The report is dedicated to the memory of
Dr Howard Cooper,
Director of mindful, Centre for Training and Research
in Developmental Health, and an inaugural partner
of the Take Two consortium.

Dr Cooper’s commitment to supporting and ensuring high quality
services for troubled children and young people
was positively challenging and inspirational.
Who are the evaluators:

The contracted agency for the evaluation of Take Two is La Trobe University, School of Social Work and Social Policy. The evaluation team is located within the School of Social Work and Social Policy and within Berry Street Victoria.

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Margaret Kascamanidis is a Research Assistant at La Trobe University who provided technical assistance and contributed to the design of graphs and tables. Tenille Abell is a Research Assistant at La Trobe University who contributed to the presentation and design of the report. Lindsay Barker, Anna Castles, Amy Fogarty and John Sabato provided data input and research assistance.

Case vignettes

The case vignettes presented throughout this report have had names and some of the details changed to protect the identification of clients.

Citation

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Foreword

None of us like to hear of child abuse. When we read or listen to autobiographical narratives we will often find the experiences in which a child was concurrently threatened and unprotected the most disturbing features in the story. Those who tell their stories of trauma and those of us who hear such stories feel impelled to redress the consequences of such harm and to instigate healing.

The Take Two program is designed to provide a healing response to experiences of child abuse and neglect. It is an intensive therapeutic service. It is a new initiative, funded by the Victorian Department of Human Services and provided by a partnership between Berry Street Victoria, Austin Child and Adolescent Mental Health Services, La Trobe University School of Social Work and Social Policy and the mindful (centre for training and research in developmental health). It is designed to respond to their experiences with efforts to heal and to learn from their stories. In recognition of so many people who have carried their experiences of childhood trauma into adulthood, the Take Two program is designed to offer opportunities for healing to those children who currently suffer the consequences of abuse or neglect.

This Evaluation Report reports on the first year of Take Two operation (2004). It closely examines the experiences of the first 320 children and young people referred to the program. In a systematic and unadorned manner, this report profiles the experiences of these children, and introduces us to their complex lives of trauma and loss. The experiences of the large portion of Aboriginal children within the cohort seem particularly poignant, as their individual stories of harm are set within a broader Australian story of dispossession, loss and trauma for whole communities of indigenous people.

If we are to provide an intensive therapeutic service to children such as the 320 profiled in this report, we are obliged to offer nothing but the safest and best quality service that can be provided. Through its “centred quadrant” of analysis (p. 15), this Evaluation Report reflects the complexity of our multi-layered clinical program, but also simplifies the complexity by focusing on the primary consideration for all Take Two activity: the experience of the child. This report is the first of three evaluation reports that will review the first three years of Take Two operation. The methodology used by the research team provides effective monitoring and evaluation of the quality and effectiveness of the complex Take Two program. The evaluative strategy should keep our program honest, because it never loses sight of the needs of the children who receive our service. This first Evaluation Report profiles the needs of the children and the service they have started to receive from Take Two. Subsequent evaluations will help us track the stories of the children and start to build a database of measurable client outcomes. We know the stories of children referred to Take Two are stories of harm and its consequences. By the conclusion of the three-year evaluation cycle we will know if Take Two can introduce genuine healing into these stories.

I congratulate the principal authors of this report; Margarita Frederico, Annette Jackson and Carly Black, on their honest and informative first evaluation. I acknowledge, as they do, that this report is the product of collaborative work between a large number of knowledgeable, thoughtful and committed people, and I thank the La Trobe University School of Social Work and Social Policy for recruiting such an effective team to the task of evaluating Take Two.

Ric Pawsey
Director Take Two
Executive Summary

Background
Take Two is a developmental therapeutic service for child protection clients who have suffered trauma, disrupted attachments and other adverse consequences as a result of serious abuse and neglect. Take Two is auspiced by Berry Street Victoria (BSV) in partnership with the Austin Health Child and Adolescent Mental Health Services (CAMHS), La Trobe University School of Social Work and Social Policy and mindful (centre for training and research in developmental health). The program is funded by the Victorian Department of Human Services (DHS) to provide a statewide service to infants, children and young people who have been severely abused or neglected and are at risk of developing or already demonstrate severe emotional and/or behavioural difficulties.

This summary report is the first in a series of three evaluations on the implementation and ongoing operation of the Take Two program. This report describes the design, structure and implementation of Take Two in its first year of operation. There is a description of the Take Two client group and their social and service system context. The report also outlines the way in which Take Two has begun to intervene with these children in working towards a process of recovery and strengthening their relationships with those in their social networks.

Evaluation methodology and key findings
The methodology for this evaluation includes a literature review, collection and analysis of client data, program documentation, Take Two staff journals and interviews and surveys with Take Two staff, Child Protection staff and other stakeholders. A framework was developed to guide the evaluation of the design and implementation of the program and to provide a rich description of the client group and their context. At the centre of the framework is a holistic understanding of the internal and external world of the child. Other components to this evaluation framework include portraying the conceptual development of the program; multiple levels of assessment and intervention; reflective practice and action learning; and a highly developed and evolving program design.

Has Take Two been established according to the stated objectives and expectations?
The analysis in this evaluation demonstrates that Take Two has been established according to the stated objectives and expectations of DHS. In particular Take Two has been implemented throughout Victoria, is working with the intended client group and is working in collaboration with the children’s networks and the relevant service systems.

Within its first year of operation Take Two established a clinical service in every region in Victoria, operating from twelve sites including within Secure Welfare and the statewide Aboriginal team. A program advisory structure was developed and the research and training components were implemented and located at two other sites.

As indicated in the DHS tender documentation the intake processes for Take Two are coordinated via Child Protection in partnership with Take Two. This is a critical expectation that relies on a shared ownership by Child Protection and Take Two of the gatekeeping functions into the Take Two program.

The number of children expected to be seen by Take Two was initially 710 per annum. This was not achieved in 2004 with Take Two seeing 320 children. Although it was to be expected that there would be time-limited demands and inefficiencies associated with the first year of establishing a statewide service, there were other hurdles in reaching the expected number of clients. For example, although it was anticipated that Take Two would be dealing with highly complex situations, the absence of referrals requesting earlier intervention led to a higher proportion of clients with severe difficulties than was initially envisaged. Other factors which impacted on the numbers of clients seen by Take Two included delays in receiving some referrals due to variation of establishing referral processes across regions and the minimal number of case closures during this year. Following discussions with DHS during 2005, the total number of clients that Take Two is expected to work with was adjusted to 550 per annum.

Provision of secondary consultations was not listed as a target; however, it was an expectation of Take Two by most regions. Data analysis showed consultation occurred in relation to approximately 388 children, in addition to the 320 who were direct clients of the program.

Another expectation set by DHS was that 15% or less of cases would be re-referred to Take Two within 12 months of closure. This expectation was exceeded with only 7.5% of cases being re-referred during 2004. Almost all of these re-referrals were associated with a re-admission to Secure Welfare. When Secure Welfare cases are not included less than 0.1% of the cases were re-referred to Take Two during 2004.

What are the inputs and processes put in place in its first year of operation?
The implementation process of Take Two in 2003/2004 commenced with the conceptualisation of the program, followed by the development of the

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1 The terms ‘child’ or ‘children’ will be used henceforth to include infants, children and young people, unless otherwise specified.

Frederico, Jackson & Black (2005) Reflections on Complexity – Take Two First Evaluation Summary Report, La Trobe University, Bundoora, Australia
processes; providing training about the referral of suicide risk was also of concern. The frequency presented with mental health problems. The frequency more frequent or that when it occurs for younger children. This may indicate that it is older age group and was still a factor for a small proportion within the six to 12 year olds than in the behaviour, however, was reported in a slightly higher number of emotional/psychological harms differed depending on the age of the child. For example, 36% of young people aged 12 years or older had difficulties with intervention and closure processes, although these continued to be developed throughout the year. The final implementation stage in 2004 was the consolidation of ongoing operations and finalising core elements of the program planning. In addition to the ongoing development of operational processes there was engagement with the service system through consultation and training. This final phase in 2004 also included the development of the outcomes framework and research strategy for Take Two. The review of these stages demonstrates the development of an effective program design and structure.

**Are these inputs and processes sufficient to achieve the stated objectives for the program?**

As stated in the foundational DHS documentation the first objective of Take Two was to provide a high quality clinical service. The inputs included developing a strong governance structure and policies to facilitate effective operations. The development of the statewide referral process in collaboration with DHS was an important process in clarifying the intended client group and ensuring a clear process for referrals. This referral process was subsequently implemented in every region whereby Child Protection and Take Two collaborate in the decision-making process regarding which referrals are prioritised for Take Two. The design of the initial Practice Framework and assessment format provided a guide for clinicians. The development of an outcomes framework and research strategy has built the foundation for this and future evaluations with a view to being integrated within clinical practice.

The second objective of Take Two is to build capacity in the service system. The evaluation identified a number of activities that support this objective including the establishment of regional advisory processes; providing training about the referral process in addition to training regarding trauma and attachment to Child Protection and Community Service Organisations (CSOs) in every region; and Take Two staff networking with other service providers. The consultations provided by Take Two were a well-regarded contribution to the service system.

Areas of higher than anticipated demand for service were in relation to the Secure Welfare client group and Aboriginal children. Take Two had only one position allocated to each of these client groups which has been demonstrated to be insufficient. Take Two has since added another Aboriginal clinician to the program and is in discussions with DHS regarding the continuing development of both these components of the program.

**Is Take Two working with the intended client group?**

The children involved in Take Two are similar to those identified in previous studies of complex Child Protection clients. Data was analysed in relation to the 233 regional Take Two clients and 87 Secure Welfare Take Two clients. All ages were represented though there were fewer infants than other age groups. The largest age group (not including Secure Welfare clients) was children between 9 and 12 years of age. Two-thirds of the Take Two population in 2004 were male.

This evaluation shows that these children have experienced severe to extreme abuse of various types as described in the Children and Young Persons Act, 1989. Nearly all Take Two clients had suffered two or more types of abuse throughout their childhood and the majority (61%) had suffered four or five types of abuse. There was no significant difference in the number of abuse types suffered as a function of age. Even among children younger than six years old the majority (58%) had suffered four or five types of abuse while less than 10% had experienced only one type of abuse. The consequences of abuse were similarly categorised according to the Children and Young Persons Act, 1989. Emotional or psychological harms were the most frequent consequence (93%). Examples of emotional/psychological harms differed depending on the age of the child. For example, 36% of young people aged 12 years or older had difficulties with ongoing or frequent substance abuse, whereas this was not a factor for younger children. Repeated violent behaviour; however, was reported in a slightly higher proportion within the six to 12 year olds than in the older age group and was still a factor for a small number of younger children. This may indicate that it is more frequent or that when it occurs for younger children it is more obvious. Many Take Two clients also presented with mental health problems. The frequency of suicide risk was also of concern.
The vast majority of clients involved in Take Two in 2004 had extensive histories of involvement in the protection and care system. More than half (56%) had been notified to Child Protection on four or more previous occasions. However, it was noted that just over a third of clients (34%) had no previous substantiations prior to their current Child Protection involvement. Eighty-two percent of Take Two clients had experienced more than one placement and approximately half (49%) had experienced six or more placements. Take Two had a higher proportion of clients in residential care compared with the overall Child Protection population. Over half the Take Two clients had experienced reunification attempts prior to Take Two involvement.

The evaluation highlights the high number of negative life events in addition to abuse that these children and frequently their families have experienced. The data highlighted that children involved with Take Two had multiple, complex and changing family structures. A number of children had experienced the death of a parent (17%). It is also noted that 20% had one or both parents in gaol during Take Two involvement.

Research into child protection within Australia and internationally has lacked an emphasis on fathers or father figures. In relation to the Take Two regional client group, information regarding fathers was unknown in over a third of the cases in marked contrast with missing data on mothers. There was also little information in respect to parents’ employment.

Similarly to other reports, the data highlights that Aboriginal children are not doing well in the child protection system. Fourteen percent of the Take Two client group in 2004 were Aboriginal. Compared to non-Aboriginal clients, Aboriginal children had higher numbers of previous placements; more were using drugs or alcohol; more were self-harming and absconding; and more were demonstrating violent behaviour.

In what way is Take Two working with the client group and are the interventions in accordance with the available evidence and expectations of key stakeholders?

The evaluation identified the types of interventions utilised by clinicians with the children, their families, carers, social networks and service systems. These interventions were informed by the Practice Framework developed by Take Two that was in turn informed by the literature. In particular, the framework encapsulated trauma and attachment theories from a developmental and ecological perspective.

Take Two clinicians undertook a variety of approaches to engage the children thereby enlisting their active participation in the interventions. This was enacting the principle that engagement was Take Two’s responsibility not the child’s. A cornerstone of this approach was providing the intervention at the most appropriate location available, whether it be at the children’s home, in their placement, at school, in an office or in a room specifically designed to support therapeutic interventions. The latter was only available in some regions. Most clients were described by clinicians as successfully engaged with the intervention process (83%), a significant proportion of whom were engaged within three months of referral. For those children not yet engaged at the time of the evaluation, Take Two was continuing to explore other strategies to work towards the goals wherever possible. Support from parents and/or their carers is perceived to have been a vital influence in the engagement process.

There is evidence that clinicians spent considerable time collaborating with components of the service system around the children, such as their placement and schools. Links made with schools recognised the importance of participation in education for these children. Almost all school-aged children and young people were enrolled in school.

The role of Take Two in Secure Welfare was by necessity brief and focused primarily on providing a therapeutic assessment and making recommendations as appropriate.

What are the lessons from this first year of operation that continue to inform the ongoing development of the Take Two program?

This report concludes with an account of some of the lessons learnt during the first year of operation. These lessons included understanding the nature of the client group and their families and the crucial role of the service system in the process of recovery for these children.

Achievements in the first year

Achievements of Take Two in the first year of operations can be identified at a clinical level in the following areas:

- Recruitment of highly qualified and experienced staff.
- In collaboration with DHS, identifying the intended client group; developing referral pathways and referral documents; and building partnerships between Child Protection and Take Two within each region to implement the decision-making process regarding referrals.
- Establishing teams in every region throughout the state that are actively working with children who have experienced maltreatment and their related networks and other systems.
- The Practice Framework was developed to guide assessment and intervention.
- 320 children and their families and/or carers received clinical intervention from Take Two and
approximately 388 consultations were provided in relation to other Child Protection clients.

- A high proportion of children involved with Take Two were actively engaged in the interventions.

At an organisational level the development of the structures and systems to support the work is a major achievement. Building upon BSV’s development as a learning organisation, governance and advisory structures for Take Two have been put in place. A clear line of accountability has been drawn – an essential feature of a program which intervenes with children at risk. The partnership consortium between BSV, Austin CAMHS, mindful and La Trobe University provided a structure to guide and support the establishment and ongoing development of the program. Take Two has a highly developed and evolving program design that is supported through this consortium and as part of a collaborative effort with DHS. Furthermore, the advisory processes enable key stakeholders to contribute to the development of the program as well as being able to participate in the program learnings. The training and research strategies put in place were also considered to be major achievements and distinctive aspects of the funding model.

Take Two has a learning culture that supports action learning, reflection and constant evaluation of the work being undertaken in order to finetune the program’s capacity on an ongoing basis to meet the needs of these highly vulnerable children and those who care for them.
Chapter 1: Introduction

1.1 Overview

This is a summary of the first evaluation report of the Take Two intensive therapeutic program for infants, children and young people who have been traumatised by abuse and neglect. Take Two is auspiced by Berry Street Victoria (BSV) in partnership with the Austin Health Child and Adolescent Mental Health Service (CAMHS), La Trobe University, Faculty of Health Sciences, School of Social Work and Social Policy, and mindful (centre for training and research in developmental health). Take Two commenced clinical operations in January 2004 and is funded by the Victorian Department of Human Services (DHS). It is a partnership of the service systems of mental health and child welfare and the academic fields of psychology, psychiatry and social work.

This summary report reflects the first of a series of three evaluations and is focused upon the inaugural 12 months of the program. This first report is a formative and process evaluation providing a rich description of the Take Two program, the client group, the interventions and the broader context. The second stage of the evaluation will be undertaken at the end of the second year of the program and will include an analysis of outputs and some outcomes of the program and stakeholder feedback. At the completion of the third year the third evaluation report will continue this in-depth outcomes analysis with further recommendations regarding planning for the next three-year research and evaluation cycle.

As a formative and process evaluation this first report focused on the following key questions:

• Has Take Two been established according to the stated objectives and expectations?
• What are the inputs and processes put in place in the first year of operation?
• Are these inputs and processes sufficient to achieve the stated objectives for the program?
• Is Take Two working with the intended client group?
• In what way is Take Two working with the client group and are the interventions in accordance with the available evidence and expectations of key stakeholders?
• What are the lessons from this first year of operation that continue to inform the ongoing development of the Take Two program?

This report begins with a description of the policy context of the Take Two program, followed by a review of the literature relevant to the client group and underlying the program’s development and Practice Framework. There is then a brief description of the methodology.

There is a description of the program’s design, infrastructure and systems and how Take Two became established and operationalised in 2004. The program’s establishment includes the implementation of the training and development strategy and the broader research and evaluation functions. There is analysis in relation to ‘who is the client group’, followed by analysis of the range of interventions utilised. Specific attention is paid to the Aboriginal client group who are significantly over-represented within the program compared to the general population; consistent with their over-representation in the Child Protection system. In conclusion, there is discussion of the implications of the findings from this initial evaluation, particularly as they inform the ongoing planning and management of the Take Two program.

1.2 Policy context for the Take Two program


The government strategy aims to strengthen prevention and early intervention services and improve service responses for children more deeply involved in the protection and care system. It provides strategic directions to lead to more effective responses to the increasingly complex and chronic problems which occur for some children and families in the community. The strategy moves away from a narrow approach on risk to promoting children’s healthy development. It shifts from a focus on a crisis response within a poorly connected service system to a whole of community approach. The aim of reducing Aboriginal over-representation in child protection and out of home care systems and an increased range of culturally specific supports and services is also addressed in the strategy. Associated with this approach is a call for evidence-based interventions.

These reports noted the need for greater access to therapeutic services for children involved in the protection and care system within Victoria.

1 Aboriginal refers to either Aboriginal or Torres Strait Islander children
Dan

Dan is a seven-year-old boy, with a sister who is one year younger. They were severely neglected by their mother who had struggled with heroin addiction. Dan has recently been referred to Take Two.

Dan witnessed severe violence in his home, including the rape of his mother. His mother died of natural causes a year ago and the children witnessed the efforts to resuscitate her. After their mother’s death Dan’s father was unable to care for them. None of their relatives were able to care for the children because of their concerns about Dan’s severe behavioural problems. Dan and his sister’s first foster placement broke down ostensibly due to Dan’s behaviour problems.

His most recent foster carers are less anxious about these behaviours and have applied for permanent care of both children.

Dan had two therapists work with him in the last nine months, prior to his referral to Take Two. The first therapist stopped because of the placement change, and the second because of a change in employment.

Dan’s behaviour at school has deteriorated significantly in the last six weeks. This had not been followed up prior to his referral to Take Two. The foster care worker supporting the carer thinks Dan needs more therapy to deal with his loss and grief issues. Dan has told his carer he is behaving the way he is because he misses his Mum. The carer has told him that he needs to put this behind him and move on.

'Therapeutic services are beneficial for clients with severe behavioural and/or mental health problems. These clients have higher rates of substance abuse, aggressive behaviour, criminal activity and suicide.'

(DHS, 2003b, xvii)

The DHS submission brief for the intensive therapeutic service recognised that there was no comprehensive or integrated therapeutic service previously available to meet the needs of children who have experienced abuse and/or neglect. More recent documents comment directly on the introduction of Take Two to address the complex and long-term emotional and mental health needs of the Child Protection client group.

'Take Two brings together many agencies to share their knowledge in mental health and expertise in service delivery to children and young people who have suffered severe abuse and neglect.'

(Hon. Sherryl Garbutt, MP, Minister for Community Services, 4 June, 2004, 5)

1.3 Description of the Take Two program

Take Two is a statewide developmental therapeutic service for Child Protection clients who have suffered trauma, disrupted attachments and other adverse consequences as a result of serious abuse and neglect. Take Two is funded by DHS to provide a direct service to Child Protection clients, as well as undertaking research and training to build and disseminate knowledge and to contribute to the service system’s response to the needs of this group of highly vulnerable children and young people.

Take Two aims to respond to the child’s needs for safety, healthy relationships, recovery from trauma and promotion of their development, health and wellbeing. The program emphasises the importance of understanding each child and how they experience trauma and disrupted relationships within their life context. It aims to intervene at multiple levels to help the child harness resources available to them. In addition to a strong culture of specialist intervention and outreach, the program seeks to develop a research culture and engage all staff in monitoring outcomes and knowledge development.

One element of Take Two is early intervention within a tertiary context – to provide a service to children who have experienced severe abuse or neglect to assist them to avoid the extreme negative consequences of trauma on their lives. Another focus is to work with those children where the repercussions of this and related traumas are already evident in their emotional and behavioural responses.

1.4 Organisation of the report

Following the introduction, Chapter Two presents an overview of literature used to inform the establishment and implementation of Take Two. Chapter Three describes the evaluation methodology. This is followed by a detailed description of the design, establishment and operation of the program in Chapter Four. Chapter Five describes and analyses the client characteristics for the Take Two population in 2004 as a whole. Chapter Six explores the interventions used for the regional Take Two client group. The final chapter outlines the conclusions and lessons learnt from the first year of operation of Take Two.

Case vignettes are placed throughout the report to allow the experiences of the children to tell the story. Each vignette illustrates the complexity of a child’s situation and the role of Take Two in responding to the child’s need for specialist intervention. The following account of ‘Dan’ at the time of his referral is such an instance.
Chapter 2: Literature Review

2.1 Overview
The formation of Take Two is based on local and international research and enquiry into the emotional and mental health needs of the child protection and care population. Within Victoria, in addition to policy documents, reports such as ‘When Care is Not Enough’ (Morton, Clark & Pead, 1999) and ‘Voice for Kids’ (Flanagan, Hogan, Tucci, Worth & Hewitt, 2001) trumpeted the need for targeted and evidence-based therapeutic services for these children. The Royal Children’s Hospital Stargate pilot and subsequent report demonstrated how elements of such a service may work and advocated for Child Protection clients to have greater access to ongoing therapeutic services (Milburn, 2004).

There is a growing body of literature specific to the impact of child maltreatment. Another source of literature is focused on children’s mental health. A third and rapidly developing area of enquiry applies trauma and attachment theories to an understanding of abuse and neglect. Perspectives such as developmental psychopathology have endeavoured to bring these areas of study and research together to further understand the ramifications of child maltreatment on the mental health and emotional and general wellbeing of children.

2.2 Foundational/influential reports and pilots
The report commissioned by DHS ‘When care is not enough’ (Morton, et al., 1999) described the concept for an intensive therapeutic program for the Child Protection client group. This report portrayed ten of the highest risk Child Protection clients in Victoria. These young people’s experience of trauma and pattern of destructive relationships was highlighted along with their limited access to therapy. It also noted that most of these young people could have been identified at a much younger age for needing therapeutic services.

‘… there are a number of children and adolescents in care, who have suffered traumatic early environments, for whom care is not enough1 to effectively address the aftermath. It is argued that these young people need consistent and high quality care, which offers continuity of positive relationships. However, they also need systemic therapeutic interventions, to assist them to rebuild their lives and address post-traumatic states and developmental disturbance associated with the severe abuse and neglect they have suffered.’ (Morton, et al., 1999, viii)

Morton and colleagues (1999) recommended that a therapeutic service be developed to address this need.

They recommended the use of practice-related research to guide service development and clinical practice and the importance of dissemination of knowledge.

While this report and others, such as the ‘Overview of High Risk Adolescents in Placement and Support Services Report’ (DHS, 1997), focused on high risk adolescents, a small number of reports commissioned by DHS noted the need for greater access to therapeutic services for Child Protection clients of all ages (such as Flanagan, et al., 2001). Reports focused on infants and younger children rarely commented explicitly on the mental and emotional health of these children. When mental health issues were raised, the focus was typically on the impact of the parent’s mental health problems as a risk factor to the infant (for example, Jackson, Johnson, Millar & Cameron, 1999).

An exception to this was the Stargate report (Milburn, 2004). The Stargate Early Intervention Program for Children and Young People in Out of Home Care was a pilot developed under the Working Together Strategy by The Royal Children’s Hospital Mental Health Service, DHS and out of home care agencies in the Western Metropolitan Region of Victoria. This program provided multi-disciplinary therapeutic assessments for Child Protection clients of all ages who entered out of home care for the first time. The Stargate program operated clinically for approximately 14 months in 2002 and early 2003. The resultant report highlighted the value of providing therapeutic assessments specifically targeted to this client group. They found nearly two-thirds of the children had mental health diagnoses and required ongoing mental health intervention. The Stargate program also had a research and evaluation component.

2.3 Literature relating to consequences of child maltreatment
There is general consensus that children involved in the protection and care system have often experienced more than one form of abuse (Cicchetti & Lynch, 1995; Dong, Anda, Dube, Giles & Felitti, 2003). There is a growing body of literature concerning the consequences of different types of maltreatment on children, but little on the impact of various combinations of abuse and neglect types.

Although all forms of serious abuse and neglect can be devastating in their impact, there is always a proportion who appear to survive relatively unscathed (Deblinger, Lippman & Steer, 1996; Cicchetti & Lynch, 1995; Cicchetti & Toth, 1995). There is debate as to whether there are certain resiliency factors associated with individuals or their environment that decrease the likelihood of harm from adverse experiences. Perry and colleagues warn that what may appear as resilience may actually be surrender or covering the

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1 This phrase is bolded in the original text.
less noticeable indicators of harm (Perry, Pollard, Blakley, Baker & Vigilante, 1995). Perhaps more open questions are: what are some of the mediating factors related to the impact of abuse and are any of these within the service system’s sphere of influence?

### 2.3.1 Sexual abuse

In studying the ramifications of maltreatment on children, a major area of study has focused on sexual abuse. Summit’s (1983) ‘Child Sexual Abuse Accommodation Syndrome’ and Finkelhor and Browne’s (1985) ‘Traumagenic Dynamics’ model were influential in describing the range of consequences of sexual assault on children.

‘The…experience of sexual abuse can be analysed in terms of four trauma-causing factors, or what we will call traumagenic dynamics – traumatic sexualization, betrayal, powerlessness, and stigmatisation…These dynamics alter children’s cognitive and emotional orientation to the world, and create trauma by distorting children’s self-concept, world view, and affective capacities.’

(Finkelhor & Browne, 1985, 530-531)

Rowan and Foy’s (1993) review of research noted that post-traumatic stress disorder (PTSD) was prevalent among sexually abused children. While acknowledging some limitations of the PTSD model they contend that it provides a useful clinical and research framework for understanding some of the ramifications of sexual assault. Research supporting the relationship between PTSD and child sexual assault include: Wolfe, Gentile and Wolfe (1991), (1989); Kiser, Heston, Millsap and Pruitt (1991); McLeer, Deblinger, Henry and Orvashel (1992); Deblinger and colleagues (1996); Briggs and Joyce (1997); and Avery, Massat and Lundy (2000). These studies were careful not to over-simplify the relationship between PTSD and child sexual assault as an inevitable sequelae.

Kiser and colleagues’ study explored physical and sexual abuse and found that while just over half of the children developed PTSD symptoms, those who did not often showed other mental health problems, such as depression and aggression. Indeed it was the latter group that appeared to have the greater number of overall problems, although PTSD was associated with more severe forms of abuse. In their review of 45 studies regarding child sexual abuse, Kendall-Tackett, Williams and Finkelhor (1993) illustrated the serious consequences of sexual assault on children and how it could manifest in various behavioural and emotional responses. They conclude that while there was no single predominant symptom pattern or syndrome resulting from sexual abuse, sexualisation and PTSD were frequent but not universal responses.

Putnam (2003) reviewed the research regarding child sexual assault over the past decade. He concluded that a number of adult psychiatric disorders related to earlier sexual abuse experiences including major depression, PTSD, borderline personality disorder and substance abuse disorders. Another study also found links between child sexual abuse and long-term problems for adults, such as mental illness and parenting difficulties (Roberts, O’Connor, Dunn & Golding, 2004). Herman, Perry and van der Kolk (1989) found a strong association between adult patients with borderline personality disorder and childhood sexual abuse.

### 2.3.2 Physical abuse

The most obvious consequence to children as a result of physical abuse is the physical injury itself and the risk of death or disability. The physical abuse literature is less extensive than the sexual abuse literature on the emotional, social and mental health consequences.

In Hewitt’s literature review as part of the ‘Voice for Kids’ report (Flanagan, et al, 2001) she concluded that the physical assault is not the sole determinant of the negative impact on the child. The child’s ongoing experience of their family life was noted as a major factor.

The combination of physical abuse and emotional abuse for a child is considered especially harmful (Briere, 1992). Lynch and Roberts (1982) strongly argued for a broader perspective when examining the impact of physical abuse on children, including the effects of system intervention.

A ten-year follow-up comparison study was undertaken regarding 165 pre-school children placed on Child Protection registers in England due to physical abuse (Gibbons, Gallagher, Bell & Gordon, 1995). This study found that children who had been physically abused showed more behavioural problems at home and school, had more friendship difficulties and scored lower on some cognitive tests. Children whose parents had a critical, punitive and physical punishment style or an inconsistent approach had more behavioural problems, higher depression and more friendship problems.

Kaplan, Pelcovitz and Labruna’s literature review regarding child maltreatment found consistent difficulties in the social functioning of physically abused children. They noted a strong association between physical abuse and infants with disorganised attachment; and older children with significant peer relationship difficulties. They found a number of studies demonstrating the heightened risk of physically abused children to experience psychiatric conditions, such as depression, anxiety disorders, conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder (ADHD) and substance abuse. PTSD was not associated with mild physical abuse but was evident in cases of extreme physical abuse. Herman and colleagues’ study (1989) showed childhood experience of physical abuse had the strongest association with borderline personality disorder in adult life compared to other experiences of abuse.
2.3.3 Emotional abuse and emotional neglect (emotional or psychological maltreatment)

Emotional abuse is often understood to be inherent in all forms of significant abuse and neglect, but can also occur on its own (Iwaniec, 1997; Tomison & Tucci, 1997; Kaplan, et al., 1999; Glaser, 2002).

Mechanisms for harm as a result of emotional maltreatment include interference with the child’s capacity to form secure attachments (Thompson & Carole, 1995; Iwaniec, 1997); delaying or damaging the child’s psychological development (Thompson & Carole, 1995); interfering with the child’s physical and neurological growth and development (Thompson & Carole, 1995; Iwaniec, 1997; Tomison & Tucci, 1997; Glaser, 2002); and interfering with the child’s cognitive processes (Thompson & Carole, 1995).

