RANZCP Submission

Senate Standing Committees on Community Affairs inquiry into out of home care

October 2014

The Royal Australian & New Zealand College of Psychiatrists

Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback to the Senate Standing Committees on Community Affairs' inquiry into out of home care (the inquiry). Whilst the RANZCP commends the government for its ongoing commitment to addressing the challenge of improving the out of home care system in Australia, there remains much work to be done.

As experts in the field of psychiatry, the RANZCP has a strong awareness of the importance of providing children with a safe, nurturing and consistent environment and of the mental health and developmental implications if this is not achieved. The RANZCP has a growing body of work relevant to this topic, accessible online at: https://www.ranzcp.org. These documents include:

- Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse Issues Paper 4, Preventing sexual abuse of children in out of home care
- Submission to the Department of Families and Community Services discussion paper, Child Protection Legislative Reform
- Position Statement 59 The mental health care needs of children in out-of-home care
- Submission to the Queensland Child Protection Commission of Inquiry
- Report from the expert working committee of the Faculty of Child and Adolescent Psychiatry, The mental health care needs of children in out-of-home care

This submission provides specific responses to the terms of reference of the inquiry relevant to the expertise of psychiatrists, with particular emphasis on the outcomes for children in out of home care from a mental health perspective and best practice in early intervention and out of home care models. The RANZCP's key points are that:

- Greater investment in effective interventions to support children at risk of abuse or neglect is required. This approach would offer significant long term benefits and savings.
- Early childhood is an important developmental period when forming and maintaining nurturing and appropriate attachment relationships is crucial to long term health. Out of home care for this age group must be informed by these principles.
- Supporting at risk families and children in out of home care requires a concerted, multi-sectoral approach. Innovation, flexibility and cross-sector collaboration are key.

The RANZCP would also like to take this opportunity to bring to the attention of the inquiry certain groups that are overrepresented in out of home care, or who are at particular risk when they do enter the care system:

Aboriginal and Torres Strait Islander children

Any discussion of out of home care in Australia should incorporate an awareness of the particular context, needs, strengths and challenges of Aboriginal and Torres Strait Islander communities and families. Aboriginal and Torres Strait Islander children are over-represented in out of home care, being on average ten times more likely to be in care than non-Indigenous children, with rates as high as sixteen times more likely in some states (Davey 2014). Since the 1997 inquiry into the forcible removal of Aboriginal and Torres Strait Islander children from their families (Stolen Generation), child removal has actually increased by 400% (NAPCAN 2014).

These statistics must be understood in the context of historical trauma experienced by Aboriginal and Torres Strait Islander peoples since the arrival of European settlers. Discrimination, marginalisation and disempowerment at the hands of mainstream government including policies like the Stolen Generation have incurred intergenerational harm which is still being grappled with today. For more information please refer to the RANZCP's Position Statement 42 'Stolen generations'. The removal of Aboriginal and Torres Strait Islander children from parents who are unable to care for them must negotiate this traumatic legacy very carefully.

Aboriginal and Torres Strait Islander approaches to child rearing, family composition and care responsibilities may also be significantly different to that of the broader population, and this must be taken into account when making assessments and choosing to intervene. Understanding and expression of mental illness and health can also differ, and must be properly understood in order to avoid misdiagnosis.

Recommendations

- Early intervention and out of home care placements with Aboriginal and Torres Strait Islander children must be culturally appropriate, strengths-based and ensure that links are maintained with community, culture and land wherever possible.
- Access should be provided to professional interpreters if there is any doubt around the child and family's English skills, particularly capacity to describe complex or sensitive information about health and other issues. Family or friends should not be used as interpreters as this can lead to misunderstandings and breaches of privacy.
- Culturally appropriate assessment tools must be applied when working with Aboriginal and Torres Strait Islander children and families.

Culturally and linguistically diverse children and families

Australia is an inherently multicultural society, with almost a quarter of the population born overseas and almost half of all Australians with at least one parent born overseas and the care system must be able to cater for this diversity.

Currently there is no published data on the proportion of children in the care system from culturally and linguistically diverse (CALD) backgrounds, though it has been estimated to be at around 2-4%. A small percentage of these would be refugee children who have arrived in Australia unaccompanied and may have spent time in detention.

Child rearing practices are strongly influenced by culture and values. Family dynamics unfamiliar to the prevailing culture may be wrongly interpreted as harmful or dysfunctional if assessments are not undertaken with sensitivity.

