechanism for explaining kids and adults reactions to things. I think that it’s very very important for the mental health work we do, the developmental work we do, the educational work we do, and it informs the way we have conversations and the specific interventions that we use. (R32)

Complexity of cases and situations of ongoing trauma

Many practitioners in the evaluation spoke of their clients’ contemporary experiences of “complex trauma”, defined by van der Kolk as "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early life onset" (2005, p.402). These practitioners also noted that while children may be experiencing complex trauma, there may also be acute events that trigger trauma and stress reactions in children.

I think two important parts to understand are the part about acute stress and chronic stress. Children who come into our program are probably in an environment where there [are] chronic levels of stress, there's crowding and there's poverty and there’s arguments. But they also might have something happen that night or that day that has an even heavier impact on their ability to go through the day. They’re two big ways to look at it. When they come to our program, usually they come to our program because of some level of trauma, a combination of acute and chronic stress that’s been in their life, one issue is that that doesn’t go away because they stopped seeing us. (R32)

International reviews of the literature on treatment models for children who have experienced abuse or neglect have highlighted three models which meet the highest standards of evidence: trauma-focused cognitive behavioural therapy; abuse-focused cognitive behavioural therapy; and parent-child interaction therapy (Olson & Stroud, 2012). These models of therapeutic intervention with children and their families are most effective in situations in which sources of risk have either been removed from the child’s environment, or the child has been removed from the source of risk. There is far less evidence of which models may be effective for children who remain in high risk and high stress environments. Such environments have characterised some of the family and community settings in which clients and practitioners of the Holding Children Together Service live (see later recommendation in Chapter 4). This raised questions for practitioners about the extent to which
their practice could be effective in these settings, and also unintended consequences that may arise in the therapeutic process when working with clients to change behaviours which may not be adaptive in one context (e.g., a school setting) but which may be adaptive for high stress and threat environments which children may encounter in their homes or communities.

It’s the hardest work I’ve ever done. The level of trauma is huge and it’s around you all the time. So unless you’re living in Alice Springs with blinkers on you see it all the time. Down the street, you know, across your back fence or whatever. So I think that really means that as a worker you really have to be very aware around self care and how you do that, and trying to do that as well as what you can. And I think that the fact that, you know, the families and children are in such high levels of ongoing trauma is a really hard thing to, well, to work alongside of, but also just emotionally and physically and mentally to carry that. Yeah, to accept it, and that sometimes you’re weighing up which is the greater trauma, leaving her there or taking her there, or whatever, and whereas both are really unacceptable in reality.... (R24)

The biggest issue in Alice is how much can you afford to change the adaptive processes for children that they’ve come up with? How much can you afford to change adaptive strategies that children have developed in response to the violence and in response to stress in their life? How much can you afford to change those when that violence and stress is continuing? That question is a question that’s always there and always present. (R40)

the picture therapeutically is only able to be looking at supporting the child through levels of arousal and reactions to be able to get through them and realise he can get through them, like, you’re never actually looking to any kind of ... deeper layers of unpacking any trauma or talking about history or anything, or even cognizantly talking about why his reactions are the way they are to him, you never even get there because he’s still flipping out and he’s still going to be triggered constantly so it’s not fair to take those, I mean that flipping out constantly is a protective action, constantly absconding or getting really violent it’s a protection action and he’s needed it and he probably still needs it so that means that the implications are that you’re only ever – when I’m with him or with family - trying to model for the family how not to say amp it up and to treat him in somewhat sensory or therapeutic ways like voice tone and touching and distraction and physical stuff to get him through an episode. (R30)

Some practitioners in the CTT described how the complexity of cases seen by the Holding Children Together Service and other services in Alice Springs highlighted the need to engage in systemic thinking and collaborative practice, as well as the need to provide foundational experiences for children with significant adults who could provide responsive caregiving. More on the need for systemic approaches to service delivery and recommendations are made in Chapter 5.

... I guess it’s why I work here too because I like to work in a much more systemic way... (R27)
It’s like if you’re building a house, the foundations are going down first and if those foundations are being laid at a shaky time because of the stress, that will have an impact on all future layers that are laid on top of that. But if you can create the conditions where, for a period of that child’s life there are stable conditions – and by stable conditions I mean maybe that’s just in a room, maybe that’s just in their day, maybe – but where they have the experience of safety and positive engagement with something and not needing to be scared, that’s a place that’s been laid down and once it’s been laid down it can’t be taken away. That might not mean that’s the way they work when they go back to their life but it means that they can engage in those relationships more easily later on and that might be with their preschool teacher, it might be with year one teacher. (R32)
Chapter 4. What impact has the training, supervision and practice panel support had on the knowledge, skills, practice and confidence of practitioners?

In addition to the collegial and supervisory support provided by the CTT to practitioners undertaking complex trauma work with children in Alice Springs, the program logic identified a number of short term outcomes focused on increases in worker confidence and competence in working with children who may have experienced trauma (see Appendix 6). This chapter explores these outcomes in light of the second research question which focuses on any changes practitioners describe in their knowledge, skills and confidence as a result of their involvement in the CTT and the Holding Children Together Service, more broadly. The chapter begins with an exploration of their attitudes towards the CTT as measured using an adapted survey regarding group supervision as discussed in Chapter 1.

This survey, when administered at Time 1 highlighted positive attitudes towards the CTT, particularly with regard to worker confidence and that the supervision and training had led to clinical insights and had made practitioners aware of skills that needed to be improved. When re-administered at Time 2, significant improvements in attitudes to the CTT at time 2 compared to time 1, were seen in:

- a significantly greater impact on the quality of care provided by practitioners,
- being part of the CTT was seen to help practitioners with their self-awareness, and
- there were now seen to be better established ground rules for the CTT (see Appendix 7).

... and closer also because we know each other better. So certainly it’s feeling closer and safer. (R28)

In the first phase of interviews, practitioners similarly reflected positive views about their involvement in the CTT. All practitioners displayed a high level of engagement with the content and continued motivation to being involved. It was common for practitioners to express feeling “lucky to be involved”. Practitioners reflected positively on the group in terms of the training material and the benefits of learning from each other. The following sections focus on reflections of practitioners as gathered at Time 2 in the evaluation, and includes some reflections on changes over the course of involvement with the CTT and Holding Children Together Service.

It’s been massive for me, it’s the biggest thing that’s ever happened to me work-wise, (R22)

So I’ve been inspired and really motivated, sometimes feeling “I wish I could do that, I wish I had thought of that as quickly as they do, and how do they do that,” but mostly inspired and motivated. (R28)

I’ve found overall the whole training that we received it has changed my view so much in my work here and even in my own life (R33)

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1 Care should be taken in interpreting significant findings due to the small number of participants (n=7) completing the survey at time 1 and time 2.
Impact on knowledge

Practitioners spoke of their involvement in the CTT impacting on knowledge acquisition in several specific ways. In the first instance, the teaching methods, group and peer supervision approaches and case presentations enhanced practitioners’ understanding of neurological development and functioning, and allowed the application of this knowledge to practice. The experience of professional development in the CTT was contrasted with other forms of pre-service and in-service training.

*Obviously with a psych degree we do neuroscience pretty much every year and there’s been a component and to be honest I’ve struggled, but that’s the area that I’ve found the most difficult to retain and this experience has - it’s been completely opposite to that [in the CTT] that I’ve found - I guess because it’s much more workable and I’m using it day to day and I’ve been able to find a language that I can communicate with clients and with parents, and I’m not saying that I’m particularly fluent but that that fluency is building for me on that level of being able to use a language and communicate, but also then retain the more theoretical concepts in terms of brain structure and the development and impact of trauma.* (R27)

*Well for me it has provided me with a complete framework of working so the whole neurobiology thing has opened up a field that I have never looked at. I have at Uni and I decided, ‘Too complex, too complicated, too many fancy words, let’s leave it as it is’ but the way it has been taught to us now, with the pictures of the brain in a very slow way, what does what in the brain and how it actually works, gave me a really good insight, not only to look at, like do the developmental observations type of thing, to look at children, it provides me with a framework so I can actually conceptualise in this framework and say, ‘Look, this is where this child is coming from and this is why he’s throwing rocks at buses’. So, it gives me this framework and an explanation for it, and it feeds in well with other theories as well, from the behavioural side...* (R33)

Several practitioners spoke of key messages taken from the professional development activities which had provided shifts in thinking and practice with their client group. Others spoke of new insights being a regular outcome of the training and a key motivator for participation in the CTT.

*my favourite catchphrase of the ACF training is that, resolution or any kind of trauma-based work requires relationships, coordination and intent or purpose, and I think that’s something I will repeat forever, it’s excellent.* (R30)

*Talking to [the ACF facilitator] has helped to understand some of that, the stuff on effective co-regulation so that the Mum smiles at the child, the child smiles back, there are all these mirror neurons going on and off and there’s this good feeling of connectedness and emotional regulation. A lot of the parents who probably don’t smile at their child and the child doesn’t smile back but when we get that stuff happening with children, children learn that with the program and they go back and they maybe do something as simple as smile at their parent and then they have those neurons turn on and they smile back and sometimes it’s something just that simple.* (R32)
Every time I go we have a session and I learn something new; sometimes it’s another way of looking at something; sometimes it’s reiterating the importance of this; but it is new stuff, that’s why I enjoy going too. (R23)

Case presentations accompanied by written reports, were reported by some practitioners as particularly valuable tools in enhancing practice reflection, consolidating knowledge and providing a framework for practice.

I wrote my case presentation up and gave everyone a copy but my sense was that I’d been light on theory in terms of what I put together in what I presented so I went away and spend more time on the theory. So in that sense it was good for me. (R21)

So that report [from the case presentation] has really set that framework and that’s one of the things that I benefitted most with working with the team is having written that report. I think some others, when they’ve given their presentations, they haven’t had a report and I think that’s unfortunate for them because I really benefitted from that and I have been able to go back... and perhaps reassure myself that what I’m doing has some intention or is meaningful and there is a purpose for doing that because, “this is what I’m wanting to achieve.” I wish I would, but I won’t, do it with all the students and do it a little bit more formally. (R28)

Recommendation

3. Incorporate written reports as part of all case presentations to serve as a framework for case conceptualisation and treatment planning

Over time, the CTT monthly meeting has evolved from an environment in which knowledge translation was viewed as a one way process, to a setting in which knowledge and practice insights were being shared across the group. One practitioner noted that while they benefitted from many aspects of group participation, the external supervision and guidance from the ACF facilitator was preferred over the input of peers.

