

**Berry Street Response to Productivity
Commission Issues Paper**

The Social and Economic Benefits of Improving Mental Health

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Introduction to Berry Street

Berry Street was formed in 1877 and is Victoria's largest independent child and family welfare agency. Berry Street's vision is: *Together we will courageously change lives and reimagine service systems*. We believe that "all children should have a good childhood, growing up feeling safe, nurtured and with hope for the future".

Berry Street provides specialist family violence services, foster and kinship care, residential care, case management, trauma-informed therapeutic services, family support, education and housing programs for young people, services for families experiencing separation difficulties and several early intervention services for children and families. In addition, Berry Street, via Open Place, provides lifelong support to adults who experienced institutional care in orphanages, children's homes and foster care.

Relevance of Inquiry to Berry Street

Berry Street is a major provider of services to families and children who face severe and multiple disadvantage. Most of the children and families seen by Berry Street have either been in or are in contact with the child protection system.

The Royal Commission into Institutional Responses to Child Sexual Abuse estimated that, over the past decade in Australia, there have been 39 inquiries, reviews, and Royal Commissions focussed on finding better ways to protect children against abuse and neglect. Despite these reviews and their recommendations and the billions of dollars that have been spent, incidents of child abuse and neglect continue to rise.

All these reviews have identified common factors at the heart of child protection and the complexity of the work. The reviews have noted evidence of entrenched intergenerational patterns of family disadvantage which may include family violence, housing instability, substance abuse and mental health issues.

While reviews into the child protection system were occurring so too were multiple reviews into the mental health system. The Issues Paper, while not listing all the reviews, suggests that there has been a "plethora" of them.

Not surprisingly, given the interrelated nature of community, individual, family and community difficulties, the Child Protection and Mental Health reviews and inquiries have many similarities. Both these systems' reviews note the complexity and the increasing level of the identified problem and both note the increasingly interconnected and complex problems facing families, individuals and children including abuse and neglect of children, mental health, substance abuse, housing instability and family violence.

Many of these reviews have called for structural changes to the system under review and for an increased focus and sometimes increased funding for early intervention services.

These reviews have also noted that given the systemic nature of these problems better results will not be achieved by reforms within a single service system. Subsequent reform processes, in both the child protection system and the mental health system, have found this cross-sector imperative very challenging.

This is most evident in the failure to develop policies and programs to respond to families who are facing the greatest of challenges and are dependent on services across multiple systems. This policy failure has led to the increased use of child protection and out of home care as a first line service response to children facing severe and multiple disadvantages.

Berry Street's Strategic Plan (2019) acknowledges the lack of service alternatives for these children. The evidence is very clear; outcomes for children who are involved in these services are generally very poor. Berry Street is intent on developing earlier and more effective means of responding to the complex needs of children facing multiple and severe disadvantage.

This Inquiry, with its focus on the economic and social costs of poor and/or failed mental health interventions and the implications of this failure for abused and maltreated children, has significant resonance for Berry Street and its client population.

Synopsis

This submission will present the case that an improved range of earlier mental health interventions working alongside supportive social and health interventions can make significant inroads into the lives of severely and multiply disadvantaged children and young people. Attention will therefore largely be given to the sections in the Issues Paper on youth justice and child safety.

This submission seeks to make explicit the impact of child maltreatment and the costs (social and economic) in life that this creates for both the individual, family and the community. Mental health is both a contributing factor in child maltreatment (family/parent) and a consequence of child maltreatment (an outcome for the child). The later the interventions in both mental health and in child maltreatment the greater the cost.

Better targeted and earlier mental health interventions will play an important part in reducing the costs of child maltreatment within families facing severe and multiple disadvantage. This response must include the provision of mental health services to both parents and to children who are growing up in these families.

The submission will also identify the value of mental health intervention following the exposure of the child to a range of traumatic events; some of these children will be in out of home care. Currently this response is available to only a few who have entered the child protection system.

Response to specific questions

What mental health supports earlier in life are most effective in reducing contact with both the child protection and the juvenile justice system?

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Many factors contribute to mental health problems, including:

- Biological factors, such as genes or brain chemistry
- Life experiences, such as trauma or abuse
- Family history of mental health problems

(Cited www.mentalhealth.gov/basics/what-is-mental-health)

This submission looks at the mental health issues that stem from life experiences of abuse and trauma and that may originate in a family history of intergenerational abuse.

