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Ms Penny Armitage
Chairperson
Royal Commission into Victoria's Mental Health System
By email: contact@rcvmhs.vic.gov.au

Dear Penny

I welcome the opportunity to provide Berry Street's submission to the Royal Commission into Victoria's Mental Health System (attached). This submission builds on our preliminary submission provided in May 2019 and the submission from Berry Street's lived experience consultants in the Y-Change program.

The economic cost of poor mental health in Australia is significant, yet the social cost is even more devastating. For children and families in and at risk of out-of-home care (OOHC), these costs are experienced disproportionately, setting up a life of poor health and disadvantage rather than one of hope and opportunity.

Stark figures have already been presented to the Commission regarding the prevalence of mental ill-health and other factors of disadvantage, including drug and alcohol issues and justice involvement, amongst children and families involved with child protection systems.

At Berry Street, we see this every day as our dedicated staff and carers provide services to children, young people and families to address the effects of violence, abuse and neglect. Berry Street's statewide Take Two program, which provides specialist trauma-informed mental health services to children and young people in OOHC, is being increasingly stretched by demand. In the absence of funding growth since 2003, it has increasingly focused effort to the highest need, meaning opportunities to intervene early to address children's trauma and mental ill-health are lost.

As statutory parent, the Victorian Government has responsibility for ensuring children in OOHC are healthy and well, including having good mental health. The mental health and child protection systems should support and enable these children and families to address disadvantage, be safe and thrive. Unfortunately, these systems are currently failing to secure good mental health for many children and young people in its care.

For too many children and families, the child protection system compounds, rather than ameliorates, experiences of trauma and mental illness. The mental health system is then ill-equipped to respond to the complex experiences of trauma amongst this group.

In Victoria, over 10,000 children have experienced significant neglect, abuse and complex cumulative traumas and are in Victoria's statutory care system, growth of 41 per cent since 2013-14. Without government action, the numbers of children in out-of-home care are projected to grow to 25,000 by 2025-26. The situation is even more stark for Aboriginal children and young people, with growth of 77% since January 2015 and

projections that over 6,000 Aboriginal children could be in Victoria's OOHC system by 2025-26 unless action is taken now.

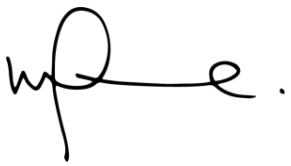
There is a need to reimagine the future. This requires action and investment of around $1billion over 4 years to reorient the child and family services and related systems toward early intervention. Evidence suggests investment at this scale will deliver significant dividends, in the form of avoided costs, across the justice, health and community service systems.

For these reasons, Berry Street calls on the Royal Commission to acknowledge the need to reduce the number of children in OOHC and examine:

- the particular needs of children at risk or in OOHC, and
- reform opportunities to reduce and address incidence and impact of trauma from abuse and neglect.

Again, I welcome this opportunity to submit Berry Street's submission and recommendations to the Royal Commission. Berry Street and its Y-Change lived experience consultants would be pleased to provide any further assistance to the Royal Commission as it undertakes this important inquiry into Victoria's Mental Health System.

Yours sincerely



Michael Perusco
Chief Executive Officer

ROYAL COMMISSION INTO THE VICTORIAN MENTAL HEALTH SYSTEM

Formal Submission

August 2019

For further information in relation to this submission contact:

Leanne Roberts

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[redacted]

About Berry Street

Berry Street believes children, young people and families should be safe, thriving and hopeful.

Berry Street has provided services to children, young people and families for over 140 years to address the effects of violence, abuse and neglect.

We are one of Victoria's largest out- of- home care (OOHC) providers. We provide a range of family support, parenting, education and family violence programs for vulnerable families, children and young people, working with partners across sectors and the community.

Since 2002, Berry Street has been funded by the Department of Health and Human Services to provide a specialist statewide intensive therapeutic service for children who have experienced trauma, neglect and disrupted attachment - Take Two.

Take Two provides an intensive multidisciplinary therapeutic response using evidence-informed clinical practices and expertise in child development to address the underlying trauma and mental health issues of children (under 18 years).

Take Two has been evaluated by La Trobe University resulting in several peer-reviewed publications describing its practice model and outcomes. Its therapeutic service model has been found by the Murdoch Children's Research Institute to be a Promising Program and its Community Wellbeing Program (CWP) that works with early childhood and school staff to strengthen the social and emotional wellbeing of children aged 3-12 years, has also qualified as a Promising Program. Take Two is currently being evaluated by Harvard University. The evaluation is using a randomised control trial methodology, with the goal of being shown to be an evidence-based program.

Berry Street continues to innovate and introduce evidence-informed and evidence-based practice in the work we do every day to improve the lives of families, children and young people. From introducing the Teaching Family Model in residential care settings to delivery of the Child-Parent Psychotherapy model and application of the Neurosequential Model to work with children at risk, we continue to use best knowledge available to make a lasting positive impact on the lives of the families, children and young people we work with.

In 2017-18, we provided services to over 28,000 families, children and young people, including over 1,000 service users though our therapeutic services, over 12,000 through our family violence services, and over 1,850 through residential and foster care arrangements.

Berry Street welcomes the opportunity to provide this second submission to the Royal Commission into Victoria's Mental Health System.

This submission builds on Berry Street's preliminary submission submitted in May 2019. (attachment 1).

It is informed by Berry Street's extensive experience working with families, children and young people who experience a range of disadvantages including trauma and poor mental health. It also complements the submission submitted by Berry Street's Lived experience consultants.

Terminology:

For the purposes of this document, we have used the term 'children' to refer to infants, children, adolescents and young people aged 0-18 years. Where we have specifically used the term young people, we are referring to people aged 16-25 years.

Executive Summary

The cost of poor mental health in Australia is significant. In 2016, the National Mental Health Commission estimated the cost to Australia at four per cent of gross domestic product – or around $60 billion to the economy[i].

The social cost is even more devastating, with a complex interrelationship with other factors of disadvantage, including family violence, childhood trauma and family separation, homelessness, interactions with the justice system, poverty and unemployment.

Numerous studies have highlighted the strong correlations between childhood trauma and developmental disorders with increased risk of mental illness, mental ill-health and suicide. Stark figures have already been presented to the Commission regarding the prevalence of mental ill-health amongst children and families involved with child protection systems. The Victorian Auditor General's recent report on Child and Youth Mental Health[ii] found that children in out- of- home care had up to 5 times higher rates of mental health problems and double the rate of serious suicide attempts compared to the general population.

As statutory parent, the Victorian Government has responsibility for ensuring children in OOHC are healthy and well, including having good mental health. Yet, the mental health and child protection systems are currently failing to secure good mental health for many children and young people in its care.

For too many children and families, the child protection system compounds, rather than ameliorates, experiences of trauma and mental illness. The mental health system is then ill-equipped to respond to the complex experiences of trauma amongst this group.

The current failure to effectively respond to this small but significant cohort results in a substantial economic and social cost to the Victorian community. This includes:

- High social costs associated with poverty, vulnerability and disadvantage
- substantially higher risk of mental illness and suicide in adolescence and adulthood
- disproportionate use of high-cost homelessness, justice, emergency and alcohol and other drug services.

In Victoria, over 10,000 children have experienced significant neglect, abuse and complex cumulative traumas and are in Victoria's statutory care system, growth of 41 per cent since 2013-14. Without government action, the numbers of children in out-of-home care are projected to grow to 25,000 by 2025-26[iii].

The situation is even more stark for Aboriginal children and young people, with:

- growth of 77% since January 2015 and
- a 20 times higher likelihood of being in the OOHC than non-Aboriginal children, the highest rate ratio in Australia[iv]..

Without taking immediate action, over 6,000 Aboriginal children could be in Victoria's OOHC system by 2025-26.

This is not sustainable. More action and investment is required immediately.

There is a need to reimagine the future. This requires action and investment of around $1billion over 4 years to reorient toward early intervention across the child protection, mental health and related service systems for these children in or at risk of OOHC and their families. Evidence suggests investment at this scale will deliver significant dividends, in the form of avoided costs, across the justice, health and community service systems.

For these reasons, Berry Street calls on the Royal Commission to:

- acknowledge the need to significantly reduce the number of children in OOHC to

address the high prevalence of mental ill-health amongst this group;
- examine the unique needs of children at risk or in OOHC and the reform opportunities that will reduce and address incidence and impact of trauma from abuse and neglect.

Berry Street's preliminary submission called for:

1. Increased investment in well-targeted, evidence-informed early intervention services that focus on family strengthening and preservation to prevent trauma and neglect and reduce reliance on OOHC.
2. Better connected, and more responsive and effective mental health and child protection systems to improve mental health outcomes for families, children and young people
3. Stronger system and workforce capability across the mental health and child protection systems to intervene early and effectively to prevent the cycle of disadvantage.

The recommendations below build on these priority reform directions.

Recommendations

Recommendation 1 – Adopt evidence-informed interventions that actively find, engage and support vulnerable families and children who may be disconnected or are difficult to engage with the services they need.

Recommendation 2: Strengthen the Families of a Parent with a Mental Illness (FaPMI) framework by including guidance on access, referral and family-focused practice for parents with a mental illness and families involved with child protection and OOHC systems.

Recommendation 3: Undertake further research to identify:
a) prevalence of children of a parent with a mental in care and
b) mental health and child and family service models that specifically respond to this group with the aim of preventing abuse, neglect and other traumatising events that lead to child protection involvement.

Recommendation 4: Invest in support and advocacy programs that help parents navigate the child protection system.

Recommendation 5: Significantly increase investment in a holistic suite of evidence-based and evidence-informed family preservation and strengthening programs that:
a) help parents to address the challenges they face which prevent them from positive parenting and supporting their child's development.
b) build parents' capacity to quickly and effectively deal with their child's challenging behaviours.
c) provide intensive therapeutic responses to families who are at imminent risk of child protection involvement.

Recommendation 6: Scale up and continue to strengthen the evidence base for effective leaving care support and accommodation models (such as Foyers, HomeStretch and GOALS), providing young people leaving care with a robust foundation for good mental health.

Recommendation 7: Update and adequately fund implementation of the Chief Psychiatrist's Guideline on Priority Access for Out -of- Home Care, ensuring that public mental health and OOHC services are positioned to respond quickly and effectively to the needs of children in OOHC.

Recommendation 8: Increase and expand capacity of Take Two – Victoria's specialist trauma-focused mental health service and a recognised Promising Program currently being evaluated by Harvard University using a randomised-control-trial methodology - for children and young people exposed to abuse and neglect. Additional funding should recognise that funding to Take Two's regional and Secure Welfare program has not increased since 2003, despite growth in the number of children in care and the increasing complexity of presenting issues.

Recommendation 9: Invest in the roll-out of evidence-based trauma-informed therapeutic service models, such as the Teaching Family Model and the Circle Program across Victoria's out- of- home care system, to minimise incidents that accumulate to create complex trauma and significantly impact on a child's mental health and functioning and to create opportunities for family reunification.

Recommendation 10: Build a stronger evidence base of effective mental health responses to children in OOHC within the mental health service system.

Recommendation 11: Build foundational knowledge across the mental health and related workforces (including emergency department and ambulance staff) of the child protection system and the effective responses for children who have experienced significant trauma, neglect and abuse.

Recommendation 12: Invest in actions to build trauma specialist capacity within public and private mental health services to respond to those in the child and family services system.

Recommendation 13: Invest in actions to build carer and child and family worker capacity to navigate the mental health service system and advocate on behalf of children in OOHC.

Recommendation 14: Pilot the introduction of a range of evidence-based programs, such as Secure Base, to build the confidence and capability of foster and kinship carers to parent children with challenging behaviours to reduce trauma and disruption of multiple placements in care.

Recommendation 15: Strengthen data collection, analysis and outcome-focused reporting across the child protection and mental health systems to support more effective service planning, collaboration and accountability.

