BERRY STREET

We're for Childhood

SINCE 1877

Royal Commission into the Victorian Mental Health System

Preliminary Submission

May 2019

About Berry Street

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

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

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

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

Berry Street believes this is unacceptable.

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

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

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

Executive Summary

Purpose

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

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

Berry Street's expertise

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

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

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

Case for change

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

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

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

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

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

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

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

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

Opportunity to make an impact

Berry Street encourages the Royal Commission to examine opportunities to:

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

1. Current situation / case for change

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

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

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

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

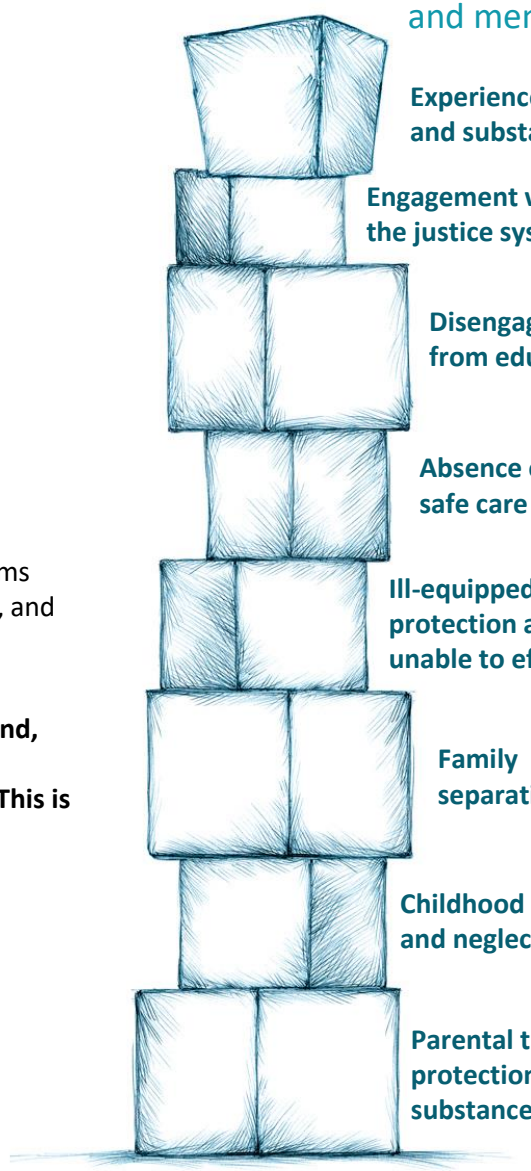
The significant adverse impacts of family separation and experiences of the child protection system, build upon the already significant trauma from the initial abuse and neglect, creating a compounding effect for both the child and their family.

