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, 30 JUNE 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 9.31 am.

ANDERSON, MS PIPER-JADE FRANCESCA (PJ)

THE CHAIR: Good morning, and welcome to the third public hearing of the inquiry into youth mental health in the ACT. On behalf of the committee, I would like to thank you, PJ, for being with us here today. I understand that you have been forwarded a copy of the privilege statement.

Ms Anderson: Yes.

THE CHAIR: Could you confirm for the record that you understand the implications of that statement?

Ms Anderson: I confirm.

THE CHAIR: I remind you that this is being recorded and broadcast live. Before we go to questions, would you like to make an opening statement?

Ms Anderson: No; we can skip straight to questions.

THE CHAIR: Can you tell us a little bit about your experience in accessing youth mental health services in the ACT?

Ms Anderson: Yes. Nearly five years ago, my family and I moved to Canberra. I have been struggling with depression and anxiety since I was about 10 years old. Getting help in New South Wales was pretty hard as well. I did a little bit of counselling, but it was still pretty difficult there. When I moved to Canberra, I went to a GP to get referrals, and my mum contacted many psychologists in Canberra. Most of them said that their books were closed. Others said that I would be put on a six to eight-month waiting list; some of them were up to a year.

At that point, I was 14 or 15 years old, and I really needed the help. I was put on waiting lists. I ended up being able to see a psychiatrist, but that psychiatrist was located in Bowral, New South Wales. For the first year or so, my mum and I would have to travel for 2½ hours to get there, once a month. I found it really difficult to try and get in, and get the help. There were not many opportunities because, with most places, their books were closed.

It took until the start of this year—maybe February or March—before my mum found that headspace in Goulburn had space to finally book me in. I went to Goulburn to have a session. I did not feel a connection or comfortable with that psychologist. People would probably say, “You finally get in after four years; why not just accept that person?” When I am talking about my personal life and everything going on, I want to feel comfortable with that person. Unfortunately, I did not feel that way with that person. I just did not have a connection with them. I then had to wait for a couple more months. headspace Belconnen then had an opening. I have been talking to them now—over the phone, unfortunately. I have finally found someone that I like; but it is hard. It has taken four years to be able to find someone.

THE CHAIR: Over that long period of time, what has been the process that you and your family have gone through in trying to find somewhere to go and speak to someone?

Ms Anderson: I was constantly getting different referrals from my GP to different psychologists. Due to some trauma that I went through when I was younger, I will only see a female psychologist. We would get referrals for every single psychologist. We would call up and ask, "When can you next get me in?" As I said, with every single one, over the years their books were either closed or I was put on a waiting list. Some of them were up to a year, or maybe longer. I have been seeing my psychiatrist for four years, which is really good, because I have made a connection with her. I get along really well with her; but it sucks that she is located 2½ hours from Canberra.

MS LEE: PJ, thank you for stepping up and being willing to give evidence at this inquiry. It is really important to get a perspective from people like you. Following on from Mr Pettersson's question about the four years, you mentioned that over that time your depression got worse and you were diagnosed with bipolar and mood disorder. You mentioned that you had the constant referrals. Did you feel that there were other places that you could go to for support or did you feel at a bit of a loss? Can you take us through that process a little bit further?

Ms Anderson: Yes. I was constantly looking. It got to the point where I was starting to give up. We were trying for such a long time. Mum was saying, "Keep trying; we'll keep trying." My depression was getting so bad at that point that I was saying, "No, I've had enough. I'm so tired of looking and being shot down every time."

Basically, I had the support from my family, which was really good, and the support from my psychiatrist. My psychiatrist would tell me, "There's the helplines and everything that you can talk to." I think that is great, but my personal preference is very much to have human interaction. I feel a lot more confident and comfortable sitting in the same room, seeing their body language and seeing how they react to what I tell them, rather than having a phone conversation and not knowing how they are acting on the other end.

It got to the point where I was just over it. I stopped looking maybe mid last year because I had had enough. I was just getting worse, and I would get upset every time we would get shut down, until mum found out that the books were open in Goulburn, then in Belconnen. My mum, who is amazing, tried her hardest; so did my GP. We just had no luck at all.

MS LEE: In terms of the period when you were not getting the appropriate support that you needed, was it just a matter of the lack of female psychologists or psychiatrists? What can you tell us about some of the services that could be improved to ensure that you would have got adequate support?

Ms Anderson: I think that there is a lack of female psychologists. A lot of the places said that males would have openings in a couple of months. As I was saying, due to some trauma that happened when I was younger, I do not feel comfortable discussing my life and what I am going through with a male. I very much connect more with a female. I found that really hard as well. I understand that there are thousands of other youths in Canberra who need the help. It is no wonder that they are fully booked out. But it would have been nice; all that I needed was a couple of appointments, just to have a conversation. I needed someone who was not relevant in my life with whom I could sit down and get everything off my chest.

Even if there was some kind of counselling—I definitely need professional help from a psychologist, but there were not even any openings to see a counsellor. People could even volunteer for counselling or something like that. For a lot of youths, it comes down to their need to have a conversation with someone. They just need to get everything off their chest and feel comfortable; otherwise I felt really alone. I knew that I had my family, but if you are feeling a certain way towards your family, you do not really want to sit there and discuss how you feel towards them.

MS LEE: Thank you for that. Chair, I do have another question, but I will wait until Mrs Kikkert has asked her question.

MRS KIKKERT: Thank you, PJ, for coming online this morning. I am deeply sorry to hear about the experiences and the struggles that you have been through over the last several years of your life. I am so sorry to hear that. I am interested in early intervention services. In your submission, PJ, you mentioned that if there had been earlier support, if you had been given that support at a much earlier stage, the things that you are experiencing at the moment could have been removed—they would not be there for you. Could you tell us a little bit about that?

Ms Anderson: It has been so many years. I cannot predict the future. I cannot predict stuff like that. I honestly feel that if I had had the support from the start, and was able to get the professional help, mentally, to this day, I would be a lot better. That is my main point. I really wish that I had had the opportunity four years ago to get the help that I really needed, but there was no availability for that to happen, unfortunately.

MRS KIKKERT: You mentioned earlier that you also spoke to your GP about the issues that you are currently going through, or even before, and being referred on to psychologists. Do you think that seeing a GP at the moment, for youth, is not sufficient at those early stages?

Ms Anderson: With seeing my GP, all that they really do is prescribe medication and give referrals. Where I go, I sit down and have a deep and meaningful conversation. I love my psychiatrist; she is amazing. Psychiatrists are there to assess what sort of medication you need to be taking. It was not like I could go there and spend an hour-long session discussing everything that was going on in my life. I would give a brief assessment of what was going on, so that she could assess what medication I needed. I really needed someone who I could tell everything to and get some advice from, especially from someone who is not relevant in my life. You have people in your life that support you and love you, but, deep down, you feel that they are judging you and have an opinion. I do not need that. I do not need someone to sit there and tell me that how I feel does not make sense and stuff like that. I really needed professional help.

MRS KIKKERT: What is one message that you would like to send to other youth who are experiencing the same thing that you are experiencing currently or even experiencing the same as you did four years ago? What sort of advice would you like to give them?

Ms Anderson: I would definitely say: hold on. There is hope. It did take four years, but if I did not have my family and if I had not pushed through and stayed positive, part of me feels that I would not even be here today. What I would tell others is just to hold on; it will get better, even though sometimes I do not believe that, and I should take my own advice. Just hold on, and things will get better.

MRS KIKKERT: Great advice. Thank you, PJ.

THE CHAIR: Ms Lee, we have a few minutes left and you had a question that you were keen to ask.

MS LEE: PJ, it follows on from Mrs Kikkert's line of questioning. You mentioned at the beginning that you started experiencing some depression from when you were about 10 years old. Could I take you back a little bit further? At that point what was some of the support that you were able to access? Was there a process so that you were able to get a diagnosis as early as at that point? In hindsight, now, what would have been something that would have been very helpful to you at that point?

Ms Anderson: I was living in New South Wales. I was getting school counselling. I knew that something was not quite right in my head, but I tried to play it off a little bit because I was young and I was thinking, "There's nothing wrong with me; I'm all good." But my mother was really worried about me. Unfortunately, with my biological father, I have nothing to do with him now but he was not a very supportive person. He never wanted to believe that there was anything possibly wrong with his children. My parents were together then. Because of him, I do feel that he stopped me getting the help that I needed when I was younger.