Recommendation 16: Take a social investment approach to prevent and address poor mental health outcomes amongst children and families engaged or at risk of engagement with the child protection system. This includes the need to inject an immediate $1 billion over four years in a suite of initiatives to prevent or minimise impact of trauma, developmental delays and behavioural issues and avoid significant demand and expenditure across high-cost justice, health and other community services.

Recommendation 17: Ensure that funding is reflective of true cost of service delivery, specifically taking account of factors that add to delivery costs, including additional travel costs and demand for language services.

Context

Victoria's child protection system seeks to safeguard and protect children under 18 years from abuse and neglect in accordance with legislated best interest principles.

For children unable to live with their families due to abuse, neglect and other traumatising incidents, Victoria's out- of- home care system provides alternative care arrangements. This includes:

- Kinship Care – placement with relatives or significant others in the child's life
- Foster Care – non-related accredited caregivers who care for the child in their home
- Residential Care – residential homes with paid staff providing care to children unable to be accommodated in more family-like settings.

Children have a right to the protection and care necessary to support their wellbeing, including good mental health. Despite good intentions, the system is not supporting good mental health and wellbeing for too many of Victoria's most vulnerable children, young people and families.

The connection between adverse experiences in childhood of physical, emotional and sexual abuse, neglect, disadvantage and mental ill-health is profound. For many children and families, the experience of separation and loss is an additional trauma, building on the complex traumas which led to the separation in the first place.

Compared to their peers, children who have been in care are at significantly greater risk of poor physical and mental health, mental illness, drug and alcohol misuse, homelessness, early pregnancy, becoming involved in juvenile offending, criminality and incarceration.[v] VAGO's report on Child and Youth Mental Health highlighted that 42 per cent of children in youth detention were registered mental health clients[vi], which is significant given the Sentencing Advisory Council also found significant cross over between children in the youth justice system and the Child Protection System[vii].

This intersectionality of disadvantage contributes to a cycle of intergenerational trauma and disadvantage.

"People need to understand how trauma affects people, it literally interrupts health development. Being mentally unwell is not something I or anyone else can just turn off" – [redacted] 22, Berry Street lived experience consultant

The Royal Australian and New Zealand College of Psychiatrists has highlighted that children in OOHC experience high rates of developmental and mental health problems warranting special attention and priority access to multi-disciplinary mental health care.[viii] Multiple studies have found high prevalence of clinical-range behavioural problems in children, requiring more attention on screening assessments and timely and effective responses[ix].

The Victorian Government's record investment in services aimed at preventing family and childhood disadvantage is a step in the right direction.

Investment in the significant expansion of early parenting centres, 3-year-old kinder, and enhanced maternal and child health services are critical prevention endeavours. A range of early intervention services, including Restoring Childhood, are also showing benefits. They provide a strong platform in the early years to support healthy childhood development and positive parenting capabilities; a critical phase in child development.

Berry Street's preliminary submission highlights other positive policy directions that will contribute to preserving and strengthening vulnerable families and children, thereby minimising risk and impact of trauma, developmental disorders and broader disadvantage impacting on family mental health and wellbeing.

There are, however, continued challenges in the system that are not met by the current reforms.

Berry Street's preliminary submission highlights challenges being experienced by: (1) families at risk, including families with parents with unmanaged mental illness; (2) families involved with child protection; and (3) children in long-term care or transitioning from care.

These challenges range across:

- Accessibility and availability of mental health and child and family-focused trauma-informed therapeutic services
- Gaps in effective treatment/service availability and design of the mental health, child and family, and child protection service systems (the systems)
- Poor alignment of investment to evidence
- Weaknesses in system infrastructure across the systems, including funding mechanisms, supports for workforce and data and evidence systems.

The Royal Commission has an opportunity to examine and highlight system changes that will make a significant impact on the mental health and wellbeing outcomes of these vulnerable Victorian families and children.

Opportunities to make impact

Invest in well-targeted, evidence-informed early interventions to help strengthen and preserve families

Overview

To make a significant impact on the number of children experiencing complex traumas, there needs to be a focus on more effective early intervention.

Over 4,000 Victorian children were admitted to out- of- home care in 2017-18 at a rate of 2.4 per 1,000 children for non-Indigenous children and 39.9 per 1,000 for Indigenous children. This is three times the rate of non-Indigenous children and five times the rate for Aboriginal children in New South Wales[x]. Of those Victorian children who exited care in 2017-18, over 34 per cent were in care for over 1 month but less than 6 months.[xi]

The best interests of the child must be paramount. While separation is a necessary process for some children, a stronger focus on preserving and strengthening family relationships is needed. A strong body of evidence has now developed to support interventions that specifically address issues of trauma, traumatising events, family violence, developmental disorders and poor mental health both with children and with families. This range of initiatives must be approached as a suite of interventions that operate together in order to deliver system-level impact.

Recommendations

Effective identification and engagement of families at high-risk is a key foundation for early intervention. Yet the service systems designed to address disadvantage and support good health and well-being are complex to navigate, and as demand has escalated, the systems have focused on gate keeping - prioritising those in the highest level of crisis. The impact for people is disengagement, a feeling of hopelessness and frustration with the systems that should be designed to assist.

As part of its Restoring Childhood program (that provides a tailored service response based on need), Berry Street has trialled the Brief Relational Intervention Screening program. This evidence-informed and innovative model targets mothers and children (0-17 years) who have experienced a potentially traumatising family violence event in the recent past. Amongst other objectives, it seeks to: decrease initial distress in the child and prevent trauma; and increase mothers' and children's uptake of other support options to promote health and wellbeing.

A pilot evaluation of Berry Street's Brief Relational Intervention Screening by the Murdoch Children's Research Institute has shown the brief intervention assisted women to develop new skills in supporting their children to regulate challenging behaviours linked to traumatising events, while also leading to improvements in the women's own mental health.

This is one example of an evidence-informed brief intervention approach.

Recommendation 1 – Adopt evidence-informed interventions that actively find, engage and support vulnerable families and children who may be disconnected or are difficult to engage with the services they need.

Most parents with a mental illness provide a positive foundation for their children to be safe and thrive. However, evidence shows parents with a mental illness are at higher risk of involvement with child protection. The risk increases where there are multiple stressors, such as family violence and drug and alcohol dependence[xii].

The Families of Parents with Mental Illness initiative (FaPMI) has sought to ensure that

specialist mental health services are equipped to provide a family focused response to parents and their children. However, the high prevalence of children within these families who are engaged with child protection and the high number of adverse incidents amongst these children means the initiative is not working effectively for Victoria's most vulnerable families. There is an opportunity to strengthen the access and referral arrangements between the FaPMI coordinator and the OOHC system. There is also an opportunity to strengthen understanding of family-focused practice with a parent in cases where the child has been placed in OOHC. There are, however, still gaps in knowledge on how to best respond effectively and in a way that is in the best interests of the child. Stronger attention on the intersections between FaPMI, the mental health service systems and the child protection and OOHC systems needs to be complemented by further research to better understand and respond effectively to this cohort.

Recommendation 2: Strengthen the Families of a Parent with a Mental Illness (FaPMI) framework by including guidance on access, referral and family-focused practice for parents with a mental illness and families involved with child protection and OOHC systems.

Recommendation 3: Undertake further research to identify:

a) prevalence of children of a parent with a mental in care and
b) mental health and child and family service models that specifically respond to this group with the aim of preventing abuse, neglect and other traumatising events that lead to child protection involvement.

Neglect, abuse and separation is traumatic for children, but often also for their parents and families.

For parents engaged in the child protection process, the system is poorly geared to ensuring they are well informed and supported. The adversarial nature of the court system, structural and cultural biases and high stakes involved can result in greater harm for some families, particularly Aboriginal families impacted by the intergenerational trauma from colonisation and dispossession.

While parents may engage legal counsel in Victoria (for most families, this is through Legal Aid), this can be cost prohibitive and an intimidating process where families report that they feel threatened and unsupported. This can particularly be the case for parents living with mental ill-health, drug or alcohol dependence, family violence or other disadvantage.

Jurisdictions, such as South Australia, Tasmania, the Australian Capital Territory and New York, have examined supports to help parents navigate the child protection system to reduce stress and trauma from the process and ensure that opportunities are maximised to preserve and reunify families.

Recommendation 4: Invest in support and advocacy programs that help parents navigate the child protection system.

Presently, only around one quarter of the Child Protection and Family Services output budget is directed to family services. In 2017-18, this included an investment of around $137 million (just 10 per cent of the Child Protection and Family Services output budget) in intensive family support services to strengthen, preserve and reunify families at risk of engagement in the child protection system [xiii].

Through its focus on reform, the Victorian government invested $6.9 million in 2017-18 to test an intensive family services response (200 hours per family) to better meet the needs of over 300 families. The program has been informed by evidence and is targeted to children who are subject to a family preservation or family reunification order. This investment is crucial. However, apart from not

being at scale, it is limited to families already well engaged in the Child Protection System.

The investment and focus is commendable but is insufficient to make a significant impact.

A range of evidence-informed responses along a continuum of interventions is needed; from building parental capacity to support their child's development and constructively responding to challenging behaviours and stressors, through to intensive therapeutic responses that work with families to address their own and/or their child's mental health problems, including those which present as significantly challenging behaviours. A myriad of evidence-based and evidence-informed interventions exist along the continuum of responses but are yet to be introduced and scaled across Victoria to make significant system-level impacts.

Evidence-based group programs, such as Triple P - Positive Parenting Program, Tuning into Kids and Tuning into Teens, have been shown to strengthen parents' capacity to respond to their children's needs and increase their capacity to parent effectively. Such programs help parents develop parenting skills and address personal barriers to effectively supporting the emotional and developmental needs of their children. They have limited reach for those on the brink or already involved with child protection but play an important role along a continuum of interventions.

Stronger Families, currently funded and evaluated by DHHS, complements these group-based programs by working directly with families to prevent family breakdown. Despite positive evaluation findings, the program is not available in all areas of Victoria. Also, the effectiveness of this multi-agency program could be enhanced by including specialist mental health services and drug and alcohol services in the partnerships, to deal with the frequent co-occurrence of mental health and alcohol and drug difficulties in family breakdown.

Building yet again on these interventions are a range of evidence based therapeutic programs, such as Family Functional Therapy and Multi-Systemic Therapy, that work with families experiencing multiple, significant challenges which put children at imminent risk of OOHC placement. These programs have been successful at preserving and restoring families, thereby reducing the number of children in OOHC, in various international and Australian jurisdictions. They successfully apply therapeutic approaches that work with children and families to reduce entry to out- of- home care, substance abuse, poor mental health, family violence and offending and recidivism.

Recommendation 5: Significantly increase investment in a holistic suite of evidence-based and evidence-informed family preservation and strengthening programs that:

a) help parents to address the challenges they face which prevent them from positive parenting and supporting their child's development.
b) build parents' capacity to quickly and effectively deal with their child's challenging behaviours.
c) provide intensive therapeutic responses to families who are at imminent risk of child protection involvement.

The transition from adolescence to adulthood presents challenges for all young people. For young people leaving care, the experience can be more challenging because of past trauma and disadvantage. They are more likely to experience homelessness, engage with the criminal justice system and experience poor mental and physical health than the general population.

A 2009 survey[xiv] indicates 35 per cent of young people in care were homeless in the first year of leaving, while 46 per cent were involved in the juvenile justice systems – both are risk factors

for mental ill-health. Another report has indicated as many as 65 per cent of care leavers experience mental ill-health, including depression, anxiety, PTSD, panic attacks and sleep disorders. [xv] These experiences build on and entrench trauma and disadvantage.

Significant evidence exists to demonstrate the cost effectiveness of supporting successful transitions from care. A range of accommodation and support models have emerged in response. Evidence supports the importance of investing in accommodation and support models to support the transition of young people from care into adulthood.

Recommendation 6: Scale up and continue to strengthen the evidence base for effective leaving care support and accommodation models (such as Foyers, HomeStretch and GOALS), providing young people leaving care with a robust foundation for good mental health.

