LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON EDUCATION, EMPLOYMENT AND YOUTH AFFAIRS
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Submission Cover Sheet

Inquiry into Youth Mental Health in the ACT

Submission Number: 22

Date Authorised for Publication: 23 June 2020

16 June 2020

ACT Legislative Assembly

Standing Committee on Education, Employment and Youth Affairs

Inquiry into Youth Mental Health in the ACT

To: LACommitteeEEYA@parliament.act.gov.au

Submission by: Communities@Work Galilee School

About Communities@Work

Communities@Work is Canberra's largest not-for-profit community organisation, working with our community to support positive educational outcomes, and build resilient, sustainable and socially inclusive communities in the ACT and capital region.

We provide a wide range of early education and care services and community services in the ACT and Capital region, delivering high quality services that support positive educational outcomes, assists in alleviating hardship, enhances quality of life and leads to positive social change.

About Communities@Work Galilee School

Communities@Work, Galilee School is a registered, independent secondary school designed specifically for disengaged and vulnerable young people in years 7-10 in the ACT and surrounding areas for whom the mainstream schooling environment has struggled to deliver positive learning outcomes. Galilee School offers a supportive and flexible learning program that aims to meet the individual needs of students.

Galilee School employs a team of highly skilled educators, youth workers and support staff who are able to support students presenting with a range of learning abilities.

Galilee School provides students with a quality education in line with the Australian Curriculum and tailored to achieve the objectives outlined in each student's Individualised Learning Plan.

Galilee School operates two campuses in Canberra: our Kambah site supports student in Years 7,8 and 9 and our Holder site supports our Year 10 students. The learning environments available at Galilee School provide a range of opportunities for students to engage with their learning and to explore individual interests and passions while upskilling social and emotional capabilities. To increase the education and employment opportunities for students, Galilee School also provides training, skill development and job ready support for students transitioning to the workforce or to further educational opportunities. The individual education needs of all students are met via a flexible support model that is learner centred; strengths based; relationship driven and restorative.

The program provided by Galilee School builds and develops long-term resilience and resourcefulness in the young people attending the school. Students leave Galilee School with a heightened sense of respect for themselves and for others as well as having increased levels of self-confidence. Galilee school seeks to inspire young people to realise their full potential by developing and utilising their unique talents and capabilities; by aiding students to find a sense of purpose and value in themselves as productive and worthwhile members of our community.

CASE STUDY 1:

Addressing Terms of Reference:
ii. ACT's current approach to prevention and early intervention strategies and services for youth mental health and addiction, and what needs to change;

iv. the availability of professional mental health services for students and their families at school and out of hours, including weekends and school holidays;

- Justin (de-identified) was a 15 year old boy referred to Galilee School by his Child Youth Protection Services (CYPS) Case Worker in 2018. Justin was enrolled for approx. 1 year, and started year 10 in 2019. Justin was living with his mother, her partner and 7 other siblings in Canberra. Justin's father had passed away in a high speed car accident in QLD in 2017.
- When referred Justin had been previously diagnosed with Oppositional Defiance Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), Tourette's (Ticks), Disruptive Mood Dysregulation Disorder (DMDD) and had self-diagnosed with Bipolar disorder. Justin's mother found it difficult to administer medications prescribed for these diagnoses, as Justin often refused to take them.
- Justin's mother told staff on Justin's first day at school, that she believed Justin to have Dissociative Identity Disorder (DID). This first day Justin spoke openly with staff around traumas he had encountered in his life in regards to his father's death, moving interstate, relationships with other members of his family and exposure to family and domestic violence. Justin also explained experiences being bullied, involvement with drug dealers in Canberra and how he was a "runner" for their crime and theft around the region. Justin explained that he had also been sexually assaulted by an older man he and friends had obtained drugs from. Justin said openly to staff on numerous occasions that his "brain was damaged", he "can't make sense of things", and his "mind is fuzzy".
- Justin presented very erratic at times and was inconsistent in his behaviours, interactions and relationships with staff. Staff consistently saw behaviours that were relative to his mother's DID concerns which staff documented for use in hopeful assessment. These included but were not limited to:
    - Asking staff to call him by different names and saying "don't call me that stupid name" (Justin / real name)
    - Changing his speaking voice throughout the day
    - Changing his relationship, and approach with staff inconsistently and without reason.
    - Saying that there were times he "fell asleep" and didn't remember large chunks of time and memory despite being awake for those times
    - Shaking his head and hitting his head aggressively when he seemed to "lose memory" or try to remember something he felt he should
    - Saying that he felt he was in places he wasn't, and asking repeatedly where he was or how he got there
    - Changing the language on his phone to Italian and writing in Italian on the whiteboards, and then later not knowing what he had written.