MS LEE: Thank you; I really appreciate you taking the time to give us that evidence.

Ms Anderson: No problem; thank you.

THE CHAIR: In regard to the long wait times that you experienced to access mental health professionals, does that place pressure on you, when you go to these appointments, to try and make it work?

Ms Anderson: A hundred per cent. I feel that, over that time, I set really high standards, which I probably should not have done, but because I was waiting and waiting, I was thinking, "I need this to be the person; I need this to be the person that I feel comfortable with, to tell them everything about what's going on in my life." There was a little bit of self-sabotage, I feel. There was a lot of pressure on me, and all I wanted was to be better, not only for myself but for everyone around me, because I knew they were struggling with seeing how I was going downhill.

When I saw the psychologist in Goulburn, to a certain extent I was a little bit nit-picky over things. If this was the person that I was going to spend most of my time with—monthly, fortnightly, weekly, whatever I needed—I needed to feel 100 per cent dedicated to that person.

THE CHAIR: PJ, thank you so much for making the time to have a chat with us today. We really appreciate it, and it really helps us in trying to make recommendations to make our system better. You will be sent a copy of the *Hansard* transcript. Read over it, see whether there are any errors in it, and let us know.

Ms Anderson: Yes, not a problem.

FROST, MISS JACQUELINE KATE

THE CHAIR: Welcome to the third public hearing of the inquiry into youth mental health in the ACT. I would like to thank you, Miss Frost, for being here today. Could you confirm for the record that you understand the privilege implications of the statement that was sent to you?

Miss Frost: Yes, I do. I have read it and I understand it.

THE CHAIR: Do you have an opening statement?

Miss Frost: Yes, I do. I am 20 years old and I have been diagnosed with a nice little list—anxiety, borderline personality disorder, bipolar disorder and complex PTSD. The list goes on. I am a victim of abuse. The reason that I am here is to talk about some issues around that, some issues around drug and alcohol abuse, where youth stand, where we struggle to get support, and generally about mental health in the ACT, because it needs to change.

THE CHAIR: I will lead off with a question. Could you tell us about any problems you experienced with youth mental health services in the ACT?

Miss Frost: Quite a lot. I am not from Canberra originally. When I first moved here, I was 10 years old. The way I saw it was that I was not really messed up enough that CAMHS could help me, but headspace did not have the right services to provide for me. I was kind of left in this loophole of not having somewhere to go to get mental health support. We did not have money, so we could not go private, either. We were relying on public, and there was not an option for that. I did not tick the boxes or fit the criteria.

I eventually got in to see someone. High school was a trying time and, from there, there were further issues. If I did not attend an appointment because I was too scared or because my mental health was not well enough that I could actually get out there and do things, I would then lose my psych, which would mean that I would have to start that whole process all over again. There were quite a lot of issues with access, and just ticking the boxes to be able to get in was very difficult.

THE CHAIR: Could you tell us a little bit more about this gap that you experienced between headspace and CAMHS? What were the key services that you think were missing that caused that gap?

Miss Frost: We are going back; that was quite a few years ago. With CAMHS, the issue, from memory, that they had was that I sort of closed down when they spoke to me and did their assessments. I did not answer questions as honestly as I should have, and, I guess, I played down my issues. Therefore, it meant that they were saying, “We don’t have the things to provide.” They were very politically correct about it, but, essentially, they did not have the supports needed to provide me with help because I did not tell them about the help that I needed.

When I told headspace about the help that I did need, they basically said that I had a few too many complex issues and I needed a bit more of an in-depth psych to support me. Therefore, they sent me back to CAMHS. There was that gap between not having enough complex issues to tick the boxes and, with the other services, having too many and they wanted me to be supported properly, which was fair enough. That meant that I had to go back to the other places that did not actually have the opening for me.

MS LEE: Thank you, Jacqui, for coming along to provide evidence to this inquiry. Before I go to my question, you mentioned in the previous answer to Mr Pettersson's question that you lost your psych and you then had to start everything again. Could you explain that process and what that meant?

Miss Frost: When I did not turn up to appointments, they basically said to me, "You need to start turning up and being involved in your therapy, otherwise we're going to have to take it away," so that they had more space for people who were going to attend appointments. It is very similar to victims of crime. If you miss one or two appointments, you then lose all of your sessions that they have allotted you.

MS LEE: Thank you for explaining that. When you first started noticing that you might need some help, can you take us through your journey in navigating and trying to find the appropriate supports, and how you found that experience?

Miss Frost: When I first realised that I needed help, I was eight years old. A lot of it was done by my mother. I remember being very not okay, a very angry little girl and needing my mum to do it all for me. I noticed her struggling to get me the supports. For a lot of it, I was not aware of the process of getting any help because I was so young. As I got a bit older and I was involved in that process, I felt extremely overwhelmed. I felt like either I was not—excuse my language; I know it is not the most politically correct—messed up enough or I was too messed up. I was stuck; I felt stuck. That went on from maybe 12 years old—11 or 12—when I started being involved in finding therapy, until maybe last year or so, when I was 19. There were a lot of years when I just felt stuck. Even when I was getting support, there was this inability to move forward. I felt like there were so many options and none of them made sense to me.

MS LEE: What happened last year? What changed last year? You mentioned age 12 until last year. What happened last year that made you change your mind and think that, perhaps, you are getting the support that you need now?

Miss Frost: I got involved with the youth drug and alcohol program and I found a psych through there. She is absolutely wonderful. Within eight months of seeing her, I was able to go into detox, get off the things I was using and get sober. She set me up with DBT. The drug and alcohol service was what changed it for me. I got the help I needed. Until then I was not getting it.

MS LEE: Were you denied access to drug and alcohol therapy or was it the fact that that was not considered to be a need for you at that point?

Miss Frost: I did not consider it a need for me beforehand. A few years prior, I had had caseworkers suggest that I get drug and alcohol help. Their process was to say, "Go to Ted Noffs." I have an issue with being in residential situations, and I did not cope with that. It was not until a year or so later that I became willing to look at other avenues, and that is when I found youth drug and alcohol.

MRS KIKKERT: Thank you, Jacqui, for coming online this morning . I want to ask you about your STEPS residential program experience. Can you talk to us a little bit about that? How old were you when you were involved in the STEPS program and for how long were you in that program before you got kicked out?

Miss Frost: I was 13 when I was put into it and I got about 2½ or two months into it. It goes for three months. I got kicked out of it, mostly because I was not following their rules. I needed to be back at STEPS and back at the residential home by a certain time after school. I did not want to do that. I hated where I was living. I hated my life. I hated everything. What 13-year-old that is angry at the world is going to catch a bus home at the right time? I mean, really! I did not obey the rules and they basically said that they could not keep supporting me because I was not taking the steps to help myself; therefore, they needed to cut the support. I got moved into a different residential care place after that.

MRS KIKKERT: Did you get an opportunity to speak about your experience in that home when you were 13 years old?

Miss Frost: No, not at all. I have been able to in retrospect, through doing things like this, but, at the time, no, not at all.

MRS KIKKERT: They did not offer an opportunity for you to voice why you were doing this—nothing at all?

Miss Frost: No.

MRS KIKKERT: After you were moved into a different residential place, did they come back and offer a second chance to participate in STEPS?

Miss Frost: No, they did not.

MRS KIKKERT: Were you interested in going back to do STEPS?

Miss Frost: A little bit. On one hand I was very angry with them and I wanted nothing to do with it, but I also very distinctly remember asking whether going back to STEPS was an option for me, and I heard nothing about it.

MRS KIKKERT: Who did you speak to about having that option?

Miss Frost: I was speaking to care and protection. I had a caseworker through care and protection. We had lots of meetings. Also, one of the people who helped to run STEPS came to the conference meetings with CYPS, and I remember asking about it at that meeting.

MRS KIKKERT: They never got back to you about going back to STEPS?

Miss Frost: No. They may have got back to CYPS, and CYPS just never told me their answer. I was never informed, which, to me, means I was told no.

MRS KIKKERT: I am so sorry that that happened to you, Jacqui. Looking back, if you had the opportunity to do STEPS again, what difference would that have made in your life?

