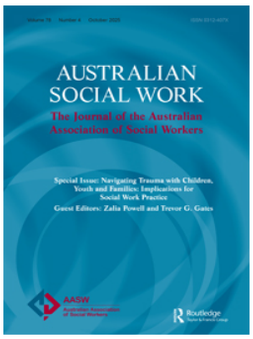

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# Trauma-Informed Mental Health: Supporting Young People Involved With Child Protection Services

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# Trauma-Informed Mental Health: Supporting Young People Involved With Child Protection Services

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**ABSTRACT**

Reported in this article are research findings about effective mental health practices for young people involved with child protection services. Five care-experienced young people and 45 stakeholders were interviewed to gather stories of effective mental health practice in Aotearoa New Zealand. The results illustrated what trauma-informed practice can look like throughout the mental health engagement, assessment, and intervention stages. The foundation of trauma-informed mental health care for this population is a deep understanding of the impact of trauma upon young people, recognition of care-experienced young people as a priority population, and a commitment from mental health services to responsively serve these young people.

**IMPLICATIONS**

- Well-resourced specialised trauma-informed mental health care is important for young people who have been involved with child protection services, many of whom face inequitable barriers in accessing quality mental health care.
- Trauma-informed clinicians, including social workers, recognise trauma responses as adaptive behaviours rather than a reason to decline mental health service provision.
- Trauma-informed mental health interventions are based on principles of choice and predictability.
- Systemic trauma-informed care aligns with critical social work perspectives and antioppressive practice.

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Young people involved with child protection services should have access to quality mental health services. However, many care-experienced young people have significant mental health needs and have not been well served by child and adolescent mental health service (CAMHS) teams (Golm, 2023). In this article, the author examines research findings on trauma-informed mental health care, drawn from a qualitative study involving care-experienced young people in Aotearoa New Zealand.

Young people in Aotearoa New Zealand are underserved by CAMHS, with an even greater gap for those involved with Oranga Tamariki, the statutory child protection

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agency (Thabrew et al., 2017). This disparity persists despite evidence that young people connected to Oranga Tamariki are twice as likely to experience depressive symptoms and four times more likely to have attempted suicide in the past year compared to the general youth population (Fleming et al., 2021). CAMHS teams are not set up to meet the types of needs these young people present with. Care-experienced young people often present with complex mental health needs in the context of traumatic relational disruption (Tarren-Sweeney, 2023). This cohort is more likely to be Indigenous and experience difficulties accessing CAMHS support (Oranga Tamariki, 2023). Standard mental health care is less effective for these young people due to the high degree of clinical and social complexity they experience (Golm, 2023). While many young people involved with Oranga Tamariki experience significant overall levels of need, often they fail to meet specific diagnostic thresholds for service entry within a context of underfunded CAMHS teams with high service demand (Oranga Tamariki, 2023).

The findings presented in this article are drawn from doctoral research on effective mental health practices for care-experienced young people in Aotearoa New Zealand. The central theme of this qualitative study is recognition of care-experienced young people as a distinct priority population in mental health care. The central focus is on findings related to trauma-informed care. Other key findings from the research, including Māori values-based therapeutic relationships, responsible subversion as an equity tool, holistic and creative approaches to recovery, and managing power in interagency collaboration—will be explored elsewhere.

## Use of Language

Throughout the article, phrases "care-experienced young person" and "young person involved with child protection service" are used interchangeably. However, I acknowledge that not all young people involved with child protection services have had experience of being in out-of-home care, and there has been significant trauma for many young people in out-of-home care in Aotearoa New Zealand (Royal Inquiry into Abuse in Care, 2021). This research was conducted in Aotearoa New Zealand. Many participants' quotes include words in te reo Māori (the language of the Indigenous Māori people) that are commonly understood within Aoteaora New Zealand. These words have remained within participant quotes, followed by the English translation.

## Author Positionality

I am a Pākehā (non-Māori) mental health social worker with significant experience in working with care-experienced young people. Social work values informed the research, including a contextual understanding of people and a social model of mental distress. I recognise that Eurocentric models dominate the healthcare and child protection systems in Aotearoa New Zealand, resulting in institutional racism and inequitable health and wellbeing outcomes for Māori (Waitangi Tribunal, 2021). I engaged cultural supervision to embed Māori perspectives throughout the research process.

# Literature Review

Research has highlighted appropriate mental health support for care-experienced young people, including some specialised CAMHS teams. There is a strong literature base on

trauma-informed care, including the effects of historical trauma on Indigenous communities. Despite this evidence, practice issues remain, and clinicians and young people continue to advocate for improved services (Coulter et al., 2022). The existing literature is explored below.

## Mental Health Support for Young People Involved with Child Protection Services

Effective mental health interventions for care-experienced young people take a systemic approach and often include assertive outreach. Most evidence for CAMHS assertive outreach comes from Victoria, Australia, where specialised teams have been funded since 1998—nearly half of their clients have had child protection involvement (Schley et al., 2008). However, research specifically focused on care-experienced youth remains limited. Australia has made more progress than Aotearoa New Zealand in developing CAMHS services for this group. While Christchurch has a specialist CAMHS service for children in care, no research has been published on it. In Western Sydney, a systemic, collaborative CAMHS model was developed with child protection services (Chambers, 2014), and similar holistic and responsive teams have developed in the United Kingdom (U.K.) (Lobatto, 2021). Australian clinicians have urged CAMHS to rethink how they engage care-experienced youth, advocating for trauma-informed approaches that view nonengagement as clinical data to inform service provision (Drever et al., 2023). They emphasised that meeting service expectations should be seen as an outcome of good care, not a precondition for access.

In a published literature review of principles for working with care-experienced young people, the author identified the importance of clinicians building trust, working flexibly, empowering youth, supporting their wider systems, collaborating across agencies, and offering extra help during transitions (Appleby et al., 2024). However, most research is clinician-driven, with limited exploration of care-experienced young people's own perspectives. This research filled a gap in highlighting lived-experience perspectives of youth mental health care.

## Choice and Partnership Approach (CAPA) Model in CAMHS

There is widespread implementation of the Choice and Partnership Approach (CAPA) model in CAMHS teams in Aotearoa New Zealand, Australia, and the U.K. (Naughton et al., 2018). CAPA aims to manage service demand and capacity by using existing resources more effectively. The model involves an initial "choice" appointment with an assessing clinician. If the young person is accepted into "partnership", they then proceed with a limited number of sessions with a different clinician, working towards treatment goals (Whāraurau, 2023). A growing body of literature supports the CAPA model as an effective approach to managing service demand (Naughton et al., 2018; Whāraurau, 2023). However, there are some critiques from social workers. In Aotearoa New Zealand, the model is criticised for its lack of adequate support for young people facing complex challenges (Smith & Appleby, 2021). Canadian social workers compared the principles of CAPA to McDonaldisation categories of efficiency, calculability, predictability, and control (Johnstone et al., 2022). They contended that the model

commodified CAMHS delivery, misappropriated the language of empowerment to justify discharging young people, and neglected to address the complex challenges many young people face.

### Trauma-Informed Care

Principles of trauma-informed care include safety, trust, peer support, collaboration, and recognition and response to cultural, historical, and gender issues (The Substance Abuse and Mental Health Services Administration, 2014). Critical social workers advocate for a structural understanding of trauma that recognises the impact of poverty, systemic discrimination, and exclusion on people with mental health issues (Ross et al., 2023). From a Māori perspective, trauma is not just something that happens to an individual, it includes intergenerational and historical trauma, colonisation, oppression, and racism (Pihama et al., 2017).

Internationally, there have been commendable attempts to implement trauma-informed care in CAMHS teams. In Australia, some CAMHS teams have been trained in trauma-informed care (Palfrey et al., 2023) and a CAMHS team in the U.K. has been using trauma-informed formulation (Miller et al., 2023). Despite these advances, most CAMHS teams are not yet providing trauma-informed care, and "usual linear CAMHS pathways and diagnostic boxing fails to address the complex and everchanging care systems in which these children and young people find themselves" (Miller et al., 2023, p. 1).

## Method

This qualitative study (Braun & Clarke, 2022) involved interviews with care-experienced young people engaged with both CAMHS and Oranga Tamariki, along with key stakeholders in Aotearoa New Zealand. Interviews took place in 2021 and 2022. Using a critical best practice approach, the author explored stories of effective care to identify themes for improving CAMHS support.

### Ethics

Ethical considerations included the vulnerability of young participants, my dual role as a practitioner researcher, and ensuring voluntary participation. As both an insider (with prior CAMHS experience) and an outsider (as a Pākehā without experience of being in care or receiving CAMHS support), I navigated these roles carefully (Shaw & Lunt, 2023). My existing relationships facilitated ethics approval and participant access, but to address cultural nuances and my distance from the lived experiences of the youth, I used reflective journalling and cultural supervision to maintain reflexivity.

There was a robust ethical approval process, including approvals from the Health and Disability Ethics Committee (HDEC) to access young people and stakeholders as participants, and the Research and Access Data Committee (RADA) to access Oranga Tamariki social workers as participants. Following HDEC approval, locality approval was gained from three hospitals to access young people and clinicians from each area as participants. Participant confidentiality was ensured by de-identifying interview transcripts and using pseudonyms and nonidentifying quotes when reporting findings. The research was guided by principles of participation, choice, and honouring people's stories.

## Recruitment

I interviewed five young participants aged 16–18 years (see Table 1 below) who were engaged with CAMHS and had a history of Oranga Tamariki involvement. Two of the young participants were Pasifika, one was Māori, and two were Pākehā. Young participants were recruited through CAMHS clinicians and contacted me directly. All care-experienced participants were based in Auckland, Aotearoa New Zealand.

I interviewed 45 stakeholders (see Table 2 below). Senior professionals in mental health and child protection across Aotearoa New Zealand were recruited directly, including CAMHS and Oranga Tamariki staff informed via their service managers. Young adult care-leavers involved in public advocacy were recruited directly for their lived-experience expertise. Additional stakeholders from foster care, education, cultural services, justice, and suicide prevention took part. Interest grew through snowballing, with several senior stakeholders requesting interviews. In total, I interviewed 50 participants (five young people and 45 stakeholders)—an unusually large number for qualitative research—providing a rich, diverse set of good practice stories. Māori and lived-experience voices were prioritised, and participation was capped at 50 despite further interest. Participants included 11 Māori, five Pasifika, and 34 Pākehā stakeholders.

## Interviews

I interviewed all young people in person in 2021 and stakeholders either in person or online in 2021 and 2022. Interviews were audio-recorded, transcribed, and participants had the opportunity to review their transcripts for accuracy. The interviews focused on

**Table 1** Pseudonyms for young participants

| Pseudonym | Age | Gender |
|---|---|---|
| Lucy | 16 | Female |
| Cara | 17 | Female |
| Jackson | 17 | Male |
| Paris | 17 | Female |
| Amber | 18 | Female |

**Table 2** Participants

| Participant type | Number of participants |
|---|---|
| Care-experienced young people aged 16–18 years with CAMHS involvement | 5 |
| Young adults with lived experience of care and CAMHS | 3 |
| CAMHS clinicians | 13 |
| CAMHS Māori cultural advisors | 3 |
| Oranga Tamariki child protection leaders | 4 |
| Clinicians from a range of social services supporting care-experienced young people with mental health needs | 6 |
| Foster care staff | 5 |
| Youth mental health consultants | 3 |
| Alternative education providers supporting care-experienced young people | 2 |
| Suicide prevention advisors to Oranga Tamariki | 2 |
| Family Court Judges | 2 |
| Youth mental health clinicians in private practice | 2 |
| TOTAL | 50 |

stories of good practice—when mental health care was helpful, what facilitated positive outcomes, and recommendations for improving CAMHS for care-experienced youth. Although participants shared negative experiences too, the interview questions focused on what worked well.

## Analysis

I analysed the transcripts inductively using Braun and Clarke's (2022) reflexive thematic analysis. While the research findings are presented in a linear order in this article, the analysis process was anything but linear, involving deep engagement with the data, and several iterations of theme development. I finally developed the theme, "CAMHS clinicians understanding the care experience", as I interpreted the degree of clinician understanding as a significant inhibitor or enabler of good practice.

I compared the findings with existing trauma-informed care concepts for this article. However, the analysis began with the data, prioritising lived-experience voices. I used a critical realism approach (Bhaskar, 1997), focusing on young people's lived experiences while acknowledging the structural factors, such as institutional discrimination, that affect their mental health care. Within reflexive thematic analysis, researcher bias is openly discussed and considered, recognising that all knowledge generation is inherently subjective (Braun & Clarke, 2023). I constructed themes from the data, informed by my social work experience and focus on equity.

# Results

This article presents a key finding on trauma-informed mental health care. A deep understanding of the effects of trauma on those who have experienced abuse or neglect is essential for effective practice. The results can be grouped around five key components of trauma-informed practice for care-experienced young people: understanding the impact of trauma, trauma-informed engagement, trauma-informed assessment, trauma-informed intervention, and antidiscrimination. Each is discussed in detail.

## Understanding the Impact of Trauma

Participants shared the importance of understanding how traumatic life experiences impact on young people's behaviour. A lived-experience advocate explained, "a lot of the time we fundamentally do not consider how challenging those young people's lives have been." Participants suggested that CAMHS clinicians should adjust their expectations of care-experienced young people to trust others after a lifetime of mistrust, and their capacity to plan and organise themselves while navigating chaotic environments. Participants discussed how these functional abilities are often used as CAMHS entry criteria. A suicide prevention consultant discussed how missed appointments can be erroneously attributed as the fault of the young person, when it could be "a symptom that we might not be meeting the needs of whānau (family) and maybe we need to do things differently".

Participants emphasised the importance of CAMHS clinicians adopting a trauma-informed perspective when interpreting young people's behaviour. A youth mental

health consultant noted that while the concept of trauma has become more widely recognised, its application often lacks depth, reducing it to something of a cliché.

> Anybody who works in trauma will tell you the catch phrase is not about what is wrong with you, but what has happened to you … but even that is "so what, oh so you have a trauma background, everybody has got a trauma background". It is having the skills to know what to do when the children are taking food out of the cupboard and hiding it under their bed or cutting holes in the wall and sticking their dirty underpants in there. It is having the patience and the ability to not take it personally.

A Family Court Judge discussed the importance of realistic expectations and celebrating small successes, "There is quite a lot going on that we should be pleased about: they are sleeping through the night after being nocturnal for the last two or three years."

## Trauma-Informed Engagement

Participants shared stories of trauma-informed approaches to engagement that enabled time for relationship building. These participants recognised that care-experienced young people often have an inherent distrust of authority, a history of disrupted relationships, and a reliance on survival strategies, such as being cautious about trusting others to safeguard themselves. Lucy explained how she is skilled at hiding her unhappiness. She recommended that CAMHS clinicians "spend more time, like if you think a kid is okay not to just leave them because they might not be okay, they might just be better at hiding it". Paris discussed how it took a long time for her to accept help from her CAMHS team:

> So, when I first started, I did not even try. I was like "no I don't want to do it" and it was very hard for me to get my mindset into thinking they were just trying to help because every person I have asked for help they haven't helped; they have made it worse … At the start I treated her like shit. I treated her like everyone else had treated me … you are just going to get up and leave like the rest did. And she didn't, she stuck with me the whole time that I was there.

Paris further explained, "It can take up to a year for me to trust you. I think after everything I've been through … I very much don't trust people." Participants emphasised the importance of clinicians taking responsibility for engagement and understanding why it takes care-experienced young people more time to engage, rather than placing the onus of engagement solely on the young person.

## Trauma-Informed Assessment

Stakeholders identified that care-experienced young people often have complex clinical presentations that meant that mental health assessment was not simple. A CAMHS clinician explained "being able to get a full assessment of these young people is really hard because you have often got really key people that are missing from their story". Participants shared stories of clinicians working with child protection social workers, transition to independence services, and foster care agencies to gather information for a comprehensive assessment.

An Oranga Tamariki leader noted, "Rangatahi (youth) present[ed] with mental health issues, but behavioural issues and components of youth justice or care and protection issues also. So, there is unpacking all of that, which is a slow process." However, participants critiqued CAMHS clinicians for not spending this extra time on assessment. Many

participants criticised CAMHS teams for wasting clinical resources by justifying the rejection of referrals on the grounds that the issues were trauma-related and thus not applicable to CAMHS. A CAMHS clinician demonstrated how the experience of trauma can be justified by CAMHS teams as a reason to not do a full mental health assessment:

> There have been a lot of things going on and there might be a certain amount of distress … then they come to a mental health service, and it is not actually like a mental health disorder. It is just a reaction to the situation that they've been in, which is reasonable that they would have that. So, it can feel a little bit unfair that we are saying "oh come to a mental health service for mental health support" even though this is kind of what we would expect after you've had 10 years of sexual assault and violence in the home … We might not look at something like ADHD or autism or a few different things if we are thinking actually this is PTSD because we don't want to incorrectly diagnose someone.

Stakeholders were frustrated with this view that trauma and mental health were mutually exclusive. A social service provider commented, "If we understand that trauma is one of the biggest risk factors in developing mental health concerns, we need to acknowledge that people working with them need to have an understanding of that." Most non-CAMHS stakeholders recognised that trauma and mental health issues can coexist, and that experiencing trauma should not be a reason to withhold a mental health assessment, despite stories of this exclusion happening regularly in practice.