Invest and reform to create more connected, responsive and evidence-informed mental health and child protection systems

Overview

Seventy-five per cent of all mental illnesses manifest in people before the age of 25. Yet multiple reviews have highlighted that escalating demand and system gaps mean that many children are not getting the support they need[xvi].

The situation is even more stark for children in care, despite their higher risk of mental ill-health[xvii]. VAGO highlighted DHHS linked data from 2014-15 that showed 19 per cent of children in care were registered mental health clients[xviii]. Given the reports of poor life-time mental health outcomes amongst children in care, this data strongly suggests the mental health and child protection systems are not giving children in OOHC the support they need.

The *Children Families and Youth Act 2005* provides a legislative framework to guide child placement decisions in the best interests of the child. Despite the robust placement principles, their practical application and the current service gaps and barriers across service system are often exacerbating rather than addressing harm. The only option for some highly vulnerable children facing multiple issues, including poor mental health, drug or alcohol dependence and justice engagement, is to be place inappropriately without access to the services they need. The result is an escalation of harm.

"A lot of reasons for my anxiety and depression are childhood trauma. That will always have happened to me. It can't be treated like it's been washed away. So what's important is that I'm well-supported to work through what I've experienced" – [redacted] 19, Berry Street lived experience consultant

Recommendations

The Chief Psychiatrist's *Guidelines on Priority Access for OOHC* (the Guidelines) recognise that infants, children and young people involved with Child Protection and placed in out- of-home care are a highly vulnerable group, with many experiencing complex loss and trauma that profoundly impacts on every aspect of their development. The Guidelines were designed to support mental health services to implement priority service access to children in OOHC[xix], yet came without additional investment.

The Guidelines echo the position of the Royal Australian and New Zealand College of Psychiatrists, which has also called for special attention and priority access to multidisciplinary care by this group[xx].

Yet, while there have been pockets of good practice built on the commitment of workers, knowledge and application of the guidelines are variable across Victoria. VAGO recently found that only one of the five mental health services reviewed as part of the audit had documented procedures to implement these guidelines[xxi]. Implementation has relied on commitment of staff, given the Guidelines were issued without additional investment. As demand pressures have impacted the mental health and child protection systems, so has the capacity to give life to the guidelines.

The need to give special attention to the mental health needs of children in care has not dissipated. There is a pressing need to:

- refresh and recommit to the Guidelines, taking a collaborative approach between mental health, child protection and out- of - home care providers and informed by people with lived experience
- ensure the Guidelines are appropriate to Aboriginal and Torres Strait Islander children

- reinvigorate governance and accountability mechanisms
- ensure adequate funding is available to implement the Guidelines in a meaningful and sustainable way.

Recommendation 7: Update and adequately fund implementation of the Chief Psychiatrist's *Guidelines on Priority Access for Out -of- Home Care*, ensuring that public mental health and OOHC services are positioned to respond quickly and effectively to the needs of children in OOHC.

"*The trauma and mental health issues my family and I have are so severe. What makes me really angry is that we have to deal with the repercussions of past trauma we've all experienced because none of us got the help we needed when we were in the system*" – [redacted] 23, Berry Street lived experience consultant

Specialised knowledge and skills are needed to address the mental health issues of children who are traumatised and feel disconnected and unsafe. This is particularly so for children in statutory care.

Take Two provides evidence-informed clinical practice and expertise to address developmental trauma and mental health issues of children who have suffered severe abuse, neglect or disrupted attachment.

While the number of children requiring Take Two's specialist response has grown along with the significant growth in children in care, Take Two's reach has effectively reduced in the absence of funding growth in its regional and Secure Welfare program.

When first funded, Take Two's regional and Secure Welfare program responded to eight per cent of children with substantiated reports, who present with significant mental health and behavioural issues associated with trauma. Take Two now sees approximately three per cent of children with Child Protection substantiated reports each year. There has been additional funding for program enhancements and specific roles to address emerging issues, but this has not addressed the demand on Take Two's regional and Secure Welfare program.

A 2018 review of Take Two identified that 79 per cent of Take Two's activities were focused on placement support, advisory assessment and interventions. The review also found the interventions were successful with children experiencing, on average, experiencing a 30 per cent average reduction in the children's presenting symptoms.

However, the vast majority of children with substantiated child abuse and neglect do not receive such services. The result is that developmental delays and the mental health of children escalate and incidents occur which produce an additional cumulative harm, rather than maximising the capacity to address the harm and support needs of the child (and family) to reduce trauma and set the foundation for a healthy and well life.

As such, opportunity is lost to intervene early to prevent or minimise trauma experienced by children, young people and their families.

Recommendation 8: Increase funding and expand capacity of Take Two – Victoria's specialist trauma-focused mental health service and a recognised Promising Program currently being evaluated by Harvard University using a randomised-control-trial methodology - for children exposed to abuse and neglect. Additional funding should recognise that funding to Take Two's regional and Secure Welfare program has not increased since 2003, despite growth in the number of children in care and the increasing complexity of presenting issues.

Specialist responses need to sit alongside robust placement practice and decisions as well as therapeutic service delivery and practice models that treat childhood trauma, mental

health conditions and support children's emotional and behavioural development.

Presently, at any one time, there are over 10,000 children in care in Victoria; approximately 400 are living in residential care, 7,000 in kinship or foster care and the remainder are in other forms of care, including third-party permanent care[xxii]. For those in residential care, they are often placed inappropriately with other highly vulnerable children, exacerbating harm and trauma issues, due to a lack of suitable alternative options with well-trained carers and connections to adequate mental health, drug and alcohol and other specialist services.

While promoting children's safety, OOHC also provides an opportunity to address complex trauma, behavioural and development issues, that often manifest because of neglect and abuse.

The Circle Program, a therapeutic approach to the provision of foster care, has built a promising evidence base to respond to the complex behavioural, developmental and mental health needs of children by improving the stability of their placement experience and improving the retention of foster carers. The program has been successfully piloted by DHHS across multiple sites but is yet to be rolled out more broadly across the state.

Similarly, the Teaching Family Model is an evidence-based model that has been rolled out successfully internationally to help families support children with:

- trauma from physical, emotional and sexual abuse, and;
- behaviours described as concerning, maladaptive or emotionally-disturbed because of trauma and developmental disorders.

There is a need to ensure evidence-based trauma-informed practice models are taken to scale across residential and non-residential settings to promote and maximise good mental health outcomes for children in care.

Recommendation 9: Invest in roll-out of evidence-based trauma-informed therapeutic service models, such as the Teaching Family Model and the Circle Program across Victoria's out- of- home care system, to minimise incidents that accumulate to create complex trauma and significantly impact on a child's mental health and functioning and to create opportunities for family reunification.

Because of the lack of attention to date, there has been little attention given to developing a strong evidence base of effective specialist mental health service responses to children in care with complex experiences of trauma, abuse and neglect. Take Two has led the development of specialist evidence-informed therapeutic response to children in child protection with complex experiences of trauma, abuse and neglect. However, there is a need to build on this understanding of what works, with a focus on building an evidence base of effective responses through the specialist mental health service system.

Recommendation 10: Build a stronger evidence base of effective mental health responses to children in OOHC within the mental health service system

Strengthen system and workforce capability across the mental health and child protection systems to intervene early and effectively and prevent a cycle of disadvantage

Overview

An effective service system requires a strong foundation: a strong outcomes focused culture; a well-trained and supported workforce and network of carers; good data systems enabling effective analysis of system issues and emerging gaps, and strong governance and leadership to steward the system. However, presently, there are system infrastructure gaps creating challenges in stewarding an effective, outcomes focused response to children in OOHC with emotional and behavioural issues and mental health problems.

Recommendations

The Royal Australasian and New Zealand College of Psychiatrists (RANZCP) has highlighted that "children in care often present with complex psychopathology"[xxiii]. The complex cumulation of trauma from multiple disadvantage and developmental delays adds to the complexity of effective assessment and intervention[xxiv]. To deliver effective responses that meet the special needs of these children, there needs to be strong workforce capacity and understanding.

Priority access to the specialist mental health system needs to be complemented with both:

- Increased awareness across the mental health and related workforce (including emergency department and ambulance staff who may be the first point of contact for a child in care with an acute mental health issue or experience of suicidal ideation) of the child protection system and the specific needs and effective responses for this group
- Specialist capacity to lead delivery of effective interventions that respond to the psychopathological complexities of children in OOHC.

Recommendation 11: Build foundational knowledge across the mental health and related workforces (including emergency department and ambulance staff) of the child protection system and the effective responses for children who have experienced significant trauma, neglect and abuse.

Recommendation 12: Invest in actions to build trauma specialist capacity within public and private mental health services to respond to those in the child and family service system.

Carers and the child and family services workforce are at the forefront of ensuring children in care can navigate and access the mental health service system, to get timely access to the treatment and support they need. This requires carers and workers to have skills in mental health first aid and understand how to navigate and advocate within the complex and fragmented mental health service system.

While training in mental health first aid has been increasingly undertaken across the carer and child and families workforces, foundational understanding of the mental health service system to build capacity of carers and workers to advocate for children has not.

Recommendation 13: Invest in actions to build carer and child and family worker capacity to navigate the mental health service system and advocate on behalf of children in OOHC.

"You can't expect someone who is living in unstable conditions to support themselves and deal with the severe mental health and trauma that comes with being a person in care" – [redacted] 23, Berry Street lived experience consultant

Presently, more than 50 per cent of children who have been in statutory care for more than 6 months will experience two or more

placements[xxv]. VAGO's review of residential care services found that around one-third had experienced 10 or more placements[xxvi].

Capacity of kinship and foster carers to care for children presenting with increasingly complex mental health and behavioural issues has a significant impact on placement stability.

Instability in OOHC placements can exacerbate trauma of the care experience for children. They also can make it extremely difficult to address the trauma, developmental delays and behavioural issues that are due to the initial experience of abuse and neglect. In addition, it places greater strain on kinship and foster carers, who play a fundamental role in the child protection system.

Programs, such as Secure Base and Keeping Foster and Kin Carers Supported and Trained (KEEP), have been found to be promising in increasing the positive parenting skills of foster and kinship carers in responding to children's difficulties. Through increasing the confidence and tools for carers, program such as these have helped reduce placement disruption and help provide stability within which to undertake therapeutic interventions that assist children to deal with trauma from abuse and neglect.

Recommendation 14: Pilot the introduction of a range of evidence-based programs, such as Secure Base, to build the confidence and capability of foster and kinship carers to parent children with challenging behaviours to reduce trauma and disruption of multiple placements in care.

Victoria's current investment, funding, reporting and accountability mechanisms often do not support delivery of cost-effective interventions that successfully respond to increasingly complex social problems.

Current investment, funding, data analysis and reporting mechanisms often fail to:

- monitor and anticipate projected local demand, emerging issues and service needs of whole communities and specific cohorts; resulting in a 'postcode lottery' where service availability and response is based on location rather than presenting need.
- support a social investment approach that directs funding to cost-effective interventions that secure the wellbeing and prosperity of all Victorians.
- reflect true costs of effective, outcome-focused service delivery, including encompassing the additional costs of regional service delivery, flexible 24/7 service availability, translation services to respond to increasingly linguistically diverse community.
- encourage and support collaboration and flexibility across providers and service systems, to maximise individual and system-level outcomes from available investment.

This is particularly evident in current investment, reporting and accountability frameworks for children and families at risk of abuse, neglect, trauma and poor mental health. For example, despite recognising that children in OOHC are a priority for specialist mental health services this has not reflected in funding, reporting and accountability approaches.

A social investment approach would start to orient new investment toward early intervention initiatives. This submission includes recommendations for a range of early intervention initiatives across a continuum of responses to children, young people and families in or at risk of OOHC. Berry Street estimates that investment of $250 million per year is required in these early intervention initiatives. Investment of this scale will deliver system-level impacts and provide dividends across government through avoided costs in the

health (including mental health), justice and other community service systems.

