



BETTER CARE FOR BETTER OUTCOMES

Anglicare Victoria submission to the Victorian Royal
Commission on Mental Health

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**BETTER
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1 Introduction:

A substantial proportion of young people in care experience mental health issues. This is related to prior experience of trauma, their experiences in the system, and the support (or lack thereof) for mental health issues provided while in care.

The poor outcomes experienced by care-experienced children and young people illustrates that the child protection and mental health systems' response to mental health issues is inadequate, and not reflective of the evidence on prevalence, risk, and outcomes.

Insufficient investment in the services and programs that can support families and children at risk before significant mental health issues develop will contribute to ongoing poor mental health and further entrench disadvantage unless addressed.

The service model outlined in section three is an example of embedding health into the delivery of child protection in order to more effectively respond. We need to re-oriented services toward an integrated strengths-based approach that maximises resilience and recovery. We need services that are accessible, appropriate, and that meet the unique needs and challenges experienced by vulnerable children, young people, and their families (including, but not limited to, those in OoHC).

We need models, tools, treatments, and therapies that support personal and cultural change that are commonly employed at a practice level in child and family welfare (including strong commitments to trauma-informed care and strengths-based interventions) and that can work to support and improve mental health and wellbeing. However, this focus is not strongly reflected in the way the child and family welfare system is conceptualised, structured, funded, and monitored.

Where the state is acting as parent/guardian/custodian (whether in children's services, youth justice or mental health), we should aim for performance measurement that goes beyond issues of compliance and safety to whether the State is effectively fulfilling its 'parenting' responsibilities, including working to support and improve the mental health of people in its care.

I therefore urge the Commission to recommend the establishment of a new, blended approach to care and support which integrates specialist mental health support into the provision of care, as outlined in this submission. We need to ensure the experience of care is not in itself damaging, as well as providing the support people need to recover from pre-existing problems and the impact of trauma. Above all, we need to have genuine ambition for the young people in the State's care.

I would be pleased to provide the Commission with further detail about this model, and the other information provided in this submission, at your convenience.

Paul McDonald
Chief Executive Officer
Anglicare Victoria

ABOUT ANGLICARE VICTORIA

ANGLICARE VICTORIA (AV) WORKS TO TRANSFORM THE FUTURES OF CHILDREN AND YOUNG PEOPLE, FAMILIES AND ADULTS. WE OFFER A COMPREHENSIVE NETWORK OF HIGH QUALITY SERVICES THAT AIM TO SIGNIFICANTLY IMPROVE IN THE LIVES OF THE YOUNG PEOPLE, CHILDREN, AND FAMILIES/CARERS WITH WHOM WE WORK. AS VICTORIA'S LEADING CHILD AND FAMILY WELFARE ORGANISATION, WE ARE SINGLE-MINDED IN OUR MISSION TO CREATE POSITIVE CHANGE FOR THE MOST VULNERABLE AND DISADVANTAGED MEMBERS OF OUR COMMUNITY.

IN ANY GIVEN YEAR WE WILL PROVIDE RESIDENTIAL, FOSTER OR KINSHIP CARE FOR OVER A THOUSAND VICTORIAN CHILDREN, HELP OVER 120 FAMILIES TO STAY TOGETHER THROUGH OUR RAPID RESPONSE AND CRADLE TO KINDER PROGRAMS, AND SUPPORT OVER 3000 PARENTS TO BUILD BETTER PARENTING SKILLS THROUGH OUR EVIDENCE-BASED PARENTZONE PROGRAM. WE EMPOWER FAMILIES TO BUILD BETTER FUTURES THROUGH FINANCIAL COUNSELLING AND IMPROVE EDUCATIONAL OUTCOMES FOR YOUNG PEOPLE IN OUT OF HOME CARE THROUGH THE TEACHAR PROGRAM, WHICH HAS DELIVERED MEASURABLE IMPROVEMENTS IN EDUCATIONAL ENGAGEMENT AND ATTAINMENT AT OVER 165 LOCATIONS ACROSS THE STATE. ANGLICARE VICTORIA IS ALSO A MAJOR PROVIDER OF MEN'S BEHAVIOUR CHANGE AND OTHER FAMILY VIOLENCE SERVICES ACROSS THE STATE.

SUPPORTED BY A DEDICATED TEAM OF 1600 STAFF AND 2000 VOLUNTEERS STATEWIDE, WE ARE COMMITTED TO A TRANSFORMATIONAL AGENDA THAT AIMS TO IMPROVE OUTCOMES FOR OUR CHILDREN, YOUNG PEOPLE, AND FAMILIES BY COMMITTING TO CONTINUOUS IMPROVEMENT, RIGOROUSLY MONITORING OF OUR OWN OUTCOMES AND PERFORMANCE, AND SEEKING NEW AND INNOVATIVE WAYS TO DELIVER CARE. EXAMPLES INCLUDE ESTABLISHING THE FIRST EVER PARENTZONE HUB CO-LOCATED WITH A LOCAL SCHOOL, AND WORKING WITH GOVERNMENT TO DEVELOP ONE OF VICTORIA'S STATE'S FIRST SOCIAL IMPACT BONDS, COMPASS — WHICH AIMS TO IMPROVE OUTCOMES FOR YOUNG PEOPLE LEAVING CARE. BUILDING ON OUR PROVEN TRACK RECORD, WE HAVE GROWN AT ABOUT 20% PER ANNUM OVER THE LAST FIVE YEARS, CONSOLIDATING OUR POSITION AS ONE OF VICTORIA'S LEADING PROVIDERS IN OUR FIELD.

AT ANGLICARE VICTORIA, WE BELIEVE THAT EVERY CHILD AND YOUNG PERSON HAS THE RIGHT TO FULFIL THEIR POTENTIAL AND SHINE. FOR ANY CHILD OR YOUNG PERSON REMOVED FROM THEIR FAMILY HOME, ANGLICARE VICTORIA CARERS AND STAFF PROVIDE HOME-BASED CARE: KEEPING CHILDREN SAFE AND PROTECTED IN A LOVING ENVIRONMENT, WORKING EVERY DAY TO MEET THEIR IMMEDIATE NEEDS, AND PROVIDING LONG TERM SUPPORT AND CARE AS THEY GROW. WE ALSO DELIVER A SUITE OF PROGRAMS WITH A STRONG EMPHASIS ON BUILDING SKILLS AND PROVIDING OPPORTUNITY TO HELP YOUNG PEOPLE OVERCOME BARRIERS AND ACHIEVE, INCLUDING A RANGE OF EXPERT SUPPORTS TO HELP FAMILIES STAY TOGETHER; BUILDING SAFE AND HAPPY HOME ENVIRONMENTS.

2 Prevalence, risk, and outcomes

RECOMMENDATION

- Provide effective, appropriate, and accessible mental health support for all children, young people, and their families who are or have been in OoHC, in recognition of the prevalence and risk of poor mental health outcomes.

2.1 Children and young people in OoHC

2.1.1 There is a significant body of evidence, both local and international, demonstrating that a substantial proportion of young people in care experience mental health issues. This is related to prior experience of trauma, their experiences in the system, and the support (or lack thereof) for mental health issues provided while in care. There is meta-analytic evidence indicating that the prevalence of disruptive disorders in OoHC populations is 20-34% (Bronsard, et al.).

2.1.2 Further evidence in the Australian context is summarised by Baidawi et al (Baidawi, Mendes, & Snow, 2014), and includes:

- A 2006 survey of young people in residential care in Victoria that found that 65% had results indicating an abnormal risk of a diagnosable mental health disorder.
- A South Australian study that found the prevalence of mental health issues among children and young people in foster care was two to five times higher than the general population.
- A New South Wales study that found that children in foster and kinship care had 'poor mental health and social competence relative to normative and in-care samples'.

2.2 Leaving care

2.2.1 There is evidence that poor mental health outcomes extend into adulthood for young people who have experience of OoHC, with studies in both Australia and the UK indicating mental health issues for between 30 and 45 per cent of care leavers. An estimated 16% of care leavers are alcohol and/or other drug dependent (Courtney, et al., 2005)

2.2.2 Tragically, evidence suggests that having been in OoHC care is also associated with increased risk of suicide and suicidal ideation¹. A systematic review of studies indicating the prevalence of suicidal ideation of young people in care was 24.7% compared to a rate of 11.4% young people in the general population, and that the prevalence of suicide attempts also showed a significant disparity (3.6% compared to 0.8%) (Evans, et al., 2017).

¹ AV does not currently have a direct role in services or programs with a primary aim of preventing suicide. However, this is an issue that affects many of the people we work with and Applied Suicide Intervention Training (ASIST) is available for all staff.

- A review of Scandinavian studies indicates a significantly higher likelihood of early mortality by suicide for people who grew up in care (Kaariala & Hiilamo, 2017).
- A Swedish study found that mothers who had been in care themselves were 2.47 times more likely to die by suicide than mothers who had not been exposed to OoHC. The same study also found that mothers with two generations of exposure to OoHC (themselves and their children) were 5.52 times more likely to die by suicide than mothers who had not been in care, and 2.35 times more likely to die by suicide than mothers who themselves had been in care but whose children had not been placed in care (Wall-Weiler, et al., 2018).
- A cross-sectional survey of the correlates of suicidal ideation and suicide attempts among prisoners in NSW found that having lived in OoHC as a child (before the age of 16) is correlated with rates of lifetime suicidal ideation 1.78 times higher (margin of error 1.33-2.39 times higher) for this cohort. The same study also found that prisoners who had lived in OoHC as a child were 2.2 times more likely to have engaged in a suicide attempt in their lifetime (margin of error 1.29-3.74 times higher) (Larney, Topp, Indig, O'Driscoll, & Greenberg, 2012).