I think probably initially it was very much [the ACF facilitator] focused learning and we’re all hanging on what he might be thinking or what comments that he had, but I think as the group has evolved there’s a lot more conversation and a lot more people adding their own very pertinent comments and suggestions to tease that out with the presentation. There’s certainly some people who have then gone on and read a lot more and are picking up on other, they bring quite a lot in definitely. (R28)

I do get a lot out of the peer workshopping and cases but in it I’m very much more interested in hearing what [the ACF facilitator’s] input is, compared with other people’s input. (R30)

Experiencing multiple perspectives, and learning and testing new practice strategies were described as benefits of CTT involvement. These are often-cited aspects of group supervision which have previously been highlighted in the mental health literature, and which are important aspects in countering burnout (Lewis et al., 1988).
I just love the practical strategies that people talk about. I find that very, very helpful. Some of it is common sense but sometimes it’s good to hear that just to reiterate that, that is a very useful thing to do, but I just like listening to and hearing what strategies other people are using, that for me is the most useful thing. In a recent one, one of the team took photos of the child to try and build a sense of the child’s self-image from another aspect rather than from seeing her as part of – just to build on the positive sense of the child – and I thought that was really useful. (R23)

I think for myself then with the presentation, it’s the feedback and the other information and some suggestions, that opportunity just to go and talk to [RANT practitioner] when I was having that difficulty ... but even more so is hearing how other people have been doing things and the questions that other people ask, because I still don’t talk much and that’s not because, and not now, not so much because I’m feeling intimidated or nervous about the group, I’m much more comfortable and confident, but I’m not a person that’s going to ask a lot of questions in a group situation or in any situation really. (R28)

Impact on skills and practice

For those practitioners who were interviewed for the evaluation at time 1 and time 2, there was evidence of knowledge translation and incorporation in practice. Practitioners were moving into different stages with their clients (e.g., from assessment to the intervention phase), and identified clear goals and outcomes regarding trauma symptoms (e.g., the goal of improved sleep routine, significant reduction in trauma symptoms including increased attention, self regulation, concentration, making friends and articulating emotions). These outcomes were also reflected in the client outcome reviews (see Chapter 5).

Many practitioners reflected that the training and monthly CTT meetings had enabled them to conduct a more nuanced functional analysis of children’s behaviour through a greater understanding of the impact of trauma on emotional and impulse regulation, which in turn assisted in developing strategies to work with children and others in their environment to help children recognise and regulate their emotional responses in response to a range of stimuli (Bath, 2008).

the stuff that [the ACF facilitator] talks about, understanding the function, structure, how it relates to the behaviours that you see, is so much more useful than trying to diagnose based on a set of conditions...You can trace things back to neurobiological basis ... we’re not going to say ADHD, we’re going to say look they haven’t developed skills in attention and they haven’t developed skills in language and that’s probably not because they have an attention disorder, it’s probably for underlying reasons and if we can create the conditions where some of that stress can be lowered, those areas possibly will experience growth and development and that’s what we notice over the course of their intensive program. (R32)

So I use [the ACF material] in all my meetings, yeah, almost every conversation with a client and every time, particularly talking about kids I’ll have to pull back some bit and say, ‘He’s probably not really making these decisions, he’s responding’, so, yeah. (R22)
I think there’s been a greater awareness of the developmental focus or the developmental needs of a child that’s been exposed to trauma so, being able to reflect on what might be behind the behaviour and what’s needed to – I love that ‘close the loop’ saying, ‘What is the child actually saying he or she needs?’ and really pinpointing it down and then … thinking about those sorts of strategies that can close that loop or meet that need so the child can move on. (R23)

Some practitioners who came to the CTT with strong trauma knowledge and practice also demonstrated impact of the training and monthly CTT meetings including an increased interest in getting a detailed history as part of assessment due to neurobiology implications. There were indications that engagement with family members was increasing for some practitioners, although others were still finding that families did not necessarily want to engage in the therapeutic process. In some of these cases, work was undertaken at the school, where significant gains were being made for the child.

The training, development and support provided as part of the CTT meetings provided a common language and understanding which assisted in communication with other practitioners and family members about the child’s experience. This assisted in explaining children’s behaviour, in encouraging others to be part of the treatment intervention for children, and in explaining strategies for intervention. These benefits also translated into work with other clients outside of the Holding Children Together Service.

So not just in terms of my understanding and having a language to communicate with other practitioners, but as I said before, a language or an explanation that’s really helpful to parents and to young ones and for me the learning and the benefit of this training hasn’t been just with the kids that I’m working with because there are other ones that don’t come under CTT that I use this with, but also with adults which is the bulk of my group that I work with, and using the same sort of conceptualisations and language with them has been really helpful... what’s happening in your brain when you’re stressing out or when you’re getting really angry or when you’re feeling really distressed and going through the mechanics of what’s happened and where the origins of that experience on a neurobiological level. (R27)

the aspect of my practice that’s changed the most...[is] being much more intentional with using neurobiological principles in my conceptualisation - A - and then B, communicating that to the client, whether that be an adult or a parent or in some way the child as well, particularly with the one that I’m seeing which are often a bit older so you can start to communicate that with them. I guess I would say that it’s not so much a practice difference because in terms of process it’s still the same - in terms of psychoeducation and conceptualisation formulation, but really focusing the content around that area. (R27)

While for some practitioners, participation in the CTT had led to major shifts in practice, for others, this new knowledge was incorporated into case conceptualisation but had not been seen to lead to substantive changes in practice.

But especially the neurobiology stuff, just that ability to have thought about when he experienced that trauma and what part of the brain was developing at that time to
understand his behaviour now. But as I say there’s probably been a little bit of change in my practice but not that much...if we video taped a session with [the child] a year ago it looks pretty similar to what was going on now. (R28)

The different practice and professional backgrounds of the CTT members, prompted caution with regard to the wholesale application of the training to practice with vulnerable children. In particular, the need for a strong practice framework within which the knowledge and practice could be incorporated and the need for evaluation of practice techniques was noted by some practitioners. The risk is that a broad (and potentially ineffective) range of practices could proliferate under the banner of trauma informed practice if practice was not grounded in clear and effective practice models. This has also been described in the broader literature regarding trauma focused approaches and the use of new or creative practice techniques, with authors identifying the need for this to be done within existing treatment modalities which have an evidence base (such as trauma-focused CBT) and which provide a framework for practice (Edgar-Bailey & Kress, 2010).

You could do anything and justify so you’re not using that to link it in with your intervention and that’s what I think the tricky part is. In terms of this program succeeding in what is intending to do, I think it’s definitely done that and I think what it can’t do though, is inform the actual practice that you do and how you actually see a case through. I think that would be my reflection. I think the stuff where they do the case presentations and there is an assessment, just that part of it is tricky, just to get everyone to agree on how to do assessment. So when it starts getting into case management skills and clinical skills, I think if people have a varied level of clinical skills in their application, there’s a limit to how well you can apply that theory to what you’re doing. (R32)

One practitioner, particularly noted their difficulty in integrating the content and strategies in their practice as part of the CTT, and noted the role of the ACF in their continued involvement in the service.

It’s very imbalanced, I’m only probably still involved because of [the ACF facilitator’s] involvement, otherwise I would have left it, because I’m struggling so hard to actually tangibly implement it in my own work, I think, but I’m still going because I’m getting massive amounts out of [the ACF facilitator’s] input. (R30)

Recommendation

4. To ensure high quality of practice, review the strength of frameworks for practice used by CTT practitioners in accordance with evidence based practice and programs for children who have experienced trauma, abuse and neglect, including children living in ongoing stressful and chaotic environments
Impact on confidence

In addition to the perceived benefits of CTT involvement for practitioner knowledge and skill development, a number of practitioners commented on the role that the CTT and professional support activities played in developing and improving confidence in their practice with clients.

*I think we’ve grown and my work has changed and it is much better work, I’m much more confident, I think everything is better* (R22)

In some cases this was in the form of validating practice and providing support for practice decisions, which practitioners had previously seen as valuable and effective with clients, but for which they did not have an a priori evidence base. As identified in the previous section, and by other authors, it is important to ensure that practices are consistent with theory and subject to empirical verification, particularly with such vulnerable populations (Perry, 2009).

*Some of the sand tray and spatial stuff that I’ve done with kids for a while, fair while, and enjoyed and found useful, I guess some of the theory validates that. And you know, it is affirming but it’s also empowering to have that kind of scientific base behind it.* (R31)

One practitioner noted how their involvement in the CTT had given them the confidence to engage in a paradigm shift in case conceptualisation and treatment planning for children who have difficulties with self-regulation.

*I think if I was to say that one of the big things that this program has helped me with is to have the confidence to go from the paradigm I was trained in, to a newer paradigm about understanding those things. I think a big part of that is, like if the child’s crying and they and they’re four and they’re not really regulating that, but you can actually say ‘that’s okay’; very very big paradigm to move from “no, no don’t want to reinforce them crying, this is a behaviour and if I go and pick them up that’s teaching them to…” you know. It’s given me the confidence and the understanding to pick kids up and meet some of those needs and also to learn that when you do that, it doesn’t make it worse, they actually get better. It’s just like needing a bit of water, they just needed a little emotional drink and now they keep moving.* (R32)

Practitioners also spoke of the ability to make a contribution to practice development and to share practice ideas, providing confidence in their work and mutual support to other practitioners to try new practice ideas.

*I’d really like to keep it going, so I’m really interested and I’m really greedy for more and I think, I’ve never had that particular type of food in my life, you know, and I want more of it, and it feels like it’s great for my life, great for my work, adults, and great for the kids, so I’d like to gee it up more and I’d like to keep it going. So, I think it’s served a great function for me about just being heard and being able to talk about my ideas, even if they’re not even my child that I’m working with, all the children I’m working with, I’ll bring examples up or I’ll listen. So, I think there’s a part of my work that just would not get supported if I didn’t have that group.* (R22)

*Probably one of the most pleasant parts of the group has been the support for people trying things outside of the group.* (R32)
Chapter 5. To what extent does the therapeutic model improve psychosocial outcomes for children receiving the service?

