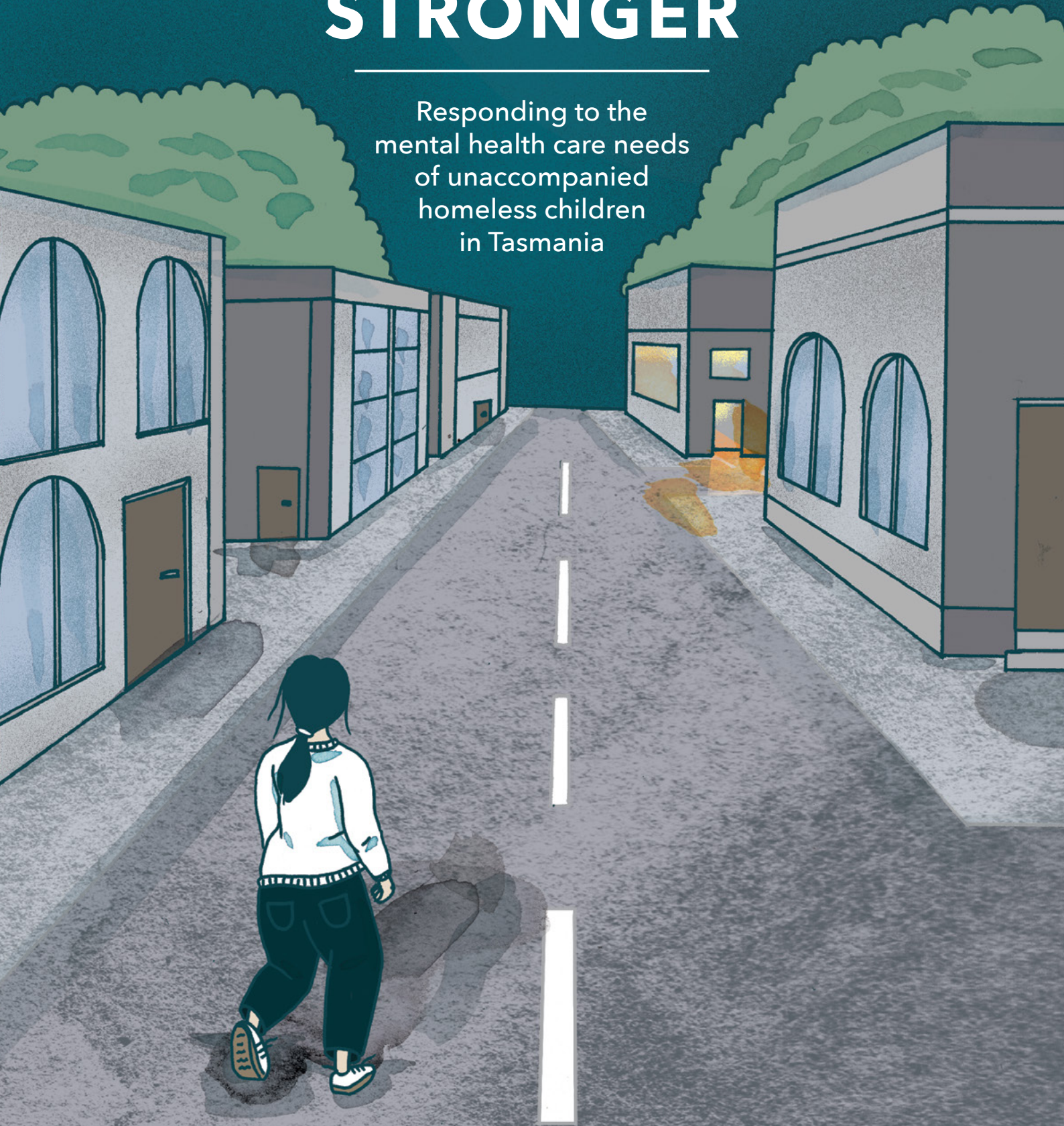


BETTER, BIGGER, STRONGER

Responding to the
mental health care needs
of unaccompanied
homeless children
in Tasmania



CATHERINE
ROBINSON

BETTER, BIGGER, STRONGER

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The team at the Social Action and Research Centre have provided light along the way.

This report is dedicated to the children and young people who participated in the research. Their hopes for their future call upon us as urgently as their pasts.