2.2.3 Locally, a Victorian study reported findings from a survey of 60 young adults who had been in care and found that they were experiencing significant disadvantage in a number of areas compared with the general population (Forbes, Inder, & Raman, 2006).

- Only a small percentage of care leavers surveyed were engaged with fulltime employment or education, and their average incomes were very low.

“We, the participants of this conference Affirm our commitment to equity in health and recognize that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. We recognize that governments have a responsibility for the health of their people and that equity in health is an expression of social justice. We know that good health enhances quality of life, increases capacity for learning, strengthens families and communities, and improves workforce productivity. Likewise, action aimed at promoting equity significantly contributes to health, poverty reduction, social inclusion, and security.”

- *Helsinki Statement Framework for Country Action (8th Global Conference on Health Promotion, 2014)*
-

- Low average incomes were associated with frequent problems with debt and housing instability.
- More than a third of the cohort had accessed drug and alcohol treatment services in the past 12 months.
- The cohort was vastly over-represented in the justice system in terms of spending time in correctional services.
- Half of those surveyed had sought help from a mental health professional in the six months prior to being interviewed.

2.2.4 These data provide further evidence of the urgent need to provide better mental health support for young people while they are involved in the care system — both to reduce short-term harm and to help build the resilience and skills that will act as protective factors after they are no longer involved in the care system.

2.3 The impact of trauma

- 2.3.1 Children and young people often present to our services with a complex range of systems and behaviours related to prior and past trauma. This is particularly damaging when it occurs in childhood, and is associated with symptoms including problems with mood regulation, impulse control, self-perception, attention, memory and somatic disorders (Wall, Higgins, & Hunter, 2016).
- 2.3.2 As noted in the paper by the Institute of Family Studies, “children who experienced both violent inter-personal *and* attachment-based (“non-violent”) traumas within the caregiver system experienced greater difficulties across several areas of impairment (including attention/behavioural dysregulation and self/relational dysregulation) and were significantly more likely to exhibit PTSD-like symptoms compared to children who had experienced neither type of trauma, violent trauma only or non-violent trauma only (Kisiel, et al., 2014)”.
- 2.3.3 Co-occurring mental health issues and disorders such as conduct disorder and oppositional defiant disorder (in children), PTSD, depression and other affective disorders, borderline personality disorder, somatoform disorders, psychotic and dissociative disorders have commonly been associated with traumatic experiences (Wall, Higgins, & Hunter, 2016).
- 2.3.4 The third evaluation of the Take Two program (Frederico, Jackson, & Black 2010) provides detailed data demonstrating the impact, type, and frequency of abuse on young people, and its ongoing effect. This includes the impact of exposure to parental psychiatric illness.
- 2.3.5 The extent and breadth of that impact suggests there is a strong argument for providing more robust mental health support with a focus on trauma-informed care for all young people

involved, or at risk of becoming involved, with the child protection system.

2.4 Anglicare Victoria client data

- 2.4.1 A key component of Anglicare Victoria's Outcomes Framework is the Strengths and Difficulties Questionnaires (SDQ) that assessed child/adolescent psychosocial wellbeing according to five sub-scales². Population norms have been established for the SDQ subscales and total difficulties scale in respect of the broader Australian population. This means we can produce a band score for each child/young person which indicates whether, compared to children and young people in the broader Australian population, they are: (1) "close to average", or experiencing (2) "slightly raised difficulties", (3) "high difficulties", or (4) "very high difficulties" (in respect of what is being measured).
- 2.4.2 The unpublished results of an internal AV analysis of client outcomes data collected between November 2019 and June 2020 (Giles, 2019) indicate that many of the children and young people in our care are doing well, considering their experiences prior to coming into care. However, there is a high proportion of children and young people where a high or very high level of difficulty has been recorded:
- 35.2% scored in the high difficulties or very high difficulties bands for total difficulties (see Figure 1). Specifically:
 - 30.7% scored in the high difficulties or very high difficulties bands for emotional problems.
 - 26.2% scored in the high difficulties or very high difficulties bands for conduct problems.
 - 28.4% scored in the high difficulties or very high difficulties bands for hyperactivity.
 - 37.5% scored in the high difficulties or very high difficulties bands for peer problems.
 - 25.0% scored in the high difficulties or very high difficulties bands for prosocial behaviour.

² The SDQ is designed to be completed as either self-report or third-party report. The latter approach was used in this case.

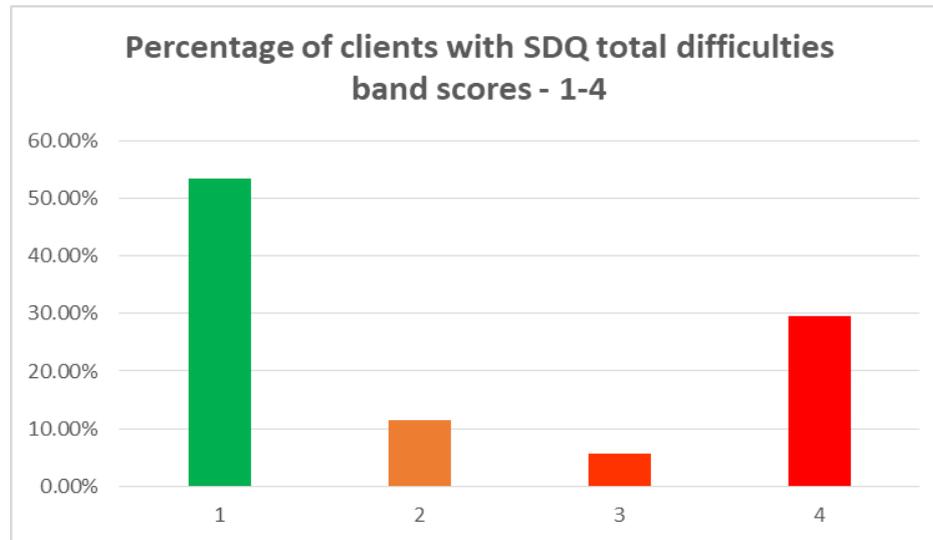


Figure 1

2.4.3 Of the 100 clients surveyed, 29 (29%) had some kind of diagnosed neurological disorder and/or psychiatric problem, 6 (6%) have an intellectual disability, 2 (2%) are on the autism spectrum, 9 (9%) have diagnosed mental health issues, and 8 (8%) have some other diagnosed neurological impairment (such as foetal alcohol spectrum disorder, global delay, etc.).

2.4.4 Only nine children and young people were diagnosed with mental health issues — this is low given the distribution of Strengths and Difficulties Questionnaire (SDQ) scores discussed above. With a strong indication of under-diagnosis (suggesting a prevalence of under-treatment or perhaps inappropriate approaches to treatment) this highlights the need for additional support for this client group, and that the support should not be linked to, nor dependent on, a formal diagnosis.

2.4.5 AV's *Children in Care Report Card* (Kandasamy, McClellan, & Corrales, 2016) highlights some of the other disparities in outcomes experienced by young people in AV's care compared to children of a similar age, and factors to be considered in care provision (Kandasamy, McClellan, & Corrales, 2016):

- 33.3% of children in care (15 years and over) had taken illicit drugs in the past 12 months compared to 17.6% (14-19 years) in the general population.
- 19% of children and young people in care (5-14 years) have a long-term health condition meeting the criteria of a disability compared to 8.3% in the general population.

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- 64.3% have attended a funded kindergarten program or early learning program compared to 98.2% of the general population.
- 30.5% of children 0-9 years old, and 15.2% of children 10-17 years old, had had 2 or more placements changes since first entering care.

3 A new model for mental health support for at-risk children and young people

RECOMMENDATION

- Embed specialist mental health capacity into service models and care teams working with vulnerable populations, particularly children, young people and their families with contact with OoHC and other child protection and family support services.
- Provide funding to allow the Anglicare Victoria/Alfred CAMHS 'Better Outcomes, Better Care' model outlined below to be introduced for all in-scope AV clients, with a view to statewide implementation.
- In order to be effective, the service model for children, young people, and families in contact with OoHC, and other child protection and family support services, should be:
 - Delivered in the clients' care/home setting as part of day to day care and support (including via outreach), through embedding mental health practitioners in the care team.
 - Address the mental health of the primary client collaboratively and in the context of their family, carer, and peer relationships.
 - Be strengths-based, trauma-informed, and work to build resilience and capacity.
 - Prioritise ongoing support and continuity across program and geographical boundaries.
 - Have a strong focus on prevention and early intervention, while facilitating access to specialist mental health services as required.
 - Provided for any young person in the OoHC or child protection system, whether or not there is a formal diagnosis or identification of a mental health issue.
 - Be culturally appropriate and co-designed with children, young people, their carers and their families.
 - Establish shared accountability for agreed client outcomes between child and family services and mental health providers.

3.1 Issues to be addressed

- 3.1.1 Anglicare Victoria's experience has been that the current service system caters poorly for children and young people and their families with whom we work. The poor outcomes outlined above are indicators that current responses are inadequate. Factors contributing to this include:

- Current service models (and associated funding) for out-of-home-care do not generally embed capacity for expert mental health support for clients. For example, only some residential care units are funded at the 'Therapeutic Rate,' which allows for part-time attendance by a counsellor or psychologist (usually Masters level trained). Even in those service models which embed some expert mental health support for clients, resource limitations often mean that work is sporadic and/or too infrequent.
- Current service models (and associated funding) for mental health services do not cater well for the high level of complexity associated with trauma, instability in home life and relationships (often including multiple placement changes while in care), and high rates of alcohol and drug use, and other types of risk-taking behaviour.
- Specialist public mental health services are difficult to access and tend to prioritise people with psychotic disorders. The availability of treatment for these more common conditions such as depression and anxiety are also often dependent on the client being willing to engage with a GP; and then only available for a limited time.
- The broader healthcare system and response from hospitals to self-harm and suicide attempts continues to be inadequate. In addition, chronic self-harmers are often not viewed as being at significant risk, despite well-established evidence that people who self-harm are more likely to go onto suicide than people who do not.
- Outreach/home-based services are needed for this client group, though are rare. Young people in care are less likely to actively seek help, and often encounter stigma and discrimination when they do. Effective engagement is therefore very dependent on the involvement and facilitation of their carers.
- There is often a reluctance on behalf of many mental health practitioners to engage with this client group, reflecting both the clinical complexities and the challenging behaviours that they may encounter. Staff in one residential service were recently advised by the mental health service they were working with that the service's staff were only prepared to provide secondary consultations, as they found the care environment too challenging to work in.
- Access to private services is generally unfunded and unaffordable.
- Foster carers are volunteers and receive support from AV staff, but receive no special access to mental health services to support or address challenging situations or behaviours that the cared-for child might be experiencing.