Recommendations

- Ensure staff are culturally informed and sensitive to diverse approaches to parenting and family functioning and that assessment tools reflect this.
- As above, professional interpreters should be used whenever there are doubts around the child or family's capacity to describe their situation in English
- In instances where CALD children are removed from their families, efforts should be made to transfer them to culturally appropriate placements where their cultural and religious needs can be catered for.

Intellectual impairment

Children with intellectual disability are at increased risk of mental disorders when they experience childhood abuse and neglect, however such comorbidities may be missed due to their impairment. Further, the care needs of children with intellectual disability are significant and it is important that their out of home care arrangements are capable of catering for these (Kowalenko 2012).

Recommendations

- All children entering care who have an intellectual disability should automatically have a comprehensive mental health assessment.
- Children in care with an intellectual disability are particularly vulnerable to comorbidities and other complications and should be prioritised for services.

Terms of reference:

a. drivers of the increase in the number of children placed in out of home care, types of care that are increasing and demographics of the children in care

The RANZCP has no response to this question.

b. the outcomes for children in out of home care (including kinship care, foster care and residential care) versus staying at home

Of particular relevance and concern to the profession of psychiatry are the mental health and developmental outcomes for children when they encounter trauma early in life, be it in an abusive or neglectful home environment or in further traumatising out of home placements.

The majority of brain development associated with language, values and complex cognitive and emotional functioning are determined by experience, rather than genetics, and much of this happens in the early years of life. Development in response to environmental factors can be useful in enabling the child to adapt to their context; however it also creates vulnerability to the effects of adversity.

Whilst the basics of food and shelter are, of course, essential to survival; the importance of stable, attuned care-giving adults cannot be overstated. Infants who experience extremes of abuse or neglect are at risk of failure to thrive, reduced brain size, impaired development and even death; even when their basic physical requirements are met. All this can lead to ongoing mental health issues.

Ensuring nurturing and consistent care is particularly important during infancy when the child begins to form and require attachment relationships. The term ‘attachment’ describes the genetically predisposed tendency for young children to seek comfort, support, nurturing and protection from at least one primary caregiver. The infant tends to form attachment in the second half of their first year, this accompanying the beginning of behaviours such as stranger wariness and separation protest (Zeanah et al 2011). The infant requires regular and sustained physical contact to form and maintain attachment. It is not until later stages of development that connection can be maintained over time and space.

Insecure attachment during the first three years of life can lead to rudimentary neuronal pathways developing in unhealthy ways, leading to problems such as conduct disorder, aggression, depression, antisocial behaviour, vulnerability to stress, difficulty regulating negative emotion and displays of hostile or oppositional behaviours. Young children in care therefore need to be able to form attachments with the caregivers with whom they live. It is not enough for this role to be fulfilled by adults they do not live with.

Early infancy and the experiences and information the child encounters at this time are of huge importance in the way the brain develops, in some ways setting the trajectory of the child’s life. The significance of this is reflected in a study by Scott et al which found that childhood adversity due to problems in family functioning is significantly associated with all types of mental illness (2010). Further, given that half of mental health disorders have their onset by the age of 14 (RCP 2013), it is crucial that vulnerable children get the support they require, including early intervention and developmentally informed out of home care placements.

Recommendations

- Approaches to out of home care should incorporate a thorough understanding of the impacts of abuse and neglect on the children’s brain and seek to address this in therapeutic ways. Incorporating the expertise of child and adolescent psychiatrists is key here.

- Out of home care should offer children secure attachment relationships that promote healthy development and brain growth. This is especially the case for younger children aged six and under. In this age group, the type of care provided should be approached differently than with older children. The foster parent must fulfil the role of primary attachment figure, not just primary caregiver. This requires specialised training and the capacity for emotional investment (Zeanah et al 2001).

c. current models for out of home care, including kinship care, foster care and residential care

Kinship care

In current practice, if a child cannot live safely with their parents, first preference is for kinship care. This tends to be provided by the child's relatives or other adults with a close bond, such as grandparents, step-parents, godparents or a close family friend. Kinship care is associated with better outcomes for younger people than other types of out of home care; however these children still tend to have more difficulties than the general population. Kinship carers tend to receive the lowest remuneration across different types of carers, and report finding the task far more onerous and complex than is often recognised (Perkins 2014). Often the role is taken on by grandparents, who incur significant financial, social and legal burdens at a time of life they would often have expected to be looking into retirement and a lessening of responsibilities.

