Submission to the Royal Commission into Victoria's Mental Health System

CCYPD/19/7685

COMMISSION FOR CHILDREN AND YOUNG PEOPLE

The Commission respectfully acknowledges and celebrates the Traditional Owners of the lands throughout Victoria and pays its respects to their Elders, children and young people of past, current and future generations.

The term ‘Aboriginal’ used in this submission refers to both Aboriginal and Torres Strait Islander individuals, people and communities. ‘Indigenous’ or ‘Koori/Koorie’ is retained when it is part of the title of a report, program or quotation.

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Introduction

The Commission for Children and Young People (the Commission) welcomes the opportunity to make this submission to the Royal Commission into Victoria's Mental Health System. It is well established that child and youth mental health warrant particular and urgent attention. The United Nations Convention on the Rights of the Child requires us to ensure that every child has the right to 'the highest attainable standard of health'.[1] The mental health service systems for children and adolescents require significant reform and expansion, as the Victorian Auditor-General has recently shown.[2]

This Royal Commission is important for Victoria's children and young people. Intentional self-harm, including suicide, was the leading cause of death of Victorian adolescents aged 15 to 17 years in 2017.[3] Mental health problems commonly manifest prior to adulthood; 'more than half of lifetime mental illness' develops before the age of 14 years[4] and three-quarters begin before the age of 24 years.[5] The Royal Commission has already heard about the prevalence of mental illness in children – one in seven children and adolescents aged four to 17 years 'have been assessed as having mental disorders in the previous 12 months'[6] – and about the dramatic increase in 'young people with mental disorders and mental health symptoms' presenting to the Royal Children's Hospital Emergency Department.[7] One in four Australians aged 16 to 24 years experience a mental health condition.[8] Victorian children and young people aged 15 to 19 years have identified mental health as among the top three personal issues they are most concerned about,[9] and as *the* most important issue in Australia today.[10] Any successful reform program arising from this Royal Commission, must address the antecedents of mental ill-health, which requires prevention efforts that target children and young people, starting with the early years.

The likelihood of mental ill-health increases exponentially where other 'indicators of vulnerability' are present, as highlighted by the Victorian Auditor-General in his recent report on child and youth mental health.[11] This is borne out by the Commission's experience discharging its core functions, which focus on vulnerable children, including those in the child protection, out-of-home care and youth justice custody systems.[12] The Commission's experience is that these children and young people not only experience more mental ill-

1 United Nations Convention on the Rights of the Child, Article 24.
2 See Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*.
3 Consultative Council on Obstetric and Paediatric Mortality and Morbidity 2019, *Victoria's Mothers, Babies and Children 2017*, page 64.
4 See, for example, National Mental Health Commission 2018, *Monitoring mental health and suicide prevention reform: National Report 2018*, page 47.
5 See, for example, Fusar-Poli, P 2019, 'Integrated Mental Health Services for the Developmental Period (0 to 25 years): A Critical Review of the Evidence', *Frontiers in Psychiatry*, Volume 10, Article 355.
6 Lawrence, D, Johnson, S, Hafekost, J, Boterhoven De Haan, K, Sawyer, M, Ainley, J & Zubrick SR 2015, *The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Department of Health, Canberra.
7 Evidence of Dr Richard Haslam, 5 July 2019, page 304 (lines 4-8); page 308 (lines 13-23); page 309 (lines 23-29).
8 ABS 2007, *National Survey of Mental Health and Wellbeing: Sumary of results*, cat. No. 4326.0, Australian Bureau of Statistics, Canberra.
9 Mission Australia, *Youth Survey Report 2018*, pages 159-160.
10 Mission Australia, *Youth Survey Report 2018*, pages 165-166.
11 Victorian Auditor-General's Report, *Child and Youth Mental Health*, June 2019, page 7. VAGO provides the following examples of vulnerability indicators: neglect, abuse, poverty, housing instability, intergenerational trauma and developmental disabilities.
12 **Attachment A** outlines the Commission's statutory role and key areas of focus.

health (as data shows), but they are also more likely to face particular challenges obtaining appropriate mental health support.

This submission sets out the Commission's insights into the drivers of mental ill-health for children and young people in these cohorts, their mental health needs and the extent to which the current service system meets these needs. Many of the issues experienced by children and young people involved with the child protection, out-of-home care or youth justice custody systems reflect broader problems affecting all children and young people with mental health issues.

Children and young people subjected to child abuse or neglect are particularly vulnerable,[13] and there is a clear association between childhood trauma and adverse mental health outcomes for children and young people, as demonstrated through the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia.[14] While there are a number of drivers of mental ill-health, this submission will focus on those connected with adverse experiences in childhood; it is the Commission's view that the prevention of mental illness must include a focus on preventing, and supporting recovery from, adverse childhood experiences.

Aboriginal children and young people's mental health outcomes are significantly worse than their non-Aboriginal peers, with suicide rates four times as high.[15] Like other First Nations children, Aboriginal children and young people continue to be disproportionately impacted in their developmental years by negative outcomes in key domains such as maternal, physical and mental health, homelessness and intergenerational trauma. The Commission's unique vantage point, as one of only two jurisdictions in Australia with a Commissioner for Aboriginal Children and Young People, has enabled it to champion structural change, including applying the learnings from Taskforce 1000,[16] the current Koori Youth Justice Taskforce and related independent Commission inquiry,[17] and the holistic approach to supporting Aboriginal young people's social and emotional wellbeing outlined in *Balit Murrup* – Victoria's Aboriginal social and emotional wellbeing framework.[18]

More broadly, in her discussions with children and young people throughout the state, mental health issues are the single most common concern raised with the Principal Commissioner. The Commission has also spoken with a small number of young people in some depth specifically for this submission. Their perspectives on the Royal Commission's

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13 Child abuse includes including sexual abuse, physical violence, behaviour that causes significant emotional or psychological harm and significant neglect.

14 The Commission administers two regulatory schemes – Child Safe Standards and the Reportable Conduct Scheme – that are intended to ensure that the safety of children sits at the centre of the organisations that care or interact with them. They do this by promoting child safety, preventing child abuse and independently overseeing responses to suspected child abuse. The Commission can provide further information about the schemes if this would assist the Royal Commission.

15 See, for example, the Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 82.

16 Taskforce 1000 was a systemic inquiry into services provided to Aboriginal children and young people in out of home care in Victoria. See the Commission's 2016 report, *Always was, always will be Koori children – systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria* (*Always was, always will be Koori children*).

17 The Koori Youth Justice Taskforce, which the Commission is undertaking jointly with the Department of Justice and Community Safety, is presently examining all Aboriginal children and young people involved with the youth justice system in Victoria. At the same time, the Commission is conducting an independent inquiry *Our youth, our way: Inquiry into the overrepresentation of Aboriginal children and young people in youth justice*.

18 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*.

questions, based on their own personal experiences of mental ill-health and of the mental health system, are set out in **Attachment B**. The Commission is pleased that the Royal Commission has already heard from young people, and encourages ongoing consultation with children and young people to understand their experiences, views and needs.

Overview of submission

The Commission has limited its submission to areas where it has particular insight and expertise based on its oversight, regulatory and inquiry functions. A summary of the Commission's response to questions is below:

- Question 2 (prevention and early intervention) – focuses on the need to prevent childhood trauma and adverse childhood experiences more broadly, to minimise their impact when they do occur, to use contact with the child protection and other statutory systems as opportunities for early intervention, and to respond holistically to 'indicators of vulnerability' and trauma.

- Question 4 (access to and experience of mental health support) – highlights service system issues affecting Victorian children and young people, including in particular those involved with the child protection, out-of-home care and youth justice custody systems, and Aboriginal children and young people.

- Question 9 (priority areas for reform) – sets out five priority areas for reform.

While the Commission has not addressed other questions, where young people consulted have provided a perspective on these questions based on their personal experiences, these are included in Attachment B.

Attachments

- Attachment A gives an overview of the Commission.

- Attachment B contains our interviews with young people for this submission (with identifying information removed).

Question 2

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Preventing adverse childhood experiences and trauma

While there are many drivers of mental ill-health, this submission will focus on those connected with adverse experiences in childhood. At the recent Australian Government-led roundtable on mental health and suicide prevention, there was strong support for a 'focus on prevention' related to 'support for children and families'.[19] The Commission agrees with this and considers that reforms to Victoria's mental health service system must be complemented by substantial and co-ordinated reform to, and investment in, prevention and early intervention efforts.

The connection between adverse childhood experiences (ACEs) and chronic diseases, mental ill-health and unhealthy behaviours such as offending and substance abuse in adulthood is now well established and supported by longitudinal research.[20] The majority of mental illness has its onset in childhood and adolescence,[21] and the first 1000 days of a person's life have been highlighted as a critical period for neurodevelopment. While social determinants influence the likelihood of mental illness developing across the life course, they are particularly critical during this first 1000 days, where a number of vital skills and abilities develop.[22] Academic research on children at risk of mental illness in Australia highlights the importance of the early years in the prevention of mental illness. Using data from the Longitudinal Study of Australian Children to estimate the prevalence of individual risk factors and the magnitude of multiple risk in children, researchers found critical opportunities to intervene at the earliest stage of the life course to prevent adult mental illness:

> In 12 infants, 1 has risk factors for adult mental illness and 1 in 40 has ⩾5 risk factors. By the time children are 10–11 years, 1 in 5 children have ⩾5 risk factors…We find that modifiable risk factors for adult mental illness occur at the earliest stage in the life course and at greater prevalence than is commonly recognised. Considerable capacity will be required in child and adolescent mental health services and complementary family support programmes if risk factors for adult mental illness that are already apparent in infancy and childhood are to be addressed.[23]

Building on this research the same group conducted a subsequent study to examine the level of mental health service delivery and expenditure on infants, children, adolescents and young people in Australia, finding:

> …the youngest age group are underserviced relative to need, even noting infants and children may receive services for behavioural/mental health issues from providers not captured in our study (such as paediatricians). The developmental origins of mental illness underlies the urgency of adequate provision by governments of perinatal, infant and child

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19 See National Mental Health Commission Media Release, *Government-led roundtable meeting to review investment to date in mental health and suicide prevention*, 5 June 2019.

20 See, for example, Centers for Disease Control and Prevention, Adverse Childhood Experiences (ACEs) at www.cdc.gov/ace.

21 More than half of mental illness develops before the age 14 years: see, for example, National Mental Health Commission 2018, *Monitoring mental health and suicide prevention reform: National Report 2018*, page 47.

22 See the National Mental Health Commission's Submission to the Productivity Commission's Mental Health Inquiry, page 5.

23 Guy, S, Furber, G, Leach, M, Segal, L 2016, 'How many children in Australia are at risk of adult mental illness?', *Australian & New Zealand Journal of Psychiatry*, Volume 50 Issue 12, pages 1146-1160.

mental health services to avoid loss of life potential and reduce the pressures on the justice, child protection and welfare systems.[24]

The Commission's work conducting inquiries into deaths of children involved with child protection, its systemic inquiries, and its oversight of the out-of-home care and youth justice custody systems in Victoria has identified missed opportunities for earlier positive and co-ordinated intervention in children's and young people's lives. This was particularly stark in the Commission's 2018 inquiry into cumulative harm and suicide.

Inquiry into issues of cumulative harm and suicide

In 2018 the Commission conducted an inquiry into cumulative harm and suicide, looking at 26 cases where children committed suicide and had Child Protection involvement in the year before they died. This systemic inquiry focussed on the extent to which Child Protection identified, understood and responded appropriately to the children's experiences of cumulative harm – the effect of experiencing multiple forms of abuse or maltreatment in childhood.[25] All 26 children had experienced multiple and recurring forms of abuse, including family violence (96 per cent of cases), neglect (77 per cent of cases) and emotional abuse (62 per cent of cases). Half of the children had been the subject of sexual abuse allegations. The majority of children had a parent with a mental illness,[26] problematic alcohol or other drug use[27] and/or their own history of childhood abuse,[28] showing the existence of intergenerational trauma. Most of the children were living at home with a parent when they died.[29] Their ages ranged from 13 to 16 years at the time of their deaths.

In general, the children had lengthy histories with Child Protection, sometimes from an early age.[30] Each report to Child Protection presented an opportunity for intervention to better protect the child or children involved, and to provide their families with the necessary support. However, these opportunities were missed for the 26 children studied in this inquiry. Instead, the majority of reports were closed at intake or investigation; where Child Protection made a referral to a voluntary services such as ChildFIRST, these referrals did not result in engagement with the families. Despite the persistent and often serious harm experienced by these children, the child protection system did not result in any effective intervention or change to the children's lives.

Cumulative harm can be devastating for children's physical and mental health and increase the risk of suicidality.[31] Mental ill-health and suicidal ideation and behaviour were prevalent among the 26 children. Around 70 per cent had a diagnosed mental illness and more than half had previously attempted suicide, while more were recorded as having expressed thoughts about suicide (69 per cent) and as having demonstrated self-harming behaviours

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24 See Segal, L, Guy, S, Furber G 2017, 'What is the current level of mental health service delivery and expenditure on infants, adolescents, and young people in Australia?' *Australian & New Zealand Journal of Psychiatry*, available at https://journals.sagepub.com/doi/full/10.1177/0004867417717796.

25 Victorian Government 2009, Cumulative Harm: A conceptual overview. Best Interests Series.

26 Eighteen of the 26 children – 69 per cent.

27 Seventeen of the 26 children – 65 per cent.

28 Fifteen of the 26 children – 58 per cent.

29 Nineteen of the 26 children – 73 per cent.

30 As reported in the Commission's 2017-18 Annual Report (page 27), the children came to the attention of Child Protection an average of seven times; the number of reports ranged from two to 25. More than 90 percent of the reports were closed at intake or investigation and two thirds were closed without any further action. Despite the complexity of the children's risk factors and vulnerabilities, only around ten percent of reports resulted in some level of protective intervention.

31 R Miller 2007, Cumulative harm, a conceptual overview, Victorian Government, Department of Human Services.

(77 per cent). Most of the children were recorded as having contact with mental health services (85 per cent). One child presented to various hospitals 14 times in a three-year period; five presentations followed a suicide attempt and nine involved suicidal ideation. All children were recorded as having experienced multiple factors associated with suicide.

The patterns identified in the cumulative harm and suicide inquiry, which examined child deaths from 2007 to 2015, continue to be seen by the Commission. As a result, the Commission is currently updating the report with additional analysis of the experiences of seven children who died by suicide between 2016 and 2019. The unfortunate theme across each child's case is one of 'missed opportunities' to address significant and persistent harm suffered from an early age.

