Inquiry into Youth Mental Health in ACT

A submission to the:
Standing Committee on Education, Employment and Youth Affairs

Prepared by:
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Introduction

yourtown greatly welcomes the Standing Committee on Education, Employment and Youth Affairs inquiry into 'Youth Mental Health in ACT'. We are greatly encouraged to see the Committee specifically identify the mental health of children and young people as a key area of policy focus. Given the nature of our work, and the number of children and young people we work and have worked with, we have significant insight in relation to young people and their mental health to share with the Committee.

Half of all lifetime mental illnesses develop before the age of 14,[1] and 75% of all mental health problems first appear before young people reach 25 years old.[2] In fact, mental ill health is the top health issue facing young people worldwide.[3] In Australia, one in seven students aged 4-17 years have experienced a mental disorder in the previous 12 months,[4] 1 in 10 adolescents have engaged in self-harming,[5] whilst suicide is the leading cause of death of children and young people.[6] Furthermore, the prevalence of mental ill health amongst this cohort is rising across a number of different indicators.

Although highly susceptible to mental health issues and a key at risk group, young brains are also highly malleable and responsive to treatment and learning new skills. There is therefore significant opportunity to prevent and reduce the escalation of mental health issues and the considerable, detrimental, social and economic effects that they have on individuals over the life course, as well as on their families and communities, by targeting children and young people with effective policies and interventions.

Yet we know that the current mental health system is complex, somewhat uncoordinated and difficult to navigate and predominantly tailored to meet the needs of adults. Where face-to-face services do exist for children and young people with mild to moderate mental health issues, all have long waiting lists. Few services are for children and young people with complex mental health needs, whilst conversely, many children and young people are screened out of available services on the basis that they do not meet service eligibility criteria as their needs are not severe enough. Furthermore, there are no specific services for children under 12 and very few in rural and remote areas. We see the detrimental effects of this service gap and unmet need every day in our work with clients of all ages and development accessing our services.

For example, in 2019, 68 per cent (49, 359 contacts) of all counselling sessions to Kids Helpline (KHL) related to concerns about mental health, emotional wellbeing, self-harm and suicide. Moreover, since 2012, mental health concerns have increased by 16% over this time, and suicide concerns by 19%. Indeed, recognition of considerable unmet need amongst children and young people led to

[1] Kessler, RC, Berglund, P, Demler, O, et al. Archive of General Psychiatry (2005), 62 (6). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication.
[2] Australian Institute of Health and Welfare (2014). Australia's Health 2014. Canberra: (Cat. no. AUS 178).
[3] Global Burden of Disease Study (2017) as cited by the Victorian Auditor-General's Office in: https://www.audit.vic.gov.au/report/child-and-youth-mental-health?section=
[4] The Australian Child and Adolescent Survey of Mental Health and Wellbeing (2013-14): https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies
[5] Lawrence, D. et al (2015) The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra.
[6] Australian Bureau of Statistics (ABS) data on Causes of Death, Australia, 2017.

the development of KHL's complex and multifaceted role in the mental health system providing a 24/7 safety net, prevention, assessment and specialist referral services.

Furthermore, the range of services we deliver with vulnerable communities has highlighted the relationship that disadvantage, and particularly intergenerational disadvantage, such as homelessness, disengagement from school, unemployment, domestic and family violence, child abuse and other trauma has on the mental health outcomes of children and young people. Through our work to reengage children with school, help find young people a job or with young parents with young children, we see firsthand how disadvantage detrimentally affects the mental health of children and young people at key life stages throughout their early childhood, adolescence and young adulthood.

Critically, however, whilst we see the detrimental outcomes of a mental health system and broader society ill-equipped to support good mental health amongst children and young people, our work shows that there is much that can be done to address gaps and reverse the effects of disadvantage.

In our submission, we identify some of the key areas on which we believe the ACT should focus if we are to effectively support the mental health needs of children and young people, and help prevent and reduce the unmet and escalating mental health needs over the life course. These areas include:

- Investing in mental health services for children and young people, including for those children under 12 years old and services such as digital health resources and telephone counselling that help overcome access barriers to support
- Identifying and seeking to address the broader root causes and factors that exacerbate mental health issues, and particularly those factors related to intergenerational disadvantage and trauma
- Meeting the holistic needs of children and young people through assessing and monitoring them at key points in their life including preschool and at transition between primary and high school, to employment and to parenthood
- Early mental health service intervention and prevention that apply whole family, trauma-informed and whole of government approaches
- Developing a specific, youth focused national strategy to prevent suicide, which is underpinned by the views and voices of young people and education campaigns and strategies that are co-designed with children and young people
- Mental health and broader service support for young people at risk of or disengaging from school
- Mental health support embedded within services for unemployed young people

Finally, these areas of reform must be supported by long-term, political and policy commitment to sustained and appropriate levels of funding and to maintain momentum and focus. Without this commitment, the ACT is unlikely to ever make significant progress in changing the lives of our most vulnerable children, families and their future generations and, therefore, in supporting their good mental health.

yourtown services

yourtown is a national organisation and registered charity that aims to tackle the issues affecting the lives of children and young people. Established in 1961, **yourtown's** mission is to enable young people, especially those who are marginalised and without voice, to improve their life outcomes.

yourtown provides a range of face-to-face and virtual services to children, young people and families seeking support. These services include:

- Kids Helpline, a national 24/7 telephone and on-line counselling and support service for 5 to 25 year olds with special capacity for young people with mental health issues
- Employment and educational programs and social enterprises, which support young people to re-engage with education and/or employment, including programs for youthful offenders and Aboriginal and Torres Strait Islander specific services
- Accommodation responses to young parents with children who are at risk and to women and children seeking refuge from domestic and family violence
- Young Parent Programs offering case work, individual and group work support and child development programs for young parents and their children
- Parentline, a telephone and online counselling and support service for parents and carers'
- Mental health service/s for children aged 0-11 years old, and their families, with moderate mental health needs
- Expressive Therapy interventions for young children and infants who have experienced trauma and abuse or been exposed to violence.

Kids Helpline

Kids Helpline (KHL) is Australia's only national 24/7, confidential support and counselling service specifically for children and young people aged 5 to 25 years. It offers counselling support via telephone, email and via real time webchat. In addition, the Kids Helpline website provides a range of tailored self-help resources. Kids Helpline is staffed by a paid professional workforce, with all counsellors holding a tertiary qualification.

Since March 1991, children and young people have been contacting Kids Helpline about a diverse group of issues ranging from everyday topics such as family, friends and school to more serious issues of child abuse, bullying, mental health issues, drug and alcohol use, self-injury and suicide.

In 2019, Kids Helpline counsellors responded to nearly 150,000 contacts from children and young people across the nation, with an additional 1,414591 unique visitors accessing online support resources from the website. During 2018, Kids Helpline made its 8 millionth contact response.

yourtown submission

In our submission, we work consecutively through the Committee's areas of inquiry and provide feedback where relevant.

I. Mental health challenges and needs of young people in the ACT across the full spectrum from mental distress to enduring psychiatric illness

In this section, we set out our insights in terms of the service needs and mental health issues we know children and young people have in the ACT who access Kids Helpline in particular, as well as how the complex disadvantage that confronts our clients intersects with mental ill health, both causing and compounding it.

Frontline insights into early mental health and system gaps for children and young people

- **Role of Kids Helpline in the ACT**

Although not funded by the ACT government, Kids Helpline (KHL) plays important and distinct roles in its mental health infrastructure (for more information see Appendix I: Key ACT Insights 2019 and Appendix II: KHL role in the ACT mental health infrastructure), and the ACT Government promotes KHL and refers young people to it for mental health support.[7] Delivered by tertiary qualified and youth specialist counsellors 24/7, KHL performs both generalist and specialist roles. It:

- **performs a preventative role** in motivating children and young people to talk about issues early given they can call KHL 'any time, any reason', and therefore, about issues that intersect with their mental health (e.g. bullying, family violence, child abuse). It thereby promotes wellbeing, encourages help-seeking and facilitates early referral to intervention supports.
- **acts as a 'front door'** for children and young people in need of mental health support, which they can easily access as it is free and provided in three different modes (phone, webchat and email) and helps them to navigate the system by sign-posting and referring them to community services (e.g. headspace, GPs and emergency) as well as additional KHL services (e.g. digital health resources, the Niggle app and KHL Circles – for more on these see our response to V. Identifying and responding to young people with mental health and addiction challenges).
- enables children and young people with **emerging or undiagnosed mental health needs 'soft entry' into the mental health system** so that clients can anonymously talk to a counsellor in a less confronting and more comfortable way and even test the service by calling about any random issue or 'their friend', thereby psycho-educating them and preparing them to access formal services.
- **provides a safety** net to those children and young people with diagnosed mental health needs who are unable to access mental health support after hours, due to long waiting lists or given the lack of services available to them and ensures they do not slip through

[7] https://www.health.act.gov.au/news/child-and-youth-mental-health

the system cracks by 'holding' them until they are able to access services in the community;

- **case manages children and young people with complex diagnosed mental health needs**, which includes undertaking assessments, case planning, safety planning, goal-setting, undertaking case reviews, coordinating support services around them, referring them to other services, as well as organising and participating in multidisciplinary case teleconferences (with GPs, psychiatrists and psychologists).

It is through providing KHL support and a wide range of specialist youth support services to children and young people across the nation (for more info see section above on **yourtown** services), that we see the widespread detrimental effects of mental illness on their lives and life outcomes as well as the challenges and barriers to them accessing the services they need.