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

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

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

Compounding issues of trauma and mental illness



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

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

2018-19

$1.47b

Child protection, family services, family violence & related supports

$1.61b

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

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

2016-17

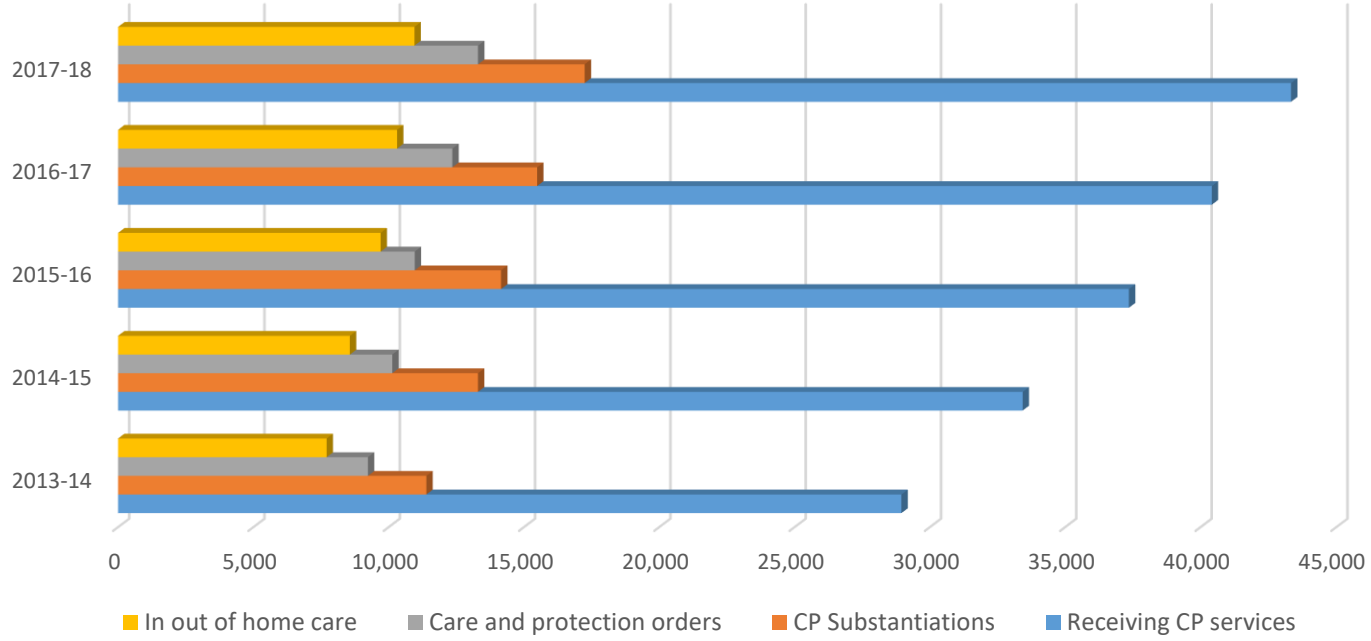
$1.2b

Medicare-subsidised mental health-specific services

$511m

Mental health-related subsidised prescriptions[2]

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



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

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

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

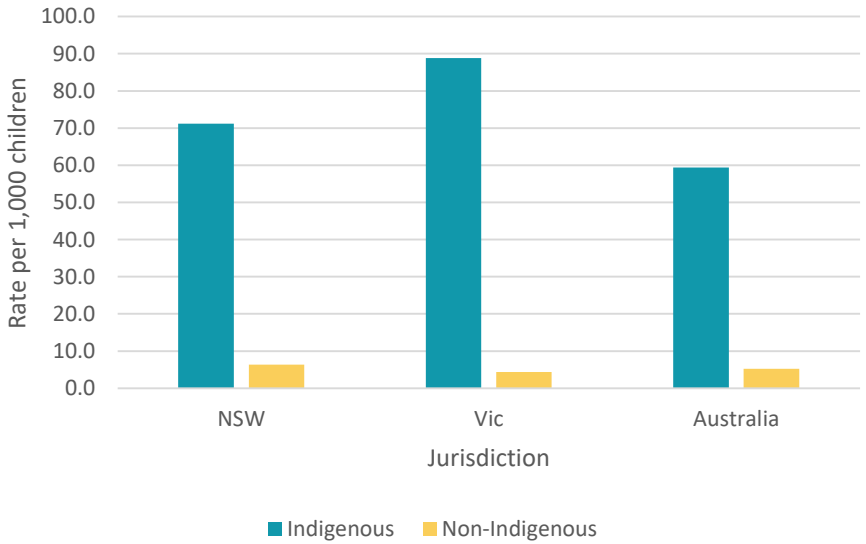
Victoria is performing poorly across a range of out of home care domains, especially when compared to other jurisdictions

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

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

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

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



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

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

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

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

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

A statistical snapshot [1]:

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

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

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

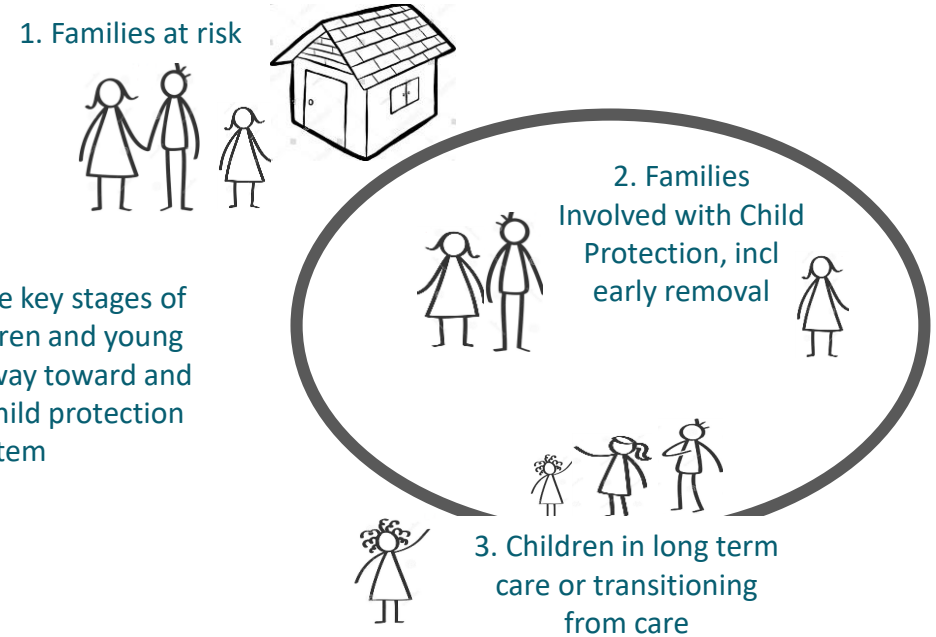


Figure 1: Three key stages of families, children and young people's pathway toward and through the child protection system

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

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

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

8

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

The human faces:

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

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

What's working & what has promise:

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

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

The systems failures:

Overarching

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

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

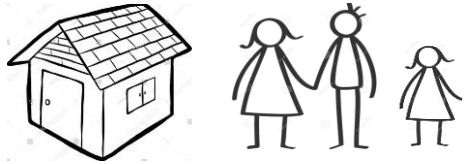
- Barriers to access by parents and families with lower incomes or higher levels of disadvantage and complexity, including cost barriers to private psychiatry and psychology services and availability of appropriately skilled mental health clinicians to address the complexities of these families.
- Programs,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

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

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

Child protection and other service systems

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



Families at risk

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

The human faces:

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

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

What's working and what has promise:

Victorian mental health system

- Specialisation in perinatal mental health.

Child protection and other service systems

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

The system failures:

Overarching

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

Primary mental health system

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

Victorian mental health system (includes CAMHS and AMHS)

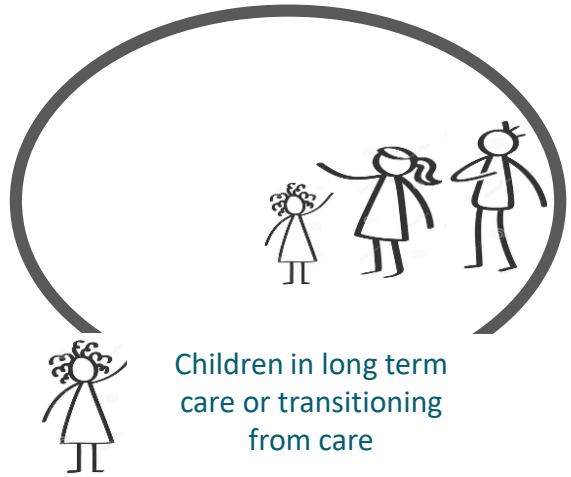
- Lack of inclusive and culturally safe practices, resulting in barriers to access and engagement by Aboriginal and diverse communities.
- Inadequate responses to children and young people on youth justice orders, especially females with mental illness that have led to justice involvement
- Limited adoption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

Child protection and other service systems

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

10

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



The human faces:

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

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

What's working and what has promise:

Child protection and other service systems

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

The system failures:

Overarching

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

Victorian mental health systems

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

Child protection and other service systems

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

[1] Berry Street's 2018 residential care census

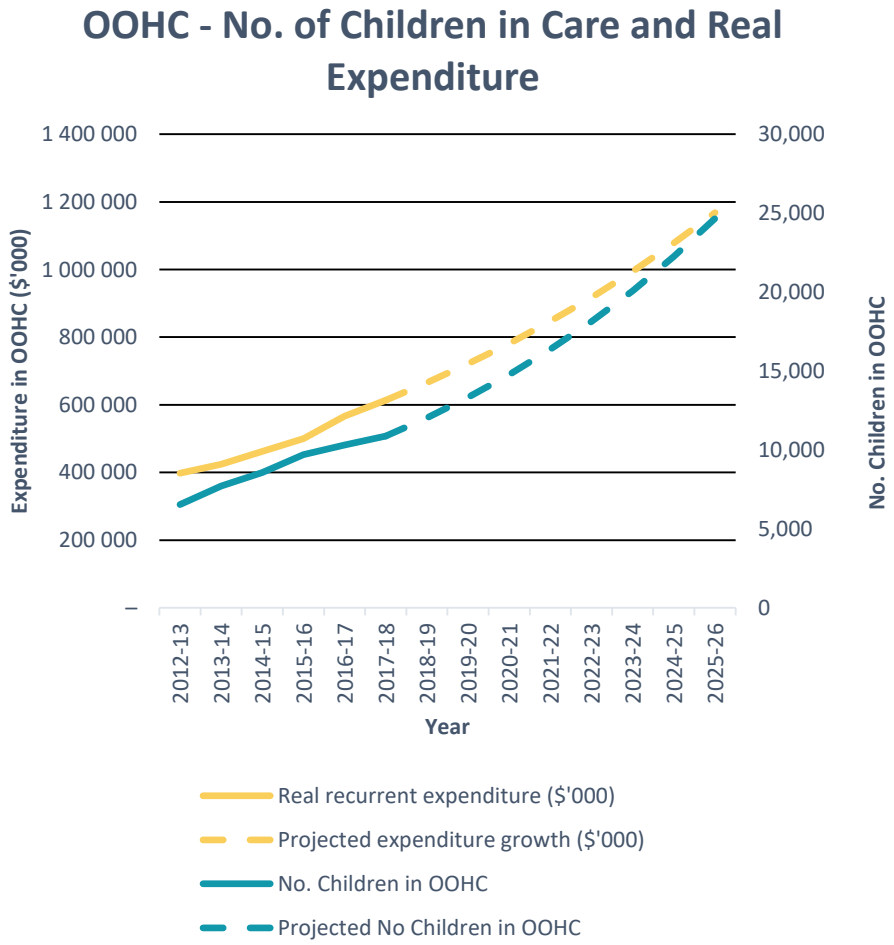
Impact of mental health and child protection systems failures

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

The system needs to:

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

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

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

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

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

The system needs to:

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

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

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

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

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

The system needs to:

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

3. Appendices

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

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

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

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

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

Key features include:

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

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

A recent evaluation found that:

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

Outcomes

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

This includes:

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

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

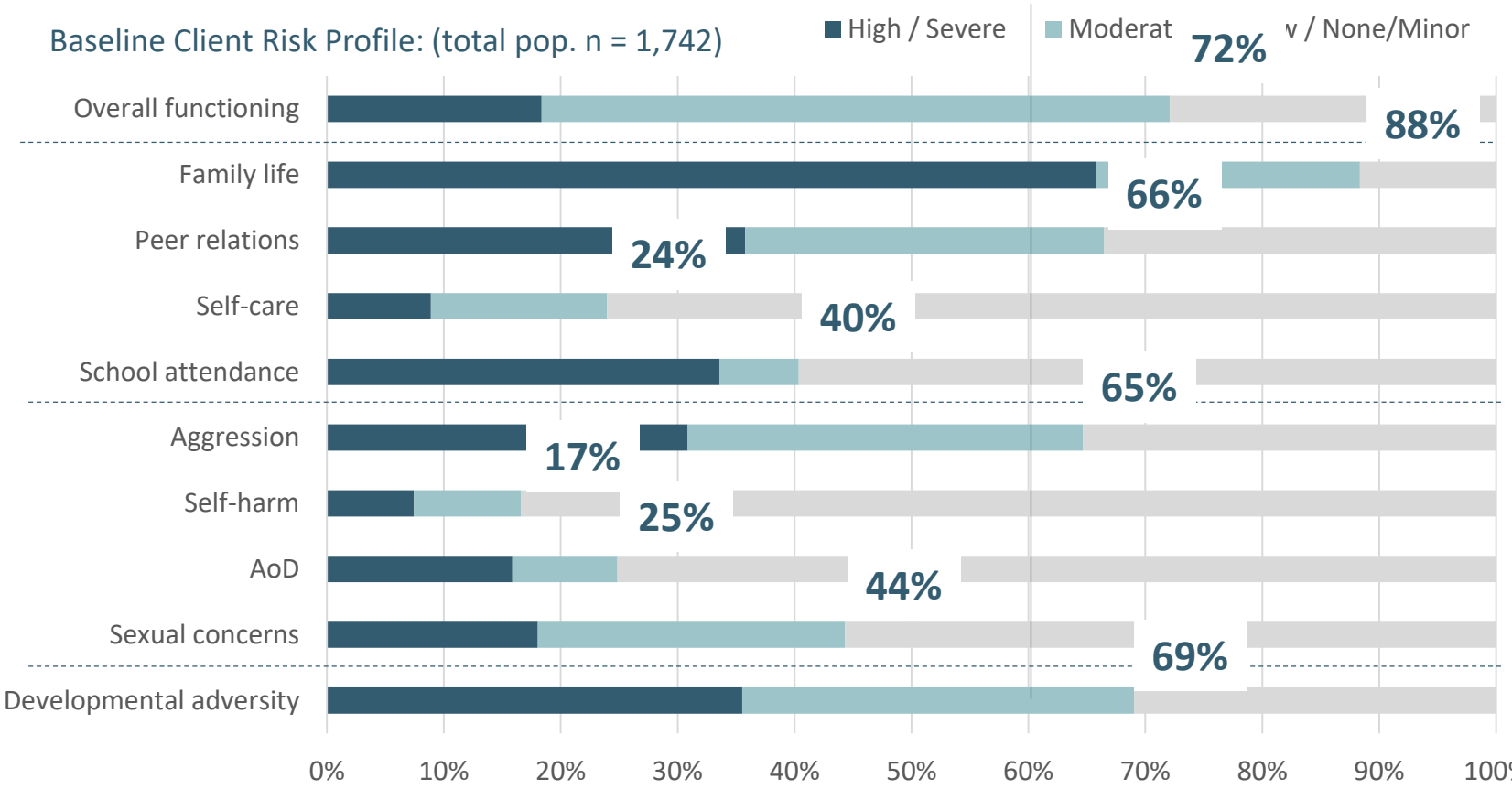
c. more than one-third showing improved self-care skills.