Context for achieving better outcomes from early intervention

The theoretical rationale for the benefit of early intervention and prevention is now beyond dispute. **The First Thousand Days: An Evidence paper** (Moore et al. 2017) provides a systematic review of the evidence of the importance for providing a strong foundation for lifelong health and well-being during the first 1000 days. Many challenges in adult life including obesity, heart conditions and mental health problems are now known to be linked to processes and experiences that take place during the first 1000 days. The imperative for early intervention has been put like this:

...early intervention is nothing new. What has changed is that our knowledge and understanding of human development, especially in childhood, has grown to the point that we can now identify many more problems earlier; some we can even anticipate, or clearly predict a risk factor. Practice has also developed to intervene more effectively to address many of these problems...we appear to have reached a tipping point where our knowledge and practice have progressed sufficiently to make the policy question not whether we should invest in early intervention, but how can we not do so? (quoted in Fox et al 2015 p.12)

We now need to define what is meant (and what this submission means) by “early intervention”. Many of the population improvements in social wellbeing and health (including mental health) have and will continue to be generated by the provision of a universal platform of supports and services available to all children and families.

There is, however, a smaller significantly at-risk population that requires early intervention services in addition to and beyond that provided by an expansion of universal and specialist services. This population is well known to child protection services. It is to this population, described as “severely and multiply disadvantaged”, that the notion of “targeted programs” to reach those in most need has been developed. This is the population that makes up the subject of this submission.

This population continues to grow; the number of both child protection reports and children in out of home care increase year by year and the social and economic costs to the community continue to grow. Strong evidence exists that children, raised by parents suffering from mental illness and/or who abuse alcohol, experience intergenerational trauma (Kezelman 2015). The continuing and unaddressed impact of intergenerational abuse may, in part, explain the complexity of the needs of children who are entering out of home care. Tomison (1996) suggests that the rate of transfer of abuse and neglect from parent to child is between 30-90%. In Victoria it is estimated that 40% of child protection activity is generated by 10% of families (Centre for Excellence in Child and Family Welfare Inc 2018).

Costs of not providing early intervention to this population

In Australia several studies have sought to establish the costs arising from vulnerability and dysfunction, including the tertiary end interventions intended to alleviate some aspects of these problems (Fox et al 2015). These studies have also identified the lack of early and sustained services for this population. In these circumstances inadequate services to this vulnerable population is associated with a likelihood of involvement with the criminal justice system, the homelessness system and poor health outcomes (including mental health) in later life (Baldry 2012).

Intergenerational trauma has long been associated with child abuse and neglect. Social and economic costs of childhood trauma are handed down in this way.

The direct economic costs of child abuse and neglect are substantial. The additional indirect costs and those costs associated with the long-term effects of child abuse and neglect make the prevention of child abuse and neglect a priority for governments, non-government organisations and the community. More importantly, preventing child abuse and neglect is critical because of the social costs of child abuse and neglect and the imperative to prevent children from experiencing its devastating effects. (CFCA 2018)

Two studies of the cost of reduced quality of life and the increased need for specialist services for adults who were abused as children put the lifetime cost for cases of child maltreatment in one financial year at over \$9 billion (McCarthy et al 2016 and Kezelman et al 2015).

What aspects of the child protection program (in Victoria) are effective in improving mental health outcomes for children and young people in contact with it?

Useful interventions that are targeted towards the multiple and severely disadvantaged can be broadly classified into three categories based on timing of intervention. These interventions, at whatever stage of timing, will require systemic and multidisciplinary attention to the internal and external environment experienced by the child. Some interventions will need to continue throughout the life of a child.

Intervention with families facing severe and multiple disadvantage may occur during some or all of the phases listed below:

- Prenatal and early infancy
- Preventing entry into care
- Working with child in care

The submission provides two case studies as examples of positive outcomes that can be achieved in child protection. It will be noted that these three case studies describe a sustained caring and therapeutic response to traumatised children **only** when they are in out of home care. It will be evident from each case study that earlier opportunities for working with the families of each of these children was always a possibility, but intervention was either not attempted, could not be sustained or was not available.

The interventions in these case studies have been provided by the Berry Street Take Two program and the therapeutic foster care and therapeutic residential care programs. Details of these programs are attached to the submission. Brief mention of these programs is again made when discussing the Issues Paper's question "alternative approaches to child protection work'.

Case study 1

Jacinda

Jacinda was born into a home that was unpredictable and chaotic. Jacinda's parents regularly abused alcohol and suffered mental health issues.