Specific mental health diagnoses associated with emotional abuse include depression, reactive attachment disorder, dissociative disorders and PTSD (Thompson & Carole, 1995; Glaser, 2002). Other consequences include emotional unresponsiveness, unhappiness, fear, distress, anxiety, impaired social development, dependency, low self-efficacy, eating disorders, substance abuse, aggression, withdrawal, school problems and criminal activity. There is also evidence of a relationship between emotional abuse and suicide or self-harming, thereby indicating a physical risk to the child (Thompson & Carole, 1995; Doyle, 1997; Glaser, 2002).

Glaser (2002) noted that psychological neglect in the first two years of life is associated with significant problems later in life, including withdrawal, non-compliant behaviour and lower academic achievement. Perry, Colwell and Schick (2002) wrote that when emotional neglect is a constant reality for a child under the age of three, the child may have difficulty in forming close and enduring relationships.

Emotional abuse and emotional neglect are considered by some to be the most destructive form of maltreatment (Tomison & Tucci, 1997; Glaser, 2002). Kaplan and colleagues (1999) reviewed studies that showed children who had experienced emotional abuse were significantly more at risk of developing internalising and externalising disorders, and at significantly higher risk of suicide attempts, compared to those who had experienced physical abuse.

‘The specific problems resulting from neglect can vary. The problems are more pervasive and severe if the neglect is more pervasive and severe. The problems are most difficult if the neglect occurs early in life when the child – and the brain – is most rapidly developing. The specific outcomes depend upon the timing, nature, duration of the neglect and the timing, nature and duration of the remedial and enrichment experiences provided after the neglect occurs.’ (Perry, et al., 2002)

Emotional consequences of neglectful backgrounds include children presenting as more passive, withdrawn, aggressive and indiscriminate in their social interactions (Kaplan, et al., 1999; Perry, et al., 2002).

Neglect can have major impacts on other aspects of development as language. This in turn has implications for their behaviour and social relationships (Allen & Oliver, 1982; Kaplan, et al., 1999). Allen and Oliver contend that language therapy is needed for many of these children as their language development will not spontaneously improve. Kaplan and colleagues (1999) found contradictory research regarding whether or not physical neglect had psychopathological consequences.

2.3.4 Physical neglect

Physical neglect in an extreme form can have a similar risk of death or disability as physical abuse. According to Perry and Pollard (1997) neglected children are at high risk of developing emotional, behavioural, cognitive, social and physical delays and dysfunction. Perry and colleagues (2002) highlighted the critical developmental window of early childhood in terms of neurological development and the enormous damage that can occur physically to the brain if deprived of necessary experiences, such as sensory stimulation (e.g., sound, smell and touch) and adequate nutrition.

‘The specific problems resulting from neglect can vary. The problems are more pervasive and severe if the neglect is more pervasive and severe. The problems are most difficult if the neglect occurs early in life when the child – and the brain – is most rapidly developing. The specific outcomes depend upon the timing, nature, duration of the neglect and the timing, nature and duration of the remedial and enrichment experiences provided after the neglect occurs.’ (Perry, et al., 2002)

The percentage of families where family violence was noted as a parental characteristic for substantiated child protection cases in Victoria increased from 38% in 1996-1997 to 52% in 2000-2001 (DHS, 2002).

Children who witness family violence have been found to be at risk of behavioural and emotional problems with mixed findings in relation to children’s social, cognitive and physical functioning (Kolbo, Blakely & Engleman, 1996; McCloskey, Figueredo & Koss, 1995).
Smith, O’Connor and Berthelsen (1996) undertook a study in Australia of the effects of witnessing family violence on the psycho-social adjustment of young children. They found significant correlations between the child's level of adjustment and the amount of verbal and physical family violence prior to parental separation.

'The results of this study support the proposition that there is a need for professional intervention services for children who have witnessed domestic violence. Unfortunately, whilst almost half of the mothers indicated that concerns about their children’s emotional and physical safety were a primary reason for separation, many mothers indicated to the interviewers that they were still seeking counselling for their children because services were limited in this area.'

(Smith, et al., 1996, 8)

There is a demonstrated association between children’s exposure to family violence, regardless of whether or not they were also maltreated, and significant behavioural problems (Kernic, Wolf, Holt, McKnight, Huebner & Rivara, 2003). Blanchard (1993) noted similarities between children exposed to family violence and children exposed to disasters and war.

Examples of emotional, social and mental health issues associated with children’s exposure to family violence include PTSD, somatic symptoms, lower school achievement and increased behavioural difficulties (McCloskey, et al., 1995; Tomison, 2000; Mathias, Mertin & Murray, 1995; Lee, 2001). Herman and colleagues’ (1989) study showed that a history of exposure to family violence as a child was common to adults with borderline personality disorder. Studies have shown a prevalence of fear, anxiety, sadness and anger in many of these children (Blanchard, 1993; Lee, 2001). Mathias and colleagues (1995) found no distinction between children who directly witnessed family violence and those who were otherwise aware of it occurring; in other words both groups were at risk.

‘In summary, family violence is a major issue for our community and therefore a major issue for the Child Protection service in Victoria. We will continue to examine ways to ensure that the experience of children is recognised and responded to, and that children are adequately assessed and protected from the pervasive harm of family violence.’

(Callister, 2002, 16)

2.4 Child and adolescent mental health

Child maltreatment and longstanding parent-child relationship problems are frequently acknowledged as major contributing factors for a number of childhood mental health problems (AACAP, 1997). Children in the protection and care system are considered a high-risk population for socio-emotional, behavioural and psychiatric problems requiring mental health treatment (Cicchetti & Lynch, 1995; Arcelus, Bellerby & Vostanis, 1999; Richardson & Joughin, 2000; Gilray, 2001; Walker, 2003; Leslie, Hurlburt, Landsverk, Barth & Slynem, 2004).

‘We know that children in care are more likely to have experienced significantly more risk factors which predispose young people to develop mental health problems.’

(Lindsey, in Richardson & Joughin, 2000, 7)

Kahan (1989) wrote that more is usually known about children in care’s mental health than their physical health. She noted that some children in care were evidently doing well, but as a group were performing poorly in areas such as behavioural difficulties and school attendance and attainment. Despite this there is often limited inclusion of this population when considering child and adolescent mental health issues within the community (Arcelus, et al., 1999).

The DHS (2005) ‘Victorian Families, Children and their Carers in 2016’ report described a national study documenting the general decrease in inpatient treatment for children in Victoria, except in relation to a slight increase noted for children with emotional-behavioural problems. Projections in relation to outpatient treatment showed a steady increase, albeit not as great as the increase predicted for adults. The DHS (2005) report noted that children and adolescents from sole-parent, step/blended or low income families were more likely to have mental health problems. This report also referred to studies relating to children in care, such as a national study in 2000 that noted children in residential care had approximately three times more incidence of depression and conduct disorder and approximately 40% higher incidence of ADHD.

In the early part of this decade DHS undertook a series of audits in relation to the wellbeing of children in different forms of care. The Audit of Children in Residential Care (DHS, 2000) undertook a cross-sectional analysis of the total population of children in residential care. The audit showed that 38% of children in residential care had mental health problems, which was approximately 2½ times the rate of the general child population. Common diagnoses included ADHD, depression and conduct disorder. The proportion of children with mental health difficulties increased with age. The Audit of Children and Young People in Home-Based Care (DHS, 2001a) undertook a cross-sectional analysis of a sample of more than 50% of children in home-based care. This audit found 18% of the sample was identified as having mental health problems, which was marginally higher than the general child population. The Audit of Kinship Care
The most common disorders experienced by children in out of home care include anxiety, depression, conduct disorder and attachment disorder (Arcelus, et al., 1999; Lindsey, in Richardson & Joughin, 2000). According to the Stargate report 62% of the children met criteria for a major psychiatric diagnosis, such as PTSD, attachment disorders and behaviour disorders (Milburn, 2004).

The difficulties experienced by child protection clients in accessing mental health services have been raised in the literature (Morton, et al., 1999; Arcelus, et al., 1999; Richardson & Lelliott, 2003; Walker, 2003; Leslie, et al., 2004; Milburn, 2004). Such barriers include:

- waiting lists (Arcelus, et al., 1999; Richardson & Lelliott, 2003);
- limited resources within mental health (Richardson & Lelliott, 2003);
- mental health services’ reluctance to take on this role (Richardson & Lelliott, 2003; Arcelus, et al., 1999; Morton, et al., 1999);
- unfamiliarity of therapeutic settings (Richardson & Lelliott, 2003);
- referral procedures within the mental health system (Arcelus, et al., 1999);
- frequent moves or changes in placement (Arcelus, et al., 1999; Richardson & Lelliott, 2003);
- delays in seeking mental health assessment due to the frequency of change experienced by the child (Arcelus, et al., 1999);
- unclear arrangements in organising assessment and treatment (Arcelus, et al., 1999);
- change of case manager (Richardson & Lelliott, 2003);
- changes of case plan, such as reunification (Richardson & Lelliott, 2003);
- lack of targeted treatment options (Morton, et al., 1999);
- type of placement, e.g., kinship care (Leslie, et al., 2004); and
- lack of recognition that the child needs therapy (Leslie, et al., 2004).

Leslie and colleagues (2004) examined the use of mental health services by children who had suffered maltreatment. They found that sexual abuse victims were more likely to access mental health services, especially compared with those who had experienced physical neglect. This finding was regardless of age, gender or presentation of need. Their hypothesis was that this was due to a perception by case managers that neglected children were in less need of mental health services as addressing their physical needs was believed to meet their mental health needs. This study found other factors correlated with reduced access to mental health services, such as young age, being female and African-American cultural background.

Walker (2003) emphasised the importance of timely access to mental health services as prevention for long-term mental health problems.

“The evidence demonstrates conclusively that one of the biggest risk factors in developing adult mental health problems, is a history of untreated or inadequately supported childhood mental health problems (Department of Health, 1998; Howe, 1999; Department of Health, 2001).” (Walker, 2003, 675)

Lindsey (2000) wrote that failure to acknowledge significant mental health problems in children can lead to major problems in their placement.

‘Recognition of mental health problems alleviates [carers and workers] personal guilt, allows them to be realistic about what can be achieved and enables them to seek help. For the young people, it may mean that they have a chance to recover.’

(Lindsey, in Richardson & Joughin, 2000, 9)

Henggeler and colleagues (2002) cited the U.S. Surgeon General’s Report on Children and Mental Health (DHHS, 1999) that listed assumptions guiding an understanding, assessment and treatment of children’s mental health:

- Mental health problems are multi-determined, complex and multilayered, and ecological.
- Children and families strive to adapt to their context. Therefore when environments are chaotic or dangerous, the adaptations made by children and their families may seem pathological and dysfunctional, but may nevertheless be critical for their survival. These functions therefore need to be understood as part of any assessment and intervention planning.
- The critical importance of the caregiving environment.

2.5 Attachment, trauma and children

Safety is in relationships not in isolation. Humans are outstandingly ill-prepared to care for themselves when they are very young (Carlson & Sroufe, 1995; Kagan, 2004). Attachment styles are usually described as secure or insecure attachments referring to the level of confidence the child shows that the adults in their lives will respond to their needs and keep them safe. What is considered a normal pattern may well be culturally determined and so assessment of attachment needs to include a cultural context (Yeo, 2003). Children with an insecure attachment have a set of strategies (e.g., clinging or distant behaviours) that they have learnt increases the likelihood that the adult will respond and keep them safe. However, a
phenomenon more recently identified is when the source of supposed safety is also the source of harm, such as when there is child maltreatment. How does a child develop a strategy to elicit protection and nurture from the very person who is placing them in danger? This can lead to children having a disorganised attachment, as defined by Main and Solomon (1990), where they have no organised strategy to elicit care from others.

“For some infants, the caregiving environment is so bizarre, threatening, unpredictable, violent, or frightening that not only are the infants insecure, but they also cannot organize a coherent strategy for ensuring protective access to their caregivers.”

(Cassidy & Mohr, 2001, 278)

When infants have a disorganised attachment they typically initiate one form of attachment behaviour towards the caregiver and then switch to another (Putnam, 1997). Disrupted attachment is defined by Schore (2000) as relational trauma.

‘Children who suffer disrupted attachments may suffer from damage to all of their developmental systems, including their brains and we are particularly ill-suited to having the people we are attached to also be the people who are violating us.’

(Bloom, 1999, 2)

While attachment theory has been influential in child welfare and mental health over the past 40 years, trauma theory is a relatively new and rapidly growing area of study, particularly in relation to child maltreatment.

‘Trauma arises when the child cannot give meaning to dangerous experiences in the presence of overwhelming arousal.’

(Garbarino & Kostelny, 1996, 39)

Harris, Putnam and Fairbank (2004) summarised the seven highest risk groups of children for traumatisation including five which significantly overlap with children in the protection and care system. These high-risk groups were children who have been maltreated; children in out of home care; children who witness family violence or violent death of significant others; children in the juvenile justice system; and children requiring psychiatric hospitalisation for problems such as suicide and absconding. They noted that children known to have been maltreated received nil or minimal therapeutic interventions for this traumatic experience.

‘Child maltreatment is the single largest source of childhood trauma and the one most closely associated with serious psychiatric sequelae. Maltreatment outcomes are diverse.’

(Putnam, 1997, 44)

While there was earlier debate as to whether children or adults were most affected by trauma, it has become widely understood that children are more vulnerable. Their age and naivety is not a buffer, but a higher risk factor for the mediation of the impact of trauma (Wraith, 1994; Terr, 1990; van der Kolk, 1989; James, 1994; Herman, 1992/1997; Putnam, 1997; Johnson, 1998; Bloom, 1999; Maercker, 1999; Osofsky, 2004; Lieberman & Van Horn, 2004). This vulnerability is heightened when the trauma occurs within the family and is perpetrated by those responsible to protect the children from harm.

‘The most pernicious trauma is deliberately inflicted in a relationship where the traumatized individual is dependent – at worst, in a parent-child relationship.’

(Allen, 1995, 7)

Although PTSD is mentioned in some studies regarding child maltreatment, especially sexual abuse, the findings vary as to whether PTSD is more or less prevalent for children compared to adults (Perry, 1999; Salmon & Bryant, 2002).

‘Symptoms of PTSD are not usually prominent and tend to be obscured by their other cognitive, affective, social and physical problems. Despite this, a significant proportion of children studied in child maltreatment research are diagnosed with PTSD. PTSD diagnoses for children have ranged from 15 to 90% in different studies, but always higher proportion than in adults.’

(Perry, 1999)

Regardless of whether or not children are more or less likely to be diagnosed with PTSD when exposed to significant trauma they are at risk of showing certain clusters of PTSD symptoms. Perry (1999) wrote that children are often misdiagnosed with other disorders such as ADHD, depression or conduct disorders. Perry and others argue that while many traumatised children may not fit the diagnosis of PTSD, this is due to the inadequacy of the diagnostic criteria, such as not incorporating developmental differences, rather than due to the children not being seriously affected.

In relation to the ‘fight, flight and freeze’ responses often associated with trauma, Hellett & Simmonds (2003) maintain that children cannot usually run away and so run in other ways, such as through dissociation and becoming disengaged. They note that fighting is not a straightforward option for children, especially if the threat is from a powerful adult. Even a verbal protest from children may be ignored, overpowered or place them at heightened risk. Children may attempt to fight through crying, tantrums and aggressive behaviours. Children who fight can be seen as disobedient and aggressive (Hellett & Simmonds, 2003; James, 1994). Children who freeze may be described as oppositional or defiant (James, 1994). T err (1990) in her groundbreaking research applied the neurobiological and psychological findings of trauma theory to children. She wrote that ‘psychic numbing’ could become a way of life for children into adulthood.

‘Children begin to develop the ability to deny reality once disasters start piling up. Because second, third, and fourth ordeals can no longer surprise, a battle-weary
child finds himself bracing for shocks. He prepares. In an attempt to see no evil, hear no evil, speak no evil, and feel nothing, the youngster starts ignoring what is at hand. His senses go numb and he guards against thinking.’

(Terr, 1990, 79)

There are many implications when applying trauma theory to understanding child maltreatment. They include the increased understanding of the neurobiological consequences of child abuse and neglect (e.g., van der Kolk, 1996a); similarities and differences for child abuse victims with other traumatised people such as war veterans and rape victims (e.g., Herman, 1992/1997); the growing amount of evidence-based interventions for traumatised people; the issue of secondary traumas; and the reality of multigenerational trauma whereby the child is directly and indirectly affected by their parents’ experience of trauma.

Trauma can interrupt not only a moment in time, or a lifetime, but can also pervade through generations. It can create a dynasty of trauma. Although they did not use the language of trauma, Fraiberg, Adelson and Shapiro’s (1975) landmark article ‘Ghosts in the Nursery’ used ‘ghosts’ as a metaphor of the multigenerational re-enactments of trauma. Nader (1998) found children of parents who had previously suffered trauma showed greater vulnerability to being traumatised when a new event occurred. She concluded that some of these children developed PTSD as a result of the current traumatic situation, and their parents’ previous traumatisation led to a heightened vulnerability and increase of symptoms.

Another key understanding from the study of trauma is the realisation that much of the child’s response is not within their control (e.g., Hellett & Simmonds, 2003).

‘The response to traumatic stress is not within a child’s control. Trauma overwhelms even the most healthy and well-developed capacity to regulate stress.’

(Hellett & Simmonds, 2003, 75)

A major learning from trauma theory is the understanding that those who have been traumatised are trying to survive, even if their behaviours and presentation appear contrary to this. They may develop adaptations in their lives in order to gain some sense of control, albeit fleeting and illusory. These adaptations can include substance abuse, suicide, self-harm, violence to others and withdrawal (van der Kolk, 1996b). Hellett and Simmonds (2003) wrote that children living in traumatic environments learn to do whatever is required to survive. They will seek mastery over their situation, even if it is ultimately futile.

‘Children living in these circumstances are not free to learn, play and explore the world like other children – they respond to the world as a dangerous and frightening place where they get hurt. They become primed to look for and protect themselves from these threats.’

(Hellett & Simmonds, 2003, 76)

There are profound implications of trauma theory for therapeutic intervention. While there is debate regarding the use of different types of interventions for traumatised individuals, such as cognitive behavioural therapy (CBT), psychodynamic approaches, family therapy, and others, many researchers agree that therapy for this population should be staggered. Herman (1992/1997) summarised a number of treatment approaches based on trauma theory involving three stages. Although different language was used the first stage of intervention according to most is based on establishing safety and stabilisation of symptoms. It is not until the person is no longer feeling out of control or unsafe that interventions directed to the retelling and remembering of trauma are suitable. The third stage is often focused on reconnecting to self and others.

The most commonly acknowledged first principle underlying treatment for traumatised people, and children in particular, is that their safety must be established before other aspects of treatment can begin (Wraith, 1994; Herman, 1992/1997; Cicchetti & Toth, 1995; Perry, et al., 1995; van der Kolk, 2001; Hellett & Simmonds, 2003; Lieberman & Van Horn, 2004).

‘The first task of recovery is to establish the survivor’s safety. This task takes precedence over all others, for no other therapeutic work can possibly succeed if safety has not been adequately secured…No other therapeutic work should even be attempted until a reasonable degree of safety has been achieved.’

(Herman, 1992/1997, 159)

Cicchetti and Toth (1995) suggest that where safety is not reasonably certain, the therapist’s role may involve helping the child to develop a resource network to enable access to avenues of safety and security. They highlight that individual therapy with the child in these situations may increase risk of further harm. For example, as it is likely that children in trauma therapy will be practising with how to control their affect and behaviours, this may trigger certain danger points within other relationships. Similarly, some of their symptoms may still be essential for survival, so if their responses change their safety may be in jeopardy. Herman (1992/1997) writes that not only must the traumatised child be safe, but he or she needs to be aware that there are adults who are protecting them. Van der Kolk (2001) wrote that many young people who have been traumatised cannot teach themselves to be safe, as they lack a baseline for understanding what ‘safe’ feels and looks like.

Another aspect of safety is establishing the child’s sense of security. In other words, for many children in care or who have been recently returned home, significant work may be required for the child to have a sense of belonging and stability. For many children involved in the protection and care system, their time in their current placement may be uncertain...
and their longer term placement may be unknown.

‘A child needs to feel safe and start to learn about and talk about what has happened to them. They cannot do this unless they feel that they are living in a secure and stable environment and that the abuse has stopped.’

(Hellet & Simmonds, 2003, 76)

Lieberman and Van Horn (2004), while reinforcing the imperative of safety, contend that challenges to this may be outside the control or influence of the therapist.

‘The most basic principle in the treatment of early trauma is the establishment of a safe environment for the child and for the caregiving adults. This prerequisite can be challenging, particularly when the trauma involves interpersonal violence within the family, in the neighbourhood, or in the larger social context, and when the threat of violence is ongoing. The creation of safe external conditions is often beyond the scope of what the clinician can undertake to achieve.’

(Lieberman & Van Horn, 2004, 123)

Many theorists contend that effective therapeutic intervention must be multi-layered and may take considerable time, especially when there has been multiple traumatic events; the trauma has occurred within the family; there is disrupted attachment; multi-generational trauma; and the future is not yet certain for the child regarding which adults in their lives will keep them safe and ‘in mind’. (Herman, 1992/1997; Luxzenberg, Spinazzola, Hidalgo, Hunt & van der Kolk, 2001; Johnson, 1998; Putnam, 1997; Hughes, 1997). Perry (2005) contends that chronically traumatised children need to have consistent enriched developmental and relational opportunities to help regulate their physiological and neurobiological responses to trauma. This takes repetition, time and a ‘therapeutic web’ of people in the child’s life. This is not to say that brief interventions cannot be timely and effective at certain points in a child’s development as they are trying to make sense of what happened to them or to respond to specific symptomatic behaviours.

2.6 Developmental psychopathology perspective

Current theory understands the impact of severe maltreatment on children as traumatising, disrupting attachment and impeding children’s development. Developmental psychopathology is an approach which combines an ecological and developmental perspective. In particular it grapples with the complex range of consequences of maltreatment to children at different ages and depending on their interacting contexts. This perspective emphasises the need to provide therapy to maltreated children that includes a focus on the ecological context of the experience.

‘A primary issue to consider when providing therapy to a maltreated child involves the need to address the ecology of the maltreatment experience. Even when a therapist is providing individual child psychotherapy, it is important to remember that the child does not exist in isolation, but continues to be affected by the home, school, and broader community.’

(Cicchetti & Toth, 1995, 556)

Cicchetti and Toth (1995) note the need to respond to the broader systemic forces surrounding the child, as these can be very powerful. They highlight the need for services to be coordinated and for interventions to be unified and comprehensive.

Table 1 (p. 12) is a portrayal of the research regarding major examples of stage salient tasks in children’s development and their implications for maltreated children. These examples have been derived from articles by Cicchetti, Toth and Bush (1988); Cicchetti and Lynch (1995); Cicchetti and Toth (1995); and Cicchetti and Toth (1998).

2.7 Aboriginal and Torres Strait Islander children

Given the disproportionate numbers of Aboriginal children in the protection and care system within Victoria, particular attention has been paid to how best to understand and respond to their experiences of abuse and neglect. For example, understanding the individual trauma needs to be combined with understanding both historic and current community trauma, due to processes such as colonisation, marginalisation and the stolen generations (Stanley, Tomison & Pocock, 2003; Human Rights Equal Opportunity Commission (HREOC), 1997; Raphael, Swan & Martinek, 1998; Atkinson, 2002).

‘The release of the ‘Bringing them Home’ report in 1997, and more recently the work of Read (1999), have focused attention on the multiple layers of trauma experienced by the ‘stolen generations’ (as well as by the mothers and other family members involved).’

(Stanley, et al., 2003, 10-11)

There is, however, a lack of research regarding ramifications of trauma in general, or abuse and neglect in particular, in relation to Aboriginal children (Raphael, et al., 1998; Stanley, et al., 2003). A body of literature is developing regarding the essential role of understanding culture in therapeutic interventions.

‘…cultural customs and rituals help individuals control their emotions, order their behavior, link the sufferers more intimately to the social group, and serve as symbols of continuity. Such processes of restitution, outlined in many ethnographic studies, are disrupted when cultures as a whole are traumatized.’

(deVries, 1996, 405)

In studies reviewed by deVries (1996) individuals who strongly identified with cultural values benefited from increased social support. Connection to their culture buffered them from the impact, and even the occurrence, of traumatic events. For those who were
less culturally connected, stress had a strong negative impact on their physical and mental health. As Raphael and colleagues noted in relation to Aboriginal people:

'It is their human right to have appropriate support and resources to overcome the effects of the present and the past, and to preserve an Aboriginal future for themselves and their children.'

(Raphael, et al., 1998, 337)

### 2.8 Interventions and programs focused on similar client groups

Local and overseas therapeutic programs ranging in role, auspice, length of involvement, style and focus of intervention and theoretical frameworks are targeted to similar (though not identical) client groups as Take Two. While there are programs working with similar depth of issues, such as with abuse, this literature review discovered few therapeutic programs that are expected to cover the same depth and breadth of client and system issues as Take Two. For example there are usually differences regarding age groups, types of maltreatment, child’s placement, case planning and/or the required stability of child placement. Therefore, while Take Two needs to draw upon the experience and knowledge developed from these and other programs, it faces different challenges in providing effective interventions to meet the breadth and depth of experiences and developmental needs of the client group.

Another challenge in developing a therapeutic service is the limited research available to assist in determining the most effective interventions. Studies which do exist focus largely on treatment of children who have been sexually abused. Studies regarding other forms of abuse such as physical abuse and neglect focus mainly on treatment of parents to prevent further abuse, rather than treatment of children regarding the consequences of such abuse. There are some interventions being developed for both parents and children where physical abuse has occurred, such as abuse-focused CBT (Kolko, 1996) and Parent Child Interaction Therapy (Urquiza & McNeil, 1996).

A growing number of studies have focused on behavioural presentations of children, such as treatment for young people with conduct disorders. For example, Multisystemic Therapy (MST) is based on an applied ecological framework for young people with anti-social behaviours (Henggeler, 1997). These represent a significant group but not the majority of the child protection population.

A number of studies cite ‘sexual abuse specific’ CBT as useful in ameliorating symptoms of children who have been sexually abused (Deblinger, et. al., 1996; Berliner & Saunders, 1996; Cohen & Mannarino, 1996, 1998). This is now known as Trauma Focused CBT (Saunders, Berliner & Hanson, 2004). Briere (1996a) asserts that though few studies have attended to the efficacy of treatment for children who have been abused; those which have been conducted indicate that children who entered treatment show fewer symptoms at post-test than children without treatment. However, which treatments are the most effective, and what treatment modalities ‘fit’ which forms of abuse or cluster of symptoms, are still a matter of debate.

CBT is one of the few interventions that lends itself to being measured, as it is a relatively standardised approach. However, some warn against being over-reliant on interventions that can be tested in a randomised control trial, as many situations cannot be measured in that way (Tomison, 2000). Similarly, while these studies contribute to our understanding of interventions (Briere, 1996a), there are concerns that studies often exclude many of the children who form a large part of the child protection population, such as children in out of home care, children with more than one form of abuse; and children who do not have a non-offending parent.

Recently developed interventions that are more targeted to chronically traumatised children include Perry’s (2005) ‘neurosequential’ model and Bloom’s ‘sanctuary model’ (Abramovitz & Bloom, 2003). Perry’s (2005) approach privileges an understanding of the impact of trauma on child’s neurological development and the need for a comprehensive, developmentally
Table 1: Examples of stage-salient tasks and implications for maltreated children

<table>
<thead>
<tr>
<th>Examples of stage-salient ontogenic tasks</th>
<th>Examples of implications for maltreated children</th>
<th>Examples of authors</th>
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</table>
| Maintenance of physiological or homeostatic regulation (0-3 months onwards) | • Physiological dysregulation; e.g., increase hyperarousal and decrease capacity to modulate moods  
• Hypothesis that they require greater external stimulation to affect the chemical reactions for soothing  
• Atypical neurohormones, relating to the fight, flight or freeze response to stress and trauma | Emde, Gaensbauer & Harmon, 1976; Greenspan, 1981; Sroufe, 1979; van der Kolk, 1989; Perry, et al., 1995 |
| Affect regulation (4-6 months onwards) | • Affect dysregulation, such as excessive negative affect or blunted patterns of affect  
• Hindered capacity to assess stressful situations  
• Disorganised communications; e.g., withdrawal, lack of pleasure, inconsistency and unpredictability, shallowness and ambivalence  
• Early signs of fear in the face of infants (3-4 months instead of 8-9 months)  
• Greater distress when witnessing inter-adult hostility  
| Forming attachment relationships that build on early affect regulation and interactions with carers (6-12 months onwards) | • Insecure attachments, especially anxious-avoidant  
• Disorganised attachment  
• These atypical attachment styles are more likely to be fixed in maltreated children  
• A confused pattern of relatedness with their mothers | Ainsworth & Wittig, 1969; Crittenden, 1985; Egeland & Sroufe, 1981; Main & Solomon, 1990; Main & Cassidy, 1988 |
| Development of the autonomous self and move away from other management (18-24 months onwards) | • They are more likely to show neutral or negative affect on visual self recognition  
• They become more angry, frustrated with mother and noncompliant – difficulty in transitioning toward autonomy  
• They talk less about themselves and their internal states  
• Lower in ego control and self esteem  
• They may have more effective in caring for others than self  
• Have difficulty recognising their own needs  
• They may have trouble being alone  
• Maltreated girls showing more shame and less pride  
• Maltreated boys showing re-enactment of parental roles and concrete events | Schneider-Rosen & Cicchetti, 1984, 1991; Egeland & Sroufe, 1981; Egeland, Sroufe & Erickson, 1983; Vondra, Barnett & Cicchetti, 1989; Alessandri & Lewis, 1996 |
| Symbolic representation, such as language and play (24-36 months) | Language:  
• Delays in both expressive and receptive language, especially as a result of severe neglect  
• Shorter length of utterances for maltreated toddlers  
• Secure attachment may be a protective factor for language competence amongst maltreated children  
• Less internal state language  
• Proportionately less contingent speech  
Play:  
• Their play patterns are less cognitively and socially mature  
• In free play, they engage in lower total amounts of play  
• Their cognitive play is mainly functional, sensorimotor, and less symbolic  
• Display routine, stereotyped use of materials, simple motoric activities and show greater touching of toys without direct manipulation  
• More restricted in the themes of their play, in affect expressed and in type of fantasy transformation that is involved  
• Their play involves re-enactment of parental roles and concrete events | Allen & Oliver, 1982; Culp, Watkins, Lawrence, Letts, Kelly & Rice, 1991; Fox, Long, & Langlois, 1988; Wasserman, Green & Allen, 1983; Gersten, Coster, Schneider-Rosen, Carlson & Cicchetti, 1986; Morisset, Barnard, Greenberg, Booth & Spiker, 1990; Coster, Gersten, Beegly & Cicchetti, 1994; Alessandri, 1991 |
Table 1: Examples of stage-salient tasks and implications for maltreated children

<table>
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<th>Examples of stage-salient ontogenic tasks</th>
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<th>Examples of authors</th>
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</table>
| Symbolic representation, such as language and play (24-36 months) | Mental Representational Models; e.g., via attachment:  
• Less detailed conceptions of others  
• Projective assessments show more negative view of the relational world  
• Tell fewer stories where adults and peers reciprocate kind acts of children, and tell more stories where they justify parents’ unkind acts on basis of their own bad behaviour  
Social Information Processing:  
• Less accurate in encoding social cues  
• Generate more aggressive responses to problematic social situations  
• They recall a greater number of distracting aggressive stimuli | Lynch & Cicchetti, 1991; Lynch, 1992; McCrone, Egeland, Kalkoske & Carlson, 1994; Dean, Malik, Richards & Stringer, 1986 |
| Peer relationships (4 years upwards) | • Peer relationships are maladaptive  
• Interact less often and display fewer pro-social behaviours  
• Physically abused children are less popular with their peers, less positive reciprocity and more insular social networks with higher levels of negativity  
• Greater mistrust of other children  
• Maltreated children, especially physically abused children, show higher levels of physical and verbal aggression in peer interactions  
• Abused preschoolers are more likely to cause distress in their peers  
• They are more likely to respond with anger and aggression to friendly overtures and to signs of distress in others  
• Maltreated children, especially neglected children, have high degrees of withdrawal from and avoidance of peer interactions  
• Some children exhibit aggressive and withdrawn behaviours  
• Sexually abused children can be unpopular with peers  
• Physically abused children experienced problems developing and maintaining close personal relationships  
• Physically abused children and friends showed less intimacy  
• Physically abused boys and friends showed more negative affect during game playing  
| Adaptation to school (6 years upwards) | • They perform worse on standardised tests; obtain lower grades; are more likely to repeat a grade; lower in math & reading  
• They receive significantly more discipline and suspensions  
• Neglected children showed the most severe and variable school problems including lowest performance on cognitive assessments; anxious, inattentive, unable to understand their work, lacking in initiative and heavily dependent on teachers for help, approval and encouragement. They rarely expressed positive affect or humour  
• Physically abused children more likely to be aggressive, noncompliant and acting out  
• Sexually abused children are excessively dependent on their teachers; they appear passive and lacking in autonomy in their school functioning  
• Child’s security in relation to his/her mother in interaction with maltreatment status significantly affected school adaptation | Egeland & Abery, 1991; Eckenrode & Laird, 1991; Erickson, et al., 1989 |
sensitive and biologically informed response from all those involved in the child's life. The 'sanctuary model' is also a trauma informed approach within a therapeutic community context. (Abramovitz & Bloom, 2003).