The cost of these missed opportunities is substantial. As Orygen, The National Centre of Excellence in Youth Mental Health (Orygen) and Phoenix Australia outlined in their report on trauma and young people:

> Experiences of complex trauma in childhood, such as abuse and neglect, bear significant economic, as well as personal, costs. The Australian Childhood Foundation, Child Abuse Prevention Research Australia and Access Economics estimated that the cost of child abuse to the Australian community in 2007 was $10.7 billion, and as high as $30.1 billion. More recently, Pegasus Economics estimated that the cost impact of child abuse (sexual, emotional and physical) to the Australian and state/ territory governments could be a minimum of $6.8 billion annually, representing both government expenditure on services and systems, as well as lost tax revenue.[32]

The Commission's updated inquiry report will be tabled in Parliament later this year and the Commission will provide a copy to the Royal Commission when it has been tabled.[33]

Contact with child protection and other service systems – opportunities for early intervention

The Commission sees vulnerable children and young people when they are in the child protection system, out-of-home care and youth justice custody systems. In most instances, these are children and young people who needed support much earlier in their lives. Early intervention for groups of children and young people at greater risk of experiencing poor mental health must be prioritised, including to reduce the risk of contact with the youth justice system.[34]

However, when a child or young person comes into contact with the child protection or broader child and family service system this should be seen and used as a point of intervention, both to prevent children's ongoing exposure to harm and to support recovery from previous trauma, including mental health implications.[35] As recently noted by the

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32 Bendall, S, Phelps, A, Browne, V, Metcalf, O, Cooper, J, Rose, B, Nursey, J & Fava, N 2018, *Trauma and young people. Moving toward trauma-informed services and systems.* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, page 28.

33 The full inquiry report is not publicly available at this stage. It was provided to relevant Ministers and the Secretary of DHHS but not tabled in Parliament at that time (as would normally occur following a systemic inquiry), so that a greater level of detail about individual children's cases could be provided to drive improvements to the provision of services.

34 See, for example, the Commission's joint report with the Victorian Equal Opportunity and Human Rights Commission 2018, *Aboriginal cultural rights in youth justice centres*, page 5; See *Report of the Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory*, volume 2B, chapter 27, pages 411-412.

35 See, for example, *Report of the Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory*, volume 2A, chapter 15, page 349; also see Orygen, The National Centre of Excellence in Youth Mental Health's Policy Briefing, *Double Jeopardy: Developing specialised mental health care for young people engaging in offending behaviours,* available at: https://www.orygen.org.au/Policy-Advocacy/Policy-Areas/Youth-justice/Double-Jeopardy/Orygen_Double-Jeopardy_policy_brief?ext

Sentencing Advisory Council '[c]hildren in out-of-home care, particularly residential care, are some of the most vulnerable, traumatised and disadvantaged children in our community'.[36]

Responding holistically to 'indicators of vulnerability' and trauma

Evidence from the World Health Organization shows that actions to address the social determinants of health, of which early childhood development is one, are likely to have the greatest impact on health.[37] This has prompted governments in other jurisdictions to implement reforms designed to provide interventions early and address vulnerabilities and how they cluster over time. New Zealand, for example, has a Ministry for Children – Oranga Tamariki, to create 'circles of protection and care' around children whose wellbeing is at risk.[38] It is mandated to support 'tamariki' and 'whānau' at-risk of experiencing maltreatment, not just those already within formal care and protection thresholds.[39] New Zealand is also developing a national Child and Youth Wellbeing Strategy[40] and recently became the first western country to design its national budget on wellbeing priorities, requiring all of its ministries to design policies to improve wellbeing.[41] The rationale underpinning this approach was articulated clearly in the Report of the Government Inquiry into Mental Health and Addiction:

> if we wish to make significant inroads into improving mental health and addiction outcomes, we need to address the wider social determinants that influence not just mental health, but overall wellbeing. These social determinants also underlie and perpetuate inequitable outcomes for many Māori and other groups in New Zealand society. We need to invest in broader prevention and promotion initiatives...[42]

The need to focus on 'indicators of vulnerability' in an early intervention context was highlighted in the recent VAGO report on Child and Youth Mental Health.[43]

Holistic prevention and early intervention for Aboriginal children and young people

The Aboriginal community in Victoria has been leading the way in collaborating with the Victorian Government to design system wide reforms that address indicators of vulnerability. Victoria's Aboriginal Social and Emotional Wellbeing Framework, *Balit Murrup*, recognises that Aboriginal children and young people are a specific priority group, with the highest rate of reported mental health conditions in the country.[44]

> Social and economic disadvantage (often intergenerational) place Aboriginal children at greater risk of behavioural and environmental harm including exposure to racism, family

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36 Sentencing Advisory Council 2019, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 1: Children Who Are Known to Child Protection among Sentenced and Diverted Children in the Victorian Children's Court*, page 93.

37 National Mental Health Commission 2018, Monitoring mental health and suicide prevention reform: National Report 2018, page 46.

38 See https://www.orangatamariki.govt.nz.

39 Oranga Tamariki Evidence Centre 2019, *Children's Teams evaluation: Final Report*, Oranga Tamariki – Ministry for Children, Wellington, New Zealand, page 6.

40 See Department of the Prime Minister and Cabinet, *Child and youth wellbeing strategy*, at https://dpmc.govt.nz/our-programmes/child-and-youth-wellbeing-strategy.

41 See https://treasury.govt.nz.

42 See the National Mental Health Commission's submission to the Productivity Commission's Mental Health Inquiry, at page 4, referring to *He Ara Oranga – Report of the Government Inquiry into Mental Health and Addiction* (2018).

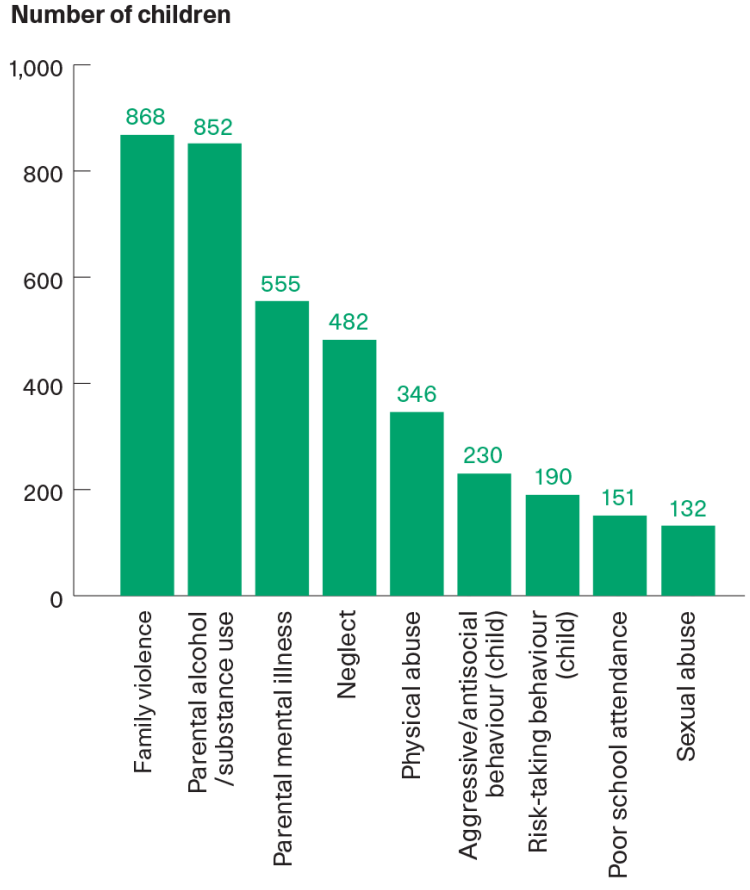
43 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 15-16.

44 See page 19 and see, for example, the Australian Institute of Health Welfare's report *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*. This reported that Victoria (along with Tasmania) had the highest rate of Aboriginal young people aged 15 to 24 reporting mental health conditions.

violence, or poor-quality parenting. The impact of this is an often undetected, underestimated and misunderstood determinant of mental health.[45]

Known risk factors for children reviewed during Taskforce 1000, the systemic inquiry into services provided to nearly 1000 Aboriginal children and young people in out-of-home care in Victoria, highlighted the need for a holistic, whole of family and community approach, grounded in connection to culture to tackle complex and multiple risks pervasive in the lives of these young Victorians:[46]

Figure 1: Known risk factors for children reviewed during Taskforce 1000



n = 980 children
Source: Appendix 1, Table A8.

Throughout Taskforce 1000, the Commission heard about the impact of family violence, sexual and physical abuse and neglect, intergenerational trauma, and other factors such as substance abuse on the mental health of children and young people:

> It was apparent that there is a pressing need for the service system to work in a more holistic way with children and their families, recognising the Aboriginal concept of health and the need for Aboriginal-specific trauma responses.[47]

45 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, page 19.
46 *Always was, always will be Koori children* 2016, page 6.
47 *Always was, always will be Koori children* 2016, page 94.

Interventions through *Balit Marrup* take such a holistic approach,[48] designed to be led by Aboriginal families and communities, and support culturally safe programs across education, health, housing, child welfare and youth justice to 'prevent the escalation of social and emotional wellbeing and mental health issues immediately and in later years'.[49]

Balit Marrup also recognises that connection to culture, family, community and country are central to prevention and early intervention.[50] As highlighted in the Commission's recent joint report with the Victorian Equal Opportunity and Human Rights Commission, Aboriginal culture and Aboriginal people's cultural rights are fundamental to supporting Aboriginal children and young people's 'resilience and wellbeing' and 'can reduce the impact of stress'. Recognition of and support for culture is central to Aboriginal children and young people's social and emotional wellbeing, and the approach to supporting their social and emotional wellbeing must be holistic.

48 The Commission acknowledges this framework is one of a number of key strategies, all of which are interrelated in seeking to support self-determination, connection to culture and community-led approaches to reducing harms and improving outcomes. See, for example:
Marrung: Aboriginal Education Plan 2016-2026, which aims to ensure universal service systems in Victoria are respectful and responsive to Koori learners and their families across early childhood, school and post-compulsory education sectors.
Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement, which is a shared commitment between government, the Aboriginal community and the child and family service sector to work towards a future where all Aboriginal children and young people are safe and living in culturally rich Aboriginal families and communities.
Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017-2027, which serves as a 10-year plan to work alongside Aboriginal communities towards a better and fairer future for Aboriginal people.
Dhelk Dja: Safe Our Way – Strong Culture, Strong Peoples, Strong Families - The Aboriginal 10 Year Family Violence Agreement 2018-2028, which is a shared commitment between Aboriginal communities, services and government.
The Victorian Aboriginal Justice Agreement (AJA), the fourth stage of which, *Burra Lotjpa Dunguludja*, includes development of an Aboriginal Youth Justice Strategy and the Aboriginal Youth Justice Taskforce.
These frameworks are outlined in the Victorian Government's *Aboriginal Affairs Report 2018*.

49 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, page 19.

50 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, page 8.

Question 4

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

The Commission is concerned about current limitations and gaps in the capacity of the mental health system for children and young people. While we do not have a specific mandate to review mental health services provided to children and young people, our inquiries and other oversight activity gives us considerable information about the way the mental health service system works, including delays in access to mental health services and an absence of service co-ordination necessary to ensure that children and young people receive holistic wrap-around support that is responsive to their needs.

Victorian children and young people generally

VAGO recently highlighted that Victoria's child and youth mental health system is not addressing the needs of Victorian children and young people with moderate to severe mental ill-health.[51] VAGO identified that the system is fragmented, over-stretched, under-resourced and unable to meet service demand, and that many children and young people cannot access the support they need.[52] VAGO's findings are consistent with observations in other recent reviews, and from the sector itself. The 2017 Armytage and Ogloff *Youth Justice Review and Strategy* found that '[s]ystem gaps and demand pressures on mental health services currently limit the access of all young Victorians to essential mental health services'.[53]

This is illustrated by Orygen's recent submission to the Productivity Commission's Mental Health Inquiry, which highlights that Orygen Youth Health, the specialist mental health service at Parkville, is only able to provide care to one in four young people referred to the service. Orygen notes that increasing demand related to population growth, without concomitant funding growth, has seriously diminished the service's capacity to provide 'adequate care and treatment to young people' and has restricted access to care 'for even the most seriously unwell young people'.[54]

The Royal Commission has also already heard about the significant service gap relating to the 'missing middle' – children and young people whose conditions are too severe to be managed at the primary care level but do not meet the threshold for access to tertiary services[55] – and the pressure on the Royal Children's Hospital Emergency Department due to increased presentations by young people with 'mental disorders and mental health symptoms'.[56] The Commission has heard directly from other hospitals that an absence of adolescent inpatient beds results in young people with serious psychiatric illness being accommodated in emergency departments for prolonged periods.

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51 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 8, 25.

52 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 8, 24, 26, 79.

53 *Youth Justice Review and Strategy* 2017, part 2, page 45.

54 Orygen, The National Centre of Excellence in Youth Mental Health and *headspace* submission to the Productivity Commission's Mental Health Inquiry, page 28.

55 See evidence of Dr Richard Haslam, 5 July 2019, pages 309 (line 31) to page 310 (line 36); evidence of Professor Patrick McGorry, 5 July 2019, page 327 (lines 36-41); pages 342 (line 43) to 343 (line 46). Also see Orygen, The National Centre of Excellence and *headspace* submission to the Productivity Commission's Mental Health Inquiry, pages 4, 8, 27-29.

56 See evidence of Dr Richard Haslam, 5 July 2019, page 304 (lines 4-8).

Children and young people involved with Child Protection

As the Productivity Commission has noted, mental ill-health is 'widespread' among children and young people involved with the child protection system.[57] The Commission's child death inquiries frequently bring to light service issues affecting children and young people with experiences in Victoria's child protection system.[58] The inquiries are detailed examinations of the services provided to the children before their deaths, focussing on child protection services.[59] Typically, however, the Commission finds that children had contact with multiple services, including mental health services.

Due to their sensitivity, inquiry reports are provided to the Minister and Secretary of DHHS confidentially.[60] For the purposes of this submission, the Commission conducted a preliminary analysis of completed cases from the past two years (1 July 2017 to 30 June 2019) to identify themes that may assist the Royal Commission. Fourteen relevant cases were identified – eight cases in which a child had a diagnosed mental disorder and another six cases in which a child without formal diagnosis evidently experienced childhood trauma. All fourteen children had very difficult lives, which included (almost universally) family violence, neglect (e.g. poor living conditions and inadequate food), exposure to parental drug abuse, emotional, physical and, in some cases, sexual abuse. Five of the children died by suicide, another three from a drug or alcohol-related death. In nine cases (64 per cent), a child was using a state or other mental health service.

