MacKillop Family Services

Royal Commission into Victoria's Mental Health System

MacKillop Family Services response

July 2019

Introduction

Thank you for the opportunity to provide a submission to the Royal Commission into Victoria's Mental Health System. MacKillop Family Services (MacKillop) is a leading provider of services to children, young people and their families in Victoria, New South Wales and Western Australia. MacKillop has approx. 1500 staff and the programs we deliver in Victoria include home-based and residential out-of-home care services, disability services, specialist education services, early intervention services, family support and family violence services and services to women and men who, as children, were in the care of the agencies that founded MacKillop. MacKillop also provide training nationally.

MacKillop is committed to being a trauma-informed organisation and is the national provider of the Sanctuary Model which has been embedded in MacKillop for the past 6 years.

Set out below are MacKillop's responses to the questions set out in the guide to completing a Formal Submission. The questions and accompanying responses are numbered as they appear in the guide. Where MacKillop did not have a view these questions have been marked with 'No response'. Where we have included a recommendation this is included next to the relevant question.

MacKillop Family Services

MacKillop acknowledges the high number of children and young people living with mental illness. Based on the second national survey of the mental health and wellbeing of Australian children and adolescents, the *Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing* indicated that in the 12 months prior to the survey around one in seven (13.9%) children and adolescents aged 4-17 years experienced a mental disorder – equivalent to an estimated 560,000 Australian children and adolescents[1].

Many of the service users we work with are living with mental illness and may also be involved with Victoria's mental health system. For example, as a provider of family support and out-of-home care services we acknowledge mental illness, together with family violence and substance use, is one of the three drivers of child protection notification and children entering out-of-home care[2]. We also note that children in out-of-home care are two to five times more likely to experience mental health problems and also experience double the rate of serious suicide attempts of the general population[3].

MacKillop is a provider of Cradle to Kinder services in Ovens Murray, Inner East (Melbourne), and Lodden areas. The services commenced operation in 2017. Each service has a capacity of 20-22 families. Demand for the services is high and each of the services is currently operating at capacity. The services are a multidisciplinary model delivered by a consortium of organisations led by MacKillop. The skill mix includes

[1] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer., M., Ainley, J. and Zubrick, S.R. (2015) *The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Commonwealth of Australia.
[2] Community Affairs References Committee 2015. *Out–of–Home Care*, Senate Community Affairs Committee, Parliament House, Canberra, pp. 64.
[3] Victorian Auditor General's Office (2019), *Child and Youth Mental Health: Independent assurance report to Parliament, 2018–19: 26*, Victorian Government Printer, Melbourne

early childhood development, infant mental health, maternal and child health, psychology, social work, as well as experience in trauma-informed therapeutic practice. Internal data collected in these services indicates that the proportion of the families where a mental health issue is present (such as Post Traumatic Stress Disorder, Depression and Anxiety) ranges from 61 to 75 percent.

The high proportion of individuals living with a mental illness in these programs is also reflected in other services we provide and highlights the significant proportions of services users engaged with our organisation who live with mental illness. As such, MacKillop is well placed to make comment on the intersections between vulnerable services users and Victoria's mental health system – system strengths, gaps and opportunities for development. We have seen first-hand the considerable variability in responses to addressing the mental health needs of the children, young people and families we work with. This submission pays particular attention to the needs of these vulnerable groups, their access to responsive mental health services and reforms to improve the mental health and wellbeing of the Victorian community.

Response to questions

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

MacKillop supports the implementation of a public awareness campaign to increase community awareness of mental illness and to reduce stigma and the discrimination of individual living with a mental illness. We note the evidence presented from VicHealth indicating that:

> Campaigns using social marketing and social contact, publicity campaigns, public education and user-based programs have been found to be effective in reducing stigma and discrimination, improving attitudes, and increasing awareness, knowledge and understanding of mental health issues[4]

Despite work in recent years to address the stigma associated with mental illness there is still considerable amount of work to be done it in this area, particularly for children and young people. For example, based on a self-report the most common reason for not seeking help or receiving more help given by 13-17 year olds with major depressive disorder were related to stigma or poor mental health literacy with 62.9 percent of respondents worried what other people might think or not wanting to talk to a stranger[5].

There is evidence to suggest that online resources have been shown to effectively engage young people, enhance knowledge about mental health issues and increase help-seeking behaviour for children and young people

- ReachOut.com[6]
- FRIENDS, Cool Kids, MoodGYM and SPARX-R[7].

MacKillop recommends:

Further investment in public awareness campaign to address the stigma of mental illness stigma and discrimination against individual living with mental illness and tools to promote help seeking.

[4] Welsh, J., Ford, L., Strazdins, L. and Friel, S (2015) *Evidence Review: Addressing the social determinants of inequities in mental wellbeing of children and adolescents*, report prepared by National Centre for Epidemiology and Population Health and the Regulatory Institutions Network for VicHealth, Melbourne.
[5] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer., M., Ainley, J. and Zubrick, S.R. (2015) *The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Commonwealth of Australia, p. 10.
[6] Welsh, J. et al, p.26.
[7] Centre for Mental Health Research, Australian National University (2019) *Submission to the Mental Health Inquiry Productivity Commission* available at https://www.pc.gov.au/__data/assets/pdf_file/0013/240304/sub148-mental-health.pdf

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

Building a trauma-informed mental health system

MacKillop believes there is considerable scope to improve trauma-informed care and practice across the mental health system[8]. Building capacity across the system would sharpen the focus on the experience and safety of service users, staff and carers and improve the quality of practice. As highlighted by the Mental Health Coordinating Council,

> TICP [trauma informed care and practice] exemplifies a 'new generation' of transformed mental health and human service organisations and programs which serve people with histories of past and current trauma. It is a practice that can be utilised to support service providers in moving from a 'caretaker to a collaborator role'…When a human service program seeks to become trauma-informed, every part of its organisation, management, and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of a person seeking services[9].