Miss Frost: I believe it would have made quite a lot. As I said, I was a very angry child and I did not want to abide by the rules; but I do believe that if I went back and I knew that it was my last chance, my second chance, to do this right, I would have put some more effort into helping myself. After STEPS and the residential care placement that I went into, post that, everything went downhill for many years. I truly believe that STEPS was that “make it or break it” moment for me as a child, in my teenage years. Being able to do it again would have changed quite a lot for me.

MRS KIKKERT: Wow. That is quite—

Miss Frost: In theory.

MRS KIKKERT: Yes. That is quite powerful, Jacqui. Would you have liked your caseworkers in CYPS to hold on to you a little bit longer, encourage you to attend STEPS, and do whatever was necessary at the time to give you that second chance?

Miss Frost: Yes, definitely. I probably also would have told them where to go, because that is the sort of behaviour I had; but it would have been nice if they had held on for a little longer, if they had tried a little bit more, or maybe came along with a softer approach. I believe that there were other ways around it, and that they could have handled things differently.

MRS KIKKERT: You spoke to our secretary about your brother’s experience with foster care. Would you like to elaborate on that?

Miss Frost: Yes. There is a lot to elaborate on. Is there anything specific you would like to know about?

MRS KIKKERT: Basically, his experience, the failure that he went through and what would have been done to make it right.

Miss Frost: He was essentially taken away due to CYPS ruling it as neglect from my mother. My mother had just gone through some traumas and they basically blamed her for being unwell, because of the traumas on her, for being neglectful. Yes, she went through traumas. She struggled to do things. When you look at what she went through and what happened to her, I do believe that her falling apart a little bit was quite valid.

He was taken away due to that. Within days of being taken away, he was falling apart. He was eight or nine years old when he left. As any young child would, he fell apart. He was not offered counselling services, as far as we know. Mum and I—because I was quite involved in the process of him going into care—spoke a lot about how he needed mental health support. He is on the spectrum. He has some issues. Being ripped away from your home is terrifying. Even if you move with your family, a move is terrifying, so to be moved without his family broke him.

He was not given mental health support until, I think, three or six months later. I am not exactly sure how long it took, but it took a while. I believe that he should have been given crisis counselling straightaway. He was taken from school. All of his friends had to see it go down. It was not handled well, and it hurt him. He definitely needed some more support than he was getting. I believe that he is getting it now, two years on, but at the time he was not getting it.

MRS KIKKERT: What impact did that have on him and also on his family, including you?

Miss Frost: It had a lot of impact on him. He fell apart. He became very enclosed. He is very loud and boisterous. He is a very big kid, and he became small. He became really small, which was very hard to witness. It hurt the family a lot, seeing him like that. Our father is not around, so it is me, my mum and him. As he was gone and my mum fell apart, I had to be the strong one for all of them. It is not my responsibility but I chose to take that on. It was draining. It was painful and traumatising for all of us. What really sticks out to me is that it was draining. It drained us all so much, and there was no help.

MRS KIKKERT: You are a courageous big sister, Jacqui. He is very fortunate to have someone like you.

Miss Frost: Thank you.

MRS KIKKERT: Going back to the time that you were trying to contact CYPS, or anyone, to support him when he was removed from his family, what was the obstacle? What were the hurdles that you experienced?

Miss Frost: Quite a lot of them. The first one that I came across was the fact that, because I was not his parent, they said, “You don’t need to be here. You don’t need to talk about this.” Sure, I am not his parent, but I am a registered young carer for him. I have a right to ask these questions. That was the first big one that I had.

Another one was that, once they respected the fact that I had a right to ask, I was then told that I had no legal rights to get the answers. My mother was told the same thing. They generally refused to involve us in his transition. We were there to speak at case conference meetings; we got to do all of that, and we had visitations with him. In terms of his mental health, he got put on medications. We did not know about that until a few months after he got put on the medications.

With respect to anything to do with supporting him at close quarters with mental health issues and everything like that, we were pretty much just cut from it. We tried to get answers. They would avoid the question and they would dodge the topic. We get a lot of that.

THE CHAIR: One of the issues that you flagged with me before you appeared today was a shortage in funding and support for those with eating disorders in the ACT. Could you expand on that?

Miss Frost: Yes. I, and a few people close to me, have had battles with eating disorders. One thing that I have discovered is that, unless you have a psych who is particularly interested in eating disorders and support around that, it is very difficult to get specialised support, unless you have money to pay for a dietitian and everything like that.

I was offered the chance to go to the eating disorder clinic on the south side. I went there; essentially, you sit there and have a little chat. They tell you why eating disorders are bad for you. People with eating disorders know why they are bad. It was information we already knew. They would get you to eat—sit down and have lunch, or a brunch-type thing. You would basically be told the theory around how it can damage your body and how it was not good for A, B and C. It is all information that we know about. As far as I have discovered, and the friends I have that have eating issues, those are the only supports dedicated solely to eating disorders that we have been able to find. Maybe there are some that we do not know of, but we should know of them. If they are out there, we should know, and if they are not out there, why aren't they there? That is mainly my issue around it—the lack of options and the lack of funding for the option that is there. That service had zero funding, essentially.

THE CHAIR: We are out of time. Thank you so much for appearing today, Jacqui. Your contribution has been really helpful to us, and it will help to inform our recommendations. We will send you a copy of the *Hansard* transcript. Double-check it; make sure everything that is written there is what you said. Once again, thank you for being here today.

Miss Frost: Thank you so much for listening to me and giving me this opportunity to speak.

THE CHAIR: The committee will now take a short break.

Hearing suspended from 10.11 to 10.20 am.

WERNER-SEIDLER, DR ALIZA, Senior Research Fellow and Clinical Psychologist, Black Dog Institute, University of New South Wales

THE CHAIR: Welcome. On behalf of the committee, thank you, Dr Werner-Seidler, for being here today. I understand that you have been forwarded a copy of the privilege statement. Can you confirm for the record that you understand the implications of that statement?

Dr Werner-Seidler: Yes, I understand it and that is all fine.

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

Dr Werner-Seidler: I thought that it would be useful, for the committee, to give a little background about the Black Dog Institute and my role. I want to start by thanking the committee for the opportunity to contribute to this inquiry. It is incredibly important and I am really looking forward to answering some of your questions.

In terms of my role, I am a clinical psychologist and senior research fellow, so I am primarily an academic but I also have experience working both in treatment services and in prevention and early intervention for people’s mental health.

The role of the Black Dog Institute is, essentially, that we are a research translation organisation. One of the things that I often get asked is how we differ from other mental health organisations like Beyond Blue, for example. We do not do service delivery. We deliver research and we have a real focus on the evidence and the development of evidence-based programs. Then we work with communities to get them delivered and sustaining those communities. So we do not have a vested interest in particular programs or products. We are just very interested in programs that work to improve young people’s and all people’s mental health.

THE CHAIR: Thank you. Could you tell the committee what further work needs to be done in understanding youth suicide, and potentially what the ACT government needs to do more of or better?

Dr Werner-Seidler: Youth suicide has so many different causes; there is not one area that needs to be focused on. Some work that we are doing in our LifeSpan project, which you may or may not have read about in our submission to the inquiry, is looking at raising awareness and helping young people and the people who are surrounding young people speak safely about suicide and seek help when there is a need.

I will speak very briefly about some of the programs that we are doing. The expansion and sustainability of those programs is something that the ACT government should certainly be looking at, because these are evidence-based programs. I am happy to speak about that evidence.

Something that we know about suicide prevention is that one intervention or treatment target is not going to work. There needs to be a systems approach, a broader approach, across many different social communities in order to have an effect, so we are working with ACT schools, parents, and community members, and school counsellors as well, to focus on this issue.

The first thing is directly to school students. We are delivering something called YAM, the youth aware of mental health program. Essentially, what happens is that qualified trainers go into schools and talk safely to young people about suicide and mental health. I guess that the core objective of the program is to increase young people's awareness and their ability to provide support to their peers, and also encourage them to seek help when they are feeling suicidal.

That is a program that was developed in Sweden, in the EU. It has a very strong evidence base. It reduces completed suicide deaths in young people by 50 per cent and it decreases suicidal ideation in young people at a rate of about 25 per cent. Suicidal ideation is thinking about suicide, contemplating it, and that is a necessary precursor to suicidal behaviour. So it is really important to move the whole continuum of young people down the spectrum. By reducing suicidal thinking, you are also ultimately going to be reducing suicidal deaths.