In some of these cases, it was challenging for the child or young person to access timely or appropriate mental health services. In one inquiry, a state mental health service accepted it did not provide an adequate service to a child, where failure to appropriately assess the risk of harm to the child delayed their access to specialist treatment. In another case, a child's access to ongoing mental health supports was delayed by having to tell her story of trauma to multiple services in a multi-tiered referral process. The mental health system did not appear sensitive to the child's experience of trauma and the process made it too difficult for the child and her parent to access the treatment she needed.

Another recurring theme was that, for reasons connected to their experience of trauma and instability, many of these children and young people were difficult for mental health services to engage or to keep engaged. This suggests that alternate service models, including intensive, coordinated support and assertive outreach, are necessary if services are to effectively support children and young people who are most at risk.

The most common issue across these children and young people's experiences – apart from the issues relating to child protection services – was a lack of information-sharing, co-ordination or collaboration between different services involved with a child (12 of 14 cases or 86 per cent). Examples include:

- Poor collaboration between two DHHS child protection divisions, when a child was transferred from one region to another. The new region did not agree to continue to fund psychological services the child had been receiving. As a result, the child did not receive any counselling for a six-week period, until a new service was engaged.

- In one inquiry, a mental health service did not understand its obligations to share information with Child Protection and refused to provide information when requested,

57 Productivity Commission 2019, *The Social and Economic Benefits of Improving Mental Health – Productivity Commission Issues Paper*, page 25.

58 The Commission conducts an inquiry in all cases where a deceased child had contact with the child protection system in the 12 months before their death: CCYP Act, section 34.

59 They do not examine cause of death, which is the Coroner's role. The Commission routinely provides its inquiry reports to the Coroner.

60 CCYP Act, section 46.

while in another Child Protection did not respond in a timely way to requests for assistance from a mental health service. As a result, the child did not receive the mental health support they needed.

- In a case where a child was involved with the youth justice system, Youth Justice did not report information about the child's escalating self-harm and suicidal ideation to a mental health service the child was waiting to get into.

Poor information sharing between Child Protection and a mental health service providing treatment to a child was also a feature in one of the cases examined in the Commission's cumulative harm and suicide inquiry (detailed in our response to Question 2). This inquiry found that children in contact with the child protection system that present with risk indicators for suicide benefit from a collaborative service response from a range of services, which is likely to involve a range of actions and responses by a range of services, which will need to be co-ordinated and planned. The inquiry's findings and the cases included in the preliminary analysis demonstrate it is essential that the Royal Commission consider the links and co-ordination between services dealing with vulnerable children and young people, including mental health, child protection, youth justice, family violence and education systems.[61] The need to respond to trauma in a co-ordinated and timely way across services is critical.[62]

Other common issues seen in the Commission's child death inquiries relate to deficiencies in response from Child Protection, including failures to recognise when referral to mental health services (or related service) was necessary. This occurred in 11 of the 14 cases, highlighting the importance of ensuring all professionals working with those at risk of or with mental health issues, especially with vulnerable children and young people, have appropriate mental health knowledge and skills.[63]

Given VAGO's recent findings, it is likely that many of the issues identified above are also experienced by Victorian children and young people more broadly.

Children and young people in out-of-home care

The Commission is responsible for monitoring the safety and wellbeing of children and young people in Victoria's out-of-home care system.[64] There are approximately 8,000 children and young people living in out-of-home care in Victoria.[65] The vast majority of these children and young people have been removed from the care of their parents by court order for their protection. They have commonly experienced significant emotional, physical or sexual abuse, neglect and exposure to family violence. Most are living with a relative in 'kinship care' (most commonly with grandparents), around 20 per cent are in foster care and around five per cent live in residential care facilities in the care of the Secretary to DHHS.

Mental ill-health in children in out-of-home care is often associated with exposure to the significant harm, maltreatment and trauma they have experienced in childhood. The data is alarming, with this cohort experiencing 'two to five times higher rates of mental health

61 Clause 2.3 of the Royal Commission's terms of reference require it to examine 'strengthened pathways and interfaces between Victoria's mental health system and other services'.

62 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 15-16.

63 See National Mental Health Commission Media Release, *Government-led roundtable meeting to review investment to date in mental health and suicide prevention*, 5 June 2019.

64 This oversight is established under section 60A of the CCYP Act, which requires the Secretary of DHHS to provide information to the Commission about 'adverse events' relating to children and young people in out-of-home care.

65 Data provided to the Commission by DHHS, as at May 2019. This number excludes children and young people who were on permanent care orders.

problems and more than double the rate of serious suicide attempts'.[66] Their health needs are often not recognised or not met, despite having 'increased risk for developmental and mental health disorders across all facets of their life and lifespan'.[67] Sixty per cent in this cohort have been found to have a major psychiatric disorder diagnosis,[68] yet VAGO recently reported that, in 2014-15, only 19 per cent of children and young people in out-of-home care in Victoria were registered mental health clients.[69]

Under the *Commission for Children and Young People Act 2012* (Vic), the Commission receives reports of all serious incidents affecting a child in out-of-home care from the Department of Health and Human Services.[70] From 1 October 2018 to 31 May 2019, over one in ten of the incidents reported to the Commission involved a child self-harming or attempting suicide across all types of out-of-home care (538 incidents).[71]

Over a third of the incidents were assessed to have had a 'major impact' on the child (143 incidents).[72] Of those 143 major incidents, 24 per cent involved an Aboriginal child or young person. Almost three quarters of the major self harm or attempted suicide incidents involved children in residential care.

The number of 'non-major' incidents of the same category is equally concerning. In the eight-month period of October 2018 to May 2019,[73] 395 non-major self harm or attempted suicide incidents were reported. Sixteen per cent of children involved were Aboriginal. Seventy-five per cent of the non-major self harm or attempted suicide incidents involved children in residential care.

Though most self harm and attempted suicides involve children in residential care, 67 incidents (12 per cent) occurred in foster care and 45 incidents (eight per cent) involved children in kinship care placements. The most common age of children for these reports across all care type, was 14 years of age. Alarmingly, 10 incidents involved children under 10 years of age.

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66 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 15. Also see the Productivity Commission's Issues Paper, *The Social and Economic Benefits of Improving Mental Health*, page 25 and Orygen, The National Centre of Excellence in Youth Mental Health and *headspace* submission to the Productivity Commission's Mental Health Inquiry, page 32.

67 Eadie, K 2017, 'Evolve Therapeutic Services: Outcomes for Children and Young People in Out-of-Home Care with Complex Behavioural and Mental Health Problems', *Children Australia* 42(4): 277-284, 277.

68 Bendall, S, Phelps, A, Browne, V, Metcalf, O, Cooper, J, Rose, B, Nursey, J & Fava, N 2018, *Trauma and young people. Moving toward trauma-informed services and systems.* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, page 20.

69 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 97.

70 CCYP Act, section 60A.

71 In 2018, DHHS introduced a new incident reporting framework (CIMS) which was fully embedded across out-of-home care service provided in October. Out-of-home care includes foster care, kinship care, residential care, lead tenant arrangements and Secure Welfare Services. The incident framework category does not separate 'self harm' from 'attempted suicide'.

72 'Major impact' and 'non-major impact' are used to define the two incident categories. The service provider is responsible for assessing the appropriate categorisation for the incident and in determining the category, focuses on the level of harm to the child or young person. Major impact incidents include severe physical, emotional or psychological injury or suffering which is likely to cause ongoing trauma. For more information, see the 2017 DHHS Client Incident Management Guide, page 24, available at https://providers.dhhs.vic.gov.au/client-incident-management-guide-cims-word.

73 See note above. 'Non-major' incidents include incidents that cause physical, emotional or psychological injury or suffering, without resulting in major impact. For more information see the Client Incident Management Guide, page 24.

Table 1: Self-harm and attempted suicide incidents in out-of-home care, by care type and gender, October 2018 to May 2019

Out-of-home care type	Female	Intergender	Male
Home-based care - foster	9%	0%	3%
Home-based care - kinship	4%	0%	4%
Home-based care - Lead tenant	4%	0%	0%
Residential and therapeutic care	52%	1%	22%
Secure welfare	0%	0%	0%
Grand Total	**69%**	**1%**	**30%**

The actual frequency of self harm and suicidal behaviour among this cohort could be much higher, given that '[d]ue to the stigma associated with self-harm, many young people do not present for help or disclose their behaviour'.[74]

The Commission is also currently conducting an inquiry into children and young people's experiences in this system – the *In our own words* inquiry. This has included engaging with more than 200 children and young people across Victoria who are, or have recent experience in, the out-of-home care system. Many of the children and young people reported experiences with mental ill-health, including anxiety, isolation, anger, self-harm and, sometimes, suicidal thoughts or suicide attempts. Many were engaged with mental health supports such as counsellors, school counsellors, psychologists and mental health services. The inquiry's findings and recommendations will be tabled in Parliament in late 2019 and may be of interest to this Royal Commission. Emerging themes from the inquiry and the Commission's research are outlined below.

Due to their higher, often multiple and complex needs, children and young people in out-of-home care need a high level of specialised mental health care, including priority access and comprehensive assessment.

This is reflected in the Chief Psychiatrist's 'guideline to prioritise children in out-of-home care',[75] the DHHS Community health integrated program guidelines,[76] the National clinical assessment framework for children in out-of-home care[77] and recommendations of the Royal Australasian College of Physicians and Royal Australian and New Zealand College of Psychiatrists.[78] Experts often stress 'the need for highly specialised trauma and attachment informed, multi-agency approaches'.[79]

74 Robinson, J, McCutcheon, L, Browne, V, Witt, K 2016, *Looking the other way: Young people and self-harm*. Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, page 5.

75 See Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 10.

76 Victorian Government, Department of Health and Human Services 2019, *Community health integrated program guidelines*.

77 See Australian Government, Department of Health 2011, Children and Young People in Out-of-Home Care, at https://www.health.gov.au/internet/main/publishing.nsf/Content/cyp-oohc-framework.

78 See Royal Australasian College of Physicians 2008, *Health of children in 'out-of-home care' policy* and Royal Australian and New Zealand College of Psychiatrists 2015, *The mental health care needs of children in out-of-home care: Position Statement 59*.

79 Eadie, K 2017, 'Evolve Therapeutic Services: Outcomes for Children and Young People in Out-of-Home Care with Complex Behavioural and Mental Health Problems', *Children Australia* 42(4): 277-284, 278.

Children and young people in out-of-home care often do not receive the mental health care they need.

DHHS data from 2014 showed that a quarter of children and young people in out-of-home care were not receiving the mental health services they needed.[80] The Commission heard that this remains a problem for many children and young people consulted during its out-of-home care inquiry.

Children and young people in out-of-home care have difficulties accessing mental health services.[81]

VAGO found that children and young people in out-of-home care do not generally get the priority access to mental health services that they need, despite the Chief Psychiatrist's guideline.[82] Only one of the five services VAGO audited had implemented the guideline. VAGO also highlighted that DHHS is currently unable to monitor if children in out-of-home care are accessing mental health services.[83] A recent survey of 290 foster and kinship carers' experiences of accessing health services for children by the Murdoch Children's Research Institute found that 'ease of getting an appointment was most difficult for mental health services'.[84] A CREATE Young Consultant named [redacted] outlines the difficulties she had experienced in trying to access support:[85]

> I waited a long time to get mental health support, and in the meantime my mental health became much worse… I learned that it is only if I was in crisis that I would be able to access help. Only if I said that I was suicidal would the mental health services do much to help.

The Commission heard of similar difficulties from participants in the out-of-home care inquiry and the young people we consulted for this submission.

Assessments of children and young people in out-of-home care are often lacking.

Children and young people's mental health needs are unlikely to have been well assessed on entering care.[86] When children and young people in care are assessed, it is typically through a standard 20-minute consultation, and 'time is only available in such consultations for the GP to deal with currently presented symptoms'.[87] Additionally, GPs – who conduct the majority of health assessments of children and young people in care – are not part of the child protection system and may lack 'clarity about their responsibilities within that system',

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80 Webster, S 2016, *Children and young people in statutory out-of-home care: Health needs and health care in the 21st century*, Parliamentary Library & Information Service, Parliament of Victoria, page 12 citing Victorian Department of Human Services (2014) The 2011 Looking after children Outcomes Data Project: A summary of findings, Melbourne, DHS.

81 Moeller-Saxone, K, et al 2016, 'Meeting the primary care needs of young people in residential care', *Australian Family Physician* 45(10): 706, 708. Also see the Orygen, The National Centre of Excellence in Youth Mental Health and *headspace* submission to Productivity Commission's Mental Health Inquiry, page 32.

82 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 10, 79, 82 and 84.

83 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 85.

84 McLean, K, et al 2018, Conference poster: *Foster and kinship carers' experiences of accessing health services for children and young people in out of home care*.

85 'A CREATE Young Consultant is a a young person with a care experience aged 14-25 who undertakes the [CREATE Foundation's] Speak Up training. They have a lived experience of being in the care system so they understand what works and what needs to be improved': https://create.org.au/election-hop/ [accessed 5 July 2019].

86 McLean, K, et al 2018, Conference poster: *Foster and kinship carers' experiences of accessing health services for children and young people in out of home care*.

87 Webster, S 2016, *Children and young people in statutory out-of-home care: Health needs and health care in the 21st century*, Parliamentary Library & Information Service, Parliament of Victoria, page 32.

and may not have 'specific training about the health impacts of child abuse and neglect' or 'clear clinical guidelines for assessing these children'.[88] Further, assessing professionals often lack access to individual health histories[89] (including medication history)[90] or histories of the trauma experienced by a child or young person.[91] There are no mechanisms to ensure assessments meet the standards set by the *National clinical assessment framework for children in out-of-home care* (2011), and no data collection on whether an assessment commonly results in increased health service use by children and young people.[92]

Mental health services are often not responsive to the needs of children and young people in out-of-home care, particularly the need for a trauma-informed response.

The Commission has heard that at present children and young people in out-of-home care who reach out for help are often turned away until emergency intervention is necessary. During the Commission's inquiry, children and young people in this cohort have also reported that mental health professionals have not understood their trauma or what it is like being in care. CREATE Young Consultants recommend 'mental health services that are tailored to children and young people in out-of-home care'.[93] A young person the Commission spoke with for this submission suggested something similar:

> [a] separate agency of workers that mainly deal with out-of-home care young people... having this option for kids in care is better for the kids because the counsellors actually will understand the issues that come along living in care and they understand it's not just living with ya parents or whatever, a normal family.

The Commission considers that due to their high and complex needs, children and young people in out-of-home-care need priority attention from a system that responds to their specific needs.

