Submission to Royal Commission into Victoria's Mental Health System
Organisation Name: yourtown
SUB.0002.0028.0207

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Understanding mental illness: it develops early in life

Whilst mental health issues can affect anyone from any background at any stage in their life, they typically start in people's younger years. 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 and is a trend reflected in Victoria.

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

Although not funded by the Victorian government, Kids Helpline (KHL) plays important and distinct roles in its mental health infrastructure (for more information see Appendix 1: Key Victorian Insights 2018, Appendix 2: KHL role in the mental health system and Appendix 3: KHL case studies), and the Victorian government promotes KHL and refers many young Victorians to it for mental health support. 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, GP 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 question 2).

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[1] Kessler, R.C., Berglund, P., Demler, O., et al. (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. Archive of General Psychiatry 62 (6).

[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.

- 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 (e.g. they live in rural and remote communities or have CALD backgrounds) and ensures they do not slip through 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, organising and participating in multidisciplinary case teleconferences (with GPs, psychiatrists and psychologists) and again, referring them to KHL Circles if appropriate.

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 Appendix 4: **yourtown** services), that we not only see the widespread detrimental effects of mental illness on their lives and life outcomes but also the staggering influence that stigma and discrimination has on such young lives.

In 2018, 57 per cent (9,158 contacts) of all counselling sessions (16,034 contacts) known to be from Victoria to KHL related to concerns about mental health, emotional wellbeing, self-harm and suicide.[7] Since 2012, while the prevalence of other KHL counselling concerns have remained stable, these four concerns have significantly increased, with Victorian concerns about managing diagnosed mental health illnesses increasing by some 19%, and suicidal thoughts by 8% over this time (for further breakdown on concerns see Appendix 5: KHL Victorian Statistical Summary 2018 and Appendix 6: KHL National Statistical Overview 2018). 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 52% of contacts going unanswered in Victoria – some 36,240 contacts.

Clearly, Victoria's younger generations are in need of help and our experience in service delivery and increasing research shows that communities are not sufficiently able to support their needs. Despite recent increases for funding in youth mental health services nationally, the system is still predominantly geared to support the mental health needs of adults, leaving many children and young people unable to access the support they need for mental health concerns in a timely manner, or until they are critical. For example, children and young people under 12 cannot access headspace, those who are eligible to access headspace are often confronted by long waits, whilst young people with moderate and severe needs must often wait until their needs escalate before they meet eligibility criteria. 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.[8] Indeed, at KHL, approximately 5% of our ongoing contacts are from the 'missing middle', children and young people whose needs are too high

[7] In 2018, KHL received a total of 33,009 contacts from young Victorians – 26% of all contacts made to KHL in that year. However, as we do not always know which state or location clients are from as they have contacted us through email, webchat or using a blocked number, we estimate that 38,747 contacts were actually made by Victorians in 2018.

[8] 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

to be eligible to receive appropriate community service support and too low to be eligible for acute care.

In addition, 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.[9] In light of this, it is not surprising that over recent years there has been a 46% increase in mental health presentations to Victorian emergency departments aged 19 years and under.[10]

This lack of 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 as children and young people's services have notable gaps and are drastically underfunded.

Recommendation 1: 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.

- **Supporting the mental health of children and young people presents significant opportunities**

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.[11] Given that mental health issues can impede education (including attainment and school engagement[12]), 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,[13] 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 are around double the level of healthcare expenditure on people with some types of mental illness (e.g.

[9] 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

[10] This increase was the finding in: Hiscock, H., Neely, R.J., Lei, S. and Freed, G. (2018) Paediatric mental and physical health presentations to emergency departments, Victoria, 2008-2015. Medical Journal Australia; 208 (8): 343-348

[11] 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.

[12] E.g. Orygen Youth Health Research (2014) Tell them they're dreaming: Work, Education and Young People with Mental Illness in Australia.

[13] 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)

anxiety, affective and substance use disorders), over the life course.[14] 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 2: 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.