That is something we delivered across New South Wales to about 12,000 young people as part of our LifeSpan project. We were scheduled to go ahead in the ACT. That has been put on hold due to COVID, but we are looking at reaching about 2,000 school students in the ACT by the end of the year and we are hoping to sustain that program beyond this year. That is the first thing that is directly delivered to school students, which is really important.

The next initiative is called QPR: question, persuade, refer. The committee might be familiar with it. It is a program for adults, which is, essentially, anyone in a gatekeeping position, to identify suicidal risk and then refer. You consult with the person, try to persuade them to get help and then refer them on to a specialised service. That is something that has been delivered across the ACT this year. I believe we have trained more than 600 people in the community who have some kind of relationship to schools—parent committees, boards and so on.

The third initiative that I wanted to speak about is called youth in distress. This is a face-to-face training program that we developed with the department of education in New South Wales. We have delivered it to all school counsellors in government schools. Essentially, it is to upskill and increase confidence in our school counsellors and school psychologists to deal with mental health crises. There is huge variability in the quality of training and competence of mental health professionals who are in schools. The idea behind this program was to increase their competency in dealing with high-risk suicidal young people. To date, we have trained about 66 school psychologists in the ACT and, again, we are looking to expand that throughout the year.

THE CHAIR: In terms of these programs rolling out in different states at different times, how much consistency do you expect to see between different jurisdictions in Australia when it comes to addressing youth suicide?

Dr Werner-Seidler: Anything that is done in the school context has to have a level of flexibility, because every school is different and has slightly different needs. What is really important is that the core therapeutic content of the intervention stays the same. We have things like delivery manuals or therapists manuals, which protect what we call fidelity—that is the active ingredient in what is making the intervention work—but the implementation will change across different jurisdictions.

For example, I just spoke about the youth in distress program. In New South Wales we have a different level of training requirements for school counselling staff. It is lower than that in the ACT, and my understanding is that in the ACT they are all also psychologists. That is obviously going to have an implication when that is delivered in New South Wales, because you would expect a greater level of upskilling because you are starting from a lower baseline, whereas in the ACT I would hope that it is more of a refresher. You are still upskilling but, because of the greater training that these psychologists have had, it is obviously going to be experienced differently.

So there are absolutely differences. That really speaks to one of the benefits of digital mental health interventions, where the fidelity is always protected because it is delivered by a computer, so you do not have these human factors which can make it more or less effective.

MS LEE: Dr Werner-Seidler, I want to go to your submission where you talk about schools. You have already mentioned, in answer to the chair's question, some of the programs that are delivered directly to schools that you are hoping to bring to the ACT before the end of the year. You say that an integration of wellbeing into the curriculum, including through evidence-based mental health programs and e-mental health, would help students. Every teacher and principal that I have spoken to at schools here in the ACT is very conscious of the importance of making sure that wellbeing is a key part of schooling. Where are the gaps that you see in terms of school-based programs or training that we need to look into in addition to what you have already told the committee about in terms of gaps?

Dr Werner-Seidler: Most of the schools that I have liaised with, and possibly you have as well, have a real focus on wellbeing, positive psychology and building resilience in young people. That is critical. Most young people actually will not go on to experience a mental health problem, even though we do talk about a mental health crisis and with rates of 25 per cent it is very concerning.

What gets missed is that there is a pointy end: there is a group of young people, about 25 per cent of them, who are going to go on and experience a mental health problem. My experience with schools is that they often shy away from effective prevention programs. They do not want to use words like suicide and depression; they do not want to use the cognitive behavioural therapy programs, which have been described to me by principals as a downer. They do not want to upset the kids and so on. From the evidence and the research, that is simply not the case. Young people are experiencing a lot of stress. They are talking about suicide with each other or they are too embarrassed to speak to anyone about it but they are certainly thinking about it. Having a safe space to learn some skills and strategies to help themselves in the first instance is really important.

I am concerned that there are a lot of wellbeing and positive psychology programs available but they do not necessarily have an evidence base to reduce symptoms of mental illness. They may increase self-esteem, which is really important. They may increase communication with other students, which is really important; but, ultimately, they are not having the mental health preventative effects which are really needed.

We have programs around mental health literacy to understand mental health concepts and ideas. We have stigma reduction programs. They are all really important but they are not necessarily going to reduce symptoms of mental disorders at times of increased stress. That is where I think the gap is. Most of the schools that I speak to—school counsellors, principals and teachers—are completely confused about where to go to find out what programs have an evidence base.

I think that in schools a lot of the psychologists and counselling staff are spending their time with the pointy-end, high-needs crisis students, which is absolutely appropriate because they are in need; but the rest of the cohort do not necessarily get access to what they need. So what my recommendation would be is to upskill teachers, wellbeing staff and even assistant principals. More than 50 per cent of these staff members say that they do not receive adequate mental health training. Nobody is asking them to be mental health professionals but there is no reason why they cannot deliver curriculum-based mental health prevention programs. Looking at digital technologies removes the need for the individual to be an expert. They need to be able to support students to do these programs and to lead safe discussions about mental illness, but they do not necessarily need to be the experts delivering the intervention. That is what I think is missing.

If you look at popular directories for mental health programs, government-supported ones, you will see very few that have a strong evidence base. It is almost impossible for somebody who is not very familiar with the field to decipher which programs work and which programs look really nice on the surface and may be derived from evidence-based principles but have actually never been tested, so we are just not sure.

MS LEE: The anecdotal evidence that we are starting to get through is that we are seeing mental health issues start to come out in younger and younger cohorts. Have you got any advice about what we need to do to ensure that we are getting to these people in need as they come out younger and younger? What is missing at this current stage, especially in the school environment?

Dr Werner-Seidler: Certainly, that is absolutely consistent with my experience, speaking to schools. Most of the work done by the Black Dog Institute to date is in secondary schools, but we are now looking at moving to primary schools because we are seeing a decreasing age in terms of mental health problems and a need, particularly for teachers, for programs. We work closely with the department of education in New South Wales and they are really keen on programs for younger age groups.

For primary school aged students, you would look at the key mental health issues that they are experiencing. They tend to be anxiety disorders and also the externalising disorders—more conduct and behavioural problems, which has a huge impact in the classroom. There are nowhere near as many programs available but there are some. One really popular one from the US is called the good behaviour game, which is delivered to primary school students who are quite young. We are looking at late infants, year 2, early primary school, year 3. It is about increasing prosocial behaviour and it helps with classroom management, so teachers really like it. Basically, the evidence from that is that if you deliver the program early on, you can see a reduced risk of suicide 10 to 15 years later. So there are very large long-term effects. That is something that is of interest to the New South Wales government that we are looking at implementing from next year, so that is something the ACT might like to consider as well.

The other thing is that there are very good online programs for anxiety disorders in younger children. They often involve parents, and this is potentially something which has been missed. Positive parenting programs and equipping families to deal with emerging mental health problems or providing supportive environments before mental health problems emerge is really important.

Looking at the younger age groups, you have several benefits. One benefit is that you are in a primary school. You have a single teacher overseeing a group of students and they are in a very good position to identify a change in behaviour or that there may be a mental health problem. Whole-of-classroom activities for that age group and discussion—previously, if we ever tried to run a suicide prevention program with year 6 students, we would absolutely be told no because "They're too young. We don't want to talk about suicide; we don't want to put ideas in their head." I want to be really clear that the evidence has shown that talking about suicide does not increase the risk; it actually decreases the risk, because people are more likely to disclose their thoughts and feelings about suicide and get help. So the potential adaptation of some of the programs we are using to a younger age group would definitely be worth exploring.

Finally, there is the involvement of families and parents. Of course, not everybody has a supportive family or parents who are invested in their mental health, and that is incredibly unfortunate. For those who do, this can be really powerful in making sure that young people stick with treatment: that they are not just seeing, for example, a psychologist for one hour a week and in all the other hours are not practising what they have learnt. To have that consistency and support at home and at school and to implement the skills that you have learned in a therapeutic context for younger kids is hugely beneficial, and we see really excellent outcomes.

The earlier you intervene, the better the outcome over the whole life course. So I think that there is a real opportunity. Rates of mental illness in young people before the age of 10 or 11 are quite low. There is definitely an opportunity to intervene at that time, before we see a huge spike in the onset of mental health problems around adolescence.

