TARROT

TRAUMA.ASSESSMENT.REFERRAL & REHABILITATION.OUTREACH.TEAMS.

A description of the program and an evaluation of its impact

2016-2019

A report to the Commonwealth Department of Health
October 2019
Indigenous Australians Health Program

NGAOARA

WE ARE NGAOARA

LOVE.CULTURE.STRENGTH.

NGAOARA ACKNOWLEDGES THE WISDOM, GENEROSITY AND LEADERSHIP OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES.

This photograph was taken by a member of the evaluation team visiting TARROT's office in Moree. The messages of love and hope proudly displayed on the office reflect TARROT's key principles of supporting children who have experienced trauma to realise their full potential.

Acknowledgments

This report is assembled from the independent inputs of the following consultants:

- Carol J Vale of Murrawin Consulting provided a draft report documenting the adaptation and growth of the TARROT initiative and the models of service delivery. This draft report was based on in-depth interviews with key TARROT staff members and a review of reports prepared by the TARROTteam;
- The Australian Centre for Child Protection at the University of South Australia reviewed the available literature around models of care for responding to complex trauma in Aboriginal and Torres Strait Islander children and adolescents;
- The Australian Childhood Foundation provided input into therapeutic responses and the capacity development of service staff to provide trauma informed care.

These inputs were collated by A/Prof Peter Azzopardi (the Burnet Institute), Ms Chloe Green and Ms Kathy Mott- these contributors have provided logistical support to the TARROT program but have not otherwise been involved in service delivery or previously travelled to the communities that TARROT partners with.

To better understand the needs of clients accessing TARROT, a review of de-identified and aggregate data collected at time of referral was undertaken. To better understand impact, in-depth interviews with community members and service providers who had directly engaged with the TARROT program was undertaken (further supported by Dr Tara Purcell from the Burnet Institute).

This report and its findings were reviewed by Prof Ngiare Brown and TARROT's clinical team with the purpose of providing additional information and to enable reflection and service improvement. Data collected and provided by independent consultants has not been modified or suppressed.

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Contents

Purpose of this report

This report serves three inter-related purposes:

1. To describe the importance of responding to trauma in Aboriginal children and adolescents, and how the *Trauma Assessment Referral and Rehabilitation Outreach Teams (TARROT)* program has been designed to fill existing gaps in service response;
2. To document how TARROT has been implemented between 2016-2019 across two distinct settings - within the Moree region, NSW, where needs are substantial and largely unmet by existing services, and within an Aboriginal Community Controlled Health Service in the ACT, where existing services have not been specifically focussed on trauma in children; and
3. To evaluate the impact of the TARROT program on responding to trauma in Aboriginal children and adolescents.

We hope that this report is of value to the TARROT team to reflect on its activities, further strengthen its model of care and promote the initiative to be taken to scale across more communities. We also hope that this report is of value to the Department of Health when considering improving systems and service responses for children and adolescents affected by trauma and with complex social, emotional and cultural needs.

Professor Ngiare Brown and the TARROT Team

Executive summary

Trauma - exposure to events which pose a real or perceived threat to wellbeing - is now recognised as a key driver of the persistent and intergenerational disparities experienced by Aboriginal and Torres Strait Islander (Aboriginal) people. While there is a need to address trauma across the life-course, there is a particular need to address trauma early in life- this is where trauma is usually first experienced, and left unchecked, can have devastating impacts on the developing brain. As such, responding to trauma in early life can yield a triple dividend of improved health and wellbeing of young Aboriginal people, future adults, and the next generation. Yet despite its importance, trauma has remained largely neglected in health and social responses for Aboriginal people, and particularly so for Aboriginal children.

Professor Ngiare Brown (Founding Director of Ngaoara Limited) has established strong relationships with Aboriginal communities throughout Australia. Leading up to 2015, several individuals and service providers approached Professor Brown with concerns regarding the safety and wellbeing of Aboriginal children and young people in their communities. Services did not have the capabilities to identify the effects of trauma nor the capacity to respond to such complex trauma, meaning the needs of children were not being recognised or adequately addressed.

Ngaoara Limited is a not-for-profit that works with Aboriginal children and their families, service providers and government agencies to develop and deliver child centric, trauma informed assessment and care. In response to community and service requests, and building on the best available evidence, Ngaoara developed the Trauma Assessment, Referral and Rehabilitation Outreach Teams (TARROT) program. The TARROT program involves small teams of clinical and allied health professionals and cultural educators who provide health and cognitive assessment and referral outreach services for children affected by trauma and with complex comorbidities.

In 2016, the TARROT project received grant funding from the Australian Government to consolidate existing early work in to a 'lighthouse project'. The program model was developed around the following core principles:

- Child centric;
- Integrated and multisectoralin response;
- The promotion of positive cultural practices;
- Culturally informed and safe services;
- Treatment as prevention;
- Outreach with specialist teams;
- High quality assessment of needs;
- Care planning;
- Coordination of care and case management;
- Capacity development of existing services and professional development of staff.

To date, TARROT has been successfully implemented in Moree and the ACT and continues to deliver services in both sites - through a community-based model in Moree, and an Aboriginal Community Controlled Service model in Canberra, where TARROT is embedded within Winnunga Nimmityjah Aboriginal Health Service. This evaluation summarises the TARROT initiative and its development to address the unmet needs of children and families, and the impact that TARROT has had on children, their communities and service providers associated accessing the program.

The evaluation utilised a mixed methods approach which included - a review of aggregate, de-identified data captured at intake; an independent review of progress reports and documentation compiled by the TARROT program; key informant interviews conducted with staff of TARROT; and in -depth interviews with community members and staff.

From June 2016 to September 2019, TARROT multidisciplinary teams have conducted 78 outreach visits to Moree and Canberra. Across both sites, 135 referrals have been made to TARROT for children presenting with trauma related symptoms. Note however, that dozens of additional referrals have been made to the team seeking specialist input, without necessarily requiring face to face assessments. Further, many appointments with team members have also been for follow-up of the same children, as requested by families and services, but also, importantly, by the children themselves.

Of those referred, most experience a significant burden of poor social and emotional wellbeing and high rates of comorbidity that had not previously been comprehensively addressed. Additionally, not one child had a care plan and very few had ever received a prior assessment of needs. The TARROT team have completed 157 specialist assessments and have provided ongoing support and additional assessments for children presenting with highly complex comorbidities. All children assessed have received a care plan detailing their needs across the domains of health, wellbeing and culture. The majority of children that TARROT have formally engaged with have demonstrated complex needs which were previously not recognised or diagnosed. Specifically, nearly all children were abovethe threshold for toxic stress and mental health disorders, placing them at risk of clinically significant behavioural and emotional problems.

TARROT has demonstrated multiple impacts, including the visibility of children and how their trauma is being recognised and addressed. The most significant impact as identified by community members and confirmed by aggregate data has been the implementation of comprehensive specialist medical assessment and care planning. Specialist assessment is highly valued – families believe it fills a significant gap in service delivery, and addresses health and wellbeing needs of children and young people that have been previously unmet. Assessments have also enabled the behaviours of young peopleto be reframed as largely stemming from unresolved trauma which can be addressed. To further promote awareness of trauma, TARROT partnered with the Australian Childhood Foundationto develop and deliver capacity building workshops to school and service staff and to build local workforce capacities to recognise and respond to complex trauma and resultant behaviours.

Care planning has ensured that children receive appropriate care by bringing together different organisations and specialists to discuss and plan the care of young people. In Moree, a local Child and Family Advocate was employed by TARROT to facilitate case planning and follow up, improve co-ordination of care and increase accountability across agencies. Care planning has brought together multiple organisations to foster an integrated multi-sectoral approach to care for children and their families. Case discussion and co-ordination works to ensure that there are fewer gaps in service delivery, and that each service works to fulfil their roles and responsibilities in the best interests of the child. For the TARROT Aboriginal Community Controlled Service model, the development of a paediatric cascade and referral algorithm increased the capacity of Winnunga Nimmityjah to be responsive to the needs and priorities of children, rather than reactive to adult perspectives. Additionally, partnering with Gugan Gulwan Aboriginal Youth Corporation has increased young people's access to specialist services and more streamlined casemanagement.

Prior to TARROT, existing services were not able to meet the needs of children, and there weremultiple barriers to accessing specialist services or therapeutic care. The TARROT program's capacity to provide culturally informed, sustained outreach specialist assessments free of cost to families or services has assisted to dismantle some of these barriers. In Moree, TARROT has also established an independent physical office space that has fostered a safe environment for children to engage with specialists. Additionally, TARROT has recruited additional senior psychologists committed to monthly outreach to providemuch needed consistent therapeutic support.

Perhaps most important overarching impact of the TARROT program has been to promote aspiration and hope. Many services have given up on children affected by trauma due to their emotional volatility, difficult attitudes and challenging behaviours. TARROT has demonstrated that repair, rehabilitation and healing is possible and that collectively we can empower Aboriginal children to positive trajectories. Early intervention is crucial in addressing trauma and breaking the cycles of intergenerational disparity.

Background and context

Trauma as a key driver of health inequity experienced by Aboriginal Australians

Over half of the Aboriginal and Torres Strait Islander (Aboriginal) population are younger than 24 years of age.[1] Young people are at the core of Aboriginal existence and survival- they are central to the community wellbeing, cultural continuity and prosperity of Aboriginal people. [2] The majority of Aboriginal young people are doing well and live in loving and nurturing environments, however many experience substantial inequities in health and wellbeing.[3,4] As just one indicator, Aboriginal children 10-14 years of age have a mortality rate twice that of their non-Aboriginal counterparts, and are eight times more likely to die as a result of intentional self-harm.[3] One third of Aboriginal adolescents report high rates of psychological distress. Underlying determinants are complex, but include a disproportionate burden of psychological trauma, physical and emotional maltreatment, neglect, and greater exposure to violence and abuse.[5-7] These determinants all have their origins in forced separation from land, family and community; systemic racism; adverse contact with out of home care and the justice system; and ongoing marginalisation and poverty.[7,8] Collectively, these exposures and experiences can be considered as *trauma*, increasingly understood to underpin many of the health inequities experienced by Aboriginal Australians. The need to have specific focus on trauma amongst Aboriginal children and adolescents is increasingly recognised,[9] and has been identified as an urgent target for response by the Australian Federal Government and National Health bodies.[10,11]

'Many of the problems prevalent in Aboriginal and Torres Strait Islander communities today—alcohol abuse, mental illness and family violence … have their roots in the failure to acknowledge and address the legacy of unresolved trauma still inherent in Aboriginal and Torres Strait Islander communities. [12,13]

Concepts of trauma and complex trauma

This conceptualisation of trauma for Aboriginal people is consistent with broader understandings of trauma. Trauma occurs when a person is exposed to an event that poses a real or perceived threat to their emotional and/or physical wellbeing; causing the individual to become psychologically overwhelmed.[12,14] Complex trauma emerges when an individual is subjected to ongoing and prolonged exposure to traumatic events. Complex trauma is generally imposed interpersonally in several ways, including; physical, emotional, sexual and economic abuse and commonly begins in early childhood, extending throughout the life-course.[12,15] As delineated by the Substance Abuse and Mental Health Services Administration (SAMHSA); the impact of complex trauma can have ongoing adverse impacts

on an individual's functioning, including; psychological, mental, emotional, physical, social and spiritual wellbeing.[16] There is also strong evidence that trauma impacts on neurocognitive function:

> *'Experiences of abuse and neglect (trauma) create significant neurological damage, especially of the Autonomic Nervous System (ANS) that, if not repaired, carries with us throughout our lives. Among its many functions, the ANS is commonly understood as controlling our "flight or fight" stress response. The ANS affects all domains of functioning, including emotional, behavioural, interpersonal, and cognitive throughout a person's lifetime'*[17]

Trauma in the Aboriginal and Torres Strait Islander population is related to historical events with intergenerational and transgenerational impacts including; repeated exposure to life stressors; specific, intense life experiences; and adverse childhood experiences including complex and developmental trauma.[18] It is well documented that the impact of transmission of this trauma is at the heart of much of the poor social and economic life outcomes currently being experienced by Aboriginal and Torres Strait Islander people.[8,19]

Indivisible from the current trauma experienced amongst Aboriginal children and adolescents is the enduring impact of colonisation and the cumulative impacts of past traumas. There is an emerging differentiation in the literature between Indigenous Historical Trauma and other forms of trauma including PTSD, intergenerational, and transgenerational trauma. Indigenous Historical Trauma provides a nuanced understanding of trauma for Indigenous people by bringing a focus to the impact and effects of colonisation, including the collective impact, cumulative nature and cross-generational transference.[20]

Indigenous Historical Trauma, like racial trauma….. grapples with contextual influences on psychosocial and health phenomena to better appreciate the experiences of historically oppressed and socially marginalizedpopulations.[21]

The imperative to address trauma in childhood and adolescence

While there is a need to address trauma across the life-course, there is a particular need to address trauma early in life. Childhood and early adolescence are developmental stages where the foundations for social and emotional wellbeing (SEWB) across the life-course are established. Neurocognitive development, psychological development, social skills and personality are all impacted on by positive and negative experiences. As such, the effect of trauma experienced in childhood and adolescence can be much more profound than trauma experienced later in life.[12,22]

Van Der Kolk (2007) refers to early childhood trauma as developmental trauma, in which the experience of trauma early in life restructures the normative organising of the brain and impairs the development of executive functioning that assist in reaching developmental milestones.[15] Developmental trauma reorganises the brain to function primarily using survival mechanisms, inhibiting the functioning of learning mechanisms. [15]

The survival mechanisms look to anticipate, prevent or protect against the damage caused by potential dangers. In traumatised individuals, there can be a trade-off in which avoiding harm (the survival mechanisms) takes priority over healthy growth and development (the learning mechanisms). This trade-off comes at a high cost for children's mental and physical wellbeing and education [12,23]

Exposures and developments in early life extend into adolescence, a time when young people make important transitions in education (a critical determinant of health) and establish new relationships, particularly those with peers. It is a time of identity formation, including cultural identity, and for too many, it is when adverse consequences of trauma emerge, including involvement with the justice system, substance misuse and anti-social behaviours that lead to school exclusion. Empirical studies have demonstrated the compounding and cumulative effects of trauma by identifying the significant relationship between Adverse Childhood Experiences (ACEs) and subsequent etiological challenges.[15,24] These trajectories are not fixed, but rather, determined by social environments and circumstances (both supportive and adverse) that young people grow up in.

