

Improving Access to Evidence-Based Treatment for Trauma-Exposed Children and Youth:

An International Society for Traumatic Stress Studies Briefing Paper



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Take Home Messages for Policy and Practice:

- Depending on factors such as the type and frequency of trauma exposure and level of social support available, most children and youth who experience a traumatic event will either not develop difficulties or will recover from initial difficulties. However, a significant minority will require professional support, and it is crucial that all professionals working with children and youth can effectively identify and support those who may be struggling.
- Trauma and stress-related disorders are some one of the most commonly treated disorders in child and adolescent mental health services in many countries. It is vital that services actively plan and implement strategies to improve identification of need and access to evidence-based mental health care for trauma-related disorders.
- If left unaddressed trauma and stress-related disorders can have a major impact on a child's developmental trajectory, with personal, family, social, and economic consequences that can be lifelong. We know that more vulnerable groups (e.g. children in poverty, refugee or asylum-seeking children, those in child welfare settings) are often the least likely to have access to evidence-based care.
- Routine screening for traumatic events and trauma-related disorders by health professionals is key to providing access to trauma-focused treatments. Screening should include validating the child's experiences, assessing safety, and securing evidence-based treatment (EBT) if needed.
- There are effective, feasible, and efficient EBTs for trauma-exposed children and youth that reduce posttraumatic stress symptoms and co-morbid disorders such as depression. These treatments are usually short-term (several weeks or months) and always address the trauma directly.
- There are common elements across trauma-focused EBTs (TF-EBTs), including: establishing a strong therapeutic alliance, providing psychoeducation, enhancing recovery skills, processing trauma memories, and altering maladaptive cognitions. With the exception of trauma memory processing these are also common treatments for other types of mental disorders and can thus be easily learned and implemented by professionals.
- Available evidence supports talking about trauma and processing trauma memories during treatment. Concerns about these treatment methods "retraumatising" children and youth are unfounded.
- Once a mental health specialist has received sufficient training in a trauma-focused EBT and if they can access ongoing supervision, their prior clinical experience,

therapeutic background, or educational level are no longer significant factors in successfully implementing the treatment.

- Key options for improving access to evidence-based care include enhancing multi-system collaboration, broadening training opportunities, task shifting, and setting up services to consider accessibility from the outset and build bridges between youth, families, and providers.

Terminology and acronym key:

PTEs = potentially traumatic events

EBT = evidence-based treatment

TF-EBT = trauma focused evidence-based treatment

TF-CBT = trauma focused cognitive behavioral therapy (a type of TF-EBT)

EMDR = eye movement desensitization and reprocessing (a type of TF-EBT)

PTSD = posttraumatic stress disorder

CPTSD = complex posttraumatic stress disorder

For more information about evidence-based treatments for trauma-related mental health difficulties please refer to the [ISTSS Posttraumatic Stress Disorder Prevention and Treatment Guidelines](#).

1. Traumatic Events and Mental Health in Children and Youth

Exposure to a potentially traumatic event (PTE) during childhood and adolescence is common. Most children and youth will experience a PTE before their 18th birthday. PTEs include serious accidents (such as motor vehicle accidents), child abuse, sexual assault, domestic or community violence, frightening medical procedures, war, and/or natural disasters. A considerable proportion of those children exhibit resilience trajectories and do not develop a psychological condition that requires formal therapeutic intervention. Thus, they demonstrate an adaptive capacity to navigate and recover from these challenging life experiences. However, a noteworthy subset of this population does develop post-traumatic stress disorder (PTSD), as well as have an increased risk for a range of other common childhood psychological conditions and outcomes (e.g., depression, anxiety, disruptive behaviors, self-harm, and suicidality) (Lewis et al., 2019). PTSD prevalence rates are reported to be around 3.7 - 26.2% for trauma-exposed children and youth (Visser et al., 2025) and the risk of developing PTSD is particularly pronounced among female adolescents and those who have endured interpersonal PTE, such as abuse or war (Visser et al., 2025; Alisic et al., 2014). A recent study of children and adolescents receiving care in publicly funded state mental health systems in the United States—based on roughly 13.5 million records from the Mental Health Client-Level Data—found that the proportions diagnosed with trauma- and stressor-related disorders increased between 2013 and 2021. The authors note that some of these trends may reflect changes in clinical diagnostic practices but also parallel rising population-level prevalence, underscoring a growing need to identify and treat these conditions in youth (Mojtabai & Olfson, 2025). The clinical implementation of trauma screening, assessment, and evidence-based interventions is lagging behind the research, with high short- and long-term costs to individuals and society (Danese et al., 2020).

