LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES

(Reference: Inquiry into youth suicide and self harm in the ACT)

Members:

MS J BURCH (Chair)
MR A WALL (Deputy Chair)
MS N LAWDER
MR J HINDER

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 14 APRIL 2016

Secretary to the committee:
Mrs N Kosseck (Ph: 620 50435)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 20 May 2013

The committee met at 2.02 pm.

BOURKE, DR CHRIS, Minister for Aboriginal and Torres Strait Islander Affairs Minister for Children and Young People, Minister for Disability, Minister for Small Business and the Arts and Minister for Veterans and Seniors
COLLIS, DR MARK, Executive Director, Office for Children, Youth and Family Support, Community Services Directorate
MATTHEWS, MR DAVID, Acting Deputy Director-General, Community Services Directorate

THE ACTING CHAIR (Mr Wall): Good afternoon, everyone, and welcome to the public hearing of the Standing Committee on Health, Ageing, Community and Social Services inquiry into youth suicide and self-harm. Could I just confirm everyone has read and understands the privileges card that is before them? Minister, if you would like, I invite you to start with an opening statement.

Dr Bourke: Thank you, acting chair. Children and young people are the lifeblood of any community. Most have happy childhoods and lead fulfilling lives as adults but we know that, for some, life is much tougher. The ACT government is committed to ensuring that all children and young people across the ACT have the opportunity to reach their potential and that support is provided to those who need it most. As Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Disability and Minister for Children and Young People, I know of the acute difficulties that some children and young people experience.

I would like to talk about some of the ways that the ACT government is providing support. Drilling down to one particular area of my responsibility, we know that the traumatic backgrounds of children and young people in out of home care put them at greater risk than the general population of experiencing mental illness, drug and alcohol abuse and domestic violence as adults. They are also more likely to have contact with the justice system. That is why we are overhauling our approach to both out of home care and youth justice. One of the main reforms is A step up for our kids, the ACT government's new five-year out of home care strategy. A step up for our kids creates a therapeutic trauma-informed system of care based on the understanding that all children and young people who enter care have suffered trauma and that service providers, carers and families are aware of the impact that trauma has on a young person's behaviour, health and development.

For these children, assessed by the Child and Youth Protection Services and their carers as some of the most vulnerable and traumatised children in the ACT, we have established Melaleuca Place, the ACT government's specialised trauma recovery centre. Melaleuca Place works with children aged from birth to 12 years, their families and their support networks to provide a consistent, therapeutic support that is trauma informed and holistic in its approach. This specialised team works to support children whose trauma impacts on their behaviour and everyday function.

We know that trauma can be a precursor for later mental health issues and, therefore, increased risk of self-harm and suicide. Through the provision of high quality intensive therapeutic support, Melaleuca Place is providing a service that facilitates

healing, recovery and positive life outcomes for children who have suffered abuse and neglect. Melaleuca Place is also playing a key role in supporting the awareness of childhood trauma across our community.

For all children entering care we have implemented therapeutic assessments to provide a holistic assessment of the child or young person's needs across a wide range of domains. We know that by identifying and managing developmental and behaviour needs early we are better placed to reduce the severity of ongoing issues into adolescence and adulthood. Through A step up for our kids we are also supporting children and young people as they transition out of the care system and into the adult world.

The transition to adulthood is a difficult period for any young person, particularly those leaving care. That is why Child and Youth Protection Services continue to provide supports for young people on a voluntary basis until the age of 25 to ensure their successful transition to adulthood. There are few jurisdictions that provide this level of support to young people leaving care. When a young person turns 18 they can decide to continue receiving support on a voluntary basis. The level of support and interaction is determined by the young person, who can opt in or out of support until they reach 25.

The ACT is the only jurisdiction to continue to support carers financially for young people over 18 years of age as they transition to adulthood. We are doing this by extending therapeutic plans and any associated supports to young people as they mature out of the care system and extending carer subsidy payments to carers until the young person turns 21 where the young person continues to live with the carer.

Similarly, in youth justice we are providing far greater support than before in addressing the needs of individual young people. In Bimberi Youth Justice Centre young detainees are monitored closely so that any sign of suicidal behaviours can be monitored and addressed. All young people in Bimberi are assessed by forensic mental health and ongoing monitoring support and intervention is provided for young people as required.

As I reported last week in the Assembly, the latest progress report on the ACT government's blueprint for youth justice in the ACT is achieving sound results. Over the past three years we have achieved significant reductions in the level of youth offending and the number of young people in contact with or becoming further involved in the youth justice system. A main component in the success of the blueprint has been its focus on reducing risk factors faced by young people and strengthening protective factors which enable them to feel strong, safe and connected.

Age and disability can be a barrier for children and young people who have difficulty in identifying and communicating the nature and extent of their feelings and mental health needs. Children and young people with severe or profound disability or who have learning disabilities have a higher risk of self-harming behaviour or attempting suicide. Research suggests that children and young people with an intellectual disability are at a higher risk of intentional self-harm, suicidal behaviours and death by suicide with rates as high as 42 per cent.

The national disability insurance scheme involves major changes to how people with a disability and their families will get the support and services they need. The commonwealth government has allocated sector development funding of $12 million to support readiness activities in the ACT. One initiative focused on Aboriginal and Torres Strait Islander children involves local service provider Gugan Gulwan, which is in your electorate, acting chair. Data from the 2012 survey of disability, ageing and carers identified that Aboriginal and Torres Strait Islander children nought to 15 were more than twice as likely as non-Indigenous children to have a disability. The small team at Gugan Gulwan has been working with schools and with networks through Winnunga Nimmityjah, Carers ACT and the children and family centres to identify the people who need to know about the NDIS.

Every year at least five per cent of all deaths of Aboriginal and Torres Strait Islander peoples across Australia are due to suicide. For those aged 15 to 34, suicide is the leading cause of death, accounting for a third of all loss of life. One-third of all Aboriginal and Torres Strait Islander people in our country aged between 15 and 34 take their own life. Unfortunately, young Aboriginal and Torres Strait Islanders are suiciding and self-harming at alarming rates. It makes some of our reforms in out of home care and youth justice particularly important. The first step is to talk about it.

