I would like to make a submission to the Victorian Mental Health Commission regarding the management and treatment of young people in Out of Home Care (OOHC). As a Social Worker, I have worked in residential care units, in the community as a Family Services Case Worker and in public mental health - in the context of both assessment and ongoing treatment.

These children and young people represent an incredibly vulnerable population, one who can easily become a case file number or a conglomeration of difficulties to be 'managed'. These children and young people represent a population that has survived pathogenic care, abuse, rejection and failures of the systems surrounding them.

These children and young people can either bring about a sense of nurture and protection within those who attempt to provide care and support or can project their sense of low self-worth with such intensity that those systems surrounding them do not feel the desire to provide them with the care they so desperately seek.

In my experience as a Child & Adolescent Mental Health Clinician I have been witness to the stories that young people bring with them in the context of significant behavioural difficulties and anxieties from the carers and organisations that attempt to address their needs with the "Best Interests of the Child". Often these children have experienced such abuse and neglect, the only option can be residential care - an option that can often exacerbate their mental health, attachment and developmental difficulties.

The children and young people we work with often present with a multitude of mental health diagnoses - Depression, Anxiety, Post-Traumatic Stress Disorder, Borderline Personality Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder, Conduct Disorder, neurodevelopmental diagnoses such as Autism Spectrum Disorder and Attention Deficit Disorder, speech and language difficulties, Intellectual Disabilities, difficulties with Executive Functioning - the list goes on. The underlying suggestion is that ultimately these children and young people have experienced traumas that far surpass what any young person should experience; and then this trauma and the relational templates that they have experienced are often reproduced and repeated, sometimes in worse circumstances.

Evidence proposes that these young people - particularly those with symptomatology that aligns with psychiatric illnesses in the context of relationships - need treatment in the form of consistent and stable care. These young people need to be able to transport themselves back to early childhood or even infancy and be able to re-learn how to trust and rely on others. To be able to have someone beside them to scaffold their experiences in a way that allows them to be challenged but also supported. To be able to explore, knowing they have a secure base to return to. To feel worthy of love in the way that any child has the right to.

In our mental health system today - we don't, and can't provide this. We do the best we can within a system that removes children from a home of abuse, neglect, rejection and dysfunction, to a place of residence that is shared with other traumatised young people who have already understood that the system - in some way - will eventually reject them. They join in with the maladaptive coping strategies that whilst unsafe, at least provide them with a sedation from the intensity of the emotions that come from relational disruption and disconnect. Alcohol, drugs, sexual exploitation, isolation, deliberate self-harm and expression of suicidal thinking. We as a system *see* these behaviours, but do we really *see* the child that is underneath the surface that is screaming as loud as they can for help. These behaviours are seen in the context of 'risk assessment', and yet it is truly a form of communication in a way a traumatised child only knows best how to express.

Emergency Services are overloaded with these young people screaming for help - and yet their communication can often be seen as 'behavioural difficulties'. The psychiatric illness or diagnosis can get lost in the behaviour, so too can their experiences and ultimately the underlying reason for their presentation.

Too often we find that the young people represented in OOHC are left to take responsibility for their actions which they cannot be asked to do. We see their disengagement or non-attendance to clinic based services as low motivation to change, an unwillingness to accept a helping hand. They are discharged in a way that can often again be seen as a rejection and another proof of evidence that they are not worthy of support and care.

Too often we see children - as young as seven years old - floating through the Child Protection, residential care and mental health systems. Anxiety takes over to the point where the system feels stuck, frozen and at a loss with what to do. Is it mental health? Is it protective? Is it behavioural? Staff and carers are traumatised as the more the child experiences a rejection from a foster carer, respite carer, is moved to a new residential unit - the more 'intolerable' and 'unmanageable' their behaviours become. Then the cycle begins again.

It sometimes feels simple. Provide these children with consistent, stable care and they will be 'treated'. But we need to find these people in the community, those who are willing to take on board a child or young person who will test every boundary presented to them. I ask - how much do we spend a year on one child to be accommodated for in residential care? How much do we spend on Emergency Services to provide crisis treatment when they are absconding, presenting with risk-taking behaviour, self-harming, attempting suicide? How much do we spend on forensic care and incarceration? How much *will* we spend on adult mental health services? If we add up the dollar amount this could result in - could we not provide carers with the financial assistance to meet the needs of these children in a loving, caring, consistent, predictable environment and home?

One of the biggest difficulties with this issue is - which service provider does this sit with? The answer is all of them. To best meet the needs of a child we need all services and systems to be working together to best provide a solution. Mental health needs to be consulting and informing based on the knowledge they have of a child / young person's presentation, their diagnosis, treatment and prognosis. The Child Protection Services system needs to be listening to the evidence that demonstrates the increased need for treatment to be in the form of consistent care rather than individual and even clinic based therapy. The residential care system needs to be better informed of this evidence to help them provide a more stable and predictable roster system. The foster care system needs more funding to be able to offer carers a pathway to provide the care these children and young people need.

It is a complex issue and a tragedy of our society. Every child deserves to feel worthy, to feel loved, to feel safe, to have stability, to feel supported in their dreams and to be able to bring to life their aspirations for a bright future. We know that this is happening, we know the system is flawed. What will it take for us to put in the time, effort and finances for our children that we as knowledgeable and informed adults are ultimately responsible for?

It has long been said that *"it takes a village to raise a child".* We need to be that village.