LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON EDUCATION, EMPLOYMENT AND YOUTH AFFAIRS

(Reference: Inquiry into youth mental health in the ACT)

Members:

MR M PETTERSSON (Chair)
MRS E KIKKERT (Deputy Chair)
MS E LEE

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 26 MAY 2020

Secretary to the committee:
Ms S McFadden (Ph: 620 70524)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

WITNESSES

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Amended 20 May 2013

The committee met at 9.33 am.

THORPE, MRS RACHAEL

THE CHAIR: Welcome to the first public hearing of the inquiry into youth mental health in the ACT. I thank Mrs Thorpe for being with us this morning. I understand that you have been forwarded a copy of the privilege statement. Could you confirm for the record that you understand the privilege implications of the statement?

Mrs Thorpe: Yes, I do.

THE CHAIR: I remind everyone that proceedings are being recorded by Hansard and webstreamed and broadcast live. We will work through questions down the line, but before we start would you like to make an opening statement?

Mrs Thorpe: I just want to say I had a very close friend who lost her 24-year-old daughter to mental illness and for the last nine years it has been one of my greatest fears. I thank all of you for your work in this inquiry because I truly believe it is essential to save lives. It is just so incredibly important. I just wanted to take the time to thank you for doing that. That is all.

THE CHAIR: I have read your submission, but I was wondering if you could talk to your submission, for those that have not read it. What was your experience?

Mrs Thorpe: Probably the thing that struck me the most was needing to find a female psychiatrist—it had to be female due to previous trauma—and naively assuming that, living in the capital city of Australia, where I had recently relocated to, that would obviously be easy. I had come from a more regional area and understood that in a regional area it would be difficult. I discovered that there simply was not a female psychiatrist in Canberra, with space on their books, treating adolescents. And I found that incredible.

We drove, and still do drive, to Bowral, two hours away. I could understand the reverse. I could understand living in Bowral and having to come to Canberra. But I really struggle with having to leave a city like this to go to a regional area to get the help that we have desperately needed. That was one significant thing.

The other significant thing was having a hospital attendance related to mental illness and being taken to a hospital far further from our home, on the grounds that there was no mental health team at the closest hospital, but then getting to the hospital and, after five hours of waiting, being told there simply was nobody that could help us and that we would be better off going home.

I have cancer and I have found that there are plenty of services for that, and if you turn up to a hospital there is somebody that can see you and somebody that can help you. I find it distressing that there does not seem to be the same level of importance given to mental health, and it is just overwhelming for parents like me that are trying to advocate for children and keep them alive at the end of the day. There do not seem to be the resources available, or it is not an efficient use of resources, because you have so many different places and you are trying to work out what the best option is and you are floundering because you do not know what you are doing or where to go or who to talk to.

THE CHAIR: I will lead off with a question and then we will work our way through. You talk about there being no female psychiatrists accepting new referrals. I was wondering if you could expand on how you came to that conclusion. Do you have to trawl through all the psychiatrists or is it just word about town that any referrals—

Mrs Thorpe: At the time it was a combination. I called multiple psychiatrists. Our GP called multiple psychiatrists. And we kept getting the same response: there is nobody taking referrals; there is nobody taking referrals. I then asked in a support group and got the same response: that there just simply was nobody taking referrals. There was possibly a male at the time that we could have gone to but there was not a female. I cannot say that we called every single psychiatrist in Canberra, but I think between the GP and me we probably covered virtually every female one at the time.

THE CHAIR: How did you finally come to get in contact with the person in Bowral? Did you just keep expanding further and further out with your search?

Mrs Thorpe: That is right. That was the GP. She asked her contacts, other GPs that she knew, and it literally was a word of mouth operation. This was a couple of years ago, but I think there was one in Sydney—it might have been two in Sydney—and then the one in Bowral. We tried the Bowral one first, on the grounds that it was closer than the two in Sydney, but that is what we would have done if we had no option.

It really was a word-of-mouth thing between the GP talking to the people that she knew and getting a bit of an inside tip for me that this person potentially was available. That just does not seem to me to be a very efficient way of actually being able to find a specialist. That is how I see it: that there should be an easier way than having to make umpteen phone calls. The GP did not charge us for her time in making all these phone calls for us either, and she made a lot.

MS LEE: Thank you for your time. If I can take you to your submission, where you talk about your experience with your other child, who is currently receiving some services through CAMHS and that is now going to finish when they turn 18. Can you tell us a little more about that experience?

Mrs Thorpe: CAMHS we got onto after a hospital presentation, and they referred us to them. We went and did—I do not know what you call it—an interview, really. There were three people there and they spoke to my husband and me, and our child, and had a discussion about what the needs were. Then they have a team meeting and match to you the best therapist. It was just very lucky that we got a fantastic therapist that my child has bonded with extremely well. I believe that that has made the real difference to why our child is still alive. I am not quite convinced that they would have been alive, and even they have said to me that this therapist has saved their life, literally.

It has been a really, really good service which we would be happy pay for. But it is funded, which is fantastic. Our child attends based on need. Sometimes that might be three times in a month. Other times a couple of months might go by. The therapist and our child work out between them what is going to be most effective at the time.

But we were advised that once they turn 18 they will have to be weaned off that service as such, and that is really scary because we will have to try and find a replacement therapist that our child is going to bond with in the same manner, that is going to be able to provide the same things that we have had off the therapist at CAMHS. I found that to be really good as well. But, again, it is about finding these services. We had not been in Canberra long. When you do not know, you do not know where to start. I had not even heard of them until the hospital actually referred us to them.

MS LEE: In terms of the transition or the weaning, as you referred to it, what support, advice or information have you been provided to assist you in trying to find that alternative service?

Mrs Thorpe: For me personally, the difficulty is that, once they turn 14, as you would be aware, you do not really have any entitlement to any medical information at all. Periodically, our child will agree to my being able to speak to the therapist. But that depends on the day. At other times there is a refusal in terms of my doing that.

I have had one very brief discussion with the therapist, who has said that they will try and find someone, a private psychologist that we can go to, that will have a similar personality. The therapist has said that they are willing to help with the transition and talk directly to the psychologist et cetera. But that is really all I know. I do not actually know who to ask, because you cannot get any direct information about your child's medical care.

I understand the reasons for that. Obviously, in certain family dynamics that would be essential. But when you are trying to do the best for your child it is really difficult when you cannot have direct conversations with anybody about anything, which just makes it more challenging than it needs to be, I feel.

MRS KIKKERT: Thank you so much for coming in this morning. I am really interested in supporting families who have youth that are currently having mental health issues. In your submission you referred to mental health first aid, and that was very, very helpful for you. Can you tell us a little about it? Who suggested that service to you or doing the course for you?

Mrs Thorpe: That was just me googling out of desperation one night at about 11, thinking, "I have got to do something." I literally did not know what to do. And that just popped up. I went, "Okay, that is really interesting." I looked into it further and discovered that you could do it as a course. It was two days, from memory, I did at the beginning of the year. I just found it and funded it myself. I think it cost me about $300 for the two days. But it was really, really helpful. It was nothing that had ever been suggested before. In fact, I did not even know that such a thing existed.

I had done, several times, a traditional first-aid course but had no concept that there was a mental health first-aid course. I found it really, really helpful in terms of giving me a better understanding, when someone is in a mental health crisis, of the things that you should and should not do or say. Some of them were counterintuitive. It was really helpful to get that information.

But I believe that financially that would be out of the reach of a lot of families, plus most of them would not even know about it. I have spoken to a lot of friends who have gone, “You did what? We did not know there was such a thing available.” I just think that, if families could be provided with access to that, maybe subsidised or at least assisted to find the information, it would be a huge help. It is the most practical thing I have done, in my experience, in the nine years in terms of the mental health that I have been dealing with.