Here in the ACT the Gugan Gulwan Youth Aboriginal Cooperation has released a DVD titled "It's okay to talk about it," a suicide prevention video or DVD featuring personal stories from the Aboriginal and Torres Strait Islander community. The video is an early tool that brings awareness to the growing mental health issues facing young people and will assist in suicide prevention.

One group of people often forgotten when we talk about youth suicide are veterans. In January 2016 the Department of Veterans' Affairs reported that nationally there are 133 veterans under the age of 30 in receipt of treatment cards, 114 of which are due to service caused or related conditions such as post-traumatic stress disorder, depression and anxiety, to name a few.

Of the 133 veterans under 30 years, 99 are male and 34 are female. It is imperative that we ensure that these young men and women are not forgotten and that appropriate supports are provided to enable mental health and wellbeing to flourish and to prevent the tragic outcomes experienced by the 262 veterans that we know have lost their lives to suicide. Indeed, it is imperative that we ensure all young people in our community get the help they need before it is too late.

THE ACTING CHAIR: Thank you, minister. If I might kick off with a question. Does the directorate have any idea of the increased likelihood that a young person who is involved in either youth justice or care and protection or out of home care systems—someone in that space—will go down the road of considering suicide or self-harm compared to someone outside of the system?

Dr Bourke: I will get Dr Collis to answer the question.

Dr Collis: The first thing I would like to say is that youth suicide knows no particular sector of the community. Indeed, completed suicide, as I read the national data, defies any attempt to try to parcel it into one segment of the community or another.

However, having said that, in the relatively small number of young people who are engaged with the child protection system or the youth justice system, the behaviours around self-harming are noted to be increased from the general population. It would be our experience that young people who are in the youth justice and child protection system nearly always have experienced multiple and repeated traumatic events in their lives, the outcome of which has usually been the dislocation of social connections and all of those factors that lead to support when young people experience problems in their lives.

So our experience would be that self-harming, in particular, is a significant issue for young people in youth justice and care and protection. The nature of suicidal behaviour is that, whilst it is an enormous tragedy and has an enormous effect on people, it is a relatively small number in relation to the ACT. However, it is something which occurs in the ACT.

THE ACTING CHAIR: Is there an age at which these kinds of things become an issue for young people? Is there an age point when this kind of behaviour or tendency starts to become more evident or more prevalent?

Dr Bourke: I think, overall, from my understanding, the teen years are a particularly dangerous time, but I will get Dr Collis to provide some more detail.

Dr Collis: Again, talking about the relatively small numbers that exist within the ACT, we have to try to identify trends which look as though they are aligned to national trends. Regarding the latest national trends in youth suicide which have pointed to an increase in youth suicide over recent years, one of the more alarming factors for us is that it appears that the ages of completion and attempt are drifting downwards. So now it is not as uncommon as it was for 10, 11 and 12-year-olds to be engaged in self-harming and youth suicide.

I would like to point out that, as the committee would know, self-harming and youth suicide are not necessarily identical concepts. They can be related, but they may not be related. A large proportion of self-harming can be a strategy a young person uses to deal with internalised pain. It is for some young people an effective means of doing that, unfortunately, both biologically and socially.

What we are discovering is that those behaviours seem to be migrating younger and younger down the age range. But that is from the national data. I have no particular data from the cohorts in youth justice and care and protection to indicate that that trend is current with our cohorts.

THE ACTING CHAIR: Just a final question: minister, you touched on the Indigenous affairs portfolio and you said that for 18 to 34 year-olds suicide is the leading cause of death among Indigenous people. Why do you believe that suicide is the leading cause of death in Indigenous circles and what specifically is being done at a local level to really try to curtail that trend?

Dr Bourke: This question really relates to the country we live in and the background of that over the past 200 years. Suicide, within my understanding, within Aboriginal

and Torres Strait Islander communities, is an outcome of the trauma that Aboriginal and Torres Strait Islander people experience throughout their lives from family violence, from drug and alcohol issues and from mental illness. These are precursors and risk factors for suicide.

You might ask how that has come about. Well, if you are a people who have been subject to 200 years of invasion, oppression, racism, forms of apartheid and in some places attempted genocide, you would have to expect that you would have higher levels of those precursors for suicide within that community.

We are attempting to manage this not just at the systemic face in the work that I was talking about with Gugan Gulwan but in an overall part of our effort not only to close the gap, which is so important—closing the gap in Indigenous health outcomes—but also to tackle the social determinants of health, education, housing and employment, as well as looking to reconciliation which is going to provide that key support for a better relationship between Aboriginal and Torres Strait Islander people and non-Indigenous people in this country so that we can live in the kind of country that we want to live in, not the one that we have inherited from our ancestors. That is, I think, the key point to reconciliation.

MS LAWDER: Minister or Dr Collis, someone mentioned young people who had been in the care and protection system or the youth justice system having a higher level of suicide or self-harm than is the case in the general population.

Dr Collis: No, I would like to correct that. I do not think that we have the data to suggest that. What we do know is that young people who have been in out of home care have had, as adults, poorer life outcomes, which include mental illness, lower educational standards and poorer health standards. There are currently studies underway to determine whether there are higher levels of suicidal behaviour.

What I did recognise, in deference to this committee's purpose of trying to address issues in the ACT, is that amongst this group all the precursors the minister talked about indeed exist in the population; and that we witness, on a not infrequent basis, self-harming behaviour in this group at rates that we do not see in other populations.

Dr Bourke: And, of course, that trauma that these children have experienced in their lives which has led them to be placed in out of home care we can see in the recent Institute of Health and Welfare study. It showed that their interaction with the justice and youth justice system was higher than for kids who had not been involved in out of home care.