MS LEE: What would you say is the biggest barrier or challenge for early intervention?

Dr Werner-Seidler: There are two ways of doing early intervention. You can deliver a prevention program to everybody. That is not really early intervention; it is screening those who are showing elevated symptoms of risk. That is something we are currently looking at at the Black Dog Institute. We have an online platform called smooth sailing which we are implementing through schools. We started in high school.

The basic idea is that everybody comes in and does a very brief mental health survey. They are assessed for anxiety and depression. It takes five minutes and it is all online. Then we use a step care approach to deliver the right intervention.

If they are not showing any symptoms, they have the opportunity to read some information about mental health if they want to; they do not have to. If they are showing moderate-level symptoms, then they are offered an online intervention—what we call a low-intensity intervention. It does not cost anything; they can guide themselves through it. If they are showing high levels of symptoms, they are then connected with the school psychologist or counsellor either for individual therapy or to be referred out to an expert service.

I am very puzzled as to why schools routinely assess numeracy and literacy every year but not mental health. I have spoken to many people in schools who view mental health as outside the realm of what they, as a school, need to be doing in terms of delivering educational outcomes and academic achievement but not social and emotional care for their students. We know from the research that if you do not have mentally well and healthy young people, they are not going to perform well academically and their learning is impaired. So I see these two things not as separate. I would really like to see a time where mental health screening in schools is routine. You do your numeracy, your literacy and a quick mental health check. That is a way that you can identify young people who are starting to show symptoms and link them into early intervention at the right time.

MRS KIKKERT: Dr Werner-Seidler, I am so excited that you are on this morning. As I was reading your submission, I came across the cognitive behaviour therapy online games, particularly SPARX. My son and I checked it online this morning and it is really good. I have five kids and, having teenagers who play games, I think that this is a really important way of getting to our youth who are not into looking outside their home for help. Could you talk to us a bit about SPARX? I understand from the trailer we saw this morning that it is based in New Zealand. Do we have an Australian version?

Dr Werner-Seidler: We do not. SPARX was developed by the University of Auckland. For the other committee members, who may not be familiar with it, it is a seven-module serious game. It is a gaming intervention based on cognitive behavioural therapy. It has been shown to be an effective treatment. What we did in Australia is that we adapted it for prevention.

It was designed with young people—you have completely hit the nail on the head—who do not want to speak to a psychologist like me, who want to go online. Often, online is one of the first places that they will look for help. They can find something that is not pages of text and is not boring. They do not want to read. They told us that they do not want to read stuff; they do not want to write stuff; they just want to learn. You move through fantasy worlds and learn a different skill or strategy at each level. It includes things like realistic thinking, relaxation, challenging your negative beliefs—very core CBT strategies.

A New Zealand trial found that it was effective for the treatment of depression. We tried it in New South Wales a few years ago. We did not adapt it for an Australian audience; it is culturally sensitive for our New Zealand and Kiwi audience but we just left it as it was. We tested it in Australia. We found that we could reduce symptoms of depression in the lead-up to final school exams in year 12 students by getting them to play this game in the lead-up to exams, which is huge. If you look at the Mission Australia mental health report, you will see that some of the main worries for young people are school and study worries. We know that the final school exams are one of the most stressful things that young people go through. Simply by playing a game—there are seven modules, 20 minutes each—you can actually decrease your risk of experiencing depression during that year, which is a huge finding. Those findings were sustained for six months and we were really encouraged by that.

That has led to our next stage of work, where we are doing something called the future-proofing study. You may or may not have heard of it. Essentially, we are testing the use of this intervention at scale in schools. We are going to 200 schools around Australia. We are hoping to reach about 10,000 young people. We are delivering this game, SPARX, to see if we can get similar effects on depression and suicidality.

Some of the feedback that we have had from year 12 students is that they are a bit advanced for a game like this, so this time we are going to year 8 students; we are going much younger, to 12 to 13-year-olds. That is also, again, before we see a spike in the onset of mental health problems, so we really want to look at prevention and early intervention where everybody gets it. There is no harm in learning relaxation strategies and coping skills, even if you are not on a trajectory towards mental illness. These are skills that can help everybody.

What we want to show from this study is that these digital interventions can work and that they can be delivered through schools at scale. We are doing some work around the implementation, with the hope to show that it can be sustainable and low cost. We are doing some cost-effectiveness analysis around it.

Something that is really puzzling to me is that the government has invested four times what it used to over the last 25 years in mental health treatment services and we have not seen a corresponding decrease in mental illness. That completely blows my mind. How is it that research has advanced, treatment has advanced and government investment has advanced but we have not seen a decrease in the prevalence of mental illness?

Treatment in and of itself is not going to be the answer. The expansion of treatment services is absolutely not the answer. I am a clinician. Getting mental health support is really important but it is not the panacea for the mental health problems and issues at a population level. With prevention and early intervention, you can move about 22 per cent of people off the trajectory towards mental illness, which is a huge number. That is more than the number of people we successfully treat with the interventions we have now, including antidepressant medication.

These interventions, done well in school, increase access. They are lower cost. There is a return on investment. There is a lot of cost-effectiveness analysis that shows that digital interventions that have an evidence base are going to be economically beneficial. There is a very low cost associated with it because you do not have a professional delivering it. It does not matter that a significant proportion of people who go through the program will not actually need it for their mental health problems, because relaxation is good for everybody. Coping with stress, challenging negative thinking—this is really good for everybody.

To go back to your question, we do not have an Australian version; the New Zealand version seems to be working really well. We are looking at licensing it so that young Australians can access it online as well. Alongside that, one piece of feedback that we get quite consistently from young people who are into gaming is that this now looks outdated. It was developed about eight years ago. I do not know if your children are gamers or not, but we have been told that the graphics are no longer up to scratch. That is really important, because digital interventions do change and the biggest issue with our digital programs is getting young people engaged in them and seeing them out.

With this feedback, we have taken that on board and we are developing a new program using the same skills and strategies, the same ideas—it will be gamified—but providing an update and an Australian version of what you have seen. That is a three-year project that we are working on at the institute at the moment. As soon as we have pilot data to show that that is effective, we hope to make it available to students. That will be much more straightforward because we do not need to license it.

MRS KIKKERT: It is fantastic. I actually love the New Zealand Maori language at the end, because it does make it even more like you are in a fantasy world because you do not really understand the language. Having seen that coming from a Maori perspective and a Maori image and language, I was thinking: what if Aboriginal people here in Australia could have access to a role model for them? We know that our Aboriginal youth suffer a lot. Seeing them connect through their culture and connect through their language through an online game—I think it will be marvellous for our youth to have that access to it. That is just a little feedback.

Dr Werner-Seidler: You raise a really important point. One of the things that we are working on, that we have developed, is an app called iBobbly, which was developed in partnership with Aboriginal and Torres Strait Islander communities. It uses Aboriginal art and Aboriginal voiceovers, and the goal is suicide prevention. It is for young adults, I think aged 16 to 30. It was tested in a community in the Kimberly and it increased help-seeking and decreased suicidal ideation. That is now possibly available. I am not 100 per cent sure. If it is not available yet, it is in the pipeline to be made available to Aboriginal and Torres Strait Islander young people.

MRS KIKKERT: That is good to hear.

THE CHAIR: Unfortunately, we are out of time. Dr Werner-Seidler, thank you so much for being here today. Your evidence has been, I think, very important in forming our recommendations. You will be sent a copy of the *Hansard* transcript. Make sure that you double-check it. This is a remote hearing; it is probably better to be safe than sorry when it comes to online meetings. Let us know if any updates are needed.

McNEVIN, MR TIMOTHY, Principal, Communities@Work Galilee School
DRYSDALE, MRS KAILA, Youth Worker, Communities@Work Galilee School
ARTUP, MR JOEL, Head of Student Support, Communities@Work Galilee School

THE CHAIR: Welcome. I would like each of the witnesses to confirm that you have read and understood the privilege implications of the statement that was sent to you.

Mr McNevin: Yes, I have.

Mrs Drysdale: Yes, I have.

Mr Artup: Yes, I have.

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

Mr McNevin: Thank you for the opportunity to make a submission and also for us to appear today. As a school, we strongly support the need for a constructive, inclusive, positive community conversation around youth mental health. The issues affected by youth mental health are significant and impact the young person, their family and the community.