This chapter focuses on the clients of the Holding Children Together Service and their presenting problems, progress towards outcomes and the potential contributions made by the Holding Children Together Service to this progress. It was beyond the scope of this evaluation to collect information directly from children and their families. The information in this chapter has been triangulated from project reports to the funding body, client outcome reviews conducted by practitioners and interviews with practitioners.

Client presentations

Client outcome reviews were provided to the evaluation team for 36 clients, representing 22 girls aged 5-12 years and 14 boys aged 5-14 years. When the audits were conducted, children had been engaged in counselling for between 8 and 44 weeks (mean 27.1 weeks, SD 10.2 weeks), and had received between 3-40 sessions with practitioners (mean 15.5 weeks, SD 9.0 weeks). On average, practitioners had spent 6.3 sessions with family members per child (SD 6.0 sessions, range 1-30 sessions) and 5.9 sessions with other members of the child’s network (SD 4.4 sessions, range 1-15 sessions).

Streeck-Fischer and van der Kolk (2000, p.903) have noted that “children with histories of exposure to multiple traumatic experiences within their families or in medical settings usually meet criteria for numerous clinical diagnoses, none of which capture the complexity of their biological, emotional and cognitive problems. These are expressed in a multitude of psychological, cognitive, somatic and behavioural problems, ranging from learning disabilities to aggression against self and others.” Acknowledging this, the evaluation’s client outcome review process incorporated a modified form of goal attainment scaling (Mailloux et al., 2007) which allows the high level of variability and complexity in the presentation of children who were clients of the Holding Children Together Service to be taken into account.

Practitioners were asked to identify up to three problem behaviours which reflected their clients’ experiences of trauma or chronic stress. A total of 119 responses were given to this question (see Table 1). The most frequent behaviours identified to be addressed in the goals for intervention included children’s inability to regulate their own behaviour, often manifesting in the form of emotional outbursts, tantrums and aggressive behaviour. This was closely followed by internalising behaviours including being withdrawn, uncommunicative, and attachment-related problems including fear of separation from caregivers and lack of trust in relationships. Problems with school attendance and an inability to remain focused on tasks or to follow instructions were also frequently identified behaviours for intervention. Less frequently identified behaviours included feelings of low self worth, sleeping problems, sexualised behaviours, parentification and running away.
Table 1. Problem behaviours identified in client outcome reviews

<table>
<thead>
<tr>
<th>Problem behaviours</th>
<th>n²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperarousal, lack of self-regulation, inability to calm or soothe self, tantrums and emotional meltdowns</td>
<td>18</td>
</tr>
<tr>
<td>Violent, aggressive and reactive behaviour including damage to property, angry outbursts</td>
<td>16</td>
</tr>
<tr>
<td>Withdrawn, non-communicative, alone, very shy, emotionally shut down, numb</td>
<td>13</td>
</tr>
<tr>
<td>Refusal to attend school/poor school attendance/truancy/conflict with school staff</td>
<td>11</td>
</tr>
<tr>
<td>Attachment problems including separation anxiety, checking where parent/grandparent is, fear of abandonment, lack of trust in relationships</td>
<td>10</td>
</tr>
<tr>
<td>Unable to remain focused on tasks, not able to follow instructions, delayed learning</td>
<td>9</td>
</tr>
<tr>
<td>Poor self-confidence, negative sense of worth, hopelessness, looking to others to make decisions</td>
<td>8</td>
</tr>
<tr>
<td>Sleeping problems including nightmares and fear of sleeping alone</td>
<td>6</td>
</tr>
<tr>
<td>Controlling and bullying behaviour including with peers</td>
<td>5</td>
</tr>
<tr>
<td>Negative feelings towards sibling including fighting</td>
<td>4</td>
</tr>
<tr>
<td>Crying, sobbing</td>
<td>3</td>
</tr>
<tr>
<td>Dissociation in the classroom</td>
<td>3</td>
</tr>
<tr>
<td>Poor health</td>
<td>3</td>
</tr>
<tr>
<td>Sexualised behaviour, poor behavioural boundaries</td>
<td>3</td>
</tr>
<tr>
<td>Poor emotional literacy</td>
<td>2</td>
</tr>
<tr>
<td>Parentification</td>
<td>2</td>
</tr>
<tr>
<td>Running away, being on the street at night</td>
<td>2</td>
</tr>
<tr>
<td>Soiling self due to anxiety</td>
<td>1</td>
</tr>
</tbody>
</table>

The multiple and complex nature of children’s difficulties were noted by several practitioners. In one example, this child had social, language and cognitive difficulties as a result of early traumatic experience.

[She] says that she would really like to have a best friend. I mean, her ability to actually form other relationships with her peers has been impacted by the trauma. Her language development has also been impacted by that, as well as English as a second language, but it’s more than that... and certainly her learning is very compromised still because she missed a lot and so in terms of numeracy and literacy it’s pretty low. Emotional literacy too is pretty low (R24).

Client outcomes
Practitioners were then asked to identify the frequency and duration of these behaviours in the initial phase of treatment, the goals set for changes frequency and duration of these behaviours, and their frequency and duration at the time of the review. This information was used to calculate the proportion of goals achieved at the time of the review as per goal attainment scaling (Mailloux et al., 2007). Due to a large amount of missing data for the duration of behaviours across these questions and because of problems with description of behaviours or frequencies of behaviours (e.g.,

²In three cases information about behaviours could not be provided as it was too early in the counselling process for this information to have been obtained.
behaviours described as happening “often” rather than an actual frequency being given), of the 119 behaviours identified, only valid behaviour and frequency data could be used for 60 behaviours to calculate goal attainment scores.

There were significant improvements in these behaviours as reported by practitioner outcome reviews. Of these 60 behaviours, only 1 showed worsening of behaviour, and for 44 of the behaviours 100% or more of the goal was achieved; for 15, the progress ranged between 40-98%. The mean goal attainment scale score was 99% (SD 48%). This is highly consistent with practitioners’ ratings of improvements in these behaviours – of 80 behaviours examined, only one was noted as having deteriorated and one was noted as no change.

The other thing that he’s been doing much more is putting up his hand and not just shouting out. So he’s able to be a bit more restrained or regulated with his calling out. So I think there’s been quite a lot of improvement in the school stuff… so he’s sitting and attending for longer periods and he is also, I suppose, increasing in his learning capacity...I suppose the other thing is that he can articulate understanding of his own emotions and others’. (R28)

There have been changes; it took a while for caregivers to actually adjust to what would suit them the best as well as the child and because there were two caregivers it took them a while to agree on how to do it the best way but they have decided that the child is sleeping much more now and it’s much easier to get to bed and she is actually staying mostly in bed and when she doesn’t stay in bed they’re actually handling it in a different way so, instead of getting cranky with her they actually reassure her and put her back to bed so I think it’s been quite successful. (R23)

Twenty-nine audit responses were collected reflecting practitioners’ discussions with teachers regarding children’s progress in school (see Table 2). Of these responses, the vast majority described improvements in the child’s capacity to engage in learning opportunities at school (86%), in the child’s capacity to manage emotions (72%), and in the child’s relationships with others (86%).

Yes, and so now that there is some feedback that he actually has some friends and that if they’re doing some small group work, that he is doing that cooperatively and he is playing with students in his year level at play time and lunch time rather than younger students. (R28)

That’s from the teacher and the indigenous workers. He is walking out rather than exploding which is an initiative. The school don’t like it but it’s a much better strategy. The school won’t engage is the sense I’ve got. (R21)

The same questions were asked of practitioners regarding the views of others working with the child (see Table 2). Of the 37 responses received, 86% had reported that other practitioners had noted improvements in the child’s capacity to engage in learning opportunities, 89% in the child’s capacity to manage emotions, and 89% in the child’s relationships with others. And finally, the same questions were asked regarding whether caregivers had expressed to practitioners that they had noted improvements in the same areas (see Table 2). Of the 34 responses, 62% reported that caregivers had noted improvements in the child’s capacity to engage with learning opportunities, 68% in the child’s capacity to manage emotions, and 66% in the child’s relationships with others.
Table 2. Perceptions of children’s progress as reported to practitioners from teachers, other practitioners and caregivers

<table>
<thead>
<tr>
<th></th>
<th>Teachers (n=29)</th>
<th>Other practitioners (n=37)</th>
<th>Caregivers (n=34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity to engage in learning</td>
<td>86%</td>
<td>86%</td>
<td>62%</td>
</tr>
<tr>
<td>opportunities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity to manage emotions</td>
<td>72%</td>
<td>89%</td>
<td>68%</td>
</tr>
<tr>
<td>Relationships with others</td>
<td>86%</td>
<td>89%</td>
<td>66%</td>
</tr>
</tbody>
</table>

This parent says ‘I can take him shopping now. He used to have tantrums and I couldn’t go shopping and it was very stressful’ she’d have to get other family to look after him and that caused other fights and stuff like that. But just simply being able to help improve that child’s attention and, I guess you’d call it emotional regulation, so he was four but not having two year old tantrums. He’s actually able to sustain a shopping journey. That improves the mother’s experience of that day and also leads back to probably a better relationship when they get home. (R32)

For the 36 children for whom client outcome reviews were provided to the evaluation team, 15 children had a Strengths and Difficulties Questionnaire (SDQ) completed in the assessment phase, and 11 of these children had a subsequent assessment using the SDQ (see Table 3). There were no significant changes in SDQ scores between assessments, although there was a trend for improvements in SDQ total scores and hyperactivity scores. The lack of changes in total and domain SDQ scores do not reflect the changes reported by practitioners through the case review audit, which could be a result of the small sample size, but also could reflect limitations in both measures and measurement in this evaluation. More is discussed about the difficulties of outcome measurement in the next section.