Children and young peoples' experiences in out-of-home care can worsen mental ill-health

The experiences of children and young people in out-of-home care can expose them to further trauma and/or worsen mental ill-health, with removal from family, friends, community

88 Ibid, page 24 citing Underwood, P et al, 1999, *Understanding and improving the provision of general practice services to children in state care: Final report, General Practice Evaluation Program*, GPEP Report 705, Adelaide, Primary Health Care Research and Information Service, Flinders University, and Webster, SM & Temple-Smith, M 2010, 'Children and young people in out-of-home care: are GPs ready and willing to provide comprehensive health assessments for this vulnerable group?' *Australian Journal of Primary Health 16*, pages 296-303.

89 Ibid, page 24 citing Chambers, MF, Saunders AM, New BD, Williams CL & Stachurska A 2010, 'Assessment of children coming into care: processes, pitfalls and partnerships', *Clinical Child Psychology and Psychiatry*, 15, page 511.

90 Webster, S 2016, *Children and young people in statutory out-of-home care: Health needs and health care in the 21st century*, Parliamentary Library & Information Service, Parliament of Victoria, page 1.

91 Ibid, page 24 citing Tregeagle, S 2010, 'Red tape or gold standard? Australian service users' experiences of child welfare case managed practice', *Australian Social Work*, 63(3), pages 299-314 and Frederico, M, Jackson AL & Black CM 2008, 'Understanding the impact of abuse and neglect on children and young people referred to a therapeutic service', *Journal of Family Studies,* 14(2), pages 342-361.

92 See in general McLean, K, et al 2019, 'Health needs and timeliness of assessment of Victorian children entering out-of-home care: An audit of a multidisciplinary assessment clinic', *Journal of Paediatrics and Child Health*.

93 See https://create.org.au/election-hop/ [Accessed 5 July 2019].

and school.[94] In the course of its contact with children and young people in out-of-home care, the Commission has heard that many children and young people feel unsafe in out-of-home care, and residential care in particular can be experienced as volatile and unsafe, with impacts on residents' wellbeing. This is supported by the Commission's observations in its monitoring capacity, receiving more than 350 incident reports relating to physical assault allegations and 132 reports relating to allegations of sexual assault or rape in 2016-17.[95] Many children in out-of-home care experience frequent movement between placements, causing disruption and instability.[96] This is both upsetting and dislocating; placement changes are recognised to present risks of further trauma and psychological distress,[97] as well as loss of continuity of care and practical disruptions to the provision of therapeutic services.[98]

These systemic issues present clear risks to the mental wellbeing and of children and young people in out-of-home care, and compromise access to consistent care. The Commission's out-of-home care inquiry will include recommendations for reform to ensure that children and young people in out-of-home care receive the mental health support and services they need.

Complex needs of children and young people in residential care

Residential care houses some of Victoria's most vulnerable children and young people. As the Sentencing Advisory Council recently reported, 'residential care units [group] together some of the most traumatised, vulnerable, at-risk and complex-needs children, some of whom have ended up in residential care because other out-of-home placements have been unable to manage their problematic behaviour'.[99] There were approximately 430 children and young people in residential care in May 2019.[100] These children and young people are more likely to have complex mental health needs.

The recent 2019 VAGO report on child and youth mental health highlighted the challenges involved in caring for children and young people in the residential care system, particularly where mental health problems coexist with intellectual disabilities and/or autism and challenging behaviours. VAGO cited the Royal Children's Hospital:

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94 Sentencing Advisory Council 2019, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 1: Children Who Are Known to Child Protection among Sentenced and Diverted Children in the Victorian Children's Court*, page 38.

95 See the Commission's 2016-17 Annual Report, page 35. These incidents reports were across all types of out-of-home care.

96 Placement changes are extremely common. In 2017 the Commission examined placement data relating to 8,784 children and young people in out-of-home care over a six month-period. Almost 1,000 children experienced two placement changes; more than 500 experienced three changes; 400 experienced four changes; more than 170 children experienced between 11 and 20 changes; and 21 children experienced more than 20 placement changes within the six month-period. See the Commission's 2017 *'…safe and wanted' inquiry into the implementation of the Children, Youth and Families Amendment (Permanent Care and Other Matters) Act 2014*, page 162. Almost half of the children (n = 4, 196; 47.7 per cent) did not experience any placement change during the period examined.

97 See, for example, the Productivity Commission's Issues Paper, *The Social and Economic Benefits of Improving Mental Health*, page 24.

98 Sentencing Advisory Council 2019, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 1: Children Who Are Known to Child Protection among Sentenced and Diverted Children in the Victorian Children's Court*, page 38.

99 Sentencing Advisory Council 2019, *'Crossover Kids': Vulnerable Children in the Youth Justice System. Report 1: Children Who Are Known to Child Protection among Sentenced and Diverted Children in the Victorian Children's* Court, page 38.

100 Data provided to the Commission by the Department of Health and Human Services, as at May 2019.

> Difficulties such as severe challenging behaviours in adolescents with Autism Spectrum Disorder pose a major practical, physical and emotional difficulty for carers as well as lead to substantial burden on the residential care system. Across the state, clinical services through regular CAMHS/CYMHS and private practitioners is difficult or impossible to obtain. These young people represent a 'blind spot' or service gap, with high morbidity and cost.[101]

In a recent inquiry, the Commission observed the following concerning example of the failure to provide the necessary mental health support to a child in residential care.

Jamie's story[102]

In June 2019, the Commission finalised its inquiry into services delivered to Jamie across a six-month period. Jamie is a child living in residential care with a lengthy history of child protection involvement.

The inquiry was established in the context of Jamie experiencing chronic levels of self-harming and suicidal behaviour, multiple hospital presentations, police attendances and admissions to secure welfare services.

For the period reviewed, it was the consistently expressed opinion of mental health professionals that Jamie's presenting issues were a consequence of 'behavioural' factors rather than a manifestation of poor mental health.

The inquiry found that attribution of Jamie's presenting issues to 'behavioural' causes had a profound impact on the way non-mental health services viewed and responded to Jamie, which was compounded by the following factors:

- a lack of clarity regarding application of the term 'behavioural' in a mental health context and implications for the ongoing provision of mental health services
- inferences being drawn by non-mental health service providers regarding the term 'behaviour', particularly with respect to Jamie's capacity to assert control over self-harming and other presenting issues that resulted in the use of frequently negative language used to describe Jamie's conduct
- how the attributed 'behavioural' causes aligned with pre-existing diagnoses and associated medication regime.

Complicating matters further, the inquiry found that Jamie's presenting issues were exacerbated by Jamie's experience of residential care. This exacerbation occurred in the context of Jamie's exposure to:

- over 50 different residential care workers named as responsible for providing day-to-day care over a six-month period
- high risk co-clients within the residential unit
- a general lack of structure around day-to-day routines
- grossly inadequate communication around Jamie's medication intake which resulted in Jamie not being offered medication at alarmingly high rates.

For Jamie, a lack of shared understanding by mental and non-mental health services about the 'cause' of Jamie's presenting issues resulted in a disjointed service response that failed to consistently support Jamie's safety, wellbeing and development. This occurred in the context of a residential care experience that was found ultimately to have harmed Jamie's mental health and also impacted upon Jamie's ability to access therapeutic treatment.

The Commission can provide further information about this inquiry to the Royal Commission if this would assist.

101 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 102.

102 A different name has been used and other identifying information removed to protect privacy.

Children and young people in youth justice custody

The Commission monitors the safety and wellbeing of children and young people in Victoria's two youth justice centres and advocates for evidence-based responses to children and young people who become involved with the youth justice system.[103] Mental ill-health is prevalent among these children and young people.[104] The Youth Parole Board's latest survey of the youth justice custody population showed:

- more than half of the 226 children and young people presented with a mental health issue (53 per cent)
- 30 per cent have a history of self-harm or suicidal ideation
- 70 per cent had experienced trauma, abuse or neglect.[105]

It is particularly concerning how these proportions have risen over the past three surveys, as shown in the table below. The Board's Chairperson, Judge Bourke, specifically highlighted the increased prevalence of mental health issues among child and young people in youth justice custody in the Board's latest Annual Report.[106]

Table 2: Data from Youth Parole Board surveys 2015-2018

	2015-2016[107]	2016-2017[108]	2017-2018[109]
Presented with mental health issues	30 per cent	40 per cent	53 per cent
Had a history of self-harm or suicidal ideation	18 per cent	22 per cent	30 per cent
Were victims of abuse, trauma or neglect	63 per cent	71 per cent	70 per cent

103 The Commission's statutory oversight of youth justice focuses on children and young people in custody and does not extend to community youth justice and children and young people in the community. As well as having oversight of treatment of children and young people in youth justice centres, the Commission also monitors the safety and wellbeing of children under the age of 18 detained in Victoria's adult correctional facilities. In recent years, the Commission has conducted a number of inquiries in the youth justice context, including *The Same Four Walls* (2017), a systemic inquiry into the risks and impacts associated with the management of isolations, separations and lockdowns, as well as two specific inquiries into the provision of services to particular children, which were not tabled in Parliament for reasons of confidentiality.

104 The Armtyage and Ogloff review of Youth Justice in Victoria found that that children and young people 'with mental health needs are significantly over-represented in youth justice systems': *Youth Justice Review and Strategy: Meeting needs and reducing offending*, part 1, page 157.

105 Youth Parole Board Annual Report 2017-18, page 15. A recent study of over 200 children and young people in Victorian Youth Justice confirmed 'a strong connection between childhood traumatic experiences and suicidal behaviours for youth in detention': see Sherpherd, S, Spivak, B, Borschmann, R, Kinner SA & Hatchel, H 2018, 'Correlates of self-harm and suicide attempts in justice-involved young people', *PLoS ONE* 13(2): e0193172. https://doi.org/10.1371/journal.pone.0193172.

106 Youth Parole Board Annual Report 2017-18, page x.

107 Youth Parole Board Annual Report 2015–16, page 14.

108 Youth Parole Board Annual Report 2016–17, page 16.

109 Youth Parole Board Annual Report 2017–18, page 15.

Since March 2016, the Commission has received reports of serious incident (called 'category one' incidents) relating to any child or young person in the youth justice centres, including incidents of self-harm or attempted suicide.[110] Recorded incidents of self-harm and attempted suicide increased substantially between 2016 and 2018, as shown in the table below. Data for 2018-19 is yet to be confirmed at the time of writing, but information provided to the Commission through the year indicates that few incidents involving self-harm and suicide attempts have been recorded.

Table 3: Category one self-harm and attempted suicide incidents in youth justice custody, 2016-2018[111]

	2016-2017	2017-2018
Self-harm	1	15
Suicide attempted	1	7

This data does not capture all incidents of self-harm or attempted suicide by children and young people in youth justice custody – it only shows the incidents that were considered 'category one' incidents. These are defined as:

> Actions/behaviour with the intention to take one's life that requires urgent action such as assessment, medical treatment, mental health treatment and/or hospitalisation.

Since December 2018, the Commission has also been receiving (by agreement) reports from the Department of Justice and Community Safety about 'category two' self-harm and attempted suicide incidents, which are considered to be less serious than category one incidents. While the Commission is not in a position to report on this data in this submission, the latest Productivity Commission data provides an indication of these incidents, by reporting incidents of self-harm or attempted suicide that did not require hospitalisation, as well as incidents that required hospitalisation. The data records that no incident required hospitalisation in 2017-18, but there were 46 reported incidents that did not require hospitalisation. As shown in the table below, there was a large increase from 2016-17 to 2017-18 in both the number of incidents and the number of young people involved in the incidents.

110 Section 60A of the CCYP Act requires the Secretary of the Department of Justice and Community Safety to disclose any information about an 'adverse event' relating to a child or young person detained in a youth justice centre if the information is relevant to the Commission's functions. A memorandum of understanding between the Commission and Department defines adverse events as 'category one' incidents. Other incidents considered less serious are classified as 'category two' incidents. Category one and category two criteria vary across incident types. For attempted self-harm and attempted suicide incidents, category one incidents are 'Actions/behaviour with the intention to take one's life that requires urgent action such as assessment, medical treatment, mental health treatment and/or hospitalisation'. A new incident framework is currently being developed.

111 As reported in the Commission's 2016-17 and 2017-18 Annual Reports.

Table 4: Productivity Commission data relating to self-harm or attempted suicide incidents not requiring hospitalisation 2016-2018[112]

	2016-2017	2017-2018
Incidents of self-harm or attempted suicide	12	46
Individual children or young people involved in incidents	3	20

Despite recent reviews, systemic issues remain

Issues relating to mental health support in youth justice custody have received attention in recent years, including in the Commission's 2017 *The Same Four Walls* inquiry into isolation and lockdown practices, the 2017 Armytage and Ogloff Youth Justice Review and the 2018 parliamentary inquiry into Victoria's youth justice centres. In particular:

- In *The Same Four Walls*, the Commission identified issues including use of isolation rooms to manage children and young people at risk of self-harm contrary to therapeutic principles; inadequate involvement of clinical staff; failures of youth justice staff to intervene when children and young people were self-harming; and inappropriate detention of a number of children and young people in custody who were deemed 'unfit to plead' due to mental illness or intellectual disability.[113] The Commission highlighted the need for a dedicated adolescent mental health facility and recommended a review of responsibilities and processes for observing children and young people who are at risk of self-harm.[114]

- The Armytage and Ogloff Youth Justice Review found that children and young people in the youth justice system (both in custody and under community-based orders) were not receiving the mental health care they needed.[115] The Review identified gaps including inadequate screening and assessment; lack of dedicated forensic mental health facilities for children and young people, with the consequence that 'young offenders with serious mental health issues [were] often held in custody, perhaps inappropriately'; and lack of continuing care after a child or young person returned to the community.[116] The Review's recommendations included:
  - strengthening the focus on identifying and intervening with young people to address their mental health needs in custody and supporting referral to mental health services in the community[117]
  - embedding a systems approach to identifying and meeting needs[118]
  - establishing priority access to mental health (and other) services for children and young people in youth justice[119]
  - establishing a youth forensic mental health precinct.[120]

112 Productivity Commission, *Report on Government Services 2019*, Table 17A.19. In 2013-14 there were four reported incidents involving three young people; no reported incidents in 2014-15; and four reported incidents involving three young people in 2015-16.
113 *The Same Four Walls: Inquiry into the use of isolation, separation and lockdowns in the Victorian youth justice system*, pages 61-3.
114 Recommendation 7.
115 *Youth Justice Review and Strategy: Meeting needs and reducing offending*, part 2, pages 45-6.
116 *Youth Justice Review and Strategy: Meeting needs and reducing offending*, part 2, pages 45-46.
117 Recommendation 6.9.
118 Recommendation 6.13.
119 Recommendation 6.13.
120 Recommendation 6.14.