MacKillop notes that the Mental Health Workforce Strategy – a key deliverable of Victoria's 10-year Mental Health Plan – includes a focus on building the 'trauma informed' capacity of the mental health workforce. 'Trauma informed' is identified as a critical principle and the strategy notes:

> The impact of traumatic experiences on people who access health and human services can be profound and can vary considerably from person to person. Service delivery will be provided in a way that is informed by the impact of trauma on the lives of people requiring mental health treatment and care.[10]

MacKillop is of the view that building a trauma-informed system goes beyond 'workforce development'. We believe there is an opportunity for the Victorian government to show national leadership by augmenting the National Standards for Mental Health Services (2010) with a Victorian standard with the aim of building a trauma-informed system. This would go beyond workforce development to embed trauma-informed approaches to triage, assessment, planning, induction, supervision and practice. Our experience suggests that the implementation of clear standards are an effective means of drive practice change and practice improvement across a service system.

We are aware that the Department of Health and Human Services is currently in the process of developing a *Framework for Trauma Informed Practice* to promote the physical, emotional and cultural safety for people

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[8] See also Mental Health Coordinating Council, (MHCC) 2013, *Trauma–Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia*, A National Strategic Direction, Position Paper and Recommendations of the National-Trauma-Informed Care and Practice Advisory Group, Authors: Bateman, J and Henderson, C (MHCC) Kezelman, C (Adults Surviving Child Abuse, ASCA

[9] Ibid, p.3.

[10] Department of Health and Human Services (2016) *Victoria's 10–Year Mental Health Plan Mental Health Workforce Strategy*, Victorian Government, Melbourne, p.11.

in contact with services for children, young people and families in Victoria. Our understanding is that in the first instance this work is targeting child and family services including family violence services. We believe this work could provide the foundation for a new standard to augment the National Standards for Mental Health Services.

MacKillop recommends:
The development and implementation of a Victorian standard to augment the National Standards for Mental Health Services to build trauma informed practice across the mental health system.

The Sanctuary Model

The Sanctuary Model (Sanctuary) is a blueprint for organisations to build safe communities that help people to heal from trauma. MacKillop has been an accredited Sanctuary Model organisation since 2015 and is the home of the Sanctuary Institute Australia – the only accredited Sanctuary Model training and consultancy service provider in Australia. Sanctuary is implemented through a collaborative three year process, led by a steering group and core team from each participating organisation, instructed by the Sanctuary Professional Learning Program for all staff and supported by a Sanctuary Institute Australia Faculty consultant, to build on the strengths of the organisation.

Sanctuary is an evidence-informed approach that was developed in the early 1980s by American psychiatrist, Dr Sandra Bloom and her colleagues[11]. Their model, developed in an acute care psychiatric unit where most of the patients were survivors of traumatic childhood experiences has since been adapted to a range of organisational settings including residential care, youth detention, schools and other community services.

Sanctuary focuses on safety and creating an understanding of how past adversity can continue to have an impact throughout life. It recognises that trauma has an impact not only on the people who have experienced it, but also on the staff and carers who work with them and on organisations as a whole. As set out in **Figure 1**, Sanctuary has a focus on developing an understanding of trauma and a shared trauma-informed language and practice to build organisational capacity and, in turn, improve outcomes for service users and staff.

[11] Bloom, S. & Farragher, B., (2013) *Restoring Sanctuary: a new operating model for trauma–informed systems of care*, Oxford University Press, New York.