That is central to why we have changed our philosophy to go into A step up for our kids, which is a trauma-based approach to supporting children, to providing support and training for foster carers, carers and the workers with those families and those children. It is so that we can start to deal with the real issues that these kids have so that when they come out of those out of home care placements or even, indeed, do not go into them in the first place, which is a much better way to do things, we can be far more confident that we have dealt with some of those issues around trauma, which is the fundamental, philosophical change we have implemented through our program over the past couple of years.

MS LAWDER: My question is trying to establish what it was that you had said. Do you have, or will you provide, the statistics of the comparison between those who have been in out of home care and those who have not in the general population? Are you able to provide those figures?

Dr Collis: It is not possible for me to provide that kind of information. I think this is a topic that the child death review committee has turned its attention to and it is the appropriate body to deal with that. The reason why we have difficulty with this is because of the incredibly complex and tragic nature particularly of suicidal behaviour. Quite rightly so, people like us are not given the authority to determine whether suicide has actually happened or not. So there really need to be authorities which consider appropriate decision-making around that. The numbers also are very small, so I would think that the Child Death Review Committee would be the appropriate body to make that judgement.

Dr Bourke: In other words, if you wanted to see a particular trend in this, you would be better off looking at national statistics rather than the very small population that we have in the ACT.

MS LAWDER: But, on the other hand, it is about what we as a community and the government can do at the ACT level. So you need the local data to inform that.

MR HINDER: My question is about Indigenous youth. I was shocked yesterday to hear that the Canadian parliament has been recalled to deal with some very high levels of Indigenous attempts at suicide in very small isolated towns. I think the numbers were something like 10 or 15 young people in a town of 2,000 in one weekend. They have recalled their parliament, which seems like a much more reasonable reason to recall your parliament than some of the reasons we do it for federally.

Can you, minister, tell us what it is that you have done to reduce the number of Aboriginal and Torres Strait Islander young people in care and protection and whether you see any better outcomes for those people in the recent data?

Dr Bourke: That is a big question. Looking at the Canadian news, it is really quite distressing to see that happening in a small, remote community. It is not dissimilar to what we see happening in small, remote communities in other jurisdictions here in Australia. It is really very shocking when you hear that kind of information and that story.

Certainly the issues around Aboriginal and Torres Strait Islander young people in care and protection are significant. That reason Aboriginal and Torres Strait Islander young people are in care and protection is for them to be safe so that they can grow and have happy and healthy lives. The most common reasons children are taken into care and protection involve those three precursors for suicide that I talked about before: mental illness, drug and alcohol abuse, family violence.

There are significant issues, as you know, of family violence in Aboriginal and Torres Strait Islander communities. A recent report indicated that young Aboriginal women present to hospital or are hospitalised as adults 17 times more than non-Aboriginal

women. So there are significant issues built upon that backlog of 200 years of history in this country which have got us to this position.

But I think what we should be more interested in is what we are going to do to reduce those numbers of kids, Aboriginal and Torres Strait Islander kids, in care and protection, which in the ACT is of the order of some 25 per cent, as I recollect.

Firstly, when working with those intensive strengthening high-risk families programs it is particularly important where care workers are placed in the family home for considerable periods of time to try to hold that family together, to try to get a normal family life happening to provide the kind of supports that we would have enjoyed growing up: the regularity, the going to school, the meal preparation, all the things that happen in a family life.

Of course, only last week I was looking at a development for Karinya House. I am sure you are aware that it is in our electorate of Ginninderra. Karinya House is going to be providing intensive support for mums and new babies who have particular problems and their intake of Aboriginal and Torres Strait Islander women will be significant.

Right at the very get-go what we are trying to do is to make sure that as many kids as possible do not go into out of home care by providing the support to strengthen those high-risk or vulnerable families before the care and protection intervention is required.

At the same time, it is a small comfort to know that a significant number of those Aboriginal and Torres Strait Islander kids do go into kinship care. I think it is in the order of 50 per cent. Fifty per cent of Aboriginal and Torres Strait Islander care kids go into kinship care, which means they still have a connection to family, which is so important for them culturally.

MR HINDER: I have a supplementary, chair.

THE ACTING CHAIR: Continue on.

MR HINDER: You almost segued to my supplementary. In terms of specific supports, you talked about the fact that the territory offers supports to young people until much later than most jurisdictions; up to the age of 25. What specific supports are in place for young people preparing to leave government care?

Dr Bourke: I will get Dr Collis to go through that in more detail for you.

Dr Collis: First of all, the forum for protecting Australia's children, the national forum that came out of the COAG and that oversees the third action plan for the protection of Australia's children strategy 2008-20, has now acknowledged in the three priorities the importance of transition of young people in out of home care into adulthood. They have done that by having it as one of the three priorities.

You will see in that document that the ACT has been put up as an exemplar of that process. We are the only jurisdiction which provides financial support at the age of 18 for children in out of home care who wish to stay with their foster carer or kinship

carer. This is an acknowledgement of the significant feedback the community gave when we were doing the consultation for A step up for our kids. It said that the world had moved on. I do not know; my children at 18 and 19 were still in need of significant parenting. They were still costing me quite a bundle as well, I am here to tell you.

MR HINDER: You do not have to tell me that; I have my own.

Dr Collis: It was unreasonable to have this cut-off of time. Bear in mind also that kinship carers are amongst the poorest groups in our community as well and usually at the end of their career phase or even past their career phase; so their earning potential is quite low. That financial support to 18 to 21—again, we are the only jurisdiction which has undertaken that and there was legislation for that last year to allow us to undertake it—is one of the very practical supports.

That marks a statement, I think, for kids in the community that we actually care about them. We are not a parking lot for children in out of home care. I think that when the Assembly passed that act and allowed that to happen, that was an incredibly powerful statement to our young people to say, "We actually care about you. We care about you, not only about getting to 18; we care about you translating that into a future—a future which includes education, a future which includes a loving, caring family, a future which usually involves some reconnection with other family and past family involvement as well. So that is one particular area.