Recommendation 15: Strengthen data collection, analysis and outcome-focused reporting across the child protection and mental health systems to support more effective service planning, collaboration and accountability.

Recommendation 16: Take a social investment approach to prevent and address poor mental health outcomes amongst children and families engaged or at risk of engagement with the child protection system. This includes the need to inject an immediate $1 billion over four years in a suite of initiatives to prevent or minimise impact of trauma, developmental delays and behavioural issues and avoid significant demand and expenditure across high-cost justice, health and other community services.

Recommendation 17: Ensure that funding is reflective of the true cost of service delivery, specifically taking account of factors that add to delivery costs, including additional travel costs and demand for language services.

Conclusion

Childhood is a significant life stage. Experiences in childhood can considerably impact their physical and mental health and wellbeing during adulthood.

The Government has acknowledged that Victoria's current mental health system does not adequately respond to the mental health needs of children. This is particularly true for children who have experienced abuse and neglect.

For children and families involved with child protection, the fragmented mental health system and traumatising experiences in the child protection system can contribute to life-long disadvantage. This includes higher prevalence of homelessness, engagement with the justice system, experiences of family violence, chronic health issues and serious mental health problems. The result is substantial economic and social costs to the Victorian community.

As statutory parent, the government responsibility for the health and wellbeing of children in OOHC. An essential component is ensuring the system designed to keep children safe and well achieves this aim, and ensures they receive timely access to effective mental health services.

Leading mental health practitioners, including the Chief Psychiatrist, have recognised the need for priority access for children in OOHC to high-quality, trauma-informed mental health services. Yet practice across Victoria's mental health services falls short.

More broadly, the current child protection and OOHC systems have a traumatising impact on too many children and families, which is compounding on trauma of abuse and neglect. With an unacceptable increase in the number of children entering child protection and OOHC, Berry Street asserts investment of around $1 billion over four years is needed across a range of early intervention services.

Given the current system gaps in responses to children and young people, the Victorian Government's submission invites the Royal Commission to specifically examine opportunities to improve children and youth mental health responses. Berry Street supports the Victorian Government's position.

Berry Street also calls on the Royal Commission to examine the particular needs of children in OOHC in light of current cross-system failures. This includes examining opportunities to intervene early to prevent and address childhood trauma that can lead to life-long mental health problems and disadvantage.

Berry Street welcomes the Royal Commission's examination of Victoria's Mental Health Services and appreciates the opportunity to provide this submission.

Endnotes

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BERRY STREET

We're for Childhood

SINCE 1877

Royal Commission into the Victorian Mental Health System

Preliminary Submission

May 2019

About Berry Street

Berry Street has supported and empowered children, young people and families for over 140 years to address the effects of violence, abuse and neglect. We are one of Victoria's largest out of home care providers and we deliver a specialist statewide mental health services for children and families impacted by child abuse and neglect - Take Two. We also provide a range of family support, parenting, education and family violence programs for vulnerable families, children and young people. In 2017-18, we supported and empowered over 28,000 families, children and young people, including over 1,000 service users though our therapeutic services, over 12,000 through our family violence services, and over 1,850 through residential and foster care arrangements.

Berry Street continues to innovate and introduce evidence-informed and evidence-based practice in the work we do everyday to improve the lives of families, children and young people.

Berry Street believes children, young people and families should be safe, thriving and hopeful. Despite the best efforts of our passionate and committed workforce and carers, the infants, children, young people, parents and families we work alongside experience significantly poorer mental health than the broader community. They also are at significantly higher risk of poor education outcomes, unemployment, chronic physical health issues, homelessness and disconnection from family and community.

Many of the children and young people Berry Street works with become parents as adults. In the absence of effective interventions that address the experiences of trauma and mental illness, we see the cycle of intergenerational disadvantage, trauma and engagement with child protection.

Berry Street believes this is unacceptable.

We know there are programs that work, such as Berry Street's Take Two program. Since 2002-03, Take Two has been providing intensive multidisciplinary mental health service using evidence-informed clinical practices and expertise in child development to address the underlying traumas and mental health issues of children (under 18 years) who have suffered severe abuse, neglect or disrupted attachment. Addressing the mental health issues of traumatised children and young people who may still be feeling disconnected and unsafe, requires a specialist response. Take Two is currently being evaluated by Harvard University with the goal of being recognised as an evidence-based program. **Appendix 1** provides further details of the program.

The programs we know work are either not funded, have not had funding grow commensurate with demand, or are not funded at a scale to make the level of impact needed to deliver significant system-wide and community-wide benefits.

This submission is built on Berry Street's extensive experience working with and hearing the voices of families, children and young people who experience, are at risk of, or are adversely impacted by mental illness.

Executive Summary

Purpose

This preliminary submission sets out at a high level the key issues and areas of focus that Berry Street asserts should be examined by the Royal Commission. Berry Street will further outline the case for change and business case for action in a subsequent submission.

Berry Street's Y-change employees, a program designed to empower young people with lived experience of disadvantage to use their expertise to influence service and system design, will also provide a submission to the Royal Commission.

Berry Street's expertise

Every day through our work, we see where the government-funded mental health and child protection systems are ill-equipped to respond to the vulnerable families, children and young people we work alongside.

Berry Street welcomes the opportunity to work with the Royal Commission to examine options that reorient responses to families and children toward early intervention; reform the mental health and child protection systems, and; strengthen systems and workforce capability.

We are also pleased to provide any further information or identify suitable witnesses to present on aspects of Berry Street's position or unique programs that interest the Commission.

Case for change

National and international research has clearly found that persisting mental health problems in adults are a common consequence of child abuse and neglect. In addition, research has found that parental mental health issues contribute to entry into care by many children and young people.

Berry Street applauds the Victorian Government's record investment in services that prevent family and childhood disadvantage, including significant expansion of early parenting centres, 3 year old kinder and enhanced maternal and child health services. These prevention efforts are critical.

The next step is to significantly invest in early intervention to ensure Victoria doesn't leave behind its families, children and young people who need more support to address significant disadvantage and vulnerability.

Currently, the State is failing its responsibilities as a statutory parent in some cases to secure good mental health of children and young people in its care. The child protection system compounds rather than ameliorates experiences of trauma and mental illness for children and young people and families with the highest needs. Families' experience of trauma, mental illness and disadvantage are being allowed to escalate before they can access services – high cost, high intensity services – that then seek to address the damage done.

The human cost is substantial. Over 10,000 children and young people are now in out of home care (including permanent care arrangements), growth of 41% since 2013-14.

Without immediate government action, this figure will grow to almost 25,000 if growth rates remain the same. The situation is even more stark for Aboriginal children and young people, with growth of 77% since January 2015.

This is not sustainable. Berry Street supports and is working with Government to progress its Roadmap to Reform, which signals an intention to orient the child and families service response to earlier intervention.

More action and investment is required now to build on these substantial reform directions and investments. Government needs to invest where it can make the biggest impact. It needs to reimagine the future and this requires action and investment now to shift toward early intervention across the child protection, mental health and related service systems.

Opportunity to make an impact

Berry Street encourages the Royal Commission to examine opportunities to:

1. Invest in well-targeted, evidence-informed early intervention services that focus on family strengthening and preservation
2. Invest and reform to create more connected, responsive and effective mental health and child protection systems that deliver positive mental health outcomes for families, children and young people
3. Strengthen system and workforce capability across the mental health and child protection systems to intervene early and effectively to prevent a cycle of disadvantage.

1. Current situation / case for change

Families, children and young people in or at risk of child protection: A priority group for the Royal Commission

Trauma from abuse and neglect + **Significant impact of being removed** + **Experience of the system** = **Lifelong risk of serious mental illness**

National and international research clearly demonstrates that the adverse effects of abuse and neglect are significant, impacting not only children in care, but also their families and communities. Research also indicates parent mental illness contributes to entry into care by many children and young people.

Compared to their peers, children who have been in care are at significantly greater risk of poor physical and mental health, mental illness, drug and alcohol misuse, homelessness, becoming involved in juvenile offending, criminality and incarceration (CFCA, 2014).

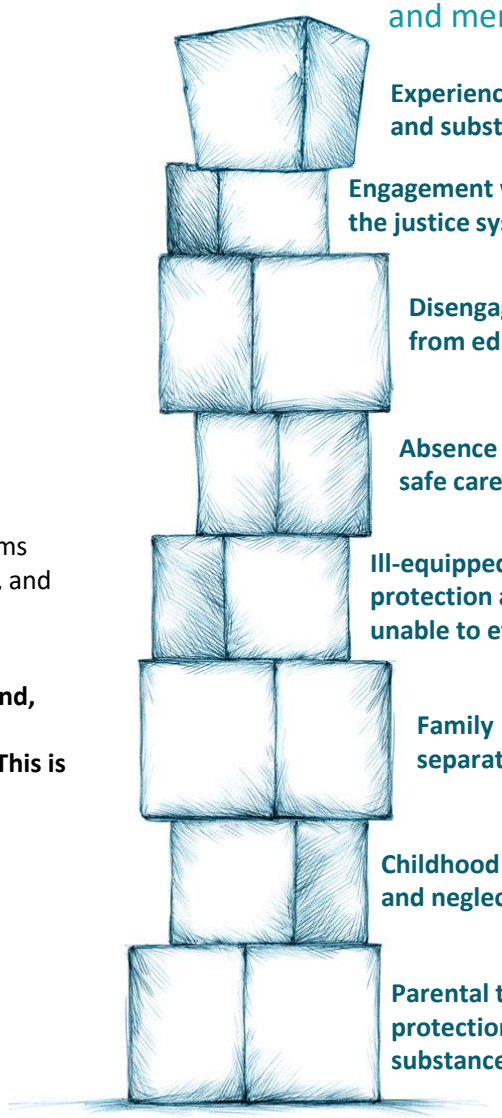
The significant adverse impacts of family separation and experiences of the child protection system, build upon the already significant trauma from the initial abuse and neglect, creating a compounding effect for both the child and their family.

As the statutory parent, the State has responsibility for the mental health of children and young people in its care.

Yet, the current child protection system's design often contributes to children, young people and families experiences of trauma and mental illness rather than ameliorating it. Children and young people in care can experience multiple placements, mental health symptoms caused by an absence of a safe, stable care relationship, and placement in residential care with equally traumatised children and young people.

As trauma and mental health issues build and compound, the child protection and mental health systems are presently ill-equipped to respond in an effective way. This is leading to a cycle of intergenerational trauma and disadvantage.