- **Stigma is widespread**

Children and young people tell us that they turn to KHL as it helps them to overcome the barriers to access, barriers which include stigma and discrimination. Indeed, children and young people can find face-to-face services daunting and intimidating, and fear they will be judged - for those who live in rural and remote communities in particular as communities are small. Indeed, stigma was found to be the main reason that children and young people told us prevented them from actively seeking help in our research with them about suicidal ideation.[15] 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.

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.[16] However, we know that educating children and young people works to overcome barriers to help-seeking. Schools in Victoria have the highest uptake of 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 to feel 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,[17] and we know this figure is less - although growing - in Victoria.[18] 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.

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[14] 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.

[15] **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

[16] 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.

[17] AIHW (2019). Expenditure on mental health services. Canberra: AIHW.

[18] https://www.theage.com.au/national/victoria/victoria-s-failing-mental-health-system-following-path-of-us-cities-20180613-p4zla3.html

Recommendation 3: 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 seek help for mental health issues.

Recommendation 4: 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.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Mental health services and young people: what can be done better?

Like the systems of other Australian states and territories, Victoria's current mental health system is; complex; lacking coordination resulting in difficulty in navigation for service users, particularly the young; predominantly tailored to meet the needs of adults and; underfunded.[19] Although in recent years there has been an increased focus on the mental health and wellbeing of children and young people (e.g. through increased Federal funding for school-based educational programs and interventions), we know that fundamental reform of the current system is still required to effectively meet their needs.

Indeed, in our experience through working with children and young people in need of mental health support and through providing specific mental health and therapeutic services in some states,[20] 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.[21] This has significant implications as incomplete treatment for psychiatric disorders may result in deterioration.[22]
    - 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. 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.

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[19] For example, see our research with children and young people about suicide: **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

[20] 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.

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

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

- **do not** have the capability to **respond to complex needs or to manage crises situations,** including post-crisis.
- **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 (e.g. remote and rural communities in particular) 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.

Hence, while many services currently provide appropriate services for children and young people (such as headspace) and there are examples of successful interventions to support them with a range of different conditions (e.g. cognitive or dialectical behaviour therapy), there are simply not sufficient services tailored to their needs and preferences available.

In addition, we also know that 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 (for more on this please see our response to question 4).

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.

Recommendation 5: 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 6: The Victorian Government should invest in the design of mental health responses to meet the specific needs of children under 12 years old.

Recommendation 7: The Victorian Government should make representations to the Australian Government in relation to reviewing Better Access and the current limit of ten sessions so that it is able to support clients with complex mental health needs. In addition, access to Better Access should be free for those who are found to be unable to pay the gap.

Mental health services and young people: what is working well?

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.[23] 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.[24] 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 fewer 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.[25] Research has also shown that digital health resources are effective for young people with low to moderate mental health concerns.[26] Indeed, KHL clients are showing an increasing preference to engage with the service through webchat, whilst in 2018 we had some 250,000 hits made by Victorian visitors to our KHL online resources and tip sheets.

We strongly urge the Commission, 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 in rural and remote areas who have greater challenges in accessing mental health services in their communities.

[23] 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.

[24] 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.

[25] 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.

[26] 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.

In addition, we are currently designing an app to better support clients with ongoing, severe and complex needs ('the missing middle') through providing an online portal to case manage their needs together. The app will facilitate improved client access to case documentation (e.g. safety plans), more efficient scheduling of contact and communications between clients and KHL counsellors and client-counsellor collaboration on goal-setting, case-planning and therapeutic work.

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 Victorian 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%).

Recommendation 8: The Victorian 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.

3. What is already working well and what can be done better to prevent suicide?

What can be done better to prevent suicide of children and young people?

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.[27] 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,[28] and although there is hope that Victorian deaths by suicide are beginning to decrease, it is one of the top reasons children and young people from Victoria contact Kids Helpline to seek advice, with 15% of all KHL counselling contacts being suicide-related in 2018, up from 13% in 2015.[29]

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.