Table 3. SDQ scores at first and subsequent assessments and related samples t-test results

<table>
<thead>
<tr>
<th>Scale</th>
<th>First assessment Mean (SD)</th>
<th>Subsequent assessment Mean (SD)</th>
<th>Difference in scores Mean (SD)</th>
<th>t-test, p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total score</td>
<td>16.40 (7.27)</td>
<td>13.91 (7.34)</td>
<td>-3.27 (5.44)</td>
<td>1.99, 0.07</td>
</tr>
<tr>
<td>Emotional stress</td>
<td>5.12 (3.02)</td>
<td>5.36 (2.84)</td>
<td>+0.45 (2.07)</td>
<td>.73, 0.48</td>
</tr>
<tr>
<td>Behavioural stress</td>
<td>3.12 (3.30)</td>
<td>2.82 (2.82)</td>
<td>-.18 (2.04)</td>
<td>0.30, .77</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>5.35 (3.18)</td>
<td>4.00 (3.63)</td>
<td>-1.64 (2.98)</td>
<td>1.82, .10</td>
</tr>
<tr>
<td>Difficulties with others</td>
<td>3.47 (2.21)</td>
<td>4.00 (3.00)</td>
<td>+.82 (4.47)</td>
<td>.61, .56</td>
</tr>
<tr>
<td>Kind helpful behaviour</td>
<td>5.71 (2.57)</td>
<td>6.82 (3.28)</td>
<td>+1.18 (4.96)</td>
<td>.79, .44</td>
</tr>
</tbody>
</table>
In addition to exploring statistical significance in changes in SDQ scores, clinical significance was examined by exploring the number of children whose change scores had shifted from higher to lower levels of clinical risk on the total problems score. Out of the 11 children with two SDQ assessments, 3 children scored unlikely to have clinically significant problems at both assessment points, 3 children scored as high risk of clinically significant problems at both assessment points, 1 child showed a deterioration in scores shifting from being unlikely to have clinically significant problems at time 1 to having substantial risk of clinically significant problems at time 2, and 4 children showed improvements in their level of risk for clinically significant problems.

**Difficulties with outcome measurement**

A number of difficulties with outcome measurement were identified in the course of the evaluation and related to elements of: relevance and applicability of the measures for the client group; the sensitivity of measures to change over time, particularly when behaviours were severe but infrequent; worker familiarity and confidence in using standardised measures with teachers and caregivers; and the reliance on retrospective case audits in calculating goal achievement scale scores. It was noted that both for purposes of evaluation and for practitioner feedback about client progress, some form of outcome measurement is required.

Practitioners had mixed views regarding the applicability of a measure such as the SDQ for measuring change for clients in Alice Springs who had experienced trauma, abuse or neglect. This had been a focus of discussion at CTT meetings.

No, we haven’t really got any formal measures. We’ve got the Strengths and Difficulties Questionnaire, and that really has got very limited capacity, and I think I gave it to her teacher...but I’m not even sure I got it back. I don’t even think I got it back, and then she’s changed schools .... Well, it’s very broad and it’s - there is some sort of process where you can actually score it, but that you have to do online and he did send us the link the other day but it didn’t work, it was the wrong link or something... and I know some people in the CTT have used it and others haven’t. So I guess if we get the scoring down and have the same teacher, then it might show something. But for some of these kids they don’t necessarily - I mean some really do act out big time in the classroom, but others don’t, and she’s one of these ones who doesn’t so she’s actually quiet and compliant and, you know, isn’t creating any fights or anything like that, appears to be attentive, all that sort of stuff. (R24)

The assessment didn’t accurately affect the goals mostly because the formal assessment was the Strengths and Difficulties Questionnaire and it didn’t actually elicit too many problems, she was fine as far as the teacher was concerned. The caregivers were more concerned about her behaviours at home that were a little bit like externalising outbursts I suppose so the goals were linked, I guess, to the initial referral problem which was that there had been some suggestion of sexual interfering and also there was some suggestion that her very early needs weren’t being met. So we were looking at ways of addressing that rather than addressing the outbursts (R23)
I think there’s been some vague discussions and there’s a lot of disparity and disagreement and think there’re psychologists, probably a few, that use them – I think there’s sort of agreement that some [measures] would be good (R22)

As noted above, the complexity and variability of behavioural presentations of children who have experienced trauma makes the identification of a single outcomes measure, difficult (Streeck-Fischer & van der Kolk, 2000). Recently, Michael Tarren-Sweeney (2012) has developed the Brief Assessment Checklists for Children aged 4-11 years and Adolescents aged 12 to 17 years. These assessment tools have been developed from the longer Assessment Checklists for Children and Adolescents which were originally designed because standard behavioural measures for children and young people did not necessarily adequately address the presenting issues for children in out of home care. McLean (2012) has also noted that many outcomes measures used with this population of children assess the symptomatic behaviours which children may present with, rather than the underlying functional impairments from which the behaviours may result (e.g., problems in executive functioning, problem solving, communication skills); an understanding of which may better guide treatment and case planning. Even less is known about whether standard outcome measures would provide valid and reliable data for children and young people from Aboriginal backgrounds. This should be a focus of future evaluation.

In this evaluation, goal attainment scaling has demonstrated promise as a way of measuring progress towards client-centred goals in trauma-informed practice in Alice Springs. Due to the formative nature and time constraints of this evaluation, the scaling was done using retrospective client case reviews as prepared by practitioners, and there were significant gaps in the data. Future evaluation would benefit from prospective goal attainment scaling and standards for goal setting and scaling to provide meaningful evidence of change (Mailloux et al., 2007).

But then in my general counselling role I thought I would struggle with some of those things with the behaviours and the frequencies because I haven’t been doing that and that’s something I’m thinking “well I could have ...” I could have done some even other measurements, just counting the number of times he raised his hand in a half hour period, I would have like to have seen that. So I do, I find that very valuable and that would have been good to have some concrete evidence of those improvements, even though we can say it just from noticing and observations and other people’s feedback, I do like to have that concrete evidence. (R28)

there are some definite barriers around standardised instruments being used here. so I guess I go more along the lines of the goal achievement scale with this little one, but also just checking in with her and mum every session and having the same aspects that we reflect on and even small things like something that I guess psychology would use. ... and so just checking in with her on her perceived level of anxiety from week to week, and getting mum’s assessed strength of that as well. So I guess that’s for more of her internal experience, but the bit outcome then tracking against the goal achievements scaling - is her attendance at school because that was a primary one. The frequency of the cutting has been another one, and the conflict within the family unit but particularly mum and her. I’m sorry there’s a big one that I forgot at the start which is her sleeping
patterns which were completely disordered and impacting on her school attendance as well. (R27)

Recommendations

5. Examine the applicability of the Brief Assessment Checklists for Children and Adolescents as potential outcome measures for the Holding Children Together service

6. Develop standards for goal attainment scaling and use this method prospectively to measure progress towards client-centred goals

Perceived contributors to outcomes for children

As part of the client outcome review process, practitioners were asked to describe the factors they thought had contributed to each child’s outcomes. This included what the practitioner may have contributed through direct work with the children, as well as changes in the child’s environment and the contributions of family members and other service practitioners. Responses to this question noted how the impact of their direct work with children both influenced, and was influenced by, the developments in other areas of the child’s environment. In a small number of cases, children’s problems resolved or were exacerbated by changes in life circumstances that were beyond the control of the service. In some of these cases, practitioners may have had a role in assisting children and their families through these crises or transitions, but in other cases, for example where children left Alice Springs suddenly, the role of the practitioner has been limited.

As with other large service initiatives which respond to children who have experienced trauma, abuse or neglect (Frederico & Jackson, 2010), practitioners in the Holding Children Together service came from a range of practice backgrounds and provided a therapeutic response to children of various ages, trauma experiences and with far ranging behavioural presentations. In describing the therapeutic practices that were seen to contribute to client outcomes, this evaluation has attempted to identify common goals of therapy which have been drawn from the literature regarding child-focused interventions for children who have experienced trauma, abuse and neglect (Bath, 2008; Cohen & Mannarino, 2008; Cook et al., 2005; Goldfinch, 2009; Jackson, Frederico, Tanti, & Black, 2009).

These goals of therapy include the promotion of physical and psychological safety including through trusting, reliable relationships; strengthening connections and relationships with caregivers through enhanced parent-child interaction, parenting skills and self-reflective capacity; strategies to promote children’s abilities to manage emotions, regulate behaviour, build social skills and enhance self-reflective thinking; and processing traumatic experiences and events by developing trauma narratives, identifying thoughts associated with the event/s and managing distorted thoughts (Bath, 2008; Cohen & Mannarino, 2008; Cook et al., 2005; Edgar-Bailey & Kress, 2010; Goldfinch, 2009; Jackson et al., 2009).
Promoting physical and psychological safety

In this evaluation practitioners spoke of components of their practice which contributed to building safe relational environments for children. This included engagement and trust building with children and their families in both the home and school setting. For nine clients, practitioners wrote of providing a nurturing and safe place in therapy through the design of the therapeutic space, the approach of the practitioner and the establishment of safe boundaries. This included building a trusting relationship through being non-judgemental and open, doing things at regular times with clients and providing consistency and follow through. Spending time in the child’s classroom and modelling appropriate behaviour were noted as instrumental to building trust and engagement with clients and those in their environment in a small number of cases.

I’ve gone to great lengths over time this is - so I’ll just say one thing every session – ‘I’m not anything to do with going to school, if you need help and part of that is going to school I can help you, but I am not here to go to school or not go to school, if you never go to school I will still come and see you. I’m nothing to do with school. I’ll help you, I’ll have a meeting with school’. (R22)

Safety planning, was seen as particularly relevant in contexts with ongoing risk to children, and was described in sixteen cases. This included exploring safety issues with children, with their families and with other practitioners including teachers, including identifying protective behaviours for children, identifying safe people and places in the child’s family and community, and techniques to reassure children that the caregivers themselves are safe by letting children know where their caregivers are and who they are with.