Compounding issues of trauma and mental illness



Mental Health and Child Protection systems: Failing Victoria's most vulnerable children, young people and families in or at risk of statutory (State) care

In 2018-2019, the **Victorian Government** is investing[1]:

2018-19

$1.47b

Child protection, family services, family violence & related supports

$1.61b

Mental health inpatient, community and ambulatory services, including services to identify mental illness early

The **Australian government** spent (in 2016-17):

2016-17

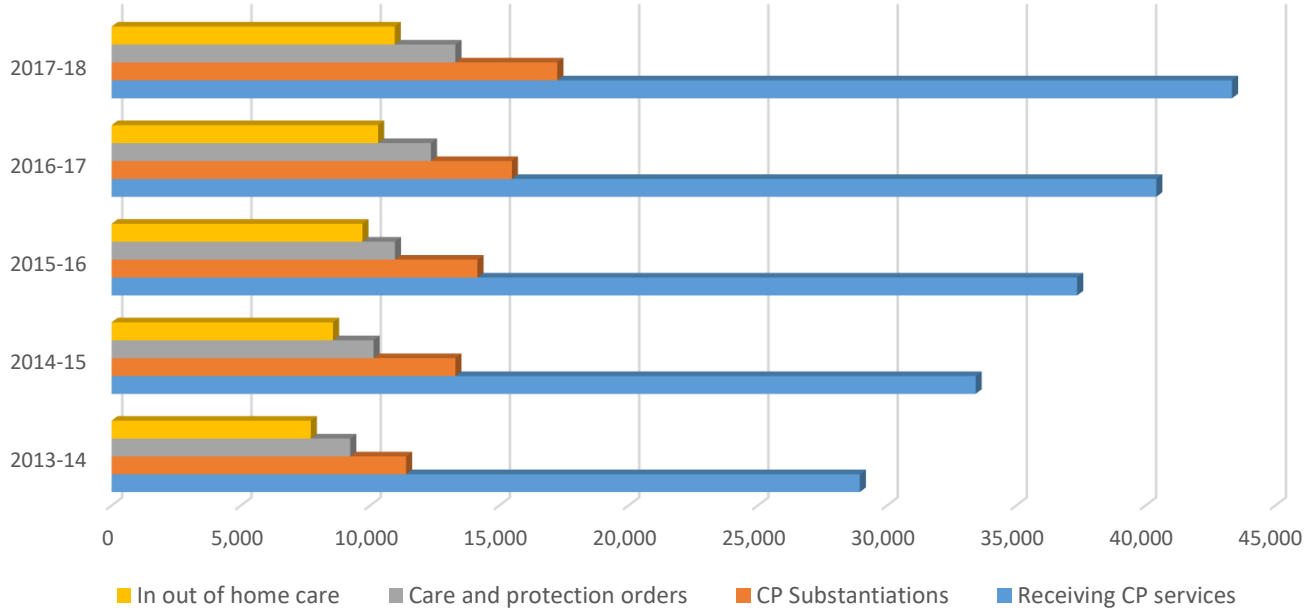
$1.2b

Medicare-subsidised mental health-specific services

$511m

Mental health-related subsidised prescriptions[2]

Despite record levels of investment, **Child Protection involvements, substantiations and care and protection orders have grown by around 50%** [2], while the population has grown by 9.6% [3].



Note: Since 2017-18. third party parenting arrangements have been excluded from Victoria's OOHC reported figures but have been included in the graph above.

[1] 2018-19 Victorian State Budget – Budget Paper 3 [2] AIHW, Data tables: Child Protection Australia 2017-18 [3] ABS Australian Demographic Statistics

Mental Health and Child Protection systems: Failing Victoria's most vulnerable children, young people and families in or at risk of statutory (State) care cont.

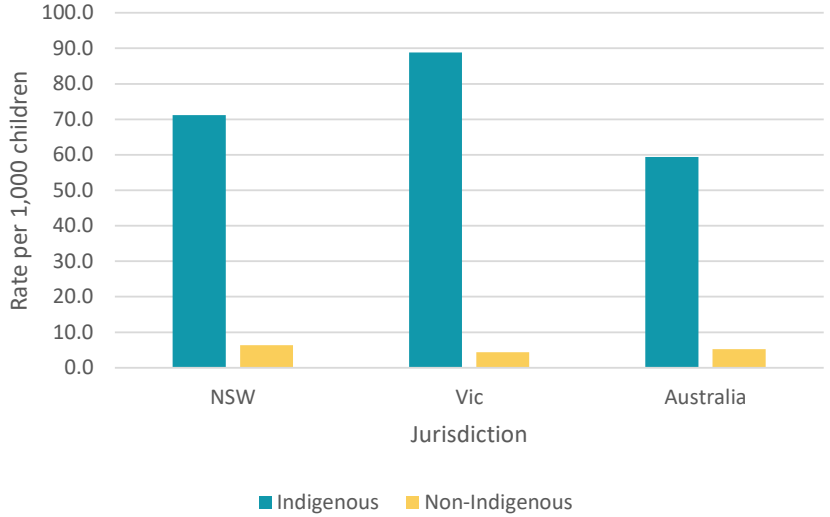
Victoria is performing poorly across a range of out of home care domains, especially when compared to other jurisdictions

Children/young people entering out of home care 2017-18[1]

Each year more children and young people enter care in Victoria than in NSW. However, 50 per cent of children admitted to care for the first time in Victoria return home within six months.

Data suggests a strong correlation between family violence, teen pregnancy, emergency department presentations and Indigenous status with rates of admission to out of home care.

Children in out-of-home care, by Indigenous status, 30 June 2018[1]



The rate of Indigenous children in Victoria's out of home care system is over 20 times higher than non-Indigenous children. This compares to the Australian rate of Indigenous children in out of home care being 11 times higher than non-Indigenous children.

Victoria's rate of Indigenous children in care is also significantly higher than NSW and the Australian average.

Appendix 2 provides an overview of Victoria's out of home (State) care system

[1] AIHW, Data tables: Child Protection Australia 2017-18

Families, children and young people in or at risk of child protection: A snapshot

A statistical snapshot [1] **:**

- Over 43,000 children and young people received child protection services in 2017-18, over a quarter of whom received out of home care services.
- For out of home care, 29% of children were under 5 years and a total of 56% were under 10 years.
- For Aboriginal families the picture is stark. 39.9 Aboriginal children in every 1,000 were admitted to out of home care. This rises to 96 in every 1,000 for infants under 1 years.

For the purpose of this paper, families, children and young people in or at risk of child protection have been classified under 3 key stages (see figure 1):

1. **Families at risk** and who need additional family and individual supports to prevent abuse and neglect that leads to child protection involvement.
2. **Families involved with child protection** through a notification, which may have led to investigation, substantiation and possibly the first stages of removal from family.
3. **Children in long term care or transitioning from care**, which includes children and young people in kinship care, home-based care or residential care as well as children and young people returning home or ageing out of care.

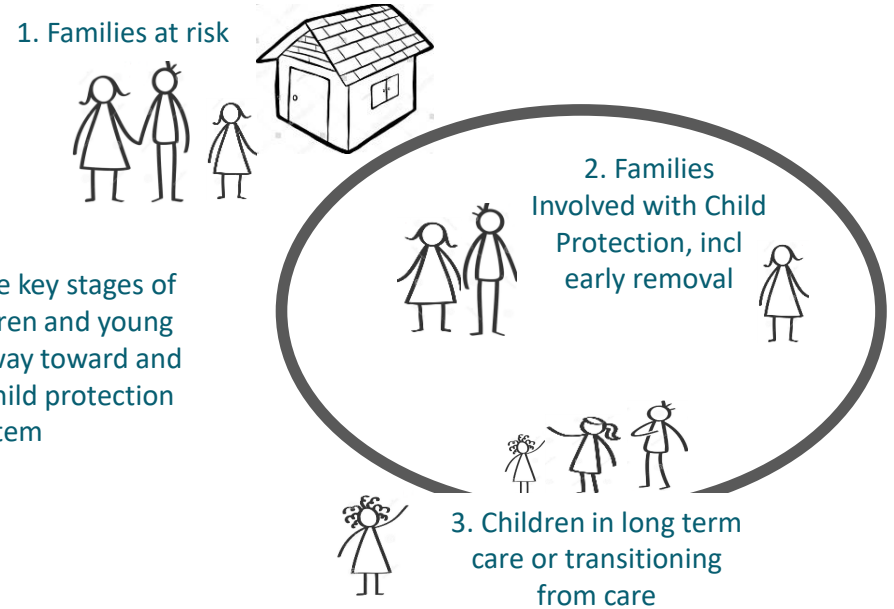


Figure 1: Three key stages of families, children and young people's pathway toward and through the child protection system

Overview of government investment and actions that are working or showing promise for families in need

- Record investment in prevention approaches, including enhanced maternal and child health services, 3-year old kinder, and early parenting centres, which aim to support children and families to thrive.
- Introduction of Child Safe Standards to prevent and mitigate risk of physical and sexual abuse of children and young people, particularly those in out of home care.
- Victoria's statewide specialist mental health services – Take Two and recent investments in family violence therapeutic interventions, which have been designed to provide specialised, therapeutic responses to people experiencing significant trauma from violence, abuse and neglect.
- The Orange Door (Support and Safety Hubs) and Information Sharing Schemes, which have been designed to strengthen support and safety for children and families.
- The shift to self-determination by Aboriginal communities, including delegation under section 18 of the Children, Youth and Families Act 2005 and strengthening the capacity of Aboriginal Community Controlled Organisations to provide care to Aboriginal children and young people.

[1] AIHW, Data tables: Child Protection Australia 2017-18

8

How the mental health and child protection systems are failing **families at risk**

The human faces:

Vulnerable families at risk or under stress are often characterised by:

- Previous individual, parent or family experience of disadvantage, trauma and child protection.
- A parent with a mental illness who needs additional medical and community service supports to ensure the family is safe and thriving.
- Limited capacity to navigate the complex mix of systems that together would deliver the support the family needs to stay healthy, safe and well.
- Facing barriers to getting assistance with support needs early in the episode, including limited service options, resulting in disconnection and an escalation of issues.

What's working & what has promise:

In addition to the investments and actions outlined on page 5 -

- Moves to shift attention and investment to promising, evidence-informed and evidence-based intervention
- Increased focus on mental health first aid across universal platforms, such as through schools and local community groups.

The systems failures:

Overarching

- Ineffective assessment, navigation and engagement approaches to ensure timely access to the right services by families.
- Insufficient attention to the family unit at key intervention points. For example, treatment of a parent's mental illness is focused on their individual needs and available options, without due regard or focus to their role as parent and connection to their child.
- Absence of targeted therapeutic interventions for infants and primary school children that would repair attachment relationships with their parents or other key adults in their lives.
- Limited availability and accessibility of services in regional areas, resulting in significantly higher rates of children being in out of home care.

Primary mental health system (MBS-funded mental health plan services)

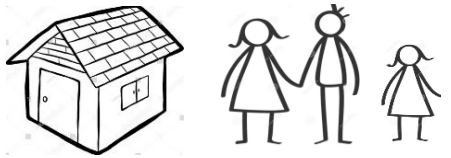
- Barriers to access by parents and families with lower incomes or higher levels of disadvantage and complexity, including cost barriers to private psychiatry and psychology services and availability of appropriately skilled mental health clinicians to address the complexities of these families.
- Programs, such as Headspace, not adequately servicing young people in or with histories of State care, including failure of the model to actively engage this often complex and disengaged group.

Victorian mental health system (including Child and Adolescent and Adult Mental Health Services)

- The VMHS's orientation to the most complex cases means that early intervention opportunities are lost even though the benefits of intervention outweigh the costs.
- Inadequate service models in the Adult MHS which fail to consider their patient's role as parents.

Child protection and other service systems

- Lack of evidence-based therapeutic and treatment options targeted to families prior to break down and experiences of abuse and neglect. For example, a program like Take Two does not extend to this group.
- Lack of an integrated outcomes focus across the child protection and mental health systems, resulting in risk-based approaches that miss opportunities to intervene early.



Families at risk

9

How the mental health and child protection systems are failing **families involved with child protection, including early stages of removal from family**

The human faces:

For families engaged with child protection and in the early stages of removal there can be fear and stigma. This adds to stresses and there is often an adversarial relationship with child protection. This is further exacerbated by the court system, compromising the potential for positive change in the family by the child protection intervention.

The children involved – particularly in the first stages after removal from family - experience anxiety and confusion around the separation, even in instances where they are placed in environments that provide substantially better safety and care. This can create disrupted attachments, internalisation of fault by the child, and a lack of perceived safety and stability for the child, all which contribute to long term poor mental health outcomes.

What's working and what has promise:

Victorian mental health system

- Specialisation in perinatal mental health.

Child protection and other service systems

- Promising programs, such as Circle (Therapeutic Foster Care), Stronger Families and the Teaching Families Model.
- Implementation of evidence informed practice approaches in Take Two, the statewide intensive mental health service for children experiencing trauma from abuse and neglect.

The system failures:

Overarching

- Failure to provide timely responses that are agile and are available and accessible when parents, children and families are ready to act.
- Workforce knowledge and clear, effective referral and collaborative pathways between the mental health and child protection systems.
- Limited availability of services or inadequate funding models in regional settings, where service, workforce and transport availability is an issue.

