– Not Government Policy –

Queensland Mental Health Commission

Consultation paper:

Development of a whole-of-government Trauma Strategy for Queensland

The experience of trauma by Queensland children

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What is this research about?

This paper outlines key insights from well-established and emerging evidence and expertise about trauma in childhood (5-12 years). This includes its incidence and impact, and implications for policy, investment, programs and practice. It should be read in tandem with other QMHC papers on trauma in the perinatal, infancy and adolescent periods, and in adulthood. Together these provide an understanding of trauma and its profound inter-generational and lifelong effects at individual, family, community, institutional and systems levels, as well as some of its social and economic consequences. The paper also canvasses opportunities for reform.

The context for this research

Growing recognition of the factors that help or hinder safe, happy, healthy childhoods has been propelled by:

- tools such as *The Nest*, Australia's wellbeing framework for children and young people, which centres the child in an ecological framework, integrating the domains and elements of what it takes to thrive[2]
- studies of positive and adverse childhood experiences (PACEs) and their effects, since the original Adverse Childhood Experiences (ACEs) study[3]
- the severe over-representation of First Nations children and adults in tertiary systems such as child protection and youth justice systems, and higher rates of disengagement and exclusion from schooling
- advancing sciences of child development, learning, family functioning, community development and systems, including the biology of adversity and the physiological and psychological effects of trauma
- public inquiries and reforms, such as those into mental health, domestic and sexual violence, institutional abuse, child deaths, suicide, abuse of people with disability, bullying, educational disengagement, child protection, family law, youth justice and residential care
- growing attention to the lived experience of child, youth and adult survivors of abuse, trauma and adversity, as a result of violence, COVID-19, natural disasters, or institutional and other harms, and
- emerging evidence about 'what works and why' in trauma prevention, responses, recovery and growth, as well as about the need to better recognise trauma at personal, collective and systems levels.[4]

These studies, inquiries and reforms reflect mounting evidence that what and who surrounds us, as well as what happens to us, shapes us. This is especially so during childhood.[5],[6] Our development, wellbeing and resilience results from the complex interplay of biological, psychological, social, institutional, ecological and systems factors, as well as the impacts of trauma and adversity. As Shonkoff states:

> "*The science is clear that the foundations of learning, behaviours and a lifetime of physical and mental health are shaped by the interactive influences of genes and environments over the continuum of developmental timing. Responsive relationships, health-promoting experiences, and sufficient material resources to meet basic needs all strengthen the foundations of healthy development. Excessive adversity, which may arise from many sources and affect children across the developmental spectrum, can disrupt biological systems [neural, immune, metabolic] with lifelong consequences. The cumulative hardships of inter-generational poverty, systemic racism and other societal-level burdens faced by many families with young children underscore the complex challenges facing policymakers, clinicians and other service providers attempting to prevent harm and build resilience*".[7]

The Nest wellbeing framework is a way of considering the whole child in the context of their daily lives - in their families and communities - and their interactions with institutions, services, systems and environments. It highlights the importance of supporting caregivers and families, enabling place-based, child-focused

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community development and creating safe and healthy environments. Increasingly, agencies and initiatives are using *The Nest* as a framework for strategic directions, policy proposals, community engagement, data collection and workforce development.[8]

A holistic, ecological, cultural and systemic approach to wellbeing aligns with the wisdom long held and practised by Australia's First Nations peoples, as do their collective child-rearing practices. There is much to learn from these ways of doing, being and knowing, including from integrated, culturally-grounded and strength-based approaches to healing individual, inter-generational and collective trauma, and from the resilience and growth demonstrated by First Nations people over many generations.[9]

Key finding: Childhood trauma is more prevalent than often thought, especially amongst certain groups

There are limited population studies of traumatic experiences or responses, especially amongst younger age groups. However, converging evidence indicates childhood trauma is common and that its risk factors and consequences may be increasing.[10] There is also evidence that trauma is not equally distributed due to factors such as stigma, disability and disadvantage including inequitable access to effective, timely support.[11] Those living in regional, rural and remote areas are more likely to experience a range of life challenges.[12] First Nations people are additionally impacted by the profound, ongoing and cumulative effects of colonisation, including inter-generational trauma, recurring grief and loss and individual and structural racism and discrimination.[13] When a person identifies with more than one at-risk group, the rate of adversity can be even greater.[14]

By the age of 10-11 years, 52.8% of Australian children have been exposed to at least two of the following family adversities: legal problems; family violence; household mental illness; household substance abuse; harsh parenting; parental separation/divorce; unsafe neighbourhood; family member death; and bullying. Multiple adversities are significantly more reported by First Nations and culturally and linguistically diverse (CALD) families, especially those experiencing socio-economic disadvantage.[15]

In the Australian Child Maltreatment Study (ACMS), the country's first prevalence study of its kind, a large and representative group of 16–65-year-olds reported their experience of childhood neglect, and exposure to domestic violence and abuse (physical, sexual and emotional). At least one type of maltreatment had been experienced by 62.2 % of respondents, and 23.3% had experienced 3-5 types, with multiple maltreatment more common amongst females and young people.[16] Prevalence rates of individual and multiple maltreatment were very high amongst gender- and sexuality-diverse respondents, especially those aged 16–24-year-olds.[17]

Other data is indicative of early trauma and adversity. For example, in 2021 just under half (45.2%) of Queensland's Prep students were vulnerable on at least one of five developmental domains. This rate was higher amongst those in remote regions, in areas of high socio-economic disadvantage and among students from a non-English speaking or First Nations background.[18] While the proportion of vulnerable Queensland children as indicated by the Australian Early Development Census has been declining, they are on average more vulnerable at this age than the average Australian child.[19]

The COVID-19 pandemic contributed to a range of risk factors, including widening inequality due to pre-existing disadvantage.[20] It was associated with an increase in cyberbullying[21], racism[22] and mental health problems.[23]

Disasters - along with associated effects including the fear of harm and loss, disruption, displacement and family stress - are an increasingly frequent and impactful experience for Queensland children, and have drawn growing research attention.[24] A substantial minority struggle after a disaster, including floods[25], bushfires[26], cyclones[27] and drought.[28] Children's psychological adjustment can be negatively affected by a range of factors including parental PTSD[29], and positively through education for caregivers on how to support their child.[30]

Bullying is a trauma experienced by many school-age children, with bullies often themselves also victims of bullying or other trauma. An estimated 15% of Australian children and adolescents have self-reported being bullied in the previous 12 months. Five percent report bullying others, with 8.13 % describing being both a victim and perpetrator[31]. In the 2020 *Growing Up in Queensland* survey[32], the greatest proportion (nearly 30%) of 8–

12-year-old respondents identified bullying either in person or online as the most important issue for their age group. Bullying was more frequently reported by young Queenslanders who identified as female, First Nations, LGBTIQA+ and living with a disability, long-term health condition or mental health problem.

Racism, both inter-personal and systemic, can also be traumatic, and is experienced early and often by certain groups. Parental reports suggest that by the age of 6.6 years, 14% of First Nations children had been bullied or treated unfairly at school because of their cultural background.[33] Up to 68% of ethnic minority 10–15-year-old Victorians reported direct racial discrimination, and up to 83% witnessed it against others.[34]

Other groups for whom the experience of trauma can be more frequent, serious and/or compounding include children with disability[35]; those who experience road traffic accidents[36]; those living with chronic and or serious medical conditions[37]; and children who are asylum seekers or refugees.[38]

Traumatic experiences are especially common amongst children in tertiary services including emergency departments[39], public mental health services[40], family law courts[41] and child protection.[42] In the year to September 2023, the Queensland Department of Child Safety, Seniors and Disability Services received 141,853 'Child Concern' reports.[43] Due to compounding historical and systemic trauma, First Nations people are over-represented in tertiary sectors including youth justice. In Queensland in 2020-21, they were 21 times more likely to be under community supervision/in detention than a non-Indigenous young person.[44]

Children associated with the youth justice system are significantly more likely to have experienced early adversity. In young offenders aged 10-19 years, the overall prevalence of cumulative ACEs is 39.4%. [45] Within the Queensland setting, boys exposed to domestic and family violence were on average younger at their first contact with Youth Justice and had more extensive offending histories.[46] Chronic youth offenders are more likely to reside in rural/remote[47] and/or low socio-economic areas[48], with concerted cross-sector responses recommended to target driving factors in offending behaviours.[49] Principles to address First Nations over-representation include self-determination, healing, culture as a protective factor and justice reinvestment.[50]

Children may experience re-traumatisation and/or systemic trauma due to interactions with staff, services or institutions not well equipped to provide evidence-based, trauma-informed, neuro-capable and developmental services and supports. Service providers have themselves experienced childhood trauma at higher rates than the general population[51], which can play out in the workplace if not appropriately managed.

Caregivers may experience a range of responses to a child's trauma[52] which can inadvertently exacerbate their child's distress and maladjustment, highlighting the need to also support and educate caregivers. Children and families can experience the burden and sometimes trauma of re-telling their story, with some caregivers reporting self-stigma[53] and limited capacity to access help for adversity when needed across both health and social care sectors.[54] A 'village approach' is needed to reduce siloes and build connectedness for families experiencing multiple adversities, including being interdisciplinary, strengths-based and culturally-sensitive.[55]

Key Finding: Addressing childhood trauma is an important opportunity for all

Nature needs nurture

Adverse life outcomes can be explained in part by trauma's impact on child development.[56] Early, prolonged and unsupported experiences of trauma and adversity can elevate a child's stress response which in turn affects optimal development of other biological systems vital to lifelong health, including those relating to our neural/nervous systems, immunity, hormones, digestion and cardiovascular functioning. Early trauma can also disrupt attachment with a child's primary caregiver[57], which in itself is a risk factor for lifelong adversity[58]. These factors can together impair cognitive and language development and delay the acquisition of learning and skills, including those involved in forming relationships and managing emotions.

Childhood also represents an important opportunity to influence the sensitive developmental period of adolescence[59], when neural pathways laid down in earlier years are "pruned" to allow the brain to work more efficiently. In optimal circumstances it also coincides with the development of more advanced reasoning,

planning and problem-solving skills - including managing impulses and risk - as well as psychological tasks such as establishing identity, independence and life goals to support a healthy transition into adulthood.

The harms of childhood trauma can be enduring and expensive

There can be a wide range of reactions to trauma in this age group, in part due to diverse developmental presentations.[60] Direct personal impacts can include shame; dissociation; and loss of safety, trust, danger cues, intimacy, physical connection to the body, sense of self and/or self-worth.[61]

In a review of 19 studies across multiple types of trauma amongst 3-18 year olds[62], five themes emerged of their lived experience: onset of daily life problems; negative responses to trauma across multiple domains; the need for support, information and play; using a range of coping strategies; and in some cases psychological growth.

Trauma experienced in childhood can cast a long shadow across the lifespan, and create its own spiral of adverse consequences. The ACMS found Australians reporting maltreatment were also more likely to:

- report any type of mental disorder, with this rate highest for PTSD (reported at a rate 4.8 times higher than for those who experienced no maltreatment);[63]
- be cannabis dependent, self-injure and attempt suicide;[64] and
- engage with all health professionals/ services identified, including hospital admission.[65]

Hughes et al (2017)[66] found that reporting at least four ACEs was linked to increased risk of all health outcomes compared with individuals with none. Associations were:

- moderate for smoking, heavy alcohol use, poor self-rated health, cancer, heart and respiratory diseases;
- strong for sexual risk taking, mental ill health and problematic alcohol use; and
- strongest for problematic drug use, and inter-personal and self-directed violence.

Strong evidence exists for a causal relationship between bullying victimisation in childhood or adolescence and the subsequent development of mental health problems and substance use.[67] Cumulative exposure to racial bullying and discrimination contributed to socio-emotional difficulties in First Nations and CALD 10–11-year-olds, with higher exposure to both stressors associated with increased risk of overweight/obesity.[68]

Education is a significant protective factor for lifelong wellbeing, but early adversity can impact a child's readiness for, and adjustment to, school. Elevated ACEs have been associated with reduced academic success and/or school disengagement.[69] A survey of Department of Education school leaders (n=182) and teachers (n=169) across Queensland found that while most endorsed the importance of schools identifying and responding to complex trauma, barriers including variable leadership and access to training impacted on uptake of a whole-school approach.[70] In its absence, traumatised children may experience punitive and/or unresponsive reactions to the emotional and behavioural challenges they are more likely to display.[71]

Young people have attributed their journeys away from school to early adversity, with girls noting ACEs contributed to limited academic achievement and boys reporting ACEs led to risky behaviours, punishment, and disengagement.[72] Disciplinary practices such as suspensions and exclusions have been implicated in antisocial behaviour[73]and greater likelihood of entry into the criminal justice system.[74] Queensland has led the development of national guidelines to enhance trauma-informed education responses and systems.[75]

Without timely intervention, the effects of early adversity can cascade into other life domains and increasingly draw in other service systems. Higher ACE scores have been associated with reduced economic prospects[76], homelessness[77] and incarceration.[78] They have also been implicated in higher rates of mortality[79], accounting for 15% of American deaths in 2019[80], and significantly contribute to Australian lives lost to suicide.[81]

In a 2021 report[82] commissioned by the Queensland Child Death Review Board, ACEs were implicated directly and indirectly in the suicidal behaviour of young people involved in child protection services. The report recommended development of a cross-sectoral trauma-informed framework across all services working with children and young people, and that this should be underpinned by a shared, tiered professional development program; increased collaboration; greater access to data; and stronger engagement with high-risk groups.

The effects of trauma and adversity can also span generations. There is a strong association between high parental ACE scores, harsh parenting practices and child mental health and behaviour problems.[83],[84] Queensland data confirms the potential longevity of adversity, noting that that parents reported for maltreatment and with their own child protection history were more likely to receive their first diagnosis of mental illness in adolescence.[85] Breaking the cycle of trauma can pay dividends across multiple generations.

Childhood trauma also exacts a huge financial toll. An Australian study has estimated the annual cost of unresolved childhood maltreatment alone amongst adults could be as high as $24 billion.[86] This excludes the costs of supporting currently-affected children and young people, such as the demands placed on caregivers and the service system. As at 2019, Australian governments were spending $15.2 billion each year on high-intensity and crisis services for problems that may have been prevented had they invested earlier.[87]

Systems that fail to provide optimal early support can also increase the risk of psychosocial hazards for staff including greater distress, vicarious trauma and burnout, leading to increased service costs associated with inefficiency, sick leave and turnover. Failure to adopt a trauma-informed approach can undermine collective wellbeing, resources and momentum, perpetuating a cycle of potential harm for children, staff and systems.

Key finding: Childhood trauma is preventable and treatable

Fortunately, risk is not destiny. There is emerging evidence[88], including in the Australian context, to indicate that childhood adversity (including maltreatment) is preventable by targeting risk, protective and developmental factors at individual, family, community, structural and environmental levels.

There is also emerging international evidence about the barriers, enablers and impact of public health and systems approaches to preventing and responding to childhood adversity and trauma.[89] For example, the Alberta Family Wellness Initiative in Canada has operationalised the principles of optimal neuro-informed child development via a dynamic tool known as the Resilience Scale. This approach has been taken to scale at the individual[90], organisational[91]; and system[92] levels, with other countries adopting it for their local context.[93] There is early interest to apply The Nest and Resilience Scale frames and tools in Queensland.

There are also well-evidenced outcomes from a number of client-level interventions for children and young people aged 2 – 18 years.[94] One of these is trauma-focused cognitive behaviour therapy (TF-CBT)[95], a medium-term treatment delivered in community and in-patient settings. Eye Movement Desensitisation and Reprocessing (EMDR) is another intervention readily used with young children.[96] Both are effective in treating trauma in children and adolescents, although TF-CBT has been found to be marginally more effective.[97] The Australian Clinical Guidelines for the Treatment of PTSD strongly recommend TF-CBT for this cohort and their caregiver, and conditionally recommend EMDR.[98] Young participants exposed to TF-CBT have described an improvement in their understanding of their trauma, sense of safety and ability to draw meaning and growth.[99] It has been successfully implemented in a community Child and Youth Mental Health Service (CYMHS) clinic in the ACT[100] through the resourcing and well-planned rollout of staff training[101], and represents a good return on investment.[102] There is also promising evidence for dyad-level interventions that address caregiver capability and relational attachment between caregiver and child.[103]

However, the extent of effective screening, diagnosis and treatment of trauma in community, clinical and other potential settings in Queensland is currently unclear. While there exist pockets of exemplary practice, most interventions offered in Queensland seem to be generalised counselling delivered within a set of trauma-informed principles. This is despite robust research evidence for the effectiveness of client, caregiver and family level interventions for childhood trauma. This likely occurs for a variety of reasons, including lack of understanding of the translation of research into practice; the costs associated with training, supervision and maintenance of fidelity to evidence-based models; skilled workforce shortages; and a general lack of understanding of what being trauma-informed entails, despite there being much conversation about it. This observation is also true for the delivery of neurologically and developmentally-informed practice.

What does this research mean for policymakers

All children have the right to love, play, grow, learn, dream and contribute, and deserve to be well supported and equipped to deal with life's ups and downs, and to be buffered as much as possible from traumatic experiences and their impact, to enable them to thrive.[104]

While there are existing Queensland policy and practice initiatives focussed on improving outcomes for children, there are also opportunities to implement and strengthen approaches that have been shown to make a real difference in outcomes. Development of a Queensland Trauma Strategy and implementation plan provide a vital opportunity to better prevent, reduce, respond and enable recovery for Queensland children who experience trauma and adversity and its often life-long personal, familial and public consequences.

Culturally-responsive and First-Nations-led service and system responses are critical to creating healing opportunities for First Nations children and young people. Along with adopting a trauma-informed approach, these include incorporating brain-based approaches, using the wisdom of culture, empowering communities to find their own solutions (self-determination) and operating from a First Nations world view.[105]

There is a clear need for development of more skilled and culturally-competent workforces and institutions, including schools, to adopt developmental and healing approaches that better support children who have experienced trauma.[106] This includes genuine partnerships with, learning from and strengthening of First Nations organisations to enable their healing prevention and intervention approaches to engage and empower children and families where trauma has been experienced and compounded by systemic factors and failures.

Key implications of established and emerging evidence include:

Insight:	This requires:
• much childhood maltreatment, trauma and adversity is preventable and treatable, however, there are gaps in the services, treatments and care available to support child development and recovery	• additional and well-balanced investment and capability and capacity development across a continuum of prevention, identification, early intervention, and intensive treatment and care
• understandings of child development and the incidence and impacts of trauma and adversity could be better understood at community, workforce, organisational, institutional and systems-levels	• evidence-based translation of emerging science, evidence and experience in ways that are relatable and that shift ill-informed mindsets and attitudes
• children can be vulnerable to inter-personal and inter-generationally transmitted trauma, as well as trauma a result of historical, collective, institutional and systemic maltreatment, trauma and adversity	• holistic, ecological, cultural and systemic approaches to address the inter-dependencies; and core principles need to be embedded in policies, investments and practices at systems, organisational and community levels
• a life-stage and life-course approach is required due to the enduring impacts that can cascade from one age, and one generation, to another	• integrated strategies for early childhood development, the middle years and the adolescent years; inter-generational approaches; child-services that are family-oriented and adult services that are child-aware
• First Nations children, young people, families and communities are more likely to experience trauma and adversity – individually and collectively - including systemic racism and institutional injury	• Aboriginal and Torres Strait Islander-led and delivered services, including healing spaces, as well as full implementation of *Closing the Gap* and *Healing Our Way* commitments
• not all children and families will experience trauma and adversity equally or in the same way	• individual support that is personalised, equitable and culturally responsive, along with public health and population-level approaches
• all children who experience trauma and adversity can be assisted in ways that aid hope, healing and recovery, build abilities and strengthen relationships	• a concerted developmental approach - that builds capabilities for thriving and healing - should be taken in all services and systems

• children can be (re) traumatised by poor experiences with adults, institutions and interventions that are not trauma- and neuro-informed	• deliberate efforts to grow and embed understanding, language, skills, practices and processes at workforce and organisational levels, including pre- and in-service
• there are substantial public, personal and governmental costs associated with the lifelong impacts of child maltreatment and adversity	• better accounting of the costs of trauma and adversity and of the opportunities to reduce harm at personal, family, community and public levels

Options for reform

Recent Queensland Government reforms and initiatives, and a suite of existing strategies, policies, programs and services, indicate a significant commitment to addressing the causes and consequences of childhood trauma and adversity. The *Putting Queensland Kids First* (PQKF) draft plan signals an intention to take a holistic, ecological, preventive and developmental-oriented approach to child wellbeing, focuses primarily on the first 3000 days of life. Further work is warranted on like-frameworks and effective investments for 5 – 12-year-olds to address what is increasingly referred to as the 'missing' middle years of childhood[107].

The following should be explored in the development and implementation of a Queensland Trauma Strategy:

Whole of person and family

- greater efforts to build public and caregiver understanding about child development, responsive caregiving and prevention and mitigation of maltreatment, trauma and adversity.
- for all children, universal access be provided to comprehensive developmental, health and wellbeing screening and assessments when indicated, across the early and middle years of childhood.
- for children and caregivers navigating and utilising services and supports from multiple services and systems due to trauma, adversity or complex needs, better access to integrated service responses be enabled and a single, shared core child development and care plan be developed.
- for children disengaged from schools and engaged in tertiary and acute systems, greater efforts be made to prevent, assess, address and reduce the incidence and impacts of trauma, including extension of initiatives such the recently announced Youth Engagement Education Reform package, as well as initiatives such as Hope and Healing, Navigate Your Health and Evolve Therapeutic Services (CYMHS), and cultural supports for First Nations.
- for primary school aged children, all education systems continue to advance capabilities and capacities for evidence-informed, integrated whole-school and community approaches to student health and wellbeing, as well as expanded use of initiatives such as GPs in schools, mental health and wellbeing in schools, dedicated child telehealth services, learning support, and tools to measure student wellbeing.

Whole of community

- greater efforts to enable place-based, community-led, collective-impact and child-and family focused approaches in communities with higher-than-average levels of vulnerability and adversity.
- greater support for positive informal, community-engagement and connectedness for families through play, sport, recreation and outdoor activities.
- Queensland's Disaster Management frameworks, arrangements and capabilities be strengthened through consideration of national and state work on child development, wellbeing and resilience.

Whole of organisations

- actively support and learn from holistic approaches to support First Nations peoples that may not fit current funding programs but provide a healing and strengths-based prevention and intervention model.
- each major system with which children aged 5-12 years and their caregivers engage – health, education, child safety, youth justice, NDIS, mental health, housing, sport and recreation – develop, appropriately resource, implement and evaluate a dedicated Child Wellbeing and Resilience Action Plan, including a focus on trauma prevention, response and recovery, with consideration for addition/ enhancement and appropriate support of a peer workforce to foster empowerment and growth for children and families.

- relevant service and organisational standards and workforce competency frameworks (such as the Human Services Quality Framework[108]) be reviewed to ensure due attention to the capabilities required to address risk and protective factors and the incidence, impacts and implications of childhood trauma.
- funded and regulated organisations with which children aged 5-12 years and their caregivers engage be provided with support, such as toolkits, coaching and templates, to develop Child Wellbeing and Resilience Action Plans, including a focus on trauma prevention, response and recovery.

Whole of systems

- Concerted Leadership:
  - the series of whole of community and government plans, starting with *Putting Queensland Kids First*, be finalised to support child development, health, learning and wellbeing, articulated to the forthcoming Queensland Trauma Strategy and other related existing strategies such as *Our Way*, *Healing Our Way* and *Working Together*.
  - robust cross-sectoral leadership fora be established or repurposed at state, regional and local levels to support integrated implementation of *PQKF*, the Queensland Trauma Strategy and other child-related strategies.

- Stronger workforces:
  - concerted, flexible efforts be taken in pre- and in-service workforce learning and development to build core, common, contemporary knowledge, skills and practice regarding child development, trauma, adversity, recovery, healing and resilience.
  - explore uptake of evidence-based treatment modalities in relevant intervention settings in Queensland (inclusive of dissemination through online means), and if warranted strengthen/ enable services to be trained and supported in application to traumatised children.
  - further efforts be taken to foster staff wellbeing and psycho-social safety.

- Smarter investment:
  - overall investments be assessed to ensure adequate and well-balanced investment in the continuum of prevention, response and recovery services for childhood trauma and adversity.
  - budget processes assess the relative impacts on child wellbeing, health, development and safety.
  - program specifications for investments in child development, health, learning, family support, child safety, violence prevention and responses etc are reviewed to assess the currency of scientific and evidence related to child development, trauma, recovery and resilience.

- Integrated and developmental delivery:
  - implementation of the Resilience Scale tool be accelerated as a means of facilitating practice, service and system integration and coordination at organisational and local levels.
  - further efforts be made to expand access to evidence-based services and integrated systems initiatives such as child and family hubs and Head 2 Health Kids, underpinned by a relevant child- and family-centred, neuro-capable frameworks.
  - explore collaborative initiatives such as Victoria's Child Information Sharing Scheme.

- Child, public and caregiver engagement:
  - greater use of evidence-informed framing and campaigns to enhance widescale accurate knowledge about child development, caregiving, trauma, adversity, healing and recovery.
  - continue to advance school-based initiatives such as those related to student engagement, place and cluster-based approaches like Schools in Communities, and school-based hubs.

- Data, evidence and experience:
  - enhance means for children, young people, caregivers and communities with experiences of adversity, trauma, recovery and growth to have a meaningful voice in policy, program, practice and

data processes in a way that builds self-determination, supports data sovereignty and helps build positive narratives of individual and collective resilience, wellbeing and healing.
- progressively enhance patient/ student/ client information systems to screen, assess and as appropriate share information on trauma and adversity in meaningful and culturally-sensitive ways
- invest in Queensland-based research and evidence-generation and translation.

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