- **ACT Kids Helpline data**

In 2019, 30% (486 contacts) of all counselling sessions (1,604 contacts) known to be from the ACT to KHL related to concerns about mental health, whilst suicide and self-harm concerns in the ACT have remained relatively stable at around 13% and 7% of all ACT counselling contacts. Interestingly, a significantly greater percentage of ACT contacts to KHL are from boys and young men than the rest of the country (37% of ACT contacts are male, compared to 21% nationally).

Furthermore, we know that there is much unmet need since resourcing constraints (lack of funding) prevents Kids Helpline from responding to all contacts from children and young people, with around 48% of contacts going unanswered in ACT – some 3,038 contacts. We further explore reasons for unmet mental health needs in ACT in section II.

On the following pages are some case studies of the types of issues clients present to KHL with (note all names have been changed), which demonstrate the nature, seriousness and complexity of the mental health issues that some children and young people must overcome as well as some of the challenges that confront young people when they try to seek support through face-to-face mental health services.

Case managing complex mental health diagnoses: Jenny, 19 years old, metropolitan area

Jenny has been diagnosed with autism, anxiety, PTSD, persistent depressive disorder, binging and purging and borderline personality disorder. She has reported chronic suicidal ideation, and planning and urges to overdose since she was a teenager. Jenny experienced sexual abuse over 3 years when aged between 7 to 10 years old.

Jenny has been contacting KHL for over a year now. Having been in the mental health system since she was a teenager, she has recently transferred to the adult mental health system. She first called KHL in crisis after finding out about her transfer to adult mental health services. She was scared of the transition and her friends and other people had told her some concerning stories about their own experiences in the adult mental health system.

Jenny has reported she is dissatisfied with the mental health system and has noted inaccuracies in their record keeping, denial of her experiences of inpatient emotional abuse and neglect, use of restrictive practices and lack of communication between departments.

Jenny is being case managed by a KHL counsellor and a wraparound integrated support strategy is in place with her mental health case manager and psychologist. She contacts Kids Helpline mainly; in crisis for support to manage her mental health symptoms, suicidal ideation and urges to overdose; to talk through experiences of dissatisfaction with her mental health services; to seek support to contact emergency services due to intentions to act on her suicidal urges and to talk through other stressors.

Jenny has a detailed crisis management plan that she has created in collaboration with her regular counsellor at Kids Helpline. All staff are able to access her file and follow the crisis plan when she connects with the service. Jenny has agreed to contact KHL on a weekly basis and now contacts the same counsellor around the same time each week for a counselling call. She recently noticed that she has not contacted Kids Helpline for crisis support since this weekly call. She also recently commented that she is always given the time and space to talk through what she needs to discuss when she connects within the Kids Helpline service.

Preventing suicide: Lucy, 25 year old, metropolitan area

Lucy first contacted Kids Helpline when she was 20 years old. At that time, she was experiencing suicidal thoughts and was seeking support to manage them.

From then on, Lucy made contact with KHL when she was feeling especially vulnerable, including times where she had made plans to end her life and times where she was at immediate risk of acting on suicidal thoughts.

Through ongoing counselling contacts with the same KHL counsellor, Lucy was able to articulate her challenges, needs, and goals, whilst sharing information about her support network. In particular, Lucy discussed her goal of coping with anxiety so that she could progress with her social, academic and employment goals. Her anxiety had developed from negative experiences early in her life, which left her with low self-esteem.

On one occasion when Lucy connected with her regular KHL counsellor, she was extremely distressed and said she was going to end her life and was at a location of significant risk to her life. Lucy sounded ambivalent about her decision to end her life

Her counsellor engaged in a collaborative risk assessment and safety plan with her, whereby they gently explored the options that may be available to her to make her environment safe. At the same time, a shift supervisor was alerted and listened in to the call to provide support and guidance to the counsellor. Lucy and her counsellor worked together to the point where she was able to get to a safe place physically. They then established a stabilisation plan together to help Lucy cope with her psychological distress.

The outcome of this intervention was that through using a client-centred, collaborative and strengths-based approach with Lucy, she was able to remain safe from suicide. As a result, Lucy continued to engage in further counselling with her regular counsellor, with whom she had developed significant trust and rapport, with evidently reduced suicidal ideation in the following months.

Providing a safety net: Emily, 22 years old, regional area

Emily is a young Aboriginal woman who has been in contact with KHL on and off since she was 16 years old. Her current mental health diagnoses are depression, anxiety, and PTSD. In addition to her mental health issues, she regularly experiences the emotional effects of ongoing intergenerational trauma in her community, as well as mental health, drug and alcohol and child protection issues in her immediate and extended family networks.

Emily seeks support from KHL for emotional stress and what she describes as enduring suicidal thoughts that seem to have no trigger and come and go on their own, but are linked with the legacy of experiences of complex psychological abuse in her family and past sexual assault.

KHL counsellors have provided ongoing continuity and stability of support, with Emily working with three different regular counsellors for 1-2 years each. Emily has required crisis support, whereby her counsellor has collaborated with her to manage her safety, including working with emergency services after she has overdosed.

Sometimes, Emily connects with KHL a few times a week, sometimes weekly and sometimes every few months. She has consented to KHL coordinating regular wrap around care with her GP, psychologist and psychiatrist to manage risk and to prevent stockpiling of medications.

Emily has reported that she benefits greatly from her sessions with her KHL counsellor and from building trust from talking with the same counsellor. Since first contacting KHL, she has completed school, a university degree, has got engaged and has a full-time job that she loves. Emily has said KHL has been part of what has kept her alive.

- **Intersection between disadvantage and mental health**

If left unaddressed, mental health issues can detrimentally affect children and young people's life outcomes, as evidenced in lower educational attainment, poorer engagement with study and school and higher drop-out rates.[8] Indeed, we see the significant impact and prevalence of mental health issues in our work with students to reengage them at school, as well as the effects that continuing mental ill-health has on their lives when transitioning to find work (for more on this see our responses to VII and IX).

Through our work, we also observe how social and economic factors contribute to mental ill-health. With the cohorts of children and young people with whom we work, we see how the social determinants of health, and in particular, how deep and persistent disadvantage – consisting of a combination of issues such as homelessness, parental unemployment, drug and alcohol abuse, interaction with the justice system, domestic and family violence, child abuse, colonialism and other trauma – causes, contributes to and/or compounds this ill health. There is also significant research that demonstrates that racism is responsible for poorer physical and mental health among Aboriginal Australians, with racism experienced in the health sector additionally, detrimentally affecting future health-seeking behaviour as well as contributing to further negative psychological

[8] Australian Government Productivity Commission (2019) The Social and Economic Benefits of Improving Mental Health – Issues paper: https://www.pc.gov.au/inquiries/current/mental-health/issues

effects itself.[9] This is in keeping with wider research showing higher prevalence of mental ill-health in disadvantaged communities, [10] and for example, mental health issues being widespread in cohorts of children and young people in out-of-home-care and who have left out-of-home-care.[11]

Furthermore, in working with young children and their families, we are aware of how poverty is correlated with poorer developmental outcomes for children. The Australian Early Development Census (AEDC) shows that significant, poorer child developmental outcomes for disadvantaged communities are notable from the first year of school.[12] These developmental vulnerabilities include physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, communication skills and general knowledge – all factors that can affect the ability of students to engage with and succeed at school, and with peers. These vulnerabilities and the challenges that they present to children trying to make their way through school have an inevitable toll on their mental health, rendering school an anxious and stressful environment as they struggle to fit in, communicate and relate to their peers, teachers, school work and life. At their most extreme, these vulnerabilities can lead to the development of mental health conditions and/or disengagement from school completely, affecting a range of long-term life outcomes thereon.

A further issue impacting youth people's wellbeing is unemployment. The youth unemployment rate has historically been higher than the overall unemployment rate and this remains the case today standing at 8.8% in January 2020, compared with 3.2% for all persons in the ACT and, in our experience as a youth specialist employment services provider, is a driver of mental illness.[13] What's more, increasing numbers of young people are experiencing long-term unemployment. A tragic start to a young life and a factor we recognise as a barrier to finding work itself, long-term unemployment occurs disproportionately among young people who comprise 16% of the total population, but 26.1% of long-term unemployed people.[14]

Hence, we encourage this inquiry and the ACT government to view the mental health challenges and needs of children and young people in their broadest sense (like the Productivity Commission has recently done), and consider how to address the broader root causes and compounding factors of mental illness and not simply provide reactive and acute services designed to manage mental health issues.

Recommendation 1: That the inquiry identify, explore and set out to address the social determinants of mental health issues amongst children and young people, with a particular focus on the impact of, and response to, intergenerational disadvantage.

II. Ready access to mental health support and services by young people

While many services currently provide appropriate care for children and young people (such as headspace) and there are examples of successful interventions to support them with a range of

[9] E.g. Kelaher, M., Ferdinand, A.S. and Paradies, Y. (2014) Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. Medical Journal of Australian; 201 (1): 44-47.
[10] As cited in: https://www.theguardian.com/australia-news/2015/mar/01/large-gap-between-rich-and-poor-areas-in-use-of-mental-health-services-revealed
[11] AIHW (Australian Institute of Health and Welfare) (2018) Child protection Australia 2016-17, Cat. no. CWS 63, Child welfare, Canberra.
[12] https://www.aedc.gov.au/
[13] ABS data on Labour Force, Australia, January 2020
[14] Australian Government (2018) The next generation of employment services. Discussion paper. Appendix G, 108

different conditions (e.g. cognitive or dialectical behaviour therapy), there are simply not sufficient services.