... and that level of care wasn’t there for her on a routine basis so we talked about playing games at home that would reassure the child that her caregivers would always be there for her and a lot of the work went into a bedtime routine and sleeping patterns because this child was not very good at being able to sleep well and sleep on her own and actually go to sleep without constant reassurance so we worked on setting out a bedtime routine that would provide her with that reassurance and make sure she actually got enough sleep to cope with life the next day. (R23)

Strengthening connections and relationships with caregivers

Practitioners spoke of changes within the home and caregiving environment observed over the course of their involvement with clients. This included improved communication between child and caregiver/s (n=7); caregivers taking greater responsibility for care and safety of the child (n=7); greater safety in home through caregiver monitoring unwanted visitors and supervision (n=6); greater caregiver understanding of child’s needs/child development/triggers (n=5); better communication, relationships and consistency between caregivers (n=5); a heightened awareness of the importance of education, including cultural education (n=4); the family being more socially engaged and connected to other services including respite (n=5) a decrease in parental alcohol use and related to this, fewer trips into town for drinking (n=3); greater family contact/access visits (n=2); improved confidence in working with school/better engagement with school (n=2); the caregiver receiving therapeutic support (2); and the family involving the child in decision making (2).
It is difficult to determine the extent to which these changes within the family and school environment are attributable to the work of Holding Children Together practitioners; as noted by many practitioners themselves many of the changes were unexpected or beyond their sphere of influence. However, it was noted that some of the environmental changes were attributable to collaborative case work with family support and child protection services in Alice Springs, and through direct work with adults and siblings in the children’s environment (see Table 4).

Table 4. Practice activities with family members of clients

<table>
<thead>
<tr>
<th>Type of work with family and siblings</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed developmental needs, including friendships, developmental expectations and appropriate parenting</td>
<td>9</td>
</tr>
<tr>
<td>Referral/advocacy for services for caregiver (eg., counselling, English lessons, respite care)</td>
<td>6</td>
</tr>
<tr>
<td>Family meeting</td>
<td>5</td>
</tr>
<tr>
<td>Explore need for access/contact with absent family member (e.g. mother), observe relationship and support this access directly</td>
<td>5</td>
</tr>
<tr>
<td>Explore impact of worry and trauma on the brain and behaviour</td>
<td>5</td>
</tr>
<tr>
<td>Explore family relationships</td>
<td>5</td>
</tr>
<tr>
<td>Discuss role of family as primary teachers of children</td>
<td>3</td>
</tr>
<tr>
<td>Maintain contact and communication with family, build relationship slowly</td>
<td>3</td>
</tr>
<tr>
<td>Emphasise specialness and potential of children with caregivers</td>
<td>3</td>
</tr>
<tr>
<td>Build relationship with siblings and develop strategies for them</td>
<td>3</td>
</tr>
<tr>
<td>Discuss importance of cultural and mainstream education</td>
<td>2</td>
</tr>
<tr>
<td>Model transparency with DCF and appropriate behaviours</td>
<td>2</td>
</tr>
<tr>
<td>Family therapeutic sessions</td>
<td>1</td>
</tr>
<tr>
<td>Assist families in meeting own goal of safety</td>
<td>1</td>
</tr>
</tbody>
</table>

One day when the whole lot of the kids were around, Mum was getting quite stressed and a bit snaky with the kids and I deliberately modelled some softness back into the children and she picked that up and stopped. Not making her wrong, but modelling something else that she could pick up on. (R21)
Strategies to promote children’s self-regulation, social skills and reflective thinking

Unsurprisingly for a children’s counselling service, the majority work of practitioners in the Holding Children Together Service was described as focusing on children’s abilities to self-regulate their emotions and behaviours, to engage in reflective thinking and to enhance social skills. For a number of children, practitioners spoke of counselling strategies which promoted engagement through reflecting and harnessing children’s strengths, enhancing emotional and social literacy, assisting children to communicate and learn new skills, assisting children to tell their narratives about their experiences, and helping children attach feelings to their experiences (Hecker, Lettenberger, Nedela, & Soloski, 2010). Vehicles for therapeutic intervention included the use of art, drawing, games and creative play, strengths and emotions cards, engaging in physical activity, and computer-based activities. Social skills training including emotion recognition and turn-taking, was used as an approach to build social skills in children. Client-led sessions were described as a strategy for ten clients, with these children directing therapeutic sessions with peers, therapists and caregivers. Relaxation strategies were also used in a small number of cases.

So you know, I’ll have things in mind for that as to what she missed out on. And with some of the language development and memory stuff I’ve done like a story, not only of her day, but also - so it’s a photo story, so it shows photos of, you know, when she gets out of bed and has a shower and has breakfast, walks to school and gets into the classroom, which is to give her some sense of consistency in life, and that okay, when I leave home there’s actually this predictable timeline which creates safety for her then. (R24)

Specific to Aboriginal clients seen by the service, practitioners spoke of the exploration of identity as a feature of the counselling service for five children. Identity was explored through creative arts, genograms and cultural activities (such as returning to country), and particularly focused on children’s connections to others and position and role in the family, as well as helping children process early traumatic memories.

Management of traumatic memories

Five practitioners described helping children manage traumatic memories, primarily through helping children create and explore narratives through play and photo stories and in assisting children through graduated exposure of children to environments and sensations which provoked fear responses.

Contributions to children’s outcomes from changes in their environments

The largest number of responses (n=13) regarding changes within the family which may have led to improvements in children’s functioning related to changes in living arrangements including the family being able to obtain stable housing in a safe environment, the child being relocated to live with a relative or foster carer who was able to provide structure and boundaries, the departure of the child’s father leading to less fear in the household, and in another case, the return of the child’s father to the household providing more security and stability for the child. Many practitioners noted the difficulties in influencing these family contexts, and at times in engaging caregivers in the
therapeutic process, but highlighted that there is a need for change in these environments for children to be supported in their psychosocial development.

the circumstances around this child’s situation changed around about the time or just before I took her on so, a lot of the development that she has had, the positive development, has been as a result of her changed circumstances, the fact that she now has two caregivers that are involved with care and working with them has provided her with the support that she’s needed to flourish. (R23)

I guess in all of them we have in that she’s going to school much more regularly now. She’s not cutting at all now for about the better part of this year, and she’s sleeping much better but that’s due to taking medication mainly I think, but that started this year as well. The conflict within the family and the dynamics there are much more difficult to change and the change has been slower and I’m finding it’s peaks and troughs with them that they’ll have really good weeks and have really bad weeks. So that’s been the one that hasn’t changed as much. (R27)

Four practitioners also noted changes within the child’s school environment, such as transition to a new class or the creation of time out/chill out spaces which were seen as directly affecting children’s behaviour and emotional states.

It’s more like a case management at the moment to find a safe spot for him and my goal would be that he learns that this is a safe spot and I can’t influence if it’s safe or not so sometimes it’s really unfortunate that we’re sending them back to this traumatic thing over and over, and I’m hoping that a placement for him works out in the next couple of weeks and that my goal would be for him to be there safe, sleep there, and go to school. So the goal would be some consistency in his life, a bit of a routine. (R33)

So, one of the things I did, yeah I haven’t talked to them and I haven’t done the interventions I might do with a European family and also targeted families sort of work with the parents, the grandma and the mother, so I tend to work just with him and it’s sort of a bit silo, it’s not really fully effective like this, but I once said to them, and I think they took this onboard, if he’s lying down and what they would do is, yell at him and push him and drag him out of bed and try and get him ready for school, they really wanted him to go to school, but he would get really angry, so I said, ‘Can you just say something and if he gets up to a little bit of anger, just leave him, it’s his choice to go to school’. So, my perception is that made some changes in the family. I gave them an out, they didn’t have to get this kid to school if he chose not to. Other things like, we never got around, well we just didn’t work, switch off the playstation, switch off all computer games. His brother is at home playing computer games, he’s safe at home, why would he go to school if there’s no reason to go to school. (R22)

**Collaborative and systemic approaches**

As identified earlier, practitioners of twelve clients spoke of direct collaborative work with teaching staff and family members, to provide consistent, non-punitive approaches to working with children
that acknowledged their behavioural responses to trauma. In eight cases practitioners wrote of working with staff from their own or other organisations such as Aboriginal support workers to engage family and support child living with another caregiver, and to ensure transportation of children to school, and with the Department of Children and Families about access and placement options for children.

_ I think if we go back to some of the educational things we might be talking to teachers about, it is that these children come from homes where it’s not that they’re not listening to you, it’s not that they don’t want to be good kids, it’s that they don’t necessarily have the ability themselves to behave that way._ (R32)

_Work closely with the teachers of all the kids and their strategies in the classroom we design as we go with them. And it’s kind of imperative because, you know, the kids spend a lot of time at school and a lot of the behaviours at school that, you know, we can work on together and if there’s a consistent approach these behaviours often, I’m finding with all the kids I work with, these behaviours often change._ (R26)

It is beyond the scope of any one service to be able to address the multiple and complex needs facing families and communities in Alice Springs, but children’s development and wellbeing is multiply determined by just such systems. The course of this evaluation has suggested that optimal results for children are obtained when other services and supports can be engaged to ensure safety and stability for children and engage with the psychosocial and physical needs of caregivers.

The intergenerational impacts of collective traumatic experience suggests that interventions to assist healing and recovery need must incorporate the multiple levels of child, family, community and nation, as described earlier (Menzies, 2008). It is pertinent therefore to explore the possibility of more formal relationships to incorporate the Holding Children Together Service as an active part of a multidisciplinary “system of care” for children involved in child protection services and related family support services and adult-focused therapeutic and treatment services. This funding and service collaboration would reflect the recommendations made by the Growing Them Strong inquiry report regarding collaborative investment strategies between government and non-government services, and a focus on preventative and therapeutic services.

### Recommendations

7. Explore the possibility for the Holding Children Together Service to be a funded component of a “system of care” for children with open child protection cases and their families, together with targeted and intensive family support services and adult-focused therapeutic and treatment services.


9. Identify opportunities for a commitment of long-term funding and ongoing evaluation for the Holding Children Together Service components as a feature of workforce development and retention, sector capacity building and service delivery to vulnerable children in Alice Springs. Long term funding is recommended given the impact on workers, clients and community members of turnover and change fatigue caused by short term funding.
Chapter 6. Summary and Future Directions

Summary
This formative evaluation of the Holding Children Together service has identified a significant impact of the service on service provision for vulnerable children in Alice Springs. The service was developed in response to an identified gap in service provision for children and uses an innovative approach to simultaneously increasing the reach of the service and providing considerable workforce development and supervision for a group of practitioners in Alice Springs.