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; set up an organisational-wide working group to ensure that our staff and service responses are equipped to effectively manage client and colleague suicidality; developed specific age-appropriate comics to help children seek help who are affected by this issue;[30] and developed and disseminated a position statement setting out our recommendations for policy and service change.[31] We are also currently working with Roses in the Ocean, the only suicide prevention lived experience network in the country, to develop a lived experience network of young people.

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).[32] Males account for 71% of suicides by young people, whilst young females are around

[27] Australian Bureau of Statistics (ABS) data on Causes of Death, Australia, 2017.

[28] Ibid

[29] Ibid

[30] See: https://kidshelpline.com.au/comics/suicide

[31] **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

[32] 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

twice more likely to attempt suicide than males.[33/34] 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.

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. [35]

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 (see next page):

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."

[33] Australian Bureau of Statistics (ABS) data on Causes of Death, Australia, 2017.

[34] 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.

[35] **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

- "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!"

Given that we know that the amount of Medicare funding and the numbers of mental health staff are significantly less in rural and regional areas than major cities, we would expect children and young people in these areas to find these barriers to accessing appropriate mental health services more acute. Furthermore, we would expect these barriers to be further compounded by other locational factors such as knowing local health professionals and counsellors and finding it harder to confide in them and trust their confidentiality given the small community in which they live, as well as economic issues such as being more likely to have unemployed parents or parents unable to afford access to support services.[36]

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 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

[36] National Rural Health Alliance Inc (December 2017) Fact Sheet: Mental Health in Rural and Remote Australia.

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.[37]

- **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".

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

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 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,[38] and in the National Suicide Prevention Implementation Strategy 2020–2025: Working

[38] Orygen, The National Centre of Excellence in Youth Mental Health (2016) Raising the bar for youth suicide prevention. Parkville: Orygen.

Together to Save Lives (priority action 4.2), [39] confidential telephone and web-based counselling available 24/7 are a critical part of the mental health service system and 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.

Recommendation 9: The Victorian Government should take a leadership role in the development of a specific, youth focused national strategy to prevent suicide.

Recommendation 10: 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 11: 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 12: 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 13: Integrate services and care pathways to enable a seamless care journey - from early intervention to long-term continuing care following a suicide attempt.

[39] https://www2.health.vic.gov.au/mental-health/national-suicide-prevention-implementation-strategy

Recommendation 14: Increase funding or start to fund critical national crisis services and mental health infrastructure such as Kids Helpline, Lifeline, headspace, reachout and beyondblue.[40]

Recommendation 15: Develop a whole family approach to suicide prevention targeting children and young people.

Recommendation 16: Undertake further research into youth suicide prevention.

Recommendation 17: Facilitate collaboration between the multitude of community organisations and health services that have a role to play in preventing and treating youth suicide.

[40] https://www2.health.vic.gov.au/mental-health/national-suicide-prevention-implementation-strategy

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

Mental health and disadvantage

We know mental health issues commonly first emerge when people are young, and if left unaddressed, these issues can detrimentally affect a range of their life outcomes, including education outcomes such as lower educational attainment, poorer engagement with study and school and higher drop-out rates.[41] 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 response to question 8).

However, through our work, we also observe how mental ill-health is typically dependent on other aspects of a child's or young person's life. 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, racism and other trauma – causes, contributes to and/or compounds this ill-health. This is in keeping with wider research showing higher prevalence of mental ill-health in disadvantaged communities, [42] 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.[43]

Furthermore, in working with young children and their families, we are aware of how early signs of disadvantage and their outcomes become apparent and research indicates that 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.[44] For example, in Bridgewater, Tasmania, a region in which **yourtown** is developing an early childhood strategy to increase educational outcomes, AEDC findings show that first year school-aged children residing in Bridgewater are two to three times more likely to have multiple developmental vulnerabilities compared to other children in the same age range nationally.

Developmental vulnerabilities include physical health and wellbeing, social competence, emotional maturity, language and cognitive skills and 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.