Recommendations

- The remuneration, training and ongoing support for kinship carers should be increased.
- Evaluation of kinship care should include examination of the level of support required for extended family to parent safely and the extent to which contact with biological parents can be safely maintained.
- Careful assessments should be undertaken as it is often likely that the grandparents or other close family members will have similar risk factors as the biological parents.

Family-based foster care

The demand for family-based foster care continues to increase, whilst the availability of such placements decreases. This has been attributed in part to the increasing expectations on carers, without the accompanying requisite support, recognition or remuneration. It is estimated that the financial burden of raising foster children is more than 50% higher than for a child not in out of home care, due to the complexity of their needs (AFCA 2014).

The neurobiological development of children who have been subject to abuse or neglect can make them difficult to parent, their needs going beyond 'normal' parenting and loving care. An extent of expertise and ability for therapeutic parenting is required that attends to the developmental and attachment needs of children in out of home care. This requires a careful selection of carers who are willing to go through training and are able to provide therapeutic support.

Recommendations

- Australia must look to examples of best practice from overseas, such as in the United Kingdom, where foster care is well-regarded and recognised as an important service. This is made possible by providing foster carers with adequate reimbursement, social recognition and high quality courses on child development, trauma and therapeutic parenting.

Residential care

Residential care tends to be for children over the age of 12 who are unable to be accommodated in family based care. These placements generally occur because of the complex behaviours or needs of the children, or because an appropriate foster family cannot be located at that time. These placements tend to be viewed as transitional, with a view to stabilising the young person so they can eventually be moved to a lower level of support.

Ideally such placements provide therapeutic care, but this can vary significantly depending on the expertise of the carers working at the facility. When positive dynamics between carers and children are achieved, the benefits of residential care can be invaluable. However, there is the risk that these become 'holding facilities' for young people with nowhere else to go, and who receive little therapeutic benefit from their stay.

Recommendations

- Residential care should be adequately funded to attract and retain skilled staff who receive ongoing training to enable them to deliver high quality, therapeutic care.

Secure residential care

There is a small group of young people who are on child protection orders but who have disengaged from placements and services. It is estimated that the majority of this group are adolescents, but they can sometimes be younger. They tend to have intermittent contact with services when in crisis; often via the emergency department or encounters with police.

These young people often exhibit challenging and complex behaviours, including physical aggression, property destruction and self harm, leading to repeated placement break-downs and difficulty maintaining consistent contact. This population are at high risk of substance misuse, rough sleeping, exploitation and assault. They are difficult to engage, even by services with the resources to undertake intensive assertive outreach.

Occasionally these young people will be admitted to acute adolescent mental health in-patient units; however this approach is rarely successful. These facilities are designed for intensive, short term interventions for young people with acute, treatable mental illness. The long term, therapeutic support required cannot be provided in these environments.

Adequate support for these young people would require placement of twelve months or more in a therapeutic facility where their emotional, psychological and educational needs can be met through the establishment of links with highly skilled and supported care staff, where their externalising behaviours can be safely managed. At present such specialised facilities do not widely exist in Australia. Young people tend to only be provided with access to such secure, long term and intensive care when they have a significant forensic history, and are therefore already quite embedded in behaviours that could be difficult to change.

Recommendations

- Best practice models from overseas, such as the 'secure children's home' in the United Kingdom should be looked to as examples of how to provide therapeutic support to these particularly vulnerable young people.
- Criteria for placement in secure children's home should be measured according to the child's risk and welfare, not their forensic history, the aim of the placement being explicitly therapeutic and not punitive.

Adoption

Adoption is relatively uncommon in Australia compared with other developed countries, however it is considered one of the best ways of providing children with the permanency of care they require. In 2012 in the United Kingdom 3500 children were adopted from care, compared with just 100 children in Australia (Howe 2013). Children who are adopted, rather than brought up in foster care, are understood to have higher levels of emotional security, sense of belonging and general wellbeing. This is in large part due to the more secure attachment relationships they are able to forge with their primary caregiver.

Recommendations

- Best practice models from overseas, including the United Kingdom, should be looked to for ways of promoting adoption as often the best solution for children who require out of home care, particularly infants, who benefit from secure, long term attachment from their primary caregiver.

Continued support beyond the age of 18 years

In the general population, parents tend to support their children through to young adulthood and sometimes beyond. In Australia, the government offers little support to young people who have been raised in out of home care after they turn 18.