The Victorian Government has implemented some recommendations and is working towards implementing others. However, the Commission is concerned that significant risks remain that warrant the Royal Commission's attention. This is particularly important given the Youth Parole Board data indicates that mental health problems, suicidal behaviour and experiences of abuse, neglect and trauma among children and young people in youth justice custody are increasing.

Mental health responses are not well embedded in youth justice centres' operations

The Commission has had ongoing concerns about staff responses to, and management of, children and young people self-harming since its *The Same Four Walls* inquiry, which found failures to intervene when children and young people were self-harming in isolation rooms.[121]

After the inquiry report was tabled and published in March 2017, the Commission wrote to the (then) Department of Justice and Regulation in August 2017 about six incidents involving children and young people actively self-harming under staff observation, without immediate or timely staff intervention. In one instance, a child engaged in a series of self-harming behaviours for approximately 60 minutes under constant staff observation. During this time, the child used different ligatures, vomited and was seen to be lying motionless on the floor before staff intervened.

In response to the Commission raising these serious issues, the Department developed policies and rolled out staff training on responses to self-harming and suicidal behaviours. Youth Justice policies now include some direction about the involvement of clinical advice in determining observation levels, in response to the recommendation in *The Same Four Walls*.

The Commission had reason to write to the Department again in January 2018, following a further incident involving a young person self-harming under direct observation. In this instance, the young person created a ligature and tied it around his neck then harmed himself with an object over a period of 15 minutes before staff intervened.

Towards the end of 2018, the Department also agreed to provide the Commission with reports of all 'category two' self-harm and attempted suicide incidents for review, to enable the Commission to monitor the degree to which improved policies and procedures were being embedded in youth justice centre operations. As a result of this oversight, the Commission identified that significant risks remain this year. Commissioners wrote to the Department about further examples from November 2018 to January 2019 of inadequate responses to children and young people self-harming.[122] In response, the Department had advised that it shares the Commission's concerns and further improvements will be made. The Commission acknowledges the Department's commitment to making improvements in this area, but is concerned that this pattern of inadequate responses and overall management of self-harm incidents may indicate inadequate engagement between mental health professionals, youth justice centre management and staff.

The Commission acknowledges that health service providers in the youth justice centres changed in February 2019. For mental health, both youth justice centres have a 24-hour, 7 day a week primary mental health service delivered by Correct Care Australasia and a specialist mental health services delivered by Orygen Youth Health onsite. The primary mental health service is the first point of contact if youth justice custodial staff have any concerns about a child or young person's mental health. Custodial Forensic Youth Mental Health Services provided by Orygen Youth Health offers further specialist multi-disciplinary mental health treatment and care and accepts referrals from the primary mental health service.

121 Page 62.

122 All incidents were classified as 'category two' incidents.

We encourage the Royal Commission's review of forensic mental health in youth justice custody to assess current co-ordination and engagement between mental health services and youth justice management and staff.

Lack of forensic mental health facilities for children and young people continues to be a significant issue

In Victoria there is no dedicated forensic mental health facility for children and young people with acute mental health issues. Youth justice staff typically struggle to provide adequate support to these children and young people and do not have the benefit of embedded mental health specialists, as is provided in adult correctional facilities, or a suitable built environment.[123] Facilities for children and young people with significant mental health needs fall grossly short of those available in Victoria's adult correctional system.

The lack of suitable facilities for children with acute psychiatric illnesses has been well recognised. In 2009, a Parliamentary Inquiry advised the government that a secure forensic mental health treatment centre was required.[124] Since this time, similar recommendations have been made by the Victorian Ombudsman,[125] the Armytage and Ogloff Youth Justice Review[126] and the 2018 Victorian Parliamentary Inquiry into Youth Justice Centres in Victoria, both of which recommended the establishment of a young justice forensic mental health precinct.[127]

The Victorian Government's 2017-18 budget provided funding for a two-bed secure adolescent inpatient unit, a Custodial Forensic Youth Mental Health Service and Community Forensic Mental Health Service. The new youth justice facility being constructed at Cherry Creek will include a 12-bed mental health unit.[128] The Commission strongly supports the establishment of dedicated facilities to support children and young people who are experiencing significant psychiatric and psychological issues. However, these facilities will not be operational for some time. It is necessary to ensure that children and young people do not go without the treatment and support they require now. Without proper treatment, mental health conditions can get worse and rehabilitation is unlikely.[129]

Lack of appropriate facilities for children and young people unfit to plead

In addition to the general cohort of children and young people in youth justice custody, the Commission has been deeply concerned about children and young people found to be 'unfit to plead' due to mental illness or intellectual disability under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*, being held inappropriately in Victoria's youth justice centres. The Commission identified this as a significant issue in *The Same Four Walls*.[130]

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123 The Commission's *The Same Four Walls* inquiry included a visit to Thomas Embling Hospital to view isolation spaces. The hospital included rooms where staff could remotely manage patient's access to the bathroom sliding doors to reduce risks when required.

124 Parliament of Victoria, Drugs and Crime Prevention Committee 2009, *Inquiry into Strategies to Prevent High Volume Offending by Young People,* page 282.

125 Victorian Ombudsman 2010, *Whistleblowers Protection Act 2001: Investigation into conditions at the Melbourne youth justice precinct*.

126 Recommendation 6.14.

127 Parliament of Victoria, Legal and Social Issues Committee 2018, *Inquiry into youth justice centres in Victoria – Final Report*, page 96, recommendation 15.

128 See the *Government response to the Parliamentary Inquiry into Youth Justice Centres in Victoria*, pages 14-15, available at https://www.parliament.vic.gov.au/images/stories/committees/SCLSI/Youth_Justice_System/GovernmentResponse_SCLSI_Youth_justice_centres_in_Victoria.pdf. Also see page 3.

129 *Youth Justice Review and Strategy: Meeting needs and reducing offending*, executive summary, page 13; part 1, page 181; Parliament of Victoria, Legal and Social Issues Committee 2018, *Inquiry into youth justice centres in Victoria – Final Report*, page 94.

130 'The Same Four Walls', page 63

The practice was continuing during Armytage and Ogloff's Youth Justice Review. Armytage and Ogloff recommended that the practice cease immediately and Youth Justice commence a process to find appropriate alternative accommodation.[131]

The Commission is aware that children and young people on *Crimes (Mental Impairment and Unfitness to be Tried) Act* orders continued to be placed in youth justice custody in 2018. To the Commission's knowledge this systemic issue remains unresolved and therefore the risk remains that children and young people on CMIA orders could continue to be held inappropriately in youth justice centres.

Youth justice custody environment and practices

The Commission has ongoing concerns that the current environment and practices in Victoria's youth justice centres – while the subject of government attention and reform – are likely to compound rather than alleviate children and young people's mental health concerns. While the Commission acknowledges that changes are in train, youth justice centres continue to be environments that negatively affect the wellbeing and safety of children and young people and staff alike.

The Commission has been particularly concerned about isolation and lockdown practices. *The Same Four Walls* inquiry found children and young people were subjected to unacceptable levels of isolation and routinely 'locked down' in their rooms. The report cited international research showing isolation is not only often ineffective in managing behaviour and may be counterproductive, it can cause significant distress to children and young people and may lead to psychological damage.[132] During the inquiry, children and young people told the Commission about how being in isolation affected them:

> I don't feel safe – you can take a rock and cut yourself – you could choke yourself out – you go nuts – you try being on your own – you don't even have a family member to talk to.
>
> I know myself when I don't have radio or TV, I become suicidal because I think about things all the time.
>
> Mentally f**ks with my head – same thing all the time.

The Northern Territory Royal Commission similarly heard evidence about the serious harms caused by isolation, including 'psychological damage',[133] and found that isolation practices used in Northern Territory youth justice centres had 'very likely' caused 'lasting psychological damage' to children and young people in some cases.[134] Since *The Same Four Walls*, the Commission has continued to monitor isolations and lockdowns closely and later this year will conduct a follow-up piece of analysis to assess improvements.

More broadly, research has shown the experience of being in custody itself is traumatic and often triggering:

> One quarter of those in youth detention who had ever had thoughts of suicide or self-harm reported an increase in those thoughts after entering custody.[135]

131 Recommendation 8.51.

132 Page 13.

133 *Report of the Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory*, Volume 2A, chapter 14, pages 285-288.

134 *Report of the Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory*, Volume 2A, chapter 14, page 330.

135 Moore E, Gaskin C & Indig D 2015, 'Attempted suicide, self-harm and psychological disorder among young offenders in custody' *Journal of Correctional Health Care* 21(3): 243–54, as quoted in the *Australian Institute of Health and Welfare's National data on the health of justice-involved young people: A feasibility study 2016-17*.

The adverse effects of detention must be avoided to the greatest extent possible. This means maximising diversion and bail. We encourage the Royal Commission to consider the Commission's submission to the Productivity Commission's Mental Health Inquiry, which outlined various ways youth justice systems could better protect and improve children and young people's mental health and increase their prospects of rehabilitation.[136]

Aboriginal children and young people

While there is no data relating specifically to Victorian Aboriginal children and young people, the higher rates of psychological distress and higher rates of suicide among Aboriginal children and young people nationally are well-known[137] – and recognised nationally as requiring urgent action.[138] Last year the Australian Institute of Health and Welfare reported that Victoria (along with Tasmania) had the highest rate of Aboriginal young people aged 15 to 24 years reporting mental health conditions.[139] This is the 'most vulnerable age group of Indigenous Australians… where suicide is over five times more prevalent than in non-Indigenous Australians of the same age'.[140]

As the Koori Youth Council's *Ngaga-Dji* report explains, the social and emotional wellbeing of Aboriginal children and young people is affected by social, cultural, historical and political determinants.[141] Victoria's Aboriginal Social and Emotional Wellbeing Framework, *Balit Murrup*, acknowledges the range of historical, cultural, social and economic factors that drive poorer mental health and social and emotional wellbeing among Aboriginal people, including the profoundly negative effects of colonisation, racism, discrimination and disadvantage and intergenerational trauma.[142] The intergenerational effects of the historical polices that removed children from their families were highlighted in a recent AIHW report, which showed Aboriginal children aged under 14 years living in a household with a family member who is part of the Stolen Generation, are more likely to experience stress and have poor self-assessed health, compared with other Aboriginal children.[143]

136 This submission is available on the Commission's website.

137 See, for example, Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 8 and 82. Also see the Australian Institute of Health Welfare's report *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*.

138 See National Mental Health Commission Media Release, *Government-led roundtable meeting to review investment to date in mental health and suicide prevention*, 5 June 2019; Royal Australasian College of Physicians Media Release, *Health bodies declare Aboriginal youth suicide an urgent national priority*.

139 Australian Institute of Health Welfare 2018, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*, Cat. no. IHW 202. Canberra: AIHW, page 129.

140 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, page 17.

141 Koori Youth Council 2018, *Ngaga-Dji (Hear Me) – Young voices creating change for justice*, page 41.

142 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, pages 6, 10, 20.

143 Australian Institute of Health and Welfare 2019, *Children living in households with members of the Stolen Generation*. *Balit Murrup* notes '[o]ver 47 per cent of Aboriginal people have a relative who was forcibly removed from their family due to Stolen Generation Policies in Victoria': page 16.

Balit Murrup also recognises the barriers Aboriginal people have faced in accessing mental health support and services.[144] This includes 'experiences of racism' in health service settings, which can 'compound' Aboriginal peoples' higher levels of psychological distress and affect their decisions about seeking help from health services and 'acceptance of and adherence to treatment'.[145] *Balit Murrup* acknowledges that 'the mental health and primary health service systems have been largely ineffective in responding to the high rates of psychological distress experienced within Aboriginal communities'.[146]

VAGO recently reported that it is not possible to determine whether Aboriginal children and young people are using Victoria's mental health services at a rate that matches their need for treatment. Research suggests this is unlikely to be the case,[147] and *Balit Murrup* highlights that 'only one in four Aboriginal children experiencing traumatic life events are accessing appropriate services'.[148]

The Commission's 2016 inquiry relating to Aboriginal children and young people in out-of-home care found that lack of Aboriginal specific services was a common issue raised, along with other issues relating to the mental health system.[149] The Commission heard from many health professionals about the need for resourcing of and greater access to culturally appropriate mental health and drug and alcohol services for Aboriginal children in out-of-home care.[150] The Commission considers that Aboriginal children and young people need access to both well-resourced Aboriginal community controlled health services and culturally safe mainstream mental health services, which work in partnership – as discussed in our response to Question 9.

The problems highlighted above relating to child protection, out-of-home care and youth justice custody disproportionately affect Aboriginal children and young people, given their significant over-representation in these systems. As highlighted in *Balit Murrup*, this over-representation is both related to the 'level of social and emotional wellbeing and mental health problems in Victorian Aboriginal communities' and a fundamental reason for whole-of-system reform of the mental health system to improve the social and emotional wellbeing and mental health of Victoria's Aboriginal children and young people.[151]

The Commission has made various recommendations to protect and improve the social and emotional wellbeing and mental health of Aboriginal children and young people who are involved in the child protection system, placed in out-of-home care and detained in youth justice custody.[152] The fundamental need to protect and respect Aboriginal children and

144 Pages 17-18.

145 Page 17. Also see Kelaher, MA, Ferdinand, AS, Paradines, Y 2014, 'Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities, *Medical Journal of Australia*, 201(1), pages 1-4.

146 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 18.

147 See, for example, Westerman, T 2010, 'Engaging Australian Aboriginal youth in mental health services', *Australian Psychologist*, 45(3): pages 212-222. Also see Orygen, The National Centre of Excellence in Youth Mental Health and *headspace* submission to the Productivity Commission's Mental Health Inquiry, page 31.

148 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, page 19.

149 *Always was, always will be Koori children*, page 50.

150 *Always was, always will be Koori children*, page 95.

151 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, pages 16-17.

152 See, for example, *Always was, always will be Koori children*, recommendations 2.2, 8.1 and 8.5; and the Commission's joint report with the Victorian Equal Opportunity and Human Rights Commission, *Aboriginal cultural rights in youth justice centres*, recommendation 3. The Commission's inquiry into issues of cumulative harm and suicide in child deaths (detailed in our response to Question 2) also included a relevant recommendation.

young people's cultural rights, including connection to culture, country and community, is at the heart of these recommendations. Our current inquiries relating to experiences of children and young people in out-of-home care and over-representation in the youth justice system (along with the joint Youth Justice Taskforce with the Department of Justice and Community Safety) will also address Aboriginal children and young people's wellbeing and safety in these systems.

Question 9

Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change.

Based on the issues the Commission has highlighted in the previous responses, we suggest the following priority areas for reform.