[41] 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

[42] 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

[43] AIHW (Australian Institute of Health and Welfare) (2018) Child protection Australia 2016-17, Cat. no. CWS 63, Child welfare, Canberra.

[44] https://www.aedc.gov.au/

What can be done to improve this?

As a multifaceted and complex problem, we know that there is no one intervention, approach or principle that will alleviate intergenerational disadvantage. To disrupt cycles of disadvantage, a combination of different universal and targeted interventions accommodating children, families and communities and tailored to a range of needs are required. As set out below, interventions must be underpinned by;

- Early intervention;
- A whole family approach;
- Effective pathways at key transitional periods;
- Trauma-informed practice and;
- A whole of government approach and collaborative working between stakeholders

Finally, this system 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, Victoria 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.

- **Early intervention**

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, Victoria 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 a key foundational development stage, 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 and a child's school career.

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.[45] 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.

- **A whole family approach** (see our response to question 6)

- **Effective pathways at key transitional periods:**
  - During school (see our response to question 8)
  - To employment (see our response to question 8)
  - To parenthood (see our response to response to question 6)

[45] 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.

- **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.[46]

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, our staff are aware of parents medicating their children, who may be hyperactive, have poor attention spans or display other challenging behaviour, with cannabis. In addition, 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 with 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. [47]

The community of schools and services (COSS) model is an example of this approach and underpins the 'Geelong Project' in Victoria.[48] 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. This is the major limitation inherent in school referrals. 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 psychological distress and mental health issues. Following pilots in three schools, its

[46] 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.

[47] Kania, J. & Kramer, M. (2011). Collective impact. Stanford Social Innovation Review, Winter, 36-41

[48] MacKenzie, D. (2018) The Geelong Project Interim Report: https://apo.org.au/sites/default/files/resource-files/2018/02/apo-nid133006-1208531.PDF

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.

Recommendation 18: Support the holistic needs of Victoria's youngest (first 1,000 days) and most vulnerable children, including their mental health, early to prevent the effects of trauma and disadvantage from detrimentally affecting the development of foundational life skills.

Recommendation 19: 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 20: Ensure easy access to effective mental health interventions at key transitional periods during a child and young person's life including:

- At school
- To employment
- To parenthood

Recommendation 21: Provide trauma-informed practice training to all gatekeepers of services supporting children and young people.

Recommendation 22: Facilitate collaborative partnerships between government and services supporting the welfare of children and young people, and their families.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

Children and young people living in Victoria's most disadvantaged communities are most susceptible to mental health issues that intersect with other issues, including:

- **Disadvantage/intergenerational disadvantage.** As discussed in our response to question 4, children and young people experiencing disadvantage are more likely to have poor mental health.
- **Unemployment.** The youth unemployment rate has historically been higher than the overall unemployment rate and this remains the case today standing at 9.4% in May 2019, compared with 4.4% for all persons in Victoria.[49] Hence, the lack of job opportunities for children and young people living in areas of Victoria with the highest unemployment can be a driver of mental ill-health. 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.[50]
- **Inverse care law and lack of high quality services.** The inverse care law means that 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. [51] 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.
- **Racism.** There is 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 impacting on future health-seeking behaviour as well as contributing to further negative psychological effects itself. [52]

Recommendation 23: Apply collective impact strategies in communities which have been identified as highly economically and socially disadvantaged that are focused on issues that contribute to intergenerational disadvantage.

Recommendation 24: The Victorian Government should investigate how to provide and engage disadvantaged communities with high quality clinical services.

[49] ABS data on Labour Force, Australia, May 2019

[50] Australian Government (2018) The next generation of employment services. Discussion paper. Appendix G, 108

[51] 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

[52] 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.

6. What are the needs of family members and carers and what can be done better to support them?

Disadvantage and parenting

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.[53] 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.