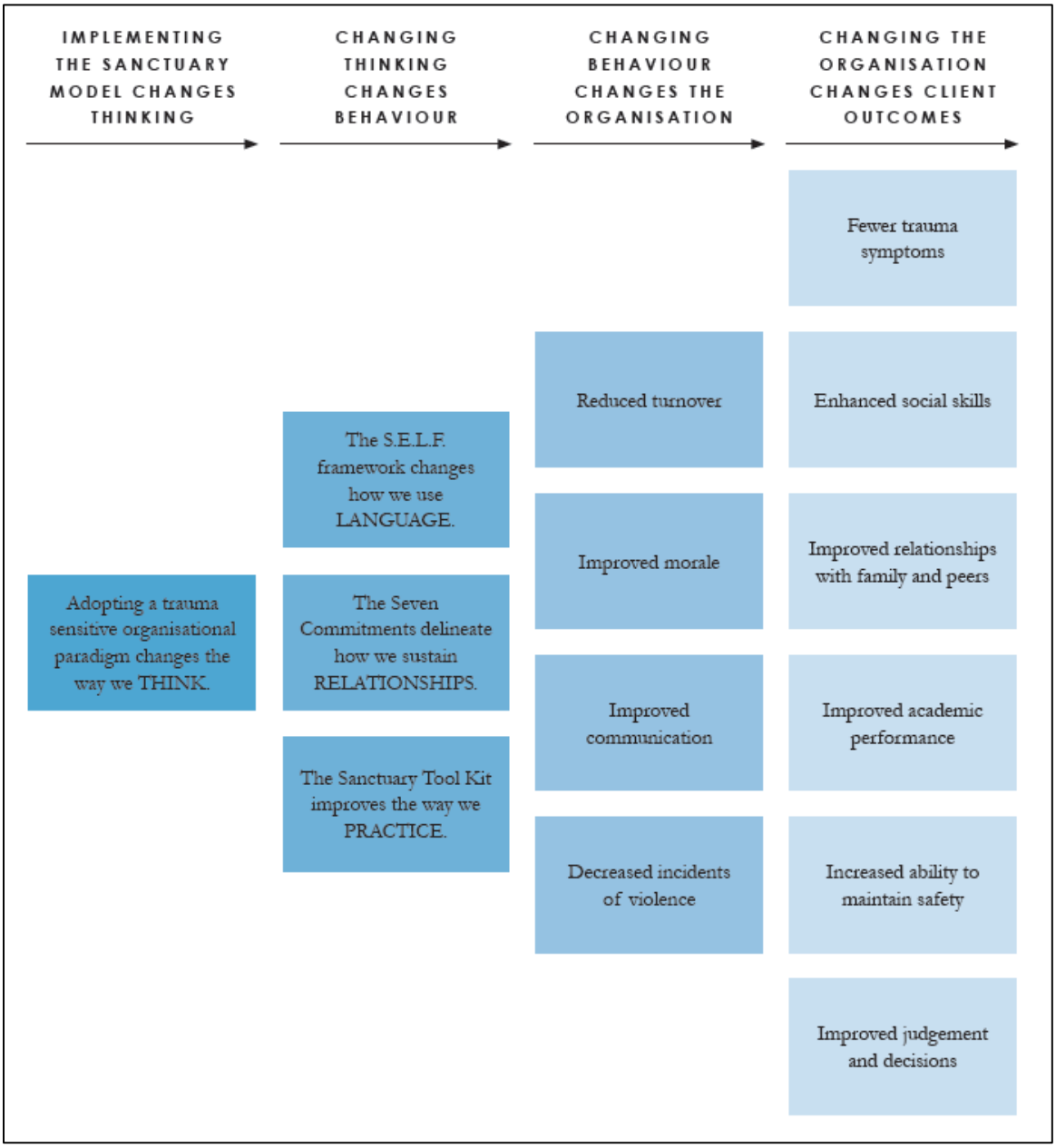

Figure 1: How does the Sanctuary Model work?

Sanctuary enables an organisation to create a safe, non-violent environment and relationships that teach people to self-manage stress and trauma more effectively. Sanctuary is structured around four 'Pillars' – an understanding of trauma theory, Seven Commitments or 'values', and trauma-informed problem solving framework SELF (safety, emotions, loss and future) and a set of practices within the Sanctuary 'Toolkit'[12]. Through a planned process of implementation, each of these interrelated pillars is embedded to provide a foundation for trauma-informed practice.

MacKillop acknowledges that are a number of trauma-informed models have been developed in recent years (see also Attachment Regulation and Competency framework (ARC) and Children and Residential Experiences

[12] Spicer, M. and Burton, V. (2019) 'Setting up a 'whole of culture trauma informed care model in Australia', in Benjamin, R., Haliburn, J. & King S. *Humanising Mental Health Care in Australia*, Routledge, New York, pp. 331-341.

(CARE)) and believes that services providers should be required to implement a trauma-informed framework to better support the delivery of safe and responsive services.

MacKillop recommends:
Consider a requirement for services working with people living with a mental illness to adopt a trauma-informed framework.

Evidence-based models and service innovation

MacKillop has been, involved in a number of initiatives to support children, young people and families to experience good mental health or respond to the mental health needs at an earlier stage.

Family Focus Multisystemic Therapy - Psychiatric

MacKillop is the Lead Agency delivering the Family Focus Multisystemic Therapy – Psychiatric (MST-P) Treatment Model in Victoria together with two Aboriginal Community Controlled Organisations (the Victorian Aboriginal Child Care Agency and Wathaurong Aboriginal Co-operative Ltd). This model has been in operation in the Western suburbs of Melbourne and Geelong since May 2018. Receiving referrals from Child Protection, Family Focus Multisystemic Therapy (MST) program is a family and community-based service for young people and their families. The first MST program in Victoria, Family Focus MST takes a different approach where the team works within the child's universe, meeting with family, community, school and peers, and working hand in hand with the whole family.

Multisystemic Therapy (MST) is an evidence-based family and community-based treatment for young people with complex clinical, social, and educational problems (e.g., violence, drug abuse, school expulsion). MST-P is an adaptation of MST created to serve families with young people at risk of out-of-home placement due to serious behavioural problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, impulsivity and substance use/abuse.

The goal of MST-P is to improve behavioural problems, mental health symptoms, suicidal behaviours and family relations while increasing the amount of time youth spend going to school and living in home-based placements. MST-P clinicians receive standard MST training and ongoing quality assurance support as well as supplemental trainings designed to address:

1. Safety risks associated with suicidal, homicidal and psychotic behaviours in youth
2. The integration of evidence-based psychiatric interventions for youth and caregivers
3. Treatment of adolescent and caregiver substance use/abuse utilizing an evidence-based treatment, contingency management
4. Evidence-based assessment and treatment of youth and caregiver mental illness including anxiety disorders, depression, bipolar affective disorder, thought disorders, attention deficit hyperactivity disorder, impulse control difficulties and symptoms of borderline personality disorder

While the program has been in operation for a relatively short period (one year), the strong indications are that this program has been successful in reducing admissions to both out-of-home care and inpatient psychiatric services. For example while all referrals to the young people are at risk of entering out-of-home care are the point of referral, 86 percent of young people were living at home at discharge.