In 2015, it was found that 14% of 4-17 year olds had a diagnosable mental illness and only half of those had accessed services in the previous year.[15] At KHL, approximately 5% of our ongoing contacts are from the 'missing middle', children and young people whose needs are too high to be eligible to receive appropriate community service support and too low to be eligible for acute care.

Through working with children and young people in need of mental health support via KHL and through providing specific mental health and therapeutic services in some states,[16] we know that mental health services for children and young people typically:

- **have long-waiting lists** and, as a result, risk missing an optimal time to engage with a client who has reached out for help, as well as an opportunity to prevent and effectively manage needs before they escalate.
- **provide inadequate access** to counselling sessions funded through Medicare as:
    - Under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative, Medicare rebates are available for patients with a mental disorder to receive up to ten individual and up to ten group allied mental health services per calendar year. However, evidence suggests that ten sessions is inadequate for anyone with more than mild depression or anxiety.[17] This has significant implications as incomplete treatment for psychiatric disorders may result in deterioration.[18]
    - For children and young people who do not want to talk to their parents about their mental health issues, being listed on their family's Medicare card prevents them from accessing support through their GP.
- **are cost prohibitive** – Better Access is only subsidised with some people finding the gap they must pay unaffordable whilst, in addition, where waiting lists are too long for patients to access publically-funded services then many people also find private services to be unaffordable.
- **have exclusionary eligibility criteria**:
    - The specialist services for children and young people of which we are aware exclude under 12s, being accessible to over 12s only (see below on this below). However, Kids Helpline data from 2018 revealed that 29% of all contacts about suicide were from people aged between 10 and 14.
    - There is a 'missing middle' whereby the needs of children and young people are either not severe enough or are too severe to be eligible for service support and hence young people with moderate and severe needs must often wait until their needs escalate to crisis before they meet eligibility criteria.
- **do not** have the capability to **respond to complex needs or to manage crises situations,** including post-crisis.

[15] Lawrence, D., Johnson, S., Hafekost J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., & Zubrick, S.R. (2015) The Mental Health of Children and Adolescents. Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra

[16] Examples of specific mental health and therapeutic services we deliver in some states include Starfish and expressive therapy, as well as employment, education engagement, youth justice, and holistic family services and accommodation for young parents and women experiencing family violence.

[17] https://www.abc.net.au/news/health/2019-04-01/mental-healthcare-needs-major-re-think-experts-say/10957812

[18] National Mental Health Commission (2014) Report of the National Review of Mental Health Programmes and Services. Volume 2. Sydney: NMHC.

- **are inaccessible**, as, for example, they are face-to-face services. Face-to-face services can be extremely hard to engage with in close-knit communities due to fears of young people that their contact with these services will become known in the community with resulting risk of stigma and the fear of being judged by people in the community (see more on the barrier of stigma below).

We know that, compounding these access issues, many parents do not seek support for younger children experiencing mental ill-health as they believe that their child will 'grow out' of their mental health problems meaning that most children and young people only access services when their needs are critical or their symptoms externalised.[19] In light of this, it is not surprising that over recent years there has been significant increases in mental health presentations to emergency departments of patients aged 19 years and under.[20]

We also know that the inverse care law means that children and young people from disadvantaged backgrounds are less likely to be able to receive the care and support that they need. With regards to mental health care specifically, Monash University researchers have demonstrated that the most highly qualified mental health staff (psychiatrists and clinical psychologists) were used up to three times as much by people in wealthier areas compared to those in the most disadvantaged areas. [21] A key reason for this was that practitioners simply do not practice in the most disadvantaged areas, despite them having higher rates of mental illness.

Furthermore, the traditional approach to mental health has been siloed in that it has not understood or accommodated the social determinants of health or how mental health intersects with other factors such as intergenerational disadvantage - including homelessness, disengagement from school, unemployment, domestic and family violence, interaction with the justice system, child abuse, being in out-of-home-care and other trauma – and the impact it has on the mental health outcomes of children and young people.

Such an approach is unable to effectively prevent and reduce mental health illness as it focuses on tackling illness when symptoms arise and does nothing to tackle its inherent causes. Instead, the range of causes and implications for and of poor mental health in terms of how other issues intersect with it must be fully understood by government and the community. There should be no wrong door to accessing support and mental ill-health should be effectively identified and supported no matter where people come into contact with key government services including education, employment, housing, domestic violence and other welfare support.

This lack of appropriate services and sufficient resources for children and young people points to a lack of community understanding about the importance and potential of preventing and managing mental ill-health early and the notable gaps in and underfunding of services must be addressed.

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[19] Lawrence, D., Johnson, S., Hafekost J., Boterhoven De Haan, K., Sawyer, M., Ainley, J., & Zubrick, S.R. (2015) The Mental Health of Children and Adolescents. Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing, Department of Health, Canberra

[20] https://www.abc.net.au/news/health/2018-05-07/youth-mental-health-emergency-departments/9728918

[21] As cited in: https://www.theguardian.com/australia-news/2015/mar/01/large-gap-between-rich-and-poor-areas-in-use-of-mental-health-services-revealed

Recommendation 2: Invest in existing service infrastructure such as headspace, KHL and other evidence-based interventions so children and young people can access support to effectively manage and treat conditions. Mental health services for children and young people must:

- accommodate their age and developmental needs
- be accessible, using channels in which they feel comfortable (e.g. digital services, outreach or within school)
- be freely available
- support mild, moderate, severe and complex needs
- ensure timely support to high risk groups of young people concerning suicidality
- be more accessible to support them at times of crisis.

Recommendation 3: The ACT Government should invest in the design of mental health responses to meet the specific needs of children under 12 years old.

Recommendation 4: The ACT Government should make representations to the Australian Government in relation to reviewing Better Access and the current limit of ten individual sessions so that it is able to support clients with complex mental health needs. In addition, Better Access should be free for those who are found to be unable to pay the gap.

Recommendation 5: Co-design educational resources with children and young people to improve community understanding of how mental health illnesses develop in childhood and adolescence so that children, families and communities are better able to identify, prevent and support mental health concerns early.

Recommendation 6: The ACT Government should investigate how to provide and engage disadvantaged young people with high quality clinical services.

- **The barrier of stigma to accessing mental health services**

Children and young people tell us that they turn to KHL as it helps them to overcome many barriers to access, including stigma and discrimination. Indeed, children and young people can find face-to-face services daunting and intimidating, and fear they will be judged. Indeed, children and young people told us that stigma was the main reason that prevented them from actively seeking help in our research with them about suicidal ideation.[22]

By offering a layer of anonymity through different modes of access, phone, webchat and email, KHL clients feel they can overcome the stigma of reaching out for help in relation to mental health issues. The removal of barriers and the provision of professional support are major contributing factors to increasing contacts to KHL about mental health concerns. Hence, such is the influence of stigma in relation to mental health help-seeking in our communities that even Australia's youngest generations are aware of it and struggle to seek help and/or find ways to reach support undetected by their friends, families and communities.

[22] **yourtown** (2016) Preventing suicide: The Voice of children and young people: https://www.yourtown.com.au/sites/default/files/document/2.%20Preventing%20suicide%20by%20children%20and%20young%20people.pdf

National research also shows that stigma and discrimination are factors playing a role in preventing many children and young people with mental illness from accessing the mental health services they need.[23] However, we know that educating children and young people works to overcome barriers to help-seeking. Free Kids Helpline @ School sessions on a range of topics that seek to increase help-seeking and emotional resilience with those who partake in them found students felt more comfortable to seek help post session/s.

Finally, despite mental ill-health accounting for 14.6% of the total disease burden in Australia, in 2016/17 mental health services received only 7.4% of health funding nationally.[24] The level of stigma and discrimination about mental health can be seen in this very fact. Hence, significant investment into services will help to raise the profile of mental health in the community and highlight the importance of good mental health and how it should be seen and discussed no differently from physical ill-health. With more mental health services in our communities, both physical and digital, mental ill-health will be increasingly seen as just another type of illness that can be prevented, managed and cured.

Recommendation 7: Utlilise existing education and community settings to normalise and entrench help-seeking behaviour amongst children, young people and families so they feel encouraged and supported to proactively seek help for mental health issues.

Recommendation 8: Significantly increase investment in tele-web counselling services to increase access for children and young people to receive adequate, age and development-appropriate, and timely early intervention and prevention services to meet their mental health needs.

III. Identifying roles and responsibilities of the family unit in supporting youth facing mental health and addiction challenges, and supporting families in carrying out these roles and responsibilities

Parents and families are notable protective factors against poor mental health and suicide ideation, and can be positive resources to help ensure that children and young people can access the support they need, when they need it. With many of the clients with whom we work affected by intergenerational disadvantage, often their parents and families are unable to help them in this way. Below, we explore this issue and set out best practice approaches to addressing the impacts of intergenerational disadvantage on the mental health of a new generation.

- **Parents and disadvantage**

Parents are not only a child's first teacher, they are also their first caregiver and thereby play a significant role in shaping the person the child will become and the opportunities in life the child will have.[25] Secure attachment with their parent/s in the early years positively impacts on a child's later development and life chances, with insecure attachment negatively affecting educational attainment as well as social and emotional development.

[23] Hiscock, H., Mulraney, M., Efron, D., Freed, G., Coghill, D., Sciberras, E., Warren, H. and Sawyer, M. (2019) Use and predictors of health services among Australian children with mental health problems: A national prospective study. Austraian Journal of Psychology.
[24] AIHW (2019). Expenditure on mental health services. Canberra: AIHW.
[25] Duncan, G. and Murnane, R. e. (2011). Wither Opportunity? Rising Inequality, Schools and Children's Life Chances. New York: Russell Sage Foundation.