Jacinda was a sick and unsettled baby and could not soothe and be fed easily. Her mother experienced post-natal depression and her father was often impacted by alcohol and was physically abusive.

Another two babies were soon born into the family. Her mother provided loving care when she could, but it was erratic and unpredictable. Jacinda was learning that she couldn't trust adults to consistently meet her needs and keep her safe

The family was referred to Child FIRST but could not be engaged with. Referrals by Child Protection to parenting services were not taken up. Finally, after multiple notifications all three children (Jacinda was 5) were removed from their parents' care. The three children were placed separately.

Take Two started working with Jacinda when she was about to turn six-years old.

She was having trouble making and maintaining friendships with other children. She became very distressed when her carer tried to leave her at school. She attended school only a few days a week because it was so distressing for everyone involved.

Over the following two years Take Two clinician Maddie provided Jacinda with more than 80 weekly individual sessions of one-on-one play-based therapy. Jacinda was diagnosed with PTSD from the violence she'd seen and heard at home.

"She couldn't sit still and every time she was in a new situation or felt a bit uncomfortable she'd get very anxious and stay very close to her carer," says Maddie

When they started the therapy sessions, Jacinda initiated games hiding from Mummy and Daddy.

"Over time this changed, and she started acting out the role of Mummy being the one that cares for the baby. It was really great to see nurture themes emerging in her games."

During this time Jacinda's behaviour also changed. She was willing to stay at school more often. But if she became nervous or uncomfortable, Jacinda would seek out her teacher and other adults nearby and demonstrate a very high need for affection and attention. She would attempt to sit on their laps and needed to be held like a baby.

Maddie could see Jacinda was seeking more nurture now because she had learned how comforting it was. She suspected Jacinda might specifically be craving the physical touch she had received so little of as an infant.

Jacinda's foster carer says Jacinda has also recently become a lot better at expressing herself verbally and managing her feelings and behaviours.

"It's amazing the difference in Jacinda, it sounds silly, but it's actually the simple things."

DEAR Maddie
YOU ARE
THE BEST
PERSON
OF ALL TIME
BY JACINDA

"She's now able to say when something has given her a fright – that's a huge breakthrough. She's also often got a big ball of blu-tack in her hand as she finds it calming to mould it between her fingers when she's nervous."

Jacinda now says that she "loves" school; her attendance is now regular. Her reading and writing is on par with her class peers. During their final session together Jacinda gave Maddie a card she'd made herself. Maddie says it still features proudly on her desk at work.

It reads:

"Dear Maddie you are the best person of all time! By Jacinda."

Case study 2

Kassie

Kassie came into foster care as a toddler. She was severely developmentally delayed and malnourished. She couldn't walk or talk. She couldn't hold eye contact and didn't know how to play. She vomited frequently, often up to 40 times a day, for no obvious physical reason.

Kassie is an Aboriginal child. Kassie's mother was abused and brought up in care. Her own childhood trauma remains unaddressed. All seven of her children have been removed; her addictions make it impossible for her to care for them safely.

As a toddler, Kassie's mum left her alone in a public park. She was found by a passer-by sometime later and was removed from her mother's care the next day. It was clear that Kassie had been severely neglected and it was likely she'd been sexually assaulted by several men who visited the house where Kassie and her mother had been living.

Kassie was placed into long-term foster care with Andrea and Blake and their 8-year-old son.

Kassie immediately found it very difficult to not be near Andrea at all times. She would become so anxious, when in the same room as Blake, that she would bang her head on the floor. She'd get hysterical if either foster carer tried to bathe her. In her cot at night she would frequently scream very loudly and eventually go quiet and stare into space. When anyone went to her cot she'd have her eyes open but wouldn't react to any noises and seemed not to see when someone leaned into her field of vision and talked to her.

Kassie's foster carers became part of the *Circle* program; the therapeutic foster care program that works with the most challenging of children. When the carers first met their Take Two clinician, Catherine, they told her they didn't think they could keep caring for her – they were really trying, but it was taking a huge toll on them and their son. They doubted that they had the skills needed to help her recover.

A thorough assessment of Kassie was undertaken. Catherine quickly observed that Kassie's previous experiences had made her terrified of men and of water, and that she was unable to engage in age-appropriate play with other children at childcare. She was very developmentally delayed; physically, cognitively and emotionally.

This assessment assisted, and the weekly sessions Andrea and Blake had with Catherine helped them understand and to better deal with Kassie's acting out and withdrawal behaviours.

