Increasingly throughout 2019 my staff and I have become deeply concerned by the lack of breadth, and insufficient depth, in the support services available for at risk young people in our community in Portland. This is not new. Beyond the Bell, the GSGLLEN, the Glenelg Shire, Portland District Health, community groups and schools have been working collaboratively to provide our young people with the best possible opportunities for their health and wellbeing for a long time.

And for those young people engaged in school we are having a good deal of success. The safety net though is not catching and rescuing those young people who disengage for whatever reason.

At Bayview we are also frustrated by, what we see as, inaction by the organisations tasked with caring for at risk young people. We have students with significant needs and these needs are not being met.

Firstly, on a positive note, the introduction of Headspace to Portland has made it possible for more young people to seek support and guidance who would previously not have had this opportunity. In addition, as a community the Glenelg Shire is in its third year of successfully rolling out the *Live4Life* program which is providing young people, and a significant number of adults, with Mental Health First Aid.

This increased provision and awareness is having a positive impact on a large number of young people.

However, there is a distinct gap and shortfall in services and suitably qualified practitioners who are able to engage with young people, treat and diagnose serious Mental Health issues. As a result our young people are suffering.

Individual schools and families can only do so much when dealing with serious issues, chronic school refusal, anxiety, and other mental health issues. We need the branches of the Health and Education systems to support our work.

There is a misconception that parents who send their children to independent schools will have the capacity to pay private health practitioners, to travel to larger towns to access professional support for their sons and daughters (where there is a significant waiting list), and the intellectual/emotional capacity to negotiate the system. Not all parents do. As an Independent Christian School we accept students regardless of their capacity to pay fees; as such we have a number of students in out of home care, in financial need and who have experienced trauma. These young people are with us because the families choose to have their child educated in a Christian school. This choice should not prevent them from access appropriate health and mental health care when needed.

The Portland community urgently needs specialist Psychologists and Psychiatric practitioners locally who can work directly with young people and their families. We need an investment in programs to address school refusal and its causes. We need to attract and retain skilled workers in DHS who have a manageable case load so that they can truly develop and implement plans to assist young people and work more closely with school communities.

To illustrate the concerns we as a staff have, please bear with me as I share 4 case studies. These young people are of particular concern at the moment because we

have done everything as a school that we can, we have sought support from community agencies and nothing positive is happening for them.

Case Study #1

[redacted] – This young person commenced with us whilst in foster care. He had been in several foster homes with his younger brother over several years. DHS transitioned him back to his birth mother in the middle of 2018 (his younger brother is still with the foster family). Since returning to his birth mother his attendance has decreased from [redacted] His physical condition has deteriorated, he has reported being fearful of his older sister and one of his mother's friend, and has spoken about taking his own life and having no hope for the future.

Exercising our duty of care, and more importantly our moral obligation, we have reported every change in his demeanour, every concern raised with DHS and more recently CAMHS.

This young man has had several DHS case workers in the past 12 months, the most recent appointed a month ago. There is no continuity of care, no in-depth understanding of the family, and no 'relationship' with the young person. The young man is not currently engaging with the new case worker, he states that he does not trust DHS to have his needs at the heart of their decision making, and despite our schools best efforts, he is slipping through the system.

Our staff are frustrated by the apparent lack of knowledge the successive case workers have had about his life journey. At a recent meeting the case worker stated that she had not had a chance to read the file notes.

Three weeks ago when the young man shared with a staff member his plans to take his own life, the emergency appointment with CAMHS was held by teleconference with his mother present in the room. He did not speak to the counsellor on the other end of the TV screen and was sent home with his [redacted] who has [redacted] own mental health concerns and intellectual limitations.

A traumatised [redacted] is not going to engage with an adult he barely knows via a television monitor. A mental health professional would have difficulty making an accurate assessment of his mental state via this format. Our school staff still hold grave concerns that this young man may act on his stated intent.

CAMHS are now actively seeking to have regular contact with this young man to support him, which is a positive move forward. However, no disrespect to the individuals involved, a social worker is not sufficient support for a troubled individual like this young man. Although the social worker is part of a team that includes a Psychologist and Psychiatrist, this young man needs high level regular care.

This young man is 'in the system' designed to support vulnerable young people, however, the people working most closely with him, school staff, are not being listened to carefully enough and he is experiencing further neglect

from inaction. [redacted]

Case Study # 2

[redacted] – This young man is a highly intelligent student who performs above national Benchmark. He is the youngest in a 'normal' family with no known trauma in his background. We are his second high school and he came to us with a poor pattern of attendance in the previous setting. His primary school years were uninterrupted and saw academic and social success. He has strong peer relationships here at this school and this saw improved attendance initially.

Despite a range of supports including counselling, home visits, and interventions by his loyal friends he has developed chronic school refusal patterns of behaviour. He has only attended [redacted] this year. His family now report that in the last [redacted] months he rarely leaves his room, but still welcomes his friends' visits on a daily basis.

Child First, DHS and the Victoria Police Youth Worker have all been contacted and have made visits to the family and spoken with the young man. As there is no indication of abuse these organisations are not involved with the young person or his family. Victoria Police stated that it was a family issue to deal with.

The parents have made numerous appointments with the local GP in order to initiate the development of a Mental Health Plan, but now the young man refuses to attend. This youth is at significant risk and the school and the family have nowhere else to turn.

Case Study # 3

[redacted] – An intelligent young woman who is being informally parented by her grandparents since her parents separated following issues of family violence. Her grandparents are working closely with the school to try and get support for this young woman whose attendance and physical health has declined this year. Her mother, who has custody, will not engage with the school. Child First and DHS have been briefed by the school to support the family. They have made contact, however, the family is not currently receiving any assistance from either organisation. Victoria Police Youth Worker was approached last week.

School staff, with grandparents' encouragement have taken the young person to a GP for a consultation with a view to setting up a mental health plan. The GP would not action this without a custodial parent present. The grandparents remain seriously concerned.

Case Study #4

[redacted] – Following an acrimonious divorce the siblings were enabled by the mother to miss school. Mum did not

want to “exacerbate the trauma” that they experienced when growing up within the family.

These siblings do access a private psychologist who operates in another town. The monthly appointments result in further time off school. The pattern of “illness”, “refusal”, “helping mum” resulted in the school contacting Child First. [redacted], and our fear is the students will fall through the cracks.

I am acutely aware that I am not alone with these concerns for the wellbeing of our young people in this town. Our school is a microcosm of the broader community and there would be cases like this, and worse, in our neighbouring schools. Funds and personnel need to be directed to our communities and communities like ours.

I believe that the money that is being directed into school dental vans would be far better spent in providing care for the mental wellbeing our young people. “Victorian students will get free dental treatment … as part of a $322 million cash splash in Monday’s state budget.” Dental health is important, however, the Mental Health of our young people is critical to their educational and life chances.

Kind Regards

Michelle