Parents who are living in poverty, with mental health problems or are young are more likely to struggle with parenting and attachment. Good parenting can protect children growing up in disadvantaged settings,[26] accentuating the need for early interventions with high-risk families that support parenting attachment and responsive care.[27] Secure attachment helps children thrive by learning to manage their own feelings and behaviour, improving their confidence, resilience and self-reliance. Conversely, the absence of these relationships paired with poverty and related stress, often leaves children emotionally ill-adapted to confront key life milestones, negatively affecting their long-term social, educational, economic and health and wellbeing outcomes.[28]

We see the effects that disadvantage and trauma have on young parents and their ability to parent effectively as we deliver a range of parent programs to young parents with disadvantaged backgrounds across the country. This includes a unique residential family centre (San Miguel in New South Wales) to one of the most vulnerable population groups in our communities: young parents aged 25 years or younger - often single mothers - and their children who are at risk. These young parents have commonly been brought up in out-of-home-care and been affected by: family violence, drug and alcohol dependence and economic hardship.

Again demonstrating the intersection of disadvantage and mental health, these issues have come at a cost to the health and wellbeing of these young parents, meaning that they require significant support to rebuild their self-esteem and address and manage mental ill-health so that they can become more skilled parents and change the course of their children's life so that it is not beset with the same issues.

- **Supporting parents and families: a whole family approach**

In relation to a child's mental health specifically, collaborative approaches with a child's parents have been found to build on and strengthen their role in supporting child and youth mental and emotional wellbeing both at home and within the context of their community.[29] Indeed, we know that there is little point working solely with a child to support their mental health, if they are only to return home to a family environment that has not changed and addressed the many issues that have resulted in the child's poor mental health. Furthermore, parental input is essential to a child gaining access to the services they need, at the very least since parental consent is required to work with children and young people.

The whole family approach, or the two or three generational approach, is widely acknowledged as being critical to disrupting deep and persistent disadvantage and, given the cohort of children and young people with whom we work, is a central element to successfully address a range of issues they face, including mental health.[30] It is an approach we adopt at San Miguel and, given the evidence behind it, we believe that many more services seeking to help children and young people with mental health issues, as well as a range of other complex challenges, must adopt the whole family approach in their work if they are to be effective in the long-term.

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[26] Gutman, L. M. and Feinstein, L. (2010). Parenting behaviours and children's development from infancy to early childhood: changes, continuities and contributions. Early Child Development and Care, 180(4), 535-556.
[27] Moulin, S., Waldfogel, J. and Washbrook, E. (March 2014). Baby Bonds: Parenting, attachment and a secure base for children.
[28] Ibid
[29] Kuhn, E. and Laird, R. (2014). Family support programs and adolescent mental health: review of evidence. Adolescent Health, Medicine and Therapeutics. 5, 127-142.
[30] E.g. The Aspen Institute and the Bernard Leer Foundation (2016) Breaking the cycle of poverty: whole family approach: https://bernardvanleer.org/app/uploads/2016/09/Breaking-_the_Cycle_Framework_AspenAscend_BernardvanLeer.pdf

However, meaningful engagement with parents and/or carers, and especially families living in the most socially disadvantaged communities does come with significant challenges. These include:

- Parents worrying that by asking for help they will be judged negatively and perceived to be struggling.[31]
- Parents who have social anxiety themselves and that do not want to mix with other parents or interact with services or take their children to appointments.
- Service access barriers:
    - Complexity of the system and its lack of coordination makes it hard to navigate
    - Lack of childcare and transport
- Parents struggling with many other personal and family issues causing stress in the home– such as poverty, unemployment, family violence, past trauma or mental health issues – that make seeing their child's mental health as a priority difficult.

Therefore, a whole family approach must consider how to overcome these barriers if intergenerational cycles of disadvantage – and mental health – are to be effectively reduced.

Recommendation 9: Support the holistic needs of the ACT's youngest and most vulnerable children (first 1,000 days) to prevent the effects of trauma and disadvantage from detrimentally affecting the development of foundational life skills, including support for their social and emotional wellbeing.

Recommendation 10: Take a whole family approach to supporting children and young people at risk of poor mental ill-health or showing symptoms of mental illness.

Recommendation 11: Identify and respond to the holistic needs of young parents in disadvantaged communities, particularly parents in the child protection system or at risk of contact with the children protection system, including through providing life skills, housing, employment, transport, trauma and mental health.

Recommendation 12: Acknowledge the significant mental health needs of children in the child protection system and/or those at high risk of entering the system, and develop formal partnerships with providers to meet their specific mental health needs.

[31] Ipsos. (2016). Talking Families Campaign: Detailed Findings and Technical Report: https://www.qfcc.qld.gov.au/talking-families-research-report#Research-report

IV. Prevention and early intervention of mental health and addiction strategies

If we are to be successful in reducing and preventing child and lifelong mental ill-health and its subsequent social and economic implications for individuals, families and communities, the ACT must start by ensuring that every child receives appropriate support in their early years (first 1,000 days) and prior to commencing school. Allowing children to start school already significantly disadvantaged from their peers provides the conditions for mental ill-health to occur and, left unaddressed, the gap between their peers and their own development will continue to grow throughout their young lives.

Therefore, given how vulnerabilities intersect with and compound mental health issues at key foundational development stages, supporting early child development in its broadest sense - including addressing the many areas of disadvantage that a child and their family has in their life - is undoubtedly a critical foundation to developing positive mental health throughout childhood.

Intervention early in life is particularly important for a child's mental health because it is during the transition from childhood to independent adulthood that foundational resources and conditions for a fulfilling and productive future are created.[32] Services need to in place to intervene and treat and manage issues early before they escalate, which means delivering services early to children and young people that are adequately-funded and age and development-appropriate and accessible.

To this end, we support the Productivity Commission's recommendation within its Draft Report on Mental Health on expanding social and emotional early childhood checks to preschool.[33] However, we would like to see the expansion of early childhood checks to preschool fit into a bigger piece of work and model that sees the social and emotional development of children and young people screened at key milestones in their school careers. In doing so, where issues arise – whether they be, for example, trauma-related through family conflict, violence or abuse or related to bullying and their relationships with their peers - children and young people can receive the support they need, when they need it. Screening whole populations in this way will help normalise help-seeking and prevent the stigmatisation of the resulting support children and young people and their families receive.

[32] Purcell, R., Goldstone, S., Moran, J., Albiston, D., Edwards, J., Pennell, K. and McGorry P. (2011). Toward a Twenty-First Century Approach to Youth Mental Health Care. International Journal of mental health. 40(2),72-87.
[33] https://www.pc.gov.au/inquiries/current/mental-health/draft

- **Trauma-informed practice**

Trauma-informed practice should be a core aspect of any service dealing with at risk children and young people. A significant body of research shows that trauma and chronic stress can have long lasting effects on brain development, which can contribute to a range of poorer life outcomes. Experience of trauma and neglect at an early age is associated with poor emotional regulation and impulse control, learning and behavioural difficulties at school, mental health problems, risky behaviour and later offending.[34]

In our experience, in the absence of formal support this negative pathway can be inadvertently strengthened by inappropriate responses from families and schools. For example, a significant proportion of our clients who have youth offending history, for example, advise that they have been 'diagnosed' with Attention Deficit Hyperactivity Disorder (ADHD) yet have never been assessed or consulted by appropriate professional staff. We fear that children displaying problematic behaviour at school are labelled ADHD (without any follow-up care), when in fact a history of untreated, complex trauma is likely to be responsible for their behaviour.

- **A whole of government approach and collaborative working between stakeholders**

The complexity and interdependency of the challenges that confront disadvantaged children and young people means more effective collaboration between all stakeholders is critical. However, whilst this is well known, effective collaboration is extremely difficult to execute in practice owing to a host of intra- and inter-organisational factors such as competing priorities, funding, ways of working and IT and data systems, compounded by the number of stakeholders involved in a child's journey to adulthood.

We suggest that complex problems such as intergenerational disadvantage require more than traditional collaboration, and that the collective impact approach shows the most promise. Collective impact refers to 'long-term commitments by a group of important actors from different sectors to a common agenda for solving a specific social problem'. Collective impact is more than collaboration, with organisations committing to a common agenda, a shared measurement system, mutually reinforcing activities, ongoing communications, and support for an independent backbone organisation with staff dedicated to facilitating collective effort. [35]

The community of schools and services (COSS) model is an example of this approach and underpins the 'Geelong Project' in Victoria.[36] Led by Barwon Child, Youth and Family, this early intervention project is a place-based partnership aimed at preventing young people at risk of disengaging from or leaving school from becoming homeless and entering the justice system.

The three main indicators used to identify the most at-risk students were the 'At-risk of Homelessness Indicator', the 'Disengagement from School Indicator' and the Kessler K10 scale for

[34] Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R.,& Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex Trauma in Children and Adolescents. Psychiatric Annals. 35. 390-398.
[35] Kania, J. & Kramer, M. (2011). Collective impact. Stanford Social Innovation Review, Winter, 36-41
[36] MacKenzie, D. (2018) The Geelong Project Interim Report: https://apo.org.au/sites/default/files/resource-files/2018/02/apo-nid133006-1208531.PDF

psychological distress and mental health issues. Following pilots in three schools, its evaluation has found that: youth homelessness could be reduced by 40 per cent, the risk of school disengagement could be halved and early school leaving could be reduced by more than 20 per cent.