Galilee School is a special assistance school in Canberra. Our dual focus is on the social and emotional development of young people, as well as their academic learning journey. Our experience of youth mental health has made us understand that the barriers present in a young person's social, emotional and psychological worlds oftentimes need to be overcome first if they are to be truly successful as an academic learner.

This focus that we bring as a school requires resources. I acknowledge the strong support that we, as a school, receive from our parent organisation, Communities@Work. I also acknowledge the strong social impact Communities@Work has across the community. It is oftentimes supporting families that are enrolled at the school in ways other than school attendance.

To provide the level of support that we do, we seek to maintain a staff to student ratio of one to five. Our dual focus sees us employing both qualified teachers and qualified youth workers and support staff. We also seek to design learning environments that support trauma-informed care principles. We are deliberate and ongoing in our efforts to develop our staff to continue to equip them to best support our young people.

It is good work that we do. It is hard work that we do. We feel that we have achieved positive outcomes. We are constantly looking to improve our practice. We are willing and wanting to partner with others. We believe that an approach that puts the young person at the centre of the decision-making process is the best way to proceed.

THE CHAIR: Thank you. Could you tell the committee about the challenges that you see in young people accessing youth mental health services in the ACT?

Mr McNevin: Sorry, did you say after they have seen youth mental health services?

THE CHAIR: No; the question was about any problems that you have seen young people having in trying to access youth mental health services.

Mr McNevin: Young people come to Galilee School having not yet thrived in mainstream education, so they have a story before they come to Galilee, and that story has so much comorbidity normally present in it that their lives are very complex. One of our big challenges is to quickly help them share that story with us without necessarily having to retell it again. We also need to quickly establish trust in us as an "institution", because many of our young people have had that trust damaged over time because of their engagement with other institutions, through no fault of theirs or of those institutions.

What we find is that we are often operating as pseudo case managers on behalf of our young people. Due to the capacities of the young person themselves and the capacities of their family, they find it very hard to navigate what is a relatively complex system that to us, at times, feels disjointed, not aligned, and with communication flows that are not efficient. As we take on that case management role, we are having to advocate on behalf of the young person. At times, their past history sees them being resistant to engaging with those services a second, a third, a fourth time—whatever the case may be.

So it is slow progress oftentimes, first needing to establish trust in us in the heart of the young person, then seeking their permission and approval to advocate on their behalf, and then working with those other services to hopefully connect the young person with the sorts of supports that we think they might need.

I preface all of that with an acknowledgement that we are not mental health experts. We are educators, we are youth workers, we are social workers, and we bring our life experience and our professional experience to bear on the advice that we seek to provide to families and young people.

Mr Artup: I will add to the things that we come up against from a challenges point of view. Tim has touched on some of them. One of the biggest ones that we come up against is wait times within services. It feels like often with our young people, given that they have had various different levels of service experience in the past, their patience, when it comes to accessing support and help, is quite low. We try to use the sort of terminology of striking while the iron is hot. If a young person has spoken to us or spoken to a teacher or a family member and said, "Hey, I'd like to access some supports around my mental health," we feel that addressing that in a timely manner is crucial. It sometimes feels that that is the first roadblock we come up against.

Trying to identify the correct service that suits that young person's needs is obviously a challenge, but then there is accessing that service within a timely manner. I have seen wait times upwards of six months to get an initial meeting for a young person to see a counsellor. In my opinion, that is not timely enough to support that young person where they are at in that moment. We know that young people are impatient at the best of times, let alone those that are experiencing mental health concerns.

Mrs Drysdale: I agree with the statements around wait times and accessibility of certain services. Those are definitely things that I feel, as someone who makes a lot of referrals for our young people that we have at the school, are a big barrier. Along with that, a lot of the things that I find really challenging in those sorts of situations when trying to work with a young person in a crisis, to try to get them in, are little things—like around their gender, around their age, around what they feel that they may need counselling for—as opposed to the bigger picture which Joel and Tim mentioned.

The experiences that they had previous to their time with us, we know, can affect them severely in their future and their current time within the school. Whether that is what they see as their main problem, their main issue at the moment—so when they say, “I would like to go to a counsellor because of this,” when they go to a counsellor for that one topic, they often uncover a lot of other things, which means that that service will no longer see them. The ability to have them referred or to give us an option outside of that to have these young people go on to, despite the hesitations that the young people already have around going somewhere new and retelling their story—it is quite drastic.

We have young people who turn 16 and 17 before they leave us, and the age restriction on certain services is often a lot lower than that. As well, there is a lack of access to services because of gender and other concerns, as well as wait times and money. Finance is also a really huge one for our young people and our families in accessing services. We can often try to get into psychologists or counsellors through a private practice with a more available wait time, but financially it is not applicable to our students or our families at all.

MS LEE: The submission that you provided gave us a really good insight into the diversity of some of the students that you have at the school and, on a personal level, having had the chance to visit, I have at least a little insight into the work that goes on in that school.

Right at the end of your submission you talk about many young people who present at the school having been overdiagnosed from a young age. Are you able to expand on that? Does that go to some of the concerns that perhaps, Kaila, you just raised? What do you mean by “overdiagnosed” and how does that manifest when they present at the school?

Mr McNevin: I might ask Joel to initially respond and then Kaila to follow up.

Mr Artup: If you could just give me a minute, I would like to find this statement so that I can reread it.

MS LEE: It is on the final page, under the general statement, and it is the third dot point, the first line.

Mr Artup: Often when young people come to us what they feel is that at the end of their journey they have exhausted so many options, and a lot of the language I hear from young people and families often has many, many different labels—the number of young people that tell me they have dyslexia, ADHD, ODD, depression, anxiety, conduct disorder, and the list goes on.

We are trying, as a school, to then work out what is the best way to support that young person, what is the best way to support the family of that young person, and then putting education at the heart of it and trying to work out what is the best way to have that young person learn and engage in education. We understand the complexities of young people and that over their journey they have seen different school psychologists and different people doing different assessments.

We are not disregarding those assessments at all; but for us to then present with a challenge of how we get to what is the root cause of that young person's mental health concerns or disengagement, how we then seek a clarification of those diagnoses and access the right services and assessment for them in order to work out what is the best way forward is a challenge. It is a challenge for us. I hope that does answer your question without being specific to cases. Kaila might have some more to add.

Mrs Drysdale: Yes. Joel covered that quite well. Very often we will have a young person come to us who has been through multiple services, multiple doctors, multiple clinicians, that all seem to have very differing opinions and a different diagnosis and stuff like this for these young people. When you are approaching over five and up to 10 different mental health diagnoses and different medications at times as well, and different appointments and three or four different counsellors and psychologists or doctors and stuff throughout one week, it is often very overwhelming and very daunting for a young person and especially for their families as well.

With mental health, there is obviously still a stigma that is attached to having those diagnoses and there is also, really, uncertainty for a lot of young people around how they then identify with that diagnosis and with that stigma attached to them as well. When they have that many put on top of them, there is a limitation on how they then are able to see themselves through their multiple mental health issues and diagnoses, rather than just them as a person.

We also find that, when we have young people come to us, often in their mid to late teens, they are still attached to diagnoses that they have had since they were quite young, very early on through GPs and stuff like that. They would feel that they have this diagnosis that may have developed or may change or may not have been the case. The limited resources and stuff and the limited access or engagement that they have decided to have in certain services and certain clinicians throughout that time have definitely not given them clarity around that but more just made it a confusing process for them and not really knowing what they have, why they need to have it, if they still have it, what medication or what treatment or early intervention is the best method for them moving forward to try and overcome this as they grow older rather than just having more opinions over opinions.

Accessing someone who is willing to look at all of those diagnoses from the past, try to clarify it for them and their family and come up with a treatment plan that is going to clarify those problems is a really big concern for our young people as well. It is something that we have a massive issue trying to find or finance or access. It is a really big challenge to try and get them that clarity moving forward, especially after they end their time with us and do not have us anymore as part of their support team.

Mr Artup: I would like to add to what Kaila has said. I know that mental health is at the heart of what we are talking about, but we cannot consider it on its own. Often, we need to consider a young person’s behaviours, then their mental health, also drug and alcohol abuse and whether that plays a role, then also any diagnosed disabilities and how that may affect that young person. Often, the diagnoses are from any four of those categories.