There is a range of therapeutic programs that work with certain sub-groups within a similar client group. For example, there are programs specific to types of abuse, such as sexual abuse (e.g., Centres Against Sexual Assault), physical abuse and neglect (e.g., Physical Abuse and Neglect of Children Service: PANOC – NSW), and family violence programs (e.g., Child Witness to Violence Project – Boston Medical Center). Other programs working with a similar breadth of childhood experience are often focused on specific age groups such as therapeutic services developed for infants and young children (e.g., The Louisiana State University Health Sciences Center – Early Trauma Treatment Network; Osofsky, 2004) and the Metta Scheme which provides therapy for older adolescents and young adults who are at risk of homelessness due to earlier experiences of trauma and disrupted attachment (Harms & McDermott, 2003). There are programs that work with children in particular types of placement and case plans. The therapeutic service (e.g., Mental Health-Child Safety Therapeutic Support Teams) being developed in Queensland is aimed at children in out of home care. Other therapeutic services are embedded within specific care models, such as therapeutic foster care (e.g., Family Future’s STEP program) and therapeutic residential care (e.g., the Andrus Children’s Center, New York).

At this stage in its development, the Take Two Practice Framework is informed by the literature and other forms of evidence and is evidence-based where such evidence is available and applicable to the client group.
Chapter 3: Methodology

3.1 Overview of the methodology

The Take Two Research and Evaluation Strategy (Frederico, 2004) provides the context for this evaluation. This first evaluation report focuses on the Take Two program in 2004, its first year of clinical operation. The evaluation strategy for Take Two is based on an action research methodology. Its aim is to provide analysis and feedback on a continuous basis to inform the ongoing implementation of the program.

To illustrate the process of the design and implementation of Take Two the evaluation provides a narrative of the development of the service. This approach portrays the complexities of the service and addresses the diverse core components which make up the Take Two program.

The following framework has been developed to guide the evaluation of the design and implementation of the program. At the centre of the framework is a holistic understanding of the internal and external world of the child which is integrated with, informed by, and contributed to by, the other four components. There are four other areas that facilitate the specialist intervention of Take Two in meeting the desired outcomes for the child. The five components are:

1. A holistic understanding of the internal and external world of the child (the central focus)
2. The conceptual development of the program
3. The multiple levels of assessment and intervention
4. Reflective practice and action learning including integrated and ongoing evaluation and training
5. The highly developed and evolving program design.

The central focus and each quadrant combine to form the totality of Take Two. Each is under constant development and will be reviewed at all stages of the evaluation. Moreover, the quadrants are not mutually exclusive and individual items can be in more than one quadrant.

Diagram 1: The Take Two evaluation framework

<table>
<thead>
<tr>
<th>Conceptual foundation of the program</th>
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<tbody>
<tr>
<td>• theoretical framework</td>
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<td>• practice framework</td>
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<td>• outcomes framework</td>
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<tr>
<td>• culturally sensitive</td>
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<tr>
<td>• evidence based practice</td>
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<tr>
<td>• informed by practice knowledge &amp; wisdom</td>
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<tr>
<td>• understanding trauma, abuse, neglect, loss</td>
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<td>• developmental needs</td>
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<td>• attachment</td>
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<td>• parenting</td>
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<td>• research</td>
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<td>• policy</td>
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<tr>
<th>Multiple levels of assessment &amp; intervention</th>
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<tr>
<td>• culturally sensitive</td>
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<tr>
<td>• engaging the child</td>
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<td>• engaging the family</td>
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<tr>
<td>• engaging the community</td>
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<tr>
<td>• engaging the service system (child protection, mental health, out of home care, education)</td>
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<tr>
<td>• referrals</td>
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<td>• assessment &amp; formulation</td>
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<td>• interventions</td>
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<td>• enhancing the service system</td>
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<td>• evidence informed practice</td>
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<table>
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<tr>
<th>Holistic understanding of the internal and external world of the child</th>
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<tr>
<td>• client group</td>
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<td>• family</td>
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<td>• carers</td>
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<td>• peers</td>
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<td>• culture</td>
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<td>• community</td>
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<td>• service system</td>
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<tr>
<th>Reflective practice and action learning including integrated and ongoing evaluation and training</th>
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<td>• practice framework</td>
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<td>• outcomes framework</td>
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<td>• stakeholder feedback</td>
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<td>• research</td>
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<td>• service system development</td>
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<td>• action learning</td>
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<td>• reflective practice</td>
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<tr>
<th>Highly developed &amp; evolving program design</th>
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<tr>
<td>• four strong partners (BSV, Austin, La Trobe, mindful)</td>
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<tr>
<td>• experienced leadership</td>
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<td>• specialist knowledge</td>
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<tr>
<td>• culturally sensitive</td>
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<tr>
<td>• internal policies</td>
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<tr>
<td>• robust infrastructure –leadership, evaluation, training and support</td>
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<tr>
<td>• local, regional, statewide</td>
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<td>• inter-service relationships</td>
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<td>• staff</td>
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<td>• outreach</td>
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<td>• rural &amp; urban settings</td>
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<tr>
<td>• area, regional &amp; specialist teams</td>
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<td>• advisory groups</td>
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Frederico, Jackson & Black (2005) Reflections on Complexity – Take Two First Evaluation Summary Report, La Trobe University, Bundoora, Australia
This stage of the evaluation focuses on the central part of this framework; that is, the internal and external world of the child. This includes identification of the client group by taking a socio-ecological perspective such as complex family structures, community relationships and social systems of the child. The client group is analysed according to a number of variables such as age, gender, statutory status, type of abuse experienced, health status, cultural background and family characteristics.

To collect data for each of the five components of the framework the evaluation has used data triangulation and investigator triangulation (Denzin, 1978) and both qualitative and quantitative methodologies. The use of multiple methods is considered appropriate, especially when there is a range of research and evaluation questions. Different questions require different methodologies (Greene, 2000; Darlington & Scott, 2002).

‘No single method is perfect; that is, no method guarantees the right answer to a particular question. However, if different methods, each with different imperfections, provide the same answer, then greater confidence can be placed in the validity of one’s conclusions.’ (Shotland & Mark, 1987, 77)

The evaluation focuses on the questions outlined earlier regarding the implementation of the program; the client group, the interventions utilised and reflections that inform the program’s ongoing development.

While quantitative data analysis is important to demonstrate the scope and scale of the Take Two program, qualitative data analysis enables exploration of the range of interactions, dynamics, contexts and meanings (Daly, 1992; McLeod, 2001; Patton, 2002). Evaluations of programs in changing environments need to record the process of the developing program and have a feedback loop to staff contributing to future development (Austin, Cox, Gottlieb, Hawkins, Kruzich & Rauch, 1982).

The evaluation aims to provide a narrative that tells the story of the first year of implementation of Take Two. Qualitative methods such as staff journals, interviews and case vignettes are examples of such story telling (Greene, 2000). As the focus of the evaluation is on the implementation of a new program, qualitative methods provide staff who are in the ‘box seat’ of this implementation the opportunity to express their experiences in their own language and to learn from these experiences in the process. Journals or diaries of some form are a commonly used qualitative measure, especially in a program with an action research framework (Wadsworth, 1991; Handel, 1992). In addition to their usefulness in the analysis, quotations from these journals have been interspersed throughout the report to illustrate specific points.

3.2 Data collection
3.2.1 Implementation of the program

Sources of data regarding the program’s implementation data included:

- Feedback surveys from CPAG members using a five point Likert scale and open-ended questions. There were seven responses. The return rate was 54%.
- Feedback surveys from RAG members using a five point Likert scale and open-ended questions. There were 13 completed responses from five regions, from a potential population of over 100 members in ten RAGS.
- Semi-structured interviews with Child Protection Managers in every region [9] and a number of Child Protection workers [5], team leaders [5] and unit managers [10]. One Child Protection Manager’s feedback was via email due to her being on leave during the data collection process.
- Feedback was received from ten CSOs via email, mail and phone calls. As this feedback was anonymous it was not always clear which region they came from, but at a minimum feedback was from five regions.
- 693 Take Two staff journals were completed in 2003 and 2004.
- Feedback surveys from training of Take Two staff.
- Feedback surveys from training of external participants, especially Child Protection and CSO workers who attended training about the referral process and trauma.
- Document analysis such as program documents, minutes of meetings, management reports and Take Two Weeks (fortnightly internal newsletter edited by Director).

3.2.2 Client group and interventions

Data collection regarding the client group examined all clients referred to Take Two in 2004. There was also analysis on specific groups such as clients referred to the regional Take Two teams and clients referred to Secure Welfare Take Two. Other groups explored in detail were Aboriginal clients and children of specific age groups.

Data sources related to the client group and interventions included:

- All documentation from referrers.
- Time record sheets completed by Take Two clinicians reporting client-related activity.
- File notes from the Secure Welfare Take Two Senior Clinician.
- Semi-structured interviews with every Take Two clinician (except Secure Welfare) regarding a retrospective review of all cases. This also included Take Two staff completing Harm Consequences Assessments.
- 693 Take Two staff journals.
Where the data appeared to be out of date, missing or inaccurate, this was cross-checked in terms of internal consistency and in interviews with Take Two clinicians.

3.3 Statistical analysis
Data was analysed using the Statistical Package for Social Sciences (SPSS 13). Statistically significant differences were determined using chi-square analysis for categorical data and Analysis of Variance (ANOVAs) and Analysis of Co-Variance (ANCOVAs) for continuous variables.

3.3.1 Missing data
For the majority of the data presented in this report the amount of missing data ranges from zero to ten percent.

Where the amount of missing data was 10% or more, mention of this has been made in the report. Sometimes this data was still included due to the importance of the information but it is vital that results are considered only indicative of the client group. In other instances data was not reported on if due to the large amount of missing data interpretations could be misleading.

3.4 Limitations to methodology
As this is the inaugural evaluation of the program in its first year the purpose was to provide a process and formative analysis. Therefore output and outcome data was not available at this time.

A major limitation to the methodology was the amount of missing or unavailable data. The missing data was due to a number of factors including the unfamiliar referral process to Take Two in the early stages; missing or inaccurate data on some DHS records; a small number of cases where referral documents were not received; and the absence of a Take Two computerised client information system which meant that some Take Two data was not readily available. Interviewing the Take Two staff and reviewing client referral documents and Take Two files reduced the amount of missing data. However, data that was still missing despite this interview process primarily arose where the case was closed at the time of interview, the file was archived and the Take Two clinician had left the program. Not conducting interviews in relation to Secure Welfare Take Two clients meant that missing data was a more pronounced issue and so some information could not be presented or only in an indicative format for that client group.

Another limitation was the retrospective nature of the interview methodology. The entangled and frequently changing lives of many of these children and their families were a reality which also added complexity to the evaluation methodology.
As the Harm Consequences Assessment (HCA) is based on the Children and Young Persons Act, 1989, there is no specific domain for ‘neglect’. Experiences that reflect neglect are in the abandonment/no appropriate carer domain (e.g., lack of supervision); the developmental/medical abuse domain (e.g., deprivation, lack of medical care and lack of stimulation); and the emotional/psychological abuse domain (e.g., absence of affection, emotional unavailability and inadequate caring relationships). This made it difficult to analyse the experience of neglect.

As this is the first stage of the evaluation there is minimal feedback from a range of stakeholders including clients and their families. Stakeholder feedback will be a key component of the second stage of the evaluation. The low return rate of surveys from Regional Advisory Group (RAG) members was also a limitation.

3.5 Summary
Evaluation has been embedded in the design of Take Two. The first evaluation report has used multiple data sources and a triangulation approach. The approach taken has minimised the limitations and provides a rich description of Take Two and the client group and an analysis of the implementation of the program in its first year of operation.
Chapter 4: Implementation of Take Two

4.1 The objectives and expectations of the Take Two program

The original specifications as set by DHS stated that the objective of the intensive therapeutic service is:

‘...to improve the emotional and behavioural functioning, safety and wellbeing of children and young people subject to Child Protection intervention. It will do this through the early identification of children and young people in need of the services as well as the provision of timely and effective therapy and treatment to address problematic emotional and behavioural disturbance.’

It was understood that this program would be a new initiative while building upon the experience and knowledge of other services. The overall objectives of this therapeutic service were stated as the following:

1. To improve outcomes for Child Protection clients through the provision of high quality services to the client group either directly and/or via work with significant others including family, carers, teachers and peers; and

2. To contribute to ongoing development and improvements within the protection, care and therapeutic services as they relate to Child Protection clients.’

In the DHS submission brief it was noted that the intensive therapeutic service would be expected to do the following:

- Establish strong working relationships with Child Protection, placement services, CAMHS and other related services.
- Develop a cross-programmatic practice framework to ensure greater linkages and service coordination between the service and other stakeholders providing services to Child Protection clients.
- Develop a tool to assist early detection and assessment of children who are at risk of developing severe emotional and behavioural disturbance.
- Provide professional development and training for Child Protection and CSO staff.
- Provide assistance and consultation to Child Protection, CSOs and other organisations.
- Undertake research in order to achieve better outcomes for the client group and promulgating this knowledge to relevant services.

The designated structure of the intensive therapeutic service according to the original DHS specifications included the following:

- The clinical program to be statewide and integrated in order to ensure access and consistency in service delivery.
- The program to be managed centrally and to have premises in each region.
- Each regional team to have a Senior Clinician in addition to other clinicians.
- The program to have a designated position to provide services to Secure Welfare clients.
- The program to have a training and development component for Child Protection and other agencies.
- The program to have a research and evaluation component to improve policy and practice.

The DHS submission brief stated that the intensive therapeutic service would only accept referrals from the regional Child Protection Manager. The Take Two consortium included in the program design that in addition to only accepting referrals via Child Protection, the decision-making role regarding prioritisation of referrals would rest with Child Protection, albeit in collaboration with Take Two. While the submission brief did not specify particular interventions, it noted the need for outreach and evidence-based practice. The draft service deliverables as written by DHS are summarised in Table 2.

4.2 Overview of the establishment of Take Two

There were six stages in the establishment of Take Two up to the end of 2004. The first was the work undertaken by DHS and consultants to demonstrate the need for such a service and to determine the parameters and budget allocation. The second stage was the submission and competitive tender process. For the Take Two consortium these activities included creating the partnership, clarifying roles and developing the tender submission. Following the decision by DHS to award the tender to this consortium, the concept of Take Two was launched by the Minister of Community Services on 1st May 2003.

In between the second and third stage the name of the service was finalised. After much discussion with DHS and the partnership members, the name of Take Two was decided upon to reflect a range of ideas including:

- It takes more than one person to facilitate recovery;
- There is and needs to be more than one chance; and
- The idea of reflection taking more than a moment.
The third stage was the finalisation of the partnership arrangements and the recruitment of management. The fourth stage was the major recruitment of staff, establishment of premises and core program development tasks. The next stage was defined as the clinical establishment period. This began when the program officially accepted referrals on 1st January 2004. The sixth stage was the consolidation of operations and cementing core elements of the program planning. These last four stages of implementation are shown in Diagram 2.

4.3 Core elements of the Take Two program

Take Two is a therapeutic clinical program with an embedded research and training component. This is reflected in the staffing structures and ongoing clinical, research and training operations. Core elements of the Take Two program design, many of which are unique, include:

- The partnership of mental health, child welfare and academia in providing the governance of the program.
- The referral decision-making process is a partnership between Take Two and Child Protection.
- The nature of the client group and their varied types of involvement in the protection and care system.
- The Practice Framework incorporates outreach as required, interventions at multiple levels and within the child’s various contexts and targeted interventions based on assessment. The framework includes an understanding of trauma and attachment within an ecological and developmental context.
- The strength and depth of experience and qualifications within the staffing group.
- The training strategy focuses on both Take Two and other services.
- The embedded research and evaluation components of the program.
- The Senior Clinician position in Secure Welfare that provides responsive therapeutic assessment and recommendations in relation to young people in secure residential settings.
- The Aboriginal Senior Clinician position that provides direct and indirect service to Aboriginal children and contributes to the program developing greater competency with this client group.
- The dual goals of direct service provision and contribution to system level improvements.
- The establishment of the central and regional advisory processes to facilitate implementation and system collaboration.
- The building of relationships and networks with Child Protection, CAMHS, CSOs and other services in each region.

4.3.1 Auspice, governance and advisory processes

Take Two partnership auspice and governance structure

Take Two is auspiced via a partnership of four separate entities: BSV, Austin Health CAMHS, La Trobe University, School of Social Work and Social Policy, and mindful. Each of the partners has clearly defined roles and responsibilities and form a partnership management group. BSV has partnership agreements with each of the other three partners and there is a memorandum of agreement between the four partners. Diagram 3 illustrates the governance structure of Take Two.

<table>
<thead>
<tr>
<th>Expected deliverables</th>
<th>Examples of deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery of the clinical service</td>
<td>Evidence of high levels of satisfaction with service by Child Protection and other service providers. Evidence of continuous improvement of regional ITS service provision.</td>
</tr>
<tr>
<td>Individual client outcomes</td>
<td>Reduction in emotional and behavioural disturbance. Improvements relationships with family, carers and significant others.</td>
</tr>
<tr>
<td>Development of program tools</td>
<td>Development of an Early Detection and Assessment for clinical service provision.</td>
</tr>
<tr>
<td>Development of research and evaluation strategy</td>
<td>Development of outcome measures for clinical service provision.</td>
</tr>
<tr>
<td>Development of training and development strategy</td>
<td>Delivery of agreed training and development sessions provided to regional Child Protection, community organisations, and cross-program staff.</td>
</tr>
<tr>
<td>Relationship with other services/networks</td>
<td>Participation in regional coordination processes.</td>
</tr>
</tbody>
</table>
### Diagram 2: Establishment of Take Two

#### May 2003 – July 2003

**The Beginning**

- The Take Two consortium announced as the successful tenderer – Ministerial launch of concept
- Finalisation of the name Take Two.
- Initial consultations with each region regarding core concepts.
- BSV undertook initial recruitment in conjunction with partnership members of the Director and the Leadership Group.
- Director began employment in late July.
- Finalisation of contract and Memorandum of Understanding between consortium partners.

#### July 2003 – December 2003

**Program Establishment Period**

- The Leadership Group and administrative staff began employment in August.
- Recruitment of 10 Senior Clinicians and 27 clinicians throughout the state involving Child Protection in recruitment process.
- Senior Clinicians began employment in October.
- Majority of clinicians began employment in November.
- Research Officer began employment in December.
- Located premises throughout the state.
- Set up premises for most teams and other functions.
- Established contracts with some organisations regarding co-location.
- Orientation of staff in November.
- Development of the Referral Tool and process by La Trobe University in partnership with DHS.
- Piloted the Referral Tool.
- Development of initial Practice Framework.
- Established staff journal process as part of the research strategy.
- Established relationships with services and local networks in each region.
- Established the CPAG, central DHS-Take Two meetings and some RAGs.
- Established the training strategy for Take Two staff.
- Confirmed data reporting requirements by DHS and finalised interim processes for collecting data prior to Client Information System.

#### January 2004 – March 2004

**Clinical Establishment Period**

- Program began clinical operations in January.
- Complete recruitment of clinicians.
- Re-classified the Aboriginal clinician to Senior Clinician.
- Three more teams moved into premises.
- Made changes to the Referral Tool on basis of pilot; made the tool electronic; and distributed the tool throughout the state.
- Development of training strategy for the Referral Tool and beginning training.
- Established RAGS in various regions.
- Established Aboriginal Reference Group.
- Began development of the Client Information System.
- Began process of ACHS accreditation.
- Official Ministerial launch of Take Two as a program.
- Establishment of T2RAC and the Training Advisory Committee.

#### April 2004 – December 2004

**Ongoing Operation and Review**

- Ongoing clinical practice and continued acceptance of new referrals.
- Refined internal procedures and guidelines.
- Finalised the Take Two Research and Evaluation Strategy.
- Decision regarding appointment of additional Aboriginal Clinician.
- Completed training throughout the state regarding the Referral Tool.
- Last team moved into their premises was the Box Hill Team in June, and the Northern Team had to unexpectedly move in August/September.
- Establishment of regular newsletter within Take Two, called Take Two Weeks.
- Introduction and training of the outcome measures in October.
The partnership management group holds overall accountability to DHS for contract compliance in relation to the Funding and Service Agreement. In addition, the role of the partnership includes overseeing the strategic development and implementation of the program; appointing the Director; endorsing the budget; and resolving any disputes between members.

As the lead partner, BSV holds corporate and clinical responsibility. The BSV Board delegates both corporate and clinical governance responsibility to the Director of Take Two via reporting to the CEO or the Director of Services. However, the Board recognises that in order to fulfil its role in clinical governance it requires access to additional clinical expertise. CPAG is the subcommittee of the Board that provides such advice — to the CEO, the Director of Services, the Director of Take Two and to the other partner organisations forming the consortium of Take Two.

The Clinical and Program Advisory Group (CPAG)

The terms of reference for CPAG include reviewing the implementation and ongoing development of the program; advising on strategic directions; reviewing program activities; identifying policy and practice issues; overseeing the quality assurance processes; providing advice to the BSV Board and the partnership management group; and providing support and advice to the Director. The CPAG commissions Australian Council of Health Care Standards (ACHS) accreditation as part of its quality assurance process for Take Two and in compliance with the funding and service agreement.

The membership of CPAG comprises representatives of central and regional DHS offices, the CEO and Board representatives of BSV, other members of the partnership management group, key stakeholders of the service system and academe. CPAG met initially every six weeks and following the establishment of the program met quarterly.

In terms of feedback regarding the CPAG, CPAG members generally noted it to be a valuable process.

Regional Advisory Groups (RAGs)

Each DHS region was required by the Child Protection and Juvenile Justice Branch (DHS) to convene a RAG to facilitate implementation of the Take Two program. The purpose was threefold. Firstly, the RAGs were established to identify other services and facilitate understanding of regional needs and capacities and processes for addressing these needs. Secondly, they were to assist Take Two in providing services, recognising that no service can meet the complex needs of this client group in isolation. Thirdly, the RAGs were to assist Take Two contribute to service system improvement.

In some regions RAG functions were undertaken by existing reference groups. In other regions specific Take Two RAGs were established. Some RAGs (for example, Southern Metropolitan Region) commenced in December 2003 while others (for example, Grampians Region) did not commence operation until late 2004. The RAGs are chaired by DHS and membership was determined by each region including CSOs, CAMHS, drug and alcohol services, Department of Education and Training, disability services, sexual abuse treatment services and Indigenous services.

In terms of feedback regarding the RAGs, four Child Protection Managers commented on the RAGs and their role in the implementation of Take Two. They queried the effectiveness of the RAGs, though they were seen as useful for information sharing. Each Child Protection Manager who discussed the RAGs was considering strategies for making them more effective in 2005. A couple of RAG members commented in the surveys on the usefulness of the RAG meetings.

Specific reference groups

As part of the implementation of the Aboriginal Senior Clinician’s role a reference group was established in early 2004 involving the Aboriginal Senior Clinician, other Take Two staff and representatives from the Victorian Aboriginal Child Care Agency (VACCA), the Victorian Aboriginal Health Service (VAHS) and the DHS Indigenous Initiatives Unit. This group changed its name during 2004 to reflect changes in the planning about the program’s work with Aboriginal children, the role of the Aboriginal Senior Clinician (including the title and job description), the expansion of the team to include another Aboriginal clinician and the role of the reference group.

The Secure Welfare Reference Group was planned in 2004 but did not commence operation until 2005. The training and research functions also had advisory mechanisms, which are discussed in subsequent sections.

4.3.2 Workforce and staffing/team structures

A fundamental expectation of Take Two was for it to establish a clinical team in each region throughout the State of Victoria in 2004. There was also a requirement that it establish a senior clinical position within the DHS-managed Secure Welfare Services. While Aboriginal clients were not specifically mentioned in the DHS submission brief, the Take Two tender document outlined the plan to employ an Aboriginal clinician.

The state was divided into three areas incorporating three regional teams each. The Western Area also incorporated line management of the Take Two Secure Welfare position and the Northern Area had line management of the Take Two Aboriginal position.

In 2004 Take Two had 48 full-time positions throughout the state. The teams were staffed with two clinicians in...
the five rural areas and four clinicians in the four metropolitan areas. Each team was led by a Senior Clinician, who was in turn supervised by one of three Area Managers.

The training function was supported by mindful, where the Take Two Training Manager was located. The research and evaluation functions were supported by the La Trobe University, School of Social Work and Social Policy, where the Research Team were located. Both the Training Manager and the Research Manager therefore have double accountability, that is to BSV as their employer and to the respective partner organisations that are responsible for the implementation of training (mindful) and research (La Trobe University). The Area Managers, Training Manager and Research Manager are all directly accountable to the Director of Take Two and together they form the Leadership Group. The Senior Administrative Officer was supervised by the Director. She in turn supervised three administrative officers. The staff structure developed for Take Two is outlined in Diagram 3.

**Diagram 3: Take Two staff structures – 2004**

- Chief Executive Officer
- Director of Services
- Director
- Senior Admin. Co-ord
- 3 Reception/Admin.
- Area Manager Western
  - Senior Clinician Western
    - 4 Clinicians
  - Senior Clinician Secure Welfare Services
- Research Manager
  - (located at La Trobe University)
- Area Manager Northern
  - Senior Clinician Northern
    - 4 Clinicians
  - Senior Clinician Loddon Mallee
    - 2 Clinicians
- Area Manager South Eastern
  - Senior Clinician Eastern
    - 4 Clinicians
  - Senior Clinician Southern
    - 4 Clinicians
  - Senior Clinician Gippsland
    - 2 Clinicians
- Training Manager
  - (located at mindful)
  - Senior Clinician Hume
    - 2 Clinicians
  - Aboriginal Senior Clinician
  - Aboriginal Clinician
- Area Manager Eastern
  - Senior Clinician Barwon/South West
    - 2 Clinicians
  - Senior Clinician Grampians
    - 2 Clinicians
Previous experience and qualifications of staff appointed to Take Two

Take Two recruited the substantial proportion of staff in late 2003. Though there were 48 positions in the program, there were 53 staff employed during the first year as five staff left. There was considerable delay in successfully recruiting to the Hume Region position.

Qualifications required for the clinical positions as specified in the DHS submission brief were ‘recognised qualifications in psychology, social worker or psychiatric nursing, together with demonstrated clinical training and experience’. As is evident from Table 3, there was a balance of social workers and psychologists employed within the program as well as other professions such as Family Therapists, Psychiatric Nurses, General Registered Nurses, Psychotherapists and Welfare Workers.

Of the 44 clinical and management staff employed in 2004, nine (19%) had more than one relevant qualification. Ten (23%) of Take Two staff had a Masters level qualification and three (7%) had a professional doctorate or PhD. Another eight (18%) staff were in the process of studying at Masters or Doctorate level. A significant proportion of the clinical staff undertook the Developmental Psychiatry Course for Allied Professionals or the Graduate Diploma for Child and Adolescent Mental Health during 2004.

Take Two staff came from a range of highly relevant employment experiences including CAMHS (38%), CSOs (38%), Child Protection (31%) and sexual assault services (8%). Staff also had experience in disability, corrections, family therapy services and general health services. Four staff had previously worked in the Stargate program. Many staff had a combination of relevant employment experiences.

In the staff journals some commented on their learning curves; from those coming from Child Protection or CSO backgrounds regarding the role of therapy; while others noted their learning curve coming from a CAMHS background regarding the nature of the client group and the system issues. Both noted some different language and core concepts.

Supervision, team structures and processes

BSV, as an already well-established organisation, had a number of personnel and related policies and training strategies in place for recruitment, supervision and performance management. Therefore Take Two did not need to initiate these, but rather adapted and implemented them as required.