## Trauma-Informed Intervention

Participants shared examples of trauma-informed interventions guided by principles of choice and predictability. Amber shared:

> I liked they brought out a lot of confidence in me, like simple things like ordering my own food or choosing what I'm going to eat and stuff like that. It was really simple, but it did impact me a lot.

Stakeholder participants shared stories about offering choice to young people about where and when they meet, inviting them to meetings that are about them, offering alternative ways for young people to provide feedback into their care plans, and making the most of any opportunity to give young people choices in their care. An Oranga Tamariki leader explained:

> These children … are often very experienced in care and having a lot of professionals around them and a lot of things are done to them, where they don't have a say in anything that happens. So, giving them a seat at the table starts to give them that sense that their voice is heard and can make a difference in what happens for them.

Young participants spoke about how important consistent appointment times were. Cara said, "Just knowing my appointment on Tuesday, it is going to be on Tuesday, and it is not going to get postponed until the next Wednesday." Paris talked about how much she valued the reliability of her clinician:

> I buried my mum this year and it was a weekend so [the clinician] didn't text me. Monday morning, I wake up and it was like 11am and I'm half dead and she had messaged me at 8am as soon as she got in to work to make sure I was okay. It was like that; she was always on call if I needed her. If she was on leave, she would leave me with a number that I could contact to make sure I had someone there if I needed someone.

A lived-experience advocate explained, "You just need someone that you can rely on and that you know actually has you." Participants shared stories featuring clinician predictability and consistency over a long time to counteract the instability and trauma that many care-experienced young people have faced.

### Antidiscriminatory Practice

The final component of trauma-informed practice is the importance of antidiscriminatory practice. Māori clinicians discussed institutional racism within CAMHS service design, highlighting how the processes are not structured to meet the specific needs of Māori people: "We are clearly failing Māori". Another Māori clinician reflected, "I just think that we have a very white dominant culture in our healthcare systems … but children in care being predominantly nonwhite, I think that is problematic that we have people who may not get their lived experience." Several Māori and Pākehā stakeholder participants suggested that CAMHS teams need to be decolonised from the dominant medical model.

Participants shared accounts of organisational discrimination against care-experienced young people. Stories of discrimination included instances where care-experienced young people were excluded from CAMHS support due to vague referral criteria and identifying trauma experiences as a basis for exclusion. An Oranga Tamariki leader discussed how CAMHS teams are funded to work with the top 3% of young people with severe mental health difficulties, but "I'm not sure that our kids always have been included in that top 3%". A suicide prevention consultant reflected on the difference between rhetoric and practice for CAMHS service provision for care-experienced young people:

> If any door is the right door, "why is there no door" would be my question. And how do you know which door because they send us to the right door except if you are an Oranga Tamariki young person.

A social service provider reflected on how care-experienced young people are often excluded from CAMHS care, which she connected with the high demands on CAMHS resources:

> Young people in care fall into the "too hard" basket. It is difficult for CAMHS to deal with Oranga Tamariki. It is difficult … when there are really challenging family dynamics or situations going on or whānau (family) are not involved at all. It is a really hard place for CAMHS to get involved with a young person. I think that, unfortunately, they end up trying to do anything they can to not have to do too much work with a young person in care.

## Discussion

Amid calls for improved mental health care for care-experienced young people, these stories of good practice serve as beacons of hope for trauma-informed mental health service transformation. The findings highlight the importance of mental health clinicians understanding the impact of trauma on young people and holding realistic expectations for how to work effectively with them. This underscores the importance of clinicians recognising the impact of trauma on a young person's behaviour, rather than allowing that behaviour to become a reason to discharge them from a service. A trauma-informed approach to mental health engagement, assessment, and intervention involves progressing at the young person's pace to build trust, making mental health assessments

accessible, thinking creatively about information sources for assessment, and practising in a way that promotes safety by offering choice and predictability. Central to this is a commitment to antidiscriminatory clinical practice, recognising care-experienced young people as a distinct population and providing tailored, culturally responsive support to address their needs.

These findings align with the trauma-informed care literature on the importance of viewing behaviour as adaptive and expectable in response to trauma (Kezelman & Stavropoulos, 2012). There is a robust evidence base on how trauma can impact young people (Sweeney et al., 2018) and how traumatising it can be to be involved with child protection systems (Royal Inquiry into Abuse in Care, 2021). The findings about extended timeframes for trauma-informed engagement processes are consistent with the international care literature (Coulter et al., 2022) and with research on the importance of relational care when working with Māori (Wilson et al., 2021). Additionally, the findings align with the trauma-informed principles of creating safety, being trustworthy and collaborative, and attending to cultural issues (Substance Abuse and Mental Health Services Administration, 2014). In addition the findings from this research align with existing research about CAMHS clinicians generally having a poor understanding of the care experience (Tarren-Sweeney, 2023). Although many stakeholders recognised the support needs for this population, stories of good practice often involved clinicians bending the rules or going "above and beyond" standard care. These were viewed by most stakeholders as exceptional instances, highlighting the general lack of fit-for-purpose care for this group.