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

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

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

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



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

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

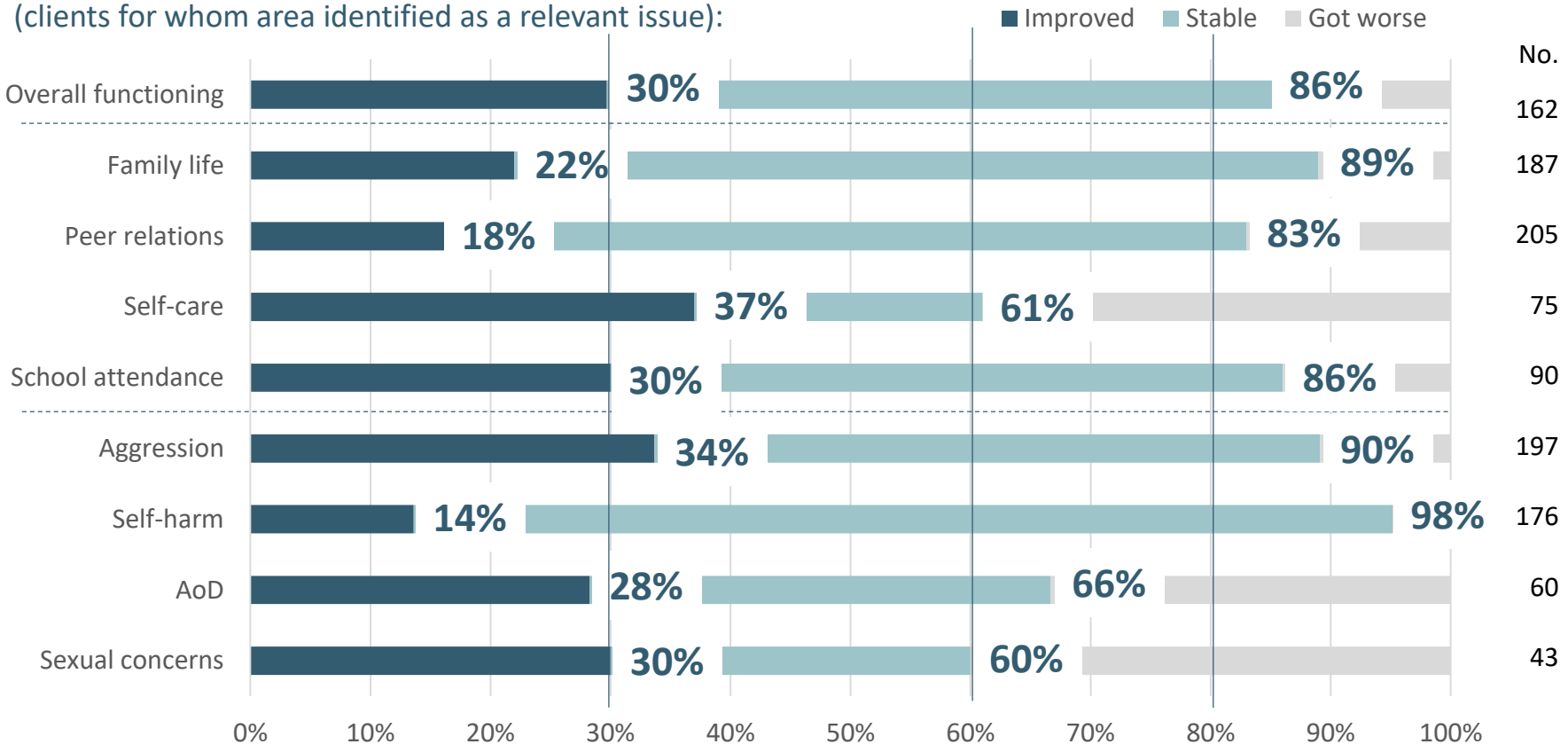
** Self-care and other behavioural issues are areas of concern for a smaller but still significant proportion of children