When it comes to something like ADHD, it is considered a behavioural disorder. Depression and anxiety are considered mental health and there will also then be substance issues and then a diagnosis of autism. Trying to work out where to start or how valid some of that stuff is is probably the biggest challenge that we face on a daily basis for this topic.

MS LEE: Does Galilee School have a school psychologist or access to a school psychologist?

Mr McNevin: No, not on staff, at present. We have got some hopes for the future, and the engagement of psychologists would certainly be one that we would be strongly considering; but that is quite an expense.

If I may take the liberty of responding, one of the conversations that we have sought to have with other partner organisations in the community is around accessing some of the services and supports that they may have in support of our young people. Quite often we are told that that is not possible because of their status and enrolment with Galilee School. It seems to us that if we are true to this notion of the young person at the centre of the conversation, the resources that are in the community—and I know that this is a very simplistic and utopian idea but it is worth pursuing—or in the education sector, or the fact that a young person needs to enrol with a particular school because that is where they thrive, should not come with an opportunity cost of not being able to access those types of services.

We are very open to partnering with other members of the community, be they in the government sector or otherwise, to explore how our young people, who we are actively working to support, can gain the targeted support that you suggest, in terms of psychologists or other mental health supports, in a way that does not require them to un-enrol from Galilee School in order to access those supports. It just does not seem like the right solution to us.

MS LEE: How is that mandated, that your students who are requiring support outside the school are required to un-enrol? Who has dictated that, if that makes sense?

Mr McNevin: They are some hard words that you are using there. That is not how we would use them. I must admit that the ACT Education Directorate are increasingly supportive of Galilee School. Our partnership with them is growing and maturing and I think it is moving in the right direction.

We have been fairly specific about asking whether or not our students might be able to access psychologist support, speech pathologist support and the like, knowing that those resources exist in the Education Directorate. The feedback that we have received has been that, whilst they are enrolled at Galilee School, accessing those services would not be possible. We will continue to advocate to try to change that position, but I know that there are much greater considerations than ours. We think that our role is to advocate for our young people as best we can.

MRS KIKKERT: Thank you for coming online this morning and I really, really appreciate the hard work that you guys are all clearly doing to support our youth at Galilee School. I want to ask you this question, Tim: in your opening statement—and you touched on it a little bit previously with Ms Elizabeth Lee—about partnering with other organisations or agencies that might help you in your work in supporting our youth, what sorts of partnerships would you like to have within Canberra to support our youth?

Mr McNevin: That is a difficult question to answer, and I say this because your experience and mine would point to the fact that oftentimes the best partnerships are formed over time, as you build the relationship and understanding of each other's capability and understanding of the cultures that various organisations bring and so on.

Perhaps I could highlight a very good example of a positive partnership that we have. Menslink, as we all know, does a fantastic job supporting young men in the ACT. We have an active dialogue with Menslink both ways. We have referred young men to Menslink and Menslink have referred young men to Galilee School. When we do so, we have a professional and sensitive exchange of information and understanding about the particular circumstances that may surround that young person so that we are able to quickly navigate that getting-to-know-you stage of the relationship building so that we can really start to get to the core of the challenges that a young man might be facing.

That dialogue then is ongoing and continual and is also multifaceted. We will bring Menslink into the school so that their faces and their names are known to our young people so that, when a referral occurs for a young man, it is not a massive jump from Galilee to Menslink. The gap between those services is much shorter and the level of comfort that the young man has in that referral is much greater because that gap is much shorter. It is that integration of personnel and understanding and cultures and purpose that make that partnership such a strong one.

If we could do that with more services, if we could have a better understanding of the limitations that some services have, then we might not feel sometimes as frustrated as we do because we know ahead of time that that referral is not appropriate, rather than discovering that at the time of referral. Those other organisations would also have an understanding of how we operate and the supports that we have already put in place around a young person, and that might help to expedite their movement through their services so that that young person does not have to retell and restart their journey of support with that service.

It is a complex question that you ask, but I think it is about relationship building and mutual understanding that will help in making those partnerships more effective. Joel, did you want to add anything?

Mr Artup: I will give it a go. Similar to what Tim said, with community organisations such as PCYC, Young Carers ACT, the Reconnect program, there are some huge positives when it comes to our connection with some of the services in the

ACT. Often it feels like those relationships are built around the people in the relationship. If someone is to leave one of those organisations, we have to start again. It would be nicer to have a deeper, more, I guess, integrated relationship with those services.

I want to touch on Tim's point about knowing the right services ahead of time. I have personally experienced, and I know that others in my team have experienced, where we have referred young people to a service and begun service involvement, only to find out that that young person is considered to have behavioural issues, as opposed to mental health issues, and then is no longer able to continue with that service. That is hard for us to swallow. It is twice as hard for that young person and their family to swallow.

I think that some of the services should have a clearer scope and maybe a wider scope around behavioural versus mental health, given that we often find that they are both present in a young person. They are not exclusive at times.

We also do not know what we do not know and if we have not got a partnership with a service then we do not know what we might be missing out on. That is where that point comes from. Are there things or further offerings that we could have for our students?

Mrs Drysdale: I think that flexibility around a lot of services that we access and have relationships with is sometimes what is going to enable further relationships, further working alongside certain services to be able to go ahead with young people. When I talk about flexibility, we work a lot with some of our students who have graduated from our school. For years after they have left they will still maintain some sort of relationship with us. We still refer and can still advocate for those young people through our existing relationships. A lot of the services that we feel we know well or have come to, or we have networked with during school holiday periods and had professional learning and all that sort of stuff, we will access, we will refer to.

If we are not a part of that young person's every day, and more like once a month or once every two, three months, then we seem to recognise a lot of, I guess, gaps in certain services that especially the young people that we come across fall through. It feels like they need that, as Tim mentioned earlier, case management side of things, someone to be really on top of things to be able to maintain those existing relationships with those services. As Tim mentioned again, we are very focused on our relationships with our young people which, I think, give us that ability to make those changes and make those advancements and referrals on their behalf.

If we refer to a service and that may not be their main focus, then that is where the relationships with us and with the young people seem to fall a little short at times. They seem to fall through those gaps or those, I guess, misunderstandings around their service or their availability or their focus, and how we can then redirect that with our students that we have currently or whether they are past students is a really difficult process.

MRS KIKKERT: I want to ask about diagnostic testing. Can you please clarify for me: does a youth at your school receive immediately or later, when it is available, diagnostic testing of their mental wellbeing?

Mr McNevin: Not at present, not specifically. We do diagnostic testing around their academic status. We will do some diagnostics. We have not yet found the perfect tool in terms of mental health and wellbeing assessment. We have tried a few different tools and none of them has really hit the mark, from our perspective. We are continuing to look and we are continuing to try different approaches that will give us that baseline understanding of their mental health when they arrive but also allow us to continue to track their mental health whilst they are with us.

If there are periods of extended absence from the school due to mental health, despite our efforts to reach out via the phone and that sort of stuff, we often find them less able to communicate with us in the absence of a face-to-face contact. The pursuit of face-to-face contact then draws resources out of the school and it starts to become a very concrete space to navigate. A well-crafted mental health diagnostic tool, such as the one we have suggested, would be a great help to us, we believe.

MRS KIKKERT: I think that it would be a fantastic help. I am just thinking about the youth that enter Bimberi. They receive a mental health assessment right away to help them in their process of rehabilitation and I am just thinking that, if your school could actually have access to the ACT mental health assessment team, that would be brilliant for you. Do you think that will be helpful?

Mr McNevin: Yes, I definitely agree that that would be helpful. Without knowing in practice what that looks like and, obviously, keeping our young people at the centre—and acknowledging that not all our young people have mental health concerns—I think that a local language of an assessment around their wellbeing would be helpful. That may need multiple stages, based on an assessment from us and some anecdotal evidence. Then, if we identify particular young people that could benefit from that, they could advance to that level. I would be cautious about having that as a mandated part of our induction process but, definitely, as a level, it would be very, very supportive.

THE CHAIR: We are out of time. Thank you so much for being with us today. Your evidence has been particularly important in informing our future recommendations. Thank you once again for being here. You will be sent a copy of the *Hansard* transcript. Make sure that you check it and let us know if there are any mistakes. Once again, thank you. The committee will now suspend briefly.

Short suspension.