Care-experienced young people (Coulter et al., 2022) and CAMHS clinicians (Golm, 2023) have advocated for more responsive CAMHS support for those in care. The research findings provide a vision of trauma-informed approaches to CAMHS care for this population. This includes extended timeframes aligned with Indigneous relational care models (Wilson et al., 2021). It involves a paradigm shift from viewing "hostile" behaviour from care-experienced young people as a reason to not offer mental health support, to recognising this behaviour as an adaptive attempt by young people to protect themselves from feeling disappointed or unsafe, and an indicator that more support from mental health services may be needed.

The research findings point to the real structural barriers within CAMHS service provision that often depend on time-limited engagement, assessment, and intervention within a context of limited service resources. Adequate resourcing is imperative to enable CAMHS teams to implement trauma-informed care. CAMHS teams are currently in crisis, struggling to meet the needs of the general youth population (Thabrew et al., 2017). Care-experienced young people often require more time from CAMHS teams with extended engagement periods. Clinicians who understand these young people are more likely to spend time working with initial hostility from young people. When CAMHS teams are trying to determine the best use of their resources, it can be easy to justify less involvement with care-experienced young people as they are often a poor "return on investment". This business model focus on efficiency and lean thinking does not support a mental health recovery orientation focused on human need.

The approach to managing service demand is influenced by the Choice and Partnership Approach (CAPA) model that is used throughout Australia, Aotearoa New Zealand, and the U.K., but which may be not fit-for-purpose when working with care-experienced young people (Johnstone et al., 2022). The CAPA model is based on assumptions that a

young person will easily engage in an assessment session and then be happy to see a different clinician for intervention following that assessment. It assumes that the young person comes willingly with a list of identified mental health needs and goals for intervention, and that they will work collaboratively with their assessing clinician to discuss these goals during a choice appointment. However, care-experienced young people may take a long time to trust clinicians and often have dynamic needs that change as their circumstances change (Drever et al., 2023). Many of these young people may not think they are worthy of support and they may have experienced minimal modelling of help-seeking behaviours in their families, many of whom do not trust government agencies (Lobatto, 2021). Their experiences of trauma result in them being highly guarded and hypervigilant—which makes it difficult for them to have the space for self-reflection and self-identification of mental health goals.

There are parallels between the marginalisation of care-experienced young people in mental health systems and the marginalisation of social work knowledge within healthcare professional hierarchies (Ross et al., 2023). Despite this, these research findings affirm social work values and antidiscriminatory mental health practice. A critical social work approach understands individual trauma responses within the broader context of inequitable mental health systems that exclude care-experienced young people.

## Recommendations for Practice

Equitable care for this population may require a revision of policy and models of care that are more suited for those who have experienced complex trauma. A trauma-informed approach should be applied to organisational processes as well as individual clinical practice. Organisational-level changes could include extended timeframes for engagement, assessment, and intervention, with adequate funding to support clinicians to take the time needed to practise effectively with these young people and their support systems. Organisational policies should be reviewed from a trauma-informed lens, examining the conditions placed upon a young person to access mental health care, such as policies around missed appointments.

## Limitations

This research involved adolescents in the community aged at least 16 years. Unfortunately, family members and carers were unable to be recruited for this project. Further research could include the younger age groups and those young people in residential or inpatient settings to explore what is most helpful from mental health teams for them. Given the importance of family-inclusive practice in CAMHS, there could be further research about trauma-informed CAMHS support for families.

# Conclusion

There is a critical need for trauma-informed mental health care for care-experienced young people. This research prioritises lived-experience perspectives to envision what a trauma-informed mental health system could achieve. Mental health clinicians, including social workers, have an opportunity to move beyond surface-level understandings of

trauma, acknowledging its profound impact on young people and families, and working to transform systems to better meet their cultural and mental health needs. In this context, trauma-informed care emphasises flexible, culturally responsive, individualised approaches to mental health engagement, assessment, and intervention. Such systems are well resourced to ensure easy access to support and the prioritisation of care-experienced young people as a population requiring specialised, responsive mental health services.

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