Throughout 2004 staff journals reflected general comments about the teams, such as the value of being part of a keen, cooperative and close-knit team; ongoing development about how the team would continue the work; and the need to raise openly concerns within the team. In the latter half of the year the comments more often noted the essential nature of the team in working with the client group and the settling into roles and routines.

‘Team is working well and hard, [has] lots of energy and demonstrates real willingness to learn and develop their skills.’

Administrative demands were frequently raised in staff journals, and setting up administrative processes was often noted in the internal Take Two documents, such as in management meeting minutes. This review of documents also found that the communication was a complex task for a statewide multi-site program, but that there were processes in place, such as the fortnightly Take Two Weeks newsletter.

The Senior Clinicians’ comments regarding their roles in teams included the vital nature of the teams, mutual supports within the team, getting used to different styles of working, the amount of time needed to invest in the functioning of the team, clarifying the role of the Senior Clinician and dealing with differences within and across the teams. One Senior Clinician wrote:

‘I really feel excited by having the opportunity to discuss and plan our progress. With the risk of sounding corny, I really do thank my lucky stars that I have been given the privilege of being part of this venture.’

4.3.3 Locations and facilities

In addition to recruiting a significant number of people simultaneously, there were other key requirements in establishing a statewide clinical program. These included locating appropriate premises and purchasing equipment.
Diagram 4 provides a picture of where the offices were located in 2004 throughout Victoria. A clinical service was established in every region and via the two statewide functions. There were 12 clinical sites, with arrangements made in some rural regions for access to other therapeutic space as required, such as in Barwon South West, Hume and Gippsland.

A major requirement in establishing these offices included consultations with DHS and other stakeholders regarding the most appropriate location. In four regions, BSV already provided other services. This led in three regions (Southern, Gippsland and Hume) to Take Two co-locating with other BSV programs. In two regions (Loddon-Mallee and Grampians) it was agreed that Take Two would co-locate with Child Protection. The Barwon South West Take Two team co-located within another CSO (Community Connections).

Alongside the need for premises was the need for equipment for a therapeutic service required to do outreach. All Take Two clinical staff were provided with vehicles, computers and mobile phones. Therapeutic equipment such as play materials were also provided although there were some difficulties in particular sites where there was limited access to storage. Play therapy kits were developed for use on outreach visits.

4.3.4 Take Two in rural and regional areas

The five rural/regional teams were established according to the tender specifications, with teams of three. Questions were raised in some staff journals and in management meeting documentation about how to support these small teams, particularly as two teams were split across two locations within the region (Loddon-Mallee and Hume). Three specific concerns were:

- Where to see clients: Rural teams cover a wide geographic area and it is not always feasible for clients to attend an office site or for clinicians to travel to the client;
- The small size of teams: This impacts on the capacity to receive referrals; potential isolation in small teams; and also on the supervisory support available to members of the team when not co-located; and
- Travel: The requirement to travel long distances restricts the capacity to take referrals, reduces the time available to see clients and may also place stress on the clinicians required to service the areas for which they were responsible.

The vignette on the following page highlights the geographical pressures that complicate the clinicians’ capacity to meet the complex needs of Take Two clients in rural Victoria.
Jen

Jen is a sixteen-year-old young woman living in a residential unit in a rural town. She continually stated that she wanted to be dead, had made numerous suicide attempts, and regularly self-harmed. She has a complex history of neglect, multiple traumas, abuse and multiple placements, and was regarded by all as being at high risk of killing herself.

Jen’s Take Two clinician is based two hours drive away from her placement. The therapeutic intervention plan involves her Take Two clinician seeing her twice a week wherever she is based. At times Jen has respite care in Melbourne. At other times she is in Secure Welfare, or in an in-patient adolescent mental health unit in Melbourne.

4.3.5 Referral process to Take Two

A core component of Take Two is the decision-making process regarding referrals. One of the requisites in the original DHS submission brief was ensuring that the program was accessible to Child Protection clients and that Child Protection was actively involved in this decision-making process. An unusual aspect of the Take Two referral process is that it does not hold its own gatekeeping and intake functions. The decision-making process regarding whether or not a referral proceeds to Take Two is made by the regional Child Protection Managers, in consultation with Take Two. Referrals can be initiated by either Child Protection or CSO case managers, but all need to be processed by the regional Child Protection Manager. There are therefore additional elements to the referral process, especially the need to ensure sufficient and accurate information is provided at the time of referral to enable effective decision-making.

The Take Two Referral Tool consists of two parts: the first is the Harm Consequences Assessment (HCA) and the second is the Referral Guide. The HCA was based on the Children and Young Persons Act, 1989 and the Victorian Risk Framework (DHS, 1999a). Referrals to Secure Welfare Take Two do not require the Referral Guide. A Child Protection document called the Client Profile Document (CPD) is also required which provides information regarding the child’s involvement with Child Protection and out of home care services.

The original goals for this Referral Tool and process were as follows:

• To provide information to the Child Protection Manager regarding screening for children who need therapy and then separately to enable the Child Protection Manager and Take Two Senior Clinician to prioritise across cases; and

All of these placements required at least three hours driving time for the Take Two clinician. The driving required takes many hours of the clinician’s time (8 to 12 hours per week) to achieve these two hours of face to face contact each week.

The care team of key workers found Jen’s management extremely difficult, and it is noted that workers were significantly affected by her behaviour. However, due to the distances involved, numerous care team discussions were limited to the phone.

Despite these challenges of distance, both Jen and the care team became very engaged with the Take Two clinician and were very positive of the changes for Jen that reflected a stronger sense of self and personal safety.

• To provide information to Take Two regarding the referral.

The Child Protection Manager usually meets with the Take Two Senior Clinician, either on a regular or ad hoc basis, to discuss the referrals. If the decision is for a case not to proceed then alternatives are discussed including secondary consultation. If there is not agreement then the final decision regarding the priority of the referral rests with Child Protection, while Take Two determines capacity.

Specific comments and suggestions regarding the structure of the Take Two Referral Tool and the details of the referral process were detailed in a report submitted to DHS in March 2005. This section summarises more general comments regarding the referral process, particularly as it relates to the relationship between DHS, CSOs and Take Two.

Each Child Protection region has developed the referral process to fit their internal and geographic structures. There was variation across the regions (and within some regions) regarding how actively CSOs were involved in the referral process. According to the Child Protection Managers and Take Two Senior Clinicians the majority of the decisions regarding referrals were made by agreement. Some decisions required further discussion and more information. There were a small number of cases where it appeared that Child Protection made a unilateral decision for the case to be prioritised and proceed to Take Two. A number of Child Protection Managers commented on how important it was that the decision-making point for referrals was with Child Protection and Take Two.

There was general agreement that all substantiated Child Protection clients probably would benefit from some sort of therapy at some time. The dilemma was not which children needed therapy, but which children were most appropriately referred to Take Two. Many Child Protection Managers stated that Take Two was seeing the appropriate client group. Some spoke of
aiming for a particular balance, such as not referring all adolescents, or all long-term cases. Others spoke of wanting to use Take Two for specific groups, such as young adolescent males or children in residential care. A couple of regions acknowledged the important work that could be done in referring young children to Take Two, whereas other regions appeared unaware that Take Two could work directly with infants. Some regions noted that they had not made referrals regarding younger children as the priorities were in relation to older children and adolescents.

In the survey responses from CPAG and RAG members, there was satisfaction with respect to the nature of cases selected for Take Two.

‘Nobody would be 100% satisfied with the cases selected, but the very best effort is going into selection and analysing the balance.’
(CPAG member)

One respondent from a RAG commented that there was insufficiently clear communication regarding the selection of cases.

There was general consensus from both Child Protection and CSOs that the Referral Tool took considerable time to complete. This was also raised in a couple of the survey responses from CPAG and RAG members. However, there were few suggestions of what to delete. As a result of the review and an audit of the referral documents, changes have been made and are in the process of being implemented.

A common complaint regarding the referral process was that Child Protection and CSO workers were not always informed of the decision to accept the referral. Where this was raised, Child Protection Managers generally accepted this as an internal DHS difficulty that they would take action to amend.

There was a perception among most CSOs who responded to the evaluation that Take Two was difficult to access; that the referral process was slow; and they were not sufficiently involved in the process. One CSO worker did comment, however, that Child Protection had consistently liaised with them throughout the referral process. There was acknowledgement by Child Protection that other agencies were not always as actively involved as they could be in the referral process, including Aboriginal services. Both Child Protection and CSO staff stated some limitations in knowledge of the referral processes. For example, despite Take Two sending the Referral Tool to every CSO with contracted case management in the state, a number of CSO workers stated they had not received it. Some Child Protection and CSO workers did not realise that CSO workers could initiate referrals. The most consistent comment from CSOs was their wish to refer directly to Take Two. A couple of Child Protection regions noted some referrals were initiated by CSOs.

Although there were concerns regarding the referral process, there were also some positive comments from Child Protection workers, Team Leaders and Unit Managers regarding the referral process.

- ‘The completed Tool was a key document on the Child Protection file that reflected the child’s overall experience rather than just the current episode of Child Protection involvement.’
- ‘I have to do it, but it was not as overwhelming as it looked.’
- ‘Did not want to complete the Tool but once it was on file it is invaluable and helps when transferring the case within DHS.’
- ‘All the information required in the Tool is necessary. There is no dead wood.’
- ‘The Referral Tool made me read the client’s file.’
- ‘The Referral Tool and process forced us to be more creative. It took more time than we wished but was worth it.’
- ‘The Referral Tool has helped workers’ practice.’
- ‘The Referral Tool led to the worker thinking differently about the child’s experience and the consequences of abuse.’

Comments from CSOs included:

- ‘…the referral process was very time consuming but felt the tools were useful in providing very thorough background of the child, particularly the harm consequence document.’
- ‘Case Managers currently feel that the Take Two Program is receiving the most appropriate referrals according to the eligibility criteria.’

Some Child Protection Managers and staff stated there was a need for further training regarding the referral process, the program and issues related to trauma and attachment especially for senior and middle management. The incorporation of the Take Two referral process to Child Protection’s Orientation Program – Beginning Practice was welcomed. There were some comments by both Child Protection and CSOs regarding training to the community sector. It was acknowledged that not every Child Protection region had invited CSOs to the initial referral training.

There was some variation as to whether Child Protection considered it important or counter-productive to inform the young person and the family of the referral to Take Two prior to knowing whether or not the referral was going to proceed. On the whole, most Child Protection Managers considered it better practice to inform the young person and family but were not sure if this always occurred.

4.3.6 The Take Two Practice Framework

One of the requirements in the DHS submission brief was for Take Two to develop a detailed ‘Framework for Service Delivery’ to underpin therapeutic interventions. Key elements of this framework were expected to be delivered in the following way:
• To be based on best practice and supported by an evidence base;
• To provide varying degrees of intensity depending on client need and in consultation with Child Protection;
• To be client centred and tailored to the child’s needs;
• To be developmentally and age appropriate;
• To involve assertive outreach and persistence with resistant and involuntary clients;
• To acknowledge the historical and current trauma within the Aboriginal community and to be thus culturally informed;
• To be appropriate for culturally and linguistically diverse communities;
• To be consistent with the Children and Young Persons Act, 1989 case planning principles;
• To be flexible across regional boundaries, services and programs to ensure continuity despite the child’s location and situation, including whether or not they are in a stable placement;
• To support smooth transition to other services as required; and
• To enhance existing partnerships between Child Protection and other service providers and stakeholders.

The Take Two Leadership Group drafted the initial Practice Framework in a process facilitated by the Take Two Training Manager, which was further refined following consultation with clinical staff, the Partnership Management Group and representatives from CPAG. The final version of this stage of the Practice Framework was completed in February 2004 (Downey, 2004).

Phillip

Phillip is a four-year-old boy referred to a regional Take Two team. Child Protection were involved intermittently during Phillip’s early childhood due to concerns of environmental neglect and his mother’s transience. When he was two years old Phillip’s mother placed him and his younger sister in the care of her sister. When Phillip was three years old, Child Protection became involved when Phillip was taken to hospital by ambulance having ingested his aunt’s medication. There was a query whether this was intentionally given to Phillip by his aunt. He was acutely ill and was in coma for five days. He was then placed in foster care. That placement broke down within a number of days and he was placed with a second foster care family. Again the placement broke down within days.

The first foster carers described Phillip as aggressive and stated that he scared the other children in their care and was completely unsocialised – for instance he had no knowledge of how to sit or eat. The second foster carers described him similarly and said it was ‘as if he had been let out of a cage’. Phillip was then placed in a residential unit, and has been there for approximately one year.

Phillip’s younger sister was removed from their aunt’s care at the same time as Phillip, and is still in placement with the first foster care family. Child Protection made the referral to Take Two, due to concerns about Phillip’s challenging behaviours such as his high distractability and not accepting any limits. Phillip experienced some language and developmental delay, apparently due to deprivation and the lack of stimulation of age appropriate activities.

He was small in height and weight for his years. He also experienced post-traumatic symptoms of hyper-vigilance, wetting, inability to go to sleep (taking up to 2 hours to go to sleep) and recent re-enactment of traumatic incidents in his play. Clinically, the starting point for this case was to do an assessment that included the whole family and system. Phillip’s aunt has refused to meet with workers. Take Two have interviewed residential unit staff, previous foster carers and Phillip’s parents.

An eco-map and social network map were completed as part of the assessment. These tools revealed that almost all of those involved in Phillip’s life are professionals. Apart from his immediate family he had no informal support networks; no contact with extended family or friends.

The use of outreach and flexibility in settings for intervention was important for Phillip. For the first session with Phillip, the Take Two clinician went to the residential unit. Phillip readily and proactively engaged with the clinician. During this session he re-enacted some of his past traumatic experiences. He is now being seen in the play therapy room at the Take Two office to see how he explores a more contained environment.

Those involved in the child’s life may also have past and present traumatic experiences of their own and may require treatment, or referral to other services. In this case Phillip’s mother has had her own traumatic childhood, as she was physically abused as a child and had multiple placements. She had no contact with her father, her mother had multiple numerous partners and she was sexually abused by one of her mother’s partners. Given this knowledge, Take Two also needs to consider how to best assist Phillip’s mother to understand her past so it does not intrude on Phillip’s future.
The Practice Framework outlined the theoretical context for understanding the children’s presentation based on trauma and attachment theories from a developmental and ecological-systems perspective. It described the range of interventions considered appropriate for this client group and for the broader system without detailing when particular interventions would be more or less appropriate.

This was the first stage of the Practice Framework, in what would be a longer term process of gathering knowledge and experience, literature reviews and action research. At the end of 2004 Take Two employed two consultants (Associate Professor Martin Ryan and Sue Jones) to interview Take Two staff as part of the process in assisting the Training Manager in developing the second stage of the Practice Framework.

The vignette on page 28 about Phillip illustrates the high level of complexity of client, family and service system issues addressed in the Take Two Practice Framework and the importance of a sustainable approach from clinicians and teams.

4.3.7 Aboriginal Senior Clinician

The Aboriginal Senior Clinician position was developed as part of Take Two’s endeavour to work towards program cultural competence. The initial report from the Aboriginal Reference Group noted that all contact with Aboriginal communities, organisations and clients will incorporate ‘an implicit acknowledgement of the profound and enduring impact of colonisation in the lives of indigenous peoples’.

The Aboriginal Senior Clinician position changed in level and title throughout the year. In addition to providing consultation to Take Two staff and co-working directly with a number of Aboriginal clients, the core tasks for this position were implemented in three stages throughout 2004.

- Providing cultural sensitivity and awareness - building sessions for all Take Two staff, including management.
- Visiting Indigenous services across the state and beginning to scope what was required in terms of ongoing liaison and relationship development.
- Implementing changes to the position, the reference group and the establishment of an additional Aboriginal clinical position.

4.3.8 Secure Welfare – Take Two

The Secure Welfare Senior Clinician position was a requirement in the initial DHS tender specifications. This position is located within the Western Take Two team and spends approximately two days a week in each of the Secure Welfare units; that is an average of four days a week.

In conducting brief therapeutic assessments, the Secure Welfare Senior Clinician usually met the young person once or twice and spoke with their case manager, Secure Welfare staff and occasionally others such as CAMHS workers, schools, placement providers and parents. Due to the brevity of the admissions, the form of assessment and intervention was equally brief and targeted to specific questions by the referrer.

The Secure Welfare Senior Clinician also undertook secondary and primary consultation and support to DHS staff of Secure Welfare and Child Protection, and CSO case managers through discussions and attendance at meetings as requested.

In the feedback processes for this evaluation, most Child Protection Managers and CSOs did not comment on the Take Two role in Secure Welfare. Those who did comment stated it was a valuable service that was well regarded in the region. Two Child Protection Managers queried some aspects of this role, such as the paperwork required in the referral and greater clarity regarding the referral process. The following is a quote from a CSO regarding the value of the Secure Welfare Take Two role.

‘By far the greatest interaction with Take Two is through Secure Welfare. I have found the work of Take Two at SWS to be invaluable in not only providing an assessment, but practical measures that can be employed by Case Management and carers to assist the young person.’

4.3.9 Networks and relationships with Child Protection and other services

A key expectation of the intensive therapeutic service was that it would form linkages with other services such as Child Protection, CSOs, CAMHS, drug and alcohol services, schools and other related services. The task for Take Two in establishing collaborative relationships with other services is a critical element in the implementation. This theme was frequently reflected in the review of the internal Take Two documents.

The RAGs were a key platform for such networking, but were never envisaged to be sufficient on their own to achieve this function. In the earlier establishment phases Take Two spent considerable time in meeting other services and beginning what was hoped would be ongoing conversations regarding roles and relationships.

There were comments in the staff journals regarding visits to other services in the child welfare and mental health service systems and the importance of building professional relationships. Particular mention was made of the importance of an effective working relationship with Child Protection, CSOs and CAMHS services.

A collaborative working relationship with Child Protection was not only essential in terms of the referral processes but also as Child Protection workers were the case managers for the majority of
the Take Two clients. Their roles were seen as pivotal in enabling effective intervention. Similarly, for those cases where the CSO was the case manager or when the child was placed within the care of a CSO, this was an important working relationship. The concept of ‘care teams’ became increasingly used throughout this first year, which actively enlisted Child Protection, CSOs, schools and other relevant services in collectively thinking about the therapeutic context for the child.

4.3.10 Take Two, CAMHS and Child Protection

The interface between Take Two and CAMHS was acknowledged at the outset as critical. The interface between Child Protection, CAMHS and Take Two was a theme which arose in feedback from seven of the nine Child Protection regions, from a couple of CSOs and from surveys by CPAG and RAG members. In the DHS submission brief one of the requirements of the intensive therapeutic services is to…

‘Deliver services in a way that maintains and supports links to mainstream services including but not limited to Child and Adolescent Mental Health Services.’

Despite this expectation that Take Two could strengthen children’s capacity to work with CAMHS, there appears to be confusion within the field as to whether or not Take Two should be an alternative to CAMHS. The introduction of Take Two and the need to prioritise referrals required the articulation of a rationale for why some children would be referred to CAMHS, others to Take Two and some to both. In some regions the introduction of Take Two was considered to create an opportunity for Child Protection and CAMHS to redefine and clarify their working relationships. Two Child Protection Managers stated they had attempted or were planning to involve CAMHS in their process of determining referral priorities to Take Two, but that this had not been practical. There were specific references made in a couple of regions to Take Two’s role in providing a bridge in terms of knowledge and already established working relationships, especially when the Take Two staff had previously worked in CAMHS.

‘Senior Clinician’s role as a go-between re CAMHS and T2 and DHS – has been a massive help.’

(Child Protection Manager)

There were differing views as to whether the Take Two–CAMHS interface should be determined centrally, such as via CPAG or DHS–central office, or whether local differences required local solutions. A couple of Child Protection Managers noted that the difficulties between Child Protection and CAMHS were longstanding and complex. One commented that it was unreasonable to expect Take Two or any one program to solve these problems but appreciated Take Two’s input. Another noted that CAMHS saw many Child Protection clients but recommended outreach services or long-term therapy, which CAMHS may or may not provide. Take Two was seen as a program that could provide both of these elements of service provision. A Child Protection Manager stated that as a result of Take Two, the local CAMHS service was accepting more Child Protection cases. Another Child Protection Manager and a couple of CSOs stated that it was unclear whether to refer to Take Two or CAMHS.

The relationship between CAMHS and Take Two was a concern for a couple of respondents from the survey to RAG members. This concern addressed disagreement with the concept of Take Two and a desire for Take Two to have been established as part of CAMHS.

CPAG members recognised that the boundaries between Take Two and CAMHS required specific attention and a working group was established between Take Two, CAMHS and DHS to explore this interface.

 ‘The interface with other therapeutic services (such as CAMHS) requires a lot of development work.’

(CPAG member)

4.3.11 Training and development

The training and development functions of the Take Two program are closely associated with both the clinical and the research and evaluation components. Take Two is required to ensure that the staff are informed and skilled in evidence-based practice, as well as to provide training to staff within the broader service systems within which it is embedded, namely Child Protection, child welfare and mental health workers.

The Take Two training strategy is supervised and supported by mindful. (centre for education and research in developmental health). It provides the majority of higher education courses for practitioners of child and adolescent mental health, as well as a series of monthly seminars and other short courses. ‘mindful’ is supported and auspiced by the Victorian Mental Health Branch, University of Melbourne and Monash University.

The Take Two Training Manager is located at mindful and is supported by the Director of mindful. This enables Take Two to draw upon mindful’s resources and well-established links, especially in relation to child and adolescent mental health. There is a Take Two Training Advisory Committee involving mindful, Take Two, the BSV Training Manager and the Manager of the DHS Child Protection and Juvenile Justice Professional Development Unit.

It was decided that the primary focus of the Take Two training strategy in the first year of operation should be on developing skills and competencies within the program. This was firstly in order to contribute to the program’s overall primary objective of providing a high quality direct service; and secondly, in order to establish credibility before providing extensive external training. The other priority for training in the first year was the training of Child Protection and CSOs regarding the referral process and providing an overview regarding trauma and attachment theory.
The Take Two Training Strategy for 2004 had five main components:

1. Orientation and initial training and development for the newly recruited Take Two staff.
2. The development of the Take Two Practice Framework that would guide the program's clinical practice.
3. The development of the ongoing training and development strategy for Take Two staff.
5. The development of the training strategy for other services in relation to trauma, attachment and other knowledge areas relevant to the Take Two client group.

A number of platforms were used to implement this strategy. In relation to the training needs within Take Two they included:

- The orientation plan for all Take Two staff beginning with a one-week orientation week in November 2003.
- A monthly all-day meeting with all Take Two staff (called the Friday Focus).
- Training Needs Analysis undertaken in relation to all Take Two staff.
- The use of BSV’s already established policies and procedures in relation to supervision and professional development.
- Specifically designed training to meet the core competencies required in the Practice Framework, such as family therapy training.
- Ensuring that Take Two staff with no previous formal training in child and adolescent mental health enrolled in either the DPC or the Graduate Diploma in Child and Adolescent Mental Health.

In relation to the training strategy for other services the main platforms included:

- The provision of training across the state to Child Protection and CSOs about the referral process and trauma and attachment theory.
- Collaboration with the DHS Child Protection and Juvenile Justice Professional Development Unit in providing four series of two-day training regarding trauma and attachment to Child Protection and Juvenile Justice staff.
- Collaboration with DHS to incorporate aspects of these sessions into the Beginning Practice Orientation program for new Child Protection workers.
- The coordination and planning of the monthly training provided to CAMHS and other interested workers held at mindful and via video-link throughout the state (called the Friday Forums).
- Presentation at conferences, workshops and local forums.
- Provision of training for specific services and networks upon request.

In relation to the training for Child Protection and CSOs regarding the referral process and trauma and attachment theory, 30 sessions were run throughout the state over a five-month period for approximately 400 to 450 workers. As seen in Table 4 approximately 22% of participants were from CSOs, with the majority being from Child Protection. These figures of participation are an underestimate of the attendance, as not all sessions had attendance sheets and not all participants completed feedback questionnaires.

<table>
<thead>
<tr>
<th>Child Protection region</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon South West</td>
<td>29</td>
</tr>
<tr>
<td>Eastern</td>
<td>36</td>
</tr>
<tr>
<td>Hume</td>
<td>38</td>
</tr>
<tr>
<td>Gippsland</td>
<td>48</td>
</tr>
<tr>
<td>Grampians</td>
<td>35</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>30</td>
</tr>
<tr>
<td>Northern</td>
<td>78</td>
</tr>
<tr>
<td>Southern</td>
<td>65</td>
</tr>
<tr>
<td>Western</td>
<td>35</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>394</strong></td>
</tr>
</tbody>
</table>

In relation to feedback from 304 participants 90% found the training ‘definitely’ or ‘mostly useful and relevant’ and 89% reported the training as ‘well’ or ‘very well presented’. In terms of the qualitative feedback from these sessions, the general response was positive regarding the combination of referral process training and an overview of the Take Two theoretical framework on trauma and attachment. There were some comments regarding the amount of content being too much, while others commented that it was a terrific use of time and they wanted more. Examples of comments which typified the variety of feedback are as follows:

- ‘Very interesting. [I] started re-thinking trauma and attachment and the importance of [the] past rather than just focusing on present day to day.’
- ‘[A] fantastic program – easiest referral tool ever.’
- ‘Thank you I really appreciate the combination of theory and practice, gives me great hopes.’
- ‘[It] wasted too much time on theory at start. Not enough time on referring & forms.’
- ‘Heaps of info. But there was no other way, well done.’

Frederico, Jackson & Black (2005) Reflections on Complexity – Take Two First Evaluation Summary Report, La Trobe University, Bundoora, Australia
The presentation was easy to understand and impressive. It will fill a huge gap in services.

‘We do not need to know T2’s inner workings. People have limited ability to digest complex learning. Build in more breaks.’

Although there were few comments made by CPAG members regarding the training, those who did comment noted satisfaction including that it was appreciated in the rural areas.

‘Training has been well received and seen to be of a high standard.’ (CPAG member)

Similarly, most RAG respondents did not comment on training, though those who did stated they had heard good feedback. One respondent felt the training of Take Two had contributed to the blurring of functions of CAMHS and Take Two, although it had been generally useful. One respondent was not aware of any training having been offered in her region. Another commented that they were satisfied with the initial liaison and training of their staff.

4.3.12 Research and evaluation strategy

The research and evaluation strategy for Take Two has been designed by La Trobe University as two integrated components, knowledge development and evaluation. The research and evaluation plan utilises an action research design, drawing on qualitative and quantitative methodologies. Action research is chosen because of its developmental emphasis, its ability to respond to new learning and its suitability to the aims of Take Two. Furthermore, it provides an appropriate framework to address the complex Take Two service delivery environment. Opportunity for stakeholders and others to scrutinise and respond to emerging data is seen as critical to development and gaining of insights throughout the process of implementation. Take Two is seeking to effectively intervene with children at risk and it is important that current knowledge on what works and the knowledge developed in implementing the program is acted upon in a timely fashion.

An action research design delivers findings that are sensitive to place, cultural differences and Aboriginal issues. The use of a mix of data collection strategies can ensure stakeholders have the chance to input data in a meaningful manner. The ability to have data sensitive to place also means that static factors (unchangeable factors) can be separated from dynamic factors (changeable factors) that are the focus of Take Two.

The research and evaluation strategy focuses upon macro and micro issues. The micro level focuses on internally generated questions from practice and identifies what works in the Take Two therapeutic intervention. The macro issues relate to the service system including the identification of barriers and gaps, service linkages and coordination that constitute good practice and policy questions.

This research and evaluation strategy has a three-year cycle, where it is envisaged that each three-year period will build on the period before it. The specific research and evaluation questions have been informed by the draft service deliverables identified in the DHS submission brief, by the program itself and by key stakeholders. Additional principles relating to the research and evaluation strategy include:

- It will be in accordance with the ethical requirements of La Trobe University, BSV and DHS.
- In relation to Aboriginal children and their community, research will be in accordance with the principles as outlined in the National Health and Medical Research Council’s (2003) Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research.
- Take Two clinical staff will incorporate action research into their clinical practice, and as such a research role is a core element of an effective clinical role.

To achieve the objectives of the research the following structures have been developed specifically or otherwise utilised:

- Take Two research team.
- Executive Research Committee that includes the principal consultant and other La Trobe University staff.
- Take Two Research Advisory Committee (T2RAC) includes key researchers in the child protection, mental health and research design fields.
- Take Two Outcomes Working Group: an internal Take Two group focused on developing the outcomes framework.
- Take Two Aboriginal Reference Group, which includes in its terms of reference to assist the strategy to be culturally appropriate for Aboriginal children and the community.
- Take Two Secure Welfare Research Working Group including DHS, La Trobe and Take Two.

In 2003 and early 2004 the emphasis was in finalising the research and evaluation strategy in consultation with DHS and other stakeholders. This strategy included:

- Establishing the process of staff journals.
- Developing, piloting and implementing the Referral Tool and referral process. This process was led by Professor Shane Thomas (La Trobe University Faculty of Health Sciences) in consultation with DHS.
- Piloting the Referral Tool in December 2003 throughout most of the state and making subsequent changes.
- Reviewing the Referral Tool and process with all Child Protection Managers and some Child Protection staff and CSOs.
• Selecting the BSV – Take Two – Robin Clark PhD Scholarship candidate: Robyn Miller.

• The monthly collection and analysis of client data, primarily for operational and accountability purposes for Take Two management and DHS–central office, but also with a research and evaluation purpose.

CPAG members made minimal comments regarding the evaluation and research design, though those who did generally showed satisfaction. One respondent commented that they would like to see more about system change variables in the methodology and another commented upon the importance of involving consumers in the process and was dissatisfied that this had not occurred. Similar sentiments were recorded in CPAG minutes. There was no feedback from RAG members regarding the research and evaluation design.

A major task of the research team in 2004 was the development of the Take Two Outcomes Framework. A report on this framework was finalised in October 2004. A fundamental dilemma in developing such an outcomes framework is ‘what is considered to be success?’

‘As the Take Two client group are children who have been subjected to severe abuse and/or neglect and may still be experiencing some primary or secondary trauma; definitions of success need to be consistent with their development, their experience of trauma and their ongoing situation. A definition of a successful outcome of treatment cannot be ‘as if the abuse never occurred’.’ (Frederico, 2004, 10)

Safety, attachment, recovery from trauma and enhanced development, health and wellbeing are the aims of the Take Two program and as such are likely clinical outcomes in individual cases. A broader conceptual framework for this client group was adapted from the Toronto Child Welfare Outcome Indicator Matrix (Trocme, Fallon, Nutter, MacLaurin & Thompson, 1999). Diagram 5 shows the adapted version of this outcomes framework for Take Two.