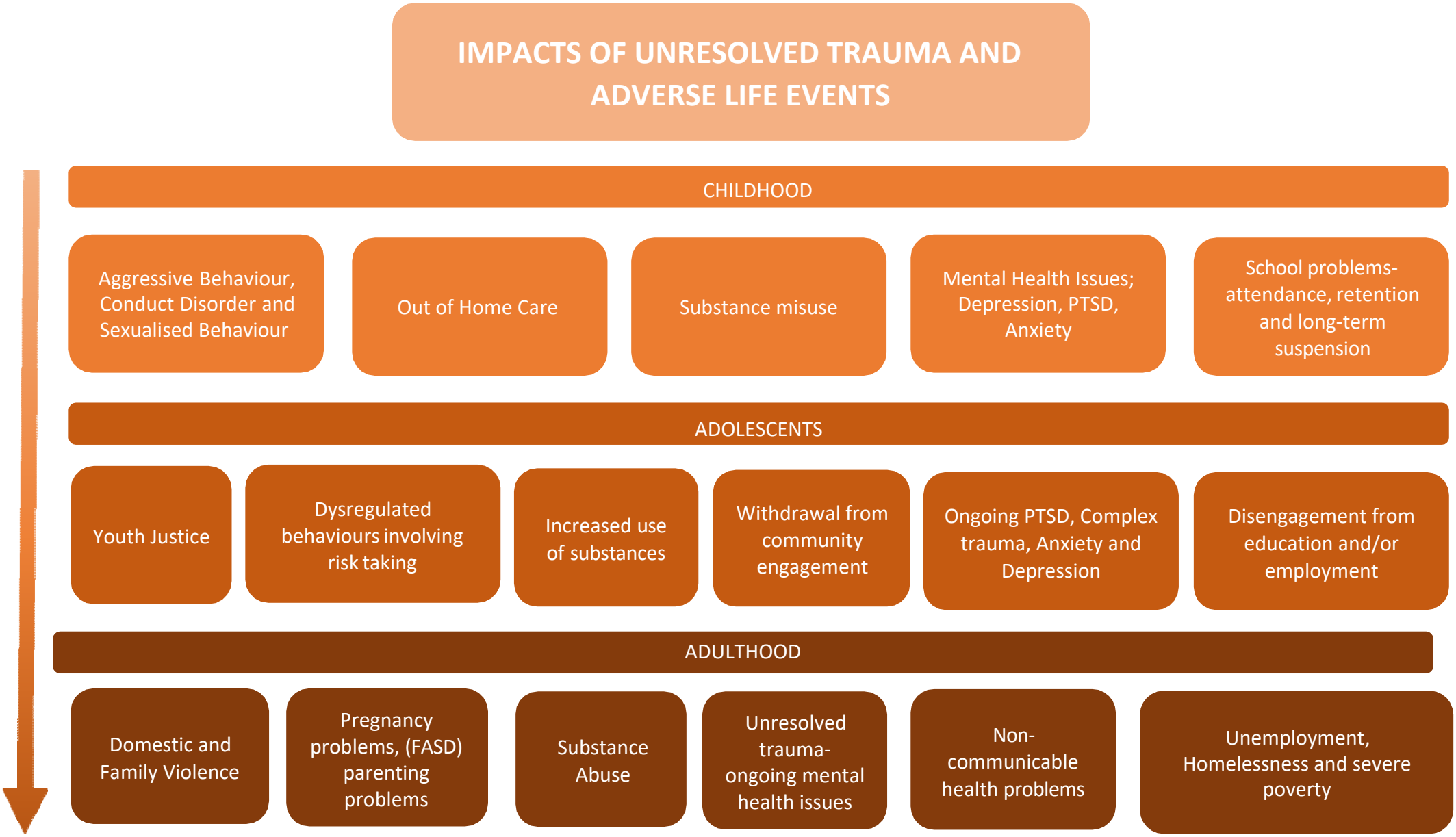
F igure 1: The outdoor space in Moree for TARROT Activities

'When a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support toxic stress occurs. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment, well into the adult years. (p.225) [25,26]

The presentation and identification of trauma disorder(s) early in life is 'atypical' and often masked due to more obvious comorbidities such as cognitive impairments; developmental and physical delays; or due to subclinical symptoms that misaligns with diagnostic criteria.[27] Misdiagnosis or failure to identify trauma in early childhood can prevent children or young people from receiving effective and appropriate early intervention that could reduce adverse health outcomes; such as impaired neurodevelopment, immune system repression and subsequent chronic physical and mental health disorders.[16,28-30]

'Research has repeatedly proven that investing in Early Childhood Development develops human capital, catalyses economic growth and encourages greater social equity.' [31]

The conceptual diagram on the following page summarises the impacts of unresolved trauma, adapted from findings of the Adverse Childhood Experience Study which described the potential impacts of adverse childhood experiences across the life-course.[32] It emphasises the sequential and cumulative impacts of trauma, and that trauma experienced in childhood can be pervasive and enduring - and as such- early and appropriate intervention is vital.


IMPACTS OF UNRESOLVED TRAUMA AND ADVERSE LIFE EVENTS
CHILDHOOD
Aggressive Behaviour, Conduct Disorder and Sexualised Behaviour
Out of Home Care
Substance misuse
Mental Health Issues; Depression, PTSD, Anxiety
School problems- attendance, retention and long-term suspension
ADOLESCENTS
Youth Justice
Dysregulated behaviours involving risk taking
Increased use of substances
Withdrawal from community engagement
Ongoing PTSD, Complex trauma, Anxiety and Depression
Disengagement from education and/or employment
ADULTHOOD
Domestic and Family Violence
Pregnancy problems, (FASD) parenting problems
Substance Abuse
Unresolved trauma- ongoing mental health issues
Non-communicable health problems
Unemployment, Homelessness and severe poverty

The inadequacy of existing responses to trauma experienced by Aboriginal young people

Despite the importance of trauma in addressing health inequity experienced by Aboriginal people, it remains neglected in health and social responses. Indeed, as identified by Atkinson, evidence for how best to respond to trauma in Aboriginal children remains in its infancy, with little evidence available in the peer-reviewed literature.[12]

As outlined above, trauma amongst Aboriginal young people is often complex in nature and inter-generational. By contrast, health and social service responses are typically focussed on individuals at a specific stage of their life, and on a particular aspect of their health and wellbeing. Aboriginal children typically face multiple barriers to accessing the care they need including: ability to provide consent and receive confidential care; financial barriers; physical availability; and cultural appropriatness. [33] When children do access care, services are often inadequate to understand and address their complex needs.

A particular challenge in responding to trauma is that exposure to traumatic events provokes different responses, and therefore, the clinical and social presentations of trauma are diverse. Indeed, the 'typical' presentations of distress, horror or fear are quite 'atypical'. Many children and adolescents present with behaviours that are disorganised or agitated; as such trauma is likely an important determinant (or missed diagnosis) for school refusal or behavioural disturbance[14]. Clinical assessment tools and guides to facilitate the early recognition are limited, and as such, there are likely many missed opportunities for therapeutic response.

A further inadequacy of our current response lies in the fact that individual patients are often expected to be solely responsible for navigating care providers, modifying exposures and their behaviours. Many people who have experienced trauma have limited capacity to effect such change, particularly so in the context of intergenerational trauma where whole families and communities can be affected by impaired capacities and capabilities.

Figure 2 Intergenerational Perpetuation of Impaired Human Capital

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Development of the TARROTprogram

The Trauma Assessment, Referral and Rehabilitation Outreach Teams (TARROT) Program was developed and implemented by Ngaoara Limited, a not-for-profit organisation that was established by Professor Ngiare Brown in 2014.

Ngaoara was established in response to concerns about the violence, trauma and neglect experienced by Aboriginal children and adolescents, the diminishment of positive cultural practices and cultural connection, and the resultant disparities in health, development and emotional wellbeing. Ngaoara believes that with cultural education and comprehensive health and wellbeing services, supported by appropriate social and political systems responses, we can empower our children to more positive trajectories across the life course. The organisation works with individuals, families, communities and services to break the intergenerational cycles of trauma and improve health and social outcomes for children and adolescents.

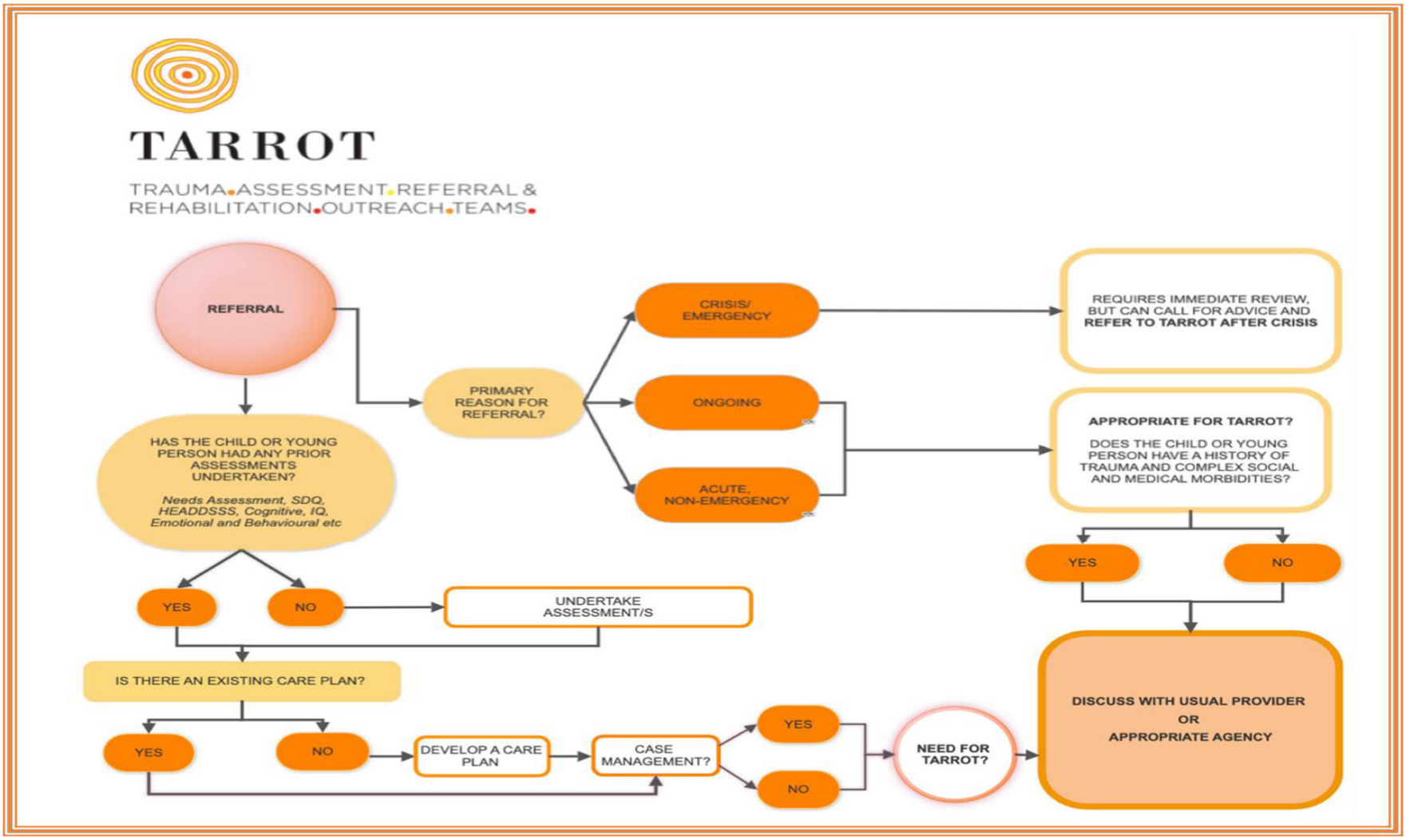
The TARROT program is Ngaoara's flagship activity and originated from an interest in developmental neurobiology; knowledge of the Adverse Childhood Experiences (ACEs) research in the US (REFERENCE), and clinical work already being undertaken by Prof Brown prior to funding from the Commonwealth Department of Health.

Prof Brown was workingas a clinician at Winnunga Nimmityjah Aboriginal Health Service, ACT. With the support of the CEO and staff, Prof Brown would see children and adolescents referred with complex health, developmental, social and behavioural issues. When she looked in to the individual and family histories of these children, she identified that trauma was a common exposure for each one.

Around the same time, she was contacted by a number of colleagues and service providers concerned about child and adolescent safety and wellbeing in communities in north-western NSW. They reported high levels of community, family and interpersonal violence; child physical and sexual abuse, including child prostitution; parents and carers with substance abuse and mental health dual diagnoses; incarceration of adults and children; declining school attendance; and escalation of antisocial behaviours.

At Winnunga Nimmityjah, to promote the integration of trauma informed perspectives into the core business of the service, a paediatric cascade and referral algorithm were developed.