Catherine also led the family in a child-parent psychotherapy approach. She spent time together with Kassie and her carers playing. The goal was to build a relationship of trust between Kassie and the male foster carer Blake, so that Kassie could tolerate being in Blake's presence without Andrea having to be there.

After just a couple of play sessions Catherine started using a therapeutic play narrative, describing what they were doing and talking to Kassie. Kassie was rapidly learning to talk

more, and she became increasingly able to tolerate Blake playing with her. Catherine started asking Andrea to leave the session early, and then Kassie started coming to the sessions alone with Blake.

Kassie would often initiate play that involved feeding a very hungry baby. Catherine would keep playing with her and Blake but would reassure her that “it’s not your fault you were hungry when you were a baby, but Daddy Blake will always make sure you have food.”

Blake and Kassie seem to have developed a common shared quirky sense of humour. Both were previously frightened of the other but are now overcoming that. Catherine has explained to Blake that shared activities are central to relationship building, and Blake has been taking Kassie to ride her bike with training wheels and play in the park. As a family, Andrea and Blake have even taken Kassie and their son to the snow, which they all loved.

Catherine’s involvement with Kassie has almost ceased. Now in kinder, Kassie has stopped needing her dummy during the day and is playing in a more age-appropriate way with other kids. Kassie is now able to come to Blake for comfort instead of always seeking out Andrea.

Just over a year ago, Kassie’s foster carers had not thought they could continue looking after her. Now they say they cannot imagine life without her.

Please note: This case study has only described the therapeutic work undertaken within the foster family and with Kassie. The case worker, working alongside the clinician, spent time with Kassie’s mother and the foster parents preparing a cultural support plan which included contact with Kassie’s mother, siblings and her Aboriginal community and culture.

Note: Names and other identifying details of the children and their families in our case studies have been changed to protect them.

Summary

These two case studies demonstrate that positive outcomes for traumatised children who have entered out of home care are possible. However, these outcomes require resources and time (eg 80 therapy sessions over some years is a massive commitment of resources and skill). These outcomes require a consistent, sustained, highly skilled and collaborative approach from multiple players in the child protection treatment and care team.

Unfortunately, these interventions are the exception. In Victoria there are nearly 8,000 children in home-based care placements; 1,618 in foster care and 5,493 in kinship care. Funding for the type of sustained, therapeutic and multi-disciplined approach (*Circle* program) that benefited Kassie, is limited to approx. 50 children per year. This is a tiny proportion of the home-based care population; many of whom present with similar histories of abuse and neglect.

There are no comparable investments (in times of resource and skill) in the phases of prenatal and early infancy and in preventing entry into care for families and children facing severe and multiple disadvantage. It is reasonable to hypothesise that if resourcing for the intensive and sustained interventions such as described in the case studies above were applied at earlier points in a child's development and life trajectory, then positive outcomes could be achieved without such cost and preventable damage to children. The next section will outline what some of these earlier intervention policy directions could be.

What, if any, alternative approaches to child protection would achieve better mental health outcomes?

These children and their families were all known to Child Protection. All of them have multiple child protection notifications. All of them were offered and/or referred to a range of early childhood services (including Enhanced Maternal Child and Health Service) parenting courses, and specialist adult services eg drug and alcohol, mental health and family violence. Some of these notifications led to weeks of monitoring and referrals to specialist services but no holistic long term supportive and therapeutic intervention and treatment was provided.

All these children suffered the effects of cumulative harm over many years. The impact on mental health of accumulated harm during a child's developmental years is profound. (Kezelman et al 2015). The child and family system is not well equipped to recognise and then respond to abuse and neglect that accumulates over time.

What is missing for these families and their children, at the earliest possible point of intervention (ante natal and early years) is a considered recognition of their circumstances and characteristics. This requires a careful and detailed assessment of history, of risks, of resources, of strengths and vulnerabilities. It also requires the ability to engage and to

develop a relationship. These are families with interlocking and often mutually reinforcing factors of family violence, mental health, substance abuse and parental experience of intergenerational abuse. They can mostly be identified in the community, often in maternity hospitals during prenatal check-ups, but active assessment and engagement remains a distant goal. Many of these families will actively repel assistance. It takes skill and persistence to engage. Holistic and comprehensive interventions are needed that respond to parental emotional distress, the stresses in family functioning (mental health, family violence) and child health and wellbeing.