Recommendations

- Outcomes can be improved by continuing social welfare and support up to the age of 21 or beyond for children who have been raised in out of home care.

d. current cost of Australia's approach to care and protection

The RANZCP is primarily concerned with the cost, both financial and emotional, incurred when the approach to care and protection of young people is not adequate, be it in harmful home environments or further traumatising out of home care placements. Experience of trauma, neglect, abuse and insecure attachment during formative childhood years can leave individuals with lifelong legacies of mental ill-health. The costs of this legacy to the individual, community and nation are often multiple, ongoing and significant.

Quantifying the situation in monetary terms helps to demonstrate how not adequately investing in early intervention and quality out of home care, and thereby safeguarding the mental health of vulnerable children, is a false economy. A study in the United States estimates that expenditure on psychiatric services for children who have been in out of home care is around 15-20 times higher than for low-income children who have not been mistreated (Zeanah et al 2011). The financial burden is similarly stark in Australia, with the annual cost of child abuse and neglect for all people ever abused at $4 billion in 2007, and the estimated lifetime cost for the population of children abused for the first time in 2007 at $6 billion (Taylor et al 2008).

The expense of childhood trauma is a long term one, with serious adversity encountered in early years often manifesting into adulthood, with high rates of adult mental health issues, drug and alcohol misuse, obesity and criminal behaviour (Shaw & De Jong 2012). Childhood adversity will often also have intergenerational impacts, with parents who were traumatised as children more likely to have attachment issues, mental illness and at heightened risk of replicating the abuse they experienced. The cost of interventions in instances of child abuse or neglect, and of providing quality out of home care should be measured against the expense of leaving these issues untreated, and the complex, long term and costly ramifications of this.

Recommendations

- Investment in early intervention and out of home care must be made in order to achieve a high quality of care for vulnerable children and mitigate the likely future expenses of failing to do so.

e. consistency of approach to out of home care around Australia

The RANZCP has no response to this question.

f. what are the supports available for relative/kinship care, foster care and residential care

The RANZCP has no response to this question.

g. best practice in out of home care in Australia and internationally

The following is a list of best practice principles the RANZCP has identified as promoting good mental health outcomes for vulnerable children locally and overseas:

Early intervention

First and foremost, early determination of parental capacity to provide safe and nurturing care is required, with timely and sensitive response if it is deemed that the parents are unable to fulfil their roles adequately or to make sustained changes. Careful analysis of the situation and attuned decision-making is required to manage the complexities of this scenario, because whereas fractured parental attachment relationships can cause significant harm to young children, the earlier intervention and removal from a harmful environment occurs, the better chance the child has of resolving early trauma and returning to a healthy trajectory.

Recommendations

- Careful negotiation is required between fulfilling the right of the child to remain with its parents wherever possible (Article 9 CRC 1989) and safeguarding the long-term mental health of the child by removing them from harmful situations at the earliest possible moment.
- The RANZCP supports the Australian Government's *National Framework for Protecting Australia's Children* report's recommendations around early intervention and urges the government to invest the necessary resources to see the proposed strategies realised (2009).

Creating consistency

As discussed above, ensuring secure attachment relationships is essential for healthy development, especially during infancy. If the infant must be removed from their parents, it should be ensured that they are able to forge a stable, healthy attachment relationship with an alternative caregiver. In scenarios where kinship care is not available, appropriate placements in foster care should be sought, taking into account the needs, history and qualities of child and carer. This is important, as the risk of problems for future placements and poor outcomes rises with each change of placement.

Realistically, placement change cannot be completely avoided. With appropriate reasons, a thoughtful, planned approach to the change is recommended. In the past, a philosophy of the 'clean break' was favoured, which resulted in children being uprooted abruptly from one placement to the next with no contact with their previous carers, often accompanied by a change of school and loss of other social connections. There is now a much greater appreciation of the damaging impact of these fractured relationships and unresolved losses for the child and an openness to transition planning and maintenance of relationships with previous carers where appropriate.

Recommendations

- As much as possible, the match between carer and child should be chosen with consideration and the aim of creating a dynamic that is therapeutic, mutually-beneficial and sustainable in the long term.
- Children in care can lose their history, the personal narrative each individual develops as part of a coherent sense of self. Maintaining the child's history through practices such as keeping diaries, photographs and stories from home and placements and interventions such as Life Story Works (www.lifestoryworks.org) can help prevent this.