Figure 3 TARROT Referral Algorithm



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In Moree, a series of community forums were convened to discuss issues of child safety and wellbeing, including sexual abuse, drug and alcohol misuse, family dysfunction, chronic community level violence, and disconnection from culture. The key issues to emerge from these forums included:

- the need to address a gap in child-specific services, particularly for those exposed to trauma;
- the need to develop services for children with serious behavioural issues;
- the need to develop programs and service responses that are culturally informed and safe; and
- the need to bring specialist expertise to under-resourced areas.

These findings informed the establishment of the TARROT program in Moree, where the team began work directly with the Barwon Learning Centre, a Specific Purpose School, to provide place-based assessment and support for children with emotional, behavioural and academic issues.

It was a chance conversation with then Health Minister, Fiona Nash, that led to funding of this early work. With her championing a proposal, and with the support of senior departmental leadership, Ngaoara was awarded financial resourcing to further develop the TARROT work in to a 'lighthouse' project, and to explore the effectiveness of child centric, trauma informed assessment, care planning and case management for Aboriginal and Torres Strait Islander children, families and communities.

Available evidence to inform an effective model of response

Evidence to inform effective interventions related to trauma is sparse,[12] but this should not be interpreted as absent, and there is increasing evidence available to inform Aboriginal child and adolescent health programming.[34] To develop and refine the TARROT program and build on the core principles defined by community, the available literature was reviewed.

To identify relevant evidence, the peer-reviewed and grey literature (key government and agency reports) were searched to identify effective approaches for treating the effects of complex trauma in children and young people, with a key focus Aboriginal and Torres Strait Islander children. The search was conducted by the Australian Centre for Child Protection at the University of South Australia, focussing on literature published since Atkinson's report in 2013.[12] A total of seven studies were identified, with substantial differences in study populations, study durations and intervention models, making comparison difficult. Significant improvements were only found in two programs: The Evolve Therapeutic Service[35] and The Take Two Program[36]. Key features of both of these programs are summarised.

Other identified programs were largely stand-alone in approach and delivered in a single setting (such as school); these were mostly short lived, showed little impact on the wellbeing of young people, and were generally not sustainable.

The Evolve Therapeutic Service (ETS)

'ETS is a program delivered in Queensland, Australia. The programme employs; a trauma-informed, collaborative wrap-round model of care in combination with; a f lexible intervention approach that is individually tailored to children and young people in out-of-home care who present with complex and extreme behavioural and mental health problems'.[35]

Key features of the ETS intervention model include:

- Co-ordinated and sustainable partnerships; *with key government, non-government and private sectoragencies;*
- Multidisciplinary specialist teams; *including, psychiatrists, psychologists, social workers, nurses and occupational therapists;*
- Multisectoral integrated co-ordinated care; *incorporating the bio/psycho/social/cultural aspects of the child or young person into intervention;*
- Comprehensive assessment; *of the child or young person and their significant others;*
- Trauma informed and;
- Flexible therapeutic intervention

Outcome from the Evaluation

The Evaluation of the ETS included 768 participants, of which 31% identified as Aboriginal and/or Torres Strait Islander; statistically significant outcomes were demonstrated in improvement of general functioning, clients moving from clinical to non-clinical subscales and decreases in components of the Strengths and Difficulties Questionnaire (SDQ).

Take Two program

'The Take Two program is a developmental therapeutic service in Victoria, Australia for children who have suffered abuse and neglect.

Key features of the Take Two intervention model ascertained from the literature review are:

- Multisectoral- The program is under the auspices of Berry Street and works in partnership with child and family services, mental health, academic and Indigenous services'
- Child-focused approach
- Integrated approach to therapeutic intervention.
- Developmental and ecological perspective
- Flexible site setting- *Providing the intervention at the most appropriate location available, whether it be at the children's home, in their placement, at school, in an office or in a room specifically designed to support therapeutic interventions.* Increasing capacity of the surrounding systems- *There is a high degree of activity spent working therapeutically with the service systems and in strengthening parents, carers and others' capacity to meet the children's emotional, developmental and other needs*

Outcome from the Evaluation

The evaluation of the Take two program had a total of 49 participants, of which 6.1% to 14.3% identified as Aboriginal and/or Torres Strait Islander; statistically significant outcomes were demonstrated in reductions of all sub-scales of the Trauma Symptom Checklist (anxiety, depression, anger, posttraumatic stress, dissociation, sexual concerns).

Overarching aim and principles of the TARROT model

The Trauma Assessment, Referral and Rehabilitation Outreach Teams (TARROT) program was designed with the aims of providing more appropriate assessments and strengthening the therapeutic response to Aboriginal children and adolescents affected by trauma. Specifically, TARROT was designed to provide assessment and referral outreach, and to facilitate support for children and their families affected by trauma. In response to the issues identified by community members and community-controlled services consulted, and the evidence available in the literature, TARROT was framed around the principles summarised below:

Child Centric

One of the most important elements of the model that drives the TARROT Program is child-centricity. Many existing trauma programs and services focus on parents and adults.[37-39] The proposition is if you help the adults to be better parents, then the children will benefit and automatically receive the love, care and nurturing they need. The risk is, however, that young people and their specific needs are not addressed, and negative consequences continue to impact on the developing child.

Community discussions highlighted that most interventionsin the community have neglected the needs of young people. Regularly, parents or carers determine the physical health, mental health, social wellbeing and educational needs of their children. This family centric approach however is biased by the subjectivities of parents and carers and may not be sensitive to the specific needs and strengths of the children themselves.

A child-centric approach to healthcare, endorsed by the United Nations and contemporary healthcare literature, asserts that health care professionals place the interests of children and young people at the forefront of models of care and practice. [37,38,40-42] The TARROT child-centric approach means that the needs and interests of the child take precedence. TARROT aims to have support and therapy provided to children directly.

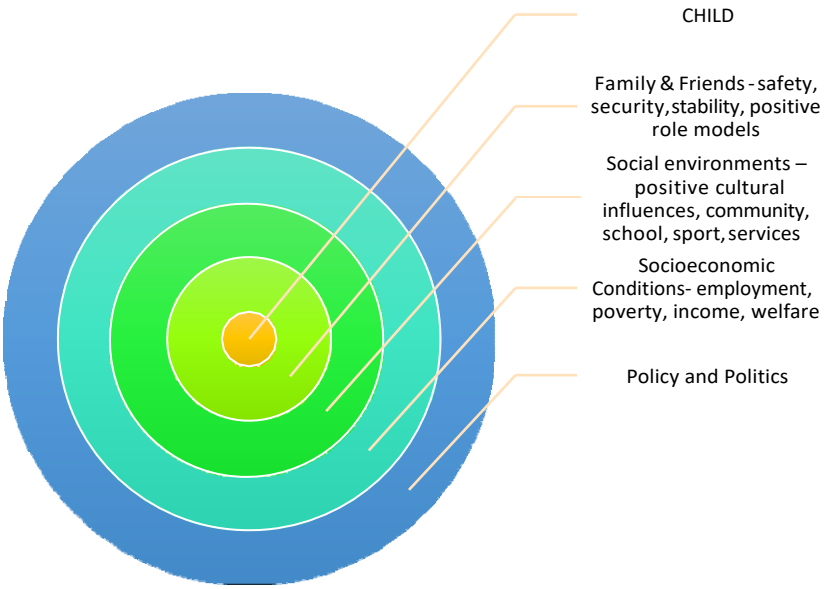
Integrated and multisectoral in response

A key message to emerge from the literature is that integrated and multi-sectoral approaches are most effective in responding to trauma.[12,16] This is also an identified priority of COAG human service policies.

COAG's National Indigenous Reform Agreement (2008) includes integration as 1 of 6 principles that underpins the approach to service delivery for Aboriginal and Torres Strait Islander peoples. [43]

In alignment with this evidence; a social-ecological framework which places the child firmly in the centre surrounded by family, social/ service providers, communityand policy has formed the basis of TARROT's model of care. It highlights the interdependence of factors that impact on the likelihood of abuse and neglect for children,[44,45] whilst also highlighting the multiple layers surrounding the child that can be resourced as protective factors. It is no coincidence that the TARROT logo reflects the social-ecological motif.

Figure 4 TARROT Ecological Model



Culturally informed and safe

Much of the intergenerational trauma and its impacts experienced by Aboriginal families has its roots in colonisation and displacement. As such, our responses need to be culturally appropriate, culturally informed and culturally safe. The leadership of Professor Ngiare Brown, as an Aboriginal woman and clinician, has been critical in ensuring culture is central toTARROT.

The United Nations Declaration on the Rights of indigenous peoples specifies that, culturally informed and safe service delivery is a fundamental human right of Indigenous peoples.[46] Culturally informed practice involves being cognisant of the cross-cultural differences that arise at the interface of health and wellbeing. Aboriginal conceptualisations of health are embedded within a Social and Emotional Wellbeing (SEWB) framework. SEWB is an inclusive, whole-of-life approach to health that recognises the interconnected relationship health outcomes have with wellbeing, involving theinterconnection of physical, emotional, mental and spiritual health, connection to country and access to cultural practices.[8,47,48]

There is also growing recognition of the importance of "trauma-informed" and "trauma-specific" care for Aboriginal and Torres Strait Islander children and young people;[49] such models of care tend to be culturally informed and recognise the cultural and spiritual legacy of the child or young person .[12] Additional international and national literature has demonstrated a strong correlation between the promotion and revitalisation of positive cultural practices and the lessening of negative impacts across social determinants of health, particularly for children and adolescents.[50-54]

Treatment as prevention

Whilst the importance of preventative intervention is recognised by partner communities, the immediate focus is on ensuring high qualitycare to those in need. This is because of the all-too-common and devastating outcomes of mental illness in these communities, including school-drop-out, incarceration and intentional harm to self and others.[3] The need to improve community mental health is recognised more broadly, with 2/3 of Aboriginal primary care services citing mental health as a key service gap.[55] Of note, treatment of mental illness in adolescence can interrupt intergenerational transmission, and therefore a provide a preventative intervention in its own right.[56]

Therapeutic responses are not just formal psychotherapy sessions delivered by specialists. Providing culturally safe and respectful care, providing a safe place, addressing basic social and cultural needs, and supporting families and communities to be safe are all important therapeutic interventions.

Healing happens in relationships and the meaningful sharing of power and decision-making…
One does not have to be a therapist to be therapeutic' [16]

Outreach with specialist teams

Access remains an important barrier to quality health care, especially so for Aboriginal people living in regional and remote settings.[57,58] One mechanism to improving access to care is through outreach, [58-60] a notion recognised by the World Health Organisation as essential in enabling health care access to rural and remote communities.[60]

The need to provide tailored outreach to facilitate better engagement
and address feelings of mistrust among the most excluded and marginalized
Indigenous children and families is also indicated. [61]

A principle of outreach provided by TARROT are teams comprised of multiple disciplines: primary care practitioners, paediatricians, psychologists, psychiatrists (child and adult), and cultural educators. All these specialists make an important and unique contribution to trauma assessment, care planning and case management.

To be effective, teams should operate in a coordinated manner to undertake medical, developmental, behavioural and psychiatric assessments; arrange referrals; coordinate existing service pathways; and support treatment pathways. The dynamism of the multidisciplinary team enables assessments to address the multiple domains of health and wellbeing impacting on the child's life. Evidence from various disciplines including paediatrics, psychology, nutrition, child development and anthropology suggests that healthy early childhood development is largely dependent on multidisciplinary approaches.[31] UNICEF have also endorsed this approach, acknowledging the interconnectedness and mutual support of growth and development.[62]

High quality assessment of needs

Forchildren and young people accessing services, there is often a lack of responsive care, or health care that is of good quality and aligned with needs and expectations. [63] A barrier to ensuring responsive care has been a limited understanding of needs, both from the perspective of young people, but also a lack of data on the specific clinical morbidities and co-morbidities.[64,65] These understandings are critical to informing the orientation of clinical services and required skills and competencies of care providers.[66] High quality needs assessment is therefore a core principle of TARROT.

Care planning, Co-ordination of care and accountability

For many young people with complex needs, care is often provided in a fragmented fashion. It is unclear who is responsible for provision of services and care, what care is being provided, and what gaps exist. As such, care planning and care-coordination are core principles of TARROT.

Care planning involves defining and planning what care is required to meet the needs of young people

Care coordination involves bringing together various care providers to agree on who will provide what care

To enable care planning, TARROT utilises a formal written care plan. It brings the concerns of the child to the forefront and ensures a focus on the specific needs of the child as identified by the TARROT multidisciplinary team, across multiple health and wellbeing domains. Specific recommendations are often provided for the family and home, given they play such a core role in the health and development of children, and they often feel marginalized in the development of care planning.

Care co-ordination involves utilising existing pathways, initiatives and infrastructure relating to child health in communities to encourage a place-based, whole-of-community response to child safety and wellbeing. In alignment with current government strategies for working with Aboriginal and Torres Strait Islander people, TARROT works together with local service providers and agencies to establish a co-ordinated care approach, that shares knowledge and refers clients between services.[67] This approach aims to ensure the child or young person has access to appropriate and ongoing reparative care in a timely and sustainable manner.

Higher level service co-ordination and integration, such as collaboration 'no wrong door' approaches (for example, co-operative activities, co-ordinated referral systems and integrated networks) and integrated 'one-stop-shop' approaches (for example, integrated work through well-defined hubs) and hybrid models, have also been declared a key strategy for building local communities. [31]

Early childhood experts advocate integrated delivery of services, including antenatal services, child and maternal health services, parenting and family support services and early learning and childcare as the best delivery platform to ensure families actually receive the support they need [68]

Care planning and coordination enables clear definition of who is responsible for what aspects of a child's care. This is fundamental to ensuring accountability.

Capacity development of existing services

A principle that permeates the whole TARROT model is the need to contribute to services system development, in order to address the needs of the actual and potential client group. TARROT does this by facilitating the provision of trauma informed and child safety capacity building and professional development opportunities for new and existing staff. Capacity building not only incentivises the workforce, but also nurtures the development of a skilled workforce that is attuned to identifying and responding to risk.