The Outcomes Working Group planned and trained all Take Two staff on outcome measures relating to the framework: the Strengths and Difficulties Questionnaire (SDQ – Goodman, 1999), the Trauma Symptom Checklist for Children (Briere, 1996b) and Social Network Mapping (Tracy & Whittaker, 1990). Other measures of the evaluation will be Goal Attainment Scaling (Kiresuk & Sherman, 1968) and stakeholder’s feedback but these were not operationalised in 2004.

4.4 Feedback on the Implementation of Take Two

4.4.1 Feedback from Take Two staff

A benefit of the staff journal methodology is that it provided staff an opportunity to record their reflections contemporaneously during the establishment of this new program. They commented on joining an organisation such as BSV, including the welcome, the organisational values, the systems in place or being developed and the change management process within BSV as a result of implementing such a large new program. There was anticipation of many elements of the program ranging from awaiting the template of the assessment report through to seeing their first client. There were concerns regarding the administrative requirements, the travel involved and the complexities in establishing key relationships in some regions.

There was realisation by Take Two staff that they were defining what the program was, which led to both anxiety and excitement.

Diagram 5: Take Two outcomes framework

<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>CHILD OUTCOME DESCRIPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Safety</strong></td>
<td>Reduction of harm related to child’s behaviour. Promotion of child’s safety.</td>
</tr>
<tr>
<td><strong>Child Well-Being</strong></td>
<td>Recovering from trauma. Reduction of behavioural and/or emotional symptoms. Improved cognitive and/or language development. Improved school attendance and/or performance. Enhanced emotional, behavioural, social and/or physical wellbeing and/or functioning.</td>
</tr>
<tr>
<td><strong>Stability/Security/Connectedness</strong></td>
<td>Strengthening attachments and forming quality relationships. Strengthening child’s identity, sense of belonging and/or connectedness. Promoting and contributing to an appropriate, stable and secure placement.</td>
</tr>
<tr>
<td><strong>Family &amp; Community Support</strong></td>
<td>Strengthening quantity and/or quality of informal and/or formal social networks. Strengthening parents’, other family members’ and/or carers’ capacity to meet child’s emotional and other needs.</td>
</tr>
<tr>
<td><strong>Specific Goal Attainment</strong></td>
<td>The goals as specified by the child and/or significant others have been achieved. The goals as specified by the Take Two clinician have been achieved.</td>
</tr>
</tbody>
</table>
4.4.2 Feedback from Child Protection and CSOs

In addition to the feedback already described, the consistent response from all nine Child Protection regions was very positive in relation to the Take Two program. There was a high degree of consensus that Take Two was making a substantial and worthwhile difference to the children with whom it was involved. Take Two was described as a new service which was adding value to the regions and was working with a client group literally crying out for therapy. Following are examples of comments from each of the Child Protection regions reflecting the positive regard for the program:

‘Workers identify the program as very helpful to both themselves and clients, good input, consultation, attending case plan meetings, very supportive.’

‘T2 has a ‘yes can do’ policy. I hear good things in terms of quality of the work.’

‘Very happy with the program – would like it to double… This is the only therapeutic program that Child Protection has exclusive access to.’

‘We’re happy with the program… we want more of T2.’

‘I’m quite convinced that some of the clients are getting a good service in terms of better prognosis — which they would not otherwise have had. It provides a catchment “a net” that was not otherwise there. At least with Take Two they still take the referrals and you “see the fruit down the track”!’

‘One kid loves Take Two so much he wants to go to see his therapist.’

‘Impressed with work of the Take Two team … Take Two has actually hung in and been consistent and constant — very impressive.’

‘Being able to see the therapist at the drop of a hat has been valuable.’

‘Take Two is the reason why one young person is still alive.’

A common concern raised by the Child Protection regions was the lack of clarity regarding the sharing of information between the two services; informed consent; and what was legally and ethically possible without such consent.

Some regions commented on the system work undertaken by Take Two. While one Child Protection Manager queried the process that Take Two used, of assigning a specific worker to focus on system issues for a client, the same manager commented very favourably on the outcome of that system work. Another Child Protection Manager emphasised the importance of the secondary consultation work with some of the residential units. There was commendation for the contribution Take Two had made to local service planning regarding out of home care. Four regions noted that they were directly benefiting from consultations with Take Two and would welcome increased access to that function.

The CSOs who provided feedback focused almost solely on the referral process as this was the specific feedback asked of them. However, there were a couple of general comments made about the program.

‘The work that Take Two have done with the two … placements has been extremely positive. I have had a good working relationship with the practitioner and the children have actually enjoyed their time working with them. More practitioners to allow more children to be treated would be of major benefit.’

‘Take Two have an excellent theoretical framework as they not only incorporate developmental theory but also work within a holistic approach. Conducting outreach within the school, placement and family setting is a progressive way of engaging young people, children and their families.’

There were comments made about changes needed within Child Protection to assist implementation of Take Two, such as Child Protection workers being better informed regarding therapeutic issues and the need for earlier intervention for children in distress. There was generally a sense of shared achievement in the implementation of Take Two, with a ‘slow but surely’ theme from a couple of the regions.

4.4.3 Feedback from Clinical and Program, Advisory Group (CPAG) members

In general CPAG respondents expressed satisfaction with the establishment, the initial service model and the strategic directions of the Take Two service.

‘I thought the establishment phase was outstandingly fast and efficient.’

‘The development work for Take Two was done in a very thorough, consultative and diligent manner.’

Comments of respondents included strong endorsement of the goals of Take Two and recognition of the gap in services being filled by Take Two.

‘Outreach mental health services are needed for kids and Take Two should be commended for this service; I would like to see the service system development function extended still further, but it is off to a very promising start; Take Two has already gained a reputation for excellent implementation.’

— January 2004

The Western Metropolitan Region and the Northern Metropolitan Region were counted as two separate regions for this evaluation, due to the different structures in place as they relate to Take Two, including referral processes. Child Protection Managers and staff from these two regions were interviewed separately. These regions had recently amalgamated.
Comments reflected a strong satisfaction with Take Two alongside recognition of a strong demand for the services of Take Two. There was agreement that Take Two provided a quality service.

‘The service is of very high quality. Unfortunately some kids who need the service are not receiving the assistance – may reflect guidelines or the capacity may be stretched.’

In reflecting upon the ongoing operation of the clinical program respondents were satisfied with Take Two’s contribution to the service system.

‘Impact on the service system is beginning and is very welcome. This area will grow over time.’

All seven respondents stated that Take Two was meeting their expectations. Comments included:

‘Has been a long time in coming, is meeting my expectations…’

‘It is still early days but I think we have made an excellent start.’

‘It is difficult to comment…but I am satisfied that senior staff are progressing well with the setting up of the framework for the service.’

‘Yes, excellent staff from an impressive range of backgrounds, well established around the state, and in the process of developing working relationships within the regions.’

‘Congratulations to Take Two for the creation of a fine service.’

Some expectations were not fully met. These were in relation to the lack of participation of clients in the planning and implementation of the program and the length of the assessment process which one respondent felt was too long.

Lessons learnt were a reflection of some of the issues which had also been discussed in the CPAG meetings. Engagement with some DHS regions was slow in developing and this was a concern at CPAG. There was recognition of the need for a more in-depth exploration of the interface with mental health services. The difficulties of responding to early intervention on a systemic level when there are urgent ‘end of the line’ clinical needs were raised.

Respondents were also asked to give suggestions for the ongoing operation of the Take Two program. Responses included a desire for forums where there is an opportunity to look at systems issues within regions in addition to client focused forums; a need for greater support from the Mental Health Division (DHS) and recognition that ongoing work with
CAMHS is imperative; regular participation of young people in the program and the importance of the quality of staff in establishing credibility of the service.

4.4.4 Feedback from Regional Advisory Group, (RAG) members

The quantitative results from RAG members are inappropriate to present given the low return and as such the results reported here utilise the qualitative comments.

With regard to the degree of satisfaction with the establishment period of Take Two there were no clear themes arising from the qualitative responses. There was support for the establishment of the Take Two Aboriginal team and Take Two Secure Welfare team, both of which were identified as important and welcomed initiatives.

There was concern for the capacity of Take Two to meet the demand for the service, such as in rural regions and the capacity of the service system to be able to utilise Take Two services, such as by organisations other than Child Protection. Other comments included an expectation that Take Two would have a greater capacity to respond to need, and yet another response that the Take Two interface with Child Protection dominated and therefore the service was distant from CSOs.

In terms of identifying lessons learnt comments included: the need for more rural services and a suggestion that a rural/metro formula for resources does not work; the length of time of the referral acceptance procedure being too long and the consequence being delayed service to clients; continuing dissatisfaction in the relationship between CAMHS and Take Two; the importance of networking early with local CSOs; and the importance of communication at all levels.

One respondent felt that the evaluation and the questionnaire was a positive step in communication and that Take Two had enormous potential; however:

‘...greater connection and communication, liaising and networking is required and building upon local initiatives.’

4.5 Summary of the Implementation of the Take Two Program

The Take Two program is continually evolving. The description and analysis of the program highlight a structure to support the implementation and ongoing development of a strong program. Within one year, Take Two was established across the state in relation to its clinical work, training and research functions.
Chapter 5: Take Two
Client Group – 2004

Is Take Two working with the intended client group?
What are the characteristics of the Take Two client group and the issues confronting them?
What are the characteristics of the children’s families?

5.1 Overview
This chapter provides a description of the 320 children who were clients of Take Two in 2004. It includes a portrayal of the children’s involvement with Child Protection, their family context, placement experience, and their experiences of and the consequences of abuse and other traumatic events.

According to the DHS submission brief, the target group for Take Two was 710 children who have experienced substantiated maltreatment and who are either showing emotional and behavioural symptoms or at risk of showing these difficulties as a result of the abuse or neglect.

5.2 Numbers of clients and other practice expectations of Take Two

5.2.1 Number of clients
The requirement for Take Two to work with 710 children per year was not achieved in its first year of operation. The 320 clients involved directly with Take Two in 2004 consisted of 233 regional clients and 87 Secure Welfare clients. There are a number of factors which combined to impact on the ability of the service to meet the required client numbers including:

• The first year of establishing a new program involves inevitable inefficiencies as the program established its personnel, systems, practices and expectations, such as the assessment process, location of some of the teams and relationships with local services;
• The development and implementation of a referral process to ensure appropriate clients were referred, including variation of this implementation across different regions;
• The need to educate Child Protection and CSOs about the referral process;
• The small number of closed cases in this first year; and
• The high degree of complexity of the client group, with minimal early intervention referrals or referrals for brief intervention.

5.2.2 Repeated referrals to Take Two
Take Two was required to have 15% or less of Take Two clients who were re-referred to the program. This target was achieved for 2004. In relation to the 21 cases who had more than one involvement with Take Two, all except one had at least one of these episodes whilst in Secure Welfare. Eighteen children were re-referred to Take Two on one occasion and three children were re-referred to Take Two on two occasions. This resulted in a re-referral rate to the Take Two program of 7.5% for the year 2004. When Secure Welfare cases are not included in this analysis, less than 0.1% of the cases were re-referred to Take Two during 2004.

5.2.3 Consultations provided by Take Two
Although there was no specified target of number of consultations to be provided by Take Two, there was an expectation in most regions for such consultations to occur. The data collected regarding consultations was not formalised but was gathered from the Take Two time record sheets relating to client-based worker activity. From this analysis it is estimated that Take Two provided consultation for approximately 388 children in 2004. This was in addition to the 320 children who received a direct Take Two service. The consultation work undertaken by Take Two was highly valued according to Child Protection Managers.

5.3 Description of Take Two client group

5.3.1 Overview of cases accepted and closed by Take Two

Table 5 shows an analysis undertaken of the number of cases accepted and closed in 2004 for each Take Two team. Given the short term nature of Secure Welfare, the Secure Welfare Take Two position accounted for more acceptances than any regional team (27%) and the majority of closures (70%). As expected due to the greater number of clinicians in the metropolitan teams these teams saw more clients than the rural teams. The Western team had the highest number of acceptances and closures of the regional teams. The Hume team had the fewest acceptances and closures during the year, which was consistent with the team having a vacant clinical position for nearly half the year.

Despite the program receiving more referrals in the first half than the second half of the year, some teams initially experienced delays in receiving referrals. Take Two teams varied in their capacity to accept new referrals on the basis of size of team, closure of cases, and some vacancies throughout the year, such as in Barwon South West, Northern, Southern and Hume.

5.3.2 Age and gender of Take Two clients
As shown in Graph 1 half (49%) of the clients were...
aged between 12 and 18 years at the time of referral. The average age of children was 11 years and 1 month (s.d. = 4 years, 5 months) with the youngest client a four-month-old baby and the oldest, a Secure Welfare client aged 17 years 11 months. Children under the age of six years were significantly under-represented and children aged 12 to 15 years were significantly over-represented ($\chi^2(5)=63.70$, $p<0.001$). The age of clients varied across the teams, especially in terms of younger children. The Southern and Western teams received the most referrals for infants and young children, while other teams had few referrals for children aged younger than six years.

The small number of infants and young children referred to Take Two are noteworthy in the light of the higher representation of infants in the Child Protection system (DHS, 1999b). It is particularly concerning given evidence available that the younger the children are at the time of abuse the greater likelihood of their suffering long-term psychological and developmental problems (Perry, 1999) and of those difficulties being more extreme (Herman, 1992/1997). There is also evidence that this first three to four years of life has distinctive opportunities to assist in the child’s development and to ameliorate the impact of abuse (Perry, 1999).

Comments provided by Child Protection and Take Two workers as part of this evaluation highlight some of the possible barriers to infants and young children being referred to Take Two, including the following:

- The perception that therapy was not appropriate for infants or young children;
- Although it was acknowledged that infants and young children were affected by abuse and neglect, their emotional and mental health needs were not given prominence or well understood;
- An overt decision in some regions to prioritise older children whose behaviours placed them at risk; and

### Table 5: Cases accepted and closed by Take Two team – 2004

<table>
<thead>
<tr>
<th>Take Two Team</th>
<th>Cases Accepted</th>
<th>Cases Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
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<tr>
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</tr>
<tr>
<td>Eastern</td>
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<tr>
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</tr>
<tr>
<td>Grampians</td>
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<td>5.3</td>
</tr>
<tr>
<td>Hume</td>
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<td>4.4</td>
</tr>
<tr>
<td>Loddon-Mallee</td>
<td>21</td>
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<tr>
<td>Northern</td>
<td>27</td>
<td>8.4</td>
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<tr>
<td>Southern</td>
<td>38</td>
<td>11.9</td>
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<td>Western</td>
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<td>12.8</td>
</tr>
<tr>
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<td>87</td>
<td>27.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>320</td>
<td>100</td>
</tr>
</tbody>
</table>

### Graph 1: Age and Gender of all Take Two Clients – 2004

The small number of infants and young children referred to Take Two are noteworthy in the light of the higher representation of infants in the Child Protection system (DHS, 1999b). It is particularly concerning given evidence available that the younger the children are at the time of abuse the greater likelihood of their suffering long-term psychological and developmental problems (Perry, 1999) and of those difficulties being more extreme (Herman, 1992/1997). There is also evidence that this first three to four years of life has distinctive opportunities to assist in the child’s development and to ameliorate the impact of abuse (Perry, 1999).
• The mechanisms by which Child Protection Managers are informed of the ramifications of behavioural and emotional health issues for adolescents (for example, via incident reports, ministerial briefings, High Risk Adolescent Registers and placement crises) and the fewer equivalent systems for younger children.

Graph 1 also shows the proportion of male and female clients. Sixty percent of Take Two clients were male, which is a significant difference ($\chi^2(1)=12.01, p<0.005$). The over-representation of male clients is most pronounced among the age groups aged 3 to 12 years. Among infants the proportion is skewed the other way, with only a third of clients under the age of three years being male (n=6). All teams, except for Secure Welfare and Loddon-Mallee, had a majority of male clients with the greatest proportion being within the Eastern team.

The story of Amy and her family outlines the harmful consequences of abuse at a young age and demonstrates the complex and critical role of intervention in the life of a traumatised infant in changing the trajectory of development.

**Amy**

Two-year-old Amy was referred to Take Two with her two older sisters, aged seven and nine, all of whom were living with their mother. Their five-year-old brother was living in foster care.

At the time of referral to Take Two, Amy had missing clumps of hair and scratches to her face and arms, all of which were self inflicted. She was hypervigilant and screamed with any movement toward her. When her mother looked at her and called her, she moved away. When distressed she clawed at her face and hid. She made no attempt to approach any of the adults for comfort.

Whilst involved with Take Two Amy was removed from her mother and had three placements, two of which were terminated due to her mother’s allegations of abuse by the carers.

Amy suffered from nightmares most nights. Her carers reported finding her screaming and tearing at herself in her sleep. Her behaviours were extremely distressing for her carers and the other children in her placements.

The Take Two clinician worked with Amy and her carers in establishing a routine of comfort and targeting the care at her developmental level rather than her age level. This involved treating Amy as if she were a much younger infant – for instance holding her when feeding, rocking and talking softly to soothe her, using a cot with a soft toy rather than a bed. Direct infant psychotherapy using play, gesture and language to engage Amy in a responsive, safe, reflective relationship also facilitated a modelling for the development of attunement between Amy and her carers.

Take Two worked closely with Child Protection, providing witness statements in court proceedings and advocating for a more permanent placement to meet Amy’s emotional needs. Take Two also established a working relationship with Amy’s mother to monitor her mental health, to help her understand Amy’s needs and to address her mother’s delusions about persecution and that Amy was possessed by a devil.

Intensive therapeutic work was provided with all Amy’s siblings individually, and other assessments were engaged; for example, neuropsychological and paediatric assessments. When Amy was moved to her new placement, Take Two clinicians regularly visited, despite the placement being in a different region. They were able to help transition Amy and her brother from therapy to the new regional services, including mental health and family support, and to assist the children’s new carer to understand their emotional and behavioural needs and provide care strategies.

Some of the notable outcomes of this intervention were that Amy, although still a very distressed infant needing intensive support, is now cared for in a more permanent placement; can now seek and accept comfort from her carer; has begun using words rather than just aggressive actions to communicate; is no longer found by her carer screaming in her sleep; and her carer feels able to regulate the mother’s contact to protect Amy.

5.3.3 Children of Aboriginal and Torres Strait Islander background

According to the DHS ‘Victorian Families, Children and their Carers in 2016 Background Paper’ (2005), Aboriginal people account for 0.6% of the Victorian population. In 2002, 12% of children in care in Victoria were Aboriginal, despite being only 1% of the general population.

In 2004 14% (n=45) of all Take Two clients were Aboriginal. Within the Secure Welfare Take Two role, this over-representation was even higher at 23% (n=19). This over-representation is consistent with the over-representation of Aboriginal clients within Child Protection, although higher than the 17% of admissions of Aboriginal young people in Secure Welfare.

After Secure Welfare the next Take Two team with the highest proportion of Aboriginal clients was the Western team (13%). When considering the proportion of Aboriginal clients as a function of the team size, the Hume team had the highest proportion of Aboriginal clients (29%), followed by Secure Welfare (23%) and then Gippsland (21%). The absence of
referrals from the Loddon-Mallee Region was surprising given that region has the highest proportion of Aboriginal people per population in the state (DHS, 2005).

There were no Aboriginal children under the age of three years referred to Take Two and only three under the age of six years, representing 6% of Take Two clients in this age group. The increasing proportion of Aboriginal clients in the older age groups is in contrast to the pattern within the general Child Protection client group, where the over-representation is most pronounced among younger children. This finding, of the over-representation of Aboriginal children among the older children, is still the case when the Secure Welfare Take Two client group is excluded. The proportion of Aboriginal Take Two clients that were male was 58%, which was very similar to the Take Two client group as a whole.

It is important to note that three of the children with Aboriginal heritage did not identify themselves as Aboriginal.

5.3.4 Other cultural backgrounds

The vast majority of the 233 regional Take Two clients were born in Australia (98%). In relation to the 18% of children whose families identified with other cultures, only a very small proportion (2%) did not also consider themselves Australian. The children identifying exclusively with other cultures included Vietnamese and Maori.

There was more missing data in relation to Secure Welfare so this analysis is only indicative. In relation to the 12% (n=10) of young people who were clients of Secure Welfare Take Two who identified with other cultures, half did not also consider themselves Australian. The children identifying exclusively with other cultures included Yugoslav, Romanian, Vietnamese and Maori.

5.3.5 Family structures (not including Secure Welfare clients)

Table 6 presents parents’ relationships for regional Take Two clients at the time of the evaluation. The Australian Bureau of Statistics (ABS) reported that one-parent families are the fastest growing type of family in Australia (DHS, 2005). While children from single parent families were a significant part of the Take Two client group, many children experienced multiple, changing and complex structures of families. This is similar to findings in other programs working with Child Protection clients such as the Families First evaluation (Campbell, 1995). It is also consistent with findings regarding the higher number of step-parents or de-facto parents in the child protection population compared with national averages (Tomison, 1996).

Eleven percent of regional Take Two clients’ parents lived together, although some of these relationships were described as inconsistent. This is not dissimilar to other studies such as the home-based care audit (DHS, 2001a) and kinship care audit (DHS, 2001b) which found that only 15% and 17% respectively of the children’s parents resided together.

Thirty percent (n=57) of children within Take Two had parents whose relationships changed between time of referral and the time of the evaluation. These changes included parents separating, forming new relationships or having a series of short-term relationships.

One finding that requires more discussion was the 33 children (15%) who had a biological parent who had died and another four children (2%) who had a step-parent who had died. While information was not always available as to the cause of death, six parents had committed suicide, three had died of injuries from assault or had been murdered and two had died from a drug overdose. Other causes of death included a workplace accident and terminal illness. Three of these

<table>
<thead>
<tr>
<th>Table 6: Parents’ relationships of regional Take Two clients (at time of evaluation or case closure) – 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents’ relationships (n=233)</td>
</tr>
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<td>Both parents together</td>
</tr>
<tr>
<td>Mother single</td>
</tr>
<tr>
<td>Mother in relationship other than father</td>
</tr>
<tr>
<td>Mother in inconsistent relationships</td>
</tr>
<tr>
<td>Mother dead</td>
</tr>
<tr>
<td>Father single</td>
</tr>
<tr>
<td>Father in relationship other than mother</td>
</tr>
<tr>
<td>Father in inconsistent relationships</td>
</tr>
<tr>
<td>Father dead</td>
</tr>
<tr>
<td>Parents separated, no other information known</td>
</tr>
</tbody>
</table>

Note. The data relating to fathers is indicative only, due to the large amount of missing data.

Due to high amount of missing data for Secure Welfare clients whenever ‘not including Secure Welfare’ is in the title this data is reported only in relation to regional Take Two clients.

Frederico, Jackson & Black (2005) Reflections on Complexity – Take Two First Evaluation Summary Report, La Trobe University, Bundoora, Australia
parents died during Take Two involvement in 2004. It was noted in referral documents that three children had witnessed the deaths or discovered their parents when they had died. Similar findings have been reported in other reports such as the kinship care audit (DHS, 2001b), the home-based care audit (DHS, 2001b) and the residential care audit (DHS, 2000). Research within Australia and internationally has lacked an emphasis on fathers or father figures. This appears to be an endemic problem in both practice and research (Tomison, 1996), and is pertinent for the regional Take Two client group where, for 37% of cases, data regarding the fathers was unknown, compared with 6% of mothers. Again this was a similar finding to the out of home care audits conducted in Victoria.

When comparing Aboriginal and non-Aboriginal family structures, Aboriginal parents were more likely to be together as a couple (26% compared with 10%) and there was less change in parents’ relationship status from time of referral to time of evaluation (18% compared with 35%); however, neither of these differences reached significance.

Table 7 shows that 4% of children had no siblings while 13% had six or more siblings (this data includes half-siblings and step-siblings.). Over a third (37%) of children had four or more siblings, including two unrelated children who each had nine siblings. Sixty-three percent of the children had at least one full-sibling; 72% had at least one half-sibling; and 13% had at least one step-sibling. There were six sets of twins (i.e. 12 children) involved with Take Two. The variety of sibling relationships denotes the complexity of many of the family structures. Whether or not the step-siblings and half-siblings were perceived as siblings by the family depended on family history, cultural background and current living situation.

The high proportion of regional Take Two clients who had siblings (96%) is similar to the findings of the home-based care audit (DHS, 2001a) where 92% of children had siblings and higher than the kinship care audit (DHS, 2001b) which indicated 84% were part of a sibling group.

Fifty-four percent of regional Take Two clients who had a sibling were living with at least one of their siblings at the time of the evaluation. Older clients were significantly less likely to be living with a sibling ($\chi^2(2)=6.23, p<.05$). There were no differences in the number of siblings of Aboriginal children compared to non-Aboriginal clients.

Sixty-one percent of regional Take Two clients had only one child from the family involved in the program. Of the 39% who had a sibling who was also a Take Two client, 33% had one sibling involved, 4% had two siblings involved and 3% had three or more siblings involved with Take Two.

Seven children had one sibling who had died and two other children (from different families) had four siblings who had died. Causes of death for siblings included murder, car accident, drowning, SIDS and terminal illness. Seventy percent (n=159) of children had at least one sibling who was identified as having experienced some traumatic event.

5.3.6 Parents’ employment

Due to the large amount of missing data regarding parents’ employment status it was not considered possible to draw conclusions, except to note the missing data as a finding in itself. The ‘Victorian Families, Children and their Carers in 2016’ report (DHS, 2005) summarised data relating to income from the three out of home care audits.

‘In all three audits undertaken in 2001-2002 between two thirds and three quarters of mothers were dependent on welfare for their principal source of income. Among parents of children in residential care fathers were only half as likely as adult males generally to derive their principal income from full-time work and mothers only one-third as likely as all adult females.’ (DHS, 2005, 35)

Data on parents’ employment status is often not obtained by Child Protection or Take Two. This data is difficult to gather due to the complex family systems and a limited understanding of its importance as a major indicator of income and therefore the presence or absence of poverty. Employment is also an indicator of the parents’ social network structures and their day-to-day activities. It is consistently linked with families in distress, substance abuse, mental illness, single parenthood (DHS, 1995) and child abuse (Tomison, 1996).

5.3.7 Protection and placement involvement

| History of Child Protection involvement of Take Two clients |

The vast majority of clients involved in Take Two in 2004 had extensive histories of involvement in the protection and care system. Graph 2 shows the number of previous notifications, investigations, substantiations and Children’s Court orders for all Take Two clients.

| Table 7: Number of siblings for regional Take Two clients – 2004 |

<table>
<thead>
<tr>
<th>Number of siblings</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4-5</th>
<th>6+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>9</td>
<td>33</td>
<td>52</td>
<td>53</td>
<td>57</td>
<td>29</td>
<td>233</td>
</tr>
<tr>
<td>Percent</td>
<td>3.9</td>
<td>14.2</td>
<td>22.3</td>
<td>22.7</td>
<td>24.4</td>
<td>12.5</td>
<td>100</td>
</tr>
</tbody>
</table>
A small percentage of clients had not been previously notified or investigated prior to the current Child Protection involvement. Approximately a third (34%) had no previous substantiated maltreatment. Over a quarter (27%) of the children had three or more episodes when Child Protection had substantiated maltreatment prior to their current Child Protection involvement, with the maximum being eight previous substantiations. The average was two previous substantiations (s.d. = 1.7) per client.

Two-thirds of Take Two clients had previously been on a Children’s Court order. Nearly a quarter had been on three or more previous court orders, including a thirteen-year-old client who had been on seven previous orders. The average was two previous orders (s.d. = 1.5) per client.

Five children had previously been on Permanent Care Orders, four of whom were Secure Welfare Take Two clients. Another child was currently on a Permanent Care Order but with Child Protection reinvolved due to risk of placement breakdown. An additional seven children had been in previous Permanent Care placements (though not on Permanent Care orders) which had since broken down. In other words, 12 (4%) children involved in Take Two in 2004 had experienced both removal from their parents and additional removal from their permanent care family.

In general children younger than six years had a less extensive Child Protection history than older children. However, there were no significant differences between the two older age groups (6<12 years; 12<18 years). Although younger children had fewer episodes of involvement with Child Protection, half of the children under the age of six had previously been on at least one court order. In contrast, while adolescents were more likely to be first notified when they were younger, 10% of children aged 12 years or older were first notified to Child Protection in 2003 or 2004.

Once age was accounted for there were no significant differences between regional and Secure Welfare clients in terms of previous involvement with Child Protection. There were no significant differences in Child Protection history between Aboriginal and non-Aboriginal children.

**Child Protection intervention at time of referral to Take Two**

The vast majority of Take Two clients (93%) were on a Children’s Court order at the time of referral. As illustrated in Graph 3, nearly half of all Take Two clients were on Custody to Secretary orders (46%), with the next largest group being on Guardianship orders (19%).

Children aged over 12 years were significantly more likely to be on a court order ($\chi^2(2)=12.06, p<.005$) than younger children, and that order was more likely to be a Custody to Secretary or Guardianship order. However, it was clear that among all age groups only a minority were not on a Children’s Court order.

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Frederico, Jackson & Black (2005) Reflections on Complexity – Take Two First Evaluation Summary Report, La Trobe University, Bundoora, Australia
History of children’s placements

One of the realities for many Take Two clients and reflective of many children in the protection and care system is the prevalence of multiple placements. Graph 4 reveals that 82% of clients had experienced at least one placement change prior to Take Two involvement. Nearly half (49%) had experienced six or more previous placements and 14% had experienced 15 or more previous placements, including two young people who had experienced 45 previous placements.

As expected the age of the child accounted for significant differences in the number of previous placements. Children aged over 12 years usually had significantly more placements than the two younger
age groups ($F(2)=11.21, p<.001$), but there was no difference between the two younger age groups. Once age was controlled for, there were no differences between regional and Secure Welfare clients. Aboriginal clients had significantly more placements ($F(1)=6.88$, $p<.01$), having had an average of ten previous placements (s.d. = 7.25), compared with an average of seven previous placements (s.d. = 6.72) for non-Aboriginal children.

Sixty percent of Take Two clients ($n=180$) had at least one experience of reunification prior to Take Two involvement: consisting of 21% who had one home return; 19% who were returned home twice; and 20% who had been returned home three or more times. Surprisingly there were no differences between age groups in relation to the number of previous home returns. There was also no difference related to whether clients were referred to a regional team or Secure Welfare, or whether or not the clients were Aboriginal.

**Statewide overview of Child Protection clients in out of home care**

Table 8 provides data regarding the total number of Child Protection clients in out of home care in Victoria during 2004. It shows the high reliance on different forms of home-based care for children who could not live at home.