Health assessment

As discussed above, the events preceding the child's removal into care will have involved trauma. This group is at increased risk of physical and mental health difficulties and require comprehensive physical and mental health checks when entering care to quantify this. Despite what is known about the risk factors for this group, however, such assessment is not routine in every state and territory in Australia. Rather, assessment tends to be sought when carers, child safety officers, teachers or other professionals identify concerns about a child. The impacts of childhood adversity can be subtle, misinterpreted or missed; routine mental health checks can help identify difficulties sooner, with early intervention likely to bring better prognosis and entry into appropriate treatment sooner.

Recommendations

- It is recommended that there be routine health checks for all children entering care, repeated at intervals while they remain in care, including:
    - physical health checks
    - developmental appraisal
    - mental health check
    - hearing and vision check
    - dental health check

Recommendations

- It should be ensured that the child's medical information is not lost if they move placements or return home. Rather, all relevant information should be transferred with them.

Child and Youth Mental Health Services

Children in care with mental health issues are recognised as a group that warrants special attention and priority access to mental health services. Child and Youth Mental Health Services (CYMHS) require adequate resourcing to enable provision of high quality, timely assessment and intervention to children presenting with mental health issues, as well as the capacity to provide training and support to other agencies working with these children.

A multi-disciplinary team approach, such as that provided by CYMHS and Infant Mental Health Services is recommended for comprehensive assessment of infants and very young children and those presenting with more severe or complex symptoms. This provides specialist consultation and supervision from a child and adolescent psychiatrist in combination with the expertise of psychologists, nurses, social workers and other disciplines working as a collaborative team to achieve the best outcomes.

At present Australia is facing a severe shortage of child and adolescent mental health workers, with recent estimations suggesting that 12,000 new workforce members would be required over the next decade to meet demand (MacKee 2013). This shortage is set to impact upon many vulnerable groups, including children in out of home care.

Recommendations

- Invest resources into building the child and adolescent mental health workforce in order to ensure that children in out of home care who are experiencing psychiatric issues can receive the treatment they require.
- CYMHS are not resourced to provide long term care so, as problems reduce and resolve, discharge planning includes assessing the child and family's needs for ongoing care and support and referring appropriately. Where a child is on medication this is likely to include recommendations for referral to private child and adolescent psychiatrists for monitoring of progress overall and medication management in particular.

Diagnosis

Experts in the field consider that diagnostic systems do not adequately capture the impact of childhood abuse and neglect. Under the current system, children who have been affected by abuse and neglect can meet criteria for several different disorders, often a combination of learning difficulties, behavioural disorders and anxiety/mood disorders. Post Traumatic Stress Disorder (PTSD) is often diagnosed, however it is argued that the usefulness of this diagnosis is limited as it is based on symptoms in adults. It is suggested instead that diagnostic criteria for Developmental Trauma Disorder be developed, comprising of a range of symptoms seen to occur after complex and repeated traumatisation. Having a specific diagnosis for traumatised children would have the potential benefit of sensitising professionals and the general public to the consequences of child abuse, neglect and traumatisation (Schmid et al 2013).

Recommendations

- The proposed diagnosis of Developmental Trauma Disorder should be considered as a way to more accurately capture the mental health implications for children who have experienced severe adversity early in life, to promote awareness amongst practitioners and support psychiatrists to provide the most appropriate treatment.

Research, monitoring and evaluation

Data collection, research, monitoring and evaluation are the foundations of evidence-based best practice and quality care. Ensuring that this background work is maintained ensures that service provision is relevant, effective and achieving its goals.

Recommendations

- There should be processes in place for routine collection and review of epidemiological data on children in care and the general population, and these processes should allow for comparison of groups such as Aboriginal and Torres Strait Islander and CALD children. All information gathered should be used to ensure that the provision of care and protection to children at risk or in care is accessible, relevant, culturally appropriate and therapeutic.

Funding issues

The delivery of best practice in out of home care is dependent on having a service system that is adequately funded and can attract and retain skilled workers to provide effective interventions. Effective interventions early in the child's life have broad-reaching and positive socioeconomic benefits. From a mental health perspective, the highest burden of disease is in the 0-18 age group, which accounts for almost a quarter of the overall disease burden. Half of mental illness starts before the age of 14 years and many disorders continue into adulthood if not treated. Childhood trauma is a significant and sometimes preventable contributing factor to mental health issues, which an effective out of home care system could address.