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,[54] accentuating the need for early interventions with high-risk families that support parenting attachment and responsive care.[55] 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.[56]

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 experiencing homelessness. 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 skilledparents 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.[57] 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, at the very least, given that parental consent is required to working with children and young people, to a child's accessing the services they need.

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[53] Duncan, G. and Murnane, R. e. (2011). Wither Opportunity? Rising Inequality, Schools and Children's Life Chances. New York: Russell Sage Foundation.

[54] 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.

[55] Moulin, S., Waldfogel, J. and Washbrook, E. (March 2014). Baby Bonds: Parenting, attachment and a secure base for children.

[56] Ibid

[57] Kuhn, E. and Laird, R. (2014). Family support programs and adolescent mental health: review of evidence. Adolescent Health, Medicine and Therapeutics. 5, 127-142.

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 addressing a range of issues they face, including mental health.[58] 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.

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.[59]
- 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 25: 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 26: 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.

[58] 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

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

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Attracting, retaining and better supporting Kids Helpline (KHL) counsellors

At **yourtown**, we endeavour to attract, retain and better support all our staff by regularly reviewing what we can do to ensure that it is a safe and productive workplace, with regular opportunities for professional development. With regards to our largest mental health workforce cohort, KHL tertiary qualified counsellors, and in addition to encouraging to time for self-care timeouts during their shifts and peer support through social activities, we also specifically:

- **Have established a Practice Unit providing monthly clinical supervision for counsellors,** including:
  - practice leadership and evidence-based clinical guidance to support quality outcomes;
  - advice and guidance on matters related to risk and duty of care, research, emerging trends and legislative changes; and
  - providing supervision, feedback and support as part of ongoing skills development and to ensure psychologists maintain high practice standards.

  The staffing model includes shift supervisors who provide on-shift support in the management of complex and/or critical presentations as well as debriefing.

  Practice and shift supervisors have tertiary qualifications in psychology/social work or counselling, combined with a minimum of 6 years practice experience. They are required to have proven skills and experience in training needs analysis and delivery, supervision practice and the use of effective psychology and counselling models in a diverse range of situations.

- **Are developing a partnership with Orygen Youth Health (Oyrgen).** This year, KHL undertook a major review of its service delivery model in response to the increasing demand on service from a small cohort of young people presenting with complex mental health needs. This review found that there were a small proportion (approx. 5%) of young people accessing the service with complex mental health needs identified, particularly in regards to young people with diagnosed Personality Disorders. The review identified that the needs of this group would likely be better suited to a targeted service response. In response, **yourtown** has engaged with Orygen to assist in developing the most appropriate and effective teleweb response to this high needs cohort.

  This developing partnership includes the development of a bespoke service model and training package for KHL staff.

- **Embedding lived experience and youth participation into our services and training. yourtown** has committed to embedding a youth participation strategy throughout the organisation to improve organisational impact through better programs and services, informed by the knowledge and lived experience of young people across Australia (including a specific LGBTIQ participation group). This includes supporting a salaried cohort of young people to train our staff and inform our service evolution. In addition, in partnership with Roses in the Ocean, we are developing a suicide prevention lived experience network for young people, with whom we will also work to develop our staff training and services.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

Realising the potential of children and young people susceptible to mental health issues

As a youth specialist in education reengagement and a youth employment provider, **yourtown** sees firsthand the transformational power of education (both academic and vocational) and employment 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.[60] Indeed, education and employment 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 and when looking for work is critical to overcoming any life barriers they have to completing their education or finding employment.

- **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.[61] 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.[62]

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.[63] 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.

[60] Waddell, G. & Burton, K. 2006. Is work good for your health and well-being? Executive Summary. Norwich: TSO

[61] The Smith Family: https://www.thesmithfamily.com.au/poverty-in-australia

[62] Ibid

[63] 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.

- **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 in 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.[64] 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.

It might be that their mental health needs are not yet diagnosed or that they have mild or moderate mental health needs, young jobactive clients with mental ill-health have not been supported by the profit and non-profit support services that the Commission's Issues Paper mentions (e.g. Personal Helpers and Mentors or Disability Employment Services). Instead, they find themselves in a system that is not well equipped to support and address their mental health issues, and therefore to help them find work.