KELLY, MS LISA, Chief Executive Officer, Carers ACT

THE CHAIR: Welcome back to the third public hearing of the inquiry into youth and mental health in the ACT. I thank Ms Lisa Kelly for being here today. Ms Kelly, I understand that you have been forwarded a copy of the privilege statement.

Ms Kelly: Yes.

THE CHAIR: Could you confirm for the record that you have read and understand it?

Ms Kelly: Yes, I have.

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

Ms Kelly: Thank you very much for the invitation to speak. I acknowledge that we are meeting today on the lands of the Ngunnawal people and pay my respect to their elders, past, present and emerging.

I just want to raise, I guess, two issues in relation to Carers ACT and youth mental health, the first one being about young carers themselves. In the 2016 census it was identified that 5.6 per cent of young people aged between 15 and 24 identify as being a young carer. That is one in 15 carers. In the ACT that equates to around 2,674 young people. Young carers report fatigue, injury, greater levels of stress and anxiety than their peers and it has been noted in many research reports as being an extremely vulnerable and disadvantaged group who are often at risk of experiencing poor physical and mental health.

Services often do not recognise young carers or the impact of caring on young people's mental health. Treatments and access to services do not cater for the additional pressures on time that are often experienced by young carers. Young carers also talk about having a sense of disloyalty about discussing the negative impacts of caring and this prevents them from seeking help.

The second group that we work with are parents or carers of young people who are experiencing mental health. Often for this group this is their first experience with mental health and with the service system. They experience heightened worry and a sense of helplessness. They face a confusing service system with many barriers to access—long wait lists, levels of acuity, the need for young people to ask for help themselves—and many carers talk about how accessing the mental health system is like learning a new language. There is an inability to access information or support for carers and it is the start of a long and challenging journey without a map or guidance and with little attention to their own self-care.

THE CHAIR: I will lead off with questions. What services does the ACT need in place whilst we wait for a public adolescent inpatient unit?

Ms Kelly: I think that we need to have services in place that fit along a full spectrum of care. We need services right down the end that address and support carers and young people as a mental health episode or illness is presenting, particularly in the areas of depression and anxiety, and we need that system to understand that families are important parts of care and of support for young people.

Too often we see a mental health system that separates the young person from their family. It is not about family therapy or family counselling. It is about how we help parents and carers learn strategies that help them care for their young people's mental health condition. We need those services and then we need services right up at the acute end.

Carers ACT is not a supporter of long-term hospitalisation of young people. What we would like to see is that young people have access to medical and inpatient support when they need it for short periods of time, followed by intensive family support within the home so that they can resume normal activities as quickly as possible.

MS LEE: What are the greatest barriers for young carers in seeking support and what are the current service gaps?

Ms Kelly: The biggest barrier, I think, for young carers in seeking support is actually having the time to do so. It is actually in having the ability to do that without, perhaps, having parental support or access. Young carers often do not have people who can drive them places. Because they are caring often for parents that also have their own mental health conditions or disabilities, they do not often have an adult that can accompany them to a service; and they often need that. As much as they will say that they do not need it, they often need that in order to be able to access a service system.

They find, and they report to us all the time, that people in the mental health system, particularly psychologists and private psychologists, do not understand caring and they do not understand young carers. They are often told things like, "You should just stop doing those things if they are causing you stress." That is not a possibility. They get told things like, "You should take time out so that you can go for a walk." If I do not have the time, that is not a possibility either. It is this disconnect that happens between the reality of a young carer's life and the way in which a service provider sees them as a young person and not as a young carer that causes the biggest barriers—along with service opening times. If it is nine to five, and I want to try and do school as well, and I have caring responsibilities, being able to access a support during that time is near impossible.

The current service gaps for us would be just that acknowledgement of comprehensive care that a young carer needs, the acknowledgement of young carers and access outside normal hours being a gap but also the need for young carers to be connected into the caring system as well. If they are presenting in a mental health service, they need to be referred to Carers ACT or CYCLOPS or those sorts of services so that we can actually support them in their caring role as well, in order to enhance their mental health.

MRS KIKKERT: What else can the ACT government do to support our young carers?

Ms Kelly: I think that the ACT government is a great supporter of young carers, actually. I think that it is a group of people that are really well recognised and really well identified and supported to a large degree. Even during recent experiences with COVID, I was contacted and asked about young carers' experiences with COVID. I think that the government has done a great job in recognising and supporting our young carers. That said, I think that money is always going to be something that is an endless need without an endless pit. I think that we need to still acknowledge that young carers are having really poor education outcomes.

MRS KIKKERT: How do we continue to support young carers to value education and be able to connect and engage in that?

Ms Kelly: I think that we need some case management support for young carers. I think that the world has become a really complex place. Having to navigate the NDIS, My Aged Care, who does what, how does that interface, what is the interface with Health, who is paying for what, and doing it when you have no power or control, is another problem.

MRS KIKKERT: What happens to a young carer whose parent refuses to engage with the NDIS and for whom all the service provision has now ended?

Ms Kelly: The young person does not have a legal right to apply for or advocate for or on behalf of that person. Carers should have an adult who can act as the navigator in that space, who can ensure that the family has access to all the supports that they need in order to not take the role away from the young person but to support that young carer role and support them to continue to engage with friends and schools as a way of reducing the vulnerability they have both now and in the future.

THE CHAIR: What challenges do young carers face when trying to assist others in seeking mental health services?

Ms Kelly: That is an interesting question. I think that young carers tend to be the carrier of their friends. There is something about being a carer that means that sometimes you are the person that is carrying everyone. I think the barriers that young people talk about in terms of mental health services are that they are scary places. Admitting that there is something wrong is scary. I think it is the nature of adolescence that to admit that maybe I am different to everybody else is just a scary thing in itself. I think that the challenges young carers face when assisting others would be the same as any young person would face in trying to help their friends seek support.

How do I do that in a way that is meaningful? I think that it is really hard. A young person wants to be able to go, "All right, I am going to have help now," and walk into the service and have it available right this second. It is not often how a service system works, though. Sorry, that is a really vague answer to that question. I am not sure that I actually have an answer to it that would be any different to the challenges that young people face generally, rather than those that young carers face. I am happy to take a subsequent question if I have not answered that well enough for you.

MS LEE: What are the greatest challenges or barriers for carers of young people experiencing mental health concerns?

Ms Kelly: I think that one is a really big one. Let us call them a parent, for the case of clarity. I think that at that point they still see themselves as parents predominantly. When a parent is facing a young person or a child that is having a mental health concern, it is probably one of the scariest and most worrying and helpless times that they will face as a parent; and yet, it is often one that they do isolated and alone.

Carers will often say, "If my child had been diagnosed with cancer, there would be this community and family support system that would be activated." Often, carers will tell me things like, "I am not allowed to talk to you because I am not allowed to tell anybody that my child has a mental health condition." They do it in secret.

We had lots of interesting times during COVID; for example, where carers had not been able to seek support because their child did not know that they were seeking support from us because they cannot identity as a carer, because the child will not identify as somebody with a mental health condition.

One of the greatest challenges, I think, is the isolation that carers and parents face. It is the sense of helplessness, which is what I hear most in their story. "I want to fix this and I do not know how to." "I am watching my child in pain and I do not know how to take that pain away or make it any better."

One of the things that I have often argued for is that we have a system where the young person comes and spends an hour a week with the psychologist and they talk about their issues and they are given some tips and strategies and off they go. And no-one actually then helps the parent learn the same tips and the same strategies. Yet the parent has 7,000 hours with the child a week.

How do we help carers feel more equipped in their role by engaging them in the therapeutic responses that are working for their child, to reduce that sense of helplessness that they can sometimes feel? I also think that the challenge—and I will just add this while I wait for the next question to pop up—is that it is really hard because we want to talk to carers at that point, because it is early in their journey. We want to be able to instil hope. We want to be able to work through the grief that is often occurring for carers at that point too.

We do not want to expose them to carers that have been long in their journey, because that is really challenging as well. I am given this diagnosis at 20, 21, 22, 23 and I am now looking at this lifelong journey. How do I come to terms with that as well? That is really challenging, I think, talking to people who have been down that path already.

Thank you for having me. I hope that was useful. Good luck with the inquiry.

THE CHAIR: Thank you. That concludes today's third public hearing into youth mental health in the ACT.

The committee adjourned at 11.35 am.