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

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

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

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



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

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

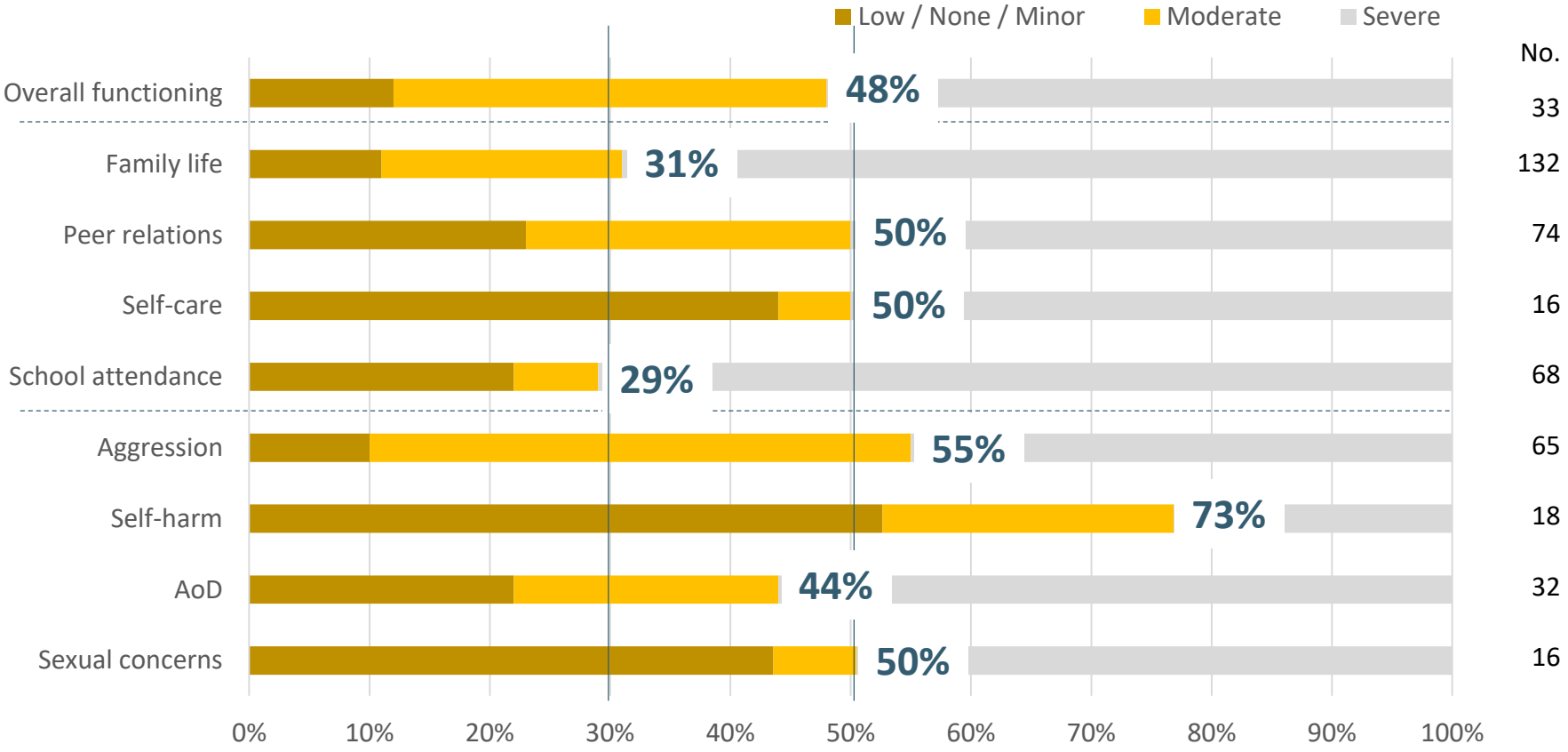
(1) Only includes review assessments conducted up until May 2017

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

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

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

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



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

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

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

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

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

Statutory Care

Kinship care

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

Foster care

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

Residential care

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

Third party parental (permanent) care

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

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

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

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

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

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

Berry Street asserts the Royal Commission should examine the following:

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

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

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

- Brief Relational Intervention & Screening (BRISC)