The service has demonstrated highly promising impacts on worker knowledge, skills and confidence, as well as on outcomes for children identified through practitioner-derived case reviews. Practitioners described the approach as highly relevant to the Alice Springs context, with worker support and networking providing an important defence against worker burnout and stress, as appropriate for conceptualising and responding to complex and intergenerational trauma, and through links with the Aboriginal Advisory Committee and Aboriginal practitioners as appropriate for practice with Aboriginal families. The quality of training and support provided was seen as exceeding expectations and experiences in other service settings. Broad effects of the service were noted, with the model providing a means of direct knowledge transfer through training and supervision of practitioners and through service delivery to parents, other practitioners involved, and at times to the children themselves.

The service responded to a wide and complex range of behaviours, and both client outcome reviews and interviews with practitioners identified improvements for children across the range of these behaviours. Results from the case audits generally demonstrated improvements in the goal areas identified (e.g., violence and aggression, angry outbursts, tantrums, sexualised acting out, school refusal, freezing, dissociation, sleep problems, bullying, crying). In some cases, these improvements were identified as due in part to changes in the child’s environment (e.g., leaving the home/situation in which violence was occurring), and in others resulting from direct work with children and their families. It is important to note the role of the CTT practitioners in reinforcing the need for children to be in stable environments with families, and in some cases the practitioners appeared to be the catalyst for these changes.

Practitioners noted that progress for children experiencing complex trauma was particularly notable when practitioners engaged in collaborative case planning and casework within their organisation or with other services. This was particularly relevant in promoting safe and stable environments for children (e.g., through new housing, identifying alternative carers for children). This highlights the need for all systems around the child to be a focus of therapy using a trauma-informed approach, and for systems of care which target multiple levels of the child’s ecology.

In undertaking this evaluation, a program logic (see Appendix 6) was created at the start of the initiative to guide evaluation activities and to test the theory of change. As a result of the initial evaluation, and subsequent interviews and reviews of practice, a revised program logic has been developed to inform future service delivery and evaluation efforts (see Figure 2). This logic more clearly identifies the professional development, service delivery and practice approach components and their direct and indirect links to short, medium and long term outcomes.
### Holding Children Together Service Alice Springs - Program Logic

**Goal 1**

**Short Term Outcomes**

- Improved social problem solving skills & decision-making
- Improved therapeutic skills including communication with children
- Service provided in supportive, inclusive & respectful way
- Recruitment of two well qualified counsellors

**Medium Term Outcomes**

- An increased number of children in Alice Springs receive therapeutic services
- Cultural background & special needs considered in planning and executing programs
- Group training model promotes peer learning and support
- Establish RANT based trauma counselling service

**Longer Term Outcomes**

- Enhanced therapeutic skills including communication with children
- Provide children and young people with opportunities and assistance to participate in decision making
- Reduced trauma based behaviour (sleep & memory problems, shame, anxiety, poor concentration, hypervigilance)
- Two-way learning between Aboriginal and non-Aboriginal practitioners

**Outputs**

- Staffing components: The who
- Professional and service development: The how
- Service components: The what
- Coordination of support with the children’s networks

**Strategies**

- Establish Community Therapeutic Team including MOUs
- Partnerships with Aboriginal staff and cultural input
- Cultural advice about the design of the program
- Intensive professional development inc. training, mentoring & grp supervision

**Target Group**

- 5-12 year-old children in Alice Springs who have been affected by interpersonal trauma (such as abuse and neglect, exposure to domestic violence, drug and alcohol abuse, mental health issues, homelessness and disadvantage), who are not on child protection orders, and whose families have at least one meaningful relationship with a service provider. The majority of clients will be Aboriginal children.

**Inputs**

- Communities for Children Funding and Alice Springs Transformation Plan; experienced RANT based counsellors; RANT management systems/infrastructure; organisational support from network agencies and existing service networks; external support from Australian Childhood Foundation; evaluation by Menzies School of Health Research; program documentation; assessment tools and measures identified

**Goal 2**

**Short Term Outcomes**

- Enhanced ability to form and maintain relationships
- Enhanced parent-child relationships
- Service provided in supportive, inclusive & respectful way
- Establishment of strong partnerships between services to facilitate an integrated response to children and their families accessing the service

**Medium Term Outcomes**

- Cultural background & special needs considered in planning and executing programs
- Service provided in supportive, inclusive & respectful way
- Recruitment of two well qualified counsellors

**Longer Term Outcomes**

- Improved capacity of local practitioners to offer therapeutic services to children and families
- Improved educational outcomes
- Enhanced practitioner confidence & willingness to provide therapeutic service
- Trauma informed approach is appropriate for work with Aboriginal families

**Outputs**

- Staffing components: The who
- Professional and service development: The how
- Service components: The what
- Coordination of support with the children’s networks

**Strategies**

- Establish Community Therapeutic Team including MOUs
- Partnerships with Aboriginal staff and cultural input
- Cultural advice about the design of the program
- Intensive professional development inc. training, mentoring & grp supervision

**Target Group**

- 5-12 year-old children in Alice Springs who have been affected by interpersonal trauma (such as abuse and neglect, exposure to domestic violence, drug and alcohol abuse, mental health issues, homelessness and disadvantage), who are not on child protection orders, and whose families have at least one meaningful relationship with a service provider. The majority of clients will be Aboriginal children.

**Inputs**

- Communities for Children Funding and Alice Springs Transformation Plan; experienced RANT based counsellors; RANT management systems/infrastructure; organisational support from network agencies and existing service networks; external support from Australian Childhood Foundation; evaluation by Menzies School of Health Research; program documentation; assessment tools and measures identified

**Goal 3**

**Short Term Outcomes**

- Enhanced ability to form and maintain relationships
- Enhanced parent-child relationships
- Service provided in supportive, inclusive & respectful way
- Recruitment of two well qualified counsellors

**Medium Term Outcomes**

- Improved capacity of local practitioners to offer therapeutic services to children and families
- Improved educational outcomes
- Enhanced practitioner confidence & willingness to provide therapeutic service
- Trauma informed approach is appropriate for work with Aboriginal families

**Longer Term Outcomes**

- Stronger partnerships between services to facilitate an integrated response to children and their families accessing the service
- Improved commitment from carers to supporting traumatised children and implementation of strategies
- Enhanced practitioner confidence & willingness to provide therapeutic service
- Trauma informed approach is appropriate for work with Aboriginal families

**Outputs**

- Staffing components: The who
- Professional and service development: The how
- Service components: The what
- Coordination of support with the children’s networks

**Strategies**

- Establish Community Therapeutic Team including MOUs
- Partnerships with Aboriginal staff and cultural input
- Cultural advice about the design of the program
- Intensive professional development inc. training, mentoring & grp supervision

**Target Group**

- 5-12 year-old children in Alice Springs who have been affected by interpersonal trauma (such as abuse and neglect, exposure to domestic violence, drug and alcohol abuse, mental health issues, homelessness and disadvantage), who are not on child protection orders, and whose families have at least one meaningful relationship with a service provider. The majority of clients will be Aboriginal children.

**Inputs**

- Communities for Children Funding and Alice Springs Transformation Plan; experienced RANT based counsellors; RANT management systems/infrastructure; organisational support from network agencies and existing service networks; external support from Australian Childhood Foundation; evaluation by Menzies School of Health Research; program documentation; assessment tools and measures identified
Future directions

The evaluation has highlighted several considerations for the next phase of the Holding Children Together Service. Some of these considerations have been discussed earlier in response to the evaluation questions (for example, quality assurance and measurement of outcomes, funding sustainability), and others are newly introduced in this section.

Quality assurance

Given the recent proliferation of therapeutic practices which are based on neurobiological responses to trauma, Perry (2009) notes the need for further evaluation of approaches which incorporate neuropsychological knowledge and concepts into clinical practice with traumatised children. This is particularly true of services which incorporate diverse practice bases and diverse client groups (Frederico & Jackson, 2010). Some respondents in this evaluation also noted the need for practitioners to have a firm practice framework in which to incorporate the knowledge and practice of the CTT to ensure that practice is consistent with best evidence, and to avoid all practice becoming labelled “trauma informed”.

This evaluation has recommended that key elements of the next steps for the Holding Children Together Service should be a focus on quality assurance through clear program documentation and frameworks, review of practice against evidence standards and relevant and accurate measurement of client presentations and outcomes. It should be noted that since June 2012 the practice manual has been updated and distributed to the CTT.

Sustainability

Elements of sustainability that were described by participants in the evaluation included the ongoing role of ACF in training, supervision and overall clinical direction, the inclusion of new group members, and funding to support the initiative. There was unanimous support for the initiative to continue.

I’d love to see it continue. I think it’s a real strength that there are practitioners in several different organisations involved and it gets a real conversation in Central Australia going around this type of work and how it’s useful to approach it. That’s a strength I’d keep. (R31)

Many participants in the evaluation noted the role of the ACF facilitator as fundamental to the process of knowledge transfer and the translation of neurobiological evidence into the complex practice setting in Alice Springs. The quality of the facilitator’s training, support and practice knowledge was highlighted. Some practitioners viewed that the ACF facilitator was playing less of a role as the CTT gained momentum and consolidated its own group identity. However others suggested that the role of an experienced external facilitator was important as both a catalyst for the group, to sustain momentum and as someone who could provide a different perspective on the cases seen by the service. It was suggested that the role of ACF could be decreased over time, now that the group had its own dynamic and internal facilitation. The documentation of the service and practice model will be essential to sustainability and ensuring consistency in practice and service delivery.

I would recommend continuing the Australian Childhood Foundation involvement... because I fear losing the momentum when somebody of that calibre isn’t around, you
know, and when we’re all together it becomes a group dynamic, and this is very hierarchical – there’s one person who knows the most and the rest of us know our clients but it’s a very top down approach, but there’s so much information up there that we could use, so I’d love to do it for another year, I’d sign on (R22)

I think for me [the ACF facilitator’s] become less important and the team are taking up more responsibility around that...and one of our huge questions is how do we keep that team alive, with funding or not, we won’t be able to afford [the ACF involvement], even if we get funding, and what will that look like, you know.  (R24)

I’d like to see it continue and with [ACF facilitator’s] input into it as well. Maybe once every two months rather than every month for [them] but I think we should meet once a month. It’s more than just the children’s thing, we all get a bit more understanding of each other and each other’s organisation and there’s a way in to each other’s organisations as well. Some my sense is I’d like to be an ongoing part of it and probably only with about three or four kids. (R21)

RANT and ACF view the service as the product of, and requiring the ongoing input of, both partner agencies. Given that members of the CTT were unaware of this partnership approach and the ongoing role of ACF in service development and delivery, this needs to be more clearly articulated to the practitioners in the CTT, and presumably the wider service community.