Two things are needed:

Firstly, the development of intensive and sustained treatment programs **that intervene early in children's lives to disrupt life cycles in families with severe and multiple disadvantages**. What will these programs look like?

- Capacity for early identification that does not stigmatise. Locating family service and clinical staff at MCH locations that can both identify and link into services is one way of doing this.
 - Assessment that engages and offers hope. Practitioners will have a range of skills and qualifications. *Take Two* could assume an expanded role in such settings in order to provide assessments, recommendations and a pathway to a specialist intervention unit. Further detail is provided in Attachment 1.
 - Intervention linked to assessment that addresses parent child relationship, child development, parenting skills, practical parenting assistance and attention to parenting problems arising from own childhood experience of and poor parenting practices. Enough authority to utilize mental health, substance abuse and family violence services as required.
 - Support of statutory child protection as necessary.
 - Program guidelines will include:
 - Flexible time lines for intervention and involvement
 - Care team involvement with family focussed around a primary worker. Parents needs attended to in context of child's developmental needs.
 - Resources for supervision and debriefing
 - Ability to work across geographical boundaries
 - Consultative panel of senior service managers (both government and non-government) to oversee the effective interface of services
 - Research component to develop data and outcome analysis
- (Fox et al 2015 and Davies and Ward 2012).

Secondly, increased resourcing into **supporting recovery from childhood trauma** is needed. The case studies above suggest that good outcomes are possible. However, these outcomes are resource and skill intensive. As an example, *Take Two* (see attachment for details of program) is the Victoria wide outreach therapeutic service. *Take Two* works with children who have suffered severe abuse, neglect or disrupted attachment. It is estimated that half of the *Take Two* clients have been exposed to severe family violence with several who have

suffered the deaths of their mothers from family violence. The impacts on child development and behaviour and the work of *Take Two* are well illustrated by the case studies.

Take Two was originally funded to work with 10% of the Victorian child protection population. The numbers of children in the child protection system has grown over the last 15 years but the funding to Victoria's only therapeutic service for these children has not. *Take Two* can now only service 3% of this population.

Mention has already been made of the minute proportion of foster care placements that have a wrap around therapeutic response (*Circle program*). Expanding this component of foster care is an important element in supporting recovery from trauma. Details of *Circle* are contained in Attachment 2.

The destructive impact of family violence on children is becoming well recognised. (The children in the case studies above all came from families where violence was a dreadful reality). Ongoing exposure to family violence significantly heightens the risk of development of mental illness among children (Bunston et al 2017). The development and resourcing of treatment and intervention programs with children affected by family violence have struggled to keep up with this recognition. More can be done in this space. *Restoring Childhood* is a demonstration project that shows hopeful signs of being able to redress the traumatic impacts of family violence on women and children. It is funded till June 2019. Details of *Restoring Childhood* are contained in Attachment 3.

Conclusion

The strongest indicator of success in life is the capacity to control and regulate emotion (Cote et al, 2010). This is a skill learnt in infancy and early childhood and requires a secure attachment and stable environment. It is a skill that is not always easily imparted by parents and readily acquired by infants and children. The case studies in this submission demonstrate the damage, over time, that is inflicted on children if they are not provided with safety, security and stability.

The case studies illustrate that with targeted, skilled and prolonged intervention this developmental damage can, in large part, be undone. The case studies also illustrate that opportunities for earlier interventions were possible but, for many reasons, did not occur. These two findings suggest that although we know what children need and, in some circumstances, this is provided, our interventions come very late. Much avoidable developmental damage has already happened.

The challenge for this and other Inquiries is to ask why do we wait until significant damage is wrought on children, before timely and effective intervention occurs in families facing severe and multiple disadvantage?

As a community we now know what children need. We have the knowledge and the skills to intervene earlier in the lives of these children whose circumstances mitigate against optimal

development. Both our children and our community will be the better for this earlier intervention focus.

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Attachments

These attachments provide further detail for programs, run by Berry Street, that have been mentioned in the submission

Attachment 1: Take Two

Overview

1. Take Two is a Victoria-wide outreach therapeutic service provided by Berry Street on behalf of the Victorian Department of Health and Human Services (DHHS) to child protection clients.
2. Established in 2003/4, Take Two is recognised internationally as a leading intensive therapeutic service for children. There is no comparable program or service in other Australian states. We are the only flagship site for world-renowned child psychiatrist Dr Bruce D. Perry's Neurosequential Model of Therapeutics (NMT) outside of the US and Canada.
3. Take Two's name recognises that a child cannot heal themselves on their own – they need help from someone else. With Take Two's help our clients can get a second chance to recover and heal.
4. Take Two clinicians work with the clients themselves but also focus on working with the families, systems and carers around clients. We know resilience is built over time within relationships with people who are in their daily lives.
5. Take Two is an intensive multidisciplinary service using evidence-informed clinical practices and expertise in child development.