1.1 Consider the environmental contexts

Ensuring that youth and families have access to proper intervention requires that practitioners understand that exposure to PTE does not occur in a vacuum. That is, the area of life where the event occurs can have a significant impact on how one responds to the exposure. For example, failing academically, as a result of trauma, can carry a much greater weight for a child for whom doing well in school is important compared to a physical injury that might carry greater weight for a child who values their sporting abilities. Experiencing the sudden loss of a family member is hard for most people, but that loss is likely experienced as more severe when one has a close personal relationship with the person, as compared to a distant relative. Thus, it is important to consider the context of the event - or where in one's

life the event occurs and the relative weight of that area to one's well-being. For most youth, any potentially traumatic or sudden unexpected loss or change in the context of family likely holds great significance to the youth's mental health.

It cannot be assumed that all potentially traumatic events (PTEs) are equal in terms of their importance to one's adjustment as a myriad of factors can influence if and how a given exposure, even a significant one, might be interpreted by different individuals.

2. Evidence-Based Treatments (EBTs) for Children and Youth

Both international guidelines (Bisson et al. 2019) and meta-analyses have demonstrated robust effects for trauma-focused evidence-based treatments (TF-EBTs) on posttraumatic stress symptoms (PTSS) in trauma-exposed children and youth, irrespective of age, gender and trauma characteristics (de Haan et al., 2024). It is noteworthy that these treatments have been shown to lead to large reductions in symptoms even under challenging circumstances and complex traumatic circumstances (Pfeiffer et al., 2025; Unterhitzenberger et al., 2019); for multiple traumatized children and youth (Hoppen et al., 2025); and for symptoms of complex PTSD (CPTSD) (Sachser et al., 2017; Jensen et al., 2022). Best estimates show approximately half of young people who receive Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and just under one-third of those receiving Eye Movement Desensitization and Reprocessing (EMDR) see at least a 50% decline in their symptoms by the end of this treatment (reflecting a large and clinically important improvement). Notably, very few (0.01%) experience a worsening of symptoms (Lofthouse et al., 2025).

Overall, TF-EBTs can be considered feasible, safe and effective in diverse contexts and populations of traumatized children and youth with PTSD and/or elevated PTSS. Additionally, almost all randomized control trials (RCTs) investigating TF-EBTs have shown that these treatments are also effective in reducing psychological symptoms across common comorbid disorders like depression, anxiety, and externalizing behaviours. This may be not surprising based on the fact that all TF-EBTs have substantial commonality of techniques and underlying mechanisms (Kooij et al., 2022), of which many are also integral parts for EBTs for other mental disorders in children and youth.

There are several feasible and efficient EBTs for trauma-exposed children and youth that reduce PTSD and comorbid symptoms. These treatments are typically short-term (several weeks or months) and always address the trauma directly.

These common elements in child trauma treatments - identified across multiple evidence-based therapies - include a consistent set of techniques and therapeutic mechanisms that support recovery from traumatic experiences. These elements are designed to help children process trauma, manage symptoms, and build resilience. Establishing a strong, trusting, and supportive alliance between the clinician, child, and caregivers (where available) is critical for successful outcomes and is consistently emphasized across therapies (Ormhaug et al., 2013; Shirk et al., 2011).