Primary mental health system

- Barriers to access by parents and families at a time of heightened stresses, including cost barriers and limited availability of appropriately skilled mental health clinicians

Victorian mental health system (includes CAMHS and AMHS)

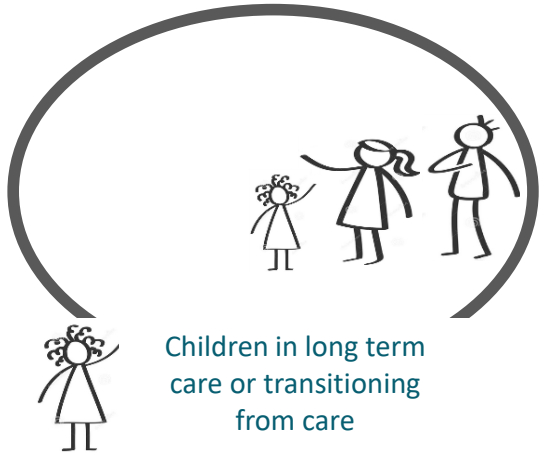
- Lack of inclusive and culturally safe practices, resulting in barriers to access and engagement by Aboriginal and diverse communities.
- Inadequate responses to children and young people on youth justice orders, especially females with mental illness that have led to justice involvement
- Limited adoption of evidence-informed therapeutic and treatment models across the mental health system that are effective for children and young people experiencing significant trauma.

Child protection and other service systems

- Insufficient funding to deliver family-oriented therapeutic interventions when families, children and young people are exhibiting warning signs of family breakdown, trauma and mental health symptoms, which have resulted in child protection involvement.
- Lack of attention and investment in evidence-base, outcome-focused preservation and reunification support services when families are first engaged with child protection or at the early stages of removal from family.
- Insufficient investment and effort to ensure practice compliance with the Aboriginal Child Placement Principles.
- Lack of practice attention to the childhood trauma associated with disconnection from peers, school and neighbourhood, which further exacerbates children and young people's vulnerability, loss and risk of mental health problems.

10

How the mental health and child protection systems are failing **children in long-term care or transitioning from care**



The human faces:

In 2017-18 over 3,700 children were in long-term care. Of these, almost 1,500 were under 10 and over 1,000 were Indigenous. Only a small proportion of children in out of home care are in residential care. However, 100% of children in residential care will be struggling with trauma. They also have higher prevalence of diagnosed mental illness (19%); intellectual, developmental or learning difficulties (24%); suicidal ideations or attempts (14%); substance misuse (45%); self harming (22%); justice connection (39%); and disengagement from education (53%) [1].

Once leaving care, young people who suffer child abuse and neglect are over represented in the youth justice system, are over represented in homelessness services and are at substantially higher risk of long-term mental health issues than those young people who have not been in care.

What's working and what has promise:

Child protection and other service systems

- Service approaches that seek to address the issues that underpin behavioural presentations rather than over-rely on prescription of psychotropic drugs to manage behaviours of young people in care.
- The South Initiative which is testing nine innovative service models for children and young people in, or at risk of entering, care services.
- Roll out of promising practice models, such as the Teaching Families Model, across residential care services.
- Adoption of evidence informed practice approaches in Take Two, the statewide intensive mental health service for children experiencing trauma from abuse and neglect.

The system failures:

Overarching

- Young people in care have cited they can't access all the services needed in care, particularly help with mental health issues.
- Restrictive eligibility requirements, long wait list and limited capacity of the mental health system to work with clients with high need are a concern.
- Availability and accessibility of services in regional settings.

Victorian mental health systems

- Absence of informed and appropriate therapeutic and treatment models that take into account the child's experience of care.
- Lack of adequate responses to children and young people in out of home care, particularly residential care, who present to Emergency Departments due to self-harm and suicidal ideations.
- Children and young people are being admitted to secure welfare is a result of failures of the child and adolescent mental health and child protection systems to work in an integrated and effective way.

Child protection and other service systems

- Inadequate family-focus in the delivery of out of home care, with a view to family reconnection or reunification.
- Absence of an adequate therapeutic response to primary school aged children and limits to evidence informed practices for some cohorts within this group.
- Inadequate evidence informed supports available to support children leaving care, particularly to address ongoing issues of trauma and mental illness associated with abuse, neglect and experiences of care, and set up protective factors that allow young people to thrive in adulthood.

[1] Berry Street's 2018 residential care census

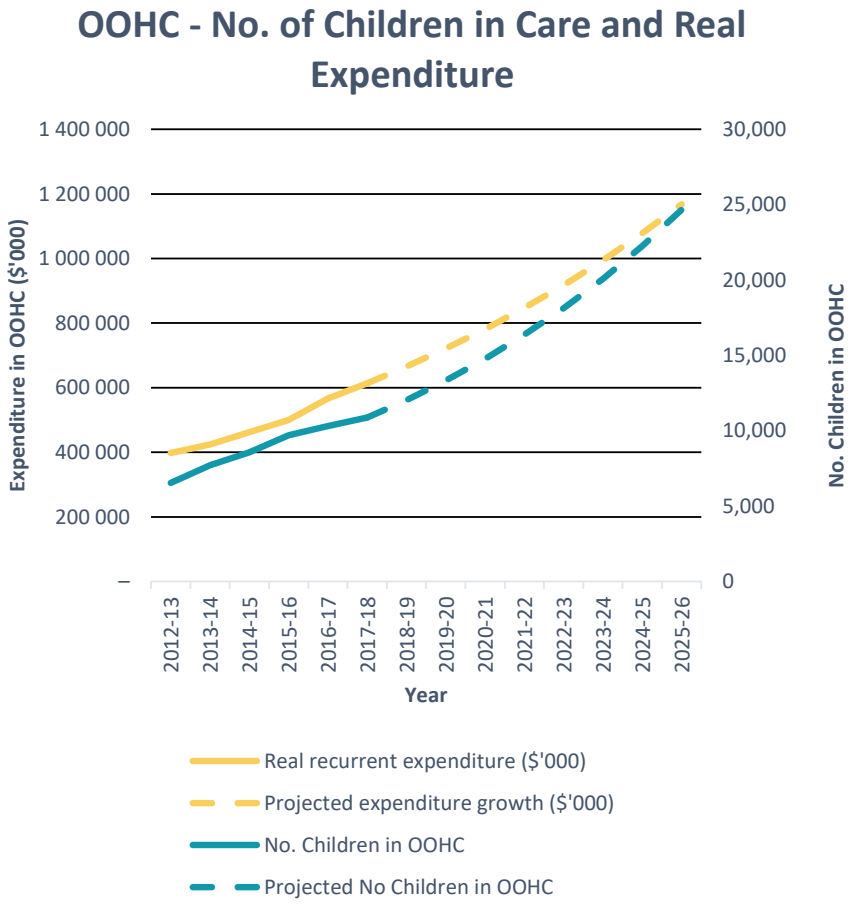
Impact of mental health and child protection systems failures

Unsustainable growth in number of children and young people in State care, meaning there is an imperative to invest differently

Over 10,000 children and young people who have experienced significant forms of neglect, abuse and trauma were in statutory care in Victoria in 2017-18. **If the numbers continue to grow at this rate, this figure will reach almost 25,000 by 2025-26.** The story of Aboriginal families, children and young people is particularly stark, with growth of 77% between January 2015 to December 2018. **At this rate of growth, over 6,000 Aboriginal children and young people will be in care by 2025-26.**

The system cannot sustain the investment required to just maintain status quo in an increasingly fiscally constrained environment. Government allocated $ 1.47 billion in the Child Protection, family services and family violence systems alone under the Children and Families output in 2018-19.

Based on the Report on Government Services (ROGS), Victoria spent almost $0.5b on OOHC in 2016-17. To maintain service levels government would need to invest over $1b in 2025-26 based on 2016-17 dollar values.



2. Opportunity to focus on key areas that will make a real and lasting impact

The Royal Commission should examine three key focus areas to improve mental health outcomes for families, children and young people in or at risk of State care

Government needs to invest where it can make the biggest impact and reimagine the future

Families, children and young people involved with child protection are a small but significant group of high volume users of high cost health, community and justice services. The intersections between mental illness, poor mental health and childhood abuse and trauma are considerable and the social and economic costs for community and the government are substantial.

As statutory parent, the government has direct responsibility to the children and young people in out of home care, but it is currently failing in some cases to secure their general well-being and good mental health. The current overall child protection system design exacerbates trauma and poor mental health outcomes for whole families. The result is a significantly higher lifelong risk of mental illness.

There's a need to reimagine the future and reorient the response to children and families toward early intervention, particularly across the family services, child protection, mental health and related service systems. The focus should be on (1) supporting 'at risk' families to stay together safely; (2) ensuring where child protection services are involved, effective interventions are in place to minimise the duration and impact of the experience for both the child and family, and; (3) preventing intergenerational experiences of trauma, mental illness and disadvantage.

Addressing this issue requires action across multiple government-funded systems and a stronger focus on evidence-informed practices and programs. There needs to be substantial shifts across the mental health and child protection systems to:

1. Invest in well-targeted, evidence-informed early intervention services that focus on family strengthening and preservation.
2. Invest and reform to create more connected, family-centred, responsive and effective mental health and child protection systems that deliver positive mental health outcomes for families, children and young people.
3. Strengthen system and workforce capability across the mental health and child protection systems to intervene early and effectively to prevent a cycle of disadvantage.

Appendix 3 provides a list of promising, evidence-informed and evidence-based practices that Berry Street asserts the Royal Commission should examine.

FOCUS AREA 1
Invest in well-targeted, evidence-informed early intervention services that focus on family strengthening and preservation

Presently, opportunities are lost to actively and effectively target, engage and respond to high risk families who are vulnerable to, or experiencing signs of, abuse and neglect. This leads to an exacerbation of trauma and poor mental health. While some good practice has been adopted and promising investments have been made in recent years, gaps exist in the system meaning that parents, families, children and young people cannot access a timely and effective response.

Berry Street asserts that there is a need to significantly shift focus and investment to evidence-informed early interventions. This means: (1) actively identifying and engaging families at risk; (2) providing a timely, effective and holistic responses before family breakdown; and (3) preventing intergenerational trauma by ensuring that young people leaving care are empowered to thrive.

The system needs to:

1. Ensure universal platforms, such as Maternal and Child Health Services, general practitioners and schools, are equipped and leveraged to actively identify, engage and appropriately refer high risk families to effective early intervention services in the mental health and family services systems.
2. Adopt appropriate family-centred assessment and practice models across mental health services and within child protection that help link families to effective supports that prevent trauma or escalation of mental health issues.
3. Invest in well-targeted, evidence-informed early intervention services that focus on family strengthening and preservation.
4. Bolster evidence-informed, early intervention services aimed at the point of pre-conception to the first 1000 days.
5. Continue to reorient and significantly increase investment in better support for children leaving care, enabling them to thrive and reduce risk of intergenerational engagement with the child protection and mental health service systems.
6. Continue to move toward self-determination by Aboriginal communities, ensuring that Aboriginal Community Controlled Organisations are sufficiently funded to deliver a suite of early intervention responses.
7. Be designed to be responsive to the particular needs of families from diverse communities, including culturally and linguistically diverse communities, LGBTQI-identifying families and individuals, and refugees and asylum seekers.

FOCUS AREA 2
Invest and reform to create more connected, responsive and evidence-informed mental health and child protection systems

The mental health and child protection systems are currently breaking down for children, young people and families involved with child protection. Families are not getting the support and treatment they need to minimise the trauma and adverse impacts of family separations, mental illness and other markers of disadvantage.

Berry Street asserts that there is a need to better connect the mental health, family services and child protection systems. There is also a need to invest in evidence-informed programs and practices across both systems that are timely and help families to recover from trauma and set them up to be hopeful and thrive.