MRS KIKKERT: I am very mindful of the time. I have many more questions and I will probably ask them by email, through Sarah. But thank you so much.

Mrs Thorpe: That is fine. If anyone wants to email or call me, that is fine. Sarah has my details.

THE CHAIR: Thank you, Rachael, for making the time to come and have a chat with us. It has been really, really helpful.

Mrs Thorpe: Thanks so much.

THE CHAIR: Thank you.

BINGHAM, MR ROSS
BINGHAM, MRS MARY

THE CHAIR: Thank you for taking the time to come and have a chat with us. I understand that you have been forwarded a copy of the privilege statement. Could you confirm for the record that you understand the privilege implications of the statement?

Mr Bingham: Yes, we do.

Mrs Bingham: Yes, we do.

THE CHAIR: I will give you the chance to make an opening statement and then we will go through and ask questions. If you have got an opening statement, would you like to give it?

Mr Bingham: That is fine.

THE CHAIR: Then I will lead off with questions and we will make our way through. First and foremost, thank you for making a submission. It is not a good story to read but it is a helpful one. I was wondering if you could maybe expand on the experience you had of trying to find a rehabilitation spot for your son.

Mr Bingham: Basically, what it simply all comes down to is that he refuses to get help. And that is what it always seems to come back to, unless he were to be arrested and charged, face a court, and a judge perhaps may put him into rehabilitation. That is, essentially, what we have got left at this point. For the last 10 years we have been trying to get him into rehab and he literally refuses to go.

Mrs Bingham: In a nutshell, if I may add, in the initial stage, when he first started off, when he was in trouble and we asked for help, we were not given any help because of all his rights. He was only 17, going on 18, and he was a kid. Now it has escalated, got worse, because he has not been treated. And it just goes on and on.

Mr Bingham: It is also his rights. Human rights are a great thing. But the thing is, it defeats the purpose when you have someone who clearly is not of sound mind to make a decision to save their own life. We, as parents, are watching our son die. And his brother is seeing this. His family is seeing this. He feels that he is fine. Clearly, he has mental health issues and addiction, and we cannot do anything about that.

Mrs Bingham: Just watch him.

THE CHAIR: What are the information pathways that you go through or the places that you go to get information when it comes to trying to find a rehabilitation place?

Mr Bingham: We went to Directions; we have been to doctors. What else is there? We have been to—

Mrs Bingham: CATT.

Mr Bingham: CATT.

Mrs Bingham: That is the number one—

Mr Bingham: We have called around several different rehabilitation places as well—some of them are quite expensive—basically to try and inspire him to get help. We know that he wants to get help because he is sick of this lifestyle. He hates it. His life depends on a drug.

Mrs Bingham: But the thing is, he changes and switches so much that one minute he will say, "I want help," and the next minute, "I am fine." It is all part of the mental space he is in. The problem with that is, once you get him in somewhere where he could be getting help, he tells them, "I am fine," and he has the right to sign himself out, which has happened every time we have put him in to get help in the hospital.

Mr Bingham: Once, when he went into the mental health hospital, when they released him, he was clearly not in a good frame of mind. He was clearly still quite scattered. Basically, we are not doctors, psychiatrists or anything of that sort, and he pretty much gets sent home for us to deal with him.

Mrs Bingham: Stick the bandaid on and send them home.

Mr Bingham: Yes.

Mrs Bingham: That is how it feels.

MS LEE: Thank you for your time this morning. You mentioned that when your son was 17 you sought help and none was coming. In hindsight, given the experience that you have had and what you have seen your son go through and what you have gone through, what would have been helpful at the time? Back when he was 17, what would have been helpful?

Mrs Bingham: I will say one thing. The initial thing we did, after going to the police, was that we rang mental health services. What, in hindsight, would have been fabulous is if they had come and spoken to Cameron—it was not impossible to communicate with him then—and extended that hand just to say, "We are here to help you," instead of saying, "No, we cannot do anything because he has not asked us for help." He has to get in a place where he is really low before anyone will look at helping him. That, in hindsight, would have made the world of difference.

It is not so much the police. The police are fabulous. They need more power, obviously. But with mental health, in that area, they need to make more of an effort to help in that situation, if that makes sense. Ross, you go ahead now. It is your turn.

Mr Bingham: Basically, the police have turned up at times and they have just taken one look at him and within the first two minutes said, "Yes, you are definitely going to hospital." We met a little resistance and then he said, "Yes, I will go." And then he went. Three hours later, he literally just signs himself out. In hindsight, yes—

Mrs Bingham: There is no duty of care.

Mr Bingham: There has to be a duty of care. It just needs to be a stricter system. It has to be a system where you do not want it to get to a point where someone permanently damages their brain until they cannot function properly for the rest of their lives. That is what we are trying to avoid. We just want him to be happy, at the end of the day, and for him to be able to have the services. The family members can come forward and say, “With all the history that we have, there is enough evidence there.”

There were all the calls to CATT and the police and so on. We should have been able to go ahead and say, “Right, you are going into mental rehab and you will not be signing yourself out. You will not be able to sign out, whether it takes six or 12 months, whatever the case, to get yourself clean and get yourself balanced, get the right medication. You need to balance your brain so that you can function as normal and simply be happy.”

MS LEE: As family members who are trying to provide this support for that, what do you think is required to assist you in the best way possible to provide that support to your son?

Mr Bingham: The police have, in the past, sent letters to us and contacted us, offering support and seeing how we are going with things. But whenever we have spoken to doctors or we have even been to some groups and all sorts of different things, they say, “You have got to look after yourself as much as you can.” And you do, to a certain degree, as far as is humanly possible. Even though, as parents, you are naturally hardwired to protect, you still have got to separate yourself a little to keep your own sanity, really, and to keep your own wellbeing. Otherwise you literally go down. You get pulled down with it. You have got to try and separate yourself. There are support services out there for those types of things.

Yes, you come home, and every day it is a different day. Some days are good, and some days are bad. As a matter of fact, just on Saturday the 23rd, just past, at 3 o’clock in the morning we were woken by things being smashed up inside the shed. It made a hell of a racket. I had to call the police in for that, to the point that he signed an order of silence. Basically, he ended up signing that and they explained to him what it was. He fully understood that if he makes any more noise or causes any more trouble then he will be literally arrested and put into lock-up and he will face the magistrates and go from there. But every day is different. As I said, one day it is good, the next day it is bad.

We have a lot of anxiety on that trip on the way home from work because we do not know what we are going to find. We have had damage through our house. Literally every room has been vandalised, holes punched through walls, doors ripped off—all sort of things—over the past 10 years. We have not seen that extent of violence recently, in the last, say, six to 12 months, which has been good. But still he does tend to just fly off the handle at the smallest things and start thumping on the floors and things like that. You do live with a lot of anxiety. There is definitely a lot of fear in there—and fear for his own safety, naturally. It is pretty taxing to see this, and particularly to have 10 years of it. It has certainly taken a toll on us.

MRS KIKKERT: I am sorry to hear about the experience that both of you have endured in the last several years. My question, basically, is about support that is given to families and also the patient when they leave a mental health unit. In your experience, when your son left the mental health unit, what sort of support was he given? What follow-up workshop was he offered?

Mrs Bingham: What support was he offered? None.

Mr Bingham: Pretty much.

Mrs Bingham: The only thing they did when he left the hospital that first time was give him pamphlets on what he can do to get help for himself. And they gave him medication, which was risperidone, which is like a blanket medication. There was no follow through. It was very disappointing. I think that when they get someone in there like that, that clearly has a problem, rather than let him go to the family and slap that bandaid on, they should keep him there when he is the space and have some sort of counselling in there, not just, "Take this medication and go home."