By targeting children and young people with effective policies and interventions, there are significant opportunities to prevent and reduce the escalation of mental health issues and the considerable, detrimental, social and economic effects that they have on individuals over the life course, as well as on their families and communities. Intervention early in life is particularly important for a child's mental health because it is during the transition from childhood to independent adulthood that foundational resources and conditions for a fulfilling and productive future are created.[37] Given that mental health issues can impede education (including attainment and school engagement[38]), employment and relational outcomes, it is critical that more is done to support the mental health of our younger generations to prevent lifelong issues from developing with increasing levels of social exclusion.

Furthermore, although highly susceptible to mental health issues and a key at risk group,[39] young brains are highly malleable and responsive to treatment and learning new skills and there are therefore opportunities to optimise the effectiveness of prevention and effective management of mental illness through targeting this cohort.

In doing so, society would significantly reduce the resources and funds it needs to invest in an individual's life including in welfare, additional education and employment support services and in health care. For example, research has estimated that the costs to some groups of individuals (e.g. children and young people) and to Australian communities of lower participation and productivity in education and employment are around double the level of healthcare expenditure on people with some types of mental illness (e.g. anxiety, affective and substance use disorders), over the life course.[40] Our communities must understand that through openly supporting children and young people with their mental health, considerable social and economic benefits will result for individuals, families and communities alike.

Recommendation 13: Introduce social and emotional childhood checks to preschool, and roll them out throughout a child's school career to provide early identification and the provision of support to the most vulnerable

Recommendation 14: Provide trauma-informed practice training to all gatekeepers of services supporting children and young people.

Recommendation 15: Apply collective impact strategies in communities which have been identified as highly economically and socially disadvantaged that are focused on issues that

[37] Purcell, R. Goldstone, S. Moran, J. Albiston, D. Edwards, J. Pennell, K. and McGorry P. (2011). Toward a Twenty-First Century Approach to Youth Mental Health Care. International Journal of mental health. 40(2),72-87.
[38] E.g. Orygen Youth Health Research (2014) Tell them they're dreaming: Work, Education and Young People with Mental Illness in Australia.
[39] E.g.: Orygen, The National Centre of Excellence in Youth Mental Heath and headspace, National Youth Mental Health Foundation. The submission to the Productivity Commission's Inquiry into Mental Health (April 2019)
[40] E.g. Bloom DE, Cafi ero ET, Jane-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, et al (2011) The global economic burden of non-communicable disease. Geneva: World Economic Forum, Access Economic (2009) The economic impact of youth mental illness and the cost effectiveness of early intervention. Canberra as cited in ibid.

contribute to intergenerational disadvantage, and that facilitate collaborative partnerships between government and services supporting the welfare of children and young people, and their families

Recommendation 16: Develop mental health policy that applies understanding of the long-term economic and social benefits that would arise from a shift towards targeting the mental health of children and young people.

V. Identifying and responding to young people with mental health and addiction challenges

Australian surveys and research asking diverse young people about mental health reveal that many young people with mental health problems tend not to access services.[41] The Child and Adolescent Mental Health survey, for example, reports that overall 246,000 children and adolescents or 44% of those who were assessed as having a mental disorder had not used services in the previous 12 months.[42] Service use was also found to be lower among children and adolescents with mental disorders living in disadvantaged families. Underuse of services also extends to parents and carers with less than a third (27%) of parents and carers using a health service in the past 12 months to help them with their child's or adolescent's problems. Reasons for this include not knowing how and where to access services, cost of services, being scared of being judged and services not being child-friendly.

Therefore, to ensure that KHL and the broader range of support services that we provide appeal to children and young people, accommodate their needs and are easily accessible, we undertake research into the use of technology in our service provision in a bid to provide support in the digital world they access daily and in which they feel comfortable. Given that children and young people readily engage with technology and new innovations in this space, we see that technological innovation presents significant opportunities to; address KHL and wider system service gaps; overcome access barriers (e.g. by providing easily accessible, early intervention resources) as well as; complement our existing and external programs to which we refer our clients.

The most current research in the area of delivering online interventions for youth mental health has demonstrated that Australian youth, aged 13-25, are more likely to engage with mental health information and services via online technologies, especially if the technologies are interactive, user friendly, supportive and provide a level of privacy control for youth.[43] Research has also shown that digital health resources are effective for young people with low to moderate mental health concerns.[44] Indeed, KHL clients are showing an increasing preference to engage with the service

[41] Bassilios et al. (2017). Complementary primary mental health programs for young people in Australia: Access to Allied Psychological Services (ATAPS) and headspace and Westerman, T. (2010). Engaging Australian Aboriginal youth in mental health services. Australian Psychologist, 45(3), 212-222.
[42] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer and M. Ainley, J. (2015). The mental health of children and adolescents: report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra: Department of Health.
[43] For example, Campbell, A., & Robards, F. (2013). Using technologies safely and effectively to promote young people's wellbeing: A better practice guide for services. Abbotsford, Victoria, Australia: Young and Well Cooperative Research Centre.
[44] O'Connor, M., Munnelly, A., Whelan, R., & McHugh, L. (2017). The Efficacy and Acceptability of Third-Wave Behavioral and Cognitive eHealth Treatments: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. Behavior therapy.

through webchat, whilst in 2018 we had 20,620 hits made by ACT visitors to our KHL online resources and tip sheets.

We strongly urge the Committee, therefore, to consider and promote the importance of digital resources in preventing, reducing and managing mental health issues amongst children and younger people. As younger generations grow, digital resources will of course have more popularity and be of use to all ages of society.

In recent years, we have undertaken two significant collaborative research projects into new interventions of this nature to support children and young people experiencing mental health issues. Below, we provide overviews of these projects – Niggle and Circles - and, given their modality, we believe they will be of particular interest and help to children and young people.

Niggle: the first interactive and integrated help-seeking app

In 2013, 89% of young Australians owned a smartphone and 83% downloaded an app in that year's first quarter. The seeming omnipresence of mobile phones in the lives of children and young people today is often seen as a contemporary cause for concern. However, rather than focus on the potential detrimental impacts of mobile phone use, we identified an organisational responsibility to find a way to turn high mobile phone use into a positive by developing ways to connect children and young people with our services. To this end, with our partners at the Queensland University of Technology and the University of Queensland, we have developed and are testing a first in e-mental health design: Niggle, a new model of an integrated mental health service that links a mobile interactive toolkit for self-directed help-seeking with KHL's more traditional modalities.

With little known about the impact of self-help resources on young people's wellbeing (e.g. our online self-help resources) or how these self-directed resources interact with current counselling modes, this pilot seeks to address the following specific questions:

- How might the wellbeing of young people be advanced in the light of new information and communication technologies (ICTs), digital literacies and multi-platform internet delivery capacities?
- What forms of networked and digital interactivity are successful in engaging young people in direct help-seeking online?
- How might participatory design of the toolkit contribute to an increase in young people's engagement with existing and future online mental health services?
- How can traditional counselling practices and text-based health communication resources, migrate and be integrated successfully into a graphical multi-platform environment?
- What is the impact of a mobile-based interactive toolkit on young people's wellbeing and engagement in online help-seeking?

The project uses an overarching participatory design methodology with end users, incorporating workshops, agile design and prototyping as well as online surveys and Google Analytics for both scoping and evaluation. We are also providing evaluation analytics to service

providers to monitor Niggle's uptake. We have ensured that the voice of young service users is key throughout the life of the project so that their views, needs and preferences inform the design of the new cross-platform interactive toolkit.

The hope is that the toolkit will provide increased agency and control to service users with respect to their wellbeing and access to appropriate support and findings so far point to reductions in suicide risk and depression in those clients who are using it. The app will be released in September 2019 and could be provided to the ACT Government to complement existing digital health services.

Circles: a new approach to online group counselling and peer support

yourtown has partnered with FGX (Future Generation Fund) and the University of Sydney to create a world-first: Circles, a social media platform in the support and treatment of young people with mental health issues, from early stage to crisis.

Following a pilot and testing phase, Circles has been developed as a social network to provide peer-to-peer group support and counselling for 13-25 year olds, in order to provide national long-term support of mental health problems. Purpose built, it is a mental health social network that is safe, free and private, and that delivers counselling 24/7 support to young people.

Once fully evaluated, the expected outcomes and benefits of Circles are to attract any young person from anywhere in the country, with any mental health concern, to a combined professionally trained counsellor+peer support group available through smart phone or computer at any time, in order to tackle and reduce the long-term national burden of chronic mental health problems. Through accessing both formal support, that they may find difficult to access in their communities, and the support of their peers who are experiencing similar issues to them, we see that Circles could have significant benefits for children and young people in rural and remote communities.

Circles is unlike any other online mental health intervention in that it contains the features of all popular social media tools (e.g. posting of videos, pictures, music, social networking games and chat functions), but without the inherent privacy and confidentiality risks of other generic social media platforms, which are understood to deter children and young people from using them. It provides professional, group counselling services anonymously within the Circles social network, at any time, whilst vigilantly monitoring discussion boards to ensure peer exchanges and engagement are positive. Circles provides the added attraction of remaining anonymous online and to the peer support group, thereby overcoming any stigma attached to accessing support. At the same time, every client is asked to sign up with an individual counsellor who knows their details to optimise their safety and wellbeing throughout their interaction with Circles.