Clients

6. Take Two work with children (under 18 years) who have suffered severe abuse, neglect or disrupted attachment. It's estimated about half of our clients have been exposed to severe family violence, with several who have suffered the deaths of their mothers in family violence. They have (or are at risk of developing) emotional or behavioural difficulties because of the developmental traumas they've suffered.
7. The young people we work with are often severely dysregulated with already very 'difficult' or dissociative behaviours. These can include substance abuse, self-harm, suicide attempts, violence, absconding, sexualised-behaviours, fire lighting and other criminal behaviours.
8. All our clients are in the Child Protection system or have been identified by Child Protection as needing Take Two's help. Some are living with their families, but most are in OoHC.
9. Many of our clients are case managed by other Community Service Organisations (CSOs) or DHHS. Client referrals are made by DHHS Principal Practitioners. We are not a service open to the public.
10. We work with clients who can't be seen by other services. The barriers to our clients using other services such as *headspace* may be cost, willingness/ability to attend centre-based appointments or substance abuse.
11. In 2017-18 FY we worked with 1067 clients, providing an average of three hours of clinician

time per client per week. We work with a client for an average of 14.5 months before referring them to other community-based services if needed. Three-quarters of our clients do not need to be referred to us again once we've worked with them.

12. We look at what's causing the young person to act in that way, rather than just dealing with the behavioural symptoms. Children act in the ways they've learned to keep themselves safest, and sometimes those ways are actually more harmful to themselves.

Aboriginal Children and Young People

About one-quarter of our clients are Aboriginal children and young people.

13. The overrepresentation of Aboriginal children in the child protection system is due to many factors. Most notable of these are colonialism, discrimination and past government policies causing trauma still being passed through generations.
14. Take Two has a dedicated specialist Aboriginal Team of clinicians working with Aboriginal communities, providing community connections and cultural expertise.

Infants

15. Take Two specialise in providing infant mental health services. We know that the most rapid period of brain growth happens in the first 1000 days of childhood and that babies need to feel safe during this period or will face life-long difficulties.
16. Intervening early when a baby has been exposed to frightening events or neglect is vital to reducing a lifetime of future ill-effects and is one of the areas where Take Two can have the biggest impact. We'd like to do more of this early intervention work.

Structure

17. Berry Street's Take Two Program is a partnership with:
 - La Trobe University: Social Work and Social Policy, Department of Community and Allied Health (research partner)
 - Mindful Centre for Training and Research in Developmental Health (training partner)
 - Victorian Aboriginal Child Care Agency (cultural partner).
18. Take Two is a program of Berry Street but provides services for clients across the child protection system – not just those case-managed by Berry Street. We are currently partnering with more than 20 other CSOs.
19. Take Two has a staff group of nearly 80 qualified allied health clinicians (psychologists, occupational therapists, family therapists and social workers - 67.2 clinical EFT) led by a small management team and supported by a handful of expert training, research and operational-support staff.
20. Our state office is in Eglemont. We can provide an outreach service to any child in Victoria. We do this by having staff based in Flemington, Ballarat, Geelong, Warrnambool, Horsham, Mildura, Bendigo, Wangaratta, Shepparton, Bundoora, Eglemont, Noble Park, Morwell, and Bairnsdale.

21. Our state-wide presence allows us to “follow” children across DHHS area boundaries and provide continuity of care if they change OoHC placements. In the last three years this has been the case for approximately 17 per cent of our clients.
22. Take Two have several internal specialists, including: a Neuropsychologist, an Occupational Therapist, a Speech Pathologist and an Infant Mental Health specialist who all provide speciality consultations to other Take Two clinicians across the state. We also have access to a child psychiatrist at our partner organisation (Mindful) who provides secondary consultations also.
23. Take Two staff work in designated clinical roles. Most staff do the DHHS-referred regional and metro area clinical work for which Take Two was initially funded, as well as two staff doing client assessments in the DHHS Secure Welfare facilities. Additionally, some staff work within newer Victorian government programs including providing therapeutic expertise for Therapeutic Residential Care unit staff and for carers in the *Circle* program (therapeutic foster care).