[64] **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

For example, jobactive's assessment (the Job Seeker Classification Instrument), which is conducted by Centrelink, has been found to not accurately stream clients, and as a result many clients with complex issues such as mental health, homelessness or integrating back into the community post detention find themselves placed into Stream A, which is designed to assist job seekers with a high level of independence.[65] In such incidences, we will reassess them so that their needs can be better met but even the scope for meeting complex needs in jobactive is limited given the caseload of jobactive staff (of around 130 clients), consisting of clients from a range of streams, whilst the reclassification process is slow meaning that supports may not be provided when they are needed.

This is of particular concern as young people are among the most disadvantaged in the labour market[66] and make up the largest proportion in long-term unemployment compared to other age groups.[67] Labour market factors such as required social capital, negative employer perceptions on 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[68] - 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 Commission 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.

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.

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[65] Education and Employment References Committee Report 'Jobactive: failing those it is intended to serve' (February 2019): https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/JobActive2018/Report?fbclid=IwAR1kN7eisItmZ8d1HiiOey1LOMln0kkhimusAmz2uEGYUbeNF6Z-dXmDuEU

[66] The youth unemployment rate has historically been higher than the overall unemployment rate and this remains the case today standing at 9.4% in May 2019, compared with 4.4% for all persons in Victoria. 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.

[67] **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

[68] Ibid

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: 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.

Recommendation 28: The Victorian government should lobby federal government to better support the mental health needs of young people accessing jobactive and/or Transition to Work, or alternatively, provide a state-funded parallel service to support these needs.

9. Thinking about what Victoria's mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?

Recommendation 1: 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 2: 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.

Recommendation 3: 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 seek help for mental health issues.

Recommendation 4: 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.

Recommendation 5: 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 6: The Victorian Government should invest in the design of mental health responses to meet the specific needs of children under 12.

Recommendation 7: The Victorian Government should make representations to the Australian Government in relation to reviewing Better Access and the current limit of 10 sessions so that it is able to support clients with complex mental health needs. In addition, access to Better Access should be free for those who are found to be unable to pay the gap.

Recommendation 8: The Victorian 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.

Recommendation 9: The Victorian Government should take a leadership role in the development of a specific, youth focused national strategy to prevent suicide.

Recommendation 10: 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 11: 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 12: 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 13: Integrate services and care pathways to enable a seamless care journey - from early intervention to long-term continuing care following a suicide attempt.

Recommendation 14: Increase funding or start to fund critical national crisis services and mental health infrastructure such as Kids Helpline, Lifeline, headspace, reachout and beyondblue.[69]

Recommendation 15: Develop a whole family approach to suicide prevention targeting children and young people.

Recommendation 16: Undertake further research into youth suicide prevention.

Recommendation 17: Facilitate collaboration between the multitude of community organisations and health services that have a role to play in preventing and treating youth suicide.

Recommendation 18: Support the holistic needs of Victoria's youngest (first 1,000 days) and most vulnerable children, including their mental health, early to prevent the effects of trauma and disadvantage from detrimentally affecting the development of foundational life skills.

Recommendation 19: 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 20: Ensure easy access to effective mental health interventions at key transitional periods during a child and young person's life including:

- At school
- To employment
- To parenthood

Recommendation 21: Provide trauma-informed practice training to all gatekeepers of services supporting children and young people.

Recommendation 22: Facilitate collaborative partnerships between government and services supporting the welfare of children and young people, and their families.

Recommendation 23: Apply collective impact strategies in communities which have been identified as highly economically and socially disadvantaged that are focused on issues that contribute to intergenerational disadvantage.

Recommendation 24: The Victorian Government should investigate how to provide and engage disadvantaged communities with high quality clinical services.

[69] https://www2.health.vic.gov.au/mental-health/national-suicide-prevention-implementation-strategy

Recommendation 25: 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 26: 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.

Recommendation 27: 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.

Recommendation 28: The Victorian government should lobby federal government to better support the mental health needs of young people accessing jobactive and/or Transition to Work, or alternatively, provide a state-funded parallel service to support these needs.

10. What can be done now to prepare for changes to Victoria's mental health system and support improvements to last?	
As with any change, appropriate consultation with the mental health workforce is important to ensure their buy-in and that changes are implemented effectively, in addition to securing cross-party support for reform and for increased and sustained investment into the system.	
11. Is there anything else you would like to share with the Royal Commission? • Appendix 1 - Key Victorian Insights 2018 • Appendix 2 - KHL role in the mental health system • Appendix 3 - KHL case studies • Appendix 4 - **yourtown** services • Appendix 5 - KHL Victorian statistical summary 2018 • Appendix 6 - KHL insights national statistical overview 2018	
Privacy acknowledgement	I understand that the Royal Commission works with the assistance of its advisers and service providers. I agree that personal information about me and provided by me will be handled as described on the Privacy Page. ☒ Yes ☐ No

Appendix 3: Kids Helpline (KHL) case studies in Victoria

Case managing complex mental health diagnoses: ██████ 19 years old, Melbourne

█████ 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. █████ experienced sexual abuse over 3 years when aged between 7 to 10 years old.

█████ 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. █████ has been contacting Kids Helpline ever since this first call.

█████ has reported she is dissatisfied with the Victorian 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. She has also disclosed ongoing anxiety and concerns around being restrained by emergency or mental health services after being restrained in an inpatient facility in Victoria.

█████ is being complex case managed by a regular KHL counsellor and wraparound care 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, to talk through other stressors, including her anxiety about being restrained and other stressful events and situations as they have come up and; to prepare for appointments. █████ 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.

█████ 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 hasn't 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 framework.

Preventing suicide: ████ 25 year old, Melbourne

████ first contacted Kids Helpline when she was 20 years old. At that time, she was experiencing suicidal thoughts and was seeking support to manage this and validation around her experience.

From then on, ████ 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, ████ was able to articulate her challenges, needs, and goals, whilst sharing information about her support network. In particular, ████ 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 vulnerable to low self-esteem.

On one occasion when ████ 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. ████ 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. ████ 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 ████ cope with her psychological distress.

The outcome of this intervention was that through using a client-centred, collaborative and strengths-based approach with ████ she was able to remain safe from suicide. As a result, ████ 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: [redacted] 22 years old, regional Victoria

[redacted] 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.

[redacted] seeks support from KHL for emotional exhaustion 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 [redacted] working with three different regular counsellors for 1-2 years each. [redacted] 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, [redacted] 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 ensure roles are clarified, especially to manage risk and to prevent stockpiling of medications.

[redacted] 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 completed school, a university degree, has got engaged and has a full-time job that she loves. [redacted] has said KHL has been part of what has kept her alive.

Appendix 4: **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** (KHL), 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
- **Mental health service/s** for children aged 0-11 years old (e.g. Starfish), and their families, with moderate mental health needs including KHL partnerships:
    - with Orygen Youth Health (Oyrgen), with Orygen helping with the development of the most appropriate and effective teleweb response to KHL clients with complex mental health needs. This developing partnership includes the design of a bespoke service model and training package for KHL staff.
    - in a new multi-partner[1] project developing, and examining the effectiveness of, a digital and population-level model of care for delivering assessment and intervention to young people experiencing common 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 experience **homelessness**, and to women and children seeking **refuge from 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'
- **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.

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[1] Partner organisations include: yourtown (Kids Helpline), West Moreton Hospital Health Service, Darling Downs West Moreton Primary Health Network, Education Queensland, Aftercare, Children's Health Queensland

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 2018, Kids Helpline counsellors responded to over 140,000 contacts from children and young people across the nation, with an additional 843,753 unique visitors accessing online support resources from the website. During 2018, Kids Helpline made its 8millioneth contact response.