- Children in OoHC are often very mobile with frequent placement changes: families re-unify, and attempts at reunification sometimes fail, leading to further placements. This is a challenge to the continuity of care if the child or young person is reliant on attending a service with a defined catchment, practice or clinic for support.

3.2 Key features of the service model

Understanding the needs of the client group

3.2.1 An effective service model that better caters to the need for mental health support within this high-risk cohort should consider:

- The unique characteristics of the client group.
- The nature of the care system in which they live, and the way in which children, young people and families interact with it.
- The features of current service models that inhibit or prevent good outcomes.

3.2.2 Key characteristics of the client group to be considered include:

- The universal experience of trauma, often severe, which can be both individuals present within the family and intergenerational. This is a particular consideration for Aboriginal children, young people, and families who are over-represented in the care system.
- Family history and experience with poor mental health, including recognition that this may have been a factor in the child, young person, or family's involvement in the care system.
- Disproportionate prevalence of disability and other disorders (as outlined in the previous section).
- High rates of substance use ranging from high-risk episodic use (e.g. binge-drinking, experimentation) to chronic or long term dependence. There is also a high prevalence of poly-substance use.

3.2.3 Clients' experience with the care system is also a relevant consideration, in that it affects both interactions with care providers and help-seeking behaviours. For example, services need to recognise that the living environment of residential care has unique characteristics. Children and young people in care often also experience a high level of instability and geographical mobility that is beyond their control, due to placement changes.

3.2.4

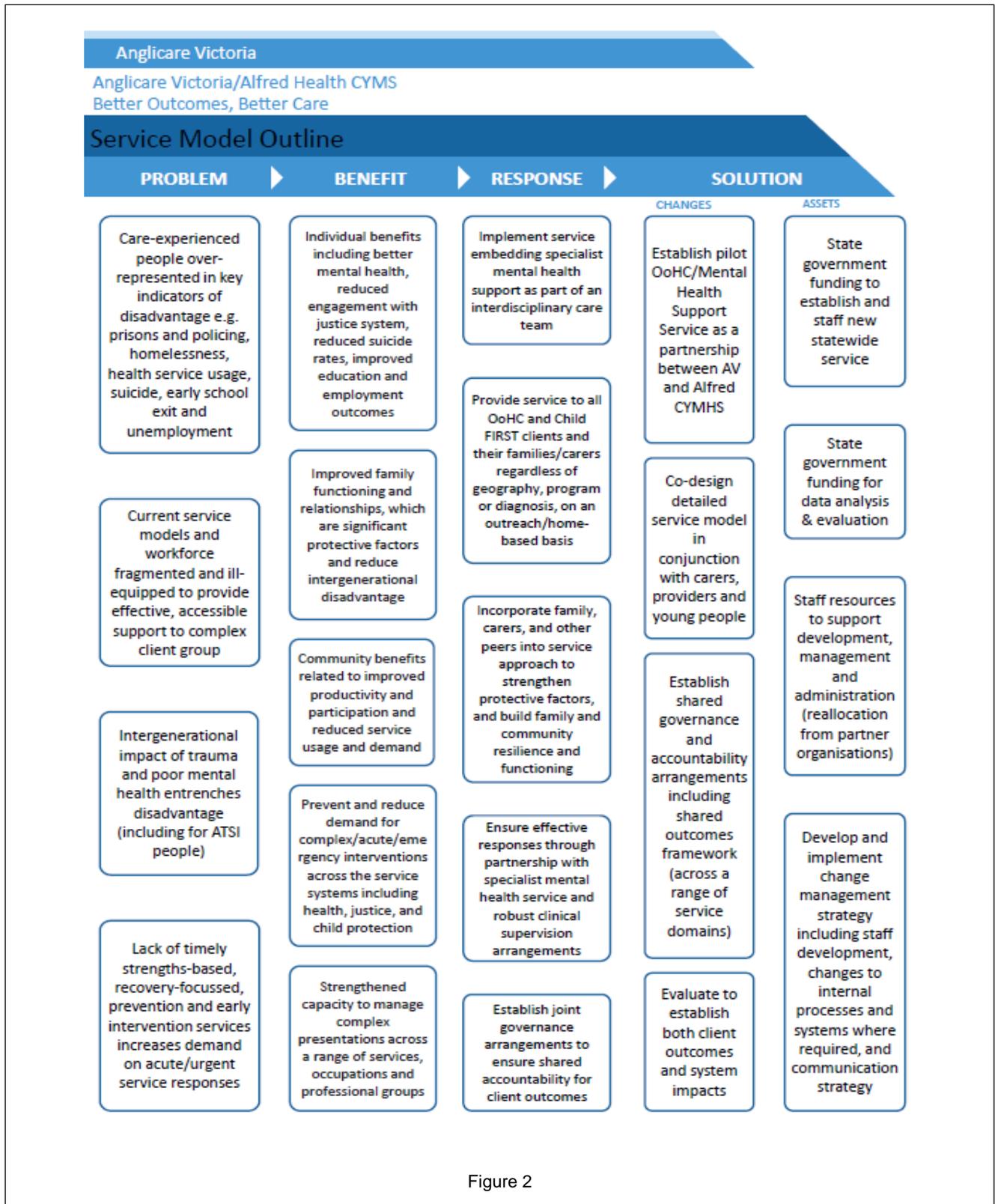


Figure 2

3.2.5 Many children, young people and families are engaged with the service at the instigation of the State, rather than having chosen to do so. Previous experience of service provision may be characterised by confrontation or perceived as coercive, particularly if it involves a child being removed from a family. In addition, these children, young people, and their families often experience stigma and discrimination as a result of their involvement with the care system. This impacts on the readiness with which a trusting and effective therapeutic relationship can be established, and ways that services can be made safe and accessible.

Implications for service delivery

3.2.6 Taking the above issues into consideration (as well as the most effective mental health issues for young people more generally), suggests that a service model that meets the needs of this vulnerable group would need to:

- Take a multi-disciplinary approach that was able to utilise the skills of practitioners with expertise in dealing with and caring for this client group; as well as those with the clinical expertise to help address mental health issues (including the ongoing behavioural and neurological impact of trauma).
- Incorporate mental health support as an integral part of the provision of care, rather than as a separate or 'add-on' service engagement, or reliance on the individual to seek help.
- Adopt a strengths-based model to help build the resilience and skills of young people to manage their own mental health, and develop skills and techniques to cope with the stresses of the environment.
- Embed support for carers, families, peers, and other key supporters into the approach to care and treatment; helping to support both sustainable outcomes and the development of healthy family and relationships.
- Be able to operate across geographical boundaries in order to maintain continuity of care, as well as have the capacity to engage with and refer to the broader clinical mental health system as required (e.g. when a need for inpatient care has been identified).
- Given the complexity and age of the client group, to be able to work with clients to support the development of good mental health, regardless of whether or not they have been formally diagnosed with a mental illness.

- 3.2.7 Given the above and the evidence demonstrating the very high risk of poor mental health amongst this cohort, Anglicare Victoria believes that the care provided to all young people in OoHC should incorporate embedded mental health care support, tailored to individual need.
- 3.2.8 A brief overview of the proposed model is outlined in Figure 2. This model has been developed with the support and advice of Dr Paul Denborough and his team at The Alfred's CAMHS.
- 3.2.8 Further information about the service model is available on request.

Key features of the service model



Figure 3

3.3 Current initiatives and key learnings

3.3.1 There are a number of initiatives currently in the sector that demonstrate the benefits of providing a combined approach which embeds mental health support into child and family- focussed service delivery. These provide a solid basis on which to build approaches that can be provided more broadly to children, young people, and families.

3.3.2 Keep Embracing Your Success (KEYS)

The KEYS program has been introduced as part of DHHS's Roadmap to reform and to improve outcomes for young people in OoHC. It is a residential care model, which is supported by a Monash Mental Health Service and MIND. The mental health support includes a clinician and a consultant psychiatrist and a family engagement worker (MIND). These clinicians work alongside residential care workers and education supports.

Key learnings have included:

- Managing communication and ensuring role clarity.
- Staff retention and managing the impact of occupational violence.
- Bringing partners from different disciplines requires an ongoing commitment and good governance.
- Exit pathways are not always readily identifiable.

In the context of its target group (4 girls involved with, or at risk of sexual exploitation; 4 boys with a criminal justice background), the program has achieved some significant outcomes including: reduced engagement with criminal justice; family reconnection; reduced sexual exploitation and dangerous drug use; and engagement with employment and education.

With further testing and investment, AV sees this model as informing the development of a residential care model that utilised embedded mental health support to deliver better outcomes for young people.

The data on outcomes for these young people is compelling, and AV would be pleased to appear before the Commission to provide further information about KEYS and the outcomes achieved.

KEYS OUTCOMES

The KEYS program is a residential care model that shows significant outcomes for young people across a number of domains including safety, engaging in employment and education and strengthening connections with family and the community.