Mr Bingham: We did, through CATT, get that side of that where he was just given a heap of pamphlets. Then, because we had been in touch with CATT—we constantly called them—he was on the, I think it is, MHAU team. Basically, what they did on a daily basis was come out and see him. The thing is, that is great, whenever they could time it right that he was actually there and would answer the door. Those guys made a lot of calls each day, during the weekends and so on. I think they probably only caught him home maybe twice, if they were lucky, two or three times. They were very good. They were amazing people to talk with him and they were really very helpful and that, just to catch up with him.

Mrs Bingham: It is not enough.

Mr Bingham: It is not enough. He needs a real buddy system to keep in contact—someone he can relate to and keep in touch with. It is just being able to be there at that same time he is there, because most of the time he has just wandered off somewhere.

Mrs Bingham: All he wants really is a good friend. That is what he has said to me on a number of occasions, in tears. He said, "I have nobody." The only one he has got is an ice addict friend. He considers these people his friends. He told me the other day, "I really want someone that cares and that I can be with, like a companion," not sexually or anything like that. It is just a companion, someone to share things with. He said, "Even to go for a coffee, Mum."

Mr Bingham: That is another spin-off from this whole thing. If he had the help that he needed, if he was able to get help or was forced to get help, whatever the case, he would not be in this position of being so, so alone. You can see why so many people take their lives—because they are so lonely. Who wants to be around these sorts of people! It is so out of control. Nobody wants to be around them. It just brings loneliness, and eventually a lot of them take their lives.

Mrs Bingham: Our home is a trigger for him. It is like a trigger because he has sad memories, things he has done, guilt. He told us the other day, “I can’t even sleep in my own bed now. I wake up. I can’t sleep.” He is in, like, hell. He really is. It is like a tormented soul, if you like.

MRS KIKKERT: I am so sorry to hear that. Please give him a big cuddle from me.

Mrs Bingham: Thank you.

MRS KIKKERT: He sounds like a wonderful boy and hopefully we can get him the support that he needs.

Mrs Bingham: Thank you.

Mr Bingham: Thank you.

THE CHAIR: We are out of time. Thank you so much for making the time to come and have a chat with us. We all really appreciate it. I think I speak for all of us when I say that we have such great respect for everything that you have gone through and that you continue to do for your son. It is truly impressive.

Mrs Bingham: Thank you. And, hopefully, things will change. Hopefully, they can do something with the legislation.

THE CHAIR: Mary and Ross, thank you.

Mr Bingham: Thanks very much.

BARKER, DR JUSTIN, Executive Director, Youth Coalition of the ACT
BARRY, MS ERIN, Director, Policy, Youth Coalition of the ACT

THE CHAIR: Good morning, everyone, including those watching online. I would like to thank Dr Barker and Ms Barry for appearing today on behalf of the Youth Coalition of the ACT. You have both been forwarded a copy of the privilege statement. Could you confirm for the record that you understand the privilege implications of the statement?

Dr Barker: I have read, and I do understand, the privilege statement.

Ms Barry: I have read, and I understand, the privilege statement too.

THE CHAIR: Wonderful. Just a quick reminder that this is being recorded for Hansard and webstreamed live. Before we proceed to questions, would you like to make an opening statement?

Dr Barker: I would like to make a brief opening statement, if that is okay. I would like to talk about two interrelated issues that we see in the youth sector; they overlap. First, I want to talk about how difficult the mental health system has been for many young people, families and youth workers, to enter and navigate. It has become quite a complex system, and it is very difficult for people to find pathways into the mental health system, and then to be able to access referrals within that system. It has been very discouraging for young people, youth workers and parents.

I think it is quite notable that a lot of youth workers who have been around for a while continue to struggle with navigating and entering the mental health system for their clients. It is very discouraging for those workers when it is their core business to help young people to navigate the services and to wrap services around them. But it is also very invalidating for the young people who are struggling to enter these systems—and often alone. So there is a real need for us to make sure that we have a comprehensive and integrated service system—something that works quite well. I think that it is all well and good to have services there, theoretically, that can meet people’s needs, but if people are not entering those services when they need to then it does not work very smoothly and effectively or efficiently.

This gets to my other key point, which you will see is quite intimately interrelated. There is, of course, a great need for people to enter the appropriate system in a timely fashion. We need to make sure we are matching the needs to the services that are being provided and that it is being done in a timely fashion to prevent things from getting worse, especially for young people who have escalating mental health issues, starting with their first presentations with mental health issues. This matching needs to happen across the spectrum of services—mild, moderate and severe—that are available.

However, we have a kind of blockage here. It is similar to what happens in care and protection systems across Australia: that in the severe end of the mental health service spectrum we are having to triage the most severe people into services and then push other people, whose needs are actually severe, back into the community sector and not attend to their needs, not because they do not need those psychiatric and mental health services but because the capacity of this system limits them entering.

This puts the mental health system—you can see the parallel to the care and protection system—in a tricky spot, where they have to triage the most severe, who have no other supports in the community, into those supports. So what we see in the youth sector is that young people who have some semblance of community support are being pushed back into the community because they do not yet meet that threshold of the capacity definition of severe, rather than the mental health need definition of severe. We have seen this, over the years, in the mental health system, where workers are supporting someone. As long as a person is being supported, they do not get any mental health support. It is only when they are really on the precipice of a crisis—they are going to harm themselves or other people—that they enter into the mental health system.

We know that there are families and young people who have been asked to go back home even though they know they are a suicide risk or even though they know they are having florid psychosis. Because the worker knows they have a family there to support them, they are not then matching them with the mental health service need that they have at that point in time. This saturated service, at the severe end, has a trickle-on effect. It affects moderate services and then mild services as well, because we are pushing people back into the community sector—and maybe even giving them the impression that they might not be severe enough to meet acute mental health needs—and asking the community to support them. And the community sector might not have that support available. The person may actually need that more intensive support. So we are seeing this blockage.

Most importantly, for both of these two key points, we see that workers, families and young people are becoming very discouraged. The discouragement sits alongside stigma as two key barriers that stop people from re-entering the system and feeling that they are going to get the support that they need when they need it. Then people stop engaging. To reach out for help is always hard for young people at the best of times, but it is even more difficult while they are in difficult circumstances and experiencing something that they feel is stigmatised. When they reach out for help and feel invalidated, put on a wait list or referred to a service and told that they are not quite severe enough yet, it is incredibly discouraging, and it might stop them from asking for help again, not just in that mental health space but more broadly. It might prevent, again, that timely, appropriate matching of a young person's needs to the appropriate service. Those are the two key points that, as you can see, are quite interrelated, that I would just like to start off talking about.

THE CHAIR: Thank you, Dr Barker. I will start off with questions, and then we will make our way through the committee. I note that the Youth Coalition has recently conducted a survey on the effects of COVID-19. I was wondering if you could talk about that survey and what it has shown.

Dr Barker: We have conducted one survey already, and we aim to conduct another during the recovery period—the return to face-to-face work and the return to school—to see what issues are emerging there. The survey initially showed us that we were seeing an increase in the needs of existing clients. People who were already engaged with youth services were having higher needs and more needs that the services needed to meet, but we were not seeing an increase in referrals during that first period of time in the COVID crisis, during the lockdown. We saw that there were some young people who were continuing to engage remotely and asking for help via different mechanisms—through Zoom and FaceTime and on phones—and that there were some young people that that did not suit at all.

One of the lessons, moving forward, is that if we see a similar situation we really need to make sure we marry the two together: the opportunity to have some degree of face-to-face support along with remote support. Research seems to suggest that it is most effective to have them as two components and not just rely on the remote work to maintain some kind of social distancing. A lot of young people disengaged from services because they needed that relationship and that interaction. This comes back to that help-seeking point I made before—that it is sometimes very difficult to directly ask for help as a young person, or for anyone. It is a lot easier to sidle your way in or lean in to asking for support when you are having a more informal relationship and face-to-face interaction.