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

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

Appendix 4
Key research and literature

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

- Australian Institute of Health and Welfare (AIHW). (2019). *Child protection Australia 2017–18* (Child welfare series no. 68. Cat. no. CWS 63). Canberra: AIHW.
- Bunston W, Franich-Ray C and Tatlow S. 2017: *A Diagnosis of Denial: How Mental Health Classifications Systems Have Struggled to Recognise Family Violence as a Serious Risk Factor in the Development of Mental Health Issues for Infants, Children, Adolescents and Adults.* Brain Science 201, 7, 133
- Baldy E, Dowse L, McCausland R and Clarence M. (2012): *Lifecourse institutional costs of homelessness for vulnerable groups.* Canberra: Department of Families, Housing, Community Services and Indigenous Affairs
- Centre for Excellence in Child and Family Welfare Inc. (2018): *Putting Children at the Centre: 2018 State Election.* Melbourne
- Child Family Community Australia (CFCA). (2014). *Effects of child abuse and neglect for children and adolescents*. Melbourne: Australian Institute of Family Studies. Retrieved from www.aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents
- CFCA (2018) The Economic Costs of Child Abuse and Neglect - Resource Sheet— September 2018, https://aifs.gov.au/cfca/publications/economic-costs-child-abuse-and-neglect
- Commonwealth of Australia. (2017). *Royal Commission into Institutional Responses to Child Sexual Abuse: Final Report*. Canberra: Commonwealth of Australia.
- Cote S, Gyurak A and Levenson R. (2010): *The Ability to regulate Emotion is Associated with Greater Well-Being, Income and Socioeconomic Status*. Emotion, 2010 (Dec), 10(6)
- Council of Australian Governments (COAG). (2011). National plan to reduce violence against women and children 2010–2022. Canberra: Department of Social Services.
- Davies C, and Ward H. (2012) *Safeguarding Children Across Services: messages from research.* London and Philadelphia: Jessica Kingsley Publishers
- Dwyer, J., & Miller, R. (2014). *Working with families where an adult is violent*. Melbourne: Department of Human Services
- Family and Community Services, (2014): *Intensive Family Preservation Guidelines,* NSW Government
- Family and Community Services, (2017) The prevalence of intergenerational links in child protection and out-of-home care in NSW, NSW Government https://www.facs.nsw.gov.au/__data/assets/pdf_file/0016/421531/FACS_SAR.pdf
- Fox S, Southwell A, Stafford N, Goodhue R, Jackson D and Smith C (2015), *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention*, Australian Research Alliance for Children and Youth (ARACY), Canberra.
- Goddard, C., & Bedi, G. (2010). Intimate partner violence and child abuse: A child centred perspective. *Child Abuse Review, 19*, 5–20.
- Kezelman, C., Hossack, N., Stavropoulos, P., & Burley, P. (2015). *The cost of unresolved childhood trauma and abuse in adults in Australia*. Sydney: Adults Surviving Child Abuse and Pegasus Economics. Retrieved from www.blueknot.org.au/Portals/2/Economic%20Report/The%20cost%20of%20unresolved%20trauma_budget%20report%20fnl.pdf
- McCarthy, M. M., Taylor, P., Norman, R. E., Pezzullo, L., Tucci, J., & Goddard, C. (2016). The lifetime economic and social costs of child maltreatment in Australia. *Children and Youth Services Review*, *71*, 217–226.
- Moore T, Arefadib N, Deery A and West S. (2017): *The First Thousand days; An Evidence paper*. Parkville, Victoria; Centre for Community Child Health, Murdoch Children's research Institute
- Muir, S. and Hand, K. (2018). *Beyond 18: The Longitudinal Study on Leaving Care Wave 1 Research Report: Transition planning and preparation.* (Research Report). Melbourne: Australian Institute of Family Studies.
- Osborn, A., & Bromfield, L. (2007). *Young people leaving care* (Research Brief No. 7). Melbourne: Australian Institute of Family Studies. Retrieved from www.aifs.gov.au/cfca/publications/young-people-leaving-care
- Raman, S., Inder, B., & Forbes, C. (2005). *Investing for success: The economics of supporting young people leaving care*. Melbourne: Centre for Excellence in Child and Family Welfare.

Appendix 4
Key research and literature cont.

- Segal, L. (2015). Economic issues in the community response to child maltreatment. In B. Matthews, & D. C. Bross (Eds.), *Mandatory reporting laws and the identification of severe child abuse and neglect*, (pp. 193–216). Dordrecht: Springer.
- Steering Committee for the Review of Government Service Provision (SCRGSP). (2018). *Report on government services 2016*. Canberra: Productivity Commission.
- Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C., & De Bortoli, L. (2008). *The cost of child abuse in Australia*. Melbourne: Australian Childhood Foundation and Child Abuse Prevention Research Australia.
- Tomison A. (1996): *Intergenerational transmission of maltreatment,* Australian Institute of Family Studies, Australian Government
- Victorian Government. (2018). *Inquiry into youth justice centres in Victoria: Final Report.* Melbourne: Victorian Government Printer.
- Wright, K., Swain, S., & McPhillips, K. (2017). The Australian Royal Commission into Institutional Responses to Child Sexual Abuse. *Child Abuse and Neglect, 74*, 1–9.