MacKillop recommends:

- **Further investment to support the adaptation and implementation of evidence-based and evidence-informed models in the Victorian context.**
- **Further investment in research and evaluation to build the evidence-base of innovative programs developed in Victoria**

Supporting collaboration and joint capacity building: The Ripple project[13] – a model for mental health, alcohol and other drugs and out-of-home care services

The Ripple project was a five year National Health and Medical Research Council (NH&MRC) funded project conducted in partnership with mental health services (Orygen Youth Health, Royal Children's Hospital), substance abuse (YSAS) and out-of-home care community service organisations (MacKillop Family Services, Anglicare Victoria, Victorian Child Care Agency and the Salvation Army) in metropolitan Melbourne. In part, the project emerged in response to the Office of the Chief Practitioner's guideline regarding the provision of priority access to young people placed in out-of-home care and the need for improved collaboration between mental health and out-of-home care services.

The aim of the Ripple project was to strengthen pathways and interfaces between mental health service and out-of-home care services and assess whether a mental health intervention that strengthens the therapeutic capacities of the out-of-home care carers of young people (aged 12-17 years) will also improve the mental health of the young people by improving (i) the quality of OoHC; and (ii) access to early intervention for prevention and treatment of mental illness.

Main components of the work:

A. Organisational Collaboration and Contribution - Developing shared language and commitment was fundamental to the mode and content of delivery of the intervention

B. Mode of Delivery – a Ripple practitioner with specialist mental health expertise visits the out-of-home care service regularly at specified times: to develop relationships, establish trust, and strengthen staff capacity to use mental health concepts and skills in their work

C. Content - Mental health/ Alcohol and drug expertise and evidence-based knowledge (for example Tuning into Teens, Toolbox http://www.youthaodtoolbox.org/ http://oohc.webtribe.com.au/

[13] For further information see https://mhaustralia.org/general/ripple-project-better-mental-health-outcomes-young-people-out-home-care

D. Menu of Therapeutic and Mental Health Knowledge and Skills – Building capacity in the areas of challenging behaviours (and the role of trauma in their development and maintenance), emotion regulation, depression and anxiety, communication and social skills, family-focused interventions, motivational interviewing, problem solving, promoting resilience and self-harm and suicide

Evidence collected for the evaluation of the Ripple project indicated that:

> [I]t is feasible to implement a complex mental health intervention across sectors with relatively modest resources. The success of the intervention appears likely to depend on the strength of partnerships between organisations within and across service sectors[14].

Unfortunately, this model ceased when the funding for the five year NH&MRC project concluded. MacKillop believes this model could be reanimated and applied more broadly to support greater collaboration with, and access to, mental health services.

MacKillop recommends:
The implementation and evaluation of models that support collaboration and service responsiveness and development between mental health services and mainstream and secondary support services.

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

For children in out OoHC there is an urgent need for greater access to psychiatric inpatient care when required. Over 90% of the children in our care have experienced severe family violence, 50% are known to have experienced sexual abuse and the incidence is thought to be much higher; and approx. 70% have experienced physical abuse. This cumulative hard and neglect results in a traumatic impact that is severe and frequently suicidal ideation is a presenting concern. We experience extreme difficulty in accessing acute inpatient care and frequently the mental health system is unable to cope with the complex presentations of young people who self-medicate with drugs and alcohol, become aggressive, violent to staff and co-residents, sexually exploited, severely depressed and suicidal. The default response to these symptomatic behaviours is the residential care system having to cope with totally inadequate funding for clinical support or secure welfare.

[14] Herrman, H., Humphreys, C, Halperin, S, Monson K, Harvey, C., Mihalopoulos, C., Cotton, S., Mitchell, P., Glynn, T., Magnus, A., Murray, L., Szwarc, J., Davis, E., Havighurst, S, McGorry, P., Tyano, S., Kaplan, I., Rice, S. and Moeller-Saxone, K. (2016) 'A controlled trial of implementing a complex mental health intervention for carers of vulnerable young people living in out-of-home care: the ripple project, *BMC Psychiatry*, 16:436,

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.

MacKillop notes the release of the Victorian Auditor General's Office report *Child and Youth Mental Health*[15] and is supportive of both the findings and recommendations. The issues outlined in the VAGO report reflect much of MacKillop's staff and service user's uneven experience of the child and youth mental health system. This is particularly the case concerning the considerable variability in the responsiveness to mental health needs for vulnerable children and families, especially children in out-of-home care.

Mental health services to children and young people placed in out-of-home care

There is ample evidence to suggest that the cohort of children and young people entering out-of-home care – particularly residential or therapeutic residential care – have pronounced mental health care needs[16]. The 10 Year Plan for Mental Health acknowledged vulnerability of this cohort in seeking to close the gap in social and emotional wellbeing between this at risk group and their peers in the wider community[17]. Furthermore, in highlighting the complexity of the cohort of children entering therapeutic residential care houses, the evaluation commissioned by the Department of Health and Human Services of therapeutic residential care (TRC) pilot services[18] outlined the degree of complexity of children and young people entering therapeutic residential care (TRC) as compared to individuals assessed as eligible for a CAMHS/CYMHS service. The report indicated:

> The mean score at entry to TRC was considerably more severe than the mean total score for children and adolescents entering CYMHS community teams across Australia…[Health of National Outcomes Scale for Children and Adolescents] HoNOSCA total scores indicate overall symptom severity; this is elevated for this sample of young people compared to available norms. Based on over 46,000 observations from CAMHS/CYMHS across Australia, the mean total score at entry to community treatment is 14, and the median is 13. The mean score of 22 at 6 to 9 months post entry for TRC participants represents a percentile score that is more severe than 89% of CAMHS/CYMHS records…on each scale, the TRC group typically have more severe symptoms compared with those entering CAMHS/CYMHS[19].