Other widely recognized common elements are (Kooij et al., 2022; Jensen et al., 2020; Layne et al., 2014; Smith et al., 2025):

- **Psychoeducation:** Providing information to both children and caregivers about trauma, its effects, and the treatment process. This helps normalize reactions, decrease stigma, and increase engagement in therapy.
- **Recollection and processing of traumatic memories:** Gradually helping children recall and talk about their traumatic experiences in a safe environment, often through narrative work or exposure techniques.
- **Cognitive coping and restructuring:** Teaching children to identify and challenge unhelpful or distorted thoughts related to the trauma, and to develop more adaptive ways of thinking.
- **Relaxation and affect modulation skills:** Training children in techniques to manage overwhelming emotions, anxiety, and physiological arousal (such as deep breathing or mindfulness).
- **Behavioral activation:** Encouraging engagement in positive, enjoyable, or routine activities to counteract withdrawal and low mood that often follow trauma.
- **Homework and practice:** Assigning exercises to practice skills learned in therapy outside of sessions, reinforcing new coping strategies.
- **Future planning:** Preparing for the end of therapy by reviewing progress, reinforcing skills for managing future stressors, and fostering hope and confidence.

Wherever possible, **caregiver involvement** is also considered an important common element across EBTs, to support the caregiver to better understand the child's needs, to develop their skills and knowledge in supporting the child, and to strengthen the caregiver-child relationships. Of course, for some young people there may be no consistent caregiver, and this should not be a reason to decline treatment.

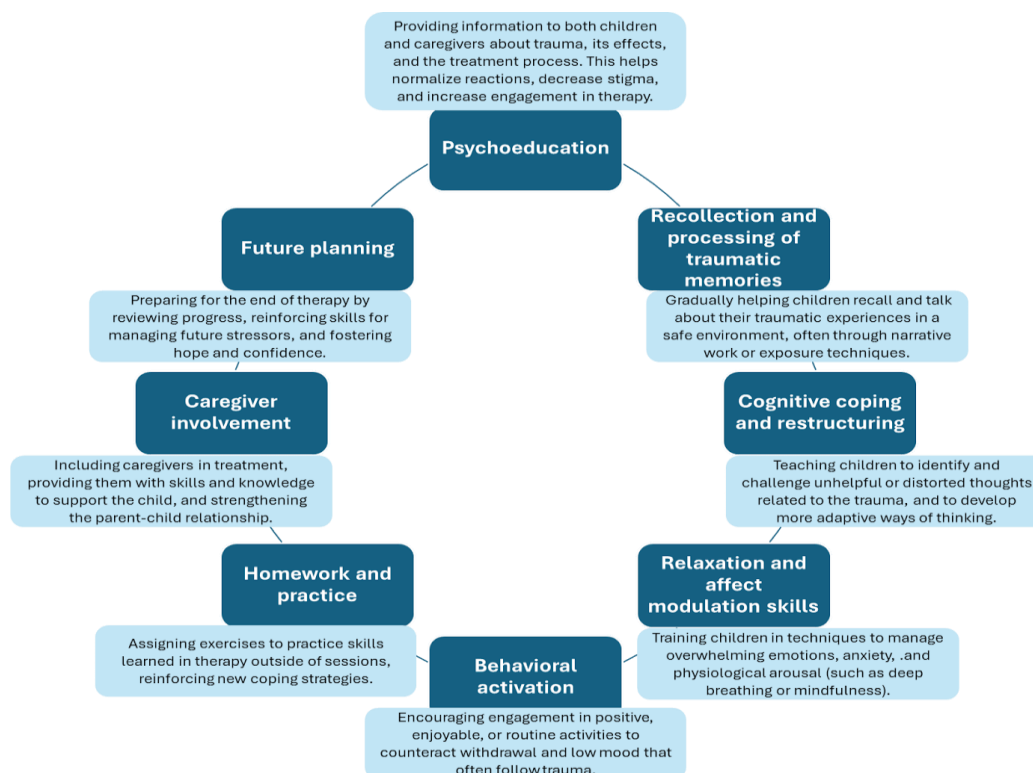


Figure 1. Common elements in TF-EBTs.