**Child's placement at time of referral to Take Two**

Seventy-eight percent of Take Two clients were living in some form of out of home care at the time of referral. While the statewide Child Protection data is based on different counting rules and so cannot be directly compared, there appears to be a much higher proportion of Take Two clients in residential care (35% of children in care) compared with the overall Child Protection population (9%).

Among the 12 years and older age group there was little difference between those in a regional Take Two team (40%) and Secure Welfare (42%). The Secure Welfare Take Two clients were slightly less likely to have been living with one or both parents (17%) compared with the same age group in regional teams (21%), slightly less likely to be in home-based care (10% compared with 15%) and less likely to be in kinship care (5% compared with 15%). The Northern and Barwon South West teams had the largest proportion of clients in out of home care (89% each). The Northern team had the largest proportion of clients living in residential care (56%). This is significantly larger than the proportion in residential placements for the overall program. In contrast, the Loddon-Mallee team had 33% living with one or both parents and another 33% living in home-based care.

There were differences in the placements of children dependent on their age ($\chi^2(24)=81.62$, $p<.001$). The younger the child the greater the likelihood of them living with one or both parents ($0<6$ years 32%; $6<12$ years 23%; $12<18$ years 19%), or of living in home-based care ($0<6$ years 40%; $6<12$ years 33%; $12<18$ years 13%). More children under the age of 12 years were placed in kinship care than children 12 years and older ($0<6$ years 20% 6<12 years 21%; $12<18$ years 10%). There was the anticipated reverse pattern in relation to residential care ($0<6$ years 4%; $6<12$ years 19%; $12<18$ years 41%). It is reflective of the complex nature of the Take Two client group that 23% of children under the age of 12 were in residential care.

Although there were some differences found between Aboriginal and non-Aboriginal clients in relation to their placement, these were not statistically significant. These differences included fewer Aboriginal children placed in home-based care (14% compared with 26%); slightly fewer in kinship care (11% compared with 16%); and a greater percentage in residential care (34% compared with 26%).

**Children's placement during Take Two involvement (not including Secure Welfare clients)**

Table 9 shows the number of children in each type of placement at the time of referral and the time of...

| Table 8: DHS statewide data regarding Child Protection clients in placement – 2004 |
|-----------------------------------|---------|--------|
| **Out of Home Placement**         | **Child Protection clients** |
|                                   | **Number** | **Percent** |
| Kinship care                      | 2262      | 24.5    |
| Shared care                       | 109       | 1.2     |
| Home-based care (e.g., foster care, ACP) | 4199  | 45.5    |
| Residential care                  | 832       | 9.0     |
| I:1 Care                          | 122       | 1.3     |
| Lead Tenant                       | 65        | 0.7     |
| Intensive home-based care         | 143       | 1.5     |
| Specialised home-based care       | 164       | 1.8     |
| Permanent care                    | 1338      | 14.5    |
| **Total**                         | 9234      | 100     |

* Data comparing numbers of children in care with children at home for the general Child Protection population was not available to Take Two at this time.

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The most obvious change is the increase in children living with one or more parents. At the time of evaluation 24% of children were living with parent/s and this increased to 42% at the time of evaluation (or closure). Twenty-three percent of children returned home during Take Two involvement of which 83% remained home.

The data in Table 9 does not reflect the multiple moves that occurred for some of these children in the intervening period. Fifty percent of children had at least one change of placement during Take Two’s involvement in 2004. Of these 117 children: 63 (54%) had one change; 25 (21%) had two changes; 16 (14%) had three changes; 11 (9%) had four to nine changes and two (2%) had 10 or more changes of placements during this time period.

A common reason for these changes was the 53 (45%) of placement changes) children who returned to one or both parents. Of the 44 children who returned home and stayed home, 15 (34%) had come from home-based care, 13 (30%) had come from kinship care placements and 13 (30%) had come from residential care. Two children who originally had no fixed address both returned home. These figures help explain the reduction in numbers of children in home-based care, residential care and kinship care over this time, but this was not always a one-way pattern. For example, another 15 children were removed from one or both parents during Take Two involvement. Nine children were at home at time of referral, then had one to eight placement changes and then returned home by the time of the evaluation. Another six children were removed from home and were placed in either residential care (n=3) or home-based care (n=3), where they remained at the time of the evaluation.

For those 116 children who experienced no change in placement, 44 (38%) experienced a change within the household in which they lived. These changes included a carer or family member leaving, a new adult moving in or other children including siblings leaving or joining the household.

The placement system and the link between the child’s placement and the viability of therapy to impact on the child’s wellbeing was a developing theme in Take Two staff journals throughout 2004. There were concerns regarding the appropriateness of some placements, the complex decision to separate siblings and the lack of more appropriate alternative placements. There appeared a growing realisation of the pivotal impact of the placement system on therapy and vice versa.

‘My reflections are a bit like this child – all over the place. I have experienced anger, frustration, compassion, pain, and sadness at what I have observed with this boy. He is quite a delightful child who is eager to please but doesn’t belong anywhere. My sense is that he feels this.’

Case plan at time of referral for Take Two clients (not including Secure Welfare clients)

Consistent with the high proportion of Take Two clients living in some form of out of home care, the largest proportion of Child Protection case plan goals were for reunification (30%). The next most frequent case plans were enabling the child to remain with the family through support services (22%), long-term placements (18%), permanent care (10%) and time-limited assessments (10%). The Western team had an interesting combination of a high proportion of clients living with one or both parents (34%) and having the highest proportion of case plans for permanent care (24%), which was more than double the program’s average.

There were more case plans for Aboriginal children to remain with family through support services (32% compared with 20%) although there was a similar percentage of Aboriginal children (25%) living with their parent/s compared with non-Aboriginal children (22%). Conversely, a smaller percentage of Aboriginal children had a case plan for reunification (16% compared with 31%).

<table>
<thead>
<tr>
<th>Placement</th>
<th>Referral Number</th>
<th>Referral Percent</th>
<th>Evaluation/closure Number</th>
<th>Evaluation/closure Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with one or both parents</td>
<td>56</td>
<td>24.0</td>
<td>98</td>
<td>42.1</td>
</tr>
<tr>
<td>Kinship care</td>
<td>44</td>
<td>18.9</td>
<td>23</td>
<td>9.9</td>
</tr>
<tr>
<td>Shared care</td>
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<td>0.4</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Home-based care</td>
<td>68</td>
<td>29.2</td>
<td>52</td>
<td>22.3</td>
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<tr>
<td>Home-based care – Intensive</td>
<td>5</td>
<td>2.1</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Residential care</td>
<td>51</td>
<td>21.9</td>
<td>36</td>
<td>15.5</td>
</tr>
<tr>
<td>1:1 care</td>
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<td>1.3</td>
<td>4</td>
<td>1.7</td>
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<td>Lead Tenant</td>
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<td>Permanent care</td>
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<td>No fixed address</td>
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<tr>
<td>Total</td>
<td>233</td>
<td>100</td>
<td>233</td>
<td>100</td>
</tr>
</tbody>
</table>
Case management at time of referral for Take Two clients (not including Secure Welfare clients)

Eighty-six percent of regional Take Two clients were case managed by DHS with the remaining 14% contracted to CSOs. The proportion of children whose case management was contracted to CSOs was lower than expected given the number of those on Custody to Secretary or Guardianship orders, as these are usually highly represented in cases contracted to CSOs. It is consistent with feedback from CSOs who found it difficult to refer or were not always aware that they could refer to Take Two. For some regions it may be a reflection of the type of cases that were contracted to CSOs.

The older the client, the more likely that case management was contracted to a CSO ($\chi^2(2)=11.26$, $p<.005$). The Hume team had the highest proportion of cases that were case managed by CSOs (36%). This was in contrast to the Loddon-Mallee and Southern teams who each only had one client contracted to CSOs for case management.

The percentage of Aboriginal clients case managed by CSOs (28%) was more than double that of non-Aboriginal children (13%) and this difference was significant ($\chi^2(1)=4.31$, $p<.05$).

Children’s contact with parents (not including Secure Welfare clients)

The noticeable finding shown in Table 10 is the number of children having minimal or no contact with their parents. At the time of evaluation 16% of children had no contact with their mothers and 48% had no contact with their fathers. This does not include those children whose mother or father had died. The high proportion of children who have no contact with fathers is similar to that found in the home-based care audit (DHS, 2001a).

At the time of evaluation there were 18 children who had no contact with either parent and an additional nine children who had no contact with one parent and their other parent had died. These 27 children account for 13% of the regional Take Two client group. An additional 19% (n=42) of children had irregular contact with both parents (n=10) or irregular contact with one parent and no contact with the other (n=23) or irregular contact with one parent and the other parent was deceased (n=9). These figures emphasise the high degree of absence and loss of parents for many of these children.

There is a substantial body of literature, especially in the child welfare/child protection field regarding the importance of maintaining children’s contact with their families. Advantages from such contact include enabling the child to experience and express their feelings about the separation, viewing their parents and carers realistically, calming their fears that the parent has died or abandoned them, allowing the child to see the parents and caregivers interacting and preventing the children and parents from becoming strangers (Littner, 1975). It is also considered an essential element to facilitating and maximising the likelihood of successful reunification (McCarrt, Hess & Proch, 1993). Fanshel and Shinn (1978) warn of the dangers of children’s fantasies, whether they be idealising the absent parent or the other extreme. The child’s imagination regarding the ‘never seen’ parent can be potentially more dangerous and undermining of their placement than the reality of most (albeit not all) parents.

5.3.8 Parents’ history of trauma and other adverse events (not including Secure Welfare clients)

Within the regional Take Two teams, 192 (82%) mothers and 113 (49%) fathers had one or more serious adverse

<table>
<thead>
<tr>
<th>Table 10: Regional Take Two clients’ contact with parents at time of referral and at time of evaluation/closure – 2004 (n=233)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Take Two clients contact with parents</strong></td>
</tr>
<tr>
<td><strong>At time of referral</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Responses No.</td>
</tr>
<tr>
<td>Lives with both parents</td>
</tr>
<tr>
<td>Lives with mother</td>
</tr>
<tr>
<td>No contact with mother</td>
</tr>
<tr>
<td>Irregular contact with mother (&lt;monthly)</td>
</tr>
<tr>
<td>Regular contact with mother (&lt;weekly &amp; &gt;monthly)</td>
</tr>
<tr>
<td>Frequent contact with mother (&gt;weekly)</td>
</tr>
<tr>
<td>Lives with father</td>
</tr>
<tr>
<td>No contact with father</td>
</tr>
<tr>
<td>Irregular contact with father (&lt;monthly)</td>
</tr>
<tr>
<td>Regular contact with father (&lt;weekly &amp; &gt;monthly)</td>
</tr>
<tr>
<td>Frequent contact with father (&gt;weekly)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Missing data:</td>
</tr>
<tr>
<td>Father</td>
</tr>
</tbody>
</table>

Frederico, Jackson & Black (2005) Reflections on Complexity – Take Two First Evaluation Summary Report, La Trobe University, Bundoora, Australia
events that Take Two clinicians considered to be traumatic. Clinicians were unaware of specific traumatic events for the remaining 18% of mothers and 51% of fathers. This could reflect an absence of adverse events but was believed to be largely due to lack of information about these parents. Given the large amount of missing data, it is not possible to draw conclusions in relation to fathers’ experiences of trauma and therefore that data is not presented.

The majority (52%) of mothers had histories of serious childhood abuse or neglect: 48% experienced family violence; 43% had histories of childhood separation from attachment figures, such as through Child Protection involvement; and 40% were sexually assaulted, other than intrafamilial abuse. Twenty-two percent had experienced the violent or otherwise traumatic death of a significant other. This exemplifies the traumatic lives of most of these mothers along with the reality of intergenerational trauma for the children. This also provides insight into the level of chaos and violence experienced by many of these children and their families. Although the presence of distressing and overwhelming events for many of these parents is not surprising, it is important to acknowledge and incorporate in understanding how to best work with these children.

Fraiberg and colleagues (1975) write of how some families appear destined to re-enact the tragedies of the past and others appear galvanised by their traumatic past to ensure the same does not occur for their own children.

‘History is not destiny … and whether parenthood becomes flooded with griefs and injuries, or whether parenthood becomes a time of renewal cannot be predicted from the narrative of the parental past. There must be other factors in the psychological experience of that past which determine repetition in the present.’
(Fraiberg, et al., 1975, 389)

An important element in understanding multigenerational trauma is recognising the role families play within and between generations in overt and implicit communication or transmission of emotion, attitude, culture and beliefs (Danieli, 1998; Nader, 1998). There were comments in some of the Take Two staff journals that while past and current trauma was the reality for many parents, there were often no services available to work with parents on these issues.

5.3.9 Parents’ imprisonment (not including Secure Welfare clients)

Table 11 shows that 47 children (20%) had at least one parent figure in gaol during Take Two involvement in 2004, with five children (2%) having more than one parent figure in gaol. Five percent of mothers and 12% of fathers were incarcerated during Take Two involvement. There were other parents who had previously been in gaol, but this data was not readily available. For example, two parents had committed suicide while on bail for charges in relation to child sexual assault.

Most of those in gaol had reasonably lengthy sentences and were in gaol throughout the whole period of Take Two involvement within 2004. Some children saw their parent being arrested or were described as being frightened of a parent’s imminent release from prison. Some children visited their parents in prison, whereas others had no contact. Eight of the 15 (53%) children whose mothers were in gaol had no contact with their mother and 19 of the 33 (58%) children whose fathers were in gaol had no contact with their father. Some gaol sentences were in relation to violent crimes including rape, murder and family violence, whereas others were indicative of a criminally active lifestyle in relation to theft.

5.3.10 Child’s experience of abuse and neglect

As recorded by the referrers on the HCA, more than 95% of Take Two clients had suffered two or more types of maltreatment throughout their childhood, as illustrated in Graph 5. The majority of the children (61%) had suffered four or five types of maltreatment.

The majority of children under six years (58%) had suffered four or five types of abuse and neglect and less than 10% had experienced only one type of

<table>
<thead>
<tr>
<th>Parent(s) in Gaol</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with at least 1 parent in gaol</td>
<td>46</td>
<td>19.7</td>
</tr>
<tr>
<td>Mother in gaol</td>
<td>11</td>
<td>4.7</td>
</tr>
<tr>
<td>Father in gaol</td>
<td>29</td>
<td>12.4</td>
</tr>
<tr>
<td>Step-parent in gaol</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Both parents in gaol</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Parent and step-parent in gaol</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>Both parents and step-parent in gaol</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Children with no parent figure in gaol</td>
<td>187</td>
<td>80.3</td>
</tr>
<tr>
<td>Overall Total</td>
<td>233</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 11: Parents in gaol during Take Two involvement – regional Take Two clients – 2004
The data indicates that the majority of all clients, regardless of age, Aboriginal background or type of referral, had suffered multiple types of maltreatment. Graph 6 shows that nearly all children (97%) had experienced emotional or psychological abuse. The next most common abuse types were abandonment or no appropriate carer (82%), physical abuse (82%) and then developmental and medical harm (62%); with sexual abuse (42%) being the least frequently noted. Neglect items were predominantly in the developmental and medical harm and the abandonment or no appropriate carer domains.

The only clear pattern in terms of frequency of abuse type among the different age groups was in relation to sexual abuse. Sexual abuse varied from 16% of the children aged younger than six years; to 40% of children aged between six and 12 years; and 51% of...
children aged 12 years and older. Sexual abuse was the only abuse type where gender differences were found: 52% of females compared with 34% of males.

There was a higher percentage of Secure Welfare Take Two clients who had been sexually abused (58%) compared to regional clients (36%). There was a smaller percentage of Secure Welfare clients who had suffered developmental abuse (43%) compared with regional clients (68%).

There were no differences in the frequency of different types of abuse between Aboriginal and non-Aboriginal children, except a tendency for less developmental abuse to be noted for Aboriginal children (52% compared to 64%). The gender differences in sexual abuse were more pronounced among Aboriginal children; 58% of female Aboriginal children had been sexually abused and 24% of male Aboriginal clients.

Examples of abandonment or no appropriate carer included parental incapacity such that they cannot care for their child (28%); extreme lack of supervision (20%); abandonment or absence of parent with no appropriate alternative carer (20%).

Physical abuse included exposure to physical harm from family violence (45%); frequent failure to ensure safety (31%); excessive physical discipline (15%); frequent serious physical abuse (13%); being hit with objects (11%); drugs misuse on child (5%); enforced confinement (4%); and being burnt or scalded (3%).

Sexual abuse included inappropriate sexual exposure (18%); victim of multiple offenders of sexual abuse (9%); exploitation (9%); sexual penetration (9%); fondling (8%); grooming behaviour (8%); and frequent serious sexual abuse (7%).

Emotional and psychological abuse included chaotic family lifestyle (62%); emotional unavailability of parent figures (56%); inadequate caring relationships (45%); high criticism, low warmth (38%); pattern of extreme rejection (31%); scapegoated (31%); pattern of overt blaming of child (27%); pattern of extreme verbal abuse (23%); pattern of highly unreasonable expectations (18%); complete absence of affection (13%); and pattern of extreme humiliation (9%).

Emotional and psychological abuse also related to parental difficulties such as exposure to parental substance abuse, family violence and parental psychiatric illness. Graph 7 shows examples of parent-related problems by age group. This graph shows that issues relating to parental problems were most readily identified for younger children. This may be due to frequency of occurrence but may also be related to the visibility of the issues for this age group.

Aboriginal children were significantly less likely to have been exposed to parental psychiatric illness (14% compared with 28%, \( \chi^2(1)=4.23, p<.05 \)). This finding is similar to the DHS integrated strategy report (2002) finding that the rates of Indigenous children with parents who had a psychiatric disability were lower than non-Indigenous children. One hypothesis for this finding is that behaviours that may indicate psychiatric illness may be more readily assumed to be drug or alcohol abuse related for Aboriginal people. This is supported by the trend for Aboriginal Take Two clients

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Graph 7: Examples of abuse relating to parental concerns prior to referral, as reported by the referrer on the Harm Consequences Assessment (HCA) for all Take Two clients (n=315) – 2004

<table>
<thead>
<tr>
<th>Category</th>
<th>0-4 years</th>
<th>5-12 years</th>
<th>12-18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child born dependent drug user</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Exposure to parental substance abuse</td>
<td>48</td>
<td>47</td>
<td>37</td>
</tr>
<tr>
<td>Exposures to family violence</td>
<td>78</td>
<td>71</td>
<td>44</td>
</tr>
<tr>
<td>Forcing child to witness violence</td>
<td>8</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Exposures to parental psychiatric illness</td>
<td>4</td>
<td>44</td>
<td>32</td>
</tr>
</tbody>
</table>

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Frederico, Jackson & Black (2005) Reflections on Complexity – Take Two First Evaluation Summary Report, La Trobe University, Bundoora, Australia
to be more likely to be reported as having been exposed to parental substance abuse (57% compared with 41%), although this trend did not reach significance.

Examples of developmental or medical harm types include extreme lack of basic care (9%); deprivation (7%); extreme lack of food or fluids (5%); extreme lack of medical care (5%); and absence of stimulation (10%).

The following vignette illustrates the impact of prolonged abuse and neglect on a child’s development and attachment. It demonstrates the challenge to engage the child in therapeutic intervention and the importance of collaborative work within the service system.

### 5.3.11 Consequences of abuse and neglect to the child

According to referrers, 94% of children involved with Take Two in 2004 had suffered more than one type of harmful consequence from their experience of maltreatment. Nearly half of the children (49%) had four or five different types of consequences of abuse (see Graph 8). Although this data is based on the assumption that these physical, emotional, behavioural and social difficulties were as a consequence of the child’s experience of maltreatment, this is supported by the literature review but needs to be examined in further research. Emotional or psychological consequences were the most common form of consequence in general (93%) and across each level of severity. Examples of emotional or psychological harms were externalising behavioural difficulties such as risk-taking (31%), lengthy or continuous absconding (27%), criminal activity involving violence (11%), repeated or serious fire lighting (5%) and killing or torturing animals (4%). Internalising difficulties included constant emotional unavailability (17%), being very withdrawn (13%), overwhelming sense of helplessness (11%) and hypersensitivity (8%).

The next most prevalent form of harm identified related to abandonment issues (85%). This was not limited to physical abandonment but included, for example, having a minimal sense of security (41%), minimal sense of permanence (35%), minimal sense of belonging (35%), minimal trust (35%) and minimal sense of future (31%). Developmental harms were the next most frequently identified harms (74%) and included minimal friendships (26%), deterioration in attention and concentration (22%), social isolation (18%) and deterioration in cognition (9%).

Graph 9 shows specific examples within the domains of emotional and psychological harm and developmental harm by age group, revealing for many specific harm consequences a clear effect of age. For example, whilst the older the child the more likely they were to show emotional and behavioural concerns,

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**Edward**

Edward, now aged eleven, has been in residential care for the last three years. Edward’s history includes eight child protection notifications, the first when he was five days old for exposure to domestic violence and psychiatric illness, with further notifications until the age of one year and seven months. Other concerns were due to physical abuse, neglect and being given pharmaceuticals without need.

Edward’s need for protection was recognised early. He and his mother voluntarily went into supported care when he was four days old and stayed there for seven months. He was then removed from his mother’s care and was cared for by a maternal aunt for ten months.

Edward was placed on a Custody to Secretary Order at fourteen months of age. Three months later he was removed and placed in foster care as he was exposed to domestic violence in his aunt’s care.

After two years in foster care, at the age of three and a half, Edward was transferred into permanent care where he lived for five years. This placement broke down and he went into residential care where he continues to live. There have been no issues of abuse or neglect in Edward’s foster care or permanent care placements although he has experienced the changes of placement as rejection.

Edward shows the impact of this trauma in his limited sense of belonging, limited trust in others, extreme lack of attachment, extreme negative sense of identity, depression, anxiety, lack of self awareness, emotional isolation and behavioural problems, including sexual harassment of others. He is described as very withdrawn, intermittently emotionally unavailable, with a confused sense of identity, limited understanding of morality/conscience, unclear sense of permanence, insecurity and lacking in confidence.

The presenting concerns underlying Edward’s referral to Take Two include: his ambivalence in interpersonal relationships manifested by hypersensitivity to other people’s moods and behaviours; poor capacity to form and maintain relationships; and a negative perception of self. He is described as dysthymic, spending long periods alone, regresses at times, particularly when excited or having limits set, and is continually pushing and testing people’s capacity to contain him and display their care for him.

Despite his long period in care there is little available information about Edward’s family history. It is known that his biological mother had a long history of drug dependence and that his biological father had a diagnosis of schizophrenia.
children between the ages of six and 12 were higher than the older age group in relation to violence to others, and difficulties in concentration, cognition and language. This may indicate that it is more frequent or that when it occurs for younger children it is more commonly noted as a concern. Children under the age of six were more likely to be described by referrers as having none or fewer of these emotional and behavioural difficulties. It is worth noting that although the numbers were small, this youngest age group was represented in examples around severe changes in affect or mood; repeated severe violence towards others; profound sleep disturbance, deterioration in cognition; and significantly impaired speech and language.
Suicidality

Nineteen percent (n=43) of regional Take Two clients had some form of suicidal risk behaviour, with 5% (n=11) making previous suicide attempts. Although there was too much missing data in relation to Secure Welfare clients to reach conclusions, 13 young people were described by the Senior Clinician as being at current suicide risk. This was 20% of the young people for whom this data was available. An additional 32% (n=21) were described as having some indications of suicidality, such as previous suicide attempts, thoughts of dying and past suicidal ideation.

Sexualised behaviours

Table 12 indicates that nearly a quarter of regional Take Two clients showed at least one form of serious sexualised behaviour towards others (23%, n=54). Twenty-two of these children had displayed more than one type of sexualised behaviour towards others.

There was a large amount of missing data in relation to sexual offending behaviours among the Secure Welfare Take Two client group. For the 73 clients for whom this information was available 12% (n=9) were described by the Senior Clinician as displaying sexual offending behaviours.

Aboriginal Children

When looking at harm consequences as reported by the referrer for Aboriginal Take Two clients a few trends were evident including:

- 34% of Aboriginal children had ongoing or frequent substance abuse compared with 15% of non-Aboriginal children.
- 25% of Aboriginal children had dangerously self-harmed compared with 12% of non-Aboriginal children.
- 21% of Aboriginal children were involved in violent criminal activity compared with 9% of non-Aboriginal children.
- 30% of Aboriginal children had shown repeated and severe violence towards others compared with 15% of non-Aboriginal children.
- 50% of Aboriginal children were continuously absconding compared with 22% of non-Aboriginal children.

‘Deanna’ is an Aboriginal child and her story tells of a history of intergenerational trauma, cultural displacement, multiple types of abuse and the harmful consequences on attachment behaviour and identity. Deanna’s individual trauma cannot be isolated from the effects of racism and the community trauma of the stolen generation. Her experience highlights the importance of culturally sensitive therapeutic intervention.

5.3.12 Experience of trauma other than child abuse and neglect (not including Secure Welfare clients)

In addition to the multiple experiences of abuse and neglect suffered by almost all Take Two clients, a majority of the regional clients (56%) had also suffered other traumatic or adverse events. This data was not available for Secure Welfare clients. In an additional 22% of cases, the Take Two clinician was not certain whether or not the event/s were traumatising for the child.

Table 13 provides examples of some of these traumatic and overwhelming events according to regional Take Two clinicians.

The extent of traumatic experiences in many of these children’s lives in addition to the trauma of abuse and neglect is one of the key findings of this evaluation. It is consistent with the findings of authors such as Herman who stated:

‘Traumatic life events, like other misfortunes, are especially merciless to those who are already troubled.’

(Herman, 1992/1997, 60)

Some of these traumatic experiences have been a direct result of the originating trauma of abuse, such as separation from families; or as part of a pervasive chaos within which they and their families live.

Overall 72% of children experienced trauma as a result of the parents’ difficulties or lifestyles, in addition to their experience of maltreatment. The two most common of these experiences related to grief and rejection of having no or minimal contact with parents (18%) and parents’ separation or divorce (15%). There were children who had witnessed what must have been terrifying events, including three children who witnessed their parent’s death; three

Table 12: Sexual offending behaviours of regional Take Two clients prior to referral and as reported by the referrer on the Harm Consequences Assessment (HCA) – 2004

<table>
<thead>
<tr>
<th>Sexual offending behaviours</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexualised violence towards others</td>
<td>10</td>
<td>4.3</td>
</tr>
<tr>
<td>Pattern of inappropriate sexualised behaviours towards others</td>
<td>34</td>
<td>14.7</td>
</tr>
<tr>
<td>Sexual harassment of others</td>
<td>10</td>
<td>4.3</td>
</tr>
<tr>
<td>No such behaviours noted</td>
<td>178</td>
<td>76.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>232</td>
<td>100</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Overall Total</strong></td>
<td>233</td>
<td></td>
</tr>
</tbody>
</table>
children who witnessed their parent’s attempted suicide, six children who witnessed their parent’s overdose on drugs and five children who witnessed parents or family members self-harming.

Deanna was born with a drug dependency. Her experience of trauma includes family violence, exposure to parents’ substance abuse, neglect, separation from and the emotional unavailability of her parents, low level supervision and prison visitations.

With removal from her Aboriginal family Deanna has experienced displacement and dislocation from her family of origin, identity, culture and community.

The impact of this trauma has left Deanna with no sense of belonging, no security, no sense of permanence, no trust, no sense of future, disorganised attachment, post-traumatic stress disorder, a negative impact to her self esteem, poor peer relationships and poor concentration at school.

She now shows some violence towards others. The presenting problems identified at Deanna’s referral to Take Two indicate a confused sense of identity and culture – through the minimal contact with her biological family, culture and community – and difficulty in forming and maintaining relationships, limited prosocial skills and controlling and at times oppositional behaviour with outbursts of anger.

Deanna’s family history shows intergenerational trauma with child protection interventions in her own, her parents’ and her grandparents’ generations. The history includes family violence, substance abuse and criminal involvement on both maternal and paternal sides, intergenerational patterns of removal into non-Aboriginal placements and associated cultural and identity issues. There is also a history of sexual abuse on the paternal side.

At the time of removal from her family and in her infancy Deanna experienced severe health problems, with multiple medical visits for ear infections, perforated ear drums and repeated respiratory infections.

### Table 13: Descriptors of trauma, other than intrafamilial abuse, experienced by regional Take Two clients according to Take Two clinicians – 2004

<table>
<thead>
<tr>
<th>Other traumas/adverse events (n=204)</th>
<th>Number</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief/loss/rejection as no/minimal contact with parents</td>
<td>36</td>
<td>17.6</td>
</tr>
<tr>
<td>Parents’ separation/divorce</td>
<td>30</td>
<td>14.7</td>
</tr>
<tr>
<td>Parent/parent figure died</td>
<td>27</td>
<td>13.2</td>
</tr>
<tr>
<td>Sexual abuse – not by parent figure or not clear by whom</td>
<td>26</td>
<td>12.7</td>
</tr>
<tr>
<td>Death of significant other(s) excluding parent/parent figures</td>
<td>16</td>
<td>7.8</td>
</tr>
<tr>
<td>Hospitalisation/medical intervention(s)</td>
<td>16</td>
<td>7.8</td>
</tr>
<tr>
<td>Abuse in care</td>
<td>15</td>
<td>7.4</td>
</tr>
<tr>
<td>Witnessing of death or other overwhelming incident</td>
<td>15</td>
<td>7.4</td>
</tr>
<tr>
<td>Exposed to general violence</td>
<td>14</td>
<td>6.9</td>
</tr>
<tr>
<td>Physical assault – not by parent figure or not clear by whom</td>
<td>12</td>
<td>5.9</td>
</tr>
<tr>
<td>Parent(s) incarcerated in gaol</td>
<td>12</td>
<td>5.9</td>
</tr>
<tr>
<td>Exposed to parent(s) violence/aggression towards others</td>
<td>11</td>
<td>5.4</td>
</tr>
<tr>
<td>Trauma related to access with parents</td>
<td>11</td>
<td>5.4</td>
</tr>
<tr>
<td>Missing data</td>
<td>29 cases</td>
<td></td>
</tr>
</tbody>
</table>
both compassion and the recognition that expectations of changes likely to occur for the client should be realistic and take into account their life experiences.

‘Our success should be measured in small and realistic ways – to see a child who has endured so much trauma, actually disclose that he has monsters under his bed is a really brave admission. For any other child this is probably no big deal but is for this child with his history, it is really significant and should not be underestimated.’

5.3.13 Health and related areas (not including Secure Welfare clients)

Mental health diagnoses

Data relating to mental health diagnoses was available for 202 of the regional Take Two clients at the time of the evaluation, of which 131 (65%) had a mental health diagnosis. Fifty-six of these 131 children (43%) had not previously been diagnosed with a mental health disorder.