Although we are awaiting the full evaluation results of Circles, to date, the views and experiences of children and young people accessing it have been positive. The latest evaluation data of Circles showed that there were reductions in mental health symptoms in clients with moderate

to severe mental health needs including in depression (by 42%), anxiety (by 37%) and stress (by 62%). In addition, we have received the following feedback about their experiences of Circles from young people presenting with suicide ideation on a daily basis and we will gather further evidence about whether and how Circles can be used to effectively provide support to high risk groups as the service develops:

> *Having a group of similarly aged people who are going through similar struggles as myself - having them there for me, along with the counsellors to talk to and console really was invaluable. I will miss this, and it gave me much more of a reason to not kill myself, through checking in with everyone at least once each week.*
>
> *This was a brilliant service. It was so wonderful to be anonymously connected to other people whom I could reach out to for support, and comfort. I felt safe, and needed. I haven't felt like that in a while.*
>
> *There are so many major benefits to Circles, so many youth just like me need this life-changing service.*

Recommendation 17: The ACT government should map existing digital health resources and those in development, and partner with universities and non-government organisations to develop an overall strategy to coordinate, foster and increase investment into the development of digital health resources.

VI. Youth suicide prevention and support for those close to someone who has taken their own life

Suicide is the leading cause of death of children and young people in Australia, accounting for more deaths than motor vehicle accidents. In the five years between 2013 and 2017, 97 children aged 0-14 years, 726 adolescents aged 15-19 years, and 1,208 young people aged 20-24 years died by suicide.[45] These figures are even more concerning given evidence that suicide is underreported. Worryingly, suicide rates for children and young people have increased over the past 10 years in Australia,[46] and it is one of the top reasons children and young people from the ACT contact Kids Helpline to seek advice, with 14% of all KHL counselling contacts being suicide-related in 2019, up from 12% in 2012.[47]

Every young life lost to suicide is one too many; a tragedy not only for the young person concerned but also for their families, friends, and communities causing long-lasting grief and guilt. Yet, despite the need for further research, we know that communities can prevent suicide. Hence, **yourtown** has prioritised youth suicide prevention as a key advocacy priority.

[45] Australian Bureau of Statistics (ABS) data on Causes of Death, Australia, 2017.
[46] Ibid
[47] Ibid

To this end, we have; undertaken research with children and young people about their needs experiences; become a member of the Policy Committee of Suicide Prevention Australia; developed specific age-appropriate comics to help children seek help who are affected by this issue;[48] and developed and disseminated a position statement setting out our recommendations for policy and service change.[49] We have also worked with Roses with the Ocean to develop a lived experience network of young people (for more on this see below).

In this section, we present the findings of our research with children and people and share the facilitators and barriers that they identified to their seeking help and present our broader recommendations on youth suicide prevention – with the intention of informing policy and service development in this area.

- **What we know about youth suicide**

There are notable gaps in knowledge about, and a lack of focus on, youth suicide and its prevention. However, we do know that suicidality affects groups of young people in significantly different ways.

Young males are at greater risk of death by suicide (although deaths by young females are increasing).[50] Males account for 71% of suicides by young people, whilst young females are around twice more likely to attempt suicide than males.[51/52] The suicide rate for Aboriginal and Torres Strait Islander young people is four times that of their non-Aboriginal and Torres Strait Islander peers. Same-sex attracted young people, young people living in rural and remote areas, young people who are in or have been in statutory care, and young people involved with the justice system are also all at higher risk of suicide.

Research also shows that the vast majority of people who die by suicide experience some kind of psychiatric disorder, particularly depression, as well as anxiety disorders, substance abuse, psychotic disorders, and borderline personality disorder. Yet shockingly, a significant number of young people experiencing suicide ideation do not have access to prevention services or receive any treatment.

- **What we know prevents help-seeking**

yourtown strongly believes that the voice of young people needs to be heard in the development of policies and interventions designed to prevent youth suicide and to support young people.

[48] See: https://kidshelpline.com.au/comics/suicide
[49] **yourtown** (2018). **yourtown** Position Statement: Preventing Suicide by Children and Young People: https://www.yourtown.com.au/sites/default/files/document/1.%20yourtown%20Position%20Statement%20-%20Preventing%20suicide%20by%20children%20and%20young%20people_0.pdf
[50] In 2008, 63 young females aged between 0-24 years old died by suicide. In 2017, this figure was 111: ABS data on Causes of Death, Australia, 2017
[51] Australian Bureau of Statistics (ABS) data on Causes of Death, Australia, 2017.
[52] Suicidal behaviours: Prevalence estimates from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing Zubrick, S., Hafekost, J., Johnson, S., Lawrence, D., Saw, S., Sawyer, M., Ainley., J & Buckingham, W. Australian & New Zealand Journal of Psychiatry 2016, Vol. 50(9) 899-910.

In 2015, **yourtown** undertook research on the lived experiences of suicide amongst children and young people and its findings have significant implications for the delivery of mental health services and specific suicide support services. Indeed, the feedback that children and young people gave in relation to their experience with suicidality and their ability to seek or not to seek help provide deep insight into the current barriers to seeking both formal and informal (often a precursor to accessing formal services) help. We discuss the barriers young people identified in this research below.

- **Barriers to seeking help**

Using an online survey on the Kids Helpline website and promoted through Facebook, 472 children, adolescents and young adults answered questions about how they got help when they were feeling suicidal, who helped them, which experiences were helpful and which were not, and what advice they would like to give to other young people, families, friends, and those who provide services for young people like them. [53]

Research participants told us about the difficulties they had with accessing support services including excessive waiting times for face-to-face services, prohibitive costs of services, and a lack of services in their local areas. To a question about what would have helped them through their experience of suicidality, participants replied the following:

yourtown insights: what would have helped?

- "Easier access to professional help, less waiting times and better Medicare subsidies so treatment is more affordable."
- "Definitely easier access to professional help would have helped immensely – it still would. Services like headspace are there but kind of inaccessible from where I am."
- "Professional services probably would have helped but we don't have many places where we live. We have expensive GPs and school counsellors but not much else that I know of."
- "It took a long time to be able to seek 'professional services' – about three months and that was during a time in my life where I really need help but all the services either 'couldn't cater for me because they didn't access that area' or were full! [We] need more services!"

Additional barriers identified by children and young people as preventing them from seeking help included:

- **Stigma in relation to mental health issues, self-harm and suicide.** As discussed previously, children and young people told us that this was the main reason that prevented them from actively seeking help: "Stigma, stereotypes and being too proud to want to ask someone in case they see me as weak or incapable of fixing things myself." They often used the words 'fear of being judged', or 'being afraid' and 'being scared' that they would not be believed or helped when they explained what made it hard to seek help: "Being scared that the way I was feeling

[53] **yourtown** (2015) Preventing suicide: the voice of children and young people: https://www.yourtown.com.au/sites/default/files/document/2.%20Preventing%20suicide%20by%20children%20and%20young%20people.pdf

would be brushed off or called ridiculous or telling someone and them not doing anything to help", "Scared of what they would say, embarrassed, felt like no one could help".

- **Fear of being labelled an attention-seeker.** Many young people told us they did not talk to anyone because they feared being labelled an attention seeker: "I feel so weak. Everyone will think that I'm using it for attention", "I didn't want to look like I was just saying that I am depressed for attention". They also described experiences that showed these fears were sometimes justified. Young people's experiences indicated that a range of people, including friends, family and medical professionals, believe the myth that self-harming or talking about depression or suicide is a form of attention seeking that need not be taken seriously.

- **Feeling worthless and being a burden on others.** In contrast to the idea that young people are 'attention seekers', previous research has shown that suicidal people often do not seek help because they feel worthless and undeserving: "I felt that I was not worth being helped", "I see many other people with problems that seem far greater than my own, so I just stay silent and deal with it myself". Young people also put the needs of others ahead of their own and do not want to worry people: "I'm extremely close with my mum and tell her everything but after seeing her cry when she saw my cuts 4 years ago I've kept almost every aspect of my mental health to myself. I don't want people to worry about me."

- **Lack of parental support.** Young people highlighted a need to overcome barriers that arise from a lack of parental support. For example, accessing services often requires parents to provide children and adolescents with their Medicare card, transport, and the financial resources to meet gap payments. In some situations, parents own challenging financial or emotional circumstances meant they were unable to support their child. In other situations, young people suggested that some parents did not recognise that depression is an illness and hence did not understand that the young person cannot simply 'get over it': "My mum will tell me that going for a walk or run would really help and joining the gym would help but what she doesn't understand is when I'm at a low I just can't get up or do anything. I don't have the energy to even eat let alone exercise! And that makes me then think my mum thinks I'm fat, I am fat, I'm lazy, she hates me, I hate me. And so on".

- **Friends, family and support staff trivialising their feelings.** Young people told us that they often have their feelings trivialised or are not taken seriously, which prevents them from seeking help. "I was told by that teacher that she knew I wasn't gonna [sic] harm myself", "After building up the courage to reach out to my mum to tell her I was feeling suicidal and that I really needed help, all she said was 'Try not to worry so much'". This sometimes appeared to be a function of age, with the responses of both parents and professionals suggesting a belief that a child or early adolescent could not be truly suicidal: "My mum told me it was just a phase which made me feel like she didn't care when she really did and just didn't know the full story."