These elements are present in most TF-EBTs for children and youth, regardless of the specific theoretical orientation. Their consistent inclusion suggests they are foundational to effective trauma treatment in youth. However, due to lack of studies we know little about what components are crucial for good treatment outcomes. For instance, not all children need to learn relaxation skills and adolescents may not want their caregivers to attend treatment. While adapting interventions is common practice, it is important to not modify evidence-based interventions without a clear understanding of the original model's mechanisms and the specific contexts in which adaptations are warranted. Making unnecessary changes can result in a proliferation of variations, making it difficult to assess their relative effectiveness and potentially diluting the essential elements of the original model. Striking the right balance between fidelity to the intervention and thoughtful adaptation remains a persistent challenge (Lange et al., 2022). Mental health professionals should be trained and supported (including via clinical supervision) to deliver EBTs as they were designed – all of which inherently allow for some flexibility to meet the child's needs and capitalise on their strengths, while maintaining the core ingredients that make the treatment effective. If this is not possible, at a baseline, professionals should focus on implementing well the common elements across TF-EBTs.

Overall, the common elements of TF-EBTs are not markedly “different” or “special” compared with elements of EBTs for other mental disorders and can be easily learned and implemented by professionals. Addressing the trauma directly via exposure is part of every TF-EBT, similar to EBTs for other internalizing disorders.

Despite the robust evidence base for the negative psychological impact of PTEs on children and youth, and the large evidence-base for trauma-focused interventions, only a limited proportion of affected children and youth receive these therapeutic options (Pfeiffer et al., 2024). This disparity underscores significant barriers on individual patient level, professional and provider level, social structures, context and societal features, and the overall health system. Consequently, the next sections will delineate and focus on strategies and solutions that professionals and service providers can implement to enhance access to EBTs for children and youth. These strategies aim to address the existing barriers within mental health service provision, fostering improved outcomes for affected youth by facilitating their timely and effective engagement with appropriate therapeutic interventions.

3. Strategies to increase access to EBTs for children and youth

3.1 Routine screening for traumatic events and trauma-related disorders

Children and youth often do not disclose exposure to PTEs, including online exposures (Finkelhor et al., 2000). They may fear disbelief, invalidation, blame or stigma (Lemaigre et al., 2017; Stänicke et al., 2014; Ullmann et al., 2020). Routine screening by mental health care providers can help overcome these disclosure barriers and convey to children and youth that they are aware of trauma and are interested to learn about their experiences and the impact of health problems. Establishing screening as a standard of care also reduces professional avoidance. This is particularly important as we know that it is often the most vulnerable young people (e.g., those with child welfare involvement) who are least likely to have their trauma-related mental health needs identified and can struggle to access EBTs – promoting a cycle of inequity (McGuire et al., 2023; 2025).

For non-mental health professionals (i.e. pediatricians, school nurses, social workers) who may act as gate keepers to mental health services for children and youth struggling with trauma-related distress, the goal is to identify exposed children and youth to support appropriate referrals and consider how to best support the child (and family) within the boundaries of their own role. In mental health settings, initial clinical assessment of children

and youth should include questions about exposure to PTEs and the current impact of these events on their mental health, including specific screening for PTSS/PTSD.

Routine screening for traumatic events and trauma-related disorders is key to providing access to trauma-focused treatments. All mental health services should routinely screen for potentially traumatic events and trauma-specific mental health symptoms as part of their standard of care, including using standardised PTSD screening.

Ideally, mental health settings will implement routine screening as part of the standard of care for all treatment seeking patients since exposure to PTEs is linked to the development of a wide array of mental health conditions in childhood. If the organization does not routinely screen or the setting is private practice, providers should implement routine screening with their own caseload or in their own practices. There are validated screening measures ([Child/Adolescent Trauma Assessments | International Society for Traumatic Stress Studies](#)) and an online training on recommended clinical procedures and implementation of screening within an organization (Screentime:<https://www.chdi.org/our-work/evidence-based-practices/screening/trauma-screentime-training>).