Of the 131 Take Two clients who had a mental health diagnosis, 90 had one diagnosis, 31 had two diagnoses and ten children had three mental health diagnoses. Comorbidities of mental health diagnoses is a common finding in the literature regarding children who have experienced trauma (Cohen, Berliner & March, 2000; Perry, 1999). Table 14 shows that reactive attachment disorder (39%) was the most common diagnosis followed by PTSD or complex PTSD (25%) and then conduct disorder (24%). In addition to these mental health diagnoses eight clients were assessed as having a personality disorder or an emerging personality disorder.

The older the child, the significantly more likely they were to have a mental health diagnosis ($\chi^2(2)=8.2$, $p<.05$). This was consistent with the residential care audit (DHS, 2000). However, the proportion of young children with a mental health diagnosis was still significant. Among children aged younger than six years, nearly half had a mental health diagnosis (48%), compared with 67% of children aged between six and 12 years, and 73% of children aged 12 years and older. The large majority of diagnoses for children under six years old were in relation to reactive attachment disorders (73%). The increases in diagnosis with increasing age are largely reflective of the increase in diagnosis of conduct disorder (0<6 years with a mental health diagnosis 5%; 6<12 years with a mental health diagnosis 11%; 12<18 years with a mental health diagnosis 49%); oppositional defiance disorder (0<6 years 0%; 6<12 years 19%; 12<18 years 13%); and attention-deficit/hyperactivity disorder (0<6 years 0%; 6<12 years 16%; 12<18 years 13%).

There was also significantly more males diagnosed with a mental health disorder ($\chi^2(1)=4.6$, $p<.05$); 75% of males had a mental health diagnosis compared with 55% of females. This difference was reflected across most of the diagnostic categories, except for reactive attachment disorder, PTSD and depressive disorders.

There was no significant difference in percentage of children with mental health diagnoses when comparing Aboriginal and non-Aboriginal children.

Physical health and disability

According to Take Two clinicians, 35% of children (n=78) had at least one identified health concern. Twenty-eight children had two or more health concerns. As shown in Table 15 the most common health concern was bed wetting (21% of children with a health concern), followed by asthma (18%), skin problems (18%), eye problems (14%), dental problems (13%) and ear problems (10%).

There were no differences in the percentage of health concerns when comparing age groups, gender or Aboriginal and non-Aboriginal children.

Examples of other health concerns included foetal alcohol syndrome, thyroid function concerns, blood disorder, miscarriage, hayfever, severe tinea, facial deformity requiring surgery and epilepsy.

In addition to these health concerns, a small number of children (n=6) had a disability, such as deafness,

<table>
<thead>
<tr>
<th>Mental health diagnoses (n=131)</th>
<th>Number of Responses</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive Attachment Disorder</td>
<td>51</td>
<td>38.9</td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder/Complex PTSD</td>
<td>33</td>
<td>25.2</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>31</td>
<td>23.7</td>
</tr>
<tr>
<td>Oppositional Defiance Disorder</td>
<td>18</td>
<td>13.8</td>
</tr>
<tr>
<td>Attention-Deficit/ Hyperactivity Disorder</td>
<td>16</td>
<td>12.2</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>10</td>
<td>7.6</td>
</tr>
<tr>
<td>Anxiety Disorders (excluding PTSD)</td>
<td>9</td>
<td>6.9</td>
</tr>
<tr>
<td>Adjustment Disorders</td>
<td>8</td>
<td>6.1</td>
</tr>
<tr>
<td>Communication Disorders</td>
<td>4</td>
<td>3.1</td>
</tr>
<tr>
<td>Other disorders</td>
<td>7</td>
<td>5.3</td>
</tr>
</tbody>
</table>
cerebral palsy and juvenile arthritis. Eight percent of clients had an intellectual disability, as reported by regional Take Two clinicians.

5.3.14 School enrolment for Take Two clients (not including Secure Welfare clients)

As seen in Table 16 there was a large amount of missing data regarding school enrolment at the time of referral. Most children (98%) who were clients of Take Two and of compulsory school age were enrolled at school and were attending some or all of the time.

Five adolescents aged fifteen years or older were not enrolled in school or any day program. There were a small number of children (n=4, 2%) who were of compulsory school age but not enrolled. This was less than the percentage of school-age children not enrolled in school in the home-based care audit (11%) (DHS, 2001a) and in the residential care audit (37%) (DHS, 2000). In contrast the kinship care audit (DHS, 2001b) showed all children of compulsory school age were enrolled at school.

According to the HCA completed by the referrers, 27% of the children exhibited school refusal behaviours and 9% were not attending school despite being of school age. In other words they were enrolled in school but not attending. This illustrates that school enrolment cannot be used as a sole indicator of school attendance.

5.4 The Take Two Secure Welfare client group and program

The DHS-Child Protection Secure Welfare Service was established in 1992, following the de-institutionalisation of child welfare services. Victoria is the only state in Australia to have such a service. Morton and colleagues (2003) highlighted the importance of Secure Welfare as a brief crisis contained accommodation program, required in adjunct to intensive therapeutic intervention for a young person whose safety is at immediate risk. Secure Welfare aims to provide a time-limited strategy to manage high risk situations effectively and meet the needs of the young person.

<table>
<thead>
<tr>
<th>Table 15: Health concerns of regional Take Two clients – 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health concern (n=78)</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Bed wetting</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Other respiratory problems</td>
</tr>
<tr>
<td>Skin problems</td>
</tr>
<tr>
<td>Eye problems</td>
</tr>
<tr>
<td>Dental problems</td>
</tr>
<tr>
<td>Ear problems</td>
</tr>
<tr>
<td>Heart problem</td>
</tr>
<tr>
<td>Weight concerns</td>
</tr>
<tr>
<td>Soilng</td>
</tr>
<tr>
<td>Infections</td>
</tr>
<tr>
<td>Eating difficulties</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Other health problems</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 16: Enrolment in school at time of referral among regional Take Two clients – 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Enrolment</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Child not attending school</td>
</tr>
<tr>
<td>Primary School</td>
</tr>
<tr>
<td>Secondary School</td>
</tr>
<tr>
<td>Special School</td>
</tr>
<tr>
<td>TAFE</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Missing data</td>
</tr>
<tr>
<td><strong>Overall Total</strong></td>
</tr>
</tbody>
</table>
Only senior Child Protection Managers or the Children’s Court can place young people in Secure Welfare and only within legislative criteria regarding immediate history of harm. DHS Policy and Procedures (1992) states that common factors in young people placed in Secure Welfare services may include a long history of involvement in out of home care; multiple placement breakdowns; abuse and/or neglect; history of chronic substance abuse; poor educational and social life skills; disabilities; mental illness; health problems and multiple family problems.

5.4.1 Role of Take Two in relation to Secure Welfare cases

Whilst there was no specified expectations of how many clients would be seen by the Secure Welfare Take Two component of the program, it was evident that in 2004 demand for this service outstripped the capacity of a sole position.

The Take Two Secure Welfare Senior Clinician had 80 clients who were not involved in other parts of the Take Two program; 7 clients who were later referred to a regional Take Two team; and 4 clients who were directly transferred from Secure Welfare to a regional Take Two team. This position also provided consultation to other Take Two clinicians when their clients were admitted to Secure Welfare.

5.4.2 Child Protection region of Take Two Secure Welfare clients

As would be expected the large majority (71%) of Secure Welfare Take Two clients were from the metropolitan regions. This was compared to an even greater percentage of young people (80%) admitted to Secure Welfare in general from the metropolitan regions during 2004. There were no statistically significant differences for any of the regions in terms of the proportion of Secure Welfare Take Two clients compared with the proportion of Secure Welfare clients in general. Table 17 shows the regional background of the Secure Welfare Take Two clients in 2004.

During 2004 there were 425 admissions to the Secure Welfare Service involving 185 Child Protection clients. The 87 admissions of Secure Welfare Take Two clients were in relation to 71 Child Protection clients. These 71 included 54 who were referred on one occasion, 15 who were referred on two occasions and one who was referred on three occasions. Thirty-eight per cent of Secure Welfare admissions were seen by the Take Two Senior Clinician, which is a large percentage of the total Secure Welfare client group given there was only one Take Two position.

5.4.3 Number of admissions and total time spent in Secure Welfare for Take Two Secure Welfare clients

Table 18 shows the number of admissions to Secure Welfare for Take Two clients ranged from 34 young people who had the one admission to two young people who had 15 admissions in 2004. The large majority of Secure Welfare Take Two clients (78%) had less than four admissions to Secure Welfare during 2004.

The maximum length of a placement in Secure Welfare is 21 days or up to 42 days in exceptional circumstances (Children & Young Persons Act, 1989, S 124(b)). However, the length of placement should be the ‘shortest period consistent with the safety of the young person’ (DHS, 2003a, 5).

As Table 19 reveals, no Secure Welfare Take Two client spent less than five days in Secure Welfare in 2004. Just less than a quarter (24%) spent between five and nine days in Secure Welfare. A similar percentage (26%) spent between 10 and 19 days in Secure Welfare, whereas 29% spent between 20 and 39 days in Secure Welfare. The remaining 21% spent 40 days or more in Secure Welfare, including one client who spent 114 days in Secure Welfare in 2004, equating to nearly a third (31%) of the year.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon South West</td>
<td>3</td>
<td>3.4</td>
<td>16</td>
<td>3.8</td>
</tr>
<tr>
<td>Eastern Metropolitan</td>
<td>19</td>
<td>21.8</td>
<td>115</td>
<td>27.1</td>
</tr>
<tr>
<td>Gippsland</td>
<td>2</td>
<td>2.3</td>
<td>9</td>
<td>2.1</td>
</tr>
<tr>
<td>Grampians</td>
<td>4</td>
<td>4.6</td>
<td>15</td>
<td>3.5</td>
</tr>
<tr>
<td>Hume</td>
<td>10</td>
<td>11.5</td>
<td>30</td>
<td>7.1</td>
</tr>
<tr>
<td>Loddon–Mallee</td>
<td>6</td>
<td>6.9</td>
<td>17</td>
<td>4.0</td>
</tr>
<tr>
<td>Northern Metropolitan</td>
<td>8</td>
<td>9.2</td>
<td>140</td>
<td>32.9</td>
</tr>
<tr>
<td>Western Metropolitan</td>
<td>11</td>
<td>12.6</td>
<td>83</td>
<td>19.5</td>
</tr>
<tr>
<td>Southern Metropolitan</td>
<td>24</td>
<td>27.6</td>
<td>83</td>
<td>19.5</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>100</td>
<td>425</td>
<td>100</td>
</tr>
</tbody>
</table>

*These four clients are not included in the following analysis as they were included in the regional analysis. Therefore, the number of clients in this analysis is 87 young people.*
5.4.4 Age and gender of Secure Welfare Take Two clients

The Secure Welfare Service is available for children and young people aged 10 to 17 years. The age range of Secure Welfare Take Two clients closely follows the age distribution of Secure Welfare clients in general, as illustrated in Table 20. The large majority of clients (87%) are aged 13 to 16 years inclusive.

There are two Secure Welfare services; a young women’s and young men’s unit, each with a ten-bed capacity. The percentage of females referred to Secure Welfare Take Two was 55%, slightly less than the 60% of females that made up Secure Welfare admissions in 2004. The proportion of male and female Secure Welfare Take Two clients closely mirrors the general Secure Welfare client population.

The following vignette illustrates the extreme high risk behaviour of young people admitted to Secure Welfare who are referred to Take Two. Marcia’s story is of a young woman experiencing severe consequences of individual and community trauma. The impact of trauma on generations of her family and people is also demonstrated. The Take Two Aboriginal and Secure Welfare Senior Clinicians worked together to use

### Table 18: Number of Secure Welfare admissions in 2004 for Secure Welfare Take Two clients

<table>
<thead>
<tr>
<th>Number of Secure Welfare admissions</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>34</td>
<td>39.1</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>23.0</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>16.1</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>6.9</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>8</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>87</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### Table 19: Total days placed in Secure Welfare for Secure Welfare Take Two clients in 2004

<table>
<thead>
<tr>
<th>Total number of days in Secure Welfare</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to 9</td>
<td>20</td>
<td>23.5</td>
</tr>
<tr>
<td>10 to 19</td>
<td>22</td>
<td>25.9</td>
</tr>
<tr>
<td>20 to 29</td>
<td>15</td>
<td>17.6</td>
</tr>
<tr>
<td>30 to 39</td>
<td>10</td>
<td>11.8</td>
</tr>
<tr>
<td>40 to 49</td>
<td>4</td>
<td>4.7</td>
</tr>
<tr>
<td>50 to 59</td>
<td>7</td>
<td>8.2</td>
</tr>
<tr>
<td>60 to 69</td>
<td>4</td>
<td>4.7</td>
</tr>
<tr>
<td>70+</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### Table 20: Age at time of admission to Secure Welfare for Secure Welfare Take Two clients – 2004

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>T2 Secure Welfare Number</th>
<th>Percent</th>
<th>General Secure Welfare Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>1</td>
<td>1.1</td>
<td>8</td>
<td>1.9</td>
</tr>
<tr>
<td>11</td>
<td>1</td>
<td>1.1</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>3.4</td>
<td>22</td>
<td>5.2</td>
</tr>
<tr>
<td>13</td>
<td>14</td>
<td>16.1</td>
<td>63</td>
<td>14.8</td>
</tr>
<tr>
<td>14</td>
<td>15</td>
<td>17.2</td>
<td>79</td>
<td>18.6</td>
</tr>
<tr>
<td>15</td>
<td>28</td>
<td>32.2</td>
<td>111</td>
<td>26.1</td>
</tr>
<tr>
<td>16</td>
<td>19</td>
<td>21.8</td>
<td>108</td>
<td>25.4</td>
</tr>
<tr>
<td>17</td>
<td>6</td>
<td>6.9</td>
<td>33</td>
<td>7.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>87</strong></td>
<td><strong>100</strong></td>
<td><strong>425</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
culturally appropriate approaches to assessment, to engage Marcia and to identify strategies to guide intervention with her in her community.

5.4.5 Reasons for referral and recommendations made by Secure Welfare – Take Two

The two most common reasons for referral in relation to Secure Welfare Take Two clients were for recommendations and mental status examinations. Also mentioned as reasons for referral, but much less often, were requests for psychological assessment, clinical risk assessment, cognitive assessment and treatment planning. Due to the amount of missing data specific figures are not given.

The Take Two Secure Welfare Senior Clinician provides brief assessment and interventions; secondary consultation and support to staff of Secure Welfare and Child Protection through discussions and attendance at meetings; and consultation to other workers, including CSOs, CAMHS, drug and alcohol services and regional Take Two teams.

Marcia

Fifteen-year-old Marcia was referred to Take Two at Secure Welfare. She first became involved with Child Protection when she was seven and has had six notifications since. Protective concerns noted at referral to Take Two include: her exposure to family violence; exposure to her mother’s substance use and mental health issues; significant emotional abuse (including severe scapegoating and rejection by her mother); significant environmental neglect; and significant physical abuse. Marcia has a history of multiple placements and changes of school. She has had three previous admissions to Secure Welfare and was also detained on remand for a two week period.

Marcia’s mother has a limited capacity to respond to Marcia’s behaviour and has minimal insight into her own contribution to Marcia’s difficulties. The birth of a younger sibling further impacted on her mother’s capacity to adequately respond to Marcia’s emotional needs, particularly when the younger child became ill and required a higher level of care. Marcia’s sibling passed away three years ago and this was a significant loss.

Marcia’s mother is Aboriginal and she strongly identifies with her Aboriginal culture. Marcia’s father has a diagnosis of schizophrenia. Marcia’s father left during her early childhood and she felt abandoned by this. He has since been incarcerated for a period of time and now has no contact with Marcia. His current address is unknown.

Marcia’s stepfather is Aboriginal. His mother died when he was nine. He has an acrimonious relationship with Marcia’s mother. They have had several separations and are not in a relationship at present.

Ongoing rejection from her mother and her chaotic childhood are likely to have led to Marcia’s current poor sense of self and the world, such that she presents with a minimal sense of future, permanence and security. Severe difficulties in regulating her emotions are likely to have been influenced by her mother’s limited capacity to support the development of emotional regulation during infancy and early childhood, and by ongoing modelling of poor emotional regulation. Current difficulties with developing and maintaining interpersonal relationships are likely to be impacted upon by early disrupted attachments with significant carers and ongoing parental rejection.

Her disrupted and chaotic early childhood and changes in school have also impacted upon Marcia’s academic functioning. Marcia engages in a number of high risk behaviours that include:

• Substance use including heroin, marijuana and alcohol;

• Engaging in severe physical and verbal violence towards others;

• Absconding from placement;

• Associating with high-risk persons (e.g., with known paedophiles and where young persons have engaged in sexual acts in exchange for alcohol and drugs); and

• Stealing.

Marcia displays poor impulse control. It is noted that Marcia has significant eating and body image difficulties – she has been described as rarely eating in front of others.

There are major cultural issues that impact upon Marcia’s family, including a history of chronic inter-generational conflict within the extended family and community. The wider Indigenous cultural issues around grief and loss also need to be considered in understanding how the immediate experiences of death and illness might have been experienced by Marcia and her family.

The Take Two Secure Welfare Senior Clinician and the Aboriginal Senior Clinician worked together to provide an assessment of Marcia and her experience of loss and trauma and its impact on her capacity to form relationships and make effective decisions for herself and her safety. Take Two was involved in a case conference to assist in revising a safety plan for Marcia of which she has some ownership.
The Take Two Secure Welfare Clinician makes recommendations to the case manager regarding future interventions and other planning. Data was not available regarding recommendations for 23% of the cases. However, the cases where recommendations are recorded provide an insight into the role within Secure Welfare. In order of frequency recommendations made included: the type of placement; medication assessment or review; individual therapy; educational or vocational planning or action; behaviour management plans; work on relationships, including family members and other attachments; and recommendations relating to social skills and social networks.

5.5 Summary
The data demonstrates that Take Two is working with the intended client group regarding children already demonstrating significant emotional and behavioural issues due to trauma and disrupted attachment. There have not been many referrals relating to children who are not yet showing these or other symptoms. There have also been few referrals for younger children, whether or not they are showing disturbance. Therefore, the degree and scale of complexity associated with these children is higher than anticipated.

A particular concern for the Take Two program is when there is concern that the children are not in a safe and consistent environment. The literature cautions against treatment if safety cannot be assured. Yet these children are sometimes living in unsafe or uncertain situations, such as indicated by those who were removed from home during Take Two involvement (6%); those who experienced some form of abuse in care (7%) either by a carer or by another client; and those who were continuing to place themselves in danger such as through suicide attempts, self harming or reckless behaviours. The high proportion of children who have experienced multiple placements in the past and who are continuing to experience moves or the prospect of changing placement is another obstacle in providing effective therapy. This report highlights the importance of a service system which promotes safety and wellbeing. The challenge for Take Two is how to best intervene with these children, whilst contributing to the system’s efforts to ensure their safety.
Chapter 6: Interventions for Regional Clients

- What are the goals and desired outcomes of Take Two intervention?
- Was Take Two able to engage with the client group?
- What interventions is Take Two using with this client group?
- What are the other service systems involved with these children?
- What are the implications of working with this client group for the implementation of Take Two?

6.1 Overview

This chapter utilises the Take Two outcomes framework to analyse the desired outcomes and goals for Take Two intervention from the perspective of the referrers and regional Take Two clinicians during 2004. The strategies of engagement and interventions with the child, family and service system are then described and the implications discussed.

6.2 Desired outcomes and goals

6.2.1 Desired outcomes for Take Two intervention by referrer

In relation to cases referred to the Take Two teams (not including Secure Welfare cases), 214 of the 233 cases had specified desired outcomes for Take Two involvement at the time of referral. The desired outcomes provided by the referrer have been recoded using the Take Two outcomes framework as shown in Table 21. The largest proportion of desired outcomes related directly to the child's wellbeing (52% of desired outcomes), with the next highest being in the domain related to family and community relationships (22%).

Some of the referrers’ desired outcomes in relation to the Child Safety domain included working with parents to reduce abusive behaviours towards the child (n=11 children), reduction or cessation of highly reckless or risk-taking behaviours (n=9), reduction or cessation of self-harming or suicidal behaviours (n=5) and reduction or cessation of absconding (n=4).

A sample of the desired outcomes under the Child Wellbeing domain included reduction of symptoms relating to anger and aggression (n=40), improved self-esteem (n=31), child to understand the impact of past experience (n=27), dealing with abandonment and rejection (n=19), improved school attendance (n=18), strengthening healthy emotional expression (n=16), assisting in the control of sexualised behaviours (n=13) and being able to communicate about past experiences (n=12).

Specific desired outcomes coded within the Stability/Security and Connectedness domain included support of home return (n=27), strengthening child’s identity or sense of belonging (n=23), contributing to

| Table 21: Desired outcomes at time of referral according to referrer for regional Take Two clients – 2004 |
|-----------------------|-----------------------------------------------|-----------------|-----------------|
| Domain               | Desired Outcomes                             | Number of responses | Percent of cases |
|                      |                                               |                  |                 |
| Child                | Reduction of harm due to child’s behaviour    | 26               | 12.1            |
| Safety               | Promotion of child’s safety                   | 19               | 8.9             |
|                      | Other child safety goals                      | 1                | 0.5             |
| Child                | Recovering from trauma                        | 111              | 51.9            |
| Wellbeing            | Improved cognitive and/or language development| 7                | 3.3             |
|                      | Improved school attendance and/or performance | 25               | 11.7            |
|                      | Enhanced emotional, behavioural, social and/or physical wellbeing | 125           | 58.4            |
|                      | Other child wellbeing goals                   | 9                | 4.2             |
| Stability/Security   | Strengthening attachments and/or forming quality relationships | 36               | 16.8            |
| Connectedness        | Strengthening child’s identity, sense of belonging and/or connectedness | 25               | 11.7            |
|                      | Contributing to appropriate, stable and secure placement for child. | 73               | 34.1            |
| Family and community | Strengthening quantity and/or quality of informal and/or formal social networks | 41               | 19.2            |
|                      | Strengthening parents’, other family and/or carer’s capacity to meet child’s emotional and other needs | 132              | 61.7            |
| Other                | Other desired outcomes                        | 31               | 14.5            |
|                      |                                              |                  |                 |
| Total                |                                               | 811              |                 |
| Missing data         |                                              | 19 cases         |                 |
child remaining in current placement (n=16), enhancing child's ability to form attachments (n=9) and contributing to the child remaining at home (n=5).

Under the domain of Family and Community some of the desired outcomes included strengthening parent-child relationships (n=38), strengthening parents’ capacity to meet child’s needs (n=36), strengthening carers’ capacity to meet child’s needs (n=19), developing or improving peer relationships (n=20), assessment of parenting capacity (n=12), strengthening parents’ emotional wellbeing (n=10) and assessment of access arrangements (n=5).

6.2.2 Desired outcomes/goals according to regional Take Two clinicians

As with the referrer, the largest proportion of goals provided by the Take Two clinician at the time of the evaluation were in the Child Wellbeing category (41% of goals). Take Two clinicians had more goals relating to Stability/Safety and Connectedness (28%) than Family and Community relationships (17%). This was the major difference between Take Two clinicians’ view compared to the desired outcomes of the referrer. It is important to note, however, that this may also reflect the difference in time, as Take Two workers were interviewed retrospectively, whereas the referrers desired outcomes were noted at the time of referral.

The Take Two staff journals revealed a common theme regarding staff’s expectations for clients of maintaining hope.

'Sometimes we can only make small changes, but small changes can have a big impact.'

'Every one of these families have complex and multilayered issues, and if this isn’t enough I then want to be able to intervene in such a way that will make a positive difference to them – I think it’s a big ask but one that I’m starting to see is more and more achievable and possible. This is even more challenging given the entrenched family dynamics and the level of trauma and mental health issues within these families.'

'Accepting that we cannot change everything and sometimes we should make our goals smaller to be more realistic and achievable.'

6.3 Engagement

There is a longstanding concern that many Child Protection clients are resistant to services and resistant to change. One of the core guiding principles underlying Take Two is ….

'Engagement is considered to be the responsibility of the service, not the client, and as such a creative, persistent, assertive and adaptive approach will be taken to maximise the opportunities for the children and their networks to be engaged with the Take Two service.' (Downey, 2004)

According to regional Take Two clinicians they had successfully engaged with 83% of those clients they had attempted to engage with in 2004, and were still working towards engagement with most of the remaining group of clients. This persistence in engagement is evidenced by the fact that during 2004 only eight of the total 320 (2.5%) cases were closed due to the client refusing the service. The length of time involved with those cases prior to closure ranged from three and a half months to nine months, not including one Secure Welfare client.

According to regional Take Two clinicians nearly three-quarters (72%) of those children who were engaged, were so within three months. This included children who engaged on a superficial level very quickly as part of their pattern of indiscriminate attachments. For 9% of clients who were engaged, engagement took seven months or longer. For 14 clients, the Take Two clinician had not yet tried to engage the client due to the early stage of the referral. Where engagement did not occur directly or quickly with the child, the Take Two clinician worked towards engagement with other members of the child’s network such as their parents or carers.

There was some discussion in the Take Two staff journals of the difficulties in engaging certain clients and questioning how long to try to engage them, for example if the clients are consistently absent. One worker noted that she had seen a child for months who was only recently beginning to show signs of connection. There was evident satisfaction when progress was made in engaging with children and their families.

'Some children and families…are starting to open up and talk more, with really significant information being discussed giving me greater insight.'

6.3.1 Strategies for engagement

The Take Two staff journals revealed a strong theme of undertaking outreach work, including doing activities with children to facilitate engagement. In fact, outreach was the most commonly reported strategy used to facilitate engagement (61% of cases) most of which occurred in the child’s home, placement, school or child care. There were also visits to the child in Secure Welfare, Juvenile Justice centres, parks and other public places. In several instances outreach to the client occurred at multiple locations during the engagement phase. Other frequently used strategies to engage were using enjoyable activities (30%); engaging with others to promote engagement with the client (such as with parents and/or carers) (21%); being consistent and reliable (20%); empathy and validation (19%); timing and flexibility of approach (17%); persistence and assertiveness (13%); doing practical things for the child or the family (13%); and purposeful choice of therapy room (9%).
6.3.2 Factors that promoted engagement according to regional Take Two clinicians

Child factors that promoted engagement included the child’s willingness to engage (9%), the child being ready to deal with their difficulties (5%) and the child’s trust and hope in change (3%).

Parent related factors included the parents’ willingness to engage (7%), parents’ support of the child receiving therapy (5%) and the fact that Take Two was working with the child’s parents (4%). Take Two’s work with the siblings was also seen as promoting engagement for 7% of cases.

Ways in which carers promoted engagement included the carers’ support of the child receiving therapy (18%), their willingness to engage (7%), and helping with transport to and from therapy sessions (6%). Factors promoting engagement related to Child Protection and CSO case management included being supportive of the child receiving therapy (12%) and the presence of effective working relationships (5%). An important way schools promoted engagement was by supporting the child to receive therapy (6%).

6.3.3 Barriers to engagement according to regional Take Two clinicians

Similar to factors that promoted engagement, there were a wide variety of factors that clinicians perceived as barriers to engaging with clients. The difficulty of engagement was a strong theme in the Take Two staff journals. This was accompanied by an understanding that the families’ resistance to services often related to their experiences with the service system and to the current situation they were in (such as court involvement). There was acknowledgement of children and families not trusting workers leading to the need for patience, persistence and creativity.

Barriers for engagement relating to the child included some children having minimal trust or fear of others (19%), their level of loss, trauma and emotional difficulties (9%), their lack of readiness or awareness (7%), absconding or missing appointments (7%), their resistance or lack of cooperation (7%), their low cognitive functioning or other disability (6%) and when they did not want to be involved with Take Two or any other service (5%).

Barriers related to parents included when they were uncooperative and not wanting to be involved (13%), their chaotic and/or traumatic lifestyles (10%), their mental health difficulties (8%), their lack of awareness or being unrealistic (8%), missing or cancelling appointments (7%), their own needs overriding the child’s needs (6%), their relationship difficulties with their child or others (6%), being guarded, untrusting, defensive or fearful (3%) and their previous negative experiences with other services (4%).

The most commonly reported barrier relating to placements was when the placement was unpredictable or uncertain (13%). Other barriers included carers being uncooperative or unwilling to be involved with Take Two (7%) and carers who were inappropriate, intrusive or unsupportive of the child receiving therapy (6%).

Barriers related to Child Protection or CSO case management included concerns about case management (14%), case plan processes and decision making (8%), unwillingness to be involved or being uncooperative (5%) and there being no case management or unavailable case management (4%).

Take Two was listed as a barrier to engagement in relation to a lack of appropriate or consistent therapeutic space in 4% of cases. For example, in a couple of regions, Take Two had limited access to appropriate therapeutic rooms when needed. A practical barrier of distance was listed for 9% of cases.

6.4 Interventions used by Take Two for regional clients

Table 22 outlines how regional Take Two clinicians’ client-related time was spent. This revealed that in Take Two’s first year of operation a third of client-related time was spent in liaison and networking activities, such as facilitating care team approaches whereby parents, carers and other workers were supported in understanding the child’s situation and their internal world. A quarter of client-related time was spent providing direct interventions. Seventeen percent of client-related time was spent in the assessment phase. Table 23 provides a description of the time spent directly with the client or their parents, carers or other members of their social network. Over a third

| Table 22: Overview of types of services provided by Take Two to regional Take Two clients – 2004 |
|--------------------------------------------------------------|------------------|
| Type of Service (n=224)                                      | Percent of time  |
| Referrals                                                    | 3.9              |
| Assessments                                                 | 16.7             |
| Interventions                                                | 25.3             |
| Liaison/Networking                                           | 33.4             |
| Supervision                                                  | 11.7             |
| Other                                                        | 9.1              |
| Total                                                        | 100              |

Frederico, Jackson & Black (2005) Reflections on Complexity – Take Two First Evaluation Summary Report, La Trobe University, Bundoora, Australia
of direct service time (37%) was in relation to assessment. This is not surprising in the first year of the program given that: firstly, all the cases were new and so each one went through an assessment period; and secondly, as Take Two was in the process of finalising assessment processes, they were more time consuming earlier in the year.

Nearly half of direct service time was spent providing direct interventions. The majority (60%) of this time was spent providing interventions to the child on their own. The remaining 40% of direct client-related time consisted of interventions for family, carers and other aspects of the client’s social network or a combination of the above.

6.4.1 Interventions with children

The most frequent interventions with children were psychotherapy and play therapy, which were provided in 46% of cases. Other frequently provided interventions to the clients included behaviour management (27%), CBT (26%), child-parent therapy (24%), multi-system interventions (15%), child-sibling therapy (9%) and crisis intervention (9%).