Service model

24. Take Two’s service model uses a series of interconnected phases, all of which have a therapeutic intent. They range in time frames depending on the client but are based around:
 - a. Referral and Intake – in consultation with DHHS Principal Practitioners
 - b. Engagement and Assessment (may take several months)
 - c. Goal and Intervention Planning
 - d. Therapeutic Intervention
 - e. Review and Planning for Closure, and
 - f. Closure (including recommendations and referrals).
25. Clinicians undertake assessments using one or more clinical tools available to them. One of the most well-known of these tools is the Neurosequential Model of Therapeutics, which looks at the child’s behaviours in the context of their family’s past traumas and relationships.
26. The intervention/s chosen may be undertaken directly one-on-one with the child or may be with a carer/another person/group of people in the child’s life. Often interventions will be with both child and carer present to strengthen their relationship.
27. Therapeutic sessions might be held in the client’s home, residential care unit, school, a community centre, a Berry Street or other CSO office. Clinicians make decisions about where to hold sessions based on their therapeutic expertise and where the child feels safest.
28. Clinicians use a suite of evidence-informed interventions including; child psychotherapy, family work, child-focussed parent therapy, play, art-therapy, music-therapy, somatosensory activities, care team conferences and psycho-education for carers.
29. In addition, numerous staff in Take Two have been supported to undertake certification in two internationally-recognised, evidence-based trauma treatment modalities: Child Parent Psychotherapy and Eye Movement Desensitisation Reprocessing (EMDR) therapy.

Outcomes

30. 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.

31. 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.

Accreditation

32. Take Two is an accredited health service by the Australian Council of HealthCare Standards (ACHS).

33. Take Two is the only flagship site for Dr Bruce D. Perry's Neurosequential Model of Therapeutics (NMT) outside of the US and Canada. We have recently received permission from Dr Perry to train other organisations in NMT principles.

Opportunities

34. Take Two's current activity is focused on family preservation (18%), specialist assessment (15%), placement planning & support (64%) and family restoration (3%).

35. Take Two would like to be working more in family preservation to help reduce the number of children entering OoHC, and more with children who have experienced or are at risk of multiple placements once in the care system.

36. Take Two's specialist OoHC expertise means we know the flashpoints within a child's life which make their placement more likely to break down (such as puberty and school transitions). So, we could predict when home-based care placements are likely to be problematic and intervene so they are less likely to break down.

37. Take Two could be providing our specialist therapeutic infant work to help babies feel safe and nurtured, so they can learn to regulate themselves and deal with stressful events in life. Babies we can work with early on are far less likely (presuming they are not re-traumatised) to become highly 'disruptive' children and really 'problematic' teens later.

38. Take Two could be better supporting ACCOs with therapeutic services as they take over case management of Aboriginal children previously placed in care through non-Aboriginal controlled CSOs.

Attachment 2: Circle, therapeutic foster care

The *Circle* Program is a therapeutic foster care model. The caregiver/s and child are supported by a specialist team that helps them to understand how trauma affects the child and to respond appropriately to their needs. The clients of this program include both new entrants to care and existing clients, with 2/3 of the target group made up of new entrants to care. The intention is to provide an early intervention option so children initially coming into care are prevented from having multiple and poor placement experiences.

Caregivers are specially recruited, trained and assessed for the *Circle* Program. They receive intensive support and training from an experienced placement worker and a therapeutic specialist and receive an enhanced carer payment. They are selected based on their willingness to play a key role as a member of the child's overall care team and their capacity to embrace the theoretical frameworks that inform the approach. The caregiver uses therapeutic parenting practices and is supported in maintaining a therapeutic attitude/environment for the child. The caregiver/child relationship is supported and nurtured. This relationship is regarded as being of critical importance as it forms the basis of healing for the child. The *Circle* Program is a small program encompassing 12 targets across a region. Berry Street is funded for 6 targets only in the Goulburn region. There are four regions in Victoria.

In addition, *Take Two* provide therapeutic support to foster care placements that are not classified and funded as "therapeutic. The Evaluation of *Circle* had this to say:

A key message from the evaluation is that the Circle Program works for children and young people. The concept of the care team surrounding the child and young person is working well. These positive outcomes are related to the overall therapeutic approach facilitated by the training of carers as well as professional staff to ensure knowledge of the theoretical basis for care of these children and young people. In addition, the role of the therapeutic specialist includes providing a therapeutic care plan and supporting the therapeutic care team and carer.