Implementation of TARROT

The initial TARROT program was awarded funding by the Commonwealth Department of Health in late 2015 to commence in July 2016 as a 'lighthouse' project. The aim of this lighthouse project was to support existing outreach services comprising an interdisciplinary team and providing multidisciplinary assessment for children affected by complex trauma.

Since 2016, the TARROT program has continued to develop and be refined to be responsive to the needs of Aboriginal children living with the impacts of trauma. The process of this implementation is shown in the figure below.

Figure 5 Model for Implementing TARROT Program in the Community

Invitation and Initial Discussion

Of central importance to TARROT has been community engagement and partnership. Early engagement has assisted with establishing trust required for this work and ensured that responding to trauma is a community priority.

- Ngaoara was originally invited to Moreeby Miyay Birray (Aboriginal youth service), community leaders and service providers to discuss the issues of child abuse, exposure to violence, adolescent drug use, antisocial behaviours and juvenile incarceration in the community. This invitation came as a result of more than 20 years of contact with the community around Aboriginal health.
- Prof Brown was working with Winnunga Nimmityjah Aboriginal Health Service, an Aboriginal Community Controlled Health Organisation in the ACT, and was supported to develop child and adolescent wellbeing services and the TARROT work. Winnunga provides a hub for the Aboriginal community in the ACT and delivers primary mental health care services, with established linkages with Gugan Gulwun youth corporation, child protection, the PHN and other health and social services.

Negotiating terms of engagement

A fundamental component of implementation for the TARROT program was exploring how it could benefit children, families and the community and support existing service providers. This involved ascertaining what services already existed and whether the implementation of TARROT would complement, support and strengthen existing services, rather than duplicate them. This early consultation and planning helped to understand the local needs and services available to respond to those needs. This stage of implementation also provided an opportunity to outline roles and responsibilities within the community and identify lead agencies that could be leveraged to ensure an integrated multisectoral response to the wellbeing of children and young people.

Mapping of Needs and Assessment

Following extensive discussions with community members and agencies, the TARROT team undertook a scoping review, which brought together service mapping and publicly available administrative data to create a community profile, this provides a contextual overview of the community and further details areas of need. This process, in combination with community engagement enabled significant gaps and/or strengths in local service delivery to be identified, which then informed the service delivery of TARROT.

Determine Composition of Team and Schedule of Visits

Once the needs of the community were identified, the composition of specialist team members required to address those needs was planned. The level of specialist care necessary was largely dependent on the available resourcing and access to specialist health care within the community. More highly resourced regions, like the ACT, generally require fewer specialists in the outreach team, as there are often existing pathways to access to paediatricians, psychologists and psychiatrists. For communities with fewer resources and limited access, such as Moree, there are additional barriers to health care. As a consequence, Moree required a greater investment of resources, including, an increased frequency of visits; a more comprehensiveteam of specialists; and the appointment of local team members.

Outreach, Care Planning and Case Management

Once the team composition was devised and scheduled visits confirmed, referred children and young people with the most complex presenting needs were assessed by specialists. As detailed below, whilst there are no formal referral criteria for TARROT, referrals were assessed to determine if they are suitable for the program or another service:

Following each visit, clinical team meetings are convened to discuss cases. Once the child has had all required assessments completed, a care plan is formulated by the clinical leads (primary care clinician and child psychologist) and a simple summary is provided to parents and carers, and, with consent, to schools and the referring agency. A coordinated case management approach is employed to ensure that the needs of the child are then met by the appropriate services.

Parallel Capacity Development Activities

In conjunction with the specialist outreach service, TARROT engaged the Australian Childhood Foundation (ACF) to providestaff support and trauma informed professional development to services and schools, with the intention of increasing the service sector and communities awareness and capacity to recognise and respond to the needs of children affected by trauma and with complex needs.

Implementation of TARROT across Diverse Settings

To date TARROT has been fully implemented in two diverse settings:

1. *Canberra, ACT,* within an Aboriginal Community Controlled Health Service setting; and
2. *Moree, regional NSW,* within a School and Community Setting.

The context of both of these settings are detailed below. In both of these settings, TARROT applied a child-centric approach to identifying and addressing the developmental, emotional and behavioural impacts of trauma. It has doneso through multi-disciplinary in-reach teams that provide comprehensive assessment, care planning, referral and coordinated case management for Aboriginal children. The TARROT program routinely involves:

- Monthly outreach;
- Core assessmentteams;
- Standardised assessments tools and processes;
- Structured approachto visits;
- A steady flow of referrals from primary sites and secondary sources (schools, other services;
- Follow-up for children previously assessed; and
- Pathways for additional assessment and ongoing management.

However, the specific implementation differed by the setting (see Figure below).


THE TARROT MODELS
HIGH QUALITY ASSESSMENT OF NEEDS
CARE PLANNING
INTEGRATED MULTI-SECTORAL RESPONSE
TREATMENT AS PREVENTION
IN- REACH WITH SPECIALIST TEAMS
CAPACITY DEVELOPMENT OF EXISTING SERVICES
COMMUNITY BASED MODEL
MOREE, NSW
Invitation from Miyay Birray Aboriginal Youth Service and other community representatives.
Negotiated terms of engagement with Barwon Learning Centre
Mapping of existing services, gaps and needs
Determine outreach team composition, work within BLC s ite
Partnership with the Australian Childhood Foundation to deliver capacity building activities for teachers and localservice providers and develop a Therapeutic educational framework for students affected by trauma.
Employ local Child and Family Advocates to facilitate Coordinated Care and Case Management
Establish clinic space to facilitate an increase in referrals and provide a safe environment for children.
Additional senior psychologists recruited to provide therapeutic sessions to children
Evaluation and monitoring
ABORIGINAL HEALTH SERVICE MODEL
CANBERRA, ACT
Prof Brown already working as clinician with Winnunga Nimitjyah Aboriginal Health Service developing child and adolescent health services
Noticed significant exposures to trauma reported by children referred - developed 'paediatric cascade' and referral algorithm
Attracted additional resourcing to support improved co-ordination of care (paediatric nurse, communitiy paediatrician visits, ANFPP position)
Outreach visits, Specialist Assessments with a focus on co-ordinated care and case management
Co-located with Gugan Gulwan Aboriginal Youth Corporation. This site is more accessible for some children and their families.
Evaluation and monitoring
Maintenance
PRINCIPLES OF THE TARROT PROGRAM
CHILD CENTRIC
SOCIO-ECOLOGICAL FRAMEWORK
POSITIVE CULTURAL PRACTICES
COMMUNITY PARTNERSHIPS AND PARTICIPATION
PLATFORM FOR CARE COORDINATION AND ACCOUNTABILITY OF SERVICES

For example, within a community setting, such as Moree, implementation requires a greater investment of time and resources, particularly for case coordination, as there were no existing structures in place to support the processes for referrals, screening or ongoing support following assessment. Moree has highlighted the challenges of initiating such complex service co-ordination, responsiveness and accountability in a regional setting. The addition of a local staff member in Moree was necessary in order to better facilitate the level of administration required for the TARROT program to be effective.

By contrast, within an AMS such as Winnunga Nimmityjah, there are organisational and professional best practice processes that already exist, so that the TARROT model was more readily enabled to embed within the existing service structures. Being co-located within an AMS facilitated the referral process to TARROT, and accessibility to local specialists, so if additional assessments wererequired, the TARROT team were able to refer to local specialists and services directly, and in a timely manner.

33% of GP survey respondents to The Canberra Hospital's 2015 General Practice Survey said that it was rarely or never clear who was responsible for following up results and 47% said that this usually resulted in clinical consequences to the patients.[69]

A strength of the TARROT model is the absence of strict intake requirements. Exposure to trauma is not a strict referral requirement- rather TARROT accepts Aboriginal children and adolescents where there is any concern about exposure to trauma, or where children have complex health and social needs, with the assumption that trauma may be a contributor to this. The information provided to parents around the program is provided in the box below. The team will also take referrals directly from parents and carers, thus removing what is often a substantial barrier to access.

When the children engage with TARROT they receive a high quality, standardised assessmentat intake. To facilitate this assessment, a series of assessment tools capture the broad needs of the child. This assessment tool has been developed with consideration for cultural issues, and of the key domains of the Australian Early Development Census: Physical health; Mental Health; Social wellbeing, including cultural connection; and Education. The box below outlines some of the tools included in the assessment forms:

To quantitatively understand the needs of children and young people, intake assessment is first completed. The TARROT intake assessment for the young person and caregiver (and teacher) incorporates other psychometric tools:

- *Strengths and Difficulties (mental health- more aligned with behavioural problems)*
- *Kessler (Psychological distress – more aligned with depression and anxiety)*
- *Child (and parent) report of post traumatic symptoms (trauma related symptoms)*
- *Paediatric Quality of Life*
- *Cultural wellbeing adapted from National Aboriginal and Torres Strait Islander Social Survey*
- *Broader measures of social wellbeing, health risk and service access.*

These tools help to gather baseline information on the child, and to consider further assessments required. These assessments are administered by a specialist to embed them within a broader clinical assessment. Completed assessments are entered into a secure database (RedCAP) to enable access and care planning by care providers. Further assessments are then planned and attended to as required.

Following assessment, specialist team members summarise significant findings from the assessment tools and outline their professional observations and recommendations. Case discussion with the rest of the specialist clinical team occurs via teleconference following outreach visits. This provides the clinical team with an opportunity to discuss young people and formulate a care plan.

Fortnightly teleconferences ensure team members check in with each other, debrief, and plan future activities, so that TARROT is proactive in its approach.

Since 2016, a total of 78 outreach visits have been made. The increase in visits over time is detailed below.

	2016 - 17	2017 - 18	2018 - 19
ACT	7	10	12
Moree	7	12	30
Total	14	22	42

Ngaoara was initially funded to engage in three sites, and negotiations were undertaken to work in the ACT, northern NSW, and the APY Lands across the NT and SA border. Despite an invitation, enthusiasm and support from cultural Elders, community leaders and service providers, we were never able to establish the third site due to circumstances beyond the control of the team. The limited capacity of the communities and service providers in very remote APY Land areas to accommodate the TARROT work, despite the level of need, reminds us that without infrastructure and workforce, even the most promising of initiatives can act as a distraction rather than an asset.

In the sections below the specific context of the two partner communities is detailed, with specific comment on the implementation of TARROT in these settings.

INFORMATION SHEET on TARROT provided to parents/ guardians

The Trauma Assessment, Referral and Rehabilitation Outreach Teams (TARROT) project is an initiative for children affected by trauma, and with complex health and social needs. Small teams of health professionals provide assessment and referral outreach, and facilitate support for children and their families. The outreach teams consist of primary care practitioners, paediatricians, psychiatrists, psychologists and cultural educators. The teams will:

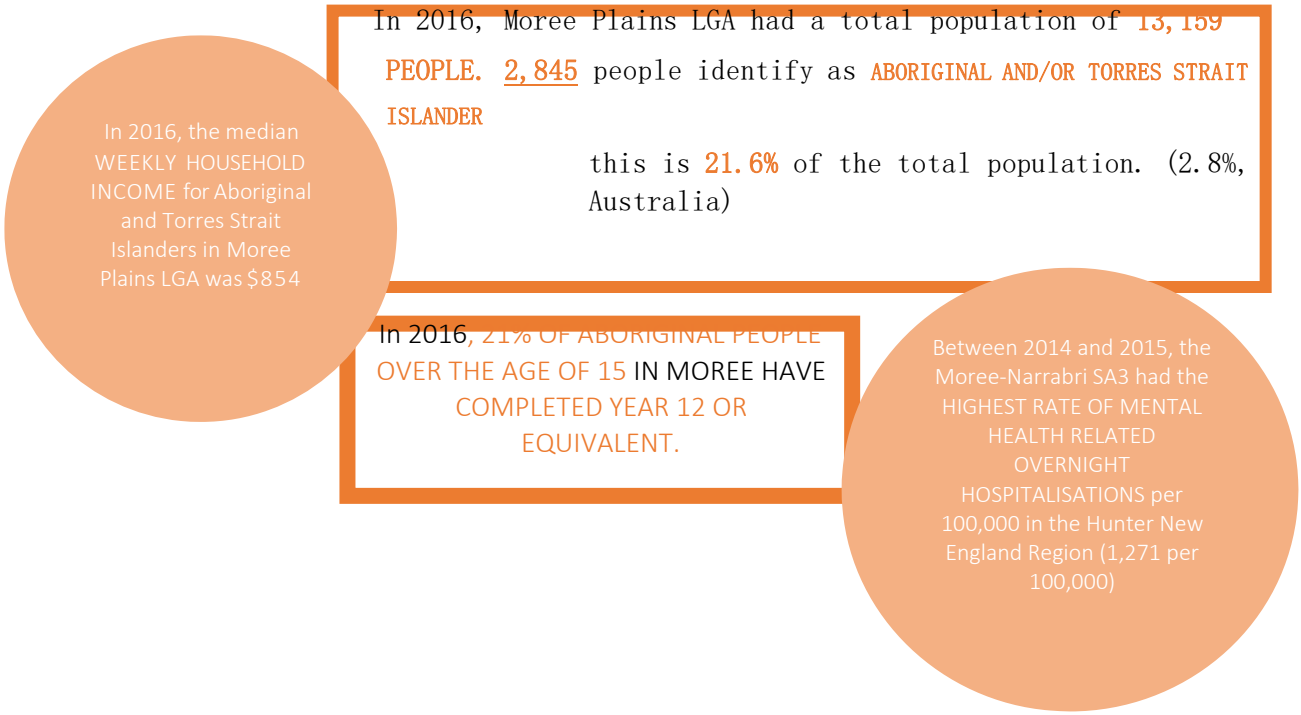
- Take referrals from, and work with, local schools and servi ces to provide regular outreach for children identified with, or suspected of exposure to, the impacts of trauma, violence and abuse;
- Support and contribute to the coordination of case management for at r isk and vulnerable children, and liaise with local service providers and agencies to ensure access to reparative care;
- Use existing pathways, initiatives and acute/ ongoing responses relevant to child health and safety;
- Support and contribute to the development of initiatives for child -centric, whole-of-community responses to violence and trauma;
- Provide specialist educators in trauma recovery and child development; and
- Support parenting and positive relationships programs for parents, carers and community members in partnership with Aboriginal Community Controlled Health Organisations, PHNs, and other local services and agencies as relevant.