Another area we have enacted in recent years is to provide for post-care support through to 25. The minister mentioned this in his speech at the beginning. There is no order here; so children are not under any orders to comply to anything. This is a voluntary offer for young people to have caseworkers sit side by side as they go through that really critical early education, early relationship development phase to 25. So it is voluntary. Young people can choose to engage with that to the extent that they wish.

We have been really overwhelmed by the uptake of that—roughly 35 to 40 young people leave care each year. Our uptake in the first three years of that program has been of the order of 80 or 90 per cent. It has been very high. We are really encouraged with that because it is a voluntary process. Often in public policy it is difficult to know whether you have hit the mark, but kids are voting with their feet in terms of that program. That continues.

We also support that process financially. So if there are needs for particular case management for young people who move outside of Canberra or go somewhere else, we have the capability to provide some extra support that is not available elsewhere through a commonwealth program or another program. All young people will have a transitioning from care plan commenced as part of their overall plan by 15 years of age as we move through.

In the reorganisation to Child and Youth Protection Services we have our teams now located notionally regionally from the north and south of the lake but also in teams of 12-plus and below 12. This is largely so that we can actually increase the continuity of relationship between case managers and young people all the way through. By

combining youth justice in that, it means that it does not matter whether the reason they touch us is through youth justice or through child protection. They can have the same case manager and caseworker who follows them through.

I could go on at some length and talk about the programs that are available at Bimberi for young people who are in Bimberi: education programs, cultural programs and employment programs. I could talk about one of the successes at Bimberi, which is the increasing leave rates that we have been getting in Bimberi, that is, young people who leave Bimberi to do education or employment opportunities while still in Bimberi. We believe that that, over the years, has been one of the reasons why we have tended to reduce the number of returns back into Bimberi.

Mr Matthews: I think it is important to say that in addition to those specific services that Dr Collis has referred to, we are talking about young citizens and we are talking about their need to access a full range of government and community services that are available in the community. So it is really important that they are supported to access the education, health, justice services and family support services that they need as well. A lot of that individualised support is about bridging the gap between those mainstream services that all citizens should have the right of enjoying.

The ACT government has released the ACT children and young people's commitment 2015-25. It articulates that whole-of-government role in making sure that all of those government agencies are actively working together to make that transition as easy as possible for those young people but, generally, to try to create a child-friendly community. So in terms of the way that we can support and nurture our young people, we want them to be in happy and healthy families, but we want a child-friendly community that understands the needs of children and young people and that works together to help them through the challenges that they might face.

The role, then, of specialist services is really making sure that we understand the specific needs of all of those children and young people and that they get all of that brought together in a way that makes sense for them. It is really important to emphasise that it is not just a responsibility of the care and protection system to respond; they have got a particular role, particularly as kids are coming out of care and youth justice. But it is that whole-of-government, whole-of-community response that is needed.

Dr Bourke: I think we are one of the few jurisdictions that has that capacity to be able to provide an opt in or opt out option. So they can opt in or opt out or opt back in again up to the age of 25. That is something particularly important that we have done here in the ACT, on the back of the fact that we are the only jurisdiction that provides a carer subsidy payment to young people who are over 18 until they turn 21 when they want to stay living the carer family.

THE ACTING CHAIR: I have a quick follow-on. Dr Collis, what proportion of youth at Bimberi were involved in out of home care or care and protection prior to their time at Bimberi?

Dr Collis: The number fluctuates because the actual number of people fluctuates. The last time that we did a snapshot of that was, I think, three years ago. It was in the

order of around 60 per cent. As of today, I think that that may be something like 40 per cent that are open child protection cases.

What research has shown, particularly the New South Wales BOCSAR research when they looked into this, is that about 60 to 70 per cent of children, of young people in youth justice, have had a background known to child protection services. Actually, if you then take the threshold as being whether they had experienced trauma within their families, you then bump it up to about 98 per cent. So about 98 per cent of children in custody in youth detention centres have backgrounds of trauma and abuse. It is very rare for that not to be the case.

MR HINDER: Minister, you mentioned the step up for our kids reforms. Is that a philosophical change from the previous strategies that were in place or is it just a renaming or bringing together of existing services?

Dr Bourke: Absolutely it is a philosophical change. It is about taking that trauma-informed approach that I was talking about before and realising that these children going into out of home care have suffered traumas that we can barely even imagine; the traumas involved in living in a family in a home where there is mental illness, where there is substance abuse, where there is family violence. These are significant traumas and they have their impact on the child.

We can already see what has happened in the past as children have left out of home care, the greater risk of them, as Mr Collis has said, being involved in youth justice or in the criminal justice system. These kids need more, and that is what step up for our kids is about. It is about taking a trauma-informed approach to providing out of home care, to providing support for the foster carers and a theme for the support workers involved in helping these kids to transition to a successful and happy life. They have come from a place of trauma, which we need to understand and we need to deal with before we can feel any confidence that they are going to have the potential for a good life.

Dr Collis: Acting chair, might I just add to my question before, just for clarity: as of today, 50 per cent of the young people in Bimberi are care and protection clients.

THE ACTING CHAIR: Thanks. Ms Lawder, a substantive question.

MS LAWDER: Thank you. Do you know whether in the ACT there is a cluster effect in youth suicide? I have read about that in some research. I think it was referred to as the Canadian example. Given the small numbers in the ACT, are we able to say whether we have seen those cluster effects?

Dr Bourke: I think, as it says in the government's report to the committee, the numbers were about six over four years so looking for clustering is going to be a little bit difficult. Just going back to my opening statement, there may have been some confusion. What I meant to say was that one-third of all Aboriginal and Torres Strait Islander deaths in our country of people aged 15 to 34 are the result of people taking their own life—not that one-third of people in that age group take their own life, which I presume people would have understood anyway.

MS LAWDER: We were just talking in the previous question about a step up for our kids. Minister, with respect to strengthening families and how we talk about meeting the specific needs of young people and supporting them to access services—how perhaps not having a local Aboriginal service like Winnunga, for example, delivering those services—do you think it is the best way to meet the needs of local Aboriginal and Torres Strait Islander youth to have services that are not based in the ACT and that do not have a lot of experience in the ACT?