  - Justin became obsessed on random days with dental hygiene. He would present at school with a bag full of toothbrushes, toothpaste, teeth whitening products, chewing gum and floss. Justin would consistently brush his teeth in class and school. He would ask people when and how they brushed their teeth, and on all of his work on these days wrote his name down as “toothpaste” and all work sheet answers were dental related words such as “Colgate, Oral B, toothpaste” etc.
  - Arriving at school bus stops and school driving stolen cars, being involved in car chases, and vehicle crashes, then explaining to the school that he didn’t remember these times.
  - Extremely disruptive, and disengaged within the school environments and for fellow students due to Justin’s inability to restrain his voice, behaviours, interactions.

- Justin engaged in extremely high risk-taking behaviours and openly spoke about committing numerous crimes including break and enters, trespassing, car theft, joyriding, and drug dealing. All necessary reports were made and family support was heavily provided to Justin’s mother. Justin spent many months during his enrolment in Bimberi Youth Detention Centre. Justin had many court appearances where school representatives were present as support for him and his family. Justin’s mother and the school contacted many services within the ACT including CAMHS and Headspace, as well as legal mental health services through the Youth Justice and police system. Existing services were also involved to a degree but distanced from day to day interaction (CYPS and Barnardos Intensive Family Support). Justin’s mother was pushing for a DID diagnosis with these services. The school advocated for Justin’s engagement with Headspace but due to him being an existing client of CAMHS, Headspace would not accept his referral. Engagement with CAMHS was turbulent and despite access and discussions with school staff as well as documentation and reports being shared to outline behaviours and concerns full assessments were not completed. CAMHS said Justin’s issues were behavioural and no DID as he would be too young to be diagnosed with that disorder. Justin’s Mother made contact with a Psychiatrist who worked with her mother (Justin’s grandmother) who was diagnosed with DID for help getting a diagnosis for Justin. The Psychiatrist replied saying that while Justin was in Bimberi they were unable to assist. This along with the cost involved for a private practitioner was outside of Justin’s family’s abilities. Through the court system, Justin’s mother and Galilee School requested and advocated numerous times for a forensic mental health assessment to be completed. This was repeatedly refused. After court appearances and sentences continued, DID was mentioned as a possibility as a defense for Justin’s criminal behaviours. However, was counteracted by the prosecution explaining that if he has DID and can’t be held accountable for his actions and he was a further risk to society. Justin was remanded again following this and CAMHS was instructed to maintain contact and complete a Mental Health assessment within the Youth Justice center. Justin’s mother explained to the school after some time that she was made aware that the assessment had been completed but Bimberi and CAMHS refused to provide her with the results without Justin’s approval. However, Justin’s mother was convinced he was “not himself” in Bimberi and was refusing or forgetting to give approval.
- Staff at Galilee School supported and visited Justin during his time remanded in detention and maintained positive and trusting relationships with Justin and his family. At the end of 2019 Justin was unenrolled from the high school and as far as the school was aware Justin did not receive any further mental health support or assistance in this area.

CASE STUDY 2:

Addressing Terms of Reference:

ii. ACT's current approach to prevention and early intervention strategies and services for youth mental health and addiction, and what needs to change;

iv. the availability of professional mental health services for students and their families at school and out of hours, including weekends and school holidays;

- Melanie (de-identified) was enrolled in Galilee School in 2015-2016 for approx. 1 year after being referred by her mother. Melanie lived with her mother and had no relationship with her father. When Melanie was enrolled she had extensive trauma history through family relationships and bullying experiences. Melanie presented with extreme suicidal ideations and self-harm tendencies. Melanie had been admitted to the Canberra Hospital and Calvary Hospital numerous times with mental health concerns. Due to there being no adolescent mental health-specific ward within the ACT, she was often admitted for short periods of time with much older people, often in a shared room.
- Melanie had many services involvement both previously and during her time at the school. Melanie had been involved with Headspace, however, was referred to CAMHS due to being a "complex case". Melanie had attended the CAMHS cottage program previous to Galilee School. During her time with Galilee School Melanie also was enrolled in an external Dialectical Behaviour Therapy (DBT) program for treatment around her repeated self-harming attempts at suicide (through self-harm and prescription pill overdoses), depression, and unstable relationships.
- Despite multiple services and therapies being in place Melanie would present often at the school with extensive self-harm which needed immediate first aid treatment. Melanie had numerous coping strategies which were implemented within the school, however, many times Melanie would reach extreme levels of distress and depression which meant she was unable to engage in the school environment or communicate with staff. Melanie would run away and become evidently distressed. This presented in but not limited to the examples below:
    - Screaming out loud within the school environment or in public
    - Running away and hiding from staff causing many searches to take place
    - Self-harming using self-made devices, stolen blades from internally and externally to the school, her fingernails in excessive repetitive scratching motions, rocks and glass found on the ground outside and rubbing wrists and arms on the gravel and road until bleeding.
    - Crying excessively and to the point of exhaustion for hours, in the one position without moving or accepting assistance
    - Punching herself in the head repetitively
    - Attaching herself to select staff members and not letting go for extended periods of time.
- During this time Melanie would make phone calls to her workers and therapists outside of the school as part of her care plan. Many times these persons and services were not available. During her time at the school, the Crisis Assessment and Treatment Team (CATT) were contacted numerous times. These contacts were for assistance in crisis situations where all other available options were exhausted. Each of these phone calls was short and resulted in staff being told to take Melanie to the emergency department at the hospital. This did not eventuate any of these times due to staff being unable to successfully move or transport Melanie in these states. Often being picked up by Melanie's mother was the only option often hours into or after an incident. Other times where Melanie was admitted to the emergency department it was reported to the school that she was observed for a few hours before being released home.
- Efforts made towards assisting Melanie in her mental health seemed to achieve short-lived minimal results. Knowledge, access, and collaboration from services was exhaustive and often met with long referral wait times, capacity dismissal and nonstop referral to other services.

- Melanie was unenrolled before further treatment options were explored while supported by the school.

CASE STUDY 3:

Addressing Terms of Reference:

ii. ACT's current approach to prevention and early intervention strategies and services for youth mental health and addiction, and what needs to change;

iv. the availability of professional mental health services for students and their families at school and out of hours, including weekends and school holidays;

- Mary (de-identified) was a 15-year-old student enrolled with Galilee School in 2019 commencing enrolment in 2020 in Year 10. Mary was referred by her mother and CAMHS. Mary lived at home with her parents and older sibling.
- Mary had previously been enrolled in the CAMHS Cottage Day program, which she completed. However, under special consideration was able to remain a client of a counsellor from the program while enrolled with Galilee School.
- Mary presented with extensive mental health concerns and had been diagnosed with Anxiety and Depression. Mary presented with extreme suicidal ideations and self-harm tendencies. Mary would often arrive at school with self-harm wounds on her arms (done externally) and request first aid. Mary at times self-harmed within the school using bought in blades or by breaking pencil sharpeners for their blades. Mary would often present in a low headspace and talked about how she didn't want to be at the school, didn't want to talk to people, and didn't want to interact or participate. Often Mary would communicate only through writing on her phone or on paper rather than orally. Mary was often late to school, and was regularly was picked up early by her mother due to her mental health deterioration.
- Mary's mother at most start of the weeks would inform staff that Mary had been admitted to the emergency department or mental health ward at the hospital due to her mental health and self-harm. Mary would tell the school that when in the mental health wards at the hospital she is often in with adults and in a very clinical nontherapeutic environment. Also when in the emergency departments would feel as if she was treated like a hindrance and get ushered back out the door as soon as possible.
- Mary missed multiple hours and days at school due to appointments with therapists and workers from CAMHS. During the lockdown period due to COVID 19, Mary's mental health went down and explained that her access to her therapists was minimal and only available over the phone which she found as a trigger and was extremely challenged to engage in this way.
- Mary was referred to the Adolescent Mental Health Unit at Shell Harbour hospital by CAMHS and was admitted for a minimum stay of 10 days. Galilee School supported this referral and maintained contact with Mary and her family during this time. After one week Mary was discharged from the hospital due to being diagnosed with "distorted eating" and that due to that diagnosis no longer was able to stay at the hospital for her mental health concerns as they were not designed to support eating disorders. Mary was disheartened after being discharged and her mental health deteriorated.
- Marys self-harming increased in consistency and severity. Mary started needing stitches for her self-harming on a consistent basis. Mary was re-enrolled into the CAMHS Cottage day Program one day a week and her attendance at Galilee School became more inconsistent. Mary's engagement in school when present decreased and she became further disengaged.
- Mary, her support team and family are continually exploring further options, programs and therapies to try and assist Mary in her recovery and intervention, but so far with little success.

CASE STUDY 4:

Addressing Terms of Reference:

ii. ACT's current approach to prevention and early intervention strategies and services for youth mental health and addiction, and what needs to change;

iv. the availability of professional mental health services for students and their families at school and out of hours, including weekends and school holidays;

- Jason (de-identified) was a 14-year-old boy, with an extensive history of trauma. Jason presented with a complex range of behaviours and mental health concerns. He was in a kinship placement due to his mother dying of a drug overdose and his father being in prison. He was a client of CYPS on was on full care orders until he was 18 years of age.
- Jason was impulsive and violent and idolized gang culture and gang ideologies. He would often fashion weapons out of everyday items and was proud of the fact he could make a weapon out of anything. He often presented as suicidal and had self-harmed several times. Jason's kinship carers were elderly. They were completely committed to him but found supporting him extremely hard. Jason had no official diagnoses and was not receiving any treatment. Galilee School knew that given his complex presentation, it was going to be difficult to sort the right supports for Jason. Over time we built relationships with him and gained his trust. We knew this was key to trying to engage him in external services as we were only able to support him during the day, Monday to Friday and he required considerably more support than we were able to offer. First, we engaged a paediatrician, but unfortunately, the paediatrician refused to see Jason again after he swore in their first appointment together. We then engaged him with Child and Adolescent Mental Health Services (CAMHS) who, once we provided with a brief of Jason and his presentations, stated his issues were behavioural and not mental health so they were unable to see him (not even a single appointment was had). We felt like to have Jason properly assessed was becoming impossible. Even after presenting to the hospital several times with suicidal thoughts, he was not reviewed or assessed. We continued to try and engage Jason in other services but this proved unsuccessful for varying reasons. Unfortunately, Jason's kinship carer passed away and Jason was placed in a residential care unit full-time. Jason continued to further deteriorate and his drug and alcohol use increased. This caused him to spiral significantly and he ended up in Bimberi Youth Justice Centre. Jason reported he received no assessments while detained however admitted he would not engage regardless by that stage. We attended Jason's case conferences with CYPS and continued to advocate for him to have a comprehensive assessment to determine the best course of action. We were told he had PTSD due to trauma and would be engaging with a counsellor. This did not eventuate. Due to Jason's behaviours, he was moved around to several different placements, where we felt like we have to start all over again as this would only further disrupt him. Unfortunately, Jason was removed from our service before we were able to further support him.
- As far as we are aware, Jason never received an assessment and continued to engage in drug and alcohol use and criminal behaviour. We felt that if we had more options back when he first engaged with us we may have had the chance to address his needs. We were turned away from health services and left with little place to go.

GENERAL EXAMPLES:

- Headspace ACT is the first go-to for many young people identifying or struggling with mental health concerns. Over many attempts to engage young people the experiences of referrals have been extremely challenging for staff and young people. Often referral forms are not responded to and when chased up, staff are told to "call for an intake interview" sometimes weeks away. Coming into

the service in a face to face fashion is not an option for the intake. Many young people have struggled with this method of intake and given the level of questions asked around personal trauma history, sexual experiences and drug engagement, young people often struggle through the process, and need extensive support throughout and after the interview, if they are able to complete it. After these interviews, young people and staff are told that the intake and referral will be assessed for eligibility and the young person will be contacted. This can often take a number of weeks, and when inquired about by staff, they often will not be told unless in the presence of the young person despite attendance limitations, or phone triggers. Often upon conclusion of assessment if a young person has been approved there can be upward of 3-6 month waiting lists. Often resulting in young people no longer being interested, or existing challenges increasing beyond service control. Collaboration with Headspace on a professional level has resulted in disappointment multiple times due to unanswered or delayed responses to emails, extensive wait times, and dismissive and awkward phone manners with young people, and inappropriate, non-individualised intake processors.

- MensLink has been a service often accessed by the school and its students. Due to open collaborations and willingness to form ongoing relationships the service has been open and adaptive to the school and it student's needs. Responses to requests are consistently prompt and followed through with. Tours and 'meet and greets' have always been an option for our young people often resulting in relaxed perceptions of the service and accessing counselling and alternative programs with positive outcomes. Due to the availability and flexibility around appointments, wait times are minimal and acceptable. Having this be a free service, accessibility is at an increased level to other programs for many more young people.

GENERAL STATEMENT:

- We need access to services in the ACT that are free and able to conduct diagnostic testing on young people. Wait times and wait lists need to be addressed with services.
- Behaviour and mental health can be one and the same and need to both be addressed by services, not just one or the other.
- Many young people who present at the school have been 'over-diagnosed' from a young age and both them and their families feel overwhelmed by service burnout, minimal success, and fear for the future. Discussions with young people around counselling or accessing alternative services for mental health concerns is often met with intense negativity and refusal due to their past involvements, or their peer's experiences. Other limitations young people face when accessing these services is around cost, and wait times. The ACT needs more accessible and free counselling and mentor services for youth (12-25yrs). Specific services for specific mental health concerns are of need, but also flexibility around individual needs and comorbidity with mental health diagnoses or mental health and drug and alcohol involvement is imperative. Short and long term specific crisis mental health support especially for young people presenting with self-harming and suicidal ideations is essential. Services available to provide much-needed assessments and diagnoses is a significant gap in mental health intervention strategies for young people. These changes need to be developed and to assure the future safety of young people within the ACT.

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