- **Risk adverse approaches to support.** A number of young people demonstrated knowledge that services have a duty of care, which limits their obligation for confidentiality when a young person is considered at serious risk of harming themselves. Consistent with other research, comments indicated that duty of care obligations and associated limits to confidentiality present a challenge to help-seeking that warrants consideration. A fear that emergency services would be called or parents would be contacted created a barrier to disclosing suicidality after having sought help for some young people. A number of young people who had experienced a duty of care response believed that the decision was not the best response to the situation. Consistent with other research, respondents to the survey often found their experience with emergency services and hospitals unhelpful and reported that the duty of care response had done more harm than good.[54]

- **Child unfriendly emergency response.** Young people's comments suggest an urgent need to investigate alternative emergency care responses, in particular, responses that do not involve police and avoid hospitalisation as much as possible. Current guidelines in regards to appropriate terminology when talking about suicide state that the phrase 'commit suicide' should not be used, because the word 'commit' implies a crime or a sin. Yet, a service response to a person at imminent risk of suicide is likely to involve the person being forcibly transported to hospital by police, leaving them feeling as if they had committed a crime: "There have been times where I purposely haven't reached out and told anyone that I am feeling highly suicidal because I feared that I would end up back in the hospital involuntarily. Luckily I was able to get through those times by myself and nothing really bad happened to me", "Often young people are just looking for someone to talk to and not necessarily looking for extensive treatment".

- **What needs to be done**

Based on what children and young people told us, we identified the following strategies and interventions as necessary to help prevent and reduce suicidal ideation and death by suicide include:

- **National, state and community-level suicide prevention education, campaigns and strategies that target the whole community as well as children and young people specifically.** The lack of focus for a national youth specific strategy in the Fifth National Plan Mental Health and Suicide Prevention Plan is a missed opportunity for non-Aboriginal

[54] SANE Australia and University of new England (2015). Lessons for Life. The Experiences of People Who Attempt Suicide: A Qualitative Research Report.

and Aboriginal communities alike. A youth specific strategy would; set clear objectives and priorities based on evidence of what works with children and young people; help coordinate activities across various levels and arms of government (e.g., state and federal; education, health, etc.) and the not-for-profit sector; fund rigorous research and evaluation and; improve data collection to more accurately and comprehensively monitor rates of suicidal thoughts and behaviour.

- **Interventions tailored to the specific needs of children and young people and high risk groups.** This includes designing interventions to meet the specific needs and preferences of different genders, of lesbian, gay, bisexual, transgender and intersex people, of the different developmental stages and ages of young people, and tailoring them to the specific contexts in which they live (e.g. urban and remote locations, disadvantaged areas). In addition, new responses to specifically address high rates of suicide among Aboriginal and Torres Strait Islander children and young people must be developed. It is critical that these interventions are designed in collaboration with Aboriginal and Torres Strait Islander young people and are led by their communities.

- **An integrated care pathway for those children and young people experiencing suicidal ideation to those post-suicide attempt.** This will help ensure that vulnerable young people do not fall through service gaps, particularly when transitioning from children's to adults' services, and that those at higher risk of suicide after leaving inpatient care following an attempt or self-harm, receive the ongoing support that they need. This needs to include holistic non-clinical support that addresses the specific contextual factors contributing to an individual's distress.

- **Gatekeeper training.** This initiative is an integral part of ensuring that there is no wrong door to accessing support and care services. This includes understanding that young people also worry that sharing their suicidal thoughts with others will result in a disproportionate, 'text-book' or clinical response to their needs. Service and staff responses must focus on the individual needs of the young person in question, and not simply follow an organisational risk-based approach, which inadvertently risks alienating the young person by making them feel unheard.

- **A whole family approach.** Families are a critical source of support for many children and young people. However, many families do not understand suicidality and do not know how to respond effectively. Educating and working with families is crucial for a range of reasons. Difficulties in the family environment can contribute to suicidality, whilst parents should be a child or young person's most trustworthy and reliable point of support, and provide ongoing help for the duration of their treatment.

- **Crisis services.** As recommended by Orygen in its 2016 report on how to prevent youth suicide,[55] and in the National Suicide Prevention Implementation Strategy 2020–2025: Working Together to Save Lives (priority action 4.2), [56] confidential telephone and web-based counselling available 24/7 are a critical part of the mental health service system and

[55] Orygen, The National Centre of Excellence in Youth Mental Health (2016) Raising the bar for youth suicide prevention. Parkville: Orygen.
[56] https://www2.health.vic.gov.au/mental-health/national-suicide-prevention-implementation-strategy

offer unique benefits to children and young people. They help overcome barriers to help-seeking - particularly to those who may not otherwise seek help, act as a soft entry opportunity and pathway to more intensive services, is accessible to high risk groups including those in remote and rural Australia, and can provide both ongoing counselling and crisis support from a trusted source.

- **Research and evaluation**. To date, we do not have a clear list of 'what works' and many interventions appear promising, but results from different studies are often mixed. This is partly due to a lack of rigorous research and evaluation. In addition, the effectiveness of any intervention may depend on contextual factors, the characteristics of the specific intervention implemented, and implementation fidelity. Understanding what constitutes best practice for any given type of intervention group is needed.

  Social media and the internet provide additional opportunities to connect with people 24/7, whenever thoughts of suicide arise, and given young people's enthusiasm for new technology, social media may be especially effective with this group. Since young people have themselves reported a desire for more peer-to-peer communication and networking using social media, research into how this help can be integrated into technology they already use needs to be funded.

- **Community collaboration.** There a multitude of community organisations and health services – both specialist and mainstream - that have a role to play in preventing and treating youth suicide. In addition, there are many academic research centres and staff undertaking research into suicide prevention. This broad sector needs to build on existing relationships and expertise to find more ways to work together to find solutions to effectively prevent and treat youth suicide. This will include sharing knowledge, partnering on research and service pilots, and learning from research findings and ensuring that they are translated into practice.

yourtown Lived Experience of Suicide Network

Following our research with children and young people about suicide, **yourtown** has developed a Lived Experience Network of young people with a lived experience of suicide - be that having experienced suicidal thoughts, survived a suicide attempt, cared for someone through suicidal crisis, or been bereaved by suicide. Today, we have five young people aged between 19- 28 who have undertaken a two-day training course with Roses in the Ocean in how to present their personal experiences to advocate on the issue.

To date, members of the Lived Experience Network have presented their stories to a group of around 30 educators, and the effect that sharing their stories can have on the practice of gatekeepers such as teachers was clear in the feedback that we received from the educators. The young people are now developing their stories for sharing online and will also work with our KHL counsellors and other service staff to ensure that their personal insight improves our work.

Through working with these impressive and generous young people, we have been struck by a common theme – that school was often;

- a trigger for their suicidal ideation;

- a place where their mental health issues developed or were compounded (through bullying for example);
- a place where they did not feel supported (again for issues around bullying that they felt were simply ignored by teachers); and/or
- a place where they or their friends were inappropriately supported - through highly impersonal risk-management strategies, through teachers taking no personal responsibility for ensuring students with thoughts of suicide actually received the support they needed or following a friend's suicide in their school.

In telling their stories, these young people emphasised the variation in support that they received as they moved between different schools. Hence, we would urge the ACT Government to consider how schools and teachers can specifically better support children and young people who experience suicidal ideation or are affected by suicide in other ways consistently across the nation. Over the course of the year, the members of our Lived Experience Network will speak at public events on their experiences, and would be willing to speak to the Committee if an opportunity arises.

Recommendation 18: The ACT Government should take a leadership role in the development of a specific, youth focused ACT strategy to prevent suicide, which is underpinned by the views and voices of young people.

Recommendation 19: Deliver education, campaigns and strategies that are co-designed with children and young people, which encourage children and young people experiencing suicidal ideation to help-seek and to talk openly, and for those around them – including professionals, family, friends and the wider community – to listen.

Recommendation 20: Design, test and deliver a range of tailored interventions directly informed by the needs and preferences of children and young people – no single intervention is sufficient.

Recommendation 21: Train adults who are in contact with children and young people (gatekeeper training) to identify and respond appropriately to the needs of those experiencing suicidal ideation, and thereby remove barriers to help-seeking.

Recommendation 22: Integrate services and care pathways to enable a seamless care journey - from early intervention to long-term continuing care following a suicide attempt.

Recommendation 23: Develop a whole family approach to suicide prevention targeting children and young people.

Recommendation 24: Undertake further research into youth suicide prevention.

Recommendation 25: Facilitate collaboration between the multitude of community organisations and health services that have a role to play in preventing and treating youth suicide.

VII. Range of services available in ACT schools including counsellors, pastoral care workers, psychologists and other mental health first aid training for teachers and learning assistants

As a youth specialist in education reengagement, **yourtown** sees firsthand the transformational power of education (both academic and vocational) on young people's lives. Obtaining qualifications and securing a stable and fulfilling job has the potential to improve a range of life outcomes, including health, wellbeing, social and economic outcomes, as demonstrated by a wealth of research.[57] Indeed, education has the power to provide every young person with the opportunity to reach their potential in life, yet their unique set of experiences and needs means that too often young people are unable to fulfil their potential, with unsupported/or escalating mental health issues being a contributing factor. For this reason, and as set out below, we believe that providing timely mental health support to children and young people at school is critical to overcoming any life barriers they have to completing their education.

- **Support children and young people disengaged/disengaging from school**

When families are experiencing multifaceted disadvantage - such as financial hardship, poor housing/overcrowding or homelessness, family conflict or dysfunction, mental health issues or drug and alcohol misuse - children's school attendance and education is likely to suffer.[58] Indeed, disadvantaged students are significantly behind in reading and maths, Year 12 completion rates are nearly 20% lower than for students from high SES backgrounds and university students from high SES backgrounds are three times more likely to attend than students from low SES backgrounds.[59]

Research findings also overwhelmingly demonstrate that poor educational outcomes lead to poor employment outcomes, whilst financial hardship induces stress and significantly impacts on people's ability to function well in other areas of life, including their mental health. Conversely, higher educational attainment results in improved employment and therefore economic outcomes for an individual, a family and a community.[60] We therefore believe that ensuring children have the right support to effectively engage with their school and education is crucial to underpinning the foundations of good mental health and reducing or managing any mental health issues that manifest during school age.

yourtown has long delivered programs to help children and young people (re)engage with school and currently we deliver Flexible Learning Options (FLOs) in South Australia and the Youth Engagement Program (YEP) in Queensland. In working with this cohort of children and young people, we have understood the value of relationship-building to their progress. Hence, investing in developing and nurturing relationships between our clients and our staff, their families and their schools to build mutual trust and respect underpins our work.