Recommendations

- The RANZCP urges the Australian government to commit adequate funding to all stages along the child's journey through out of home care. This would enable effective prevention, early intervention and support, with significant associated long term savings.

h. consultation with individuals, families and communities affected by removal of children from the home

The RANZCP has no response to this question.

i. extent of children in out of home care remaining connected to their family of origin

The RANZCP has no response to this question.

j. best practice solutions for supporting children in vulnerable family situations including early intervention

Early intervention

The first step towards reducing rates of childhood abuse and neglect and the ensuing complications of out of home care is to support parents to access the tools they need to provide appropriate care to their children and keep them at home. These tools could take the form of educational programs and supportive interventions and they should start early, even pre-conception in some instances. It is important to note that change takes time and perseverance with these strategies is required for significant lengths of time before measurable results will likely be seen.

Recommendations

- Early intervention programs, under the right circumstances, can be an effective way of avoiding trauma associated with childhood neglect, abuse and out of home care. Such programs should start early and target families with identified risk factors including parental drug and alcohol misuse, domestic violence, physical abuse and, in some instances, parental mental illness.
- Maternal antenatal assessments could include a review of the mother's psychological, emotional and physical capacity to establish a quality child-parent relationship with interventions offered for those mothers identified as being at high risk of having difficulties.
- Intensive nurse home-visiting programs for high-risk new mothers to support and guide their parenting skills have been cost-effective in improving childhood outcomes. Continued and broader funding of such programs should be considered. In addition, peer support and education programs should be considered in order to improve acceptability and accessibility for young mothers, disadvantaged mothers and other risk groups. These programs have a secondary utility as an avenue for early identification of difficulties in the mother-infant relationship.

Childcare

Access to quality childcare for at-risk and high-risk families can be an effective way for providing infants and pre-school children with a safe, secure and consistent environment that they may not be getting elsewhere. This would also give parents the time out they require to attend to their own health and welfare needs and to provide better care when their children come home.

Recommendations

- Attachment-informed childcare is preferred for such children considered at risk, where consistency of caregiver and high staff retention is prioritised. Such childcare should be targeted to high risk families and made accessible with subsidies.

Schools

Schools can also provide a safe environment for children, if they have developed positive relationships with teachers and peers. School nurses and counsellors are also well-placed to provide additional services to young people, especially those who would otherwise not have access to specialised services, for example if their parents would not facilitate specialist appointments.

Recommendations

- Schools should be supported to access the necessary resources to provide appropriate care to children who have experienced abuse or neglect. Awareness of the behaviours and needs of children who have experienced childhood adversity, abuse and neglect should be fostered across the board.
- Alternative education schools that cater to children who have experienced significant adversity should be prioritised for access to highly skilled teachers, mental health professionals and social workers to ensure that vulnerable children get the support they need.

Health care

Ideally, all children and families would have a consistent General Practitioner (GP) who is able to monitor their health and coordinate care, including with specialist services. However, anecdotally it is understood that most high-risk families often do not have a regular GP and more often attend emergency GP clinics and hospital emergency departments. Further, children in care rarely have consistent GPs, especially if they are without stability of placement.

Recommendations

- High-risk families should be encouraged and supported to engage with a GP that they see consistently, with whom they can develop a trusting relationship and who is aware of the family background and adversities. The GP would then be well placed to follow the family over time, provide regular health checks and coordinate specialist medical and mental health care as required.

Accessibility of services

Families can have difficulty getting to the various services they need to access, especially when they have multiple appointments and complex needs. Barriers to accessing services can arise in practical issues, such as location, availability of transport and lack of childcare as well as psychological barriers such as shame, fear and marginalisation. Creating services in easily accessible areas such as near transport hubs can increase use and create environments that are welcoming and appropriate to location and community.

Recommendations

- A suggested solution to this is to provide services in spaces that are already frequented by at-risk families, such as schools or shopping centres.
- Another option to consider could be to make services such as parenting groups, play groups, childcare, exercise classes, health clinics and social activities co-located in a hub environment. This would make such service provision more cost effective, and able to more holistically address co-morbidities, reduce stigma and make it easier for marginalised families to access the services they need. Access to such spaces should be related to presence and severity of difficulties and concerns, rather than being diagnosis-based, in order to avoid premature labelling.
- Home visits and other outreach services should also be considered as means to address accessibility issues.

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