Some of the most at-risk and complex young people in the State's OoHC system have shown significant improvements in relation to safety:

- Four young people who were assessed at Tier 1 Sexual Exploitation in the SOCIT model are now no longer classified at this level
- Initial data shows half as many secure welfare admissions compared to residential care
- No young people have entered or been returned to Parkville Youth Detention Centre since entering the KEYS program
- Absconding levels have decreased, criminal offending behaviour has decreased and there has been a reduction in the frequency and severity of aggression.

KEYS has shown improved connections and relationships between young people and their family members. A number of young people have reconnected with family members including returning home to live with parents or extended family.

Outstanding outcomes have been delivered in the education and employment domain. All young people in KEYS are now engaged in a range of educational & vocational activities including attending part-time or full-time school, completing pre-apprenticeship or vocational certificates and engaged in part-time & full-time work

3.3.3 Family Functional Therapy – Child Welfare (FFT-CW)

The FFT-CW® model creates a practice framework to provide risk assessment and family-focused, culturally sensitive services that address the needs of the child, as well as the needs of each family member residing with the child. While the FFT-CW® model incorporates a low risk (which is a case management model) and high-risk continuum.

The FFT-CW® evidence-based program is rooted in almost 4 decades of (a) clinical development and application in diverse families; (b) extensive outcome and change mechanisms research; (c) training and supervision of thousands of Practitioners with diverse backgrounds; and (d) international dissemination experience of Functional Family Therapy (FFT®). Based on the core principles of FFT®, AV's evidence-based model FFT-CW® has been specifically developed for supporting families with children and young people aged between 0 and 17 years.

FFT LLC research indicates that the following presenting issues are suited to FFT-CW® HR intervention. These are families who:

- Struggle with mental health diagnoses.
- Are alcohol or other drug affected.
- Have concerns about abuse/neglect or other safety concerns.
- Are experiencing family violence.
- Have criminal justice involvement.
- Are struggling to parent their children.

AV's FFT-CW program is offered in conjunction with MIND (mental health) and Windana (AOD) to ensure that there is specialist mental health, and alcohol and drug expertise embedded as part of the model.

FFT-CW & MST are examples that demonstrate the positive impact of embedding mental health and AoD support as an integral part of supporting vulnerable families. However, despite the compelling evidence, these programs are currently only funded on a small scale as pilots.

Economic benefits

3.3.4 There is significant evidence that the poor outcomes for these children and young people has significant economic impact, meaning that comprehensive and broad-scale implementation of effective, evidence-informed interventions would deliver significant economic benefit.

3.3.5 Cost savings are derived from improved access to education, employment, improved housing stability, reduced interaction with the justice system, improved access to healthcare, and reduced incidence of alcohol and/or drug dependence for young people leaving care.

3.3.6 It should be noted, however, that the potential economic gain would be even greater if the child and family welfare system was better oriented to prevent family breakdown and dysfunction that leads to young people entering care. Programs such as AV's Rapid Response demonstrate that timely, evidence-based interventions can make families safer and prevent the need for removal of children from the home.

An Example of An De-identified Family who received FFT-CW support

A family of five (mother, stepfather, eldest child (████, ███ years old), middle child (████, ███ years old), and youngest child (████, █ year old)) were referred for support in relation to physical discipline from the mother towards the █ year old daughter. A child protection notification was received from the school about their concerns for the young person. The family received FFT-CW® weekly for 6 months. The first phase of “Engagement and Motivation” was particularly crucial for this family. At the very start the family were very resistant to engaging with the Family Practitioner. Once the practitioner had built a positive, professional relationship, the family were more trusting and engaged with the support, progressing into the “Behaviour Change” phase. Skills taught to the family:

Positive and Assertive Communication

“I” Statements e.g. “I feel upset when you’re not listening” instead of “(name of child)...you need to listen to me”

Emotional regulation

Family Goals: increased positivity and hope for the family, included small activities to have all the family members involved)

Role modelling: a powerful technique which provided insight and understanding into each family member’s role in the home.

Building on healthy family relationships

Appreciating family members: again building on the hope for the family, reducing blame and negativity, and focusing on the positives.

Managing Mental Health

Manage anxiety and recognising when being triggered: Focus on the mothers, mindfulness by using adult colouring books.

Planning ahead: preparing to leave the house by assisting Mother’s anxiety and agoraphobia, using a planner in paper form and/or her phone calendar.

Generalisation - Relapse management

Application of above skills to avoid any use of physical discipline, understanding triggers and when to access support (extended family).

Capacity to reach out to services when needed in times of difficulties (services identified are Lifeline, Parentsline and Kidsline).

Figure 4

4 Youth Justice

RECOMMENDATIONS

- Provide effective, appropriate, and accessible mental health support to all young people in the justice system.
- Expand programs such as FFT and MST, that have a strong evidence base demonstrating improved outcomes.
- Provide priority access to assessment and treatment for all complex young offenders; in line with the recommendations of the Armitage/Ogloff review.
- Monitor the representation of vulnerable children in the justice system as a key system outcome measure.
- Raise the age of criminal responsibility to 14; in line with international human rights law.

4.1 Mental health needs of young people in the justice system

- 4.1.1 Children and young people drawn into the youth justice systems have significantly higher rates of mental health disorders and cognitive disabilities when compared with general youth populations (Cuneen, 2017). They are also likely to experience co-occurring mental health disorders and/or cognitive disability. Substance misuse is a major issue for most Youth Justice clients. Australian research suggests that these multiple factors, when not addressed early in life, compound and interlock to create complex support needs (Baldry, 2014; Baldry, 2017; Dowse & et al, 2014; Baldry & Dowse, 2013).
- 4.1.2 A significant proportion of young offenders receive numerous other services and interventions (e.g. child protection, family, mental health, disability and homelessness services) before or during their involvement with Youth Justice, illustrating the potential for these services to be better utilised for timely and effective intervention when problems emerge.
- 4.1.3 Professor Ogloff and Penny Armitage in the review of the youth justice system (Armitage & Ogloff, 2017) clearly identified gaps in mental health services for young people in the Victorian justice system. AV supports the recommendations of this review in relation to mental health

services, as well as further consideration of how youth justice reform more broadly can be oriented toward support and rehabilitation for young offenders.

4.2 Over-representation of vulnerable children in the justice system

4.2.1 In June 2019 the Sentencing Advisory Council released ‘*Crossover Kids: Vulnerable Children in the Youth Justice System*’ (Sentencing Advisory Council, 2019). The report shows that around 38% of the Council’s study group (n=5,063) sentenced and diverted children were the subject of a protection report at some point in their lifetime, 25% were the subject of at least one substantiated report, and 15% had experienced OoHC. 10% had experienced residential care.

4.2.2 The report further notes that the younger the child was at first sentence, the more likely they were to be known to the child protection service. “These findings are particularly concerning,” the report notes “when considered alongside the findings fo the Council’s 2016 youth reoffending study that the younger children are at their first sentence, the more likely they are to re-offend generally, re-offend violently, and receive a sentence of adult imprisonment before their 22nd birthday” (Sentencing Advisory Council, 2019, p. xxiv).

“Previous research also suggests that children in care may be more likely to be prosecuted for behaviour that would usually be dealt with in the family home, contributing to their over-representation among sentenced and diverted children”
(Sentencing Advisory Council, 2019, p. xxv)

4.2.3 This over-representation demonstrates both the devastating impact of childhood trauma on vulnerable children, and the significant benefits that could be delivered by strengthening the support children and young people receive in care — particularly in relation to the development of improved emotional and behavioural regulation and resilience. The failure to do so compounds the impact of their childhood experiences, with lifelong consequences and costs to those children, their families, and the community as a whole.

4.3 Evidence-based programs for better outcomes

4.3.1 Anglicare Victoria is committed to the implementation and development of Evidence-Based Models (EBMs) in the Australian context and continues to review programs delivered here and overseas to identify those that deliver outcomes most efficiently and effectively. There are a number of EBMs in the child and family welfare field that have been shown to deliver positive outcomes in relation to the mental health of participants.

4.3.2 We are delivering and measuring outcomes for Family Functional Therapy (FFT) and Family Functional Therapy Child Welfare in Victoria, including cohorts of young people who have had

contact with the justice system. Both of these models have a substantial international evidence-base supporting their implementation, including demonstrated positive impacts in relation to mental health.

- 4.3.3 Multisystemic Therapy® (MST®) is an intensive family and community-based treatment that addresses the multiple causes of serious antisocial behaviour in juvenile offenders. The MST program seeks to improve the real-world functioning of youth by changing their natural settings (home, school, and neighbourhood) in ways that promote prosocial behaviour while decreasing antisocial behaviour. MST teams consist of a supervisor and 4 therapists. (Supervisors must be licensed Masters mental health professionals; therapists should be Masters Level, but a license is not required.) Each team services an average of 5 families at a time.
- 4.3.4 This model has shown positive mental health outcomes include decreased psychiatric symptomatology, improvements in externalising behaviour and internalizing symptoms, reductions in sexual behaviour problems and decreases in aggression, delinquency, psychopathic traits, and oppositional defiant disorder.
- 4.3.5 Aggression Replacement Training® (ART) is another example of an evidence-based program to improve outcomes for young people and has been rated as effective in more than one study by the National Institute of Justice's CrimeSolutions.gov (only 98 programs

“A disproportionate number of young people have mental illnesses, yet services are inadequate to meet their needs. The barriers experienced by all Victorians to obtain mental healthcare are compounded for young offenders who do not have priority access to services. Practice in the community is not consistent about managing mental health referrals at intake. Practice varies between offices and depends on the informal processes set up between services and Youth Justice.