Recommendation

10. RANT and ACF to more clearly articulate the nature of the partnership between their organisations and ACF’s role in service development and delivery, and to communicate this more effectively to the CTT and other key stakeholders.

The turnover of practitioners in Alice Springs had implications for future membership and sustainability of the CTT. One practitioner suggested that in order to join the existing CTT that a prerequisite level of training or knowledge of the neurobiology of trauma and its application in complex practice settings could be a requirement.

I think there are obviously some challenges that the program has which are not things that you might change – I think one of them is people coming and going, because Alice Springs is a transient population. (R32)

with new practitioners needing to come in, that there would need to be some sort of prerequisite type of training for them to come into that, and then I think we’re all working, I think that then those practitioners that have been there, it would be good for us to be then asking those questions and using our knowledge and sharing that knowledge with new practitioners but there would need to be some bottom line type of training that they would need to have had, but I can’t think of any other changes to have. (R28)
Recommendation

11. Develop a strategy for inducting and training new practitioners into the network

A key consideration for the sustainability of the Holding Children Together Service is of course the sustainability of funding. Green and colleagues (2009) have demonstrated the role of free, locally based counselling in the regeneration of communities, but flagged that ongoing funding is essential to sustain these services and their impacts. The results of the current evaluation are promising, and suggest that sustained funding should be obtained for the service, preferably as a component of a wider “system of care” including family support and community development initiatives for vulnerable children, families and communities in Alice Springs. Sustainability of the service may be obtained by broadening the service focus (for example to be based in education and/or to focus more on a child protection population). Recommendations have been made earlier in the report with this in mind.

I would like to see – from where I sit and the need that’s in this town, there’s a huge need out there for development of skilled foster parents and I know that the program hasn’t been set up to cater for children who might be under the auspices of Department of Children and Families, but I think that if we’re going to address trauma from a local point of view, from a generalist local point of view, we need to target as many of our areas of providing skill to foster parents and making more of them available and better trained so that we can actually more efficiently address some of these very many problem areas of how to manage children who are traumatised. (R23)

Summary of Recommendations

1. Consolidate program materials including training materials, assessments and other documentation into a Holding Children Together service manual which can be updated as required
2. Regularly update members of the CTT about the terms of reference and role of the Aboriginal Advisory Group, and their activities associated with the Holding Children Together Service
3. Incorporate written reports as part of all case presentations to serve as a framework for case conceptualisation and treatment planning
4. To ensure high quality of practice, review the strength of frameworks for practice used by CTT practitioners in accordance with evidence based practice and programs for children who have experienced trauma, abuse and neglect, including children living in ongoing stressful and chaotic environments
5. Examine the applicability of the Brief Assessment Checklists for Children and Adolescents as potential outcome measures for the Holding Children Together service
6. Develop standards for goal attainment scaling and use this method prospectively to measure progress towards client-centred goals
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<tr>
<td>7.</td>
<td>Explore the possibility for the Holding Children Together Service to be a funded component of a “system of care” for children with open child protection cases and their families, together with targeted and intensive family support services and adult-focused therapeutic and treatment services.</td>
</tr>
<tr>
<td>9.</td>
<td>Identify opportunities for a commitment of long-term funding and ongoing evaluation for the Holding Children Together Service components as a feature of workforce development and retention, sector capacity building and service delivery to vulnerable children in Alice Springs. Long term funding is recommended given the impact on workers, clients and community members of turnover and change fatigue caused by short term funding.</td>
</tr>
<tr>
<td>10.</td>
<td>RANT and ACF to more clearly articulate the nature of the partnership between their organisations and ACF’s role in service development and delivery, and to communicate this more effectively to the CTT and other key stakeholders.</td>
</tr>
<tr>
<td>11.</td>
<td>Develop a strategy for inducting and training new practitioners into the network.</td>
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</table>
References


Appendices

Appendix 1. Participant interview at Time 1 of the evaluation

Questions about Case Study

1. [If not a RANT employee]: Was this child a new referral through the CTT/RANT network, or someone that you were already working with?

There are lots of ways of working with children, so we’re keen to learn a bit about how you do this kind of work; what frameworks you use. So first, regarding the assessment process.....

2. What issues are you focusing on in your assessment?

3. How do you interpret what you see? [How do you interpret that behaviour/emotional state....]

4. What theories and professional knowledge do you use to frame your assessment?

Now I’m going to move onto some questions about some of the interventions that you’re using with the child that you have in mind....

5. Have you made particular goals with this child? (What do you see as the priorities?)

6. What sort of activities (or interventions) do you do with the child? [any interventions with their family?]

7. How do you involve other people in the counselling process? [ie. Other agencies, family members etc?]

These next questions are drawing the links between this work and the training that you have attended with ACF....

8. How has the training informed your understanding of trauma?

9. Relating specifically to what you’ve told me so far about you work with this child.... How has the training with ACF informed your work with this child; the assessment and interventions?

Thinking about this child, and also more broadly about your experience working in Alice Springs....

10. How do you see this trauma framework working in some of the complex cases that we see in Alice Springs?

11. How do you think that it suits working with Aboriginal culture?
12. Relating to the Alice Springs content and Aboriginal culture…. Were the examples given in the training appropriate for the children that you work with?

**Questions about Community Therapeutic Team**

The next few questions are a bit of a summary, about your involvement in the CTT overall....

1. Thinking back to earlier in the year when you first got involved with RANT and the CTT, what motivated you to join? [purpose]

2. Is the CTT what you expected it to be?

3. At that time, how confident did you feel about working with children and trauma?

4. How has that changed?

5. Are there any conflicts with your role?

Do you have any comments that you’d like to share about your experience of the trauma framework, your practice or your involvement in the CTT?

Is there something that you feel that I’ve forgotten to ask?
Appendix 2. Participant interview schedule at time 2 of the evaluation

Questions about Case Study
Are you still working with the same child as last time?
The first questions are about the child that you’re working with through the Holding Children Together program.

When did you start working with this child?

At the moment, what does an average week look like working with this child?
  How often?
  For how long?
  Where?

Assessment and measures
Can you tell me a bit about the assessment phase. What (behaviours or symptoms) were you looking for?
  What did you assess?
  Did you use any formal measures?
  Did this lead to particular therapeutic goals?

In the work with this child, do you have a written case plan, or do you approach the sessions week by week?

Can you tell me about any changes that you’ve observed in the child over the time you’ve worked with them? (how do you know you’re making a difference)

I believe that the group has had some discussions about using formal measures, and if so which ones are appropriate... Can you tell me your thoughts about this?

Working with the child and family
- I have a few questions about working with the family. Validate if already talked about family.

What role do you see the family as having in this child’s journey/recovery?
  What sort of activities do you do with the family?
  Have you observed any changes in the family?
  Do you share ideas about working with families within the CTT meetings?

Would you describe the child situation as one of ongoing trauma?
  What are the therapeutic considerations for working with a child in a situation of ongoing trauma?

Would you say that there are issues of intergenerational trauma that impact on your work with this child and their family?
  What are the therapeutic considerations for working in a context of intergenerational trauma?
Working with others
The next few questions are about working with other workers and services. Validated if already talked about it. You may have already answered some, but I’ll ask again in case there is anything else you’d like to say about it.

School
Do you work with the classroom teacher?
What kinds of strategies are you and the teacher working on? (What is the trauma theory behind this?)
Does the CTT group share ideas for the classroom?

Other community services
Are any other agencies involved with the child? Do you work with them?
How do you coordinate your involvement with the child and family?
Do you have a shared case plan or treatment plan?

Is this child/family Aboriginal?
How does the family’s cultural background shape the way that you work with this family?

Do you work alongside any Aboriginal support workers?
How does that support the therapeutic work that you do?

The Aboriginal Advisory Group
Can you tell me about the AAG’s involvement in the program?

Questions about Community Therapeutic Team

Tools
What do you think the key elements of the ACF materials?
Which tool are the most useful to you?
Are there ways that the way you work has changed?
Are there aspects of the way you’ve always worked which have been validated?

When you consider working from a trauma informed framework, how important do you think the neurobiology theory is to that framework?

Thinking about the last [insert] months, has the way you approach working with children changed since being involved in the ACF training? How?

Format
Can you describe to me the structure of the CTT meetings?

Have you presented a case yet?
How did you find it?
What are the benefits of these kinds of presentations and discussions?

Can you tell me about the balance of learning from [the ACF facilitator] as a specialist and learning from each other as a group.

How does [the ACF facilitator] facilitate this?

Overall, what are the benefits of being in this CTT group?

Other

Can you describe to me what is it like to work in the Alice Springs context?

Finally do you have any recommendations for the future of this program?
Appendix 3. Practitioner background survey

Practitioner Background Survey

These first few questions are just quick, closed questions, to get a sense of your background......

1. How long have you been working in the NT? ____________ years/months
2. How long have you been working in Alice Springs? _________ years/months
3. How long have you been working as a counsellor? __________years/months
4. How long have you been working in this particular job? ______years/months
5. Do you receive professional/clinical supervision? (please circle) yes no
6. How often do you meet? _______________________________________
7. Have you attended all the ACF training and meetings?
   (please circle)
   July     August     September     October     February     March     April
8. What is your professional background/training? __________________________
   (ie. What profession do you identify with and/or have qualifications in?)
9. Can you give me an idea of any other significant training that you’ve done in the last few years which directly relates to your counselling work with children and trauma?
Appendix 4. Community Therapeutic Team attitudes survey (adapted from Horton et al., 2008)

**Clinical Supervision Assessment Survey**

Below are a number of statements directly related to interactions and/or understandings of the Community Therapeutic Team (CTT) in Alice Springs. Please read each of the statements and then chose the position on the scale that best represents the degree of how much you agree or disagree with each statement in relation to your experience or understanding of the CTT. There are no right or wrong answers and your honesty is appreciated.

<table>
<thead>
<tr>
<th>Community Therapeutic Team Statements</th>
<th>strongly agree</th>
<th>agree</th>
<th>no opinion</th>
<th>disagree</th>
<th>strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The purpose of the CTT is to improve client care.</td>
<td></td>
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<tr>
<td>2. The purpose of the CTT is to enable clinicians to feel confident in their own practice.</td>
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<tr>
<td>3. I am clear about what I want to get out of the CTT.</td>
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<td>4. I feel safe sharing clinical issues in CTT conversations.</td>
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<td>5. There are well established ground rules in the CTT.</td>
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<td>6. I believe that any confidences I share are respected.</td>
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<td>7. There is mutual trust between the members in the CTT.</td>
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<td>8. I feel confident about bringing issues to the CTT.</td>
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<td>9. Being part of the CTT is helping to develop my self-awareness.</td>
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<td>10. I have gained new clinical insights through the CTT.</td>
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<td>11. The CTT has made me more aware of areas of skill that I need to improve.</td>
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<td>12. The CTT has definitely had a positive impact on the quality of care I provide.</td>
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<td>13. The CTT has helped me cope with any stresses at work I may have.</td>
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<td>14. The CTT has helped me feel more confident about dealing with my job.</td>
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Appendix 5. Outcome review audit form

Holding Children Together Service
Alice Springs

Outcome Review Audit Form

Gender of Child: M / F Age: _____ Years

Name of Counsellor: _______________________________________________________

Agency: _______________________________________________________________

Date of Referral: ___/___/___

Date Initial Phase Started: ___/___/___

Length of time between referral and initial phase started: _____ (Weeks)

Date of Outcome Review: ___/___/___

Length of time between initial phase start and review: _____ (Weeks)

Number of sessions with child: _____ Sessions

Number of sessions with family: _____ Sessions

Number of sessions with child’s network: _____ Sessions

Child Outcome Review

Q1. What were the reasons for the referral?

1. _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

2. _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

3. _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
Q2. Have any of these reasons been addressed during your involvement with the child? Circle one for each need identified above. (Circle one answer per reason)

1. Not addressed  Partially addressed  Fully addressed
2. Not addressed  Partially addressed  Fully addressed
3. Not addressed  Partially addressed  Fully addressed

Q3. In the initial phase, what were three problem behaviours that you believe reflected his/her experience of trauma or toxic stress?

1. ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

2. ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

3. ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Q4. In the initial phase, what was the frequency with which these behaviours occurred? How long did each behaviour last before it stopped?

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Frequency (Number of times per day/week/month)</th>
<th>Duration (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour 1</td>
<td></td>
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<td>Behaviour 2</td>
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<tr>
<td>Behaviour 3</td>
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</table>

Q5. What level of reduction (in frequency and duration) did you hope would be achieved for the behaviours identified in the previous question?

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Goal - Frequency (Number of times per day/week/month)</th>
<th>Goal - Duration (minutes)</th>
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<tbody>
<tr>
<td>Behaviour 1</td>
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<td>Behaviour 2</td>
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<td>Behaviour 3</td>
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Q6. At the time of this review, what is the frequency with which these behaviours occurred? How long does each behaviour last before it stops?

<table>
<thead>
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<th>Behaviour</th>
<th>Frequency (Number of times per day/week/month)</th>
<th>Duration (minutes)</th>
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<td>Behaviour 1</td>
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<td>Behaviour 3</td>
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</table>

Q7. Have there been any changes in these behaviours during your involvement with the child? Circle one for each behaviour identified above.

1. Deterioration   No change   Improvement
2. Deterioration   No change   Improvement
3. Deterioration   No change   Improvement

Q8. Describe why you think each outcome occurred and what you did specifically that may have contributed to each outcome in Q7.

Family and Network Outcome Review

Q9. Identify three changes in the family that you believe have already made a difference to the child’s functioning. Give an example of each change that you have observed.

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________
Q10. Describe why you think each change occurred and what you did specifically to support each change in Q9.

Q11. Identify three changes in the child’s network of support or system that you believe have already made a difference to the child’s functioning. Give an example of each change that you have observed.

1. ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________

2. ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________

3. ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________

Q12. Describe why you think each change occurred and what you did specifically to support each change in Q11.

Q13. Direct feedback - School (Circle as many answers as you need)

Have any of the child’s teachers noted whether the child has experienced any improvements in his/her capacity to engage in learning opportunities at school?

Teacher 1  YES    NO    Don’t Know
Teacher 2  YES    NO    Don’t Know
Teacher 3  YES    NO    Don’t Know
Teacher 4  YES    NO    Don’t Know

Have any of the child’s teachers noted whether the child has experienced any improvements in his/her capacity to manage his/her emotions?

Teacher 1  YES    NO    Don’t Know
Teacher 2  YES    NO    Don’t Know
Teacher 3  YES    NO    Don’t Know
Teacher 4  YES    NO    Don’t Know

Have any of the child’s teachers noted whether the child has experienced any improvements in his/her relationships with others?

Teacher 1  YES    NO    Don’t Know
Teacher 2  YES    NO    Don’t Know
Teacher 3  YES  NO  Don't Know
Teacher 4  YES  NO  Don't Know

Q14. Direct feedback – Counsellors / Helping Professionals
(Circle as many answers as you need)

Have you or any other helping professional noted whether the child has experienced in any improvements in his/her capacity to engage in learning opportunities?

<table>
<thead>
<tr>
<th>Counsellor</th>
<th>YES</th>
<th>NO</th>
<th>Don't Know</th>
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Have you or any other helping professional noted whether the child has experienced in any improvements in his/her capacity to manage his/her emotions?

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<tr>
<th>Counsellor</th>
<th>YES</th>
<th>NO</th>
<th>Don't Know</th>
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Have you or any other helping professional noted whether the child has experienced in any improvements in his/her relationships with others?

<table>
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<tr>
<th>Counsellor</th>
<th>YES</th>
<th>NO</th>
<th>Don't Know</th>
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Q15. Direct Feedback - Child

Has the child expressed a statement that they like spending time with you?

YES  NO  Don't Know

Q16. Direct Feedback – Caregiver (Circle as many answers as you need)

Have any of the child’s caregivers expressed a view that they have found talking with you helpful?

<table>
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<tr>
<th>Caregiver</th>
<th>YES</th>
<th>NO</th>
<th>Don't Know</th>
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<td>1</td>
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Have any of the child’s caregivers noted whether the child has experienced in any improvements in his/her capacity to engage in learning opportunities?

<table>
<thead>
<tr>
<th>Caregiver</th>
<th>YES</th>
<th>NO</th>
<th>Don't Know</th>
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<td>1</td>
<td></td>
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</table>

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Have any of the child’s caregivers noted whether the child has experienced in any improvements in his/her capacity to manage his/her emotions?

Caregiver 1  YES  NO  Don't Know
Caregiver 2  YES  NO  Don't Know
Caregiver 3  YES  NO  Don't Know
Caregiver 4  YES  NO  Don't Know

Have any of the child’s caregivers noted whether the child has experienced in any improvements in his/her relationships with others?

Caregiver 1  YES  NO  Don't Know
Caregiver 2  YES  NO  Don't Know
Caregiver 3  YES  NO  Don't Know
Caregiver 4  YES  NO  Don't Know

Q17. If the Strengths and Difficulties Questionnaire (SDQ) was completed during the initial phase, provide a summary of the scores and analysis. (go to www.sdqscore.org to get scores)

Q18. If the Strengths and Difficulties Questionnaire (SDQ) was completed at the time of the review, provide a summary of the scores and analysis.

Q19. If applicable, explain any changes in the SDQ scores.

Q20. How has your participation in the Holding Children Together Service connected to the outcomes you have described for the child, family and network in the previous questions?

Q21. Please make any other comments.

Thank you for completing this outcome review. It will be added to other de-identified group data as part of the evaluation of the Holding Children Together Service.
Appendix 6. Initial program logic developed for the Holding Children Together Service
Appendix 7. Differences between time 1 and time 2 responses to adapted group supervision survey (n=7)

<table>
<thead>
<tr>
<th>Attitude Statements</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>No opinion</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>t-paired samples t-test results</th>
<th>Degrees of freedom</th>
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<tr>
<td>The purpose of the CTT is to improve client care</td>
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<td>1</td>
<td>0</td>
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<td>6</td>
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<td>The purpose of the CTT is to enable clinicians to feel confident in their own practice</td>
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<td>0</td>
<td>1</td>
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<tr>
<td>I am clear about what I want to get out of the CTT</td>
<td>2</td>
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<tr>
<td>I feel safe about sharing clinical issues in CTT conversations</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>-.795</td>
<td>6</td>
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<tr>
<td>There are well established ground rules in the CTT</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>-2.828*</td>
<td>6</td>
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<tr>
<td>I believe that any confidences that I shared are respected</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>-1.922</td>
<td>6</td>
</tr>
<tr>
<td>There is mutual trust between members in the CTT</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>-1.549</td>
<td>6</td>
</tr>
<tr>
<td>Purpose Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-3.267*</td>
<td>6</td>
</tr>
<tr>
<td>I feel confident about bringing issues to the CTT</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>-1.922</td>
<td>6</td>
</tr>
<tr>
<td>Process Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-2.828*</td>
<td>6</td>
</tr>
<tr>
<td>Being part of the CTT is helping to develop my self-awareness</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>-1.549</td>
<td>6</td>
</tr>
<tr>
<td>I have gained new clinical insights through the CTT</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-1.549</td>
<td>6</td>
</tr>
<tr>
<td>The CTT has made me more aware of areas of skill that I need to improve</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-1.00</td>
<td>6</td>
</tr>
<tr>
<td>The CTT has definitely had a positive impact on the quality of care I provide</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>-2.828*</td>
<td>6</td>
</tr>
<tr>
<td>The CTT has helped me with any stresses at work I may have</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-.400</td>
<td>6</td>
</tr>
<tr>
<td>The CTT has helped me feel more confident about dealing with my job</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>-1.00</td>
<td>6</td>
</tr>
<tr>
<td>Impact Score</td>
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<td>-1.580</td>
<td>6</td>
</tr>
<tr>
<td>Total score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-6.669*</td>
<td>6</td>
</tr>
</tbody>
</table>

* Indicates t-test with significant result, p<.05