Frederico, M., Long M., McNamara, P., McPherson, L., Rose, R., and Gilbert, K. (2012)
The Circle Program: an Evaluation of a therapeutic approach to Foster Care.
Centre for Excellence in Child and Family Welfare, Melbourne, Australia

Attachment 3: Restoring Childhood

1. Restoring Childhood (RC) is a child-focussed trauma-informed service designed to intervene early to redress the traumatic impacts of family violence on children and young people (0 - 17 years). It was designed to meet a gap identified by the Royal Commission (Royal Commission) into Family Violence in services for children and young people following family violence.
2. RC builds on other work undertaken by Berry Street including within Take Two and the TURTLE program (dyadic infant mental health work).
3. RC is a Demonstration Project funded by Department of Health and Human Services (DHHS) as part of the *Ending Family Violence: Victoria's Plan for Change*, the Victorian Government's 10-year plan. This is in direct response to the Royal Commission. It is funded until June 2018.
4. The aims of RC are to:
 - a. Minimise the impact of the family violence on children and young people and prevent the development of chronic Post Traumatic Stress Disorder.
 - b. Improve the relationship between child/ren and non-offending parent.
 - c. Build the capacity of practitioners in the service system to engage children and young people directly and support their relationships with the adults caring for them after family violence.
5. RC uses an interdisciplinary approach and draws on Berry Street's extensive expertise in providing child and adolescent mental health services, specialist family violence services and case coordination.
6. Berry Street has implemented RC across 3 local areas within the Western and Northern Divisions: Central Highlands, Hume Moreland and North East.
7. The RC demonstration projects are embedded within the Berry Street Specialist Family Violence Services (Northern Family and Domestic Violence Service [NFDVS] and Western Family Violence Service [WFVS]), from which access to services for children and their families are available centrally at our Eglemont and Ballarat centres or at out-posted locations within services situated in local geographic areas.
8. Participation is voluntary, and referrals can be accepted from other services such as Maternal and Child Health services, police, legal services, early years services, government and family violence support services, as well as other parts of Berry Street and directly from parents and families.
9. Intake is through Berry Street's Specialist Family Violence Services who make internal referrals to RC. RC Clinicians then screen and triage referrals. Take Two (an accredited health service) provides clinical governance of the program.
10. RC comprises three phases of service delivery, but some clients may only participate in the first or first and second phases:
 - a. *Specialist Intake and Triage* - face to face and telephone parent consultation focussed on the needs of their children, supported referrals and secondary

consultations

- b. *Brief Relational Intervention and Screening* (BRISC) (up to 4 weeks) – 3-4 parent/child therapeutic sessions, supported referrals and secondary consultations
- c. *Medium term intervention* (up to 6 months) – the delivery of evidence-based therapeutic interventions for children and young people, specifically designed to minimise the symptoms of Post-Traumatic Stress Disorder (PTSD).

- 11.** RC uses two evidence-based therapies for the medium-term intervention.
 - a. Children aged 0-5 years – Child Parent Psychotherapy (CPP) for non-offending parent and child together (approx. 20 sessions).
 - b. Children aged 6-17 years – Eye Movement Desensitization Reprocessing (EMDR) Therapy for the child only (approx. 6-18 sessions).
- 12.** Since it began on 1 July 2017, Restoring Childhood has worked with 811 clients (572 from Hume Moreland & North East Metropolitan regions & 239 from Central Highlights region). Of those clients, 323 have participated in the BRISC and 116 have participated in medium term interventions.
- 13.** Berry Street has self-funded (\$40k) an evaluation conducted by the Murdoch Children’s Research Institute (MCRI) of one component (the BRISC) of the RC intervention. The final evaluation report is expected by June 2019.
- 14.** Feedback from women interviewed for the evaluation report include qualitative comments looking at the perceived benefits and negatives to the child and mother.
- 15.** Analysis of the feedback is currently being undertaken, but the mothers reported benefits including:
 - a. feeling supported and understood but not judged,
 - b. improved mental health,
 - c. more confidence in parenting skills,
 - d. improved relationship with their child/ren, and
 - e. more hope for the future.

Benefits for the child include:

- f. improved emotional and behavioural functioning,
- g. less hostile home environment with less conflict between siblings,
- h. help to self-manage future relationship with father/perpetrator,
- i. noticeable improvement at school, and
- j. an opportunity to open up about the experience and manage any feelings of anger, guilt or blame.