Significant system limitations also exist for adolescent mental health services. Investigations by the Drugs and Crime Prevention Committee of Parliament (2009) and Victorian Ombudsman (2010) also recognised the need for a dedicated and secure adolescent mental health unit. Custodial facilities are ill-equipped to deal with the mental health needs of young people because, unlike adult prisoners, children and young people in youth justice do not have access to designated facilities. Thus, young offenders with serious mental health issues are often held in custody, perhaps inappropriately. Youth Justice staff have few skills and limited training in this area.

Priority access to assessment and treatment should be considered for complex young offenders. The Review sees benefit in the availability of temporary assessment orders being made available to the Children's Court at the point of remand or release on bail that enables a young person to be subject to a compulsory assessment. There is also merit in considering a youth therapeutic order for court-mandated therapeutic treatment for young offenders. This has been proposed to address these deficiencies by Magistrate Bowles (2014) and the 'What can be done' Steering Committee.” (Armytage & Ogloff, 2017)

worldwide achieved this rating). ART is a multi-modal, cognitive-behavioural, group program designed to reduce the aggressive and antisocial behaviours of young people. It uses three interrelated components: Structured Learning Training, Anger Control Training, and Moral Reasoning to promote comprehensive aggression reduction. The program has been used in Queensland and piloted in Victoria 2009.

WHY CONSIDER AGRESSION REPLACEMENT TRAINING®?

1. Estimated reductions in 18-month felony recidivism of 24 per cent and a positive benefit to cost ratio of \$11.66
2. Improvement in pre- to post-treatment follow-up measures of: improved anger control; decrease in frequency of acting-out behaviours; increase of prosocial behaviours; and significant reduction in recidivism
3. ART is one of the most effective evidence based programs in working with moderate-to-high-risk, violent young people.
4. ART can be delivered in youth custodial settings and in the community

4.4 Raise the age of criminal responsibility

4.4.1 The age of criminal responsibility in Victoria is 10 years. This is the age at which a child can be investigated for an offence, arrested by police, charged, and incarcerated in a youth prison.

4.4.2 The current legal minimum age of criminal responsibility is against medical evidence that children aged 10 to 14 years lack emotional, mental and intellectual maturity. Research shows that children's brains are still developing throughout these formative years where they have limited capacity for reflection before action. Children in grades four, five, and six are not at a cognitive level of development where they are able to fully appreciate the criminal nature of their actions, or the life-long consequences of criminalisation (Bercroft, May 2013).

4.4.3 Studies show that the younger a child has their first contact with the criminal justice system, the higher the chance of future offending. The Sentencing Advisory Council recently found that with each one year increase in a child's age at first sentence, there is an 18 per cent reduction in the likelihood of reoffending (Sentencing Advisory Council, 2016). Children who are forced into contact with the criminal justice system at a young age are less likely to complete their education, find employment, and are more likely to die an early death. The current system traps children who would otherwise grow out of the behaviours and benefit from social interventions and support.

4.4.4 Given one-third of imprisoned children diagnosed with depression only experienced its onset once they were behind bars, there is a clear link between wellbeing, mental health and youth detention. Prisons are ill-equipped to meet the mental health needs of children and young people, and certain punitive practices including the use of solitary confinement and routine strip-

searching compound trauma and exacerbate symptoms. Youth imprisonment is associated with higher risks of suicide and depression (Royal Commission into the Protection and detention of Children in the Northern Territory, 2017).

- 4.4.5 The current minimum age is in breach of international human rights law and is inconsistent with international standards. The median age of criminal responsibility worldwide is 14 years old. The United Nations Committee on the Rights of the Child has consistently said that countries should be working towards a minimum age of 14 years or older.
- 4.4.6 Calls by the Smart Justice for Young People (SJ4YP) Coalition in Victoria (a coalition of leading Aboriginal and Torres Strait Islander, social services, health, legal and youth advocacy organisations who advocate for evidence-based and effective responses to justice-involved children and young people) is calling on the Government to raise the age of criminal responsibility to at least 14 years old. This call is supported by the Australian Medical Association, the Royal Australian College of Physician, the Australian Indigenous Doctors' Association, the National Aboriginal and Torres Strait Islander Legal Services, the Lowitja Institute, as well as Public Guardians and Children's Commissioners across the country. AV supports these calls.

5 Recognising and respecting the role of families, carers, and peers

RECOMMENDATION

- Invest in support services for vulnerable families, carers, and peers such as ParentZone and Parents Building Solutions to improve mental health outcomes and strengthen resilience.
- Ensure that service models for families, carers, and peers include access to embedded mental health support (as appropriate) and strong referral pathways for more intensive services where required.

5.1.1 Prevention and early intervention approaches recognise that mental health issues affect whole families and that strong relationships and connection — whether in the form of a traditional family group or some other equally supportive network of significant others — are protective factors that increase resilience. Data from *The Mental Health of Children and Adolescents* report demonstrates the correlation between poor family functioning and poor mental health. (See figure 5)

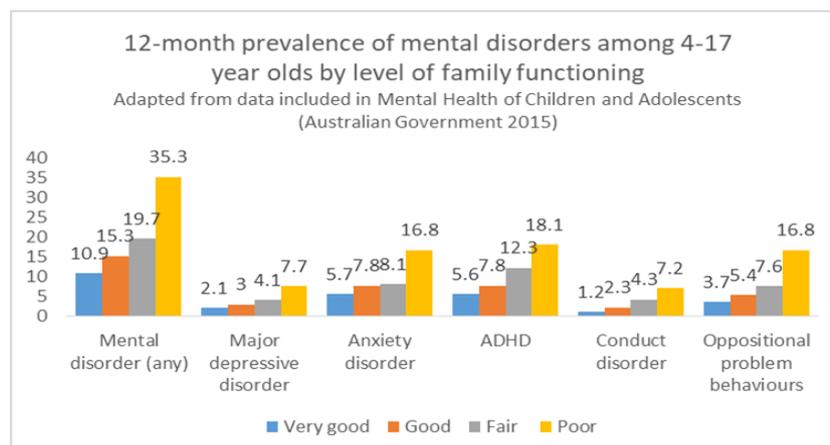


Figure 5

- 5.1.2 It should also be recognised that families and carers are an integral part of the care team for those people with an acute and/or chronic mental illness. The significant role that families and carers play needs to be better reflected in care and discharge planning — not just as a resource for the service-system to utilise, but also as a key informant with unique insights and experiences to offer about what works, and what doesn't.
- 5.1.3 The *Mental Health of Children and Adolescents* report confirms that even families that are seeking support struggle to find it, and that both parents and young people confirm that a focus on skills development is needed. Areas for improvement include:
- Strengthening families and relationship as a means to build protective factors and resilience.
 - Effective and timely responses for families experiencing problem to ensure that impact of neglect, abuse or other dysfunction as a contributor to poor mental health.
 - Integrated responses to mental illness that concentrate on better equipping both the person who is unwell *and* their families to manage and address the full impacts of mental ill-health on families.
 - With timely and appropriate interventions, families who struggle can be supported to provide a safe environment for their children, and yet, proportionally, support for families before they come into contact with the child protection system is relatively under-resourced (see question 6 for further information).
- 5.1.4 A greater focus on prevention and early intervention programs working to strengthen family functioning and skills would improve outcomes in terms of mental health and wellbeing. These approaches should recognise that the best way to make a child safe is to make the family environment safe.
- 5.1.5 Families that we work with report that mental health crisis responses services provide little or no immediate support to families, friends, and carers who are seeking: to manage very challenging and often unfamiliar situations and behaviours; resources and support to more effectively manage issues in the longer term. This needs to be addressed as a matter of urgency, either through a change in the model of service delivery or by the development or expansion of existing family support services to fill this gap.
- 5.1.6 Although the results do not establish causal relationships, these results do at least suggest that a strengthened focus on families could assist in improving mental health outcomes, and/or reduce the impact that poor mental health may have on the functioning of the family unit and relationships.

Family oriented services

- 5.1.7 Health systems and health professionals that maintain a traditional focus on one-on-one client/clinical relationships can struggle to work effectively within the context of a family dynamic. This is particularly concerning where mental health and/or drug and alcohol issues coexist with financial hardship, violent behaviour in the home, or lack of parenting skills and effective childcare.
- 5.1.8 Parents concerned about their children's mental health identify not being sure to get help (39.6%) and not being able to afford help (37%) as key barriers to seeking or receiving help.
- 5.1.9 Models such as Anglicare Victoria's Parentzone being delivered at Cranbourne in Melbourne's Southeast provide an example of how service models can be designed that provide readily accessible avenues as a range of supports, as well as provide a non-stigmatising entry point for any parents who may benefit from additional help.
- 5.1.10 This indicates that there continues to be systemic barriers for people who are seeking to support young people's mental health, and is likely to result in significant missed opportunities for beneficial intervention at an early stage.
- 5.1.11 The response provided to families who are experiencing difficulties could also be improved. There is currently limited investment in prevention and early

PARENTZONE

ParentZone is an evidence-based AV program that supports people caring for children to build parenting skills. A partnership between AV, Cardinia Shire Council, and Pakenham Hills Primary School is exploring opportunities to develop the program into an integrated multi-agency/service community hub for parents, children and the broader community.

ParentZone will respond to community needs through joint working with key stakeholders including connecting universal and secondary service systems (including family violence, mental health, AOD, legal services, Child FIRST etc.) through a co-location model. A range of universal services will be regularly available on site including:

- Parenting groups
- Playgroups
- Maternal and Child health services
- Allied Health
- GP and Paediatrician
- AV's TEACH
- Tutoring program
- Library and literacy programs
- School Psychologists
- Volunteer programs
- Parent drop-in

This will be supported by opportunities for parents to access specialist supports on site, through a range of co-located services delivered by partner agencies.

The principles the ParentZone will operate under are to:

- Remove barriers between people and services.
- Provide a highly visible entry point to supports.
- Integrate and co-ordinate available supports and making these available within the school gate.
- Simplify access to early intervention and universal services.
- Deliver services using a co-design and co-production model, engaging parents as genuine partners, active participants, leaders, and contributors to services.