This means (1) improving connections and referral pathways across the primary and specialist mental health and child protection systems; (2) adopting family-focused, evidence-informed support and therapeutic practice models across both systems, and; (3) investing at sufficient scale to ensure mental health, family services and child protection responses are timely in order to maximise opportunity and impact.

The system needs to:

1. Strengthen referral pathways and processes between the child protection system and the specialist and primary mental health service systems.
2. Increase focus on family-oriented care across primary and specialist mental health services (including Adult, Mother-Infant and Child and Adolescent Mental Health Services), ensuring that impact on children is considered as part of work with Adults who are parents.
3. Improve specialist acute mental health responses (including providing a diversity of responses, such as out-reach responses, through Child and Adolescent Mental Health Services and headspace) to children and young people in or post care who are experiencing a combination of mental illness, significant trauma and behavioural issues (including engagement with the justice system).
4. Expand delivery of evidence-informed recovery-focused therapeutic and treatment services (such as Take Two) to more young people in care, including primary school aged children in residential care who currently miss out on a service until issues intensify.
5. Adopt evidence-informed support, therapeutic and treatment approaches that strengthen the focus of recovery on family preservation and family reunification, to address trauma and reduce the significant lifelong risk of mental illness (including expansion of programs like Safer Families across the state).
6. Strengthen supports, including providing wrap around responses, to preserve kinship and foster care placements for children with multiple and complex needs, coupled with significant experiences of trauma and lifelong risks of mental illness.
7. Explore peer-based parent advocacy and support models to empower parents to address issues and engage with the child protection and the mental health systems with a focus on achieving family preservation and reunification.
8. Strengthen assessment processes to ensure that children entering out of home care for the first time receive a timely comprehensive assessment of their developmental and mental health needs to enable appropriate care planning, placement support and well-targeted therapeutic responses that may support family reunification.

FOCUS AREA 3
Strengthen system and workforce capability across the mental health and child protection systems to intervene early and effectively and prevent a cycle of disadvantage

Reorienting the mental health and child protection systems toward earlier intervention and prevention for at risk families, children and young people will require robust systems and a shift in workforce capability.

Significant work has already been undertaken across the community services sectors to plan transition of systems and workforces in line with the significant reforms underway. Led by its peak body – the Centre for Excellence in Child and Family Welfare (the Centre) – the child and families sector has already developed a plan to transition from a service system focused on crisis response to one characterised by early intervention, evidence-informed practice, and a more seamless responses to meet the needs of children, young people and families.

Berry Street asserts that there is a need to build on this work and extend this focus on system-wide reform and transition to the primary and specialist mental health sectors. This means (1) strengthening workforce capabilities to deliver family-centred, culturally-appropriate and evidence informed interventions (2) reforming funding models and approaches to enable delivery of outcomes; and (3) enabling oversight through improved outcome-focused data analysis and reporting.

The system needs to:

1. Strengthen training (including joint training opportunities) across the mental health and child protection systems to strengthen family-focused, evidence-informed practice.
2. Ensure professional supervision in the mental health service systems (whether adult, mother-infant or child and adolescent-focused) supports a family centred and trauma informed mindset.
3. Ensure that funding models and allocation approaches take appropriate account of true costs of delivery based on local conditions, including regional location, socio-economic status, availability of complementary and alternative services.
4. Enable data collection, reporting and analysis to better support integrated service planning and coordination across the mental health and child protection systems.
5. Be designed, funded and monitored in a way that enhances cultural responsiveness and inclusion of diversity.
6. Expand the focus of Child Safe Standards to also protect the safety of childhood mental health and wellbeing, particularly children and young people in out of home care.

3. Appendices

Appendix 1
Overview of Take Two: Victoria's statewide intensive, mental health service for children experiencing trauma from abuse and neglect

Take Two is an intensive multidisciplinary mental health service using evidence-informed clinical practices and expertise in child development to address the underlying traumas and mental health issues of children (under 18 years) who have suffered severe abuse, neglect or disrupted attachment. Addressing the mental health issues of traumatised children and young people who may still be feeling disconnected and unsafe, requires a specialist response. There are significant opportunities to learn from Take Two and expand the model.

Consistent with the government's tender for the intensive therapeutic treatment service in 2002-03 the purpose of Take Two is –

> "to significantly enhance the emotional and behavioural functioning, safety and wellbeing of children and young people subject to Child Protection intervention who have been identified as requiring specialist therapeutic and treatment interventions due to the aftermath of abuse and / or neglect."

The response is designed to complement the Child and Adolescent Mental Health System , which responds to acute mental health presentations.

Key features include:

- A flexible outreach service delivery model, enabling it to work in locations that best suit the child/young person
- ability to engage the families and carers as well as the child/young person it works with to address the underlying traumas and mental health issues rather than the behaviours exhibited at the surface.
- Use of a therapeutic approach across all stages of the engagement, including referral and intake, engagement and assessment, goal and intervention planning, therapeutic intervention, review and planning for closure, case closure.
- Use of a range of evidence informed clinical tools and interventions. This includes the Neurosequential Model of Therapeutics (NMT), child psychotherapy, family work, child-focussed parent therapy, play, art-therapy, music-therapy, somatosensory activities, care team conferences and psycho-education for carers.
- its multidisciplinary team of allied health clinicians (psychologists, occupational therapists, family therapists and social workers) working alongside clinical expertise held internally and with partner agencies (infant mental health specialists, dedicated Aboriginal children and young people.

Take Two responds to children in the child protection system and predominantly works with children in out of home care, although it does a small amount of work with children living with their families.

A recent evaluation found that:

- The average age of a Take Two client on first referral is 9 years. The client group spans infants (20%), children (50%) and youth (30%).
- 24% of the clients are Aboriginal.
- only 25% of initial contacts with Take Two focus on Family preservation or restoration. The remainder focus on supporting and safety placement activities.
- 76% of clients only receive 1 episode of care at an average duration of 14.5 months.
- For the remaining 24% who receive multiple engagement with Take Two, there continues to be a predominant focus on placement planning & support (64% of its activity). Family preservation (18%), specialist assessment (15%), and family restoration (3%) continue to have less of a focus.

Outcomes

Over the past three years it was found that 86 per cent of children show stabilisation or improvement in overall functioning following Take Two involvement.

This includes:

a. 98 per cent showing stabilisation or improvement in self-harm behaviours,

b. about one-third displaying improvement in school attendance, and

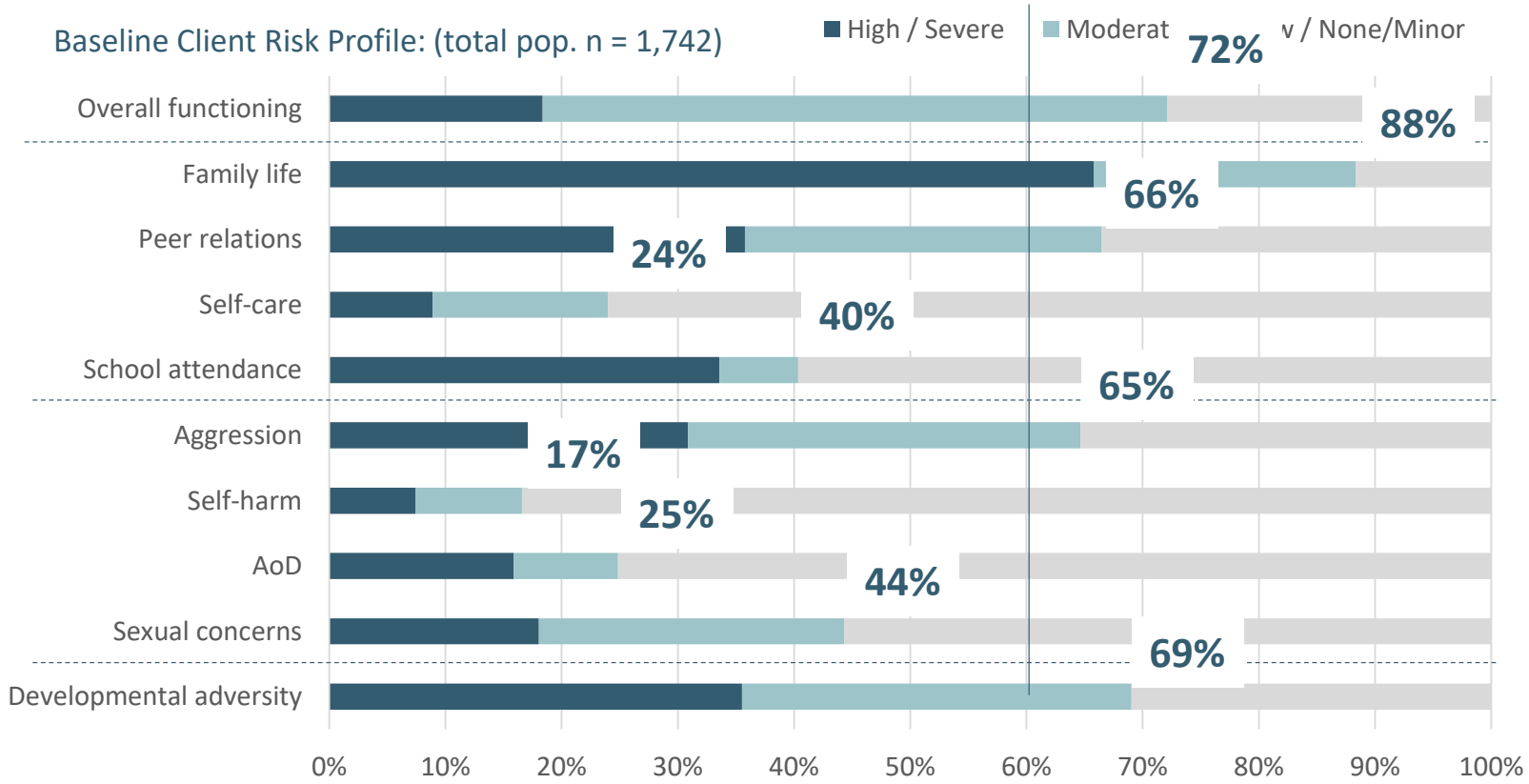
c. more than one-third showing improved self-care skills.

Further details about outcomes achieved through Take Two are set out on the next few slides.

Take Two's therapeutic service model has been found by the Murdoch Children's Research Institute to be a 'Promising Program' and is being evaluated by Harvard University (using a randomised control trial funded by Department Prime Minister and Cabinet) with the goal of being recognised as an evidence-based program.