6.4.2 Interventions with parents and carers

The most commonly provided intervention to parents was psycho-education, which was provided to parent/s of 40% of the regional clients. Other interventions provided to parents were child-focused therapy (28%) and individual therapy (28%). Interventions provided with other family members included family therapy (17%), behaviour management (11%), narrative therapy (6%), CBT (6%) and crisis intervention (6%).

As with parents, the most commonly provided intervention to carers was psycho-education (42%). Behaviour management (30%), child focused therapy (27%) and a care team approach involving carers were the next three most commonly used interventions with carers. In 10% of cases, work was undertaken with the parents and carers together.

6.4.3 Interventions with schools

A variety of interventions were provided to clients’ schools which most commonly took the form of consultancy and education (40%). This education was often regarding what was reasonable to expect of children who have traumatic experiences. Other interventions provided were advocacy for the client (21%), behaviour management (20%), care team approach (20%), complex casework coordination (13%), recommendations to refer to other services (10%) and social network development (8%).

Part of the brief for Take Two is to seek to bring about positive changes in the service system. The secondary consultations with schools and the direct work with some schools in relation to individual Take Two clients began to bring about more effective relationships during 2004 and this was reflected in staff journal entries.

6.4.4 Interventions with the broader service system

Interventions provided to the broader service system followed a similar pattern to the interventions

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Percent of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment – Child</td>
<td>12.5</td>
</tr>
<tr>
<td>Specialist assessment – Child</td>
<td>2.6</td>
</tr>
<tr>
<td>Assessment – Parent</td>
<td>8.8</td>
</tr>
<tr>
<td>Assessment – Family</td>
<td>5.0</td>
</tr>
<tr>
<td>Assessment – Child’s placement</td>
<td>4.0</td>
</tr>
<tr>
<td>Assessment – Child’s school</td>
<td>2.4</td>
</tr>
<tr>
<td>Assessment – Child’s other contexts</td>
<td>1.5</td>
</tr>
<tr>
<td>Intervention – Child</td>
<td>30.1</td>
</tr>
<tr>
<td>Intervention – Parent</td>
<td>7.3</td>
</tr>
<tr>
<td>Intervention – Child/Parent</td>
<td>2.6</td>
</tr>
<tr>
<td>Intervention – Family</td>
<td>1.7</td>
</tr>
<tr>
<td>Intervention – Child/Carer</td>
<td>1.7</td>
</tr>
<tr>
<td>Intervention – Carer(s)</td>
<td>4.8</td>
</tr>
<tr>
<td>Intervention – Child/Siblings</td>
<td>0.2</td>
</tr>
<tr>
<td>Intervention – Child/School</td>
<td>0.6</td>
</tr>
<tr>
<td>Intervention – Child/Social network</td>
<td>0.2</td>
</tr>
<tr>
<td>Intervention – Group</td>
<td>0.1</td>
</tr>
<tr>
<td>Primary Consultation</td>
<td>0.3</td>
</tr>
<tr>
<td>Follow-up after Closure</td>
<td>1.3</td>
</tr>
<tr>
<td>Information/Communication with Child/Family</td>
<td>5.3</td>
</tr>
<tr>
<td>Case Conference involving Family</td>
<td>7.2</td>
</tr>
<tr>
<td>Total of Direct Involvement</td>
<td>100</td>
</tr>
</tbody>
</table>
provided to schools. For nearly half of all cases (47%), consultancy and education was provided to the service system. There was advocacy of the child (44%); complex case work coordination (37%); a care team approach involving the service system (34%); behaviour management strategies (11%); crisis intervention strategies (10%) and interventions relating to social network development (10%).

6.4.5 Multiple interventions
For the large majority of cases there were multiple approaches to intervention. On average 9.4 types of interventions were provided for each case, with the higher proportion being with the child and the service system. This highlights the diverse therapeutic interventions that Take Two clients receive and require, given their complex experiences.

In only 6% of the cases (n=13) the client was the only person to receive direct intervention from Take Two. Most of these cases were where an assessment was the only intervention provided. There were nine further cases (4%) where only the service system was the focus of intervention. These were usually cases referred early in the establishment of Take Two, and where it was agreed soon after that the referral was inappropriate and the client was referred to another service.

For 90% of regional cases, there was more than one focus of intervention – some combination of client, parent, other family, carer, school and service system interventions. For two-thirds of cases interventions were provided to four or more of the six possible foci of interventions. This highlights the multi-faceted approach of Take Two interventions, an approach that is considered essential to effect change with this client group.

6.4.6 Location of service provision and travel
As shown in Table 24, during 2004 just over half of regional Take Two staff’s client-related service provision time was undertaken in Take Two offices with a further 20% in other offices. Eight percent of client-related service time was spent at the child’s family home, a further 6% spent at the child’s placement and 4% spent at the child’s school or preschool.

In terms of travel time, over a third of client-related travel time was spent travelling to offices other than Take Two locations. Travel to the child’s family home, placement and school or preschool accounted for 41% of client-related travel time.

6.5 Summary
The goals of Take Two interventions were primarily focused on reducing emotional and behavioural symptoms and enhancing the children’s general wellbeing. Despite the complexity of these children’s lives and multiple service involvement, Take Two did appear to effectively engage with most children and their networks. Take Two demonstrated that it took

<table>
<thead>
<tr>
<th>Location</th>
<th>Service</th>
<th>Travel</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s family home</td>
<td>7.8</td>
<td>17.2</td>
<td>10.4</td>
</tr>
<tr>
<td>Child’s placement</td>
<td>6.0</td>
<td>13.7</td>
<td>8.1</td>
</tr>
<tr>
<td>Take Two office</td>
<td>54.1</td>
<td>11.2</td>
<td>42.6</td>
</tr>
<tr>
<td>Other offices</td>
<td>19.9</td>
<td>36.4</td>
<td>24.4</td>
</tr>
<tr>
<td>Secure Welfare</td>
<td>1.6</td>
<td>2.7</td>
<td>1.9</td>
</tr>
<tr>
<td>School/Preschool</td>
<td>4.3</td>
<td>10.4</td>
<td>5.9</td>
</tr>
<tr>
<td>Public area</td>
<td>1.9</td>
<td>3.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Other</td>
<td>4.4</td>
<td>5.3</td>
<td>4.7</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
the principle of taking responsibility for engagement very seriously and proactively.

Take Two employed a range of interventions across many aspects of the child's life and context. There was a significant amount of systemic work involving concepts such as the care team and using approaches such as psycho-education and advocacy. The emphasis on the different service systems needing to work collaboratively on shared goals of ensuring the child had nurturing and healing relationships was evident.

A major dilemma is how to provide therapy for those children who are not in a secure environment and have limited access to adults who are consistent in their lives and with whom they can develop trusting relationships. Individual therapy for these children can be contraindicated but there is still often a role for Take Two to contribute to and reinforce the capacity for the child’s network to provide the essential nurturing responses that the child needs.

Another implication in working with this client group is how to provide a process of throughput so that Take Two is able to achieve its targets of expected client numbers, yet provide the level of service required for these most vulnerable children.

This case vignette highlights some of the factors relating to the amount of travel required for client work and the implications of this travel for the program.

Peter and Suzie

Peter and Suzie, aged eight and eleven years, were referred to a rural Take Two team. The children had a history of abuse in the care of their mother, who presented with a history of distraction from her children’s needs through her own traumas: including adoption, mental illness, drug abuse, acquired brain injury, low cognitive functioning and violent relationships. Since removal from their mother’s care four years ago, Peter and Suzie have suffered multiple placements due to significant emotional and behavioural disturbance. At the time of the referral to Take Two the children had moved to a new placement, the first they had had together for some time.

On assessment it was therapeutically indicated that the children would require individual sessions, possibly family sessions with the foster family and, potentially, with the mother. It was indicated that their carers would require support sessions, as would the foster care agency, Child Protection and After School Care workers. Given that the children enjoyed school and had already experienced considerable school disruption, it was in the best interest of the children to allocate session times after school hours. Also, the carers worked during the day and required sessions after hours.

This intervention plan resulted in the clinician travelling from the Take Two office at 9am, arriving in the Child Protection office around noon to complete DHS networking and consultation regarding the systems intervention related to the children. The clinician then visited the children and carers, leaving around 6.30pm and arriving back at the Take Two office around 9.30pm.

Some months after engagement with the children and support systems, the case was listed for contestation when DHS applied for a Guardianship order. The court requested Take Two to complete an attachment assessment with the mother and children over a three-month period, including individual sessions with mother and family observations. In the interim, the children, carer and support network continued to require intervention as previously.

For this assessment the Take Two clinician was required to leave her home by 7am to drive four hours for an 11am appointment with the mother. The clinician then completed either systems support or family observations, followed by meetings with the children and carer at their scheduled times, arriving back at the Take Two office around 9.30pm.

As expected, the children and carer required additional support at this time given that the mother-child contact was greater than usual, escalating the children’s behaviours and placing pressure on a placement where the carers had concern that they may lose the care of the children. Intervention with the mother was particularly difficult given her cognitive and emotional limitations, and on several occasions appointment times and spaces had to be altered at the last moment.
Chapter 7: Conclusion

7.1 Introduction
This chapter presents a series of conclusions about the commencement of Take Two and directions for future development of the service. This report covers the first of three stages proposed for the evaluation of Take Two. The evaluation addressed six questions, namely:

1. Has Take Two been established according to the stated objectives and expectations?
2. What are the inputs and processes put in place in its first year of operation?
3. Are these inputs and processes sufficient to achieve the stated objectives for the program?
4. Is Take Two working with the intended client group?
5. In what way is Take Two working with the client group and are the interventions in accordance with the available evidence and expectations of key stakeholders?
6. What are the lessons from this first year of operation that continue to inform the ongoing development of the Take Two program?

To explore these questions the evaluation utilised a framework which explores the conceptual development of the program, the development of the internal structures and culture to support the program, the training and evaluation strategy and the multiple levels of intervention utilised. In addition the evaluation analysed characteristics of the internal and external world of these children who were clients of Take Two in 2004.

7.2 Overview of findings as described in the report
The evaluation has demonstrated that Take Two has been implemented according to the requirements of DHS. The findings are presented throughout the report focusing on the first five of these six questions as summarised below.

7.2.1 Has Take Two been established according to the stated objectives and expectations?
This evaluation has demonstrated that Take Two has been established according to the stated objectives and expectations as specified in the DHS submission brief. Each region in Victoria has an established and operating Take Two service as well as the two statewide functions in Secure Welfare and the Aboriginal team. The research and training functions have also been implemented.

Establishing a new statewide service across fourteen sites simultaneously within one year is a considerable feat and required significant collaboration with Child Protection and other regional and statewide services. It also required strong leadership and commitment by the partnership organisations and within Take Two itself.

The one area where Take Two did not meet the stated objectives was in relation to the expected number of 710 clients to be seen per year. However, in discussions between DHS and Take Two it was acknowledged that this target did not reflect the reality of the other expectations of the program, such as the complexity of the client group and the service system, the referral processes where Child Protection was the gatekeeper and the need for many of these children to receive long-term therapeutic services. The target number was adjusted to 550 clients for the subsequent year. In addition to the 320 clients who were provided a direct service in 2004, Take Two provided consultation regarding approximately 388 clients.

7.2.2 What are the inputs and processes put in place in the first year of operation for Take Two?
Major inputs into implementing the Take Two program in 2004 included the following:

• The governance and advisory arrangements for the overall program were put in place.
• All staff positions were filled across the state and the various roles.
• All staff either had or exceeded the requisite qualifications.
• All teams had premises established in their region.
• Networks and working relationships with key stakeholders were developed in each region, although there was some feedback from a couple of services that this was insufficient.
• The training and development strategy was implemented for Take Two staff and external services, with a focus on internal training and training related to the referral process in the first year.
• The research and evaluation strategy was implemented including the outcomes framework,
staff journals, review of the referral processes and regular client data collection.

7.2.3 Are these inputs and processes sufficient to meet the stated objectives for the program?
As this was the first year of implementation of Take Two dedicated resources were required to establish foundational systems and processes in order to provide a high-quality service with embedded training and research components. Nevertheless, priority was given to clinical operations on an individual and program basis. The processes required to establish such a service are ongoing and incremental, and as such have continued into 2005. The ACHS quality assurance requirements provide a useful structure for the ongoing program development work.

The two areas where demand clearly outstretched capacity were in relation to Secure Welfare and Aboriginal clients. A shared understanding has developed across the various advisory processes and in discussions with DHS regarding these particular pressure points.

7.2.4 Is Take Two working with the intended client group?
The identified client group for Take Two as specified in the submission brief was to work with children who had experienced significant maltreatment and who were either showing emotional and behavioural disturbance or at risk of showing such disturbance. The data from the first year has demonstrated that Take Two is working almost exclusively with the first group and has received few referrals regarding children who are not yet showing major symptoms of disturbance. In other words, there are minimal earlier intervention referrals, despite this being an expectation in the originating documentation. The data also shows that whilst Take Two was established to work with all age groups, it received a smaller proportion of referrals for infants and young children compared to other age groups.

7.2.5 In what way is Take Two working with the client group and are the interventions in accordance with the available evidence and expectations of key stakeholders?
From the onset of referral Take Two actively considers what are the most appropriate, realistic and critical goals of interventions in order for the child and his or her system to have the best chance possible of being engaged in a process of recovery. This involves explicit questions in the referral documentation and is subsequently built on in a thorough assessment process. Take Two emphasises the principle that it has responsibility for engaging with the child, rather than the child holding this responsibility. Many of these children have learnt not to trust adults who have often been the source of harm, rejection and disappointment. However, enlisting the child’s cooperation, curiosity and hope in a process of recovery is crucial for positive change and the development of future safe and trusting relationships. Take Two clinicians demonstrated persistence and creativity in endeavouring to engage most of the children in a therapeutic alliance. Where engagement did not occur initially, clinicians engaged with other elements of the child’s network whilst continuing to explore various strategies for engaging the child directly.

Take Two intervened on multiple levels and at multiple sites, including individual, dyadic and family focused interventions using psychotherapy, cognitive behavioural therapy, psycho-education, family therapy and other therapeutic approaches. The level of system work became apparent early on in the year and in particular the use of care teams. A care team enables those interacting with a child on a frequent basis to be consistent in their approaches and thereby communicating to the child that they are able to provide a safe, nurturing and responsive environment. This reinforces to the child that there are adults who are thinking and caring about them, even when they are not present; in other words, they are keeping the child in mind.

These interventions were informed by an ongoing review of the literature, in-service training and the practice knowledge of experienced clinicians. The development of a Practice Framework with principles for engagement, assessment and intervention provided a guide to clinicians based on ecological systems perspective, trauma theory and attachment theory.

7.3 Other lessons learned
In addition to these findings, the evaluation explored the question regarding what were the learnings from this first year of operation that inform the ongoing development of the Take Two program.

7.3.1 The children and young people
Children who are clients of Take Two are demonstrably severely affected by multiple forms of abuse and neglect. This evaluation highlights numerous interacting risk factors in their internal and external worlds. A major finding is that along with many forms and episodes of maltreatment, the children have often experienced other forms of trauma and major loss. These losses included the death of a parent or significant other; one or both parents being in gaol; separation from siblings, multiple placements; and often experiencing minimal or no contact with one or both parents. The children’s behaviours need to be understood in this context of loss and trauma in order for interventions to be effective.
Many children have had repeated involvements with the protection and care system, such as multiple placements. Many are experiencing uncertainty as to whether or not there are adults in their lives who are committed to their care, safety and nurturance. These children need people to love them and yet their experience of trauma and disrupted relationships has taught many to elicit the opposite reactions from most adults. In order to be effective interventions have to address this complex reality for children at all levels.

7.3.2 Infants and young children

An over-representation of infants involved in the Child Protection system has been noted previously (DHS, 1999b) and led to such initiatives as the DHS High Risk Infant program. However, infants are not being referred to Take Two in equivalent proportions. Just 8% of all regional Take Two referrals were children under three years of age.

There is growing international evidence identifying that the younger the child is at the time of abuse, the greater likelihood of suffering subsequent psychological difficulties (Perry, 1999) and of the psychopathology being more extreme (Herman, 1992/1997). Furthermore, the life history of the adolescents involved with Take Two reflects a high incidence of their experiencing abuse at an early age. The relatively low numbers of infant referrals to Take Two suggests that a higher priority is given to referral of children and young people exhibiting challenging behaviours and that the emotional impact of abuse on infants is not well understood within the service system. These reasons highlight the importance of education for staff and management of Child Protection and CSOs regarding the impact of abuse on infants and the critical role of early clinical intervention.

7.3.3 Families

Similar to the findings reported by Campbell (1995), the evaluation found highly complex structures of the families involved in Take Two and a high degree of instability in these family structures. Many children have experienced changes in the family structure even within the relatively short time since their commencement with Take Two. Most parents of Take Two clients have themselves experienced major traumatic events. There is a relatively high incidence of parents in gaol, which also supports previous findings in relation to families involved in Child Protection. Moreover, the incidence of the death of a biological parent within this client group is similar to the findings of the Integrated Strategy report (DHS, 2002). The various types of relationships with siblings were also identified within this client group.

Clinicians have identified the vital role families have in promoting or hindering engagement. A review of Take Two interventions demonstrates that clinicians are working closely with families when possible. However, lack of information about both parents, especially fathers, hinders this approach. Information about parents’ employment was also often unavailable and would assist in understanding the social world of the child and family connectedness in the community.

The level, multiplicity and intergenerational nature of trauma in the families not only underscores the complexity of working with this group of children, but also begs the question who should be working with the parents, such as when the children are not in their care.

7.3.4 Types of abuse and the consequences of harm

This report supports the proposition that abuse is unlikely to occur in isolation (Cicchetti & Lynch, 1995). The majority of Take Two clients suffered more than one type of maltreatment; moreover, the age of the child did not account for a difference in the number of abuse types. This has implications for intervention as the impact of various consequences of abuse and neglect types has not been explored sufficiently in the research. The identification of harm consequences of the child’s experience of abuse provides important information regarding this phenomenon and is an example of the knowledge contribution of Take Two.

The severity of the impact of abuse for these children is demonstrated in the finding that there was more than one type of harm consequences of the abuse for 92% of the children. The high incidence of extreme emotional and psychological harm supports the proposition of the impact of abuse as trauma.

7.3.5 Aboriginal and Torres Strait Islander children

Aboriginal children are disproportionately over-represented in both the general Child Protection
population and the Take Two client group. However, within Take Two this over-representation is in the older age groups in contrast to that generally found in Child Protection. In relation to their experiences of abuse and other traumas no significant differences were found within Take Two between Aboriginal and non-Aboriginal children, which is consistent with the hypothesis that Take Two is working with the most vulnerable Child Protection client group. However, some differences were found in terms of the Aboriginal children’s involvement in the care system and in terms of the apparent impact of their abuse and trauma experience. When compared with non-Aboriginal clients of Take Two, Aboriginal clients had significantly more placements and were more likely to be in residential care. They were more likely to have difficulties with substance abuse, dangerous self-harming behaviours, absconding and violent behaviours.

There has been lack of research regarding the ramifications of trauma in general or maltreatment in particular regarding Aboriginal children (Raphael, et al., 1998; Stanley, et al., 2003). Take Two has the opportunity in collaboration with Aboriginal services to contribute to addressing this gap. To develop a culturally appropriate service Take Two appointed an Aboriginal clinician to participate in service development and direct intervention. By the end of 2004 Take Two had extended this to two positions. In addition Take Two has consulted with VACCA and other key Aboriginal organisations. Take Two is designed to take a holistic approach to intervention and this is in keeping with an Aboriginal approach to mental health. Developing culturally appropriate assessment and intervention approaches will further facilitate effective intervention.

### 7.3.6 Secure Welfare

The short-term nature of admission into Secure Welfare limits the length of involvement possible by Take Two within Secure Welfare. As such, the Take Two role in Secure Welfare primarily produces a specialist therapeutic assessment with recommendations. This Take Two assessment provides a basis for effective planning and ongoing interventions. When a regional Take Two client is admitted to Secure Welfare, it is usually their Take Two clinician who provides the necessary therapeutic input.

This evaluation has shown that many of the young people in Secure Welfare involved with Take Two have mental health diagnoses in addition to challenging behaviours. Moreover, there is a high incidence of suicide attempts and suicidal ideation among Take Two Secure Welfare clients. There is a relatively high incidence of sexual abuse experienced by these clients, compared to the regional Take Two client group. This finding is supportive of previous research findings regarding the severity of harm of sexual abuse.

The role of Take Two in Secure Welfare along with other specialist services provides an opportunity to explore the value of in-depth therapeutic assessment and its impact upon intervention for this client group.

### 7.3.7 Children’s experiences in the Child Protection system

The challenges the child protection system has experienced in accessing sufficient therapeutic services provided the impetus for Take Two’s establishment. This report demonstrates the extensive and long-term nature of Child Protection involvement with the majority of Take Two clients. For example, 57% had four or more investigations of reported maltreatment prior to the current Child Protection investigation. Sixty-five percent of Take Two clients were on Custody to the Secretary or Guardianship orders indicating the severity of ongoing risk to the child.

The instability of the child’s environment is illustrated by the finding that at the time of referral 82% of Take Two clients had experienced at least one placement change and nearly half had experienced six or more previous placements, including two young people who had each experienced 45 previous placements. Overall there was a higher percentage of Take Two clients in out of home care compared with the general Child Protection population in Victoria. The impact of these experiences adds to challenges to engagement and intervention with Take Two clients and specifically recognises the impact of these experiences on attachment and social connectedness.

Children’s experience of the child protection and related systems such as out of home care and the court system are likely to involve elements of secondary trauma, even when the systems and practices are abiding by principles of best practice. Some placement changes are likely to be for positive reasons, such as reunification or moving to a permanent placement. Court cases are an inevitable part of an adversarial system to ensure the safety of many of these children. Despite some of these experiences being unavoidable, they may be experienced as traumatising. Efforts are needed to help those involved to understand the children’s needs and their responses to these events and processes. There is also the imperative of all services involved, including Take Two, to work to avoid unnecessary secondary traumas where possible, such as abuse in care and destructive placement changes.

Take Two has a role in contributing to this understanding of secondary trauma. For example, Take Two has undertaken psycho-education with parents and carers in preparing children for placement moves in order to minimise, if not completely avoid, their distress and uncertainty. The role of the care team in sharing the task of ‘keeping the child in mind’ is also seen as a critical intervention.

### 7.3.8 Early intervention and screening

The DHS submission brief requires attention to early intervention for those children who have experienced
maltreatment but who are not yet showing concerning symptoms. A focus on early intervention is at the other end of the continuum to that of the characteristics of the majority of clients referred to Take Two. For the program to undertake early intervention Child Protection will need to refer a different cohort of children. The form of intervention will presumably be different for this type of referral. Such interventions would include therapeutic assessments in order to screen for potential problems and psycho-education for the child and their parents or carers in terms of how best to respond to the child’s current needs in order to reduce the likelihood of serious problems in the future. The impact of trauma does not follow a linear process and may not be visible until some time after the abuse. Also, most of these children are subjected to more than one incidence of abuse. Defining early intervention in this situation is complex. This area will be followed up as knowledge and experience develops in Take Two and in the broader system.

7.3.9 The service system

An expectation of Take Two is to contribute to the service system as it relates to the Child Protection client group, along with managing the complexity of developing and maintaining multi-sectorial relationships. The holistic approach to assessment and intervention by Take Two has included engaging Child Protection and the service system so that 'wrap around' services can be provided. The high degree of complexity in the world of Take Two clients means that a service in isolation cannot be effective in meeting their needs. It is important to recognise that Take Two is one component of the integrated strategy of DHS. Furthermore, Take Two’s effectiveness requires the knowledge and practice experience which exists within many aspects of the service system.

Enabling those who have daily contact with the child to be trauma sensitive and developmentally informed is one of Take Two’s key roles. There is clear evidence that Take Two clinicians worked with the staff of Child Protection, CSOs and other services as an integral part of the direct intervention with the child. For example, 47% of all interventions included the family and the service system. Staff journals indicate the extent to which the experiences of Take Two teams differed across regions, with different aspects of the service system.

The interface of Child Protection and Take Two is a core feature of the development of Take Two. The collaboration of Child Protection, Take Two and La Trobe University on the development of the referral process was an important stage in developing an effective interface between Child Protection and Take Two. While there were still implementation issues, agreement on this referral interface provides a good foundation for collaborative work. The DHS-central meetings regarding the implementation of Take Two also provided a forum for discussion between Child Protection on a regional and central level regarding the implementation of this new program. In addition, training was provided to Child Protection and CSO staff specifically around referral processes, attachment and trauma. There does, however, appear to be a need for Child Protection and Take Two to provide further training to CSOs due to some misconceptions regarding the referral processes.

The regional (RAG) and central (CPAG) advisory processes provide opportunities to explore policy and practice issues at a local and statewide level with key services. Development and participation in these advisory processes demonstrate a commitment to engage with the service system as a core component of the design of Take Two. Herman (1992/1997) has emphasised the importance of ensuring safety in order for therapeutic work to be effective and not harmful in itself. This will only be achieved with effective contributions from all areas of the service system.

7.3.10 Schools as part of the local service system

The majority of school-aged children in Take Two are enrolled in school, although the data regarding attendance and participation is less clear. In addition to providing education, schools play a clear role in connecting the child to the community, in linking with peer groups and in enhancing the child’s development. An analysis of Take Two interventions shows that clinicians are in regular contact with schools. The response of the schools to the needs of these children varies from helpful and proactive, to creating barriers to certain interventions. Schools need to be actively engaged in any therapeutic process due to their unique and pivotal role in the lives of these children.

7.3.11 Child and adolescent mental health

Reports such as the audits of children in residential care (DHS, 2000) and home-based care (DHS, 2001a) and the Stargate report (Milburn, 2004) found a high proportion of children in care had a mental health diagnosis. The analysis of Take Two found a higher incidence than in the audit reports and a similar incidence (65%) of mental illness to that shown in the Stargate report. This finding raises consideration of the role of CAMHS vis à vis Take Two. This is highlighted by the number of Take Two clients with a risk of suicide and where some of the requisite responses are only available from mental health or general health services, such as medication, inpatient treatment and mental health case management.

Previous research has identified a range of barriers to mental health treatment for children in the protection and care system. Through the CPAG, work has begun on exploring the roles and interface between these services; however, as yet no protocol has been
developed. At a regional level this relationship is being defined at the RAGs and through other networks. A core question still being explored is when should children be referred to Take Two, to CAMHS or to both services. It is essential that this issue is clarified, not only to reduce any potential overlaps between these services, but more importantly to ensure that these most vulnerable children receive access to mental health services when required.

7.3.12 Multiple approaches to engagement, assessment and intervention

It was not the purpose in this first stage of the evaluation to analyse the assessment, intervention strategies and outcomes. However, the evaluation has identified the broad range of strategies including outreach and service system involvement that have been utilised for engagement, assessment and intervention with Take Two clients. These strategies were seen as necessary to ensure a holistic approach. Given the degree of complexity and varied presentations of the client group it is not surprising that Take Two utilised a diversity of engagement and intervention strategies. The demonstrated creativity and persistence is considered a pivotal factor behind the high proportion of children engaged in the therapeutic process with Take Two. The multiple levels of intervention by Take Two included interventions directly with the child and with significant people in the child’s family system and service system.

7.3.13 Regional differences

Take Two was established as a statewide service, but with an expectation of localised service delivery. There is a requirement that the program recognises and works with the local communities. Take Two teams closely parallel the Child Protection regional configurations. The program design of Take Two requires enlistment of Child Protection and other services. It can be seen from patterns of referrals that regional Child Protection Offices are using Take Two differently. How much this reflects inherent differences in the regions or regional operations and perceptions of the role of Take Two will continue to be explored. For instance, some of the differences between Take Two rural and urban teams include the impact of small teams on being able to deliver an effective service, especially when also taking into consideration the impact of travelling long distances. Regions have different geographical constraints and vary in configurations of local services. These differences provide an important context that is likely to impact both on referral patterns and the types of intervention possible by Take Two.

7.3.14 Conceptual and organisational development of Take Two

This evaluation provides evidence of the multi-focus conceptual development of Take Two relating to both provision of clinical services and contributing to service system development. This conceptual model involves a range of systemic and holistic therapeutic interventions based upon the literature, practice knowledge and guided by the Take Two Practice Framework. The process of exploring the assessment framework is an example of the action learning approach to which Take Two is committed. The development of the outcomes framework and outcome measures drawing upon existing knowledge is another example of building an effective service and research model. The integration of research, evaluation and training as active components of the model provide a structure for ongoing reflection and learning.

The establishment of the partnership consortium and advisory structures to guide Take Two and to link the service into the broader service system is identified as a core part of the model. These processes are informed by a ‘community of practice’ approach (Wenger, 2000), which conceptualises the need for those of like-mind and shared commitment to collaborate across perceived boundaries and organisational structures and constraints. The evaluation suggests that, while the structures are in place for a strong engagement with the service system, this is an area which will need a stronger focus to meet the aim of the service to build capacity within the service system.

Research of organisations (Ezell, 2005) has highlighted the importance of an appropriate organisational infrastructure and culture if a service is to be successful in meeting its objectives. Establishing Take Two as a specialist service within BSV, which was already in the process of establishing itself as a learning organisation, has clearly benefited Take Two. The prior existence of a strong governance structure within the organisation assisted in the development of the structure for Take Two. The building of appropriate infrastructure and internal policies supports and guides the work of Take Two. This supports the development of a culture which cares for staff as they engage with children who have experienced horrific abuse and encourages reflection and ongoing learning to enable the creation of new knowledge. Moreover, the collaboration of the partners of Take Two brings together strong perspectives of research and training as well as service knowledge across the fields of mental health and child welfare.

7.4 Discussion and future directions

This evaluation has described the first year of the establishment and implementation of Take Two with particular focus upon the characteristics of the client group. Take Two is required to deliver services to children who have experienced extreme harm. Take Two joins Child Protection and other services in the paradox of how to enable children to work towards
recovery and healing from past destructive experiences, whilst still trying to ensure their current and future safety and access to nurturing and consistent caregiver relationships.

The formation and ongoing work of Take Two as a new, statewide service is highly visible in the service system. As the evidence-base for what constitutes and how to achieve best practice is at a relatively early stage this poses significant challenges for a new service. This is especially the case for a service that is aiming to deliver a high quality service at the same time as developing and evaluating innovative models of practice. The partnership consortium of Take Two is working towards the challenge of finding a suitable balance for the Take Two program. Whether the balance achieved is appropriate will be judged by the service system and the community via the output of Take Two including the program’s practice, training, research and evaluation commitment.

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