Content warning

This project includes impactful first hand description and discussion of a range of distressing experiences including physical and sexual abuse and violence, intimate partner violence, self-harm, suicide ideation and suicide attempts. If you are affected, please practice self-care and remember skilled support is available:

- Blue Knot (childhood and complex trauma support): 1300 657 380
- A Tasmanian Lifeline: 1800 98 44 34
- Lifeline: 13 11 14
- National sexual assault, family and domestic violence counselling service: 1800RESPECT/1800 737 732
- Kids Helpline: 1800 55 1800

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BETTER, BIGGER, STRONGER: A SUMMARY

What I'm trying to say is I'm one of the youths out there, and before they get to an adult age where they're going to be stuck with a mental health issue, or they're going to be stuck fucking homeless...What I'm trying to say is please get out there and help young youths and young people...because I know how it feels and every night I nearly cry myself to sleep because of how I feel and what I hear...I'm just saying what needs to be passed on.

In 2021 Anglicare Tasmania funded small-scale, targeted research to understand more about the neglected issue of mental ill-health experienced by Tasmania's homeless children (aged 10-17), specifically those who experience homelessness unaccompanied by a parent or guardian. The research project employed a qualitative, transformational research approach, exploring the lived experience of children, young people and professionals in order to identify the key elements of *ideal* mental health care for unaccompanied homeless children, and the system, service and practice changes that could result in effective mental health care delivery for this cohort.

This report delivers the key findings and recommendations from the research. It offers insight into the lives and dreams of 15 Tasmanian children and young people who have experienced homelessness and mental ill-health alone. It also details the experiences of 65 Tasmanian professionals working mostly in community-based and school-based services, who all report struggling to respond to the complex and competing needs presented by this group of children.

The report recommends targeted efforts to deliver equitable access to early supports through primary schools and primary and allied health providers. It also recommends a strengthened response to unaccompanied children already experiencing homelessness and mental ill-health, including the *concurrent* provision of a complex mental health care service through CAMHS and a mobile care coordination service through Children, Youth and Families.

The struggle for complex mental health care in Tasmania

Due to their circumstances, unaccompanied homeless children are often unable to access support appropriate to their needs from all types of mental health care providers, including those working in general and private practice, schools, headspace, CAMHS and hospital emergency departments. When they are left with the task of managing alone or with mismatched supports, the adversity they experience is intensified and prolonged.

The lack of moderate to severe and complex mental health service provision in Tasmania has particularly negative ramifications for unaccompanied homeless children, who commonly experience mental ill-health in the context of a lack of effective guardianship or independent income, unstable accommodation and cumulative trajectories of child and adolescent adversity, including poor physical health, abuse, neglect, bullying, grief, and sexual and physical violence.

As well as detailing the mental health struggles of children who experience unaccompanied homelessness, this report offers an account of the stress and frustration experienced by the dedicated workforce who are left holding this cohort in services not designed to meet their needs. It also captures the widespread desire to do better and to design and deliver new services that work through collaboration, build professional competency, reduce vicarious trauma, and share and mitigate risk.

Better, bigger, stronger care

Participants in this research make a compelling case for the positive impact that improved access to primary and allied health care and a complex mental health care service could make in the lives of unaccompanied homeless children *and* in the work of other agencies, services and professionals already engaged in their care.

It is also made clear that additional mental health service provision targeted to children experiencing complex needs will not *alone* be effective in responding to their mental health needs. Children, young people and professionals describe the *concurrent* provision of secure accommodation, youth outreach support and access to specialist mental health services as the ideal context in which greater physical and psychological stability and recovery can be achieved.

Given current work to strengthen accommodation options for unaccompanied homeless children under 16 in Tasmania, a focus for professionals was the crucial role that mobile care coordination could play alongside any new complex mental health service. Professionals suggested that youth workers providing mobile care coordination would help stabilise the life circumstances of children in a range of settings so that specialist mental health care could be efficiently delivered and maximised through collaborative effort. Importantly, it was argued that a dedicated care coordination service should include both youth outreach workers and a multi-agency specialist practitioner team responsible for providing secondary consultation and direct service provision to children where needed.