Providers must be confident and comfortable talking about PTEs and their impact with children and caregivers so they can respond specifically and sensitively to what children disclose during routine screening. It is more important to understand the individual narrative than to get the specific details about the event. Hence, it is important to ask not only about what happened when assessing for trauma exposure, but also how important the event was to the child. The process should always include a collaborative review of the results which creates the opportunity to validate the experiences of children and their caregivers and learn about key factors that are relevant to recovery or intervention for the specific child in the context of their own experiences, history, and circumstances. It is better not to screen for PTEs if there is not an opportunity to provide at least a minimal response acknowledging disclosure of exposure to a PTE. The effect of only asking and not acknowledging could be iatrogenic (e.g., “they asked, I told them, they didn’t care”) and is not a trauma-informed practice. Since children and youth responses to PTE’s are idiosyncratic and depend on a range of contextual and developmental factors (Birkeland, Skar & Jensen, 2022), clinicians need to assess the impact for each individual child and not respond with general assumptions (Finkelhor & Berliner, 2021). Because discrepancies have been found between caregiver and child reporting (Skar, Jensen & Harpviken, 2021; Wamser-Nanney & Campbell, 2020), we recommend always asking for both the children and the caregivers’ perspectives, where possible.

Standardized assessment of both child and caregiver and the provision of psychoeducation to everyone in the family are crucial. When screening for trauma it is important that the child's experiences are validated and the child's safety is addressed.

Additionally, screening is an opportunity to assess family responses and child safety. Clinical providers should focus on children's physical safety, perceived sense of safety, and whether the family is responding in a way that will support safety and the recovery process for children and youth affected by trauma. Engaging with their caregivers to help them respond appropriately and effectively to child disclosure during routine screening is crucial. Professionals should also have TF-EBTs in place or have predefined referral procedures to qualified professionals for those with PTSS/PTSD.

An often-identified barrier to the implementation of a screening regimen is concern for adverse effects such as “re-traumatisation” (see section 3.2.) caused by the screening itself. When accompanied by acknowledgement, feedback, and guidance, research has proven that routine trauma screening is feasible, highly accepted, and well tolerated, with most participants reporting no or low levels of upset (Skar et al., 2019). Unless PTE exposed children are identified, they cannot be supported and helped. Done in a sensitive way, routine enquiry for PTEs can be protective, restore self-efficacy and perceived control, promote recovery, and strengthen the ability of children and families to access and engage in services.

3.2 Preparing a workforce to address trauma

To deliver the evidence-based assessment and treatment for PTSD that children and youth deserve, it is vital to consider the readiness and preparedness of the professionals who work with them. A number of clinician factors have been identified as barriers to the delivery of treatments to individuals – both adults and children – with PTSD. These include issues regarding training, such as a lack of training in treatment; uncertainty of how to acknowledge trauma or when to use exposure appropriately; lack of knowledge about evidence-informed interventions; clinicians' lack of confidence; competing demands; the emotional burden of trauma work; and clinician burnout (Finch et al., 2020a). We consider in detail here the barriers relating to training and supervision for clinicians who work with children and youth, and the potential impact of “myths” on clinicians' work.

3.2.1 Training and supervision for clinicians

To take the UK child and youth mental health system as an example, a large survey highlighted a number of issues pertaining to care around trauma and PTSD (Finch et al., 2020b). Access to training in trauma-focused assessment or PTSD treatment was only

reported by half of the sample and varied significantly by profession; key staff such as nurses, occupational therapists, and social workers were much less likely to have received training during or since their professional training compared to clinical psychologists and CBT therapists. A similar discrepancy was found for the availability of supervision. Self-rated confidence in assessing trauma-exposed youth was not high (mean of 7 out of 10), and even weaker when considering treatment (5.7 out of 10); again, similar discrepancies between professions were apparent.