ParentZone is a model that can provide a readily accessible, non-stigmatising parenting support for families seeking support on mental health issues, as well as potentially acting as a gateway to targeted or specialised assessment and support where required.

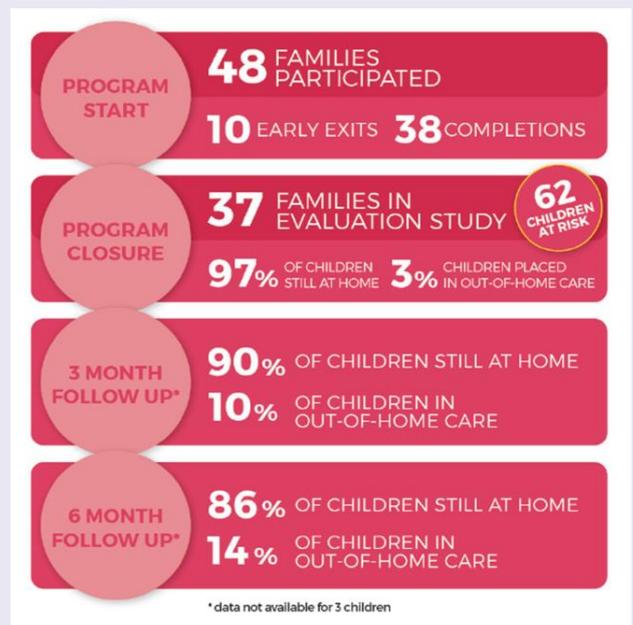
intervention services (in the form of family support) within the child protection system. According to the Report on Government Services, family support expenditure nationally per child is about 15% of the cost of OoHC services per child (\$85.95 of \$616.98), meaning successful interventions that minimise poor outcomes and the potentially traumatising need for further intervention represents a cost saving and a very positive return on investment. However, despite significant increases over the last decade, expenditure on family support and intensive family support comprises only 27% of Victoria's total expenditure on child protection services, and only 17% nationally.

5.1.12 AV also supports increased financial and practical support for foster and kinship carers given that they are often tasked with caring for young people with significant experience of trauma and other issues that potentially impact on their mental health.

RAPID RESPONSE™

Rapid Response™ is an intensive, placement prevention model that acts as a direct alternative to Child Protection intervention where a decision to remove a child from the home is imminent.

Rapid Response is not a generalist, long term placement prevention model. Critical to its success is a 'Rapid Response' and singular intervention focus by the Practitioner to support the family at the crisis point where a Protection Application is about to be issued and a child placed in OoHC.



6 Systems and policy

RECOMMENDATION

Provide accessible, appropriate outreach for mental health support for vulnerable children, young people, and their families; particularly those with complex needs and presentations.

- Embed specialist mental health support into service models targeting children, young people and their families — as described in the ‘Better Outcomes, Better Care’ model outlined in this submission (see section 3).
- Adopt a shared, whole-of-government outcomes framework for young people in Victoria addressing health wellbeing, resilience, and engagement across all portfolio areas.
- Invest in research to guide investment in improving outcomes, including investment in systems research and implementation science.
- Review child protection legislation, policies, and procedures to ensure that the system prioritises achieving benchmark outcomes for children in its care in addition to protecting them from harm.
- Support inter-disciplinary service models and workforce development to improve effectiveness of responses to vulnerable young people.

6.1 Service gaps

6.1.1 Youth Counselling Services/Youth Futures (no longer available)

Formerly, AV provided a funded Youth Counselling service for nearly a decade, with support for Wyndham City Council. Key elements of this service were:

- Flexibility in the number of sessions offered — reflecting the variability in the time taken to effectively engage young people.
- Outreach — so that young persons could access the service where they felt safe and comfortable.
- No requirement for a mental health plan — enhancing the service’s capacity to engage early and avoid unnecessary engagement with the acute mental health system.
- Linkages with other programs — so that a “wrap-around service” could be provided for better client outcomes

This program was supported by local government, however, many local governments do not see providing a service of this kind as part of their role, rather seeing it more appropriately funded through state and federal health systems.

As this service was able to provide support for hard to reach clients who may not be willing or unable to engage with other services, AV staff now identify this as a service gap.

6.1.2 Other mental health supports: GP-based access & HeadSpace

AV staff often support clients to utilise the mental health support available via GP services through a mental health plan (HeadSpace and CAMHS). However, the support available is often not adequate for our client group for a range of reasons:

- Most services offer limited or no outreach making them inaccessible to some clients e.g. to a young person who has anxiety and will not leave the house.
- Practitioners do not always have the skills, expertise, and confidence to manage and support the high levels of complexity and trauma experienced by vulnerable children and young people.
- The limited number of sessions available via Medicare does not address the ongoing impact of trauma over the life course.
- A focus on a diagnosed or identified mental health issue precludes effective early intervention and prevention strategies.
- Working with a young person's family and carer is sometimes under-valued in favour of service models that focus on individual support.

As a result, AV staff report often find themselves unable to systematically provide the kind of support to clients that is required in order to achieve program outcomes. The types of challenges experienced are illustrated by the Navigator client census data provided on the previous page.

6.1.3 NDIS

Prior to the introduction the NDIS there was a number of social groups run out of Community Mental Health Services. These services offered, mental health specific counselling, case management, support groups, therapeutic groups, social groups, and drop-in activities.

Unfortunately, the small proportion of people with an NDIS package who suffer from a Mental Health condition, more often than not, have no Mental Health support as part of their package — and even those that do fail to receive appropriate services.

Anecdotal evidence from the families we work with suggests that NDIS is unavailable to many, and even those eligible for NDIS are experiencing lengthy delays in the development of case plans and infrequent reviews. There is limited access to allied health (e.g. speech therapy) and behavioural support services, especially for those families who are struggling to manage children with physical, mental, learning or behavioural difficulties but are

NAVIGATOR

NAVIGATOR is a program funded through the Department of Education which seeks to re-engage young people who have disengaged from school.

A census of client data from AV's Navigator program indicated that

- 89% were recorded as having anxiety (89% in AV's program)
- 58% had diagnosed (33%) or suspected (25%) depression
- 19% had diagnosed (11%) or suspected (8%) other mental health condition
- 33% were identified as having Autism Spectrum Disorder, significantly higher than the state average.
- 67% were more than two years behind in literacy and
- 89% were identified as having social/emotional issues

Staff report that given the high rates of anxiety, ADS and social & emotional issues, clients were often housebound and outreach models of specialist support were required, but seldom available.

not eligible for funded mental health or disability services. This represents a missed opportunity for families, particularly those impacted by caring responsibilities, as well as missed opportunities for the NDIS client themselves.

6.2 Integration and coordination

- 6.2.1 The discontinuity between disability, primary care, and acute mental health services continues to be a significant structural weakness in the healthcare system, and many people — including many people at high risk of poor mental health outcomes — continue to “fall through the cracks” of systems driven by diagnosis-based eligibility criteria.
- 6.2.2 At local and state level, coordination and communication between acute mental health and other non-health, non-government services is limited and inconsistent. While there are area-based initiatives and forums that seek to improve coordination, these tend to happen either across education and children’s services, or across different health services, but rarely both. The presence of different outcomes frameworks for young people across education, and child and family services is symptomatic of this.
- 6.2.3 As our experience with our own dual diagnosis program has demonstrated, multi-disciplinary models of care lead to better service delivery and more efficient and effective interventions. This can be encouraged through incorporating worker liaison as an important part of service delivery, as well as building the ability to work effectively within multidisciplinary teams as a core skill-set for staff from a variety of organisation types and professional disciplines.
- 6.2.4 For example, there have been cases where a young person who is being supported to maintain stable housing in our Lead Tenant program has experience with mental illness, including periods as an inpatient in a mental health service. Greater engagement in discharge planning would enable our staff to better support that young person when they return home, and reduce the risk of further illness and re-admission. Staff report receiving little information about issues such as risks and triggers, medication, and medication safety, and how to identify and respond appropriately to symptoms reoccurring. While generic training can address this in part, it will not address the circumstances of particular clients.
- 6.2.5 There are examples of effective partnerships between mental health and non-health services that could be more broadly applied, such as Anglicare Victoria’s Eastern Alcohol and Drug Program, and Eastern Health In-Patient Units at Upton House and Maroondah. The Pilot involves a qualified Alcohol and Drug Clinician being present on the ward with the objective of enhancing referrals to AOD programs, improving the engagement of referred individuals in their post-discharge treatment and decreasing 28-day re-admission rates. Importantly, the approach also provides a more holistic support service for the patient’s family.

- 6.2.6 There is an opportunity to significantly strengthen coordination between health, mental health, and non-health services. While employing locally focussed commissioning bodies may have the potential to improve this, at present, they remained focused on specific parts of the system. PHN's, for example, may have the potential to make improvements in this area, but their engagement with non-health services to date remains minimal. All services should be part of the mental health system – either in the sense of providing a gateway, providing service models that incorporate appropriate responses to trauma and mental ill-health as part of their delivery, and at minimum, adopting a “first, do no harm” approach, ensuring that the service system itself is not impacting adversely on mental health (juvenile justice, prison, family violence response, OoHC) outcomes for vulnerable populations.
- 6.2.7 Effectively addressing and improving mental health requires engagement and involvement of a broad range of services above and beyond those with a primary mental health focus. While this reality is reflected in the highly targeted, limited capacity of the acute mental health system, it is not adequately matched by investing in evidence-based responses and building capability in the sectors outside it. Building this capacity is vital to both improving outcomes for people with acute and chronic mental illness, engaging constructively with people experiencing episodic or emerging issues, the prevention of mental ill-health, and the promotion of good mental health.
- 6.2.8 Problems of access and service continuity appear to be particularly pressing in relation to the provision of effective prevention and early intervention activities, where services can be difficult to identify and access (Australian Government, 2015), and in relation to effective discharge and transfer from one service to another (e.g. acute service to home/GP; mental health service to NDIS). Seamless transition between service providers should be a priority and is a pre-condition of delivering genuinely person-centred care.