These results are also reflected in more contemporary data (using HoNOSCA and the Strengths and Difficulties Scale) collected by MacKillop from the 11 therapeutic residential care houses we operate.

We note the criticisms in the VAGO report of the application of the *Statewide Mental Health Triage Scale* made in the VAGO report including that the tool:

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[15] Victorian Auditor General's Office (2019), *Child and Youth Mental Health: Independent assurance report to Parliament*, 2018–19: 26, Victorian Government Printer, Melbourne,
[16] Royal Australian and New Zealand College of Psychiatrists (RANZCP) (2015) *Position statement 59: The mental health care needs of children in out–of–home care*, available at https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/the-mental-health-care-needs-of-children-in-out-of
[17] Department of Health and Human Services (2015) *Victoria's 10–year mental health plan*, Victorian Government, Melbourne, p. 3.
[18] Verso Consulting (2011) *Evaluation of the Therapeutic Residential Care Pilot Programs Final Summary & Technical Report*, a report commissioned by the Department of Human Services, Melbourne.
[19] Victorian Auditor General's Office (2019), *Child and Youth Mental Health: Independent assurance report to Parliament*, 2018–19: 26, Victorian Government Printer, Melbourne, p. 150-151.

does not give any focus to developmental or cumulative risks that are critical for children and young people, does not capture the severity or longevity of mental health problems, and does not enable prioritising access for high-risk and vulnerable groups of children or young people[20].

The report highlights that the guidelines supporting the *Statewide Mental Health Triage Scale* acknowledge six challenges in the use with children and young people including:

- not recognising lower-order autism spectrum disorders
- confusing post-traumatic stress disorder symptoms with psychosis
- failing to identify depression, especially when it is masked by aggression or other forms of acting out
- dismissing some symptoms – for example, self-harming behaviour in girls, rage attacks in prepubescent boys – as personality or behaviour issues not requiring mental health services
- underestimating the risks involved when self-harming behaviour is new, as opposed to longstanding
- not acknowledging that obsessive eating behaviours may be early signs of eating disorders[21].

MacKillop staff, particularly in out-of-home care, have direct experience of these challenges in practice. Our staff can cite frequent examples of the actions of young people with significant mental health issues (including pronounced self-harming behaviour, threats of suicide) assessed as 'behavioural' and not related to mental illness. This includes rapid discharges from emergency departments in the absence of a clear or appropriate assessment and a clear disconnect between the assessment of risk by CAMHS staff and Child Protection.

MacKillop supported the 2011 introduction of the Office of the Chief Practitioner guideline to prioritise access to mental health services for young people in out-of-home care. We agree with the finding presented in the VAGO report that the guideline has not been well implemented and is poorly understood[22]. This certainly reflects our experience. The unevenness of access to appropriate and responsive mental health services is a significant and ongoing problem.

The Royal Australian and New Zealand College of Psychiatrists has developed a position statement regarding the approach to responding to the needs of children in out-of-home care. This includes:

- Access to competent, comprehensive, multi-disciplinary health and mental health services is a priority for children in out-of-home care.
- Increased recognition of and response to the high and complex needs of many children in out-of-home care within mainstream health and mental health services is necessary to enable timely access to effective health and mental health care for this vulnerable population
- There needs to be support for the development of targeted interventions for infants, young children and their carers. There is clear evidence for both the high exposure of infants and young

[20] Ibid p. 81.
[21] Ibid p.82
[22] Victorian Auditor General's Office (2019), *Child and Youth Mental Health: Independent assurance report to Parliament*, 2018–19: 26, Victorian Government Printer, Melbourne, p 84.

children to violence and adversity; as well as the benefits of early intervention and prevention in this age group.

- The influence of culture on the aetiology and manifestation of mental health problems in Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) children in out-of-home care needs to be well understood and translated into the policies and practices associated with assessing and caring for these populations.
- There should be timely decision making in relation to the best interests of children in out-of-home care and their need for stability and security in their environment. The needs of children in out-of-home care should be advocated for within the legal and child protection system.
- There needs to be increased awareness of the vulnerability of young people in out-of-home care aged 16 years and over who face having services cut back as they move into young adulthood. This cohort are often emotionally disadvantaged and ill-prepared for adult life. The New Zealand Ministry of Health's Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/Alcohol and Other Drug Services provides a good framework for planning this transition (2014).
- There needs to be support for research into the health and mental health needs of children in out-of-home care in order to:
    - inform policies and practices; and
    - provide evidence for psychological and pharmacological treatments of their complex psychopathology.[23]

MacKillop supports this framework as an appropriate model to better address the mental health needs of children in out-of-home care.

MacKillop recommends:

A comprehensive review of the implementation of the Office of the Chief Practitioner guideline to prioritise access to mental health services for young people in out-of-home care and the development of a more robust strategy to better meet the mental health needs of children and young people placed in out-of-home care.

The needs of children and young people in regional and rural areas

As a provider of services in regional and rural area we also note the pronounced service and support needs, coupled with the paucity of mental health service, in these areas. As identified in work completed by Centre for Community Child Health, children in rural Australia:

[23] Royal Australian and New Zealand College of Psychiatrists (RANZCP) (2015*) Position statement 59: The mental health care needs of children in out–of–home care*, available at https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/the-mental-health-care-needs-of-children-in-out-of

- have poorer access to early childhood intervention services, paediatricians, allied health and mental health services
- experience poverty at disproportionately higher rates
- are more likely to be Indigenous
- are more likely to live in unemployed households, with single parent families, and in families where the mother has a low educational attainment
- are more likely to be socially isolated
- are more likely to be exposed to family and domestic violence and have contact with child protection services[24]

For example, staff in our Warrnambool out-of-home care program report that:

- A service user must travel to Melbourne to access a neuropsychological assessments
- Family therapy service are not available locally
- Male Adolescent Program for Positive Sexuality (MAPPS) – an intensive group treatment program for adolescent males supervised by youth justice who have been found guilty of a sexual offence – is only delivered by one practitioner and there are lengthy waiting lists

Furthermore, our staff note that while a Headspace operates in Hamilton the service offering does not accommodate the complexity of needs of children entering the out-of-home care system.

MacKillop recommends the development of initiatives to open up access to services and supports to Victorian in regional and rural areas.

MacKillop recommends:
The development of strategies to open up access to mental health supports and services (including specialist services) to Victorians living in regional and rural areas.

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

MacKillop has deep experience of the importance of infant mental health and early parenting programs, and strongly recommends increased funding to prevent the emergence of mental health programs in later life. There is overwhelming evidence that the support of vulnerable parents, particularly young parents, who have been in OoHC or who have experienced child abuse and neglect, will prevent the transgenerational pattern from repeating, and harm to children.

MacKillop is firmly of the view that the foundation for addressing poorer mental health and improving wellbeing outcomes for Victorian children and young people relies on paying attention to the drivers of

[24] Royal Far West (2017) *The Invisible Children: The state of country children's health and development in Australia*, Manly https://www.royalfarwest.org.au/wp-content/uploads/2018/09/invisible-children-2018-web.pdf

inequities in the social determinants of poorer mental health. There is clear evidence of a link between socio-economic disadvantage and poorer mental health outcomes[25]. We view the findings of the recent work commissioned by VicHealth[26] to be valuable in this regard. A primary finding in this study is the clear link between socio-economic disadvantage and the increased risk of poorer mental health outcomes:

> Our review reveals that children living in the poorest families with access to the fewest resources, in the poorest neighbourhoods and schools, living in societies with the least communal health, economic and social resources report the poorest wellbeing and the highest rates of mental illness. Socioeconomic disadvantage intersects with gendered, psychosocial, geographical and cultural disadvantage, compounding inequities in some children and producing new forms of disadvantage for others[27].

The goal of addressing improved mental health outcomes for Victorians cannot be achieved through reforms of the mental health system (and allied sectors) alone. Sustained and population level improvement can only be achieved through a social policy reform agenda that addresses wider inequality, marginalisation and disadvantage:

> There is a clear and consistent graded relationship between mental health in children and most measures of SES [socioeconomic status]….Children with very high resilience in low-income environments still report poorer outcomes than children with very low resilience in high-income settings…Investment in childhood mental wellbeing without simultaneous improvements in the material and economic resources needed for optimal development will continue to produce health inequities over the lifetime of an individual.[28]

In addition to noting the clear link between socioeconomic disadvantages, the evidence review highlights a number of other (often interrelated with economic disadvantage) social determinates of inequities in mental wellbeing of children and adolescents. A summary of the findings is set out below:

Individual and family factors

Parenting and family – the evidence review notes that systematic reviews have shown that group-based parenting interventions (e.g. *Parent–Child Interaction Therapy*, *The Family Check–Up*, *Triple P – Positive Parenting Program*) can be effective in improving emotional and behavioural adjustment, conduct problems and anxiety disorders in children. In addition, the review highlights that maternal mental health is a powerful predictor of child mental health, further noting that programs aimed at children in these families have shown

[25] See Welsh, J., Ford, L., Strazdins, L. and Friel, S (2015) *Evidence Review: Addressing the social determinants of inequities in mental wellbeing of children and adolescents*, report prepared by National Centre for Epidemiology and Population Health and the Regulatory Institutions Network for VicHealth, Melbourne; Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer., M., Ainley, J. and Zubrick, S.R. (2015) *The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Commonwealth of Australia.
[26] Welsh, J., Ford, L., Strazdins, L. and Friel, S (2015) *Evidence Review: Addressing the social determinants of inequities in mental wellbeing of children and adolescents*, report prepared by National Centre for Epidemiology and Population Health and the Regulatory Institutions Network for VicHealth, Melbourne.
[27] Ibid, p. 33.
[28] Ibid p. 10-11

significant improvements in children's feelings of hope, connections outside the family, personal strengths and contribution to others' wellbeing, as well as improvements in children's mental health symptoms.

Additionally, MacKillop was involved in the development, and has been using, the parenting programs *Tuning into Kids* and *Tuning into Teens* for a number of years. The programs are evidence-based parenting programs[29] that focus on the emotional connection between parents and children. In particular, the program teaches parents skills in emotion coaching, which is to recognise, understand and respond to children's emotions in an accepting, supportive way. This approach helps the child to understand and manage their emotions.

Public awareness campaigns – as cited earlier in this submission, the evidence review notes that campaigns using social marketing and social contact, publicity campaigns, public education and user-based programs have been found to be effective in reducing stigma and discrimination, improving attitudes, and increasing awareness, knowledge and understanding of mental health issues

Physical activity –research indicates that exercise, particularly vigorous activity, can reduce anxiety, depression and negative mood, and improve self-esteem, sleep and cognitive functioning. Physical activity has been used successfully in a number of settings as an intervention to improve mental health

Daily living conditions

Early childhood and education – the evidence review draws on a range of studies to indicate that early childhood care and education can influence the social, emotional and cognitive development of children. Childcare and preschool settings, as well as home learning environments, play a critical role in early development, second only in importance to immediate family factors. Education, in both formal and informal settings, can help children and adolescents acquire resilience, self-esteem, social, emotional and behavioural skills, and material security.

Furthermore, the review notes that interventions to improve mental health and wellbeing in early childhood and school settings can be universal, selective or indicated. All three intervention types have been shown to be effective in various disadvantaged populations

The school-to-work transition – the evidence review highlights the transition from school to work environments as an important determinant of inequities of mental health outcomes for adolescents.

The social and physical environment – evidence is presented of community-based interventions (such as organised sport, arts and community activities) aiming to build social capital through the development of relationships and partnerships in order to improve the social environment and reduce health inequities with a number of programs achieving positive results in this area.

[29] The program is included in a number of menus of evidence based programs included the California Evidence-based Clearinghouse for Child Welfare and the Australian Research Alliance for Children and Youth (ARACY) Nest menu of evidence based programs.

Online settings – the evidence review notes the potential and emerging evidence of the use of online platforms to address mental health inequities.

Socioeconomic, political and cultural contexts

The impact of social policy levers of government in the areas of mental health policy and early childhood policy, how these can address inequities, and the role of effective governance is highlighted. For example, social policy reforms to promote 'whole of government' responses to address the social determinants of mental health inequities or policies to maximise participation in early childhood learning programs. Furthermore, effective governance through approaches to monitoring and accountability that are based on clear, comprehensive and relevant datasets to monitor impact are acknowledged and the Australian Early Developmental Census is cited as an appropriate measure of child vulnerability to inform strategic frameworks and policy planning.

The Evidence Review sets out a Framework to address the inequities in the social determinants of health (Fair Foundations: The VicHealth framework for health equity) and makes eight recommendations for action and a further five recommendations for future research based on the material reviewed the report. MacKillop supports these recommendations and they are summarised below.

1. Increase the emphasis placed on promoting wellbeing, rather than treating or preventing mental illness in interventions, particularly in middle childhood and adolescents. Evidence suggests that illness prevention or early intervention programs alone will not result in better wellbeing.
2. Recognise the importance of sustained interventions for children at all layers of the Fair Foundations Framework.
3. Ensure interventions are designed to offset or reduce time costs as well as financial costs to parents and families to improve uptake and equity.
4. Explicitly recognise the importance of psychosocial risk factors and their social patterning, in the acquisition of mental wellbeing for children. This may require moving beyond traditional understandings of who is disadvantaged to consider geographical, gendered, cultural and ethnic dimensions.
5. Apply principles of proportionate universalism to interventions. Interventions should be universal, but the level of support should be designed to match the level of disadvantage experienced.
6. Within the individual and family layer of the Fair Foundations Framework:
    a. Develop group-based family and parent education in accessible locations for families, and provide greater support for children at higher risk for poor mental health, including families affected by mental illness.
    b. Invest in interventions which increase the physical activity of children and young people
7. Within the daily living conditions layer of the Fair Foundations Framework:
    a) Invest in interventions in education-based settings (including play-based therapies) and involve parents in the interventions as often as possible.
    b) Use online settings as a medium with which to improve wellbeing.

c) Develop interventions which improve the physical and social environment.
d) Acknowledge the importance of the school-to-work transition and provide support to adolescents making this change through interventions that address the quality of work, especially insecurity, pay and work hours/schedules.

8. Within the socioeconomic, political and cultural context layer:
   a) Develop performance measures relating to mental wellbeing inequities in strategic frameworks and action plans.
   b) Consistently and regularly evaluate performance in regard to equity indicators embedded within high-level strategic documents.
   c) Use health impact assessments and the Equity Focused Health Impact Assessment Framework to evaluate public policy, including policies external to health and education.

Recommendations for future research:

i. Conduct more research on mental wellbeing (in contrast to mental illness) in children and adolescents.
ii. Collect more data on positive mental health indicators, particularly in middle to late childhood and adolescents, to inform research and policy planning.
iii. Theorise the role of psychosocial factors, including relationships and family, in frameworks to address the social determinants.
iv. Develop and implement more universal health promotion interventions for children, applying principles of proportionate universalism.
v. Implement more interventions with a wellbeing (as opposed to prevention) focus in children and adolescents. Research suggests that prevention and early intervention strategies do not necessarily help to improve wellbeing.

MacKillop recommends:

Adopting the recommendations of *Evidence Review: Addressing the social determinants of inequities in mental wellbeing of children and adolescents.*

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

MacKillop is of the view that families and carers and the central to improving the mental health and wellbeing of Victorians. Across our services and supports MacKillop has positioned our practice as family-centred; recognising families as key partners. We have invested in our capacity to better engage with families, including the through family therapy. We have self-funded six Principal Practitioner positions with clinical and family therapy training to support our OoHC programs.

The Family Focus MST (see response to Question 2) MacKillop delivers in Western Melbourne and Geelong is an example of practice that includes families at the centre of the ecosystem of a young person's life and the program staff work intensively with families in supporting young people.

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

As highlighted in response to Question 2, MacKillop is supportive of build the trauma-informed focus of Victoria's mental health system. We believe building an understanding of trauma, its impact and appropriate services responses will better support the mental health workforce. For MacKillop the implementation of the Sanctuary Model across the organisation has been a key strategy to promote the safety of services users, staff and volunteers. For example, building understanding of:

- The impact of trauma on the developing brain
- Safety for service users
- Safety for those caring for and working with individuals experience mental ill health
- Vicarious trauma
- Safety planning and self-care
- Psychoeducation

We believe the adoption of this trauma-informed framework has been a significant factor in our ability to attract, retain and better support staff.