Finally, childhood adversity emerges in this report as the fundamental driver of children's experiences of unaccompanied homelessness and mental ill-health. With cumulative adversity described as unfolding through childhood and into adolescence, it is clear that increased resourcing for targeted early intervention work in primary schools – as children's first universal and statutory service setting – could be hugely significant for children's immediate safety and wellbeing and for breathing life into their dreams of purposeful and happy lives.

Recommendations

1

RECOMMENDATION ONE:

Strengthen early responses to childhood adversity through expanding social work capacity in primary schools.

2

RECOMMENDATION TWO:

Target increased access to primary and allied health care for children and young people experiencing disadvantage through additional investment in the Youth Health Fund and mobile health care outreach.

3

RECOMMENDATION THREE:

Establish a complex mental health service with significant outreach capacity in the Tasmanian Child and Adolescent Mental Health Service.

4

RECOMMENDATION FOUR:

Develop a care coordination service through Children, Youth and Families for children and young people experiencing complex needs, comprising mobile care coordination teams and multi-agency specialist practitioner teams.



INTRODUCTION

"These are the kids no one gives a shit about."

Unaccompanied child homelessness is the uniquely distressing and complex outcome of family conflict, abuse and a lack of effective guardianship provided by families or the State. Children who experience homelessness alone may sleep rough, couch surf with extended family, friends and acquaintances, or access Specialist Homelessness Services (SHS). During this time it is likely that they will lack adequate access to care and supervision, income, health care and education. This results in inadequate nutrition, lack of physical and mental health treatment and cognitive assessment, increased violent and sexual victimisation, and extended school absences of multiple terms, even years (Noble-Carr & Trew 2018; Robinson 2017a, 2018).

Research demonstrates the personal and systemic vulnerabilities which powerfully combine to drive the cumulative experience of harm in children’s lives. Exposure to the intimate partner violence of caregivers, physical, sexual and emotional abuse, neglect and abandonment feature in children’s routes into unaccompanied homelessness. Weak health and social care, including limited early intervention, continued referral between organisations and a lack of exit points, contributes to and prolongs children’s exposure to cumulative harm. Once homeless, children’s need for sustained family reunification support and stable, age-appropriate care fundamentally confounds current service design, exposes key service gaps and escapes clear government agency responsibility (Robinson 2017b).

In 2020-2021, 393 unaccompanied children aged 10-17 accessed Tasmania’s Specialist Homeless Services (SHS), with 242 (62%) of these children reported as having a mental health issue (AIHW 2021a).¹ Within Australia, Tasmania has a high rate of presentations to SHS by those with a current mental health issue, with this rate being the highest amongst Tasmanian children aged 15-17 (AIHW 2021a). This is a pattern that can also be expected amongst the likely much larger number of children who do not and cannot access SHS and instead experience homelessness as sleeping rough and couch surfing with extended family, friends and acquaintances.

Despite the high rate of mental ill-health experienced by unaccompanied children presenting to SHS and local recognition of the acute and complex mental health needs of this cohort, there is long-standing and consistent cross-sector acknowledgment that effective mental health care is largely inaccessible for unaccompanied homeless children in Tasmania. Currently, however, there is no research evidence to support or explain this context or to explore its effects on the lived experience of children and the range of professionals who may work with them.

Intervening in the absence of locally nuanced research evidence, this project sets out to understand more about the mental ill-health of Tasmania’s homeless children (aged 10-17), specifically those who experience homelessness unaccompanied by a parent or guardian. The project employs a qualitative, transformational research approach, exploring the lived experience of unaccompanied homeless children and professionals in order to identify the key elements of *ideal* mental health care for unaccompanied homeless children and the systemic and service-level conditions that would enable the delivery of such care in Tasmania.

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1 For a full definition of ‘mental health issue’ in Specialist Homelessness Service Collection data see AIHW 2021b, p. 82.

Situating *Better, Bigger, Stronger*

In 2017 Anglicare Tasmania's Social Action and Research Centre (SARC) undertook a large project exploring the drivers of high vulnerability in the lives of older children (Robinson 2017a). This project, *Too hard? Highly vulnerable teens in Tasmania*, focused on a specific cohort of Tasmanian children aged 10-17 often known to Child Safety, Police and Youth Justice and who also experience homelessness unaccompanied by a parent or guardian.² The high vulnerability experienced by this cohort was found to stem from chronic personal and systemic adversity. Childhood trauma, neglect and abandonment were common experiences, along with falling outside the scope of nearly every possible form of care, protection and support across multiple community services and government services, including Child Safety, SHS, Learning Services and the Child and Adolescent Mental Health Service (CAMHS).