Anglicare Victoria's Eastern Alcohol and Drug Program, and Eastern Health InPatient Units at Upton House and Maroondah is an example of a successful partnership between a community services and a specialist mental health services to deliver better outcomes.

The Pilot involves a qualified Alcohol and Drug clinician being present on the ward to provide more holistic support to the patient and their family. The AoD clinician works to enhance referrals to AOD programs, improve the engagement of referred individuals in their post-discharge treatment, and decrease 28 day re-admission rates.

Currently, an Anglicare Victoria AOD clinician attends the wards numerous times a week. The clinician then works with ward staff to identify appropriate patients experiencing dual diagnosis issues, and works with the patient for the remainder of their stay, including:

- Providing an overview of the Alcohol and Other Drug Services available to the individual through Anglicare and other external services.
- System navigation.
- Completion of preliminary assessment and measurement tools (K10, Audit, Dudit).
- Additional information regarding any family member or significant others that the individual wishes to have involved in their treatment, or whom they identified may benefit from being offered individual family support.
- Immediate psycho-education, harm reduction, and relapse prevention strategies.
- Evaluation of where the individual is currently sitting within the cycle of change.
- Consent to contact family members obtained.
- Discharge date identified and first appointment booked for post discharge.

The AOD clinician is often invited to attend the discharge meetings to provide Eastern Health staff with up-to-date patient information regarding their problematic drug or alcohol use along with outcomes/recommendations, as well as provide an additional support for the patient.

Following discharge, the patient is able to access ongoing therapeutic support (as are any family members or significant others who may benefit from individual support to understand their loved one's substance misuse) and develop skills and strategies to better support them.

Initial outcomes data has shown improved engagement of both patients and their family members, as well as a significant reduction in the number of 28-day re-admissions.

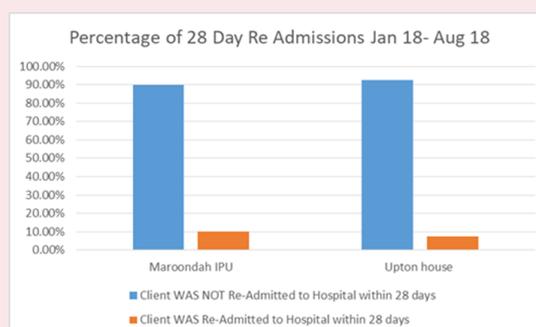


Figure 6

6.3 Performance and evidence-based decision-making

A focus on outcomes

- 6.3.1 While the respective roles of the Australian government and State government in relation to mental health services is often clear, both levels of government are highly incentivised by the current system to ‘gate-keep’ entry into their respective systems (primary versus acute care) and ration access to them. There is little in the funding arrangements of the system to structurally incentivise approaches that deliver the best outcome for clients.
- 6.3.2 Accountability and performance monitoring for funded services continues to focus on the delivery of particular services by particular branches of government and often focuses on the volume of service delivered. Anglicare Victoria is not aware of any effective accountability mechanisms that addresses the whole client journey, or measures coordination and alignment across these service streams.
- 6.3.3 Population-based outcomes measurement, including measuring outcomes for high-risk groups (such as children, young people, and families) in contact with child and family services, would provide a better basis for ensuring that high-risk groups are being effectively supported and that available resources are being most appropriately targeted.

Outcomes for children and young people in OoHC and their families

- 6.3.4 Outcomes for children and young people in OoHC and their families, either on a population or individual level, remains in its infancy and largely separate from the way service delivery ‘quality’ is measured at a systems level. For example, there is currently little outcomes data and benchmarking to evaluate the mental health outcomes and needs of young people in or leaving care and/or youth justice systems.
- 6.3.5 There is also an opportunity to tap into ‘big data’ (including longitudinal analysis) to better understand people’s pathways into the system and to identify earlier opportunities for intervention and prevention, within an appropriate ethical and privacy framework. In addition, it is hoped that the growing capacity across government to use linked datasets across portfolio areas will continue to strengthen understanding of the impact of, and inter-relationship to, other program areas with mental health issues (with appropriate privacy controls). This would also enable greater use of forecasting and trend analysis, and strengthen and inform demand management and capacity planning.

6.3.6 A continuing focus on the development of client and carer defined outcomes, which focus on the impact on a person's life experience and participation is also important — which is likely to correlate strongly with productivity outcomes for both people experiencing poor mental health and families, friends, and informal carers.

A commitment to practical, outcomes-focussed evaluation and research

6.3.7 Models of mental health care for young people as a whole have not been well developed or adequately tested (Newman & Birlleson, 2012), neither across the age range nor across tiers of care. There are few potential sources of funding for evaluation. Philanthropy often underestimates funds required for evaluation, and despite the obvious benefits for system-wide learning, there is limited government funding available for non-health services. It remains the case that when negotiating costs with funding bodies, including governments, evaluation is often the first casualty.

6.3.8 Investment in building the evidence-base is urgently needed if we are to improve mental health outcomes for young people who are in, or have been in, care. We know that mental health outcomes are poor for both children and young people in care, and adults who have experience of care in childhood, yet there is very little data available in Australia to measure or track these outcomes for this high-risk cohort. In fact, this population group is sometimes specifically excluded from collections such as *The Mental Health of Children and Adolescents* survey (Australian Government, 2015). The limited availability in Australia of specialist services or programs targeting the needs of care-experienced children and young people means that they are relatively invisible within mental health research and practice (Tarren-Sweeney & Vetere, 2013). There is also “a clear argument for more comprehensive research examining the mental health of care leavers in Australia, particularly to inform leaving care and post-care service provision” (Baidawi, Mendes, & Snow, 2014).

6.3.9 There remains insufficient data and research available on the extent to which better mental health support could reduce Australia's expenditure in relation to other significant cost items such as homelessness, justice, and child and family services (including child protection). It is important to understand these interrelationships to ensure that interventions as early and effectively as possible. In many cases, the most cost-effective point of intervention may not be the health system.

- 6.3.10 Exposure to trauma in childhood has been referred to as ‘psychiatry’s biggest health challenge’ (Sara & Lappin, 2017), yet service responses and comprehensive evaluations of their relative effectiveness remain inadequate. National OoHC standards specifically address the need to provide additional services to better address the mental health needs of children and young people in care. However, there remains a dearth of accessible, consolidated information and data to inform responses and assess how well mental health needs are being met.
- 6.3.11 Funding to support system-level research (e.g. system redesign projects, implementation studies, research to help identify most effective interventions for identified populations, testing collaborative versus integrated service delivery models, and process redesign projects focussing on referral and service pathways) is extremely limited in Australia, particularly for service models and programs that are not based in health services. For example, there is limited local research to test the mental health impacts of therapeutic models of OoHC, or on the potential for programs focussed on family support to improve mental health or to more effectively manage and mitigate the impact of mental illness.

6.4 Building a capable workforce

- 6.4.1 As noted earlier, clearer recognition of the role of both consumers and carers as an integral part of the care team would deliver better outcomes both for people experiencing poor mental health as well as minimising the extent to which that situation impacted on the participation and productivity of all members in the household in school, work, and the community.
- 6.4.2 In addition, our experience suggests there can be a lack of skill and expertise amongst some specialist health care professionals including mental health clinicians in working with children and young people who present with complex and sometimes confrontational behaviours. Because of this, clinical mental health care staff can be hesitant to work directly with highly complex clients in care settings. While this may be understandable from an individual practitioner point of view, it begs the question of who can and should provide clinical mental health services for this very vulnerable group, and what further workforce capacity should be developed to provide care. The model suggested in section 3 of this submission addresses this by reflecting a blended approach to care and mental health support, utilising the shared skills of staff to create a safe and therapeutic care environment and working environment.
- 6.4.3 Given the very high prevalence of poor mental health amongst young people in OoHC, there is a strong argument for both workers and carers in the field of child and family welfare to have strong skills both in working with people whose mental health is poor, and in providing and

delivering therapeutic interventions including preventative and early intervention strategies. For example (and as noted above), youth justice staff “have few skills and limited training in this area” (Armytage & Ogloff, 2017).

- 6.4.4 It is important to note, however, that prevailing funding arrangements do not always support the employment of staff with formal skills and qualifications in this area. For example, although we know that the outcomes for children and young people in residential care are poor, only some residential facilities in Victoria are funded at the higher “Therapeutic Residential Care” rate. Given the complexity of behaviours in these services, AV believes that resourcing and enabling providers to implement therapeutic models across residential care settings would deliver significant long-term productivity savings and better outcomes (improved health and mental health, better educational and employment outcomes, and reduced justice system involvement) across the life course of people who are placed in OoHC in childhood.

6.5 Resourcing

- 6.5.1 Resourcing for the children’s and family services is a significant barrier to implementing the systemic change and embedded mental health support that could improve outcomes for children in care and their families. This directly contributes to missed opportunities to prevent and reduce harm, particularly in relation to ‘secondary’ and early intervention services.
- 6.5.2 Some examples of where this lack of resourcing impacts on the capacity to provide timely and effective support for children and families include high case-loads preventing timely investigation and referral/intervention meaning missed opportunities to provide earlier support for families (according to DHHS data, in 2017-18 an average of nearly 19.7% cases were unallocated at the end of each quarter), and insufficient funding to provide therapeutic interventions to all children in residential care, despite evidence that that adopting a therapeutic model for all residential care settings would deliver much improved outcomes for young people.
- 6.5.3 There is a need to provide ongoing for support evidence-based programs (such as Rapid Response discussed above) that can prevent the impact of trauma by intervening earlier and preventing family breakdown; embedding them as integral parts of the service system.

7 Conclusions and summary of recommendations

Children, young people, and their families who have contact with the child protection system are at significantly higher risk of poor outcomes than those who have not. This includes poor mental health outcomes that, in turn, increase the risk that they will become involved in the justice system and that they will have difficulty engaging in education, employment, and positive personal and social relationships.

The poor outcomes experienced by those who, through no fault of their own, find themselves growing up in care is in and of itself evidence that the system is currently failing to provide adequately for their needs.

Fortunately, there is ample evidence that better outcomes can and will be achieved if appropriately designed and targeted evidence-based and evidence-informed programs are implemented on a broad scale. This has been demonstrated both in Victoria and overseas.

AV's recommendations for how this can be achieved are summarised below.

Prevalence, risk and outcomes

- Provide effective, appropriate and accessible mental health support for all children, young people and their families who are or have been in OoHC, in recognition of the prevalence and risk of poor mental health outcomes

A new model for mental health support for at-risk children and young people:

- Embed specialist mental health capacity into service models and care teams working with vulnerable populations – particularly children, young people, and their families in contact with OoHC and other child protection and family support services.
- Provide funding to allow the Anglicare Victoria/Alfred CAMHS 'Better Outcomes, Better Care' model outlined below to be introduced for all in-scope AV clients, with a view to statewide implementation.
- In order to be effective, the service model for children, young people, and families in contact with OoHC and other child protection and family support services should be:
 - Delivered in the clients' care/home setting as part of the day to day care and support (including via outreach), through embedding mental health practitioners in the care team.
 - Address the mental health of the primary client collaboratively and in the context of their family, carer and peer relationships.
 - Be strengths-based, trauma-informed, and work to build resilience and capacity.
 - Prioritise ongoing support and continuity across program and geographical boundaries.
 - Have a strong focus on prevention and early intervention, while facilitating access to specialist mental health services as required.
 - Provided for any young person in the OoHC or child protection system, whether or not there is a formal diagnosis/identification of a mental health issue.

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- Be culturally appropriate and co-designed with children, young people, and their carers and families.
- Establish shared accountability for agreed client outcomes between child and family services and mental health providers.

Youth Justice

- Provide effective, appropriate, and accessible mental health support to all young people in the justice system.
- Expand programs such as FFT and MST that have a strong evidence base demonstrating improved outcomes.
- Provide priority access to assessment and treatment for all complex young offenders, in line with the recommendations of the Armitage/Ogloff review.
- Monitor the representation of vulnerable children in the justice system as a key system outcome measure.
- Raise the age of criminal responsibility to 14, in line with international human rights law.

Recognising and respecting the role of families, carers, and peers

- Invest in support services for vulnerable families, carers and peers such as ParentZone and Parents Building Solutions to improve mental health outcomes and strengthen resilience.
- Ensure that service models for families, carers, and peers include access to embedded mental health support (as appropriate) and strong referral pathways for more intensive.

Systems and policy

- Provide accessible, appropriate outreach and mental health support for vulnerable children, young people, and their families, particularly those with complex needs and presentations.
- Embed specialist mental health support into service models targeting children, young people, and their families — as described in the ‘Better Outcomes, Better Care’ model outlined in this submission (see section 3).
- Adopt a shared, whole-of-government outcomes framework for young people in Victoria addressing health wellbeing, resilience, and engagement across all portfolio areas.
- Invest in research to guide investment in improving outcomes, including investment in systems research and implementation science.
- Review child protection legislation, policies, and procedures to ensure that the system prioritises achieving benchmark outcomes for children in its care in addition to protecting them from harm.
- Support inter-disciplinary service models and workforce development to improve the effectiveness of responses to vulnerable young people.

8 Works Cited

- 8th Global Conference on Health Promotion. (2014). *Health in All Policies: Helsinki Statement. Framework for Country Action*. World Health Organisation. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/112636/9789241506908_eng.pdf;jsessionid=3E42DF81167F1C8253741965EAAF6628?sequence=1
- Armytage, P., & Ogloff, J. (2017). *Youth Justice Review and Strategy: Meeting needs and reducing offending*. Melbourne, Victoria: Victorian Government. Retrieved from <https://www.justice.vic.gov.au/justice-system/youth-justice/youth-justice-review-and-strategy-meeting-needs-and-reducing-offending>
- Australian Government. (2015). *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Australian Government.
- Baidawi, S., Mendes, P., & Snow, P. (2014). Young People in, and Transitioning from, Out-of-home Care and their Mental Health Issues: A Call for Evidence. *39*(4), 200-205. doi:10.1017/cha.2014.27
- Baldry, E. (2014). Disability at the Margins: Limits of the Law. *Griffith Law Review*, *370*(23(3)).
- Baldry, E. (2017). 'People with Multiple and Complex Support Needs, Disadvantage and Criminal Justice Systems'. In A. Durbach, B. Edgeworth, & V. Sentas, *Law and Poverty in Australia: 40 years after the Sackville Report*. Federation Press.
- Baldry, E., & Dowse, L. (2013). Compounding Mental and Cognitive Disability and Disadvantage: Policing as Care Managers. In D. Chappell (Ed.), *Policing and the Mentally Ill: International Perspectives*. CRC Press.
- Bercroft, A. (May 2013). From Little Things, Big Things Grow: Emerging Youth Justice Themes in the South Pacific. *Australasian Youth Justice Conference on Changing Trajectories of Offending and Reoffending*. New Zealand.
- Bronsard, G., Alessandrini, M., Fond, G., Loundou, A., Auquier, P., Tordjman, S., & Boyer, L. (n.d.). The Prevalence of Mental Disorders Among Children and Adolescents in the Child Welfare System: A Systematic Review and Meta-Analysis. *Medicine*, *95*(7).
- Courtney, M. E., Dworsky, A., Ruth, G., Keller, T., Havlicek, J., & Bost, N. (2005). Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19.
- Cuneen, C. (2017). Arguments for Raising the Minimum Age of Criminal Responsibility. *Australian Social Policy Conference*, (p. September). Sydney.
- Dowse, L., & et al. (2014). Young People with Complex Needs in the Criminal Justice System. *Research and Practice in Intellectual and Developmental Disabilities*, *1*(2).
- Evans, R., White, J., Slater, T., Morgan, H., Strange, H., & Scourfield, J. (2017). Comparison of suicidal ideation, suicide attempt and suicide in children and young people in care and non-care populations: systematic review and meta-analysis of prevalence. *Children and Youth Services Review*, *82*, 122-29.
- Forbes, C., Inder, B., & Raman, S. (2006). *Measuring the cost of leaving care in Victoria*.
- Frederico, M., Jackson, A., & Black, C. (2010). *More than Words - The Language of Relationships. Take Two - Third Evaluation Report*. Bundoora: LaTrobe University.
- Giles, D. (2019). Unpublished data. Melbourne, Australia: Anglicare Victoria. Retrieved June 28, 2019

BETTER CARE FOR BETTER OUTCOMES | Anglicare Victoria submission to the Victorian Royal Commission on Mental Health

- Kaariala, A., & Hiilamo, H. (2017). Children in out-of-home-care as young adults: A systematic review of outcomes in the Nordic countries. *Children and Youth Services Review*, 79. Retrieved from https://www.researchgate.net/publication/317282805_Children_in_out-of-home_care_as_young_adults_A_systematic_review_of_outcomes_in_the_Nordic_countries
- Kandasamy, N., McClellan, M., & Corrales, T. (2016). *Children in Care Report Card*. Anglicare Victoria.
- Kisiel, C. L., Fehnbach, T., Torgersen, E., Stolbach, B., McClelland, G., Griffen, G., & Burkman, K. (2014). Constellations of interpersonal trauma and symptoms in child welfare: Implications for a developmental trauma framework. *Journal of Family Violence*(29), 1-14.
- Larney, S., Topp, L., Indig, D., O'Driscoll, C., & Greenberg, D. (2012). A cross-sectional survey of prevalence and correlates of suicidal ideation and suicide attempts among prisoners in New South Wales, Australia. *Public Health*, 12(14). Retrieved from <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-14>
- Newman, L., & Birleson, P. (2012). Mental Health Planning for children and youth: Is it developmentally appropriate? *Australian Psychiatry*, 20, 91-97.
- Royal Australian and New Zealand College of Psychiatrists. (2015). *The mental health care needs of children in out-of-home care*. Position Statement. Retrieved from <https://www.ranzcp.org/news-policy/policy-submissions-reports/document-library/the-mental-health-care-needs-of-children-in-out-of>
- Royal Commission into the Protection and Detention of Children in the Northern Territory. (2017). *Final Report*. Commonwealth.
- Sara, G., & Lappin, J. (2017). Childhood trauma: psychiatry's greatest public health challenge? *Lancet Public Health*, 2.
- Sentencing Advisory Council. (2016). *Reoffending by Children and Young People in Victoria*.
- Sentencing Advisory Council. (2019). *'Crossover kids': Vulnerable Children in the Youth Justice System. Report 1: Children Who Are Known to Child Protection among Sentenced and Diverted Children in the Victorian Children's Court*. Melbourne, Victoria: Sentencing Advisory Council.
- Tarren-Sweeney, & Vetere. (2013). In B. e. al.
- Wall, L., Higgins, D., & Hunter, C. (2016). *Trauma-informed care in child/family welfare services*. Child Family Community Australia: Information Exchange. Melbourne: Australian Institute of Family Studies.
- Wall-Weiler, E., Bolton, B., Lui, C., Wilcox, H., Ross, L., & Hiern, A. (2018). Intergenerational involvement in out-of-home care and death by suicide in Sweden: A population-based cohort study. *Journal of Affective Disorders*, 230, 506-512. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0165032718305494>