Enhanced and expanded support for children and young people

The current mental health system is not adequate for Victoria's children and young people, especially those experiencing moderate to severe mental illness, and requires urgent reform. This is clear from VAGO's findings and evidence the Royal Commission has already heard.[153]

Given the significant systemic issues, 'rising levels of distress among young people',[154] rapidly growing demand for services,[155] and that – as VAGO found – 'not all Victorian children and young people with dangerous and debilitating mental health problems' are getting the services they need, increasing their risk of having 'ongoing health problems', disengaging from education and employment and becoming 'involved with human services and the justice system',[156] the service system for children and young people aged 0-25 must be addressed as a priority. The recent Australian Government-led roundtable on mental health and suicide prevention similarly highlighted that addressing 'the current prevalence of youth mental illness and suicide prevention' must be an 'urgent priority' nationally.[157]

All Victorian children and young people experiencing mental-ill health have access to quality support and services.[158] Prevention and early intervention is also critical, as shown by the evidence set out in our response to Question 2 and the evidence that the 'optimal window of opportunity to improve the outcomes of mental disorders is the prevention or early treatment in individuals aged 0 to 25'.[159]

A reformed system centred around children and young people's needs

The reformed mental health system must be based around children and young people's needs and preferences. It must provide accessible, child and youth-friendly services that respond to children and young people's specific developmental needs[160] – as the Royal Commission has already heard.[161] VAGO has highlighted that the system currently fails to do

153 As set out in our response to Question 4.

154 Orygen, The National Centre of Excellence in Youth Mental Health and *headspace* submission to the Productivity Commission's Mental Health Inquiry, page 4.

155 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 21.

156 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 8.

157 National Mental Health Commission Media Release, *Government-led roundtable meeting to review investment to date in mental health and suicide* prevention, 5 June 2019.

158 As Dr Richard Haslam said in evidence on 5 July 2019 – page 316 (lines 17-26).

159 Fusar-Poli, P 2019, 'Integrated Mental Health Services for the Developmental Period (0 to 25 Years): A Critical Review of the Evidence', *Frontier in Psychiatry*, 10: 355, page 1.

160 Fusar-Poli, P 2019, 'Integrated Mental Health Services for the Developmental Period (0 to 25 Years): A Critical Review of the Evidence', *Frontier in Psychiatry*, 10: 355, pages 7, 8 and 15.

161 See evidence of Dr Richard Haslam, 5 July 2019, at pages 307 (lines 34-35) and 316 (lines 17-26); and evidence of Professor Patrick McGorry, 5 July 2019, at pages 331 (lines 14 to 29), 346 (lines 44-47) and 348 (lines 34-41).

this,[162] by having inconsistent age eligibility requirements,[163] using inappropriate triage tools and processes[164] and adult inpatient facilities,[165] and transferring young people to the adult system when they turn 18.[166]

The Royal Commission is encouraged to take a child and youth-centred approach to the design of the reformed system. In 2014, the National Mental Health Commission recommended a person-centred mental health system 'where services are designed around the needs of people, rather than people having to organise themselves to find their way around what the system provides'.[167] More broadly, New Zealand's Oranga Tamaraki – the Ministry for Children is implementing a child-centred operating model that puts children's needs at the centre of decisions and services.[168] This includes 'embed[ding] the voices of children and young people into decision-making at both individual and system levels'.[169]

As the Royal Commission has already heard,[170] children and young people should be involved in developing the reformed mental health system: 'young people's preferences should influence youth mental health service system design'.[171] As two young people we consulted for this submission told us:

> it has to be designed with those people who are involved in it — Jenna[172]

> [there needs to be] a better genuine understanding of where we are coming from rather than just saying it… — Paul[173]

Meeting vulnerable children and young people's higher needs

Systems and services for groups of children and young people who experience poorer mental health need priority attention, as demonstrated by the issues we have highlighted relating to children and young people in the child protection, out-of-home care and youth justice custody systems.[174] This includes (for example):

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162 Also see Orygen, The National Centre of Excellence and *headspace* submission to the Productivity Commission's Mental Health Inquiry, page 23; Fusar-Poli, P 2019, 'Integrated Mental Health Services for the Developmental Period (0 to 25 Years): A Critical Review of the Evidence', *Frontier in Psychiatry*, 10: 355, pages 8 and 15.

163 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 19, 30.

164 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 10, 82.

165 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 32-34 and 38.

166 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 38. Also see evidence of Professor Patrick McGorry, 5 July 2019, pages 325 (lines 12-14) and 330 (line 42) to 331 (line 16) and Orygen, The National Centre of Excellence and *headspace* submission to the Productivity Commission's Mental Health Inquiry, page 23.

167 *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, Volume 1, 30 November 2014, page 42.

168 Oranga Tamariki – Ministry for Children, *Strategic Intentions 2017-2022*, page 15.

169 Oranga Tamariki – Ministry for Children, *Strategic Intentions 2017-2022*, page 18.

170 See evidence of Dr Richard Haslam, 5 July 2019, at page 313 (lines 11-18).

171 Hamilton, MP, Hetrick SE, Mihalopoulos C, Baker D, Browne V, Chanen AM, Pennell K, Purcell, R, Stavely H & McGorry PD 2017, 'Identifying attributes of care that may improve cost-effectiveness in the youth mental health service system', *Medical Journal of Australia*, 207(10), page S33.

172 The names of all the young people we interviewed have been changed.

173 The names of all the young people we interviewed have been changed. The young people's views and experiences are set out in full in **Attachment B**.

174 See our response to Question 4.

- establishing priority access to services for children and young people living in out-of-home care and involved with the youth justice system (for example, through embedding services within these systems or another means)[175]

- providing the specialised care they need, including responding effectively to children and young people's experiences of trauma.[176]

Orygen and Phoenix Australia have highlighted the 'urgent need' to improve mental health services' capacity to respond to children and young people's trauma.[177] This is also evident from the Commission's inquiry into the experiences of children and young people in out-of-home care and inquiries relating to child deaths.[178]

It is important that the Royal Commission also give particular attention to the needs of other groups of children and young people who experience poorer mental health, including (for example) children and young people who identify as LGBTIQ, children and young people from culturally and linguistically diverse backgrounds, children and young people from socially disadvantaged homes and children and young people in rural and remote areas.[179]

Addressing Aboriginal children and young people's specific needs

Aboriginal children and young people are a significant priority group, as reflected in *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*.[180] Ensuring the reformed mental health system responds to their specific needs should be a priority.

The Commission acknowledges the Victorian Government's strong focus on improving Aboriginal people's mental health and social and emotional wellbeing, through the *Balit Murrup* framework. It considers *Balit Murrup* sets good direction for whole-of-system reform, with its focus on self-determination, community control and Aboriginal leadership; the holistic Aboriginal concept of health encompassing social and emotional wellbeing;[181] connection to culture; healing; trauma-informed practice; person-centred care; culturally responsive services; community participation in the co-design and delivery of services; and partnerships

175 See our response to Question 4. Also see *Youth Justice Review and Strategy: Meeting needs and reducing offending*, recommendation 6.13 and Orygen, The National Centre of Excellence and *headspace* submission to the Productivity Commission's Mental Health Inquiry, pages 30-32.

176 See our response to Question 4; Bendall, S, Phelps, A, Browne, V, Metcalf, O, Cooper, J, Rose, B, Nursey, J & Fava, N 2018, *Trauma and young people. Moving toward trauma-informed services and systems.* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, page 18.

177 Bendall, S, Phelps, A, Browne, V, Metcalf, O, Cooper, J, Rose, B, Nursey, J & Fava, N 2018, *Trauma and young people. Moving toward trauma-informed services and systems.* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, page 10. Also see pages 7-8, 39, 50-51, 57, 60-61, which report issues including inadequate assessment of trauma, inadequate diagnostic frameworks, a shortage of practitioners skilled in understanding and responding to trauma, lack of trauma-informed approaches, inadequate number of sessions of treatment under the *Better Access* scheme and lack of integration and co-ordination.

178 See our responses to Question 2 and 4 and the Commission's 2017-18 Annual Report, page 45.

179 See, for example, Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 15-16 and 80; *Always was, always will be Koori children*, pages 94-95; Orygen, The National Centre of Excellence in Youth Mental Health and *headspace* submission to the Productivity Commission's Mental Health Inquiry, pages 30-33.

180 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, page 19.

181 See, for example, *Always was, always will be*, page 95; and Koori Youth Council 2018, *Ngaga-Dji (Hear Me) – Young voices creating change for justice*, pages 41, 56.

between mainstream mental health services, Aboriginal community controlled health organisations and other services.[182]

Aboriginal children and young people (and their families and communities) need access to well-resourced Aboriginal community controlled health services, as the Commission reported in *Always was, always will be Koori children*.[183] As the Commission noted then, 'ACCHOs provide a broader approach to health assessment and treatment… and important linkages to culture and community for Aboriginal people accessing the services'.[184] There must also be access to culturally safe mainstream mental health services, which work in partnership with ACCHOs – as *Balit Murrup* acknowledges.

Balit Murrup identifies a number of priority groups. These include – in addition to young people in the justice system and people who have experienced family violence or childhood sexual assault – Aboriginal people in LGBTIQ communities.[185] The Commission has also highlighted 'the need for specific support for Aboriginal children and young people who identify as LGBTIQ'.[186]

We encourage the Royal Commission to engage with the Victorian Aboriginal Community Controlled Health Organisation (VACHHO), other Aboriginal organisations and Aboriginal communities, families and children and young people to understand how well *Balit Murrup* is being realised and what more needs to be done – or whether anything needs to be done differently – in a reformed mental health system to ensure Aboriginal children and young people receive the mental health and social and emotional wellbeing support and services they need, including (as set out in *Balit Murrup*):

> Culturally safe, Aboriginal-led, social and emotional wellbeing approaches and programs targeted across education, health, housing, child welfare and the youth justice system… to prevent escalation of social and emotional wellbeing and mental health issues immediately and in later years.[187]

We note VAGO's comments that *Balit Murrup* does not include 'any specific commitments' about children and young people and the Department of Health and Human Services advised VAGO 'that a project targeting families at risk of children needing out-of-home care is underway with positive results', with 'an evaluation planned' but otherwise 'was unable to provide evidence of the progress of any other initiatives targeting children and young people or progress against the strategy itself'.[188]

VAGO also recommended that the Department 'monitor the rate that Aboriginal young people access [child and youth mental health services] to ensure that they are getting the mental health support they need'.[189] We support this, and also agree that '[more] timely and sophisticated data and comprehensive local responses are needed to assist in the reduction of risk of further [young] lives being lost following a suicide', as highlighted at the recent Australian Government-led Roundtable on mental health and suicide prevention.[190]

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182 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, pages 8, 12.

183 *Always was, always will be Koori children*, page 50.

184 *Always was, always will be Koori children*, page 95.

185 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, pages 20-21.

186 *Always was, always will be*, pages 94-95. See Recommendation 8.5, which the Aboriginal Children's Forum considers to be in progress and on track.

187 Victorian Government, Department of Health and Human Services 2017, *Balit Murrup: Aboriginal social and emotional wellbeing framework 2017-2027*, page 19.

188 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 82.

189 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, page 82.

190 National Mental Health Commission Media Release, *Government-led roundtable meeting to review investment to date in mental health and suicide prevention*, 5 June 2019.

The loss of 20 Aboriginal children to suicide in Australia in the first half of this year sadly underlines the importance of the Royal Commission reviewing Victoria's suicide prevention approaches for Aboriginal children and young people, to ensure all is being done to prevent further loss of young lives. Strategies and solutions must be Aboriginal-led and the Commission agrees with the Royal Australian College of Physicians (RACP), Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the National Aboriginal Community Controlled Health Organisation (NACCHO) that better funding for Aboriginal community controlled services is needed.[191]

Further research relating to the social and emotional wellbeing and mental health of Aboriginal children and young people is also needed.[192] As the current evidence base is limited, we encourage the Royal Commission to also draw on research from other First Nations who share similar histories, identities, experiences and stories of dispossession – Aboriginal people from Canada, Aotearoa/New Zealand and the United States.

Much better co-ordination and information-sharing across service systems

Co-ordination and information-sharing between different services supporting children and young people with multiple, complex needs (mental health, child protection, youth justice, disability support, education, etc) should be addressed as a priority.[193] For these children and young people, co-ordinated, 'wrap-around care' (or 'systems of care') is required.[194] VAGO and our inquiries relating to child deaths have highlighted this is not currently in place.[195]

As Orygen and Phoenix Australia report, children and young people with complex needs related to trauma, including those living in out-of-home care and involved with the youth justice system, are 'at very high risk of falling through the gaps of service delivery systems due to a lack of service coordination and integration'.[196] They recommend a systems approach 'where *all services and systems involved in a young person's life* are trauma-informed and working collaboratively':

> It is important to strengthen the capacity of youth mental health services to work in connection with other systems including education, human and social services and youth justice and provide continuity of service and consistent approach for young people as they move between various youth service systems.[197]

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191 Royal Australasian College of Physicians Media Release, *Health bodies declare Aboriginal youth suicide an urgent national priority*.

192 See, for example, Kilian A & Williamson A 2018, 'What is known about pathways to mental health care for Australian Aboriginal young people?: a narrative review', *International Journal for Equity in Health*, 17:12.

193 Clause 2.3 of the Royal Commission's terms of reference require it to examine 'strengthened pathways and interfaces between Victoria's mental health system and other services'.

194 See, for example, the Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 79 and 97-98.

195 Victorian Auditor-General's Report 2019, *Child and Youth Mental Health*, pages 10, 79, 86, 97-99 and 101; and see our response to Question 4.

196 Bendall, S, Phelps, A, Browne, V, Metcalf, O, Cooper, J, Rose, B, Nursey, J & Fava, N 2018, *Trauma and young people. Moving toward trauma-informed services and systems.* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, page 69. Also see pages 8, 20, 35, 61, 63-64 and 66 and Orygen, The National Centre of Excellence in Youth Mental Health and *headspace*'s submission to the Productivity Commission's Mental Health Inquiry, page 37.