Moree, Regional NSW: a community setting with substantial unmet needs

Context

To provide context, Moree is situated in the Hunter New England region of New South Wales, 620kms from Sydney. This regional town of around 13,000 people, of which nearly 3,000 identify as Aboriginal, has long been divided by social, economic and racial tensions, with correspondingly high rates of unemployment, crime and domestic violence- all likely reflecting high rates of unresolved trauma. The figure below presents selected demographics and statistics relevant to Moree that were identified in a review of the publicly available administrative data.

Figure 6 Snapshot Moree ABS 2016 Census



What has clearly emerged over numerous discussions with community in Moree is the substantial unmet needs of children and young people, with theseneeds including those relating to mental health and trauma. A summary of key issues to arise from discussions with community members and service providers is provided below.

Moree Key Issues

SUBSTANTIAL BARRIERS TO ACCESSING HEALTHCARE

- There is a lack of specialists that work in Moree, retaining staff is hard. Youth Justice have had a psychologist position available for three years that they can't fill.
- The specialists that do visit have extremely long waiting lists, or available appointments are fee for service.

CHILDREN AND YOING PEOPLE WITH THE MOST COMPLEX NEEDS ARE NOT ENGAGE IN CARE

- There are approximately 69 service in Moree. Besides TARROT few services engage with children that have complex physical, mental and behavioural needs.
- FACS and the child adolescent mental health team (CAMHS) are significantly understaffed and therefore are not fulfilling their duties.

HOMELESSNESS- THERE ARE LARGE NUMBERS OF CHILDREN AND YOUNG PEOPLE COUCH SURFING OR SLEEPING IN PUBLIC SPACES

- There is no emergency shelter or drop in service for young people
- For many young people in Moree staying in the home environment is highly threatening and dangerous. Due to no youth shelter or refuge, there are extreme numbers of children and young people (as young as 3 years old) couch surfing and sleeping in open public spaces.

L ACK OF CAPACITY TO RESPOND TO TRAUMA

- There is limited professional capability, capacity and cultural understanding to deal with the levels of trauma being experienced by many Aboriginal children in the community.

THERE ARE NO APPROPRIATE THERAPEUTIC SERVICES

CHILDREN HAVE LIMITED ACCEESS TO FOOD

- Children have limited to no access to food, which often means they resort to stealing basic items.

ENDEMICALLY HIGH RATES OF SUBSTANCE ABUSE

- There is an endemically high use of illegal substances in Moree, including amongst the younger Aboriginal population.
- It was stated that a majority, if not all younger people engaged with TARROT had used or were actively using substances; including methamphetamines.

BACK TO BACK SUSPENSIONS

- There are high numbers of back to back suspensions from school which leave children permanently excluded.
- For many children school was at the bottom of the priority list; most are busy trying to survive.

Implementation of TARROT in Moree

TARROT initially engaged in Moree through the Barwon Learning Centre (BLC), a School for Specific Purposes and a designated NSW Department of Education facility for children excluded from their usual school for behavioural issues. This co-location of TARROT in BLC was based on the premise that many young people with unresolved trauma presented with behavioural issues and learning difficulties. This positioning of TARROT worked extremely well and enabled 35 young people with complex needs to engage with care and provided an opportunity for TARROT to support the capacity development of BLC staff in responding to trauma in partnership with the Australian Childhood Foundation.

Ngaoara discovered, however, that BLC did not have a 20-week program to support the students with their academic and behavioural issues. In addition to the trauma infirmed approach to the children at BLC, TARROT drafted a weekly timetable, populated with 'bite-sized learning' class sessions based on a Science STEAM curricular approach as imagined through an Indigenous lens, covering Science, Technology, English literacy, Arts and culture and Maths, as demonstrated below in Figure 7. Ngaoara also commissioned ACF to assist us with the development of a Therapeutic Educational Framework for schools and students affected by trauma.

Figure 7 STEAM Bite-Sized Learning

STEAM: SCIENCE, TECHNOLOGY, ENGLISH LITERACY, ARTS AND CULTURE, MATHS					
INTEGRATED CURRICULUM FRAMEWORK					
TIME	MONDAY	TUESDAY	WEDNESDAY Secondary student transitions	THURSDAY	FRIDAY Primary student transitions
0830 0900	BREAKFAST				
0900 0930	Assembly + awards, introduction to week	KT	KT	KT	KT
0930 1000	KOORI TIME (KT) Positive acknowledgement and reflections	English literacy	Technology	English literacy + movie (e.g. book and movie review)	Music
1000 1030	Drumming, movement, dance	Maths	English literacy	English Literacy + movie (e.g. book and movie review)	English literacy
1030 1100	Technology e.g. computer and IT	Maths	Maths	Technology	Maths
1100 1115	RECESS				
1115 1200	SCIENCE – western + Indigenous concepts; experiments; anatomy and physiology (Aboriginal words)				
1200 1300	LUNCH			Parents carers, guests	LUNCH
1300 1330	SOCIAL AND EMOTIONAL LEARNING – HEALTH, HEALING AND THERAPEUTIC MODALITIES e.g. counselling, behaviour modification, self-regulation, mindfulness, positive relationships, love				
1330 1430	CULTURAL STUDIES				
	Art and music – painting, weaving, photography, videography etc	Narrative Modalities – poetry, diary keeping, Gamillaroy language	Bush Tucker, land management	Kinship and country Identity, family, Indigenous Peoples of Australia and the world	Bush Tucker, land management

In 2018 TARROT began to receive referrals for children who were not enrolled or attending Barwon Learning Centre. This coincided with BLC experiencing a reduction in the number of students, and as such, a new physical site for TARROT was established. Since late 2018, TARROT has operated from an office in the centre of Moree, adjacent to the Intensive Family Based Service (which is funded by FACS and auspiced by Pius X AHS). This space has been decorated with positive messaging around Aboriginal child and adolescent wellbeing (as shown on the cover of this report) and the establishment of this outreach site has created a safe place where they feel comfortable to engage with health specialists and other service providers.

As of August 2019, visits to Moree have increased due to demand and the TARROT psychologist will now attend Moree on a fortnightly basis to manage the number of new referrals. Additionally, another clinical specialist has been employed by TARROT and will attend regularly to undertake therapeutic activities and psychodynamic therapy with the children and young people as well as psychoeducation with other services. The addition of another specialist was necessitated due to the lack of available and appropriate therapeutic services in Moree and the concerning lack of capacity within the service sector to make an appropriate service available.

To facilitate greater co-ordination of care in Moree and provide children, young people and their families with ongoing support TARROT employed a full time Child and Family Advocate. This position is filled by a local professional who has strong connections to the Aboriginal community and is able to relate to the children and facilitate their engagement with services. The addition of this position has been critical to the functioning of TARROT within Moree, as it has enabled consistent contact and ongoing therapeutic support, greater co-ordination of care and referrals to other services, as well as enabling follow-up for TARROT specialists with children.

Canberra and Southern NSW – Winnunga Nimmityjah Aboriginal Health Service

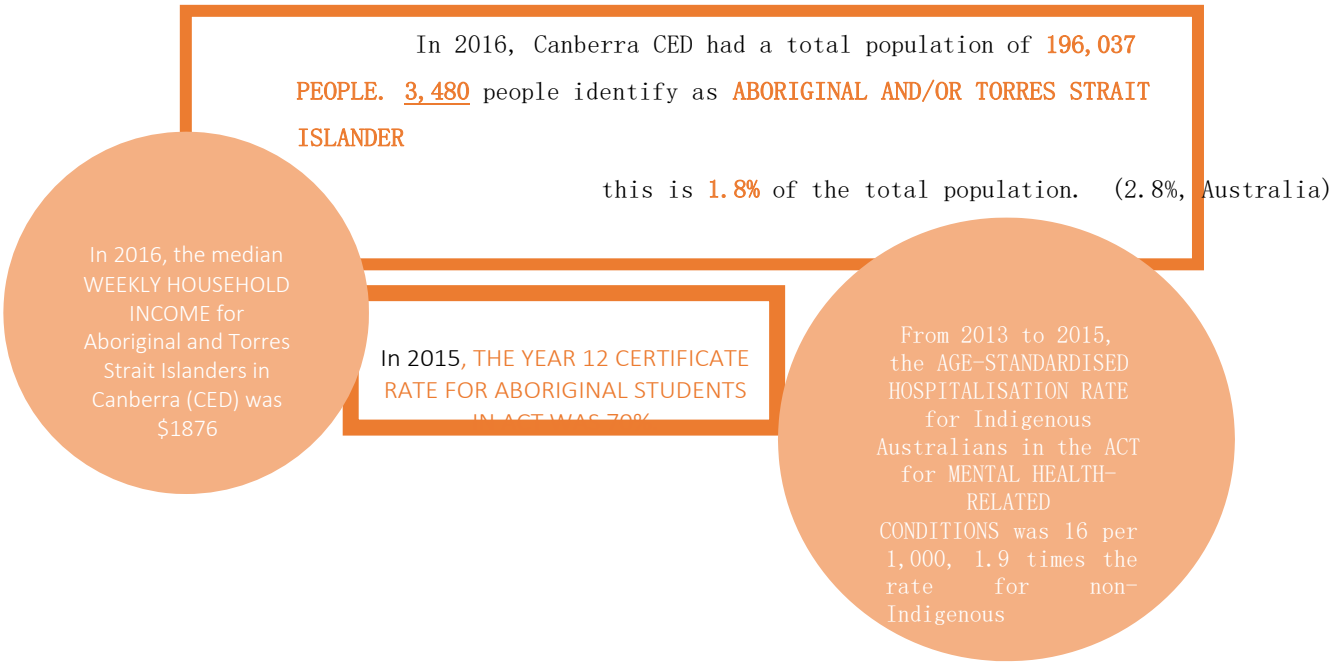
Context

As the nation's capital and large urban centre, Canberra has access to a greater number of health and wellbeing services. Winnunga Nimmityjah is a comprehensive primary care service, providing a range of health and social services to Aboriginal and Torres Strait Islander peoples from across the ACT and southern NSW, including specialist in-reach. The WNAHS annual report confirms around 6000 clients from more than 100 different postcodes presenting for tens of thousands of patient episodes.

The figure below demonstrates selected statistics ascertained from publicly available administrative data for Canberra CED and the ACT.

'In the 2017 reporting period, Canberra PHN/CHN was listed as one of the top 10 lead sites for innovative youth mental health services.'[70]

Figure 8 Canberra Snapshot ABS 2016 Census



Implementation of TARROT in Canberra

Despite the expectation of greater resourcing, availability of services and access and to specialists in Canberra, there remain barriers to children receiving the care they require.

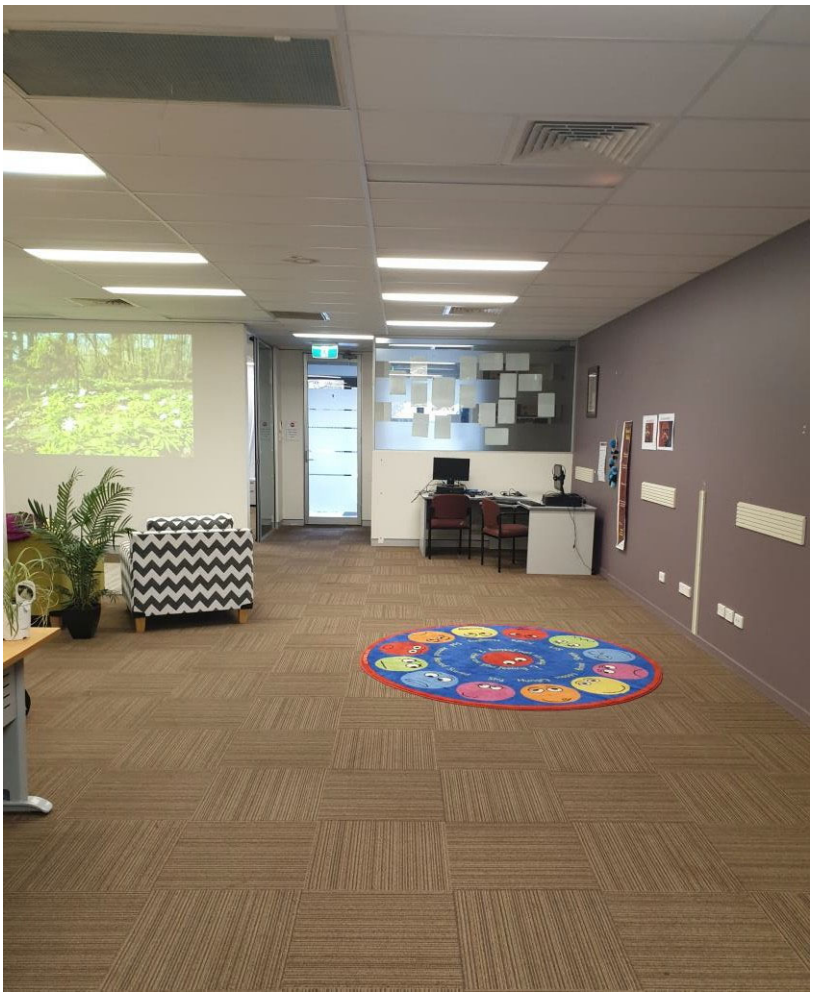
The first relates to quality assessment. Even when Aboriginal children come into contact with services, they have not always been appropriately assessed for social, emotional or mental health needs, and certainly not assessed for trauma and its impacts. Health care providers are not necessarily aware of the importance of trauma in the lives of Aboriginal children, and/or do not feel competent to assess trauma adequately. An early piece of work undertaken by the TARROT team at Winnunga was to develop several assessment tools that might assist staff and other referring agencies to understand whether TARROT is appropriate for the needs of their clients. This helped to ensure only complex cases were referred to the team. Working within an existing service, with systems for collecting information

about service contacts and clients, and with established referral systems meant the service could be established quickly and care provided in a timely manner.