Dr Bourke: Jaanimili, who are delivering the strengthening high-risk families for Indigenous families component of A step up for our kids, have a lot of experience working in Aboriginal communities like we have here in the ACT. They have a significant Indigenous focus both within their staffing and within their general philosophy. I would feel confident that they are going to be capable of meeting that particular challenge. Of course, whilst some jurisdictions do have specialist Aboriginal and Torres Strait Islander childcare agencies, in a small jurisdiction with a small population, this would perhaps be a challenge for us to be able to achieve that. Certainly within the overall tender process for a step up for our kids, which you would be aware of last year, there was not a successful bid by a local Aboriginal and Torres Strait islander childcare agency to take part in that process. I will get Dr Collis to talk a little bit more about that.

Dr Collis: I can add only a little bit more than that to say that many of the people who are working in Uniting to deliver the strengthening high-risk families are local people; they have employed locally. Indeed, the senior management of the program is an Aboriginal person who has a lot of connections to the ACT. What Uniting bring, in addition to a really deeply held mission around ensuring Aboriginal and Torres Strait Islander voice and capability are brought to bear in keeping Aboriginal children with their families, is a vast amount of intellectual property from where they have worked in other communities in these programs. What they know is necessary in terms of training, supervision and follow-up with families. They have very well formulated and well-evolved thresholds of risk, so they know when to be involved with a family and they know when it is time to move out, because they bring that intellectual property with them.

MS LAWDER: Sure. It was not intended to be a criticism of Uniting in any way. I was just interested in the local knowledge aspect, that is all. Minister, just harking back to your opening statement, you mentioned veterans. Can you remind me what you said the percentage was of veterans who had lost their life or taken their life through suicide?

Dr Bourke: Yes, I will just go back and find that for you. There are 262 veterans that we know of who have lost their lives to suicide. According to the Department of Veterans' Affairs, there are 133 veterans under 30, 99 of whom are male and 34 are female, in receipt of treatment cards; in other words, they have service-related or caused conditions such as post-traumatic stress disorder, depression or anxiety.

MS LAWDER: For the purposes of this inquiry, even though they are talking about those under 30, they not are able to give you statistics, for example, of those under 25? Would there be any in that age group?

Dr Bourke: I do not have that data available. As Minister for Veterans and Seniors, it is important for me to draw this issue to the committee's attention. I would suggest that if the committee wanted more information they could inquire from the Department of Veterans' Affairs, who would be happy to provide more information. My directorate might be able to get you some more information as well.

MS LAWDER: No, just in terms of youth suicide and—

Dr Bourke: Yes, I realise the difference between 25 and 30.

MS LAWDER: Thank you.

Dr Bourke: That is the information that they were providing in that area, but we can inquire as to whether they can provide us with under 25 information. As you quite rightly say, that is the focus of the inquiry.

MS LAWDER: It is important information, but just to narrow it down perhaps.

THE ACTING CHAIR: Following on from that, minister, you mentioned that there were 133 veterans under 30 in possession of a treatment card in the ACT.

Dr Bourke: No, nationally.

THE ACTING CHAIR: Nationally; okay. Any indication of how many in the ACT?

Dr Bourke: There may well be some in the ACT, but I do not know how many in the ACT given that we have got one or two per cent of the national population.

THE ACTING CHAIR: For those who are in possession of a treatment card, who provides the support and the care required? Do DVA and ADF continue to do that or is it provided by the state jurisdiction?

Dr Bourke: I presume it is DVA after they have been discharged.

MR HINDER: Minister, you mentioned the blueprint for youth justice. Ms Lawder, Mr Wall and I attended a PCYC launch this morning with you out at the Winchester centre.

Dr Bourke: Yes.

MR HINDER: That, as you know, was an intensive program to address recidivist young offenders. Can you tell the committee how the blueprint for youth justice was different to previous structures and strategies and whether the PCYC program—it is not in one of your portfolios—is part of an integrated government approach to dealing with the issues before the committee?

Dr Bourke: Talking about youth justice, as you will have heard when I talked about it in the Assembly last week, there are some great results coming out of the three years that this has been in place, including a 20 per cent reduction in the number of young people being apprehended by police and a 47 per cent reduction in the number of

young Aboriginal and Torres Strait Islander people who have been incarcerated. The number of young people in detention has dropped by 35 per cent, so we have actually been able to lean into the Aboriginal and Torres Strait Islander young people space more heavily rather than overall, which is, I think, a very good thing.

The key features of that program are, firstly, restorative justice, which I have been a very great supporter of in my time in the Assembly and, indeed, as you may recall, in my activity in the party before I was elected. I also take my hat off to Mary Porter for her advocacy for the Indigenous restorative justice guidance partner. You will know that the data for young people being involved in restorative justice before we had that person on board was quite poor when you compared it with the involvement of non-Aboriginal young people. It was of the order of about 30 or 35 per cent. I cannot recollect precisely, but it was of that order. I am sure Dr Collis knows. That has been a significant boost.

Currently the involvement of Indigenous young people is probably as high as, if not higher than, the involvement of non-Indigenous young people. It is a very tough process. It is not a soft option in justice. It is a tough process where the young person is confronted with the outcome of their offence and learns to feel the shame of that—the shame—which in many ways is the reason most people do not offend, because they would be ashamed to do so and because they would be ashamed if people knew what they had done. That shame factor is a powerful mechanism behind the restorative justice approach. They are confronted with the victim of their offence, and they have to explain to them why they committed the offence. It is a very important way to divert young people from detention and get them back to living a better life. That is the first part.

The second thing that we have done is establish the after-hours crisis support service, which was formerly known as after-hours bail support. That is really to help those young people who are close to going off the rails. If they have got an order that says they have to be home by 10 o'clock and they are not really close to being in the right spot, that service can reach out to them and support them to get to the right spot so they do not breach their bail and they do not end up in Bimberi.

The third element of this is through care, which has been such a potentially powerful force in the adult sphere. The Bendora through-care unit in Bimberi—and I will get Dr Collis to talk a little bit more about that in a moment—has been quite effective in reducing recidivism amongst these young offenders. I will get Dr Collis to talk more about Bendora.

Dr Collis: Just to get some context as well, Mr Hinder, when the review into youth justice in the ACT came down in 2011 I think one of the enormous successes of the blueprint was laid right at the beginning of that, and that was when around the table came the police, Justice and Community Safety and all of the providers of services into the justice system. I can say, having then taken over the chair of that task force, which turned into an implementation group, that there was an enormous commitment around that table in relation to the Galambany court, the restorative justice program and the programs that CSD bring to the party, but also in relation to the programs that Winnunga bring into Bimberi in terms of the culture, the yarning pit, and Relationships Australia with their Dunial program. That is a cultural-based program

which, in fact, reversed the notion of cultural power in Bimberi whereby young non-Indigenous people sought strong Aboriginal role models to engage and speak with and to develop pro-social values. People all around the table came to the party, including the AFP.

I have been to many jurisdictions around Australia, and we are the envy of all of them in terms of the relationship that the Australian Federal Police bring in supporting us both in after-hours programs and in the programs that you mentioned today. The relationship and understanding that we have to do something more than coerce young people in this space and that we need to help them grow is not, as you might not find surprising, a uniform view in all police services, but it exists very powerfully within the ACT, and we are very proud of that.

In the three-year report that has just come out, one of the recommendations is that we now need to move the youth justice blueprint into the broader reform in justice, which includes the justice reinvestment program, and make it a whole-of-government response, because we need to continue to challenge ourselves. One of these things is the intergenerational transmission of offending. We are stopping things at this end, but how are we supporting young people whose parents are in the justice system further down the track? For those really difficult recidivists, how do we continue to move on?

In terms of the Bendora through-care unit, which is focused on providing training, social skills and employment support, it is a unit in Bimberi where the rules are more likely to correspond to what the rules are in the community or at home with family or living independently. That is, they need to cook their own meals, they need to clean and they need to look after themselves. They are given greater degrees of freedom and expectation of involvement in looking after themselves. I know that most of the people who leave Bimberi after a period of sentencing say that the thing that scares them most is making those decisions. Again, that is how Bendora works; it allows those young people who are ready for it to develop those skills and to generally move into the community prior to their actual release into the community.

THE ACTING CHAIR: There being no further questions—

Dr Bourke: I will just say, acting chair, that I was sorry the chair was unable to be here today given her role in the instigation and formulation of many of these strategies. It was a great legacy for me to take up as a minister.

THE ACTING CHAIR: Thank you for your comment, minister. Thank you, directorate officials. I do not think there were any questions taken on notice, so there is no homework for you tonight.

Dr Bourke: The DVA data.

Mr Matthews: Did you want us to follow up on the DVA data?

THE ACTING CHAIR: If you can, that would be great.

Short adjournment.

McLEAN-ENGSTROM, MS MIRJA (MAJKA), Community Engagement Coordinator, A Gender Agenda

THE ACTING CHAIR: Welcome back to the health, ageing, community and social services committee inquiry. We welcome now A Gender Agenda to the committee. Before you there is a pink privileges statement. You have had a chance to read it—it was supplied to you previously—and you understand the implications of that card. I invite you to make an opening statement.

Ms McLean-Engstrom: Sure. My name for the purposes of today, my legal name, is Mirja McLean-Engstrom, but my preferred name is Majka as I identify as non-binary and have a preferred name.

My role at A Gender Agenda, I am the community engagement coordinator, so I am our front-line staff member working with a lot of the calls that we get and working with clients and our members. A Gender Agenda deals directly with young people, their carers, their teachers and their health professionals on a constant basis. The majority of calls we get at AGA are actually from these groups and are regularly or often regarding concerns about the mental health and wellbeing in particular of young people, particularly those aged 12 to 25, sometimes younger as well.

Many of those conversations, particularly with parents and carers and teachers and health professionals, come as a result of a young person recently coming out. These calls about the mental health concerns for young people are particularly high around holiday periods, particularly around Christmas, but also around school holidays as well and can result often in AGA services being used as a crisis service when that is not actually what we do per se.

We see people coming out as transgender and gender diverse at increasingly younger ages, so it is really important for everyone in the community that we start having conversations about the mental health and wellbeing of these young people.

In 2014 a report titled *From blues to rainbows* was produced by Latrobe University and the University of New England and is specifically about the mental health and wellbeing of young people who identify as trans or gender diverse. It is one of the ground-breaking research reports in Australia and around the world as well and has now been published in association with beyondblue.

To give you a bit of background from this report so you have a bit of data to know, the *From blues to rainbows* study is a study of mental health of gender diverse young people supported by beyondblue. It tells us that approximately 47 per cent of gender diverse young people have been diagnosed with depression by a mental health professional and 45 per cent have been diagnosed with an anxiety disorder; and sometimes those two go hand in hand, as we know.

Research from New Zealand indicates that transgender and gender diverse young people are up to four times more likely than cisgender young people—"cisgender" being somebody who identifies as the sex that they were born—to experience severe, significant depression. Another study by McNeil in 2012—prior to the *From blues to*

rainbows report—indicates that these young people are less likely to reach out for medical assistance, which is then corroborated in the *From blues to rainbows* report.

These two findings result in particularly high levels of concern for the mental health of these young people. With the *From Blues to rainbows* report it is important to recognise that at the time of the study in 2014 between 25 and 33 per cent of the young people who were surveyed—the number of young people being 189 from around Australia—had had or were having at the time of the study suicidal thoughts.

We know a lot of the mental health and wellbeing issues that these gender diverse young people face come as a result of having to come out to communities that are perhaps not as supportive as they could be. We know that 81 per cent of these young people have experienced some kind of abuse, whether that be verbal, physical or emotional. Of that 81 per cent, 80 per cent had thought about self-harm and 70 per cent had self-harmed, and 81 per cent had thought about suicide and 37 per cent had attempted suicide. So these are very high statistics. We know that 90 per cent of those who had experienced physical abuse in particular had thought about suicide because of the abuse they had been subjected to. So there is a direct link there.

We know also from statistics collected by the Safe Schools Coalition Australia that 80 per cent of abuse happens in schools. This is a time for us at A Gender Agenda to really thank the ACT government for their support of the Safe Schools Coalition. It is very important, and we see the impact of that every day.

There are a lot of things that we could be doing better to support these young people, particularly in terms of seeking professional assistance regarding mental health. Many of the young people, 77 per cent, surveyed in the *From blues to rainbows* report—and this is something that we hear in conversations that we have with young people fairly consistently—had avoided seeking professional assistance regarding their mental health for a number of reasons, with the majority of those thinking that mental health professionals are not going to understand them or will not be able to help anyway.

It is really important that mental health and medical health professionals actively seek to increase their knowledge and understanding of gender diversity, particularly in regard to non-binary identities—that is, those who do not identify as male or female—to enable them to be able to more effectively assist these young people.

There are many things that young people do to make themselves feel better, ranging from self-harm and substance use to more positive measures, such as art and talking to a friend both online and face to face. In terms of those online interactions, it is really important that professionals do not place face-to-face interactions with friends or other supports as being more valuable than those online. That is particularly important for the trans and gender diverse young people because a lot of support that they do find is online through communities on Tumblr or through other people slightly older than them or at the same age through YouTube videos, in particular, talking about their experiences of transitioning. We need to really respect that those relationships are really important.

We need to in the ACT and around Australia work to make public spaces and services

more inclusive of gender diversity. There are a couple of things we need to do for that, in particular, having options on forms for gender that are other than male and female. That is making young people choose a gender that they do not feel comfortable with, and that is not okay. That often results in young people experiencing high levels of anxiety about how they are going to be perceived or how health services are going to work with them. There is also a need to have gender neutral bathrooms, particularly at health services. That is something I hear the young people I work with say a lot: "When I go to the doctor's, there's nowhere for me to pee." They do not want to use a gendered bathroom; they feel uncomfortable and unsafe in those circumstances.

Support for young people at school is really important. Again, thank you to the ACT government for supporting the Safe Schools Coalition, and, in particular, supporting education for all staff members, including teachers and school psychologists, but also reception staff, for example, as the first point of contact that many students have at the beginning of the day. That is really important. Having resources available for young people about gender diversities is also important.

Late last year in December A Gender Agenda ran a workshop with young trans and gender diverse people in the ACT specifically about socially transitioning—"socially transitioning" being things like changing your name or changing your pronouns or changing how you dress rather than seeking medical interventions. We talked to these young people and heard their perspectives about what sorts of measures to socially transition worked really well for them or what are some things they have struggled with when they have socially transitioned.

By and large, the use of a chosen name and the correct pronouns, whether that be a gendered pronoun—he or she—or, increasingly, a non-gendered pronoun—they, them, zir, there are lot a non-gender pronouns that young people choose from—is particularly important. And it is particularly important to see that flow through all of their lives, so not just with their friends and their families but with their schoolteachers. For example, when they finish year 10 or finish year 12, having their preferred name on their graduation certificate is really important. It is those little things that make a huge difference to the lives of young trans and gender diverse people. Those are really safeguarding principles and safeguarding options for the mental health and wellbeing of these young people.

The ACT has come a really long way in the recognition of gender diversity, particularly in policy around genders on birth certificates and the ease with which those can be changed comparative to other states around Australia. That is really remarkable and something that as workers at A Gender Agenda we are really proud to say that we are in a state that the people we work with do not have to seek medical intervention to be able to change their gender on birth certificates. That is very important.

In conclusion, it is really important that there are services and specific supports for gender diverse young people, and their families as well. Unfortunately, a lot of those services are lacking in the ACT. A Gender Agenda is a gender service, but we do not provide case management, for example. We are not able to provide that, and we are not able to provide one-on-one support or psychological assistance.

Comparative to the number of calls that we get, there are not currently services that are able and open to learn about dealing with these clients and that we can refer people to knowing that they are friendly. There are just not enough services there that are aware, knowledgeable, considerate and respectful of these young people and their families.

There is a constant need to continually acknowledge the issues faced by this population as also being really separate from those faced by the LGB—the lesbian, gay and bisexual—population. They are not the same issues. Gender and sexuality are different, and that is not often recognised we feel at A Gender Agenda. It is really important that that happens. In taking all those steps we hope to see a world in which being trans or gender diverse is not seen as being a mental health issue.

THE ACTING CHAIR: Thank you very much. As the social acceptance of gender diversity increases, has the number of people seeking counselling support or services increased or decreased?

Ms McLean-Engstrom: Absolutely it has increased.

THE ACTING CHAIR: Why do you think it is increasing counter, I guess, to community acceptance?

Ms McLean-Engstrom: It is counter to community acceptance I think because there have been, particularly over the past couple of years, a lot of celebrities coming out as trans or gender diverse, for example, Laverne Cox and Caitlyn Jenner. That has a huge impact. Being able to see role models is really important. It makes young people feel a lot safer because these people have managed to come out; so they can too.

Sometimes that is contradictory to the public support that they may get when they come out, and that is really hard. That is really hard. It has huge impacts on the mental health and wellbeing of these young people. I think part of the reason that they often do feel safe coming out is because of those online communities that I mentioned earlier. They are often very inclusive and very supportive. They feel supported in those communities, whereas that might not be the case in the communities that they are in that are not online.

THE ACTING CHAIR: You mentioned in your opening statement that A Gender Agenda receives a phenomenal number of calls for help or assistance. What sort of numbers are you talking? Do you keep a log?

Ms McLean-Engstrom: We keep a log. How many calls a week do we get? Four at a minimum a week. Those range from being from health professionals, teachers, occasionally young people, but it is usually their parents who call. Their parents are often very distressed. We can spend anywhere up to an hour on the phone with them, part of that time just being, "Take a deep breath and calm down. It's going to be okay."

That is an area that we are looking to increase our support with. We have recently developed a resource pack specifically for young people and their families and those who work with young people regarding mental health in particular. It is about services that are out there, because there are not a lot of services in the ACT. But there are

some online support services for parents as well.

MR HINDER: I have a question about resource allocation. My mother is a schoolteacher. I have always had the view that the schools would be the right sort of place to target education programs. It was my first motion in the Assembly to support the safe schools program.

Ms McLean-Engstrom: Thank you.

MR HINDER: That reflects that sort of thing, I suppose. But in your view, where would you like to see resources allocated? Is it in training for perhaps the medical profession? If it was up to you to decide—and remembering that resources are always limited for every government—where would you see the best bang for your buck, if you like, to address the issues you see in this area?

Ms McLean-Engstrom: I think that is partly dependent on what safe schools is going to look like in the ACT. But I think there is generally in the ACT a lack of health professionals who are adequately equipped or adequately knowledgeable about these issues. That is something that we face very regularly: medical professionals being GPs, endocrinologists—physical health—but also mental health, in particular.

I think that is especially important for young people and for trans and gender diverse people overall because seeking hormone therapy does require, depending on your GP, between one and three letters from psychologists and psychiatrists to be able to access those treatments. But there just are not enough people for us to refer to for our clients to get those letters.

MR HINDER: As a follow-up from that, in relation to training, do you track what it is that the medical bodies are providing to their members or what the government medical agencies are providing to doctors and health professionals about the issues?

Ms McLean-Engstrom: In terms of training?

MR HINDER: Yes. And whether there is enough. I am assuming the answer is no. If there is any, is it the right sort? Then in terms of your organisation, what sort of awareness campaign do you run for those people, given that you are probably the repository of the most information locally?

Ms McLean-Engstrom: Yes, in relation to the first half of your question, I do not really know the answer to that. I know that a lot of the calls that we get from health professionals are about, "How can I help this person? I need general information. I've had no experience here. I just need the foundational knowledge." That is a lot of the calls we get.

MR HINDER: But that indicates that they know you exist.

Ms McLean-Engstrom: Yes.

MR HINDER: Which is a big start, I would think.

Ms McLean-Engstrom: Yes, it is a great start. We currently have a resource called "navigating diversity", which was produced in 2011. We are in the process of updating it at the moment. It is aimed at medical professionals, at being able to provide them with a base level of knowledge as well as resources to continue their learning in this area. So that is often what we provide our medical professionals with. We also encourage them to speak to their professional peers, particularly those at the Gender Centre in Sydney and the Zoe Belle Gender Centre in Melbourne.

MS LAWDER: I think you said at some point that some transgender and gender diverse young people avoid seeking assistance.

Ms McLean-Engstrom: Yes.

MS LAWDER: Whilst you have spoken a little about training people who are asked for assistance, how are you addressing the other side of it; encouraging or supporting young people to seek assistance?

Ms McLean-Engstrom: At A Gender Agenda we encourage them to seek assistance through forming relationships as far as we can with services in the ACT, particularly with Headspace. We refer a lot of our young people to Headspace. In fact, we have just been contacted this week by Headspace to give training to their staff members. We have worked with the trans pathways to healthcare working group that last year was run by Headspace. Now it is run by the AIDS Action Council. That was really a great stepping stone, I think.

We also have a relationship with Relationships Australia, knowing that they have received some training in this area. We have constant and open discussions about how that can be done better. But a major reason that these young people avoid seeking medical assistance, or assistance of any sort really, comes down to not knowing if the service is friendly, or LGBTI friendly—particularly T and I friendly.

It also comes down to things like over the phone not sounding like the gender that they identify with and whoever is taking their call over the phone misgenders them. That is an instant turnoff. If those first points of contact are not positive, young people are not going to go. I think that is really important to consider.

Also, these young people avoid seeking help because they are scared of the ramifications of that sometimes in terms of confidentiality, particularly at school. Also, they may be pressured to do something with their gender that they do not feel comfortable doing. I think that is often because of a history of pathologising and medicalising being trans or gender diverse when, for some young people, it is enough to just change their name and their pronoun socially. At that time, that is all that they want to do, and there needs to be some respect there that young people have boundaries that are at different places.

I think also one of the issues nationally, particularly for those under the age of 18, is the need to go to the Family Court to be able to take stage 2 hormones, those being cross-sex hormones. That is a huge barrier for young people and for their families. A Gender Agenda recently went to a panel held by the federal parliamentary friendship group for LGBTI Australians about this topic in particular. It is hugely restrictive and

causes a lot of angst for these young people and for their families. There is a lot of stress involved there.

MS LAWDER: You also mentioned that you are not a crisis service but you get a lot of calls.

Ms McLean-Engstrom: Yes.

MS LAWDER: Especially close to holidays; so you have talked about Headspace. What are some of the other organisations? Do you act as a referral then?

Ms McLean-Engstrom: We can do. If anybody—

MS LAWDER: What do you do with these calls?

Ms McLean-Engstrom: What do we do with these calls? I think it depends who is calling. For example, if we have a parent calling who is worried that their gender diverse child will take their own life, that is a very different call to receiving a call from the young person themselves. So there are different things to do. A lot of the time in terms of a crisis service we refer them to QLife, which is an online and telephone crisis support service, though it is open only from 3 pm to midnight daily; so it is not a 24-hour service. We refer them to Lifeline if we need to, the crisis and assessment team—the CAT team here in Canberra—because those crisis situations need to be dealt with in the same way that any mental health crisis situation is dealt with.

THE ACTING CHAIR: If there are no further questions, thank you very much for your time in appearing before the committee.

The committee adjourned at 3.25 pm.