197 Bendall, S, Phelps, A, Browne, V, Metcalf, O, Cooper, J, Rose, B, Nursey, J & Fava, N 2018, *Trauma and young people. Moving toward trauma-informed services and systems.* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, page 69 (emphasis added). Also see pages 8-9, 18, 61-62 and 65. Also see Orygen, The National Centre of Excellence in Youth Mental Health and *headspace* submission to the Productivity

These different systems must be supported 'to work together with a shared understanding and meet the holistic needs of what is often a shared client group', including through workforce development.[198] The recent Australian Government-led roundtable on mental health and suicide prevention similarly highlighted an 'urgent need to focus on training and supporting the diverse professionals working with those at risk of or with mental health issues'.[199] The Commission considers this should include professionals working with children and young people in the child protection, out-of-home care and youth justice systems. In multiple child death inquiries, the Commission has examined cases where Child Protection did not recognise the need to refer a child to mental health or alcohol and other drug support, and also seen examples of youth justice custody workers not responding appropriately to incidents of self-harm by children and young people. In our consultations with young people for this submission, a young person living in out-of-home care told us:

> I feel like for people in out-of-home care every single worker that works in that field should be trained in mental health. (Sarah)[200]

We encourage the Royal Commission to consider the reform ideas of all the young people we consulted with for this submission[201] – and the ideas of all children and young people who contribute directly to the Royal Commission.

Commission's Mental Health Inquiry, page 37, which emphasises the importance of care co-ordination for young people in the justice system.

198 Bendall, S, Phelps, A, Browne, V, Metcalf, O, Cooper, J, Rose, B, Nursey, J & Fava, N 2018, *Trauma and young people. Moving toward trauma-informed services and systems.* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne, page 66. Also see pages 11, 64 and 70.

199 National Mental Health Commission Media Release, *Government-led roundtable meeting to review investment to date in mental health and suicide prevention*, 5 June 2019.

200 The names of all young people we interviewed have been changed to protect privacy.

201 As set out in **Attachment B**.

Attachment A

About the Commission

The Commission for Children and Young People (the Commission) is an independent statutory body that promotes improvement in policies and practices for the safety and wellbeing of vulnerable children and young people in Victoria.

The Commission consists of Liana Buchanan, Principal Commissioner, and Justin Mohamed, the Commissioner for Aboriginal Children and Young People.

At the Commission we:

- provide independent scrutiny and oversight of services for children and young people, particularly those in out-of-home care, child protection and youth justice custody
- advocate for best practice policy, program and service responses to meet the needs of children and young people
- support and regulate organisations that work with children and young people to prevent child abuse and ensure these organisations have child-safe practices
- bring the experiences of children and young people to government and the community
- promote the rights, safety and wellbeing of children and young people.

The Commission's functions and powers are set out in the *Commission for Children and Young People Act 2012* and the *Child Wellbeing and Safety Act 2005* (the Act). In delivering these functions, the Commission aims to:

- provide advice and advocacy strongly grounded in evidence, on behalf of children and young people
- hear and highlight the views and experiences of children and young people to ensure these are central to planning and decision making
- apply a rights-based approach to our work drawing on the Victorian *Charter of Human Rights and Responsibilities* (2006) (the Charter)
- focus on the rights, safety and wellbeing of vulnerable children and young people and Aboriginal children and young people
- work in a way that is inclusive, culturally sensitive and respectful of the diversity of children and young people.

The Commission receives information about issues relating to mental health that affect children and young people known to child protection, in out-of-home care and children in youth justice custody in the following ways.

Child death inquiries

Child death inquiries are undertaken in respect of every child who has died in Victoria, who was known to Child Protection in the twelve months before their death. These enable insight into the child's interaction with a range of services including Child Protection, education and health, and can provide insight into service provision across the system.

Monitoring of serious incidents of children in out-of-home care and youth justice custody

The Commission is advised of most serious incidents recorded involving a child in out-of-home care and incidents involving children and young people in youth justice centres (custodial facilities). Incidents include allegations of physical and sexual abuse, self-harm and attempted suicide, which directly relate to the mental health of these groups of children and young people.

Individual or group inquiries

Inquiries can be undertaken into the circumstances of a child or a group of vulnerable children in child protection, out-of-home care or youth justice centres. Inquiries typically include review of the provision of mental health services and supports in place. For example, in 2018 the Commission completed a group inquiry into issues of cumulative harm and suicide in child deaths, in which it examined the services provided to 26 children who were involved with Child Protection and died as a result of suicide.

Systemic inquiries

The Commission can conduct systemic inquiries when it identifies persistent or recurring issues in delivery of services to children. For example, the group inquiry *Always was, always will be Koori children* examined services provided to Aboriginal children in out-of-home care.

Reportable conduct

The Commission is responsible for administering the Victorian Reportable Conduct Scheme, which seeks to improve organisations' responses to allegations of child abuse and neglect by their workers and volunteers. The Commission supports organisations that receive allegations in order to promote fair, effective, timely and appropriate responses, and provides independent oversight of the scheme. The Commission monitors patterns and trends in reportable conduct allegations, and this is also a source of information that informs the Commission's policy and advocacy work.

Attachment B

Young people's experiences and views

The Commission has been able to speak to six young people about their personal experiences and views of Victoria's mental health system for this submission. Their responses to the Royal Commission's questions are set out, essentially in full, in this attachment.

The names of the young people have been changed and some identifying information has been redacted, but otherwise the responses are in the young people's own words.

We gratefully acknowledge their contribution to the Commission's submission.

Each of the young people have experiences of Victoria's out-of-home care system, as well as the mental health system. Some are adolescents and are currently living in foster care or residential care. Others are in their early twenties, living independently.

Half of the group are male, half female. They live in different parts of Victoria, mostly in regional centres. The services they have used varies. Some have attended *headspace*, some have seen private counsellors or psychologists and a few have attended specialist community mental health services.

We are very grateful that these young people have been happy to share their personal experiences, views and ideas with us and are very pleased to provide these to the Royal Commission on the young people's behalf.

Cameron[202]

Cameron is 21 years old. He formerly lived in foster care.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

I found it difficult when I was in a depressed state and was desperately looking for a psych or counsellor to see. I got a health care plan from a local GP and she gave me a few local psychologists. I rang up and the earliest I could get in would be six weeks to two months. I then went into [redacted] my father/carer suggested to me to go see [redacted] I took a visit over there one afternoon, gave them my healthcare plan. They told me there was a two-month waiting list. I was very upset at the time, was looking everywhere, they put me on the list, I found it quite upsetting, like there wasn't anywhere to go.

Did they give you any interim suggestions?

They said I could see a counsellor once off, but I needed to see someone more regularly. I was not feeling well mentally, was struggling quite a bit thinking about my future and a lot of other things. I didn't have a lot of money either so it made things a bit difficult, and it felt like a pretty heavy burden. I felt like there was so much weight on my shoulders, I didn't know where to go in life.

Basically, everywhere I went I was being told there was a two-month wait. I used to see a psych but it was like $200 and after the rebate you still pay like $60 which is a fair bit for me.

3. What is already working well and what can be done better to prevent suicide?

Things like Lifeline and that are good.

Do you feel comfortable to use something like that?

I still find it a bit difficult getting myself to call someone on the phone, I am much better face to face because you can build rapport with the person better. I have used Kids Helpline.

I have thought about suicide in the past when in a bad state, but never got to that point. Having a carer who spoke to me about life, who supported me and I knew cared about me was probably the difference. The difference is having someone close to you who you have a relationship with that is positive. He allowed me to change focus to look at the other things that were good in life.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

The fact that the waiting period [to see a counsellor] was two months just made it so hard. Earlier on it was really hard to talk to new people about my past and the stuff that has happened. I wish there was a system where the counsellor could have a document that is shared so they already know what I told the last person, you know, some place like a database where a new counsellor comes in and has the

202 The names of all the young people interviewed have been changed to protect privacy.

understanding of where you come from and that, then you can get into the real guts of what you want to talk about. You know, [a system where] the person can opt in or opt out, like the new health records thing. I don't know the full understanding of it but similar to that.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

From the young people that I have associated with, at [service provider], everyone has their own experiences and is unique and different. But what I have found is that often, young people just don't know the different services. Like I had a good worker who I could speak to but others I know of weren't aware of the range of services or like where to go. I was in a good position because I had a carer that opted to look after me beyond 18.

I think having a kit with information around all services that are most beneficial for those in out-of-home care would be good. There's an app called Sortli for example which is good. All young people should be able to access this app. Even if they don't have a phone they should be able to be on the computer.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

From my perspective it would be good to have people aware of the support services within a local community. Even on an outreach basis. People who are in depressive states for example, I know myself things need to be made convenient to access support services, like if there are too many barriers it's like why is it worth even trying. The harder it gets, the deeper into depression you get. I think more outreach stuff, particularly for those who are in out-of-home care should be thought of. Basically, I come back to making it as convenient as possible. Like a social worker how they go out and visit, why can't a counsellor go to a place and make it appropriate for the young person. Like even GPs can visit through the home doctor or something.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change.

I would let people have access to more variety of support options. Like mentoring for example, they aren't a clinical support, but it is more like the relationship or friendship that creates networks, opportunities and enhances mental health before it gets bad. I had this experience when I had a mentor from Whitelion… He was doing this other work and he asked me to come along on a weekend, I found myself work out of this because of the networks.

11. Is there anything else you would like to share with the Royal Commission?

People need to be aware of how to make a complaint and how to make sure they are heard when they are unhappy with their care or whatever it might be. They should be able to complain about why these services have a two-month waitlist.

Instead of having a brick wall saying there's a two month wait, perhaps have a separate agency of workers that mainly deal with out-of-home care young people. I like social inclusion for those young people but having a separate option for kids in care is better for the kids because the counsellors actually will understand the issues that come along with living in care and they understand it's not just living with ya parents or whatever, like in a normal family.

Carli and Martin[203]

Carli is 15 years old and Martin is 14 years old. Both live in foster care.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

M: I feel like there's is a lot of stigma around men's mental health. You know they can't cry or anything and I think there isn't enough done around advertising that its ok for men to express their feelings. There is a lot of money for ads around domestic violence, which is great and should continue, but I think it's very important that men have the right and are able to express their feelings and this might help other aspects like family violence in the end

C: It's almost a trend for young girls to be self-harming and saying they have issues and depression. There needs to be more education around how to deal with our emotions, the right way, the wrong way. And how to get help. For example, the other day two year 7 girls both put up their arms and showed their self-harming and were laughing about it. It's like it was popular to not be ok. It used to be the phrase 'its ok to not be ok' which helped but I dunno I think now its dangerous. It's like a self-diagnosis of depression in some ways. Depression and anxiety, like they are complex, kids take it too far constantly. It can trigger other people. But doing it because it's popular or trendy is bad. That's where the education around this comes in.

M: I've never really seen someone self-harm.

C: At my school it's a girl thing to do it. The boys are violent and that's their thing.

M: I think that ties in with mental health, the boys will say 'I'll bash ya,' or shove, where my experience is the females are more verbal and less physically threatening.

Teenagers are quick to jump onto the extreme side of things 'I'm gonna commit suicide,' 'I'm gonna bash ya head in.' We need to make it cool to get help rather than to do the extremes.

There is one girl who seems so depressed I always check in on her. But then I wonder if that is how she feels or if that is for attention as well. I don't think she actually knows how to say, 'I'm feeling like this, what is the best way to get help?'

C: The other thing is teenagers ask other teenagers for help, and that doesn't work. The education [needs] to make it known that it is ok to have depression, but its ok to not have it as well if that makes sense.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

C: I have medication for ADHD. A side effect of that is it gives me significant anxiety. I have self-harmed in the past and I got help with that. It's a rule in my household where if you are doing any self-harm we have to go speak to someone about it. I haven't self-harmed in seven months and am very proud of myself. I continue to see my psychologist. If my carer hadn't noticed that I was self-harming I wouldn't be here. I was dealing with my sexuality, my mother all this other shit. My carer noticed and enforced that I need to see someone and she supported me doing this.

[203] The names of all the young people interviewed have been changed to protect privacy.

M: Australia spends the most money in the world on gambling yet we can't even get a spot in counselling. I asked to go to headspace and it has been seven months that I am waiting, where is the importance placed in that? If a child goes up to headspace and asks 'Can I see a counsellor?', they should take at most like a few weeks, but the wait gets to like seven months like me. We can't afford to see private counselling, it's so expensive. The government says we have all this stuff set up like headspace, but what's it even doing? It's probably wasting a lot of time with people who have some support already rather than people who actually need it.

C: With teenagers there is a lot of modelling behavior… like if teenagers see adults or other teens doing things often they will say it.

M: For a normal child or one that's not in foster care I think it is really hard. They have to use maybe a school counsellor or whatever. But for us we have a case worker so I always talk to them to make them help me get help. We have carers as well. But for the kids living with their birth parents that makes it so difficult.

C: In my school its good, we are located in a low status area, we have quite a lot of wellbeing support. There are more than seven counsellors at the school, some for the younger kids some for the older schools.

C: They encourage us to make an appointment with the school counsellor. Our school has a program for kids that can't do mainstream school. But every single kid that attends our school knows at least one counsellor and they familiarise ourselves with them.

M: The government focuses on poorer areas but then schools in other areas won't get the same amount of funding or in any case there are major gaps, at our school there isn't enough and just because it isn't a poor area doesn't mean it should be that way.

M: At our school a lot of kids have told me they don't like speaking to the wellbeing teacher because they are worried about it going to the teacher or principal.

C: Like I've done drugs, I was telling my wellbeing teacher, and she was able to talk to me about it rather than judging me. The only time she told anyone something about what we spoke about was when I threatened another student.

3. What is already working well and what can be done better to prevent suicide?

C: It's hard because suicide is such a personal thing. There are the early signs. We need to be educated about suicide and we need to know that it's a permanent solution to a temporary problem. There's no way of preventing, the only way is to see the warning signs and the red flags and help before it happens. It comes back to education and trends. Like the amount of times that you hear in the school yard, 'I want to die' just the trend of saying that is such a big thing for me anyway.

4. **What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.**

5. **What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?**

M: There is so many reasons. Trauma from childhood, could be sexual abuse when they were kids… some could be hereditary.

C: Yeah, like I was a baby that didn't get held at all. I think they call it a floppy baby. Things like that we haven't developed. We can't read social cues. We have dealt with things that adults deal with but kids can't. I say I have a three-year old brain, a 19 year old brain and a 40 year old brain. I go from having a tantrum to having a philosophical discussion about how bad racism is in our community. At different stages we have less or more maturity, I have friends when I think about my '40 year old brain' where my friends seem so dumb, where other times my friends can't be around me because I'm immature and laugh at someone saying Doo Doo. It's hard for us as well, like do we want to be our parents?

We can't look at these emotions and break down why these are happening. Like I love people myself, whereas my mother hates everyone. Like I believe all people are equal, whereas my mother is very bigoted. I don't want to become my mum so much that I am obsessed with not becoming her. All of that, plus being a teenager, plus social media…. I went to resi when I was […] years old, it was only a few months but I was moved so much.

M: The foster care system is so overcrowded. There needs to be more money in foster care to attract people. Though that could be bad because they are only in it for the money. One of the kids I used to live with was a three year old but was technically a 13 year old. They kind of lied to my carer to get her into a home, they need to be honest and be clear with the carers.

C: Even if we don't understand the things that we say that you have to do this, not saying 'I don't know.' Just need to be honest. More open and honest communication. I have an idea that I have talked to my foster carer about. We need every single kid in foster care to go to a psychologist and be able to speak about whatever they want. Someone to talk to minimum once per month. Doesn't matter how old you are but you need that opportunity. I doubt it would cost much, but it would be a huge thing for us.

M: Yeah I agree.

How would that look? Are all young people comfortable to go and sit in a psychologist's office?

M: Can't really be done better necessarily. I guess like case workers are important because you already have that relationship with them.

C: I think counsellors need to make it personal so they can make us feel comfortable being personal. I have a volunteer who works with me, she has for a couple of years and she shares things about her life and I share my life. I trust her so much because she has opened up about herself. To trust someone you need to be with someone you trust. You know equine therapy, where you aren't in a room like this you are out on a horse doing things and you are talking as you are doing it. It's a more comfortable environment that sitting in a weird room.

6. What are the needs of family members and carers and what can be done better to support them?

C: I saw this on [the film] *Instant Family*. They have a foster care support group. We need to have a way where they can go openly express themselves and not be judged but can be supported. It's kind of like that alcoholics meeting on tv. I also think they should have open access to psychologists as well, this is full on shit if you have a six-year old losing their shit because of the stuff that went on at their home. Those extra supports would be helpful.

M: Acknowledge their work better. Might be better money.

M: Workers get verbally abused and all this shit. It's horrific really, it's probably worse than being a nurse or something. My foster [sibling] is a nurse and she would get abused on a daily basis. Here they get the same, its horrific. Even my [parent] in the past (who I don't like) abused many workers and the support workers who are there to support [them].

11. Is there anything else you would like to share with the Royal Commission?

C: The popularity of being sad is an issue for younger people I think. The smarter the education around mental health, the better addressing it will become. Seeking help appropriately rather than glorifying it because it can impact people and sway them to be that way.

M: The ads for males. I think it's pretty bad how a lot of men feel about themselves which is clear with the suicides. Also the waiting time for me to get into see a counsellor after taking the step to seek one out and then waiting seven months. Also like I don't have to be a manly man. You know 'toughen up be a man, don't be a dickhead.' Like we may be different gender to females but we still have a same emotions.

C: One of my friends said his mate broke down crying to him every night for the past month and the only time he could talk about it when no one else was around. My advice is just don't give up even if the system isn't working.

Jenna [204]

Jenna is 22 years old. She formerly lived in foster care.

1. **What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?**

   I don't know, like similar things to how there are posters around in the doctors about having injections and basic health things, why not have the same [advice that] everyone has a mental health check-up. Don't make it such a big issue.

2. **What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?**

   My [sibling] had issues with that, the hospital was great they had people checking up on [them] regularly. Mostly good but then there was also a friend of mine who was bed ridden and couldn't.

   I feel like from what I can tell people struggle with the concept of mental illness because of the media and the news. So you see the news showing people who commit crime as pleading mental illness, and then the community might not accept it.

   It's not visible, it's so real and horrible for those who are suffering it but for people who don't have people around them who suffer mental health that is where they get angry about it, they think it's an excuse. I feel like the news and media has a lot to do with that and has something to answer for. When things that are so horrific have happened, people struggle to come to terms with [those things].

3. **What is already working well and what can be done better to prevent suicide?**

   Oh my goodness my partner is [African], four people in his community passed away recently from suicide. It is so sad. This is such a massive issue.

   My family friend suicided, it is just so sad. There is so much of it going around. I wish I knew how to prevent it. I know there is that RUOK thing going around. People post on social media like 'I'm here to help you etc.,' but when push comes to shove are they actually there?

   I know there is a hotline as well… I dunno… I just dunno if people call it when they are at that point.

   My brother, when I was away recently he called me and was like I want you to know I'm gonna kill myself. He's fine now. He said to me 'I don't know when I'm gonna do it but I just wanted to tell you.' I think he's ok now but I was so stressed hearing that and not being around to go see him. All I can do is be kind, check up on him when I can. I'm not sure what else we can do if someone has made up their mind. I'm really curious to know how to prevent it fully actually.

   I have got a lot of suicide around me, especially through my partner and [his] community. I don't know what to do, and I don't think he does either. You just tell them you love them and are there for them and show them that but you never know what is going through their heads.

   Every other week within his community there is just so much… we don't talk about it heaps but they have a label. It is not true and I hate it, the way people see their community. People look at him like this sometimes that he's a criminal just because he is [of African background]. This basketball tournament he was in got cancelled because of

[204] The names of all the young people interviewed have been changed to protect privacy.

the way they are treated. His [siblings], they are scared to let them walk to school because they are really worried about them and the way white people treat them and see them, and people are scared of these kids as well but for no reason… its so unfair. How can you blame the [African] community for a small group of kids called 'the apex gang' like he's not friends with anyone who is into this stuff. They are all at uni, working, playing sport and really nice guys. There is a stigma about their community absolutely. Goes back to the media portraying them. It's like people thinking all Muslim people are terrorists because of ISIS, it's like blaming all white people for the KKK but people don't do that funnily enough… white privilege right there.

6. What are the needs of family members and carers and what can be done better to support them?

Firstly, my foster mum is old school and I don't think she even thinks mental illness is a thing. She is getting old and stuff, lives in the past a bit. Perhaps having workers work closely with her to educate her about how young people can [behave if they are experiencing mental illness]. Not someone who comes in and does a seminar and they eat cake and leave, but a worker who is ongoing to teach them how to look for signs and things, [like] how to support kids when they feel depressed.

The only reason we knew there was something wrong with my brother was because he came and told us. He was really scared and had some voices in his head, so he was legitimately scared and came to talk about it. If he hadn't have told me, talked to me about being suicidal, to this day I wouldn't know how to help him or that he is even feeling like this. Like in my head I just thought my brother was really messy and lazy and loved sleeping or whatever but now because he told me it's so much clearer and I can see what was happening for him.

Like my partner's friends who have passed away, no one seems to have seen this coming.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Yeah that's tough. I think people who have the knowledge. Like for example, all kids in foster care get an assessment no matter what, a specialist assessment and then at the end of it at least at that point what is needed can be said. You know you have this group of kids who have experienced shit, so put this in place as an early intervention.

In my instance it was a little fucked up to be honest. My [kinship carers] who raised me till I was [a teenager] decided that I had autism because their [child] had it. They took me somewhere and they went around saying I was autistic. So I had to live with this thing, they were making me feel I wasn't normal and all this, then when I went to the foster carer, they sent me to a specialist counsellor that I saw for like a year or so and I am grateful for. They obviously wanted to be really thorough and check what was going on. This counsellor brought in my [kinship carer] while I was in the room and said that 'I've been seeing her for this many months and she doesn't have autism.' I remember this relief.

I began to like my psychologist heaps, it really helped me.

What was it that you liked about the psychologist?

She was so friendly. She connected so well, made it easy to open up to her and talk about things. She made me feel safe to talk. She put the control in my hands. It was so great.

9. If you could design the system how would it look?

I think that's not my spot to say, other than it has to be designed with those people who are involved in it, who feel like they have issues, maybe with communities like the [African] community who have had so many suicides.

Paul[205]

Paul is 16 years old and lives in residential care.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

To be honest I'm struggling a little in my work with mental health people, cos I don't like to open up to mental health workers anymore. Cos I guess they have to for your safety but it's annoying at times they take you for your best interests and put you into a place that is safe, then after the fact you realise they are doing it for the best interests of me. Everyone is going through their period of life and everyone at some stage is going to have issues they need help with. So for me when I look at it I think that is a strength of the system, that there is places they can take you like that. I wouldn't have thought I should go there, and at the time I don't think I do, but then after it I realise why they make that choice and decision.

It's mostly about people learning more about the symptoms before it gets to that real bad stage, I think that would be the most helpful. So for the people around to recognise that things aren't right. That would be through support I guess to be honest.

3. What is already working well and what can be done better to prevent suicide?

I guess it's about for me, when I've tried to suicide I don't want people to help me. I just want to get through it myself and kind of finish it. I know that's not the best way to do it. At the end of the day it's not the right way cos it leaves other people behind and I know that.

For me I think what I needed, is to get through those really harder times, accepting the help that is provided to me.

How would people have been able to make you accept their help?

I don't think you can make me or anyone accept it. I think that that's when people who support the people who are struggling to have the skills, to know how to help them without them knowing it maybe. Sometimes I think that's the best.

Another thing I've done is I've also talked to Lifeline a couple of times, I've found that they are very supportive and understanding and sympathetic. They took me for who I am and talked me through that situation. It took me a while to see that it was going to be a rough time for a little while but I was going to get around. I don't know if many people call them though, but they should. Maybe the Lifeline people should teach other people who work or who are around people who need help. Not sure.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Depression and anxiety are things I struggle with a lot, has been really kind of hard for me sometimes actually. It's about having someone you can trust to talk to, everyone needs that. It makes things different in your head when you trust people basically.

And are mental health workers people you can trust?

I don't find it easy having the discussions with them cos I feel like they are gonna put me somewhere that I don't want to go as I said earlier, so for me it's easier with people that I

[205] The names of all the young people interviewed have been changed to protect privacy

am more comfortable with and around more I think. I know they do good things for me but I dunno, its usually times when I'm not feeling well is the times I see them.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this? (focussing on kids who live in out-of-home care and how to make their mental health better)

For me I have been bullied a lot in resi care units and that made my mental health struggle. For me if bullying has happened the kid should be fucken moved. I didn't wanna move back, I had the most traumatic experience and it got to the point he pulled a [weapon] on me. This was after like three weeks of constant bullying and you know what that did to me, it was bullshit. They should say 'right, [he needs to be] moved'.

That seems like it had a big impact on you, so to paraphrase from your experience are you saying that putting kids together in units wasn't good for your mental health?

Being here by myself has been a huge difference for me. I get to know the workers. They don't have to sit and do notes or go and do other shit following the kids like most of the time. Otherwise you don't even know the workers they are doing notes or in the office or whatever. That's a big difference being in this house myself, and as well as I don't get bullied by anyone in the place where I am staying.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Some of the biggest issues around mental health for me are like bullying and that especially for kids. If people realise that this isn't ok and having some common sense it would have made a huge difference. For me when I was getting bullied it affected me quite a lot, actually it affected me heaps. You just want to feel like you fit in and are part of the community, but instead people block you because of whatever issues and then you feel isolated, it's not nice being left out. Actually it's a horrible feeling. So yeah, bullying. I have heard people talk about it and stuff, but it still happens so much.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change.

I always feel like people who have been through the same or kinda the same stuff as me I can connect with more, I feel like if people had more knowledge, and have a better genuine understanding of where we are coming from rather than just saying it and I think they don't get it. Like they can say 'I understand what you are saying,' but you know that really they don't have a fucken clue… so yeah, I dunno, having more people who understand where you are coming from because they have been there maybe.

11. Is there anything else you would like to share with the Royal Commission?

I just think that young people should have access to things like animals and other things that are calming influence. I used to have a pet dog and I found that so calming… I'm pushing to have pets here… hoping it happens. But those things are kind of simple I reckon so it should just be able to happen to help.

I honestly just think this is great that we are getting the opportunity to say what we think should happen I think it's great…Thank you for coming to talk to me.

Sarah[206]

Sarah is 17 years old and lives in residential care.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Initially going to get help isn't that hard. It's the wait time that is really hard. Cos there isn't that many services out there. Multiple times I've gone to places and been put on waiting lists and it's been months and months and it took such a long time to even see someone so I would move onto the next place. One of them was [a community mental health service], most of them were private. I also went to headspace like a year ago and the wait list was so long, then I went back recently and I got picked up quickly. Last year when I went it was a six month wait so I tried other options.

I got a little bit of help from the GP to source these places, but I did most of it myself.

3. What is already working well and what can be done better to prevent suicide?

That's a great question actually. Well I think what could be done better is maybe, when you call a helpline or you talk to someone when you are trying to reach out for help. A lot of people jump to the conclusion of calling an ambulance or immediately working on the safety at that point in time, that scares people and probably prevents people from calling. It's better to talk more, getting a better understanding before you jump to conclusions like it does happen currently because that has a negative effect. More time listening rather than reacting immediately.

I think the Youth Access Team [run by Orygen Youth Health] is really good. Kids Helpline has been fairly helpful sometimes to me as well so those are two things that I think are helpful currently and should continue.

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

I think that services need to talk to each other better. I have been from one service to another and there isn't a handover. That has made things really hard. They say they don't want you to feel like you are starting again but it actually is like that. It is going through it all again.

Handovers should happen and be a lot clearer. Like within the same service even, if you're psychologist left and then another one comes in, it is very hard if they don't give a clear hand over. And it's very hard also if they didn't have it clear in the discharge plan about what you have already done.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

I feel like for people in out-of-home care, every single worker that works in that field should be trained in mental health. It should be much more detailed than whatever they already do. A lot of workers I've come across don't understand mental health well. They don't understand warning signs, or anything. If you are living in a resi unit, you need workers to identify the changes in you cos that is what a parent would do for kids living at home.

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I know kids who have lived in out-of-home care for a long time and their mental health has deteriorated heaps and I feel like if they [workers] were properly trained they would have noticed it early and been able to look at supports and things to put in place. I feel like there should be a clear plan in place, like even for kids with minor anxiety, anyone new that comes into that person's life knows about. Especially people who struggle with suicidal thoughts as well, if that plan isn't clear then you know what triggers them, how they might be normally acting etc. Even agency workers, that comes back to the training and the staff having detailed plans.

7. **What can be done to attract, retain and better support the mental health workforce, including peer support workers?**

   Maybe if they didn't make it such a negative thing if people were struggling with mental health. They need to put more light on the job and how it changes people's lives. Not just say 'this is what a mental health worker does', but actually show the difference it makes to people and the impact it can have. That would make people want to work there.

8. **What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?**

   I feel like if people treated mental health like they do physical illness with the same understanding and that. Like I know some people struggle to work, but if they made the environment more accepting people wouldn't struggle as much. Things like taking a mental health day that isn't part of sick leave for example. Also more groups and programs for people struggling with mental health issues. Small steps like this, they lead to big improvements I think.

9. **Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change.**

   I feel like there should be more after hours support services. The ones they do have are really really really busy so it is hard to get support sometimes. Under the mental health plan you get 10 sessions and can only apply for 5 more, for people who have mental health issues who are in care like me that isn't long enough. So they should make it ongoing for certain circumstances, like for us.