'Stakeholder feedback highlighted difficulties around access to services when a client does not meet the eligibility requirements and advised that there is a lack of services available to those experiencing mild to moderate mental ill health.'[69]

The second barrier relates to case-management and co-ordination. Staff noted that many clients tend to be transient and move around Canberra and the region which means they often don't follow through with appointments and medical review. The family and community knowledge held by Professor Brown and her team played a strong role in ensuring people were keeping appointments and that clients with complex circumstances were accessing the services they needed. To facilitate engagement, TARROT also partnered with Gugan Gulwan, an Aboriginal Youth service in Canberra. This site was more accessible and acceptable for manychildren and their families.

Figure 9 The TARROT Moree Base



Evaluation of the impact of TARROT

This section of the report focuses on evaluating the impact that TARROT has had on the child or young person's overall health and wellbeing. The evaluation also considers the impact that TARROT has made on families, the community, and existing services.

This evaluation utilised a mixed methods approach which included: a review of aggregate, de-identified data captured at intake; independent review of progress reports and documentation compiled by the TARROT program; key informant interviews conducted with staff of TARROT; and in-depth interviews with community members and staff (summarised in a box below). The findings from these three methods have been combined so as to summarise the unmet needs of children accessing TARROT and the impact that TARROT has had on children, their families, communities and service providers.

Summary of methods used to evaluate the TARROT program

Review of aggregate, de-identified data captured at intake	As detailed above (in the section on implementation of TARROT), young people who access this program receive a comprehensive and standardised assessment capturing broad areas of need including mental health, physical health and wellbeing and symptoms related to trauma. This data is recorded on a secure database for use by the TARROT clinical team. In this evaluation, aggregate (not individual) and de-identified data was reviewed so as to understand the broad needs of young people accessing the program
Review of TARROT documentation	Murrawin Consulting reviewed program documentation including: TARROT Activity Workplans; TARROT Communication Plans; and TARROT Performance Reports. Additionally, Murrawin Consulting reviewed the Barwon Learning Centre Training Evaluation conducted by the Australian Childhood Foundation.
Key informant interviews with TARROT staff	Carol Vale of Murrawin consulting undertook six key informant interviews with clinicians and professionals engaged in the TARROT program (including 4 with employees of TARROT and 2 with employees of partnering agencies) to understand the needs of young people engaged in the program and the impacts that this program has made from their perspective.
In-depth interviews with families, community and service providers	The Burnet Institute led a series of in-depth interviews with families, community members and service providers engaged in the TARROT program. These in-depth interviews utilised a semi-structured question guide that focussed on the impact that TARROT had made on the health and wellbeing of young people and the broader impacts that TARROT has made on families, communities and services with respect to trauma. A total of 15 in depth interviews were conducted with the full informed consent of participants, each interview 60 – 120 minutes in duration. Key themes were noted by a dedicated scribe and a de-identified summary presented back to interviewees for verification prior to being included in this evaluation.

The mixed-methods evaluation primarily used qualitative methods to evaluate the impact of TARROT. Qualitative methods were used to privilege the perspectives of participants themselves. TARROT includes a number of inter-linked interventions across a number of sectors; as such, the qualitative methods used also helped to understand what aspects of the program where most impactful. Quantitative assessment of needs was included, and the project team did consider the quantitative assessment of impact; however, this would have required longitudinal follow-up and assessment of young people engaged in the TARROT program and considered beyond the scope of resources available for the current evaluation. Further, quantitative scales to measure symptoms and impacts of trauma amongst young people are in their infancy and a quantitative assessment is likely to have missed many of the important themes to have emerged in qualitative assessment. Of note, we did not include young people directly in the evaluation given these young people, by definition of their involvement in this program, have substantial mental health needs and there is potential to do harm in exploring these issues outside of a clinical context.

Substantial unmet needs of young people engaged in TARROT

Number of young people engaged in TARROT

Over the course of 78 visits to Moree and ACT, a total of 135 Aboriginal children and adolescents have been referred and engaged with the TARROT program. A number of children have required ongoing support and follow up assessments. This has meant that the number of assessments demonstrated in the table below accounts for children who have needed multiple assessments. To date, TARROT has undertaken 157 specialist assessments with children and young people.

	2016 - 17	2017 - 18	2018 - 19
ACT	20	36	40
Moree	10	18	35
Total	30	52	75

What is clear is that the number of young people engaged in the program has increased over the period of implementation, likely to reflect increased recognition of the program within the community and its perceived value. It should also be noted that engagement with TARROT was initially low for Moree (a community based setting) as compared to ACT (where the program was embedded within an existing health service), however over time engagement has increased markedly in Moree while referrals for the ACT have remained relatively constant. This finding has important implications for scaling and

replicability of this model to other settings, and underscores the need for time to develop partnerships and trust, especially when implementing this program in a community-based setting.

Identified needs of young people at intake

The majority of children referred to TARROT had limited prior assessment of needs and not one had a care plan. Indeed, the majority of referral forms were vague in nature, with mostciting concerns around wellbeing and the need for assessments for cognitive, physical and behavioural issues. Reasons for a lack of previous assessments from the perspective of families was largely related to barriers to accessing specialist services, including availability, distance, cost and cultural safety. From the perspective of health care providers there may also be barriers relating to health literacy and navigation of the health system, or health services themselves not engaging children and families with complex needs. Despite the lack of previous assessment, TARROT found the majority of the young people at intake assessment to have complex and previously undiagnosed/ unrecognised needs across broad areas of health and wellbeing. This finding in itself signifies the immense value of the structured & high-quality assessment provided by TARROT.

Young people referred to TARROT had previously been inadequately assessed,
and not one had a care plan.
The majority were found to have complex needs across many areas of health and wellbeing.

As part of the intake assessment, young people self-complete complete the Strengths and Difficulties Questionnaire (SDQ). Where possible, teachers and parents also complete the SDQ, reporting on the strengths and difficulties observed in the young person. The SDQ is a validated and widely used measure of social and emotional wellbeing for young people, including for Aboriginal and Torres Strait Islander adolescents.[8] The SDQ includes five subscales relating to: peer relationships; conduct; emotional problems; hyperactivity; and prosocial behaviour. Aggregate data for a subset of 21 young people engaged in the TARROT program was reviewed, with key findings summarised in the box below:

Nearly 100% of TARROT clients had an abnormally high SDQ score, placing them at high risk of clinically significant behavioural or emotional problems.

Nearly all young people referred to TARROT had abnormally high scores in 2 or more sub domains.

Conduct disorders were most common, followed by hyperactivity, peer problems, and then emotional problems and prosocial behaviour.

Underpinning these substantial mental health needs are substantial needs across health and the broader determinants of health and wellbeing. Some key findings from a subset of young people engaged in TARROT are summarised in the box below:

- *Around half feel they have a family member they can confide in.*
- *Around a third didn't feel a strong connection to a family member*
- *Almost all have been in trouble with the police.*
- *The majority of young people engaged in Moree have a relative in jail*
- *The majority of young people 'worried' a lot*
- *Many thought often about bad things that have happened*
- *Around half have had a health check in the last year.*
- *A third had difficulty seeing and more than half difficulty hearing.*

The consequence of these unaddressed needs is substantial behavioural disturbance. As observed by one of TARROT's senior clinicians of young people engaged in the program:

Their behaviours are consistent with multiple and ongoing traumatic, adverse childhood experiences; which manifest as developmental, emotional and physical signs and symptoms. These in turn impact on school attendance, engagement and performance, with staff unprepared and unsupported to deal with extreme behaviours on a daily basis (in and out of school).

For young people who have been assessed by visiting specialists, it is clear that these behaviours are consistent with deep and unresolved trauma.

These findings highlight that children referred to TARROT have a large burden of poor social and emotional wellbeing. Further, the young people engaged in TARROT have a high rate of comorbidity. These findings emphasise the fact that TARROT is identifying and engaging with youngpeople who have a large burden of unmetneed.

The Impact of TARROT on children, their families and communities

The evaluation of TARROT involved interviews with families, community members, service providers and TARROT clinicians. The TARROT program was highly valued, those interviewed acknowledging the significant gap TARROT has filled around responding to trauma in children and adolescents. A consistent theme to emerge was that TARROT engages with the most vulnerable young people who often have the most complex and substantial need, youngpeople that other services have not been able to engage.

Most significant change: comprehensive specialist assessment and care planning

The most significant impact of TARROT as identified by interview participants was the comprehensive specialist assessment provided by the outreach teams. This was highly valued as it fills a significant gap in service delivery and addresses a need of children and young people that was previously unmet.

Comprehensive specialist assessment and case management were identified as the most significant changes brought about by TARROT

These assessments have helped to reframe the behaviours of these young people as largely stemming from significant and unresolved trauma- and identified that they can be addressed

Care planning has helped ensure efficient and accountable response to these needs

The assessments were valued as they enabled an understanding of the needs of young people, a pre-requisite to providing responsive therapeutic interventions. More fundamentally, these assessments also helped to provide a broader context to the child's behaviours and children were understood to be experiencing significant and unmet trauma (that can be addressed), rather than being 'bad kids'. These assessments have enabled responsive care for these children and adolescents, including financial support for those who are eligible.

In addition to the assessments, care planning was highly valued, in particular bringing together of different organisations and specialists to discuss and plan the care of children (who otherwise typically operate in silos). This helped to ensure care was efficient, that there were no substantial gaps, and that it was clear who was responsible for what. Indeed, many of the service providers interviewed identified that the TARROT program has resulted in their own services reviewing the care they provided for children, and ensuring it was planned and coordinated with other services. TARROT's role in care-coordination was also felt critical, particularly in the support provided to navigate appointments, parents who in many cases have their own health and social needs and/or have difficulty navigating what is often a complex health system.

'TARROT is the only service that has stayed true. Stayed on track. Engaged the kids at most risk'.

The engagement of children most at risk and the provision of high-quality assessment and care planning has been enabled by TARROT's flexible model of delivery. Whilst TARROT is situated at the health service in Canberra and an office space in Moree, engagement with children can also occur in other settings and wherever they may feel safe.

'She (Professor Brown) and her team will get down to their (the kids) level and explain the medical specialist jargon in a way that they can understand everything'. 'They will go to where they are, and are very flexible and will see the kids where they are, be it in the school-ground, youth centre or basketball court'

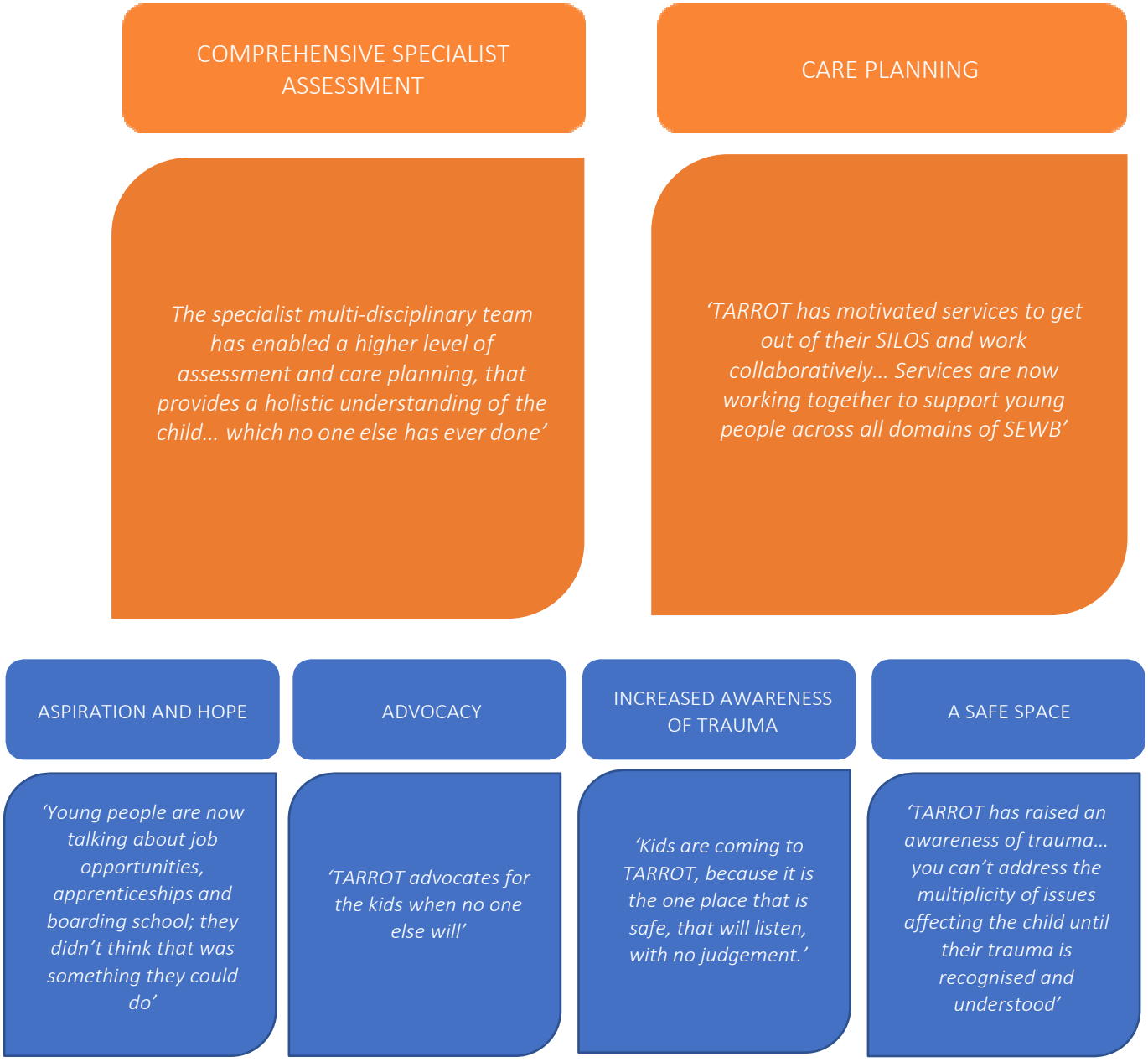
A further feature of TARROT that has enabled engagement is cultural safety- this emerged as of fundamental importance to addressing the needs of young people living with trauma. As described by a community member in Canberra:

I think at times people don't understand an individual's circumstances and they don't understand the cultural differences. We see that particularly here with specialists. And the TARROT team really get that and are flexible around that and really do their utmost to ensure that there's never an issue for accessing the services they need.

Beyond assessment and care planning, there were a number of other important, overarching impacts that TARROT has made, summarised in the figure below:

A consistent theme to emerge across the evaluation was the increased awareness of trauma amongst families, communities and service providers that has come about as a result of the TARROT program. In many ways, TARROT has helped amplify what was initially a community concern, and this increased awareness has had many positive impacts. First, it has helped change the narrative around the behaviour of children and adolescents and helped care providers to recognise the need for assessing and responding to trauma. Secondly, it has helped services recognise the need to provide trauma informed care and therapeutic services for children. It has also helped raise awareness of the importance of trauma -and the potential for recovery- at a community level which has been enabling of service access, but also for the strengthening of services provided.

Figure 10 *Most significant and overarching impacts of the TARROT program*



Linked to the role that TARROT has played in increasing awareness, a consistent theme that emerged was the work that TARROT has done around advocacy, in particular advocating for improved services and resourcing to respond to trauma. In other words, not only has TARROT raised awareness, but it has also advocated for an improved response to this important area of need. In addition to the advocacy at family, service and community level, TARROT has also advocated at a government level (both state and jurisdictional) to bring around greater investments in trauma. This has largely been made possible by Professor Brown's roles on the National Mental Health Commission and the Indigenous Advisory Council to the Prime Minister. Bridging this gap between those who experience trauma (individuals/ families/ communities) and policy makers was recognized as a really important impact of the TARROT program. There have been some tangible outcomes of this advocacy within the short period of TARROT's implementation. In Canberra for example, TARROT has supported applications for additional funding and recruitment of a paediatric nurse and ANFPP position to facilitate care-planning and co-ordination, with a particular focus on trauma.

One of the important principles of TARROT is a 'child centric' approach, and in the application of this principle, it is clear that TARROT has become a safe place for children impacted on by trauma.

> *'We should never underestimate the benefit to a child of having a place to belong- even just one- where they can take of their armor. It can and often does change the trajectory of their life'.* [71]

TARROT as a safe place for children was most apparent in Moree, where safe places for young people are limited. There is really nowhere else - they can go to McDonalds (which many are banned from) or the skate park. But what is clear is that young people come to TARROT for more than the physical space. As observed by the evaluation team during the conduct of in-depth interviews, a large number of young people drop into the TARROT offices on a daily basis– sometimes for advice – but mostly just to 'check in' because someone there cares for them.

The final, but perhaps most important, overarching impact of the TARROT program has been aspiration and hope. Indeed, as shown on the cover of this report, young people who access the TARROT building are greeted with the messages of 'love' and 'hope'. A very strong- and somewhat confronting- message to emerge across in the evaluation interviews was that many services and community members had largely 'given up' on many children and young people affected by trauma. TARROT has helped change

the narrative around these children and their behaviours- and also helped to demonstrate that recovery is possible. A clear feeling of hope was evident amongst many of those interviewed, and there were also powerful stories of how young people themselves had increased aspiration and hope as a result of TARROT. Indeed, during the evaluation a former client of TARROT dropped in for help with a CV to help in applying for their first job.

'TARROT has given the kids purpose, hope, support, advocacy, someone to turn to and someone to fight for them'

'Young people are talking about job opportunities, apprenticeships, boarding school - they didn't (previously) think that was something that they could do'

In the sections below the impacts of TARROT are explored in detail for: young people; their families; service providers; and communities.

Trauma is now being addressed for children

As one service provider in Moree explained 'If TARROT was not available, the closest specialist service for children and young people is in Tamworth (which is 3 hours' drive) or Newcastle (over 6 hours' drive). Whilst some support is available for families to access these other services (through the Isolated Patient Travel and Accommodation Scheme), there are substantial additional costs which serve as an important barrier to these largely low income or single income families. In Canberra, whilst services are physically available, TARROT has brought a focus on trauma within the service and fostered co-ordinated care for children and their families. As such, TARROT has ensured that trauma is now being recognised and addressed.

To understand the impacts of TARROT on the health and wellbeing of children and adolescents, the evaluation explored impacts on four areas aligned with the concepts of wellbeing, and the measurement framework for the Australian Early Development Census: mental health; social wellbeing and cultural connection; education; and physical health. These are explored more fully below.

Mental Health

A key impact of trauma on young people's wellbeing related to their mental health, and as reported above, almost all young people engaged in the TARROT program were found to have high levels of psychological distress. All children engaged in the TARROT program have had in-depth assessments with a specialist psychologist, withsome additionallyassessed by TARROT's visiting child and adolescent psychiatrist. Those assessed then have detailed care-plans prepared and referral to additional therapeutic services as required. This has the potential to profoundly impact the mental health status of children affected by trauma.

Recovery from trauma is a long process and improvements in mental health typically take years. However, it is clear that there have already been positive impacts on the mental health of children engaged with TARROT. As identified in many interviews, children engaged in the TARROT program feel valued, listened to and cared for, and that in itself has made an important impact.

'The self-esteem of children is growing, knowing that someone cares, by TARROT providing a little bit of love'.

As highlighted above, TARROT is child centric in its approach and in its implementation has established a safe place for children affected by trauma. They feel safe and heard, and this is also an important action in its own right to improving their mental health.

'TARROT is absolutely having an impact on the mental health of young people, by providing a safe space and opening communication.'

Further to clinical assessment and care co-ordination, TARROT has also facilitated access to a number of initiatives that have also been previously shown to improve the mental health and wellbeing of children. One such program is Drumbeat, operated by Centacare. It is a structured program where group drumming is used to foster social connection. Evaluations of the Drumbeat program in comparable populations has shown improvements in anxiety and psychological distress. In partnership with Centacare, Drumbeat has been delivered at the TARROT space in Moree as an adjunct to the clinical assessments and care co-ordination.

As the Moree TARROT venue has established a sense of safety for children and young people, it is increasingly being utilised for outreach service delivery by other mental health workers and programs. The Moree PCYC staff also run activities at the TARROT venue.

Social Wellbeing and Cultural Connection

As a result of providing culturally safe care, TARROT has made a substantial impact on the social and cultural wellbeing of children engaged in the program. The evaluation found this to be at a number of levels. At the most fundamental level TARROT provides children with basic necessities such as food, clothing and access to safe shelter.

> *'It would be devastating if TARROT shut-*
>
> *as it has been somewhere for them (young people) to eat and get clothes'*

A key strength of the program to emerge during consultations was the provision of consistent and positive support to children, whilst also establishing boundaries. By modelling positive behaviour and challenging learnt behaviours, children are developing trust and positive connections with peers and adults.

TARROT also promotes connection to culture and the revitalisation of positive cultural practices. This is especially important for Moree, where the community's connection with positive role models and cultural leadership appears otherwise limited. As shown in the figure below, there are a number of programs provided and supported through the TARROT space in Moree:

Figure 11 Program of Activities for children at Moree through TARROT

DAY	TIME	ACTIVITY	LEAD AGENCY	LOCATION
Monday	9am-12pm	Case Planning and Interagency meeting	TARROT	TARROT Office
	12pm- 5pm	Individual sessions based on identified need in care planning (715, Dental, Sexual Health etc)	TARROT	PIUS AMS, PCYC Centacare, TARROT Office
Tuesday	9am-11:00am	Individual sessions based on identified need in care planning (715, Dental, Sexual Health etc)	TARROT	PIUS AMS, PCYC Centacare, TARROT Office
	11am-12pm	RAGE Program	Centacare	TARROT Office
	3pm-5pm	Boxing Program/ Girls With a Purpose Program	PCYC, Youth Justice	Interchangeably: PCYC, TARROT Office
Wednesday	9am- 10:30am	Case Planning and Interagency meeting	TARROT/ Centacare	TARROT Office
	11am-12pm	Health Education and Counselling	DCJ Place (previously FaCS place)	PCYC
	3pm-5pm	Art Program	TARROT, PCYC, Barwon Health	TARROT Office
Thursday	11am-12pm	Drug and Alcohol Counselling	DRUG ARM	TARROT Office
	3pm-4pm	'Stronger Better Program'	Police, PCYC	PCYC
	4:30pm-8pm	'Upstart' Cultural Activities	Miyay Birray	Miyay Birray
Friday	4:30pm-8pm	'Upstart' Cultural Activities	Miyay Birray	Miyay Birray
Saturday	4:30pm-8pm	'Upstart' Cultural Activities	Miyay Birray	Miyay Birray
	8pm-11pm	PCYC Night Time Program	Intersectoral Program including: Police, PCYC, TARROT, Aboriginal Legal Service, Miyay Birray, Youth Justice	PCYC

These activities serve a number of purposes- they are fun and engaging, but also help to establish TARROT as a safe place for children. Interviews with TARROT staff highlighted numerous occasions where young people had attended to access a program and had then been linked in with other therapeutic services.

In addition to these structured activities, TARROT also provides a space that is engaging and decorated with positive images of culture and wellbeing- indeed at the Moree office space, consistent with the images of 'love and hope' on the front door, the walls have powerful images of young Aboriginal people and beautiful images celebrating Aboriginal culture - there is purposefully no visual messaging around traumaor mental health.

Education

A strong focus of the TARROT program has been supporting young people to re-engage with school, and there are a number of very powerful examples that emerged during the interviews. One community member in described a young person who had gone back to school for the first time in many years (much to the surprise of many) because they felt supported to do so through the TARROT program.

However, as many community members and service providers pointed out during the interviews, school disengagement is perhaps not the biggest priority:

> *'School is only a very small part of it (the problems)-*
> *the priority is trying to get these kids' lives back on track.*

Interview participants identified that school disengagement was a result of complex factors. For some young people, schools appeared an unsafe place where they were bullied and discriminated against; including discrimination by the school system itself in the form of overly punitive punishment and suspension for seemingly minor offenses. It also appeared that many school environments where not trauma informed, and few seemed to cater for the specific learning needs of young people that TARROT had engaged in its program. Interviews with TARROT clinical staff highlighted the substantial efforts made to re-engage young people with schools, however the adverse school environment (seemingly beyond the control of TARROT) was a major barrier to this. For example, some young people who had been re-engaged were placed in a lower grade (because of their learning needs), doing little to support self-esteem of peer connection for these young people.

Whilst changing school environments appears beyond the scope of the TARROT program, there have been a number of initiatives implemented by TARROT to improve the school environment including capacity development of staff around trauma informed care and support around establishing structured and culturally safe curriculum – these are detailed below in the section exploring TARROTs impact on services. These investments are likely to have contributed to the re-engagement (as described in the example above) and provide a strong foundation for further school re-engagement.

Physical health

The focus of the TARROT program is not on physical health, however all young people who engage in the TARROT program receive a physical health screen (including review with a paediatrician as required) and are supported to re-engage with primary health care for routine health checks. This is especially important because determinants of trauma are also powerful determinants of physical ill health. Further, trauma and its impacts can serve as a powerful barrier to health service access. A recurring example that emerged across the interviews was that of a young person living with a chronic illness that had not adhered to required follow- up – in this particular case TARROT had engaged positively with the young person and their family, identified important issues relating to trauma and established a care plan which included follow-up and care for their chronic illness. As part of care-coordination this young person was supported with transportation to access their required medical follow -up.

Support of families living with trauma

A core principle of TARROT is its child centric approach- an important difference from other responses where parents and carers have been the focus of therapeutic intervention programs. However, this should not be misinterpreted as the exclusion of parents and carers in the response- and indeed, a strong theme to emerge from the evaluation was the profound impact that TARROT has made on parents and carers.

A common theme to emerge from the evaluation that TARROT has engaged and supported families and parents who had been disengaged from all other services. Many interviewed noted that parents appeared more engaged in the therapeutic response to trauma.

'Families would call the Barwon school (a site where TARROT had engaged with) to find out when the TARROT team would be returning, which was something that had never occurred with any other program.'

Many interviewed emphasised that TARROT has engaged with families in a way that other services have previously not been able to. Those interviewed thought there were a number of reasons for this strong engagement, with cultural safety, respect, and following through with actions commonly identified strengths of the TARROT program.

The greatest impact that TARROT had made on families was support around positive parenting. As a result of intergenerational trauma, many parents have not had positive parenting experiences themselves. In some instances, this is as simple as explaining what normal childhood development involves, and how parents can best support the development of their children.

'TARROT helps the parents to understand how their behaviors impact on their children'

As part of the comprehensive assessment there is also an assessment of the needs of parents and carers, and TARROT has on numerous occasions linked parents and carers in with care. There was also a strong feeling that TARROT's positive engagement with young people had translated into parents themselves really engaging with therapeutic services.

Interviews in Canberra also highlighted that advocacy led by TARROT had been important in securing the Australian Nurse Family Partnership Program (a nurse-led home visiting program that supports first time mums pregnant with an Aboriginal and/or Torres Strait Islander child)

'we also believe that we got the Parent Nurse Partnership Program because of the TARROT team's advocacy and support, which has been a great benefit to our organisation and provides supports to clients we refer to TARROT'

Programs like the Australian Nurse Family Partnership Program are key to breaking intergenerational cycles of trauma.

Strengthening existing service response to trauma

A clear message to emerge from the interviews in both Canberra and Moree is that TARROT is filling a substantial service gap. As noted above, high-quality assessment and care planning have resulted in improved care for young people living with trauma. However, the strengthening of services extends beyond this. Perhaps most importantly, TARROT has changed the narrative around trauma- and it has demonstrated that recovery is possible.

> *'TARROT has demonstrated that recovery from trauma ispossible*
> *– and not to give up on the young people that other services have'*

A common theme to emerge from the interviews was that TARROT has modelled to other services how to effectively engage with young people and their families affected by trauma. Key strengths of the program which appear to have enabled this include partnership with community and a maintained and unconditional commitment to addressing trauma.

> *' Most other services would come and experience the poor behaviour*
> *and then leave and never return,*
> *but TARROT keeps returning.'*

As further put by a community member in Canberra:

> *'they understand our mob and will deal with those severe complex cases*
> *that other services wont deal with'*

A core component of the TARROT program is care-coordination which has included case conferencing with other service providers. This has enabled a care plan to be developed, with clear roles and responsibilities of those involved in care. Importantly, these case conferences also reduce the young person needing to retell their story and avoids re-traumatisation.

> *'TARROT is forming that link between services'*
>
> *'TARROT is more proactive – other services are reactive'*

A clear message from many service providers was that TARROT has facilitated many services to reflect on the quality of care they provide. There was a very clear message that the example set by TARROT has resulted in improved quality of care across other services. Many service providers cite they now work harder at engaging young people, and work to provide a service that is more trauma- informed.

There are a number of examples of how TARROT has impactfully built capacity. At its most basic, TARROT has provided advice and case discussion as required for care providers working across other services. Several providers cited this as being an invaluable support to the work that they do, directly translating into improved care for young people. TARROT has also provided specific training to service providers around trauma informed care. As one example, TARROT engaged Australian Childhood Foundation to provide a structured program around trauma informed care. An excerpt of the evaluation of this program is provided below:

The ACF training program was well received and provided education professionals from Barwon Learning Centre and surrounding services with theory, practice strategies and tools to support their work with, and education of, children and young people who have experienced trauma, disadvantage or violence. The three-month follow up demonstrates the resonance of the training content with the work of the participants and the positive results that stem from the application of that learning. Reinforcing this way of working with the Learning Centre and the schools and services it intersects with provides a positive future pathway.

Elevating trauma as a significant issue within community and providing hope

TARROT exists in both Moree and Canberra as a result of community concern around trauma. A clear message to emerge from the interviews as just how valued this program is. As one community member in Moree simply put it:

'We would be much worse off without TARROT'

Community partnership is central to TARROT's activities, and has provided a strong platform for advocacy and action at a number of levels:

TARROT works in partnership with community,
Aboriginal Community Controlled Health Organisations and other services and agencies
to ensure children receive therapeutic, medical and social services.

In the broader community,
TARROT encourages and supports the delivery of positive parenting and child-centric
health and protective initiatives.

At the national and jurisdictional level,
TARROT has advocated for policy reform and resourcing investments to respond to
trauma amongst young people.
It has also brought together specialist agencies who can complement
the activities of local service providers.

Much of this evaluation has detailed the programmatic and service level interventions that TARROT has provided and documented their impact. However, an important finding to emerge from the evaluation was that TARROT's impact on community has been more profound. There was a real feeling amongst many interviewed that TARROT had developed strong community partnership and stuck around to see the truths of trauma and its impacts. TARROT did not 'run away' from this - but perhaps more importantly, it has reacted to what it has seen and heard through powerful advocacy – fromcommunity to government.

TARROT has provided a platform for social, community and service change around trauma

Core to this broader change has been a redefining of the narrative of young people's behaviour- as not the result of young people being 'naughty', but as a likely consequence of trauma. To change this narrative TARROT has educated community and service providers around the neurodevelopmental impacts of trauma. This has translated into a reconceptualization of how children with complex behavioural difficulties are regarded and treated in the community- from community members and family- but also by service providers, police and justice. This dissemination of knowledge aroundtrauma and its impacts has also empowered communities and service providers to better address the substantial and largely unmet needs of these young people.

Summary and concluding remarks

Trauma is a critical issue for many Aboriginal children, and one that has been largely neglected. In partnership with community and building on the best available evidence, Ngaoara has developed the Trauma Assessment, Referral and Rehabilitation Outreach Teams (TARROT) program. This program is built around the following core principles:

- Child centric;
- Responses must be Integrated and multisectoral;
- Promotion of positive cultural practices as preventive as well as therapeutic measures;
- Treatment as prevention;
- Outreach with specialist teams;
- High quality, comprehensive assessment of needs;
- Care planning and co-ordination of care; and
- Capacity development of existing services.

TARROT has now been successfully implemented across two very different settings: a community setting characterised by substantial and long-standing dysfunction (regional NSW) and an Aboriginal Medical Service with limited child health specific services (ACT). Over the course of its implementation a total of 78 outreach visits have been made, with 135 young people assessed for needs by dedicated teams of specialists and their ongoing care coordinated across multiple relevant agencies. TARROT has also advocated on behalf of children, families and services, and accessed additional resources to build the capacity of families and services to respond to the traumas experienced by our children and adolescents.

What is clear from this evaluation is that TARROT has successfully engaged children and families who are most often hard to reach despite substantial and largely unmet needs. A review of assessments captured at intake found almost all children engaged in the TARROT program screened high against ACEs scoring and above threshold on validated screening tools for mental health disorders. Of note, was that not one of these children had a previous care plan prepared or available.

The most significant impact of the TARROT program, as identified by families and service providers, was the comprehensive specialist assessments for children, accompanied by care planning and more inclusive case coordination across multiple agencies. These assessments have helped to reframe the behaviours of children and adolescents referred as stemming from significant, ongoing and unresolved

trauma, and care planning has helped to ensure more efficient, timely and accountable responses to these needs. Furthermore, TARROT has:

- Increased family, community and service awareness of the importance of trauma;
- Advocated for improved service responses to trauma in children;
- Provided a safe place for young people to have their needs addressed;
- Supported aspiration and hope for trauma recovery.

TARROT has had impacts at a number of levels. For children and adolescents, TARROT has resulted in changing how the impacts of trauma are understood, recognised and responded to. It has had a powerful influence on mental health, social wellbeing, and cultural connection. TARROT has invested substantially in improving educational engagement, including capacity development of school staff. TARROT has also supported young people accessing quality primary and specialist services for their physical health.

TARROT has made substantial efforts to support families living with trauma. This has included positive engagement with services for children, parents and carers and parents; modelling positive behaviours; and promoting positive parenting, as well as supporting existing initiatives that aim to strengthen families, such as the Australian Nurse Family Partnership Program (ANFPP).

TARROT has made a significant impact on existing services, promoting more timely and effective responses to children and families, particularly those in crisis. TARROT has fostered linkages between existing services and worked with experts to build the capacity of local services and providers to respond to young people most at risk, and has demonstrated that trauma can be addressed, and that recovery is possible.

TARROT has also had a positive influence at the community level, highlighting trauma amongst children and adolescents as a critical social issue and demonstrating that there is potential and hope for recovery. Core to this influence has been a reframing of the narrative of children's behaviour- they are not naughty, damaged or unsalvageable…their behaviours reflect their negative experiences, where they brutalised and deeply affected by trauma and they behave in a way that they believe will ensure their survival.

The TARROT program has developed a number of tools and resources, including:

- Algorithms for the referral and intake processes (refer to page 17)
- Culturally inclusive assessments based on validated tools (refer to page 33 for list of validated tools)
- Care plan templates (refer to Attachment 1)
- Science, Technology, English literacy, Arts and culture and Maths (STEAM) timetable for students affected by trauma (refer to page 37)
- Therapeutic Educational Framework in partnership with the ACF

Perhaps the impact of TARROT is best summarised by a community member:

'We want more of it- TARROT needs to be rolled out in other places too'

The TARROT model has been successfully implemented in both a community setting and within a health service, and has demonstrated a scalable response to trauma for Aboriginal children and young people which responds to a critical area of need.

Recommendations

This section provides key recommendations pertaining to the prevention and management of trauma and its impacts on children, adolescents and families. Based on feedback from Prof Brown, the TARROT staff, community members and service providers these recommendations address individual, family, social and systems influences and build on the learnings of the TARROT program and its evaluation.

Recommendation 1: Take the TARROT models to scale through Aboriginal Community Controlled Organisation networks.

Approximately 6 years ago, when working for NACCHO, Prof Brown presented to the national membership on trauma and its impacts on development and intergenerational disparities. She suggested that Aboriginal community controlled services were the best placed agencies to identify and respond to children affected by trauma, including health services, cultural education and child protection initiatives. There was significant interest and support for the premise, however without additional resourcing it was difficult for services to add to their existing roster of programs.

In the interim, Prof Brown established Ngaoara and attracted resourcing from the DoH to further develop the fledgling TARROT work, and now there are two models which may be taken to scale, implemented in additional communities through existing Aboriginal community controlled organisations (health, social, employment etc). In fact, the next 12 months of funding will support the implementation of TARROT in two additional Aboriginal Community Controlled Health Services in Wollongong and Nhulunbuy, and deliver trauma informed services to multiple communities across the Illawarra region and north-east Arnhem Land.

Ngaoara has already been invited to these services (and many others) and has commenced the process of engagement, mapping and needs assessment. With additional funding, there is potential to scale up the TARROT work through other Aboriginal community controlled organisations nationally.

Recommendation 2: Resourcing to establish a national TARROT hub, or Centre of Excellence, focused on evidence informed prevention and intervention practices for Aboriginal children and adolescents at risk of and/or affected by trauma and its impacts

A substantial barrier to action on childhood trauma has been its relative invisibility within existing health and social services, compounded by the limited evidence base for effective responses. Within this context, Ngaoara had to invest substantial effort in to the establishment of mainstream service partnerships, the synthesis of available literature, and the development of service models that have ultimately changed the narrative around trauma – from that of misunderstanding and hopelessness, to one of recovery and hope.

A national Centre of Excellence for Aboriginal Child and Adolescent trauma would build on these established foundations, and help advance a co-ordinated national response to childhood trauma. Such a centre could serve a number of important purposes, including:

- Continued local, jurisdictional and national advocacy around trauma, its impacts, and the potential for recovery. This advocacy is not only important for service providers and agencies, but also for communities to empower them to lead change, and drive demand for improved trauma-informed services and responses;
- Contributing to and promoting the evidence base on what works (and what doesn't). This may include a clearinghouse for best practice, and a focal point for high quality research and evaluation into trauma-informed responses for Indigenous children, families and communities;
- A focal point for communities and services to access support and resources to plan and develop more culturally safe, responsive care for children, adolescents and young people affected by trauma;
- Grow a trauma informed workforce, including the professional development of current practitioners, and the development of communities of practice (health, social, education) around trauma-informed approaches for Aboriginal children; and
- Central coordination of the TARROT work as it is implemented across additional sites.

Recommendation 3: Identify Ngaoara as a Coordinating Agency

One of the many lessons learned from the establishment of the program in NSW and ACT has been how difficult it is pushing for coordinated care and case management across multiple agencies, in order to optimize responses to the needs and priorities of children referred to TARROT. Ngaoara promotes a 'coordinated care' platform, analogous to the trials run in communities some 20 years ago. The coordinated trials were developed for patients with multiple and complex conditions – their health priorities were identified, resources pooled, and care shared across multiple relevant service providers. One service was identified as the lead agency, and other services would take carriage of relevant contributions, and together with the patient/client, outcomes and impacts would be negotiated and agreed to.

Currently, although the TARROT staff are expected to shoulder case management responsibilities, the team are in fact a specialist outreach service, and have no formal, recognized standing in any of the cases, particularly where statutory agencies are involved (care and protection, justice etc).

Establishing a platform of delegated authority, and identifying Ngaoara as a coordinating agency would greatly assist in supporting care for children, and compelling other providers to meet their responsibilities and obligations.

Attachment 1- TARROT Care Plan Template

TARROT

TRAUMA ASSESSMENT REFERRAL & REHABILITATION OUTREACH TEAMS

NGAOARA

CARE PLAN SUMMARY

DATE: **SITE:**

SEEN BY:

REFERRAL BY: **DATE OF REFERRAL:**

CURRENT CONCERNS:

BRIEF REPORT:
Background
Learning
Behaviour
Physical Health
Mental Health
Exposure to Trauma
Connection to Culture

CHILD'S STRENGTHS, INTERESTS AND PRIORITIES:

PROVISIONAL DIAGNOSIS/DIFFERENTIAL DIAGNOSIS:

CARE PLAN TEMPLATE

CARE PLAN		
DIMENSIONS	RECOMMENDATIONS	FOLLOW-UP:
Educational		
Social		
Home		
Culture		
Assessments		
Therapies		
Services		

ADDITIONAL COMMENTS/SUGGESTIONS:

SHARED WITH (tick relevant):

- Child
- Family and Carers
- School
- Health care providers/GP
- Other (e.g. CYPS)

Review date:

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