It is important to consider how there can be such a lack of confidence around work with trauma and PTSD, given the robust evidence base outlined above that supports assessing for PTSD and using treatments such as TF-EBTs. To some extent this may reflect lack of awareness, but it can also reflect myths or misconceptions around supporting trauma-exposed youth. It is noteworthy that the ability to identify EBTs for maltreated children was predicted by more favourable attitudes towards evidence-supported treatments in general.

3.2.2 “Myths” around working with trauma in children and youth

There are many myths or misunderstandings that may undermine confidence in the use of EBTs for trauma-exposed youth. In our experience, clinicians often do not see the evidence for TF-EBTs as being relevant to their practice. Here, a popular misconception is that clinical trials predominantly include youth involved in single-incident PTEs (such as car accidents). In reality, most evidence relating to the treatment of PTSD in children and adolescents comprises youth exposed to multiple PTEs, including abuse, and research has shown that TF-EBTs are just as effective for children who have experienced multiple traumas as for those who have experienced a single trauma (Hoppen et al., 2023).

Sometimes, there is concern about whether a clinician is ‘the right person’ to deliver the treatment – they may think that “trauma work” can only be undertaken by the most qualified clinicians, e.g. clinical psychologists or psychiatrists. But research has shown that TF-EBTs can be effectively delivered by a wide range of clinicians (Grainger et al., 2022), and that the effectiveness of the treatment does not differ based on the clinician’s previous level of clinical experience, therapeutic background, or educational level (Pfeiffer et al., 2020).

A further common concern relates to complex PTSD (CPTSD), and whether TF-CBT is still relevant for this condition. CPTSD is a relatively new term, and more research is needed here. But the research evidence so far shows that children and youth with CPTSD still benefit from TF-EBTs (Sachser et al., 2017; Jensen et al., 2022).

Professionals from diverse backgrounds can effectively deliver trauma-focused therapies when trained and supervised in evidence-based approaches.

Possibly the most troubling concern that clinicians have around TF-EBTs is that they can cause harm. We would argue that this concern is in fact a misconception, that can be allayed by several strands of evidence. First, as noted above, a recent review (Lofthouse et al., 2025) suggests that the risk of deterioration in PTSD symptoms in youth receiving TF-EBTs is very low (0.01%). This is consistent with data from adult trials where adverse events and other forms of harm are no more likely to occur in clients receiving TF-CBT than other therapies (Hoppen et al., 2022). Second, dropout rates from TF-EBTs in children and youth are quite low. A systematic review of RCTs of psychological therapies for PTSD in youth suggests a rate under 11% for TF-CBT (Simmons et al., 2021); this is comparable to the dropout rate for CBT for depression in youth (Wright et al., 2021). A similarly low rate of dropout (13.3%) was found in a very large sample (over 1200) of Norwegian youth receiving TF-CBT (Skar et al., 2022). Third, fears around “re-traumatisation” are unwarranted. “Re-traumatisation” does not have a widely utilised definition, but broadly addresses harm, that might even be permanent or severe, that purportedly results from engaging in trauma-focused psychological therapy. A recent UK survey (Purnell et al., 2024) of adult and child clinicians who work with PTSD suggested a very low rate (3.4%) of re-traumatisation in their previous six months of clinical work. Moreover, there was a considerable breadth of views as to what constitutes “re-traumatisation”, with clinicians who were more anxious about re-traumatisation tending to have a lower bar in terms for what this might look like (e.g. they are more likely to see experiences like panic or flashbacks during a session as signs of re-traumatisation, whereas these are much more likely to be examples of quite classic PTSD symptoms that can be effectively treated using TF-EBTs).

Available evidence supports talking about trauma and processing trauma memories during treatment. Concerns about these treatment methods “retraumatising” children and youth are unfounded.

3.3 Taking into account the child’s environment

A central part of supporting psychological recovery after trauma, can be consistent, high quality collaborative support between the family, teachers, and community and mental health

support structures. Every adult around a child can make a difference in supporting a child post-trauma, including in the prevention of future traumas or victimisation.

3.3.1. The role of schools and families

Schools are critical environments for identifying and responding to trauma. For those schools that implement a trauma-informed approach, the environment provides particular attention to promoting safety, trust, and emotional regulation. School staff and teachers are sometimes the only people outside the family with whom children and adolescents have contact – and thus the only ones who might recognize that a child has been exposed to traumatic events and may be struggling with mental health issues. In truly trauma-informed schools, teachers and other education professionals must feel equipped and supported to identify children who may have experienced trauma or victimisation and be able to have direct, confident, and sensitive conversations with young people (and caregivers, where relevant). This does not need to be a formalised procedure or include formal screening tools (although there are some interesting emerging examples of this in the US; Lorig et al., 2025). It is also important that children are not forced to talk about their experiences if they do not wish to. What is crucial, though, is that adults give a clear and unambiguous message that they are there when the child is ready, that they *want to* and *can* hear what the child has been through, and that they are a safe and capable adult.

Families can also play a central role in trauma recovery. Specifically, the presence of a nurturing caregiver is likely one of the strongest protective factors for youth exposed to PTEs. For professionals, it is important to remember that trauma-informed care emphasizes key elements of specific relevance to the family unit. For example, culturally responsive engagement is important and includes assessment and intervention that acknowledges, respects, and integrates patients' and families' cultural values, beliefs, and practices. The notion of culture should include appreciation for the child's and family's race and ethnicity as well faith/religion, sexual orientation, region of residence and level of acculturation, and socioeconomic status.

3.3.2 Contexts outside of school, including facilitating access to mental health care

Other systems outside of schools and families are also relevant for youth exposed to family-based PTEs. For example, child welfare systems are increasingly adopting trauma-informed practices that include early screening and assessment for trauma exposure, as well as interagency collaboration to align services across education, health, and social care. Child welfare systems therefore need to increasingly implement sensitive policies and environments that provide youth with as many supports for positive well-being as possible.

Finally, it is important to note that effective trauma treatment must be easy to access and stigma-free (Adelman & Taylor, 2006; Guarino, 2014). Low-threshold access means services are available without complex intake, referrals, or eligibility screening. When designing mental health services an optimal approach would be to consider where children may feel best able to access care. That might be traditional mental health services, but accessible and evidence-based support within settings that children more frequently visit – for example, school or community centres – may also be helpful. Ideally, children would have options for where they can access high-quality mental health care. The best care should emphasize removing structural and psychological barriers to care and allow “soft entry” or access that allows individuals to engage gradually, without pressure or stigma.

Effective trauma response requires multi-system collaboration where schools, other gatekeeping professionals (e.g. GPs), and child welfare services (when needed) coordinate to identify PTEs early and provide wrap-around support. Services might also usefully embed peer professionals – allowing young people to also receive support from others with lived-experience, who can bridge trust gaps between families and providers.

Finally, community participation and buy-in is important and thus care should include local organizations, cultural leaders, and informal networks to ensure wide dissemination of trauma treatment care. This approach allows for communities to meet the growing demand for trauma treatment; systems are, by design, scalable models. Specifically, treatment models should include clinical staging that allows for tailoring interventions to the severity and progression of trauma symptoms. Stepped care models are also key that offer a continuum of support—from self-guided tools to intensive therapy—based on need and readiness (Storch, & Cheng, 2025). Whilst some children will need to access best-evidenced TF-EBTs immediately (e.g., where symptoms are high, chronic, and impairing), stepped-care models can support increased access for larger numbers of children, especially where there are resource issues. These models typically move from low-intensity steps (e.g., psychoeducation, self-help resources), to moderate (e.g., group therapy, short-term CBT), to higher-intensity steps (e.g., specialised TF-EBTs).

To implement these above highlighted approaches effectively, contextual systems of care (i.e., schools, community services) must invest in (a) interprofessional training, (b) embed trauma-informed principles in all levels of service delivery, and (c) use data-driven feedback loops to refine access, engagement, and outcomes for youth and families exposed to PTEs.

Key solutions for closing the treatment access gap include enhancing multi-system collaboration or building bridges between families and providers as well as between different support systems.

3.4. Using group format and digital support and interventions at all stages of access and care

The increasing implementation of TF-EBTs in a group format is noteworthy, particularly as part of a stepped-care model. Group TF-EBTs can enhance low threshold access and overall accessibility but also fosters an environment conducive to healing through shared experiences. Group therapy formats are particularly beneficial in alleviating feelings of shame, isolation, and stigma. Through collective engagement, participants may find mutual understanding, which is essential for facilitating recovery and resilience. There is evidence of effectiveness of group approaches – specifically those that draw on trauma focused CBT principles. This includes when delivered in highly complex and resource-scarce settings and to a range of trauma-exposed groups, including groups exposed to war/conflict, natural disasters, and abuse (Davis et al., 2023)

Digital support tools and digital interventions can be another way to implement and integrate routine trauma screening and trauma-focused EBTs for children and youth as well as trauma-informed training or supervision for treatment providers around the world.

Implementing a mandatory standardized digital screening and clinical feedback approach, wherever technology allows, will ensure that each child or youth seeking treatment is screened for PTEs and trauma-related disorders using resource-efficient, validated, and standardized instruments. The feedback process can be partially automated for the practitioners, facilitating the preparation of results and providing guidance for feedback discussions with the clients. This methodology not only streamlines the assessment process but also enhances the quality of care through structured engagement with young patients. It needs to be noted, though, that mandatory standardized digital screening and clinical feedback might be very context dependent and difficult to implement in low resource settings.

Evidence-based internet- and mobile-based interventions (IMIs) provide a promising opportunity to overcome structural and attitudinal barriers and expand treatment options. To enhance the state of care, therapist or clinician guided IMIs can play a pivotal role, as they require significantly less therapist time compared to traditional settings. Guided IMIs for youth with trauma-related disorders can provide significant benefits in terms of locational and temporal flexibility, the reduction of stigma associated with seeking treatment, and the capacity to tailor interventions to meet individual patient needs, thereby fostering a more personalized approach. This overall efficiency allows for broader accessibility and scalability of mental health services for traumatized youth, positioning guided IMIs as an optional treatment, with first promising evidence from uncontrolled studies and RCTs demonstrating large effects on symptoms of PTSD (Schulte et al., 2024; Smith et al., 2025).

The shift from in-person to digital training and supervisions in EBTs have facilitated the dissemination of these models in many hard-to-reach regions, especially low-and middle-income countries or crisis/conflict regions (Pfeiffer et al., 2025). Digital implementation of training programmes allows higher flexibility and less travel time for both trainers and trainees, simultaneous translations are easily incorporated, and materials can be made available directly during the training.

Consequently, the establishment and integration of digital screening, IMIs, and digital training for trauma-related disorders into standard care practices can be considered important pathways for addressing the mental health needs and closing the treatment gap for children and youth with trauma-related disorders.

Conclusion

Trauma exposure is shaped by individual, family, school, and community factors and recovery is possible when potential protective factors—like nurturing adults and safe environments—buffer against risk. In contrast to numerous other mental health disorders, there exists a substantial body of evidence regarding the effective treatment of children and youth with trauma-related mental health conditions. Specifically, the landscape of intervention research is characterized by an extensive array of RCTs: Short-term (weeks or months) trauma-focused treatment helps most children and youth (and their families), with high response, no deterioration and low dropout rates. We know what works, and to some extent also how it works. Hence, the current goal of our field is to take that knowledge and transform it into practice, to understand how best to implement TF-EBTs. This Briefing Paper described barriers that keep children and their families from receiving EBTs worldwide, such as lack of routine screening for PTEs and trauma-related disorders or factors associated with training professionals (e.g. fear of “re-traumatising” or myths around trauma and mental health). But even more importantly, this paper describes that there are promising solutions and many of them are already evaluated and implemented in several countries (e.g. stepped care approaches). Future research, clinical practice, and policies should focus more on how to increase collaboration between disciplines caring for trauma-exposed children and how to empower youth and families to seek and find adequate support.

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