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?

MacKillop is strongly of view that further investment is required to intervene at an early stage. As outlined in response to question 5, we believe the greatest impact on improving the mental health of Victorian's is to address the inequities in the social determinants of mental health.

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?

MacKillop notes the Terms of Reference require the Royal Commission into Victoria's Mental Health System to make recommendations with regard to the need to recognise and respect the needs of different population groups and communities[30]. We believe the Victorian Family Violence Royal Commission provides a valuable pathway forward in this area. The final report of the Family Violence Royal Commission included a strong focus on engaging and being more accessible to diverse populations, including children, seniors, Aboriginal and Torres Strait Islander peoples, people within culturally and linguistically diverse communities, lesbian,

[30] Royal Commission into Victoria's Mental Health System, *Terms of Reference*, p. 4

gay, bisexual, transgender and intersex people, people living in rural, regional and remote communities and people with a disability[31]. The Family Violence Royal Commission made a comprehensive set of recommendations to build a 'whole of Victorian community' response to the problem of family violence The Family Violence Royal Commission outlined its objectives as to:

- Build and ensure accessible, inclusive and non-discriminatory service delivery
- Expand understandings of the different forms and complexity of family violence across a range of communities
- Foster a recognition that family violence is a human rights issue and that responses to it must also be consistent with human rights.[32]

MacKillop is supportive of adopting a similar objectives with regard to Victoria's mental health system – with a strong focus on a whole of community response to accommodate accessibility, diversity, complexity and human rights. For example, the Family Violence Royal Commission made recommendations to:

- Ensure funding agreements for mainstream family violence organisations incorporated requirements for services to undertake cultural safety reviews and action plans in all areas of operations, governance, workforce and relationships with Aboriginal community and the investment in Aboriginal service providers to support this[33].
- Focus on LGBTI inclusiveness and promote Rainbow Tick accreditation to build the capacity and capability of the family violence services to provide accessible and appropriate services[34].
- Support training and education programs for disability workers – including residential workers, home and community care workers, interpreters and communication assistants and attendant carers – to encourage identification and reporting of family violence among people with disabilities[35].
- Ensure that accreditation and testing processes and approval of culturally and linguistically diverse translator and interpreter courses require an understanding of the nature and dynamics of family violence[36]

Each of these are examples of building sector capacity to better support Victoria's diverse communities. We support similar recommendations for the Victoria's mental health and allied services.

MacKillop recommends:

Using the recommendation of the family Violence recommendations as a guide, build the capacity of the mental health system to meet the needs of Victoria's diverse communities.

[31] Royal Commission into Family Violence, *Volume V: Report and recommendations*, Victorian Government Printer, p.1
[32] Ibid, p.2
[33] Ibid, p. 53
[34] Ibid, p. 160
[35] Ibid, p. 196
[36] Ibid, p. 124

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?

Improved governance

MacKillop acknowledges that the recent VAGO report was sharply critical of existing governance arrangements for child and youth mental health services, reporting that 'DHHS has no effective governance arrangements to provide oversight of CYMHS, as CYMHS monitoring is embedded within broader performance monitoring and system oversight[37]. The report further notes that 'it is evident that a lack of overarching governance and coordinated monitoring of CYMHS creates an unnecessary reporting burden on health services'[38]. The Royal Commission provides an opportunity to reconsider the fragmented governance arrangements. Victoria has a proud record of government and non-government agencies working in partnership to deliver health and human services. In considering lasting improvement to Victoria's mental health system, this valuable partnership approach should be leveraged. The governance framework to drive the reforms that emerge from the Royal Commission recommendations must be one that is shared between service users, government and non-government organisations.

MacKillop recommends:

The adoption of a shared governance framework to guide the reforms stemming from the Royal Commission recommendations that includes services users, their key supports (including family), non-government and government agencies.

A data driven focus on outcomes

MacKillop supports the developed of a robust outcomes monitoring framework to be applied across the mental health system. We support expanding the use of the Strengths and Difficulties Questionnaire (SDQ) and Health of Nations Outcomes Scale for Children and Adolescents (HoNOSCA) in child and youth mental health services. As set out in the VAGO report, Victorian's child and youth mental health system is not well served by existing system of performance monitoring and oversight. The report outlines a range of existing deficiencies and goes on to identify potential outcomes data that would be of benefit such as measure to assess:

- Participation in learning and education
- Participation and contribution to the economy
- Financial security

[37] Victorian Auditor General's Office (2019), *Child and Youth Mental Health: Independent assurance report to Parliament*, 2018–19: 26, Victorian Government Printer, Melbourne, p. 43
[38] Ibid, p. 44

- Social engagement and participation in inclusive communities[39].

The report also identifies the targets included in this International Declaration on Youth Mental Health that may be beneficial.

MacKillop recommends adding the systematic collection, analysis and publication of data and research relating to the accessibility and responsiveness of services to people from diverse communities.

Beyond the mental health system, MacKillop is of the view that there is scope to improve data collection and use in a wider spectrum of services to ensure mainstream services better accommodate the needs of individuals living with a mental illness.

MacKillop recommends:

- **The implementation of a outcomes monitoring framework for children and young people that includes (but is not limited to) measures to assess participation in education, participation and contribution to the economy, financial security, social engagement and participation in inclusive communities and other relevant measures from the International Declaration on Youth Mental Health.**
- **The implementation of measures on the nature and prevalence of mental illness and engagement and outcomes of service users of across services funded by government including the Department of Health and Human Services, Department of Education and Training and department of Justice and Community Safety.**

[39] Ibid, p. 71.