Initially, we saw some families and young people with heightened needs, increased family conflict and issues in the family home, but not an increase in referrals, which we think we will start to see soon. We are starting to see that now in the youth homelessness sector. We also saw that a lot of the workers were really struggling.

The people in the youth sector were really struggling because not only were they having to deal with some of the increased needs of their clients, and then struggle to engage them within the limits and the mechanisms we had, but they also had their own stuff going on. Some of them had kids at home. Some of them were also stressed out and feeling isolated because they were not getting the same feedback from their work. They were also not feeling like their work was as effective, which is part of the reason they are there; they want to be able to make a difference. So we were seeing a struggling workforce at the same time. Erin conducted the survey. Erin, do you have anything else to add?

Ms Barry: I was just going to add that the flip side of that is that we also saw services innovating and providing new ways of engaging with young people. Particularly in the education system, school health nurses, who are often providing mental health first aid to young people, and school psychologists, had to change their modes of delivery to ensure that young people could still access those services through telehealth or online.

As we know, accessing mental health supports such as school psychologists through schools continues to be an issue for some young people, particularly around stigma—the idea of having to turn up to the school psychologist’s or counsellor’s office, or not knowing where the office is. Still having some of those opportunities to access remote services alongside face-to-face services will give young people better choices around how they choose to access those supports.

MS LEE: Thank you, Dr Barker and Ms Barry, for your time today. I have a quick follow-up question from your opening statement—if that is okay, chair—before I go on to my substantive question. Dr Barker, I will paraphrase, and please forgive me if

I am putting words in your mouth. You seemed to be saying that there could be more work done in some early intervention before things escalate for young people. Is it a matter of lack of education, lack of resources or lack of expertise? Where do you see the gap and working towards closing that gap?

Dr Barker: Early intervention in mental health issues is always tricky. It is normally about the timely provision of services when you have the early signs of a mental health issue, and to make sure that you match the appropriate support at the appropriate time. One of the main barriers to doing that is about help-seeking and accessibility. And that links to that stigma issue again. There are already services out there across that spectrum—mild, moderate and severe—but people do not necessarily know where to find them and how to find them. Often, they might not even necessarily identify their issue and support needs straight away as mental health support. It might emerge as an education support, a family conflict or a drug and alcohol issue. The way that the issue is presenting itself, and where it is creating friction in their life, means that the referral into the mental health system might start in the community services more broadly.

A point that Erin touched on before was that often a young person might choose to go and see a youth worker instead of the school psychologist. They might not know where the school psychologist is. They might feel a bit of stigma about doing that. They might not even necessarily think of their issue as a mental health issue to start with. “Is this an acceptable level of stress and anxiety or depression for a kid struggling at school, or am I having an actual issue?” And often GPs are the referral points into the mental health system, but often the young person will go to a teacher, a youth worker or someone else, who will see that they are not their normal self. Or they might reach out to them.

That early intervention really means smoothing out pathways into the mental health system so that people know where to go to ask for help as soon as they have started to realise, “Oh, this could be a mental health issue.” Before that, the awareness-raising in schools and education is really important. At a population level it is important that we can all reach out to each other and say, “Hey, have you asked for help? Maybe you need to think about seeing someone?” to reduce stigma and improve that kind of peer-to-peer intervention.

We know that sometimes another young person might be the first person to say, “I’m worried about you. Are you okay? Have you thought about seeing the school counsellor?” If they say no, they can think about where else we can do this: “Do you feel okay to talk to your mum and dad?” So that broad community-based education is really important to help with early intervention. But, for the most part, it is about the timely matching to appropriate services. Alongside that, we need to make sure that there are adequate social supports—not just clinical mental health supports, but also other social supports—put in place to help them address those other issues such as education, their finance, housing and the family functioning issues.

Sometimes mental health issues for young people come to the forefront when there is family conflict, and the parents are angry at them for not engaging at school, for not acting the way that they would like them to. Now, addressing the mental health issue alone might not also address those other issues going on in the family home.

MS LEE: Thank you for that. My substantive question was in relation to some of the support available at schools. Ms Barry, you did touch on some of the concerns surrounding the lack of availability of a service and using it in context. Given that young people may be reluctant in some instances to seek some assistance from the school psychologist—whether it is because they do not know where to find them or because of the stigma, or they might not get along with that person—what support do you think needs to be available to teachers who are going to be approached by young people, perhaps sometimes in the first instance, when they start to experience mental health issues?

Dr Barker: That is an interesting point. A couple of years ago there was an initiative to help build the mental health skills and awareness of teachers so that they could use teachers as another entry point into that early intervention and accessing mental health supports. It was done at a commonwealth level and they were going around from state to state to talk about how they were going to improve that. I think they now have an online mechanism to improve teachers' mental health education. I do not know how effective that has been. Part of the problem with that was a similar problem to what we have in the youth sector. You can build the capacity of teachers and hope that they will become a new entry point to the mental health system, or even to help young people identify that they have issues—if the teacher is the trusted adult that they have—but when that teacher realises that this needs to be referred somewhere, they hit that blockage. This was the complaint from teachers: "I am already dealing with what feels like an avalanche of mental health concerns in the schools."

We see it generationally. We have higher levels of anxiety and depression in schools, and the teachers are feeling it. And they are now being expected to be counsellors, too. They say, "It is really hard to do that. And when I do do it, I get discouraged because I then realise that this young person now needs to be referred to a mental health system and there is not one that is able to take them." The same thing happens in the youth sector. We developed and provided suicide training and mental health first-aid training so that they have the capacity to deal with it. Some teachers have increased capacity, but once they realise that they have reached a limit to their capacity to deal with this, they then have nowhere to go. They have nowhere else to send them.

In the schools, we need to make sure that there are a range of choices available—a range of choices within the school so the teachers have capacity; that there are school psychologists, counsellors and youth workers. We need to make sure that there are a range of people, all of whom are able to help them siphon into the right place. There also need to be supports outside of schools, because a lot of the young people do not want to see someone in the school. They do not want to be seen walking to that counsellor's office. They do not want to be sent to the psychologist. There need to be stronger partnerships between school and non-school supports, too. We have always struggled with breaking down those silos between education and the youth sector.

MS LEE: Thank you.

Ms Barry: Can I speak to that as well? We are talking about building the capacity of teachers. The same is also true when we are talking about peers. We know that young people are most likely to go to their friends, in the first instance, to seek help, and

I think it is fantastic that we are equipping young people with skills around mental health first aid to support their friends. In doing that, we also need to be assured that if peers are trying to support their friends, they know who they can go to. Instead of taking the responsibility on themselves, they can essentially refer their peer to someone, and we need to ensure that if that is within a school context the teachers, youth workers or the person that they are talking to is not coming up against a bottleneck—that they are also able to talk to someone.

Justin's point about stronger partnerships between schools and community services is really important, particularly in the ACT, where I think around 60 per cent of mental health services are provided within the community sector. We know that a lot of those are difficult to find. Having stronger partnerships between services and schools—not just mental health community based services but also youth services that might be able to provide a lighter touch or support young people with some of the other social issues they are experiencing—is important.

We are supporting the office of mental health's project around developing a youth mental health navigation portal. We are very hopeful that the portal will go some way to helping to identify and address some of these issues as well. I know that one of the things they are considering in developing the portal is looking at ways that young people would like to engage with services, and if they would like to actively reach out to a service or if they want a service to call them. So, hopefully, that will go some way in helping to navigate the system.

MS LEE: Thank you.

THE CHAIR: Before I go to Mrs Kikkert, I have a very quick supplementary question on the navigation of the service right now. How do young people navigate the system right now?