[57] Waddell, G. & Burton, K. 2006. Is work good for your health and well-being? Executive Summary. Norwich: TSO
[58] The Smith Family: https://www.thesmithfamily.com.au/poverty-in-australia
[59] Ibid
[60] Ibid

Furthermore, critical to understanding and enhancing engagement is recognition that engagement with education is not an attribute of the student. Engagement is an alterable variable that is highly influenced by policies and practices of the school and its teachers, as well as by family, peer and community influences. Hence, interventions that aim to improve student engagement with school must not simply focus on 'improving' a child or young person but jointly seek to review and improve school and staff policies and practices to better meet the child's needs also.

Although robust evidence of what works is lacking, from our experience and research it is possible to conclude that effective programs for students who have left or are at risk of leaving school early do the following:

- target engagement, not merely attendance
- start early
- strengthen relationships between students and school staff
- work in partnership with school
- engage families
- provide intensive, long term, individualised, holistic support for both academic and personal issues
- are strengths-based
- are tailored to the local context (school and community)
- are framed by a gradual planned reintegration into mainstream school.

In addition to the factors influencing engagement for non-Indigenous Australian students, Aboriginal and Torres Strait Islander students are affected by racism and racially-based bullying, lack of cultural inclusion in schools, and mistrust of education as a result of past and present experiences and past and present government policy. Effective programs for First Australian students need to find ways to address these issues, build trust between schools and Indigenous Australian young people and families, and support them to develop a sense of belonging to their school.

Recommendation 26: Provide support for children and young people at risk of disengaging or who have disengaged from school and education, as well as consider how educational environments can be reformed to better accommodate the needs of a wider cohort of children and young people – particularly for those who have been affected by significant trauma or for whom the traditional school environment is not a good fit.

IX. Any other relevant matter

Better support the mental health needs of unemployed young people

Through our delivery of jobactive as a youth specialist, we have been struck by the prevalence of mental health issues across unemployed young people. Indeed, it is an area of the program that we have long highlighted to the Federal Government as in need of reform as research, including our own, shows that unemployed young people, and especially long-term unemployed young people, are disproportionately affected by mental ill-health than both their employed peers and older cohorts of unemployed people.[61] However, given the structure and high caseload of jobactive, it is extremely difficult to meet the mental health needs of young people who present with them through the program due to the lack of funding to support psychological and/or psychiatric interventions.

This is of particular concern as young people are among the most disadvantaged in the labour market[62] and make up the largest proportion in long-term unemployment compared to other age groups.[63] Labour market factors such as required social capital, negative employer perceptions about long-term unemployed young people, credential inflation, and employment protection are barriers to young people finding work. Furthermore, the mental health of young people suffers the longer they remain unemployed since long-term unemployment itself is a contributing factor to mental ill-health. Research with our long-term unemployed clients showed that 22% had low emotional wellbeing, and 32% had low self-esteem.

Indeed, it was this failing of jobactive that led to our research into how the needs of young jobactive clients with complex needs could be effectively addressed. As the needs of young people experiencing long-term unemployment are particularly acute – with deep and persistent disadvantage being a common factor amongst them, and which we again find is interconnected with the higher incidences of poor mental health in this group[64] - our research focused on this cohort.

From our research findings, we developed a specific model to help young people into work – **your job, your way** - and which in view of their needs, is based on providing relationship-based, holistic and intensive case management support. We are currently piloting and rigorously evaluating this model and set the details of this model below for the Committee to demonstrate what we believe is needed to ensure that the mental health needs of young people are appropriately responded to so they can successfully find and sustain work.

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[61] **yourtown** (March 2016) Tackling Long-Term Youth Unemployment: Discussion Paper: https://www.yourtown.com.au/sites/default/files/document/Long-term%20Youth%20Unemployment%20Discussion%20Paper_0.pdf

[62] The youth unemployment rate has historically been higher than the overall unemployment rate and this remains the case today standing at 8.8% in January 2020, compared with 3.2% for all persons in the ACT. What's more, increasing numbers of young people are experiencing long-term unemployment. A tragic start to a young life and a factor we recognise as a barrier to finding work itself, long-term unemployment occurs disproportionately among young people who comprise 16% of the total population, but 26.1% of long term unemployed people.

[63] **yourtown** (March 2016) Tackling Long-Term Youth Unemployment: Discussion Paper: https://www.yourtown.com.au/sites/default/files/document/Long-term%20Youth%20Unemployment%20Discussion%20Paper_0.pdf

[64] Ibid

your job, your way – responses to long-term youth unemployment

Increasing numbers of young people are experiencing long-term unemployment. Long-term youth unemployment is defined as young people aged between 15 and 24 years who have been unsuccessful in securing work for any period longer than two weeks, for at least one year. In 2006-07 over 44,000 young people were in long-term unemployment. This rose to over 51,000 young people in 2016-17.

yourtown works with more than 7% of these young people through our employment support programs. Subsequently, we have an extensive knowledge of the barriers young people face when trying to access sustainable work as well of the enduring detrimental impact that long-term unemployment can have on young lives.

What we know

Long-term unemployed young people deal with a range of highly complex and multifaceted issues, unlike those who are in short-term unemployment, which can increase their risk of social exclusion and permanent detachment from the labour market. These barriers and their consequences are compounded as time spent in unemployment is prolonged, further impeding their opportunities in acquiring long-term sustainable work. However, current difficulties in accessing suitable longitudinal data for young people means there is a lack of specific research in how to best support these young people and tackle this ongoing issue. Furthermore, rigorous evaluations of current responses to alleviate long-term youth unemployment are scant.

To help address this gap in knowledge, **yourtown** undertook a survey of nearly 300 young people in long-term unemployment across Australia. Through this research, young people told us that the following issues prevented them from finding employment:

- Educational - such as low levels of formal schooling, literacy and numeracy
- Vocational - such as limited work history and low work skills
- Contextual - such as intergenerational unemployment and living in low socio-economic areas
- Practical - such as not having a driver's licence and limited access to support through social/familial networks or services
- Psycho-social - such as mental health concerns, substance use, and homelessness
- Cognitive-motivational - such as low self-esteem and poor decision-making skills; and
- Anti-social - such as offending history and poor anger management

A diverse group with diverse needs

Our survey also showed that young people in long-term unemployment are not a homogenous group and different youth cohorts have varying experiences of long-term unemployment – critical insight when developing effective interventions. For example, young men, who have a higher rate of long-term youth unemployment than their female counterparts, told us that not having a driver's licence, limited transport, low literacy and numeracy, anger management issues, unstable accommodation, and offending history were more important barriers to employment. Young women, on the other hand, told us that they more often experience a lack of available jobs, low self-esteem and mental health issues as employment barriers.

First Australian young people ranked a lack of qualifications as the main barrier to employment, whilst young people with culturally and linguistically diverse (CALD) backgrounds rated difficulties in accessing social and institutional support due to their residency or citizenship status as a principal work barrier. The top issue for young people in regional and remote areas was the lack of jobs, whereas young people in metropolitan cities were more likely to view limited work experience, low work skills, and having no car as barriers to employment.

A new model of support

Given this cohort's complex needs, it became increasingly clear that existing caseload sizes in jobactive do not provide our consultants with the time required to develop the rapport and trust necessary to work with these clients, to comprehensively understand their individual needs, strengths and interests, or to develop a detailed plan of action in collaboration with other service providers, including post-employment strategies targeting ongoing capability development.

We therefore used our research with young people alongside other existing research into tackling youth unemployment to develop a model for support services to effectively assist long-term unemployed young people to engage in sustainable employment. Named **your job, your way**, it is designed to meet a range of different needs throughout the life of a long-term unemployed young person's journey into work. In addition, it recognises that long-term unemployment is a barrier to finding work itself and compounds existing issues that prevent job obtainment.

your job your way targets young people aged 16-21 who have been unemployed for over 52 weeks, and are at high risk of social exclusion and permanent detachment from the labour market. Central to its approach is the delivery of intensive, concurrent services and support to small active caseloads of around 25 young people. This is achieved through the provision of a dual support team of a qualified case manager (Pathways Coach) and an Employment Mentor – both of whom have been recruited for their knowledge and skills in identifying and working with people with mental health issues - who work with the young person using a collaborative strengths-based, trauma-informed approach, coupled with targeted employer engagement and intensive 'in work' mentoring to 26 weeks.

We are currently funding pilots of the model in Elizabeth in South Australia, Caboolture in Queensland and, with the Australian Department of Social Services, Devenport-Burnie in Tasmania – three areas of high disadvantage and high rates of long-term youth unemployment. The Macquarie Group Foundation is also funding the Centre for Social Impact (University of New South Wales) to provide an independent evaluation of these pilots to ensure that the effectiveness and impact of these pilots on young people and the community is thoroughly tested and measured. We are confident that we will be able to share some positive results showing how intensive relationship-based approaches can effectively transition Australia's most disadvantaged job seekers into sustainable employment in the near future.

Recommendation 27: The ACT government should lobby the federal government to seek better support for the mental health needs of young people accessing jobactive and/or Transition to Work, or alternatively, provide a territory-funded parallel service to support these needs.