Appendix 1
Overview of Take Two: Victoria's statewide intensive, mental health service for children experiencing trauma from abuse and neglect cont

A significant proportion of the children Take Two supports present with severe to moderate issues in relation to their overall functioning, family & peer relationships & behaviour



No.	% Pop.
713	41%
713	41%
713	41%
709	41%
706	40%
713	41%
711	41%
712	41%
255	15%
197	11%

** Overall functioning and relational capacity is an issue for most of the children Take Two works with, as is aggressive behaviour

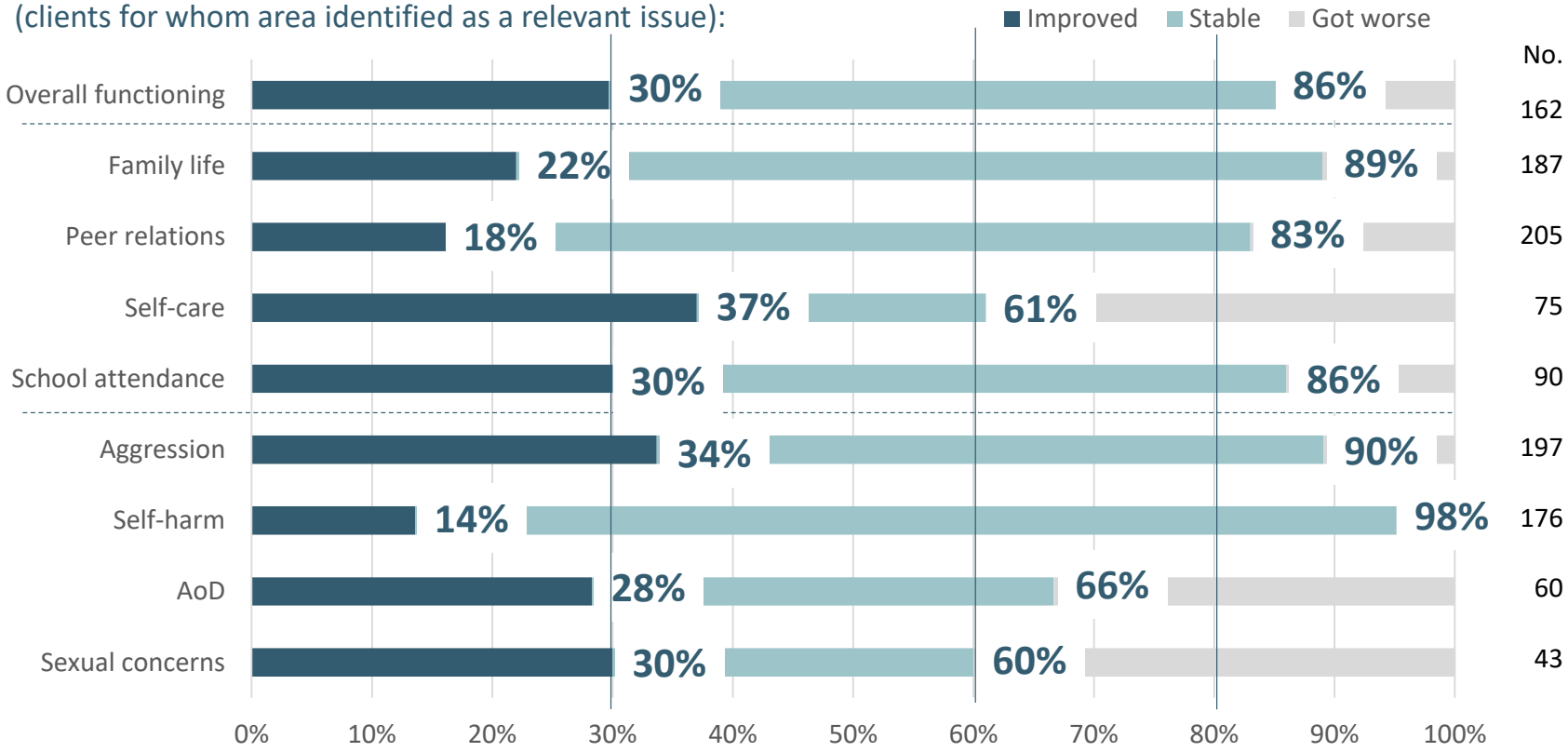
** Self-care and other behavioural issues are areas of concern for a smaller but still significant proportion of children

Source: Initial (baseline) assessment Developmental Adversity NMT = Neuro Model of Therapeutics; Sexual Concerns TSCYC = Trauma Symptom Checklist for Young Children & TSCC = Trauma Symptom Checklist for Children; all other parameters HoNOSCA = Health of the Nation Outcome Scales

Appendix 1
Overview of Take Two: Victoria's statewide intensive, mental health service for children experiencing trauma from abuse and neglect cont.

Review assessments indicate that a significant proportion of children improve or stabilise their status after accessing support from Take Two

Status Against Key Functioning, Relationship & Behavioural Parameters (clients for whom area identified as a relevant issue):



** The lower stabilisation rate for self-care is understandable given the changing context in which a number of children are living and the fact that many are adjusting to life in care

** The figures relating to AOD use and sexual concerns reflect the complexity of those issues

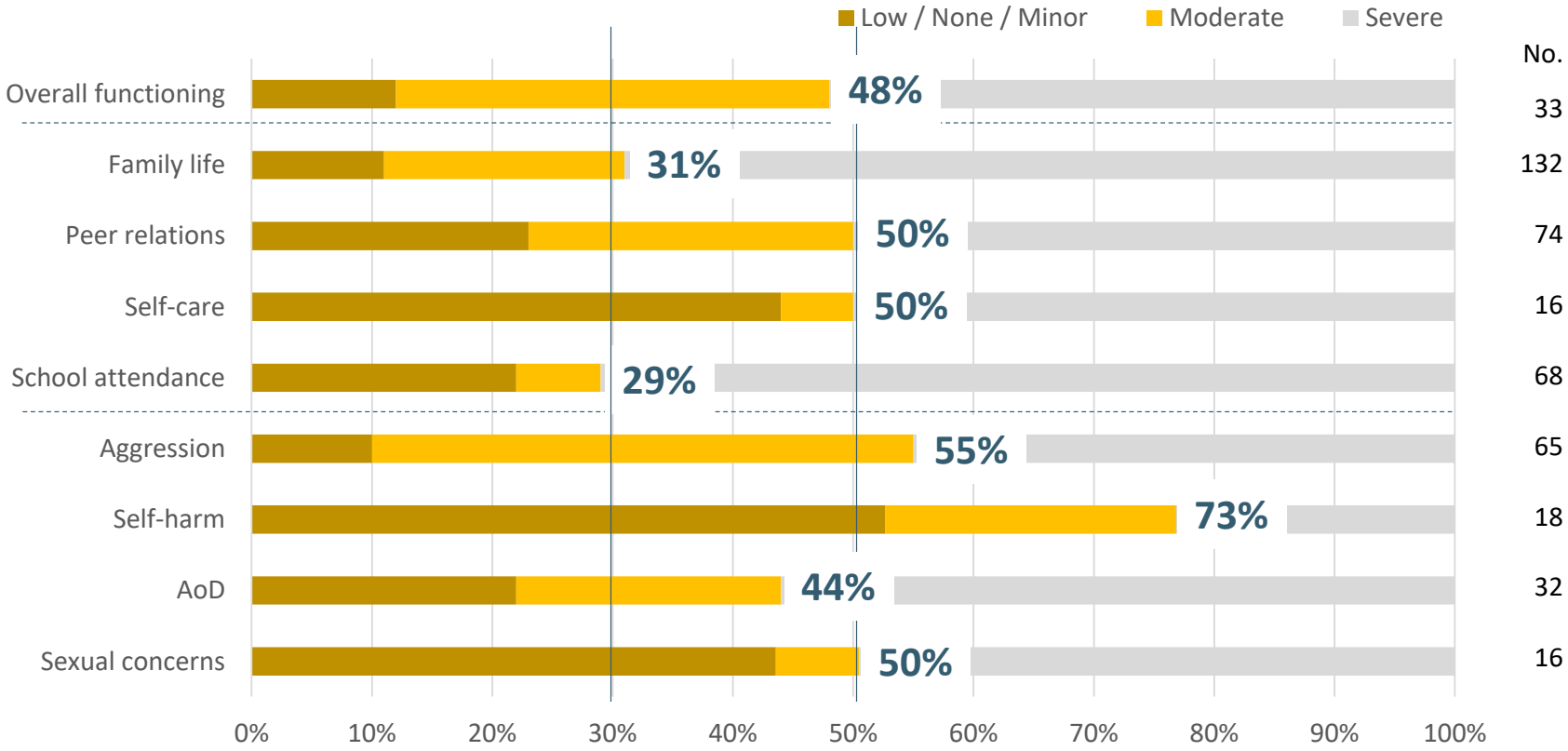
(1) Only includes review assessments conducted up until May 2017

Source: Initial (baseline) assessment Developmental Adversity NMT = Neuro Model of Therapeutics; Sexual Concerns TSCYC = Trauma Symptom Checklist for Young Children & TSCC = Trauma Symptom Checklist for Children; all other parameters HoNOSCA = Health of the Nation Outcome Scales

Appendix 1
Overview of Take Two: Victoria's statewide intensive, mental health service for children experiencing trauma from abuse and neglect cont.

Higher risk children initially assessed as having severe issues show particular improvement

Assessed Status on Review for Clients for whom Issues were Identified as Severe on Initial Assessment:



(1) Only includes review assessments conducted up until May 2017
Source: Initial (baseline) assessment Developmental Adversity NMT = Neuro Model of Therapeutics; Sexual Concerns TSCYC = Trauma Symptom Checklist for Young Children & TSCC = Trauma Symptom Checklist for Children; all other parameters HoNOSCA = Health of the Nation Outcome Scales

Appendix 2
Overview of Victoria's Out of Home (State) Care System

OOHC is the placement of children and young people aged 0–17 years with alternate care givers when they are unable to live with their primary caregivers. Placements may be short or long term and may be informal or formal.

The *Children, Youth and Families Act 2005* (the Act) mandates that the State act to protect children. The Act vests oversight of formal (statutory) care in the Secretary for the Victorian Department of Health and Human Services (DHHS), including kinship, foster and residential care. It is an intervention of last resort in line with the National Framework for Protecting Australia's Children 2009–2020 (Council of Australian Governments, 2009).

Statutory Care

Kinship care

Placement of children with relatives (kin), with persons without a blood relation but who have a relationship with the child or family, or with persons from the child's or family's community

Foster care

Placement of children in the home of a carer who is not a blood relation or connected with the child's family or community and the carer is reimbursed for expenses for the care of the child

Residential care

Placement of children in a residential building staffed by paid workers and which is intended to provide placements for children not able to be placed in home-based care arrangements.

Third party parental (permanent) care

Placement of children in a permanent care arrangement with a non-family member

	Kinship care	Foster care	Residential care	Third party parental (permanent) care
No. in 2017/18	5,493	1,618	421	3,000+[1]
% change since 30 June 2015	+16.7%	+9.5%	-4.0%	N/A
Aboriginal – No. in 2017-18	←	1,702	→	N/A

[1] Estimate based on previous year. Victoria no longer reports to the AIHW on third party parental care arrangements

Appendix 3
Promising, evidence-informed and evidence-based practice

As part of the Victorian Government's Roadmap to Reform, there has been increasing focus on adopting evidence-informed practice. Some international jurisdictions, such as New York State, have taken this further, ensuring they only invest in evidence-informed or evidence-based support, treatment and therapeutic models.

There are many evidence informed service models, focused on delivery of family support, therapeutic interventions and clinical enhancements.

Berry Street asserts the Royal Commission should examine the following:

Family Support: encompassing case management, resource navigation, parenting/caregiver psychoeducation

- Common Elements Approach
- KEEP: Keeping Foster Parents Trained and Supported
- Tuning Into Kids™ and Tuning Into Teens™
- Triple P®

Clinical enhancements: encompassing enhancements that sit alongside evidence-informed family support and treatment

- Brief Relational Intervention & Screening (BRISC)

Therapeutic and treatment programs: encompassing high-intensity intervention models tailored to child/family needs

- Child-parent Psychotherapy (CPP)
- Functional Family Therapy (FFT)
- Functional Family Therapy-Child Welfare®
- Multisystemic therapy for child abuse and neglect (MST-CAN)
- Multisystemic therapy (MST)
- SafeCare®
- Take Two

Appendix 4
Key research and literature

Berry Street's subsequent submission will set out the case for change and business case to support the proposed three focus areas in more detail. We will draw on research and literature including:

- Australian Institute of Health and Welfare (AIHW). (2019). *Child protection Australia 2017–18* (Child welfare series no. 68. Cat. no. CWS 63). Canberra: AIHW.
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- Muir, S. and Hand, K. (2018). *Beyond 18: The Longitudinal Study on Leaving Care Wave 1 Research Report: Transition planning and preparation.* (Research Report). Melbourne: Australian Institute of Family Studies.
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- Raman, S., Inder, B., & Forbes, C. (2005). *Investing for success: The economics of supporting young people leaving care*. Melbourne: Centre for Excellence in Child and Family Welfare.

Appendix 4
Key research and literature cont.

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