Dr Barker: There are a lot of different ways that young people navigate the system, depending on who we are talking about. It depends on the range of supports that the young person has in place. A lot of young people enter the mental health system through a GP—through going to a GP and getting a mental health plan. Their family might support them to do that, or someone else might suggest that they do that. Some young people still go to places like headspace. They may be referred to them from the school or by someone else in the sector, or it may just be a self-referral because there is quite an awareness around headspace.

In some ways it is a difficult question to answer because it also depends on the severity of the issue. Some young people wait for it to become severe enough for someone else to need to intervene. It comes to a point where they are not asking early, at the onset of their mental health issue. So for some it might be a presentation to the psych ward. It might be the presentation, at the more severe end, to an acute mental health service. The good question that we are hoping to find out more about is how they want to engage, rather than how they are engaging. I think the way they are engaging at the moment is suboptimal; it is less than desirable. In the consultations we have done recently they talk about how hard it is to find an entry point; how hard it is to get up the courage to do it and then enter it. And then they still do not feel that they are being serviced adequately. The question that we are going to look into, hopefully, with the office of mental health, in exploring the work of the portal, is: "How do young people want to be supported to enter the mental health system?" rather than: "How are they entering it at the moment?" Because they are entering it in very ad hoc and very different ways.

MRS KIKKERT: Hi, Justin. Hi, Erin. Thank you so much for coming. My question is basically about encouraging the youth to continue seeing service providers to help them in their mental health. You shared in your submission about transcripts and how chat-based support conversations should be able to be transcribed and then sent off to a service provider or a practitioner to help treat a young person. Can you talk to us a little bit about that? Are these chat support conversations government based?

Dr Barker: Erin, do you want to take that question?

Ms Barry: Sure. When we spoke to young people about this issue recently, it was really about young people wanting a choice in how the information was shared. On the one hand, they raised issues about having chats with psychologists or counsellors, and that being provided back to their parents without them knowing about it. On the other hand, they talked about having to share their stories over and over again, which was sometimes quite re-traumatising. That could happen if they changed practitioner, if their previous one was no longer available, or if they were referred between services. In some cases, they wished that they had been asked whether they could give their permission to have their file or their story provided to their new practitioner so that they did not have to go through that all again and, over time, work up to the same therapeutic point where they were before.

In terms of the relationship between e-services and face-to-face services, they said that in the cases where they receive online assistance—perhaps they might be seeing someone face to face and in between they had sought help in the moment online from someone—they would like to have the option to have, for example, a transcript of their online chat provided to their face-to-face practitioner so that then their practitioner was up to date on what had happened and they did not have to share that again. That is quite an innovative idea—the idea of better integrating online services and face-to-face services. But I think the main point around that is that they wanted to have the choice about how their information was used.

MRS KIKKERT: Thank you. And the e-service provider, is that government run?

Ms Barry: They talked broadly. There are a range of e-service providers nationally, including Kids Helpline, where they can hop on and chat to someone online. They did not talk specifically about a service.

MRS KIKKERT: Okay, thank you.

Dr Barker: I think that Erin's point circles back to that same issue—the need for a coordinated and integrated system. There needs to be clear communication between services, which is not what we have at the moment. Time and again, a young person goes to one service after another and continues to be assessed. They are like, "I'm not looking for another assessment. I've done my assessments. I now want to be given some kind of service to help me deal with my anxiety and my stress or whatever it is

I am feeling.”

We have had other reports and reviews done in the ACT that continue to come to that conclusion. We need to find mechanisms that facilitate and insist on there being a coordinated, integrated system so that people can exercise those choices that Erin spoke about. It is: “I would like you to pass that information on to here. I would like to not have to continue to do that.”

MRS KIKKERT: I can imagine that it would be discouraging to a lot of the young people having to repeat the same story over and over again. We want to encourage the youth to continue seeking help. Thank you.

Dr Barker: We need to remember that these therapeutic interventions are only really as good as the therapeutic alliance. The therapeutic relationship with the person the young person is talking to—who they are seeking help from—is a key determinant of how effective these interventions are. So if we are just passing them from one person to the next and we are not allowing them to develop that rapport and trust, we are just not going to be able to find out what is going on in their life and address it.

MRS KIKKERT: Agreed. Thank you, Justin. Thank you, Erin.

THE CHAIR: I was wondering if you could talk a little bit about the discontinuation of services as young people age and go into different brackets of youth.

Dr Barker: There are a few gaps. We are clearly the Youth Coalition. We work mostly with kids aged 12 to 25. I am going to talk about the early end of that developmental spectrum to start with. We know that in early childhood and under the age of 12 we really struggle to deal with mental health. We struggle with young people presenting with autism spectrum or oppositional defiance disorder, and then not being able to get a diagnosis and not necessarily being able to have any supports put in place for those young children. That is because we are often unable to medicate kids in that space unless they are in very heightened circumstances.

That is not our area of expertise but we know that, in the early childhood space, people do not feel that they can get support. This is early intervention. The first thousand days and up to the age of five and then eight is early intervention, where we really get good bang for buck. And if we do not work effectively in those spaces we are not going to get a lot of benefit later on in life. From the age of 12 to 18 there are services available. We know that some other things are in the pipeline. The adolescent mental health in-patient unit is, we believe, still in the pipeline, and we have not heard a lot about the progress on that.

Mental health supports for young people, especially in-patient supports at the severe end, need to be done differently. We cannot just decide not to work with them if they have a severe mental health issue. They need to be dealt with in a way that is suitable, developmentally, to their needs. It is very scary going to AMHU for someone who is very young—it is scary going there as an adult—so we need to make sure that there are safe places that are appropriate for young people aged 12 to 18, for them to seek severe mental health support. At the moment, they are being pushed back into the community with very little option. We are not adequately addressing mental health issues in that population group at all, especially in the severe range. We often wait for them to appear in the justice system or in the care and protection system, and then we call it trauma. Well—you know what?—we need to deal with the presentation of those mental health issues earlier.

There is also a bit of a false increase, or spike, in services available for young people at the age of 18. When you hit the age of 18, all of a sudden all the services available to anyone from 18 to the end of life, which is the bulk of the population, become available to you. So it appears that these services are available to young people aged 18 to 25. This is a particularly new at-risk group, especially in the Canberra population. This is what we refer to as the "emerging adulthood" group—18 to 25. They are still young people. They still meet the definition of "young people". They are, theoretically, able to access all the supports that are available to anyone over the age of 18, but they do not necessarily access them because they do not meet their needs, developmentally and socially.

They are at a unique stage in life. There is still a great amount of neuroplasticity at this age. It is between the ages of 18 to 25 that the personality of a person and their life trajectory becomes more concrete and solidified, so it is really important for us to work with people in this age range. We also know that, in Australia and internationally, 18 to 25-year-olds are having higher mental health needs now than ever before. There are a range of social pressures that mean they are not transitioning into adulthood in the conventional ways. They are not necessarily moving out of home or finding work that pays them enough to be able to move out of home.

Nearly everyone has to go to post-secondary education, whether that is CIT or university. There is a prolonged period where they are considering: are you staying at home or are you living independently? What are the expectations of you? We are seeing a great deal of stress and anxiety in this population group, which is heightened by the fact that they often need to work and study at the same time. So there is a great deal of pressure on them, and a lot of them are not seeking support or help.

Normally, up until the age of 18, there are mechanisms within schools. There are relatively centralised options of a teacher or a psychologist—someone for you to meet where you turn up every day. When you are 18 to 25, you lose that. The pastoral care of universities is not awesome; it is not great. We know that from university students talking about the increase in stress and anxiety. We even know which times of year we see it, and we know about their inability to seek and get the help that they need. This is a possible tipping point for them to stay engaged in education, for them to be well and thrive, or for that life trajectory to change. As I said, we are seeing, more and more, that 18 to 25 is an essential time in people's lives to make sure they can become really well-embedded, productive, thriving members of our community.

Ms Barry: I just wanted to build on that. Locally, that issue around supporting 18 to 25-year-olds came up consistently as a significant issue in the office of mental health and wellbeing's review last year. We know that they have particular priorities for the next period of time around the projects they have set, but we would like to see them do some more scoping of that space down the track to better understand those issues, particularly around tertiary education and employment and the reduced formal, structural and informal supports that young people might be getting during that time.

So we hope that that will remain on their agenda.

The other thing that we would like to see is the ACT Children and Young People Death Review Committee increase their age scope up to 25. At the moment, they review deaths for children and young people up until the age of 18 in order to try and prevent deaths from occurring in the future. Given that the ACT defines a young person as 12 to 25, we would like to see that go up to 25 so that we can identify opportunities for early intervention and prevention of suicides among young people in that group.

THE CHAIR: In regard to this 18 to 25 age bracket, I was wondering if you could articulate what the pathway to mental health services is for someone in an education context, and for a young person who has not gone on to further education and is now working.

Dr Barker: I do not really want to speculate on this one. I think that this is a great unknown at this point. It comes back to Erin's point about the need for us to look into this more—potentially with the office of mental health and wellbeing. At this point in time, we really do not know if these young people are reaching out for help and where they would go, because there are not those formal and informal mechanisms so readily available as a soft entry point into asking for help. Do you go to your parents, do you go to your lecturer, do you go to your boss, or do you turn to your friends? Or do you go online and find remote support?

So, Michael, I think you have brought up a good question. It is something that we need to know more about. It is not something that I want to speculate on at this point in time. We know that vulnerable and disadvantaged people in this population group might have access to a youth worker. They might have access to someone supporting them who can facilitate that entry, but in the broader ACT community I am really worried about those students who are struggling. They do not know where to go or how to get support, and they might not feel that they can ask their parents again. That is what makes this age range so tricky. You do not want to turn to your parents. You might want to turn to your friends, but you do not know if that is okay, either. And you cannot necessarily afford to go to the GP. So what do you do? It is a very good question and it really needs to be looked into in more detail.

MS LEE: I want to go to the part of your submission where you talk about mental health support for youth from a culturally and linguistically diverse background. You talk a lot about stigma, and there is clearly a different type of stigma when you throw in a bit of a cultural context. In terms of the mainstream training that you talked about, ensuring that people can be trained in culturally appropriate trauma therapy and the like, can you please expand on that, if you can?

Dr Barker: I will start the answer to this question and then pass over to Erin, because Erin facilitates the MYAN ACT network, the Multicultural Youth Advocacy Network. She has a lot of contact with that group. I work on the MYAN Australia group, looking at how we are working with multicultural young people in the Australian context.

When we talk about the culturally and linguistically diverse, in terms of service provision, we often slip into talking about trauma informed work, which I think is incredibly important for a lot of migrants and refugees. But then we are only talking about one population of culturally and linguistically diverse. There are a lot of people from culturally and linguistically diverse backgrounds who do not have trauma, who are not migrants and refugees in the same way. They might have different cultural barriers when it comes to entering the mental health system and asking for help.

We need to make sure that the awareness of culturally appropriate work very broadly across the youth sector, education and mental health is increased. We need greater support more broadly for how we facilitate and enable supports for people from a range of cultural backgrounds. More specifically, there is that trauma focus, especially for those people who come from a refugee background, and a resettlement framework approach. We need to have a trauma-based approach there that is also culturally appropriate. Across the sector, we need to think about how we build the capacity for people to work with people from different cultural backgrounds.

There are a couple of things that we are working on at the moment regarding the youth resettlement framework and possible training across the ACT to help to build the capacity of people to work with this population group, not necessarily with a mental health focus but with a support focus more broadly. A component of it would, hopefully, facilitate better entry points into mental health as well.

Erin, do you have anything that you want to add?

Ms Barry: I think it speaks to having a range of service options available for both young people and their families, because the ACT population is so diverse. We do have a range of amazing services that support young people, like Companion House, the Multicultural Hub and MARSS. Some young people and families will link in with those services and some will opt to link in with their schools, local communities or other services.

We do hear from service providers involved with the Multicultural Youth Advocacy Network ACT that, because some of those specialist services are so in demand, they might only be able to work with people for a certain amount of time and then have to keep supporting new people coming in. They would like to see some upskilling of practitioners in other settings, like within schools and within mainstream community services, to be able to continue providing that culturally appropriate support.

MS LEE: Do you think there is a shortage of people, or experts, from a culturally and linguistically diverse background in the sector who may be able to provide some of their experience or bring with them their own cultural background?

Ms Barry: I am not sure. I could not say whether there is a shortage of people. I certainly know that there are people within the sector that have a great deal of expertise and experience. Looking at ways that we can support those services and those practitioners to be able to share their expertise might be helpful.

Dr Barker: This mixes nicely with the previous question about 18 to 25-year-olds. International students are another area, especially in our tertiary institutions, where we see a lot of people needing support. They are away from family, they are having to make new connections and they feel quite isolated. Help-seeking might be difficult, for language reasons as well as cultural reasons. This is a very lucrative population group for Canberra, and I think we have really dropped the ball during the COVID crisis in making sure that we are adequately supporting this population group. They contribute to our economy enormously. They contribute to our society tremendously. We need to make sure that we are reaching out to those international students proactively in those education institutions. We need to build a greater capacity for this population group, not just at the pointy end but more broadly as well.

MRS KIKKERT: I am very interested in how the Youth Coalition supports families that have youth with mental health issues. You refer in your submission to a project called the safe and connected youth project. Can you tell us a little bit about that? How many families are participating in this project?

Dr Barker: The safe and connected youth program works with kids under the age of 16 and their families. They are normally referred there because they are at risk of or are experiencing homelessness, which is really code for there being family conflict and a range of complicating issues. The program is a family focused youth work model. The young person is our primary concern—their safety and wellbeing. However, we realise that it is best for them to stay, where it is safe and appropriate, within their family and build family functioning.

It takes a real wraparound approach, which means workers refer the young person to mental health services, make sure they get access to them and actively support them to enter those systems and really go in to bat for them. They sometimes have to help the parents to get that support as well. Sometimes the worker goes in there and realises that the parent needs some support, too.

The interesting thing, when we talk about case loads for this program, is that the young person is the referred young person, and we make sure that we are working with the parents and the young person, wherever it is safe and appropriate—it is not always safe or appropriate—and that we are working with whoever in that family needs to be supported to help this young person thrive.

At the moment we only have two workers, who are both 0.8 FTE. They have a case load of five families each. It is done in conjunction with the Conflict Resolution Service. To be involved in this project, we ideally want them to be taking part in mediation, as well as having someone providing those social supports in an outreach capacity—going into their home, working with them and helping to work with education, the mental health sector and other supports that they need to have put in place.

It is quite an intensive program. We have seen a lot of success in maintaining family functioning wherever it has been a possibility—the young people staying in the family home. They might still have issues with education. They might have ongoing issues with mental health. But we have put supports in place and built that capacity, and that parent-child relationship, so that, moving into the future, they will have that safety net.

MRS KIKKERT: You cover about 10 families between the two workers. Is there scope to have more families participating in this project?

Dr Barker: Certainly. At the moment we are looking at ways that we can increase the number of families that can access it, through looking at the intake criteria and how and when to exit families. We are hoping to have more workers as well. We call them therapeutic caseworkers because there is a therapeutic and counselling support aspect to their role, along with coordinating and helping them to address all of the other issues in their life—education, finance and housing. They kind of work together. We are currently looking at how we can increase the capacity to have more families come there.

It is really great early intervention work, stopping people being involved in the justice system and homelessness and, hopefully, helping them to stay engaged in education. Most importantly, it pivots around building that family functioning and parent-child relationship.

MRS KIKKERT: That is great. Thank you so much, Justin and Erin.

THE CHAIR: Thank you, Dr Barker and Ms Barry, for coming along and chatting with us today. We are, unfortunately, out of time. A copy of the transcript will be sent to you; make sure you have a close look at it. These are strange times and we are not used to doing these things online, so maybe look over the transcript once.

PROWSE, MRS HEIDI, Chief Executive Officer, Mental Illness Education ACT Inc

THE CHAIR: Good morning, and thank you for making time to speak to us today on behalf of Mental Illness Education ACT. I understand that the privilege statement has been sent to you. Could you confirm for the record that you understand the privilege implications of the statement?

Mrs Prowse: Yes.

THE CHAIR: Before we go to questions, do you have an opening statement that you would like to make?

Mrs Prowse: I will provide a little bit of information on our organisation, which was outlined at the beginning of our submission. MIEACT have been a mental health education organisation operating in the ACT for 25 years. The work that we do is focused on health promotion and prevention in the education space. We do that for all Canberrans—not just looking at youth but looking at adults as well. Our focus is on delivering evidence-based education information on the latest research and applying that to practice through utilising the lived experience, sharing with young people our lived experience stories and empowering people to share those stories in our community safely. It encourages people to help-seek early and it also addresses stigma so that they can feel confident in accessing support, should they need it.

THE CHAIR: I will lead off with questions. Could you tell us about how demand for education programs has changed over time?

Mrs Prowse: Where there has been an increased awareness of mental health and a broader acceptance of mental health conversations, over the last 25 years there has been a substantial increase in people being willing to embed and apply education around mental health in their school and community groups and workplaces. There have been great initiatives from a national perspective. Also, having local, face-to-face programs offered to our community allows people to access information and do it before they necessarily are in a crisis situation.

I have been with MIEACT for two years, and we have certainly seen an increase in organisations and school groups seeking quality, high-level, evidence-based programs that are not just about awareness but about building resilience and providing clear strategies that people can put in place today, as well as the avenues through which they can seek help, if it comes to a point that they need to do that.

With awareness, we are seeing an increase. There is a reduction of stigma in regard to anxiety and depression, but not as much in regard to more complex mental illness, such as bipolar disorder, schizophrenia or other types of mental illness. There is still a barrier for people to have in-depth conversations. Our role in the community is to have a conversation, start the conversation and allow people to know that it is okay, be more informed and have questions, to reduce stigma, so that people feel like they can put their hand up and seek help.

MS LEE: Thank you, Heidi, for your time this morning. In your submission you state that, for the under 12s, experiencing bullying was the top issue. One of the concerns being raised is that there is perhaps a lack of services available for the under 12s. Particularly when it comes to bullying, what do you see as the gaps in either services or support, or the education or resources that need to be put in place to help in this regard?

Mrs Prowse: When we look at the school curriculum, mental health education is addressed in the curriculum from year 3. At the moment there are some programs that are available in regard to education but they are not broad. At the moment they are not fully accessible to our full school community.

When you look at health services, most health services come in at the age of 12. With groups like headspace, their programs start at age 12, so we have this eight to 12-year-old group that are beginning to be at risk of mental health issues or mental ill health earlier than the services become available to them. We are almost waiting for them to get to that age before we can start either having the conversation or building resilience. We are leaving it completely up to teachers and schools to provide a complete mental health response.

MIEACT's approach is certainly to develop positive partnerships with schools so that we can either complement the activities they are doing or provide a full, in-depth education program with them. If it is raised that a young person does need some help, being able to then connect them to the right help may have limitations if the services are not available.

MS LEE: For a young person who, say, does identify—or perhaps their parent at this stage identify—that they might need support, what avenues do they have at this time in terms of where they can go?

Mrs Prowse: The landscape review that we completed last year, in partnership with the office for mental health, identified that there were very limited services available. There are a couple of online programs that are targeted to parents, but you have to be able to try and find them. Certainly, one of the things that we have been trying to increase as an organisation is education around what things you can do. Schools, obviously, do have support services available for that eight to 12 group, but they may have some limitations with access.

We also recognise that mental health does not just have an impact on the low socio-economic group. There are some programs that are available to people for free if you come within some eligibility criteria, but if you are not in that situation, you may have to look outside the ACT to be able to find that support.

MS LEE: Is that why there is a lack of support in that area—there is not enough within the ACT?

Mrs Prowse: We have seen a change in the age groups where mental health starts to impact young people. The core services that are available are starting at an older age group. MIEACT is another example of that. We have been a secondary school mental health education provider for 25 years. We recognise that mental health issues are starting earlier, so our conversation needs to start earlier. Certainly, what we want to see within the community is how to adjust our services to start at an earlier age, so that people can get the support they need. There are some services available but they are targeted services to particular groups.

MRS KIKKERT: I am very interested in educating parents who have youth that are in need of some mental health support. A parent came online earlier, speaking about how much she enjoyed doing a mental health first-aid course online, and how helpful that was for her to understand what her child was going through and how she can best support her child. Could your organisation support families in that regard? She was not aware of this existing in Canberra. She found it online, on Google, one night. I am interested in your thoughts about that.

Mrs Prowse: The mental health first-aid training program is great. It was created in Canberra and it is an internationally recognised course. We should be very proud of that particular program. I have done it myself—all of MIEACT's staff have—and we also offer annual mental first-aid training to our volunteers. You can access that program through Canberra Institute of Technology, CIT. There are a couple of other not-for-profit providers who deliver that program; there are also sole traders who deliver that program. It is really great.

Also, under the LifeSpan model for suicide prevention, there is a shorter course called Question, Persuade, Refer that is free online at the moment through the ACT government and the Capital Health Network. By being able to do a 90-minute online session, you can start to learn how to identify potential mental illness and respond to it in a way that is safe for you and the person that you are communicating with.

I would say MIEACT sits prior to those education programs. We provide information broadly and we also have targeted programs or we can customise programs. We are trying to understand how we can better reach parents. Is that through their schools? Is that through a workplace? Are there other places that we can access parents so that they do have this information and can continue their learning through mental health first aid?

As an organisation that is small, one of the things that we are trying to do is increase awareness of the services that our organisation offers, either for free or at very low cost to an organisation, so that they can learn more about what to do. In the last 12 months we implemented a pay it forward program. Every time we deliver a session into a workplace, the fees we charge allow us to reach another classroom, because we want to do more. We absolutely want to do more. We are trying to establish the mechanisms to allow us to do that. That is why I am shouting from the rooftops in regard to our organisation and the incredible work that my programs team and our volunteer educators deliver. There are education programs available, but, as you mentioned, it is hard to be able to find them.

MRS KIKKERT: Hard and costly for a lot of parents. You mentioned the pay it forward program that you are currently doing. You said that the money that is paid to you when you are conducting a mental health wellbeing project workshop in a workplace is going towards the classroom. Correct me if I am wrong: I thought that when you enter a school to conduct these workshops, it is free—or is there a fee behind it?

Mrs Prowse: It is free for the school because MIEACT have, for a long time, received funding under the mental health policy unit in ACT Health. We are able to reach more classrooms; in particular, over the last 12 months, through grants and our pay it forward program, we have been able to reach primary schools. It is free to go into the school. When we deliver a session to a school, it is always free, but it is free because of that government funding and the funding that we receive when workplaces make a choice to pay for us as a provider.

MRS KIKKERT: Does that funding cover all public schools or is it limited to a school that you are able to attend and teach at?

Mrs Prowse: At the moment our reach in ACT secondary schools is about 83 per cent. It is not limited to public; we work with both private and Catholic Education schools as well. We anticipate that, over the next 12 months, we will have a 100 per cent reach. That will be through the delivery of a new youth aware of mental health program for year 9 students. That is around having a conversation with schools for an international evidence-based program under the LifeSpan model. MIEACT are the local service agency. We would be in every school, and it is about coordinating and facilitating access to those schools and fully utilising the resources.

As an organisation, we have improved our operational model to be able to double our delivery in the last two years. We continue to look for ways to reach a greater audience. In March we launched a digital mental health and me program for year 5 to year 8 students. It was optimally timed, as all students went home and we could still reach them with a mental health program that they could go through at their own pace online. Face-to-face delivery is essential in addressing stigma, but we want to expand and improve the way that we can reach young people so that they can get more information or complementary information online as well.

MS LEE: In terms of primary schools, what is the percentage of reach and what is the youngest year that you go down to?

Mrs Prowse: Over the last 12 months we have only delivered trial programs in primary schools. We have two programs. One is targeted at year 3-4; it is about introducing the concepts of worry and it also starts to talk about bullying behaviours. It is an incredible program that we delivered to just two schools, as a way for us to co-design the program with a very high-level, experienced educator. Also, it was about people with lived experience being able to see if it was the kind of program that would work, not only for that year 3-4 cohort but linking to our local context. It was about making sure that our programs were really helpful for people that are in Canberra. We then have a year 5-6 program, and that is focused on stress.

Those two programs have been developed and delivered to around 10 per cent of primary schools in the ACT. That has been for us to develop the programs, to do them with strong research and so that they are evidence based. Importantly, they include lived experience so that that research can be translated into practice and connect to the local context.

We submitted a budget submission to get support for these programs to reach primary schools, moving forward. We have also applied for grants and to foundations to be able to get funding for those programs. At the moment we are only able to fund small groups or a small reach. We want to make sure that we can make those programs broadly available.

MRS KIKKERT: One of the submissions mentioned a program to be taught in schools to teach kids about the impact of drugs on their mental health. What are your thoughts on that? Is that part of the training or the education that you provide in schools as part of your mental health program?

Mrs Prowse: MIEACT's programs are very specifically targeted towards mental illness. We do not deliver programs specifically in relation to addiction or drugs and alcohol. We may have, within our volunteer educators, lived experience stories, interaction with experiences through addiction or alcohol and other drugs. A school or a group may specifically ask us to deliver a program that has a lived experience that is specifically in that area. Generally, we have a very broad reach and it is overarching, but it may connect into a particular volunteer's lived experience story or we may be explicitly asked to cover a specific area.

THE CHAIR: As providers of education, I assume you act somewhat as a referral service, in that you provide information to people in whatever context it may be. You might give them pamphlets or flyers. Do you have any problem with providing information as to where to direct people in the ACT? Are all areas of service appropriately covered in the ACT?

Mrs Prowse: We provide help-seeking information within every program that we deliver. There are a couple of ways that we do this. Through a lived experience story, a person may share how they sought help. We are trying to encourage young people to consider a number of different ways that they can seek help. In particular, where they may be faced with a barrier to seeking help, it is about really empowering them to continue looking. The reality is that the first place they go to may not be right.

When you are trying to find mental health support, it really has to meet you where you are and connect with you. It is not about service providers not providing a quality service; it is about making sure that the person feels really comfortable with the service they are being provided with, the person that is providing that service to them and the environment that they are coming into.

Our focus is on that part first, which is recognising that the first place you might go to may not be the right one, but do not stop—keep looking. We do not say explicitly to you, "This is where you should go." We say, "Here are all the options." We recognise that it can be challenging trying to find the right one, but there need to be a variety of different services available to help meet people where they are and the circumstances that they need—a support service to reach them.

THE CHAIR: Are there some areas of concern where there are not as many support services as you would like, as someone in this sphere?

Mrs Prowse: We found, through the children and young person review last year, that there was a need for more affordable services. As you have heard in the previous conversations during today’s hearing, it is about how we connect a young person to support prior to them being in an acute situation, while responding to them when they do ask for help. That has been the focus of the work of the children and young person review, and you have also heard about the work in regard to the youth navigation portal. If young people go through a barrier of stigma, once they finally have the confidence to be able to ask for help, they may ask in a crisis-acute setting but not be in a situation where that service is the right one.

As I just mentioned, they may face a barrier which says, “You’re not acute; this isn’t the place for you.” How do we then reconnect them back to the right place? Trying to navigate that is really difficult, especially if you are experiencing distress or mental illness of any type. I support the work of the youth navigation portal. In particular, it is being co-designed with young people so that they can ensure that what is delivered will be able to help them navigate those pathways, to make it easier to find that right service earlier.

MS LEE: When your programs are designed—obviously, they are evidence based and a lot of research goes into them—firstly, do you embed culture and the acknowledgement of cultural differences in the education? Secondly, if so, how? Could you explain that to us?

Mrs Prowse: We look at a range of evidence and research when we are developing a program. We create the program to be able to meet a classroom. We recognise that the classroom can look very different. It has to meet the classroom every time we go into that classroom, unless, as I mentioned, we are specifically asked before we go in to provide some kind of customisation to answer a particular issue. We can do that as we go through, where a particular issue might be raised.

In development our programs go through all of the latest research and consider cultural diversity, a whole range of other low socio-economic groups and any of the types of barriers that people may face. We also have a diverse pool of volunteer educators. It means that people with different backgrounds, different ages and different professional lives can walk into a classroom and share their lived experience. That immediately has a direct, positive influence on help-seeking and reducing stigma.

In developing our programs we look at the cultural research that has been done. We then always have a lived experience working group that includes young people and people who are carers or who are living with a mental illness. Those diverse groups allow us to deliver our programs out into the community.

MRS KIKKERT: In your program investing to build resilience in young people, can you share with us a few success stories?

Mrs Prowse: Certainly. In the last month we have gone through a rapid transformation in being able to reach audiences in whatever space they are. We ran a primary school stress better session for year 5-6 students, through a Google classroom. One of our educators facilitated the session. It was a one-hour session, and in that session we talked about “How do I identify stress in my body?” We talk about the general information, but what we want young people to start to think about is what stress looks like for them.

They really enjoyed learning about that. We then took them through a bunch of strategies they could use. We used three different grounding techniques that the young people could use. They are things around breathing; we teach them how to do it, and the young people can remember those and put them into place any time they feel those little stress experiences coming on.

When I read through the evaluations at the end of that session, the thing that we got asked to do to improve the session was to make it longer. It was fantastic to have young people sitting at home on Google classroom wanting a longer session. It was certainly great. We also had a number of young people say, "I just felt so relaxed and I almost fell asleep." I think that is a really good session. We are just trying to say, "There are a bunch of things that you can do when you're feeling stressed. You need to know how to work out what stress looks like for you, because it might look different to what your friends' stress looks like. And we want to give you exposure to a couple of things that you can do; then you can remember them down the track."

We have been able to receive some additional funding from the ACT government in the mental health stimulus package. We are using a large chunk of that funding to go towards moving our stress better program online. That will mean that, over the next six months, young people will be able to go online, learn those grounding techniques, learn about stress, create their own online stress response plan and have access to the local supports that are available to them, should they want to activate that.

MRS KIKKERT: That is a great story, Heidi. By the way, how much is the funding?

Mrs Prowse: We received $80,000 in the mental health stimulus package. We are doing two things with that particular funding. We are creating this digital program that we will launch before the end of June. We are also offering stress and trauma programs to workplaces for free, with that funding. That pay it forward concept is being put aside so that we can make sure that every workplace and organisation in our community can access stress and trauma-based awareness education right now, when they need it.

MRS KIKKERT: That is great; thank you.

MS LEE: I have no further questions. Thank you, Heidi, for your time.

THE CHAIR: Thank you for coming along, Heidi, and speaking to us on behalf of Mental Illness Education ACT. It has been very informative and helpful. You will be sent a draft copy of the transcript. Make sure you go over it. The committee's hearing is now adjourned.

The committee adjourned at 11.26 am.