A suite of research projects focusing on key themes raised in *Too hard?* was subsequently planned. The first project focused on the issue of unaccompanied child homelessness and the significant gap between Child Safety and SHS through which the care needs of children fall (see *Who cares?*, Robinson 2017b). The second project focused on the issue of access to education for vulnerable children and the particular struggle of community-based youth services in working to keep vulnerable children, particularly those experiencing unaccompanied homelessness, enrolled and able to access schools (see *Outside in*, Robinson 2018). The third project examined the health, social and economic impacts of COVID-19 on unaccompanied children, with rapid research undertaken through the public health emergency declared in 2020 (see *#StayHome?*, Robinson 2020a).

The fourth project, presented in this report, responds to the centrality of complex trauma, bullying, suicidality, self-harm and diagnosed mental illness in children's lives originally identified by both older children (aged 14-17) and service providers in *Too hard?*. As a short and focused project undertaken over six months, its purpose was to dive more deeply into experiences of, and responses to, mental ill-health in the context of the broader adversities being experienced by homeless children.³ It builds on key themes of complex trauma, the need for increased school supports, and poor health and mental health service access also described in *Outside in* and *#StayHome?* and will be usefully considered in conjunction with *A public health approach to ending unaccompanied child homelessness* (Robinson 2020b).

The project also responds to the communicated distress of the Tasmanian youth sector, in particular youth SHS staff, who report increasingly finding themselves on the frontline of responding to older children's complex mental health needs without appropriate staffing, training or resources. Corroborating the lived experience of Tasmanian SHS workers,
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- 2 The focus was on those children who may be known to Child Safety but who were *not* placed on formal orders. Child Protection Orders are court-ordered legal instructions on the nature of care to be provided for a child determined to be at risk. These include short-term orders for up to 12 months or until the child turns 18.
- 3 In line with definitions utilised in the Tasmanian Government's key policy and reform plan, *Re-think Mental Health, Better Health and Wellbeing* (Department of Health and Human Services 2015, pp. 39-40) in this project mental ill-health is a term used to refer in an inclusive way to the experience of mental health problems (including symptoms not meeting criteria for diagnosis) and diagnosed mental illness or disorder.

analysis of Specialist Homelessness Services Collection (SHSC) data reveals numbers of unaccompanied children (aged 10-17) experiencing a 'mental health issue' have steadily increased over the last five years from 184 in 2016-2017 to 242 in 2020-2021 (AIHW 2021a).

More broadly, the mental health care needs of unaccompanied homeless children are an emerging concern of researchers nationally (Cooper 2018; Chowdry et al. 2018; Noble-Carr & Trew 2018; NSW Ombudsman 2018). There is no research nationally which focuses in depth on the mental health experiences and needs of this cohort, but existing work points to extreme mental health challenges. Alongside poor physical health, nearly every participant in recent research on unaccompanied child homelessness in both ACT and Tasmania self-reported mental health issues including anxiety, depression, a diagnosed mental illness, self-harm and suicidality (Noble-Carr & Trew 2018, p. 31; Robinson 2017a, p. 77). In their longitudinal study *The Cost of Youth Homelessness in Australia*, Flatau et al. (2015, pp. 11-14) found that over 50% of homeless children and youth (aged 13-25) had been medically diagnosed with at least one mental health condition in their lifetime, nearly two-thirds experienced very high or high psychological distress, and one in five young homeless women had attempted suicide in the past six months.

Such findings are consistent with Australian and international reviews and medical studies which find that compared to children and young people living at home, those who are homeless have profoundly high rates of poor mental distress and illness (for example, see Edidin et al. 2012; Hodgson et al. 2013; Kamieniecki 2001; Solorio et al. 2006) and experience, as Davies and Allen (2017, p. 26) conclude, 'consistent and repetitive exposure to trauma' (see also Wong et al. 2006).

In particular, Canadian research shows that *early* experiences of homelessness (before age 16) are strikingly associated with mental ill-health, addiction and the increased likelihood of attempting suicide (Gaetz et al. 2016, p. 65). Such severity of mental ill-health and suicidality may be uniquely pronounced for unaccompanied homeless children, in part due to the prominence of abuse in this cohort's pathway into homelessness and the observed link between abuse and mental ill-health (Rattelade et al. 2014). As such, the provision of mental health care, including a trauma-informed service system, continues to emerge as a central concern in responding to and resolving homelessness experienced by unaccompanied children and young people (see for example, Yfoundations 2016; Schwan et al. 2017).

More broadly, however, there is growing evidence to suggest that despite improvements in the provision of youth-specific mental health services in Australia, they remain inaccessible or less accessible for children and young people experiencing adversity and disadvantage, particularly in regional and rural areas (McCann & Lubman 2012; Youth Development Australia & National Youth Commission 2019, p. 13; Orygen & headspace National 2019, p. 32). It has also been observed that the de-institutionalised mental health system is still evolving in Australia and that a significant sub-acute care gap remains for children and adolescents as well as adults. Commonly referred to as 'the missing middle' (see for example, Orygen & headspace National 2019, p. 27), this care gap sits between primary and tertiary or acute services and between federal (primary) and state (acute) funding and responsibilities.

As such, even if unaccompanied homeless children successfully access primary services, given the expected complexity of their mental health needs, their care needs may remain unaddressed until they become acute (for example emergency presentation or hospital admission), as they are too severe or complex for primary care services. As Schwan et al. (2017, p. 11) similarly note in the Canadian context, 'Despite evidence to the contrary, our approach to addressing the mental health needs of homeless youth has primarily been to wait for mental health challenges to become acute before intervening through emergency supports, rather than focusing on prevention'.

While the 'missing middle' of community mental health service provision has wide ramifications for young Australians in general,⁴ the combination of complexity of need and lack of personal support that unaccompanied homeless children face shapes a unique perspective on this service gap, which is less likely to be heard or become the subject of mental health system advocacy. Further, the invisibility of the mental health needs of unaccompanied homeless children is compounded whilst the conceptual and practical categories of 'youth', 'homeless youth' and 'youth mental health' continue to subsume and obscure the existence of the very specific developmental and situational needs of unaccompanied *children*. For example, the most significant recent research to emerge on youth homelessness and mental health in Australia incorporates children aged 12 to young adults aged 25 (see Boyle 2020). Whilst this research provides grounded recommendations which are powerfully relevant, they are insufficiently nuanced to respond to the needs of children under 18 without effective guardianship.⁵

Research which specifically links childhood adversity and poor mental health, in particular suicidality, makes comprehensive recommendations for early intervention support targeting families to reduce childhood adversity and educational programs in schools which focus on childhood abuse and bullying.⁶ Again, however, unaccompanied homeless children arguably occupy a blind spot in research on childhood adversity and mental ill-health just as they do in research on youth homelessness and mental health. There is a unique, extreme vulnerability experienced by this cohort of older children *once they are alone and homeless* which is rarely captured in research. This is a slippage which flows to their limited consideration in the design of health and social care systems.

The observed and expected longer-term mental health impacts of COVID-19 provide additional urgency for the need to reconsider approaches to addressing the complex mental health needs of highly vulnerable children and young people in Tasmania. Research evidences the likely negative impacts of disaster events on mental health, suicide ideation and suicide rates (Kessler et al. 2008). The Mental Health Council of Tasmania (2020) already notes the disproportionate impact of COVID-19 on children and young people, including an anecdotal sector-wide spike in need for youth mental

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- 4 Orygen, for example, describes the population-wide issues faced by children and young people in accessing complex mental health care and raises questions about whether such system gaps 'perversely increase the severity of mental ill-health (Orygen 2022).
- 5 Likewise, where homeless youth make it on to priority or vulnerable population lists for systemic youth mental health advocacy, consideration is not given to the unique needs of unaccompanied children within this broader cohort (see for example, Orygen 2019, p. 36).
- 6 For a recent summary of evidenced approaches for reducing childhood adversity, see Sahle et al. 2020.

health services and a lack of capacity for response in Tasmania. Further, research on the impacts of COVID-19 on unaccompanied homeless children in Tasmania (Robinson 2020a) has highlighted community-based support workers' concerns about intensifying mental ill-health, including suicide ideation, and increasing drug and alcohol use amongst unaccompanied homeless children (aged 10-17). This was paired with increasing difficulty accessing support for physical and mental health, including bulk-billing GPs and mental health professionals.

Disaster research indicates that impacts on mental health are expected to peak up to two years post-disaster (Horney et al. 2020). Positively, this suggests there is a current window of opportunity within which to refine supports to meet increasing and anticipated mental health care need following the public health emergency and lockdown of 2020 and subsequent impacts of the COVID-19 variant Omicron in Tasmania in early 2022. Without specific focus, however, there is a significant risk that the complex mental health needs of highly vulnerable children and young people will be subsumed under population-level responses to youth mental health.

Policy and practice: A unique opportunity for action in Tasmania

Important policy and service developments in Tasmania are creating a window of opportunity within which to holistically address the unique struggles experienced by unaccompanied homeless children. Of particular importance is current work to realign the vision and practice of CAMHS with consecutive Australian National Mental Health Plans, *The National Children's Mental Health and Wellbeing Strategy* (National Mental Health Commission 2021), the recommendations of the Mental Health Integration Taskforce report (Department of Health 2019a) accepted by the Tasmanian Government (Department of Health 2019b), and *Rethink Mental Health 2020*, the statewide plan for mental health in Tasmania 2020-2025 (Department of Health and Human Services 2015). The CAMHS Review (McDermott 2020) provides pointed instruction for the development of a new, integrated CAMHS with a broader focus that specifically includes disadvantaged children and young people with complex needs and increased capacity for outward collaboration with, and specialist support of, education and social services.

Better, Bigger, Stronger shines a spotlight on the specific mental health care needs of unaccompanied homeless children during this period of CAMHS reform and broader focus on 'horizontal' service integration (Department of Health 2019a, p. 24).⁷ There is current opportunity to foreground the complex mental health needs of unaccompanied homeless children as a point of focus for CAMHS' reforms and to explicitly advocate for CAMHS involvement in existing multi-agency and cross-sector work to address unaccompanied child homelessness in Tasmania.

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7 A useful distinction is made in *The National Children's Mental Health and Wellbeing Strategy* (2021, p. 47) between service integration and service coordination. The strategy points to the need to go beyond the more common focus on an integration of health and mental health care services to also ensure that, especially for those children experiencing complex needs, care coordination occurs reciprocally across a range of agencies and related services.

In particular, it would be useful to consider how the CAMHS reform may align with and augment specific actions outlined in the recently released *Under 16 Homelessness: Children and young people under 16 who are alone and at risk of or experiencing homelessness: A policy framework for Tasmania* (Department of Communities 2022). Likewise there may be opportunities to consider how strengthened collaboration with CAMHS may assist in maximising significant new investment in responses to unaccompanied homeless children recently outlined in the *Strong Families, Safe Kids Next Steps Action Plan 2021-2023* (Department of Communities 2021) and in the *Tasmanian Child and Youth Wellbeing Strategy* (Tasmanian Government 2021). These responses include the development of a residential care pilot for unaccompanied homeless children under 16 and the creation of youth liaison positions within the Strong Families, Safe Kids Advice and Referral Line.

Finally, the *Premier's Economic and Social Recovery Advisory Council Final Report* (PESRAC 2021, p. 47) identifies acceleration of the reform of CAMHS and implementation of the *Rethink Mental Health* plan as a priority. Ensuring that the voices of unaccompanied homeless children and those who work with them are heard during this period of COVID-19 recovery and potential policy, system and service design is crucial.

Research approach

This project is informed by the concept of practical justice and an overarching concern to challenge the embedding of inequality in social infrastructure such as health, housing and care systems and services (Aggleton et al. 2019). A specific focus of this project is to understand inequality in mental health care experienced by unaccompanied homeless children in Tasmania and to investigate system, service and practice changes that could result in effective mental health care delivery for this cohort.

The overarching aims of the project are to:

- understand unaccompanied homeless children's experiences of mental ill-health in Tasmania
- investigate barriers to mental health service provision for unaccompanied homeless children in Tasmania
- consider what models of support and service would better meet the mental health needs of unaccompanied homeless children in Tasmania.

The research questions were:

- What experiences of mental ill-health do unaccompanied homeless children have? How do they manage their mental health? If they access mental health care services, what are their experiences of these? How do unaccompanied homeless children envision ideal mental health care?
- What is known about the extent of mental ill-health and the spectrum of mental health care need amongst unaccompanied homeless children in Tasmania? How do practitioners envision ideal mental health care for unaccompanied homeless children? What currently prevents community and government programs and services from delivering ideal mental health care to unaccompanied homeless children?

A qualitative, transformational methodological approach to this research project delivers narrative investigation of the *current* experiences of unaccompanied homeless children and practitioners and also elicits accounts of what form *future* mental health care provision for unaccompanied homeless children should take.

The project was fully funded by Anglicare Tasmania and undertaken statewide through four overlapping phases of fieldwork:

1. In-depth interviews with professionals in community-based youth homelessness, youth outreach and youth mental health services.
2. In-depth interviews with professionals in Tasmanian Government school-based student support services.
3. In-depth interview with professionals in a Tasmanian Government youth health service.⁸
4. In-depth interviews with children and young people with previous or current experiences of unaccompanied homelessness and mental ill-health.

The research governance and ethics approvals process for this project was focused on actively supporting and managing the participation of a highly marginalised cohort of children and ensuring participation of professionals from a comprehensive range of organisations and services in contact with unaccompanied children. Ethics review and approval was provided by the University of Tasmania (H0018528) and research governance review and approval by Department of Education (EPR0122582) and Department of Health (SSA373).

In total, there were 80 participants in the research, with interviews undertaken predominantly face-to-face during October-December 2021. 65 professionals participated in 40 group and individual interviews; 25 group/individual interviews were undertaken in the south of Tasmania, 8 in the north and 7 in the northwest. Professional participants included:

- 45 professionals from community-based youth homelessness, outreach, health and mental health services, including managerial and frontline SHS staff, youth outreach workers, service clinical leads, psychologists, clinical social workers, social workers, a GP, and a nurse
- 18 professionals from 4 colleges and 2 high schools, including a principal, assistant principals, school psychologists, school social and youth workers and school nurses
- 2 social work professionals from a Tasmanian Government youth health service.

15 children and young people aged 15-20 years (average 17 years) participated, with 3 interviews undertaken in southern Tasmania, 4 in the north and 8 in the northwest.

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8 This phase of the research was designed to include in-depth interviews statewide with community- and hospital-based professionals from the Tasmanian Child and Adolescent Health Service. Anglicare Tasmania was unable to secure support from the Department of Health to progress required site approval for the inclusion of CAMHS staff in this project. The input of CAMHS and Youth Health South (Pulse) to the project Reference Group has been highly valued.

All child and youth participants were current clients of outreach and SHS services, with staff closely supporting their participation in the interviews by providing transport, attending interviews with clients and debriefing with their clients following their participation. Of those who participated, 3 were boys/young men, 11 were girls/young women, and 1 was female/male undecided.

All interviews were recorded, transcribed and thematically analysed, with attention given to both points of corroboration and divergence amongst the views and experiences of participants. All children and young people who participated received \$50 in recognition of the time taken to contribute knowledge, experience and advice on system and service changes.

Informal policy information and advice was also sought and received from the Mental Health and Drug and Alcohol Directorate, Primary Health Tasmania, and the Child and Student Wellbeing Unit, Department of Education. Finally, a generous Reference Group gave input and guidance to the researcher. This 15-member Reference Group included representation from Primary Health Tasmania, Mental Health and Drug and Alcohol Directorate, CAMHS and Youth Health South (Department of Health); Strong Families, Safe Kids (Children, Youth and Family Services, Department of Communities); Student Support/Learning Service (Department of Education); Anglicare Tasmania, Colony 47, Life Without Barriers, and The Link Youth Health Service.

Missing voices and scope for further research

Due to the scale of the research and a limited youth services sector in Tasmania, this project does not provide insight into the unique experiences of Tasmanian aboriginal children, children with migrant and refugee backgrounds, and children from the LGBTQI+ community. The additional barriers to accessing skilled and appropriate mental health services for unaccompanied homeless children amongst these communities were only explored at a high level with a small number of professionals.

One shared perspective was that significant cultural adjustments across Tasmanian society - in terms of educated engagement with children from LGBTQI+, migrant and refugee communities - would go a long way to addressing both poor mental health and homelessness experienced within these groups. Recognising stigma and discrimination as drivers of mental ill-health and homelessness and resourcing both universal and specialist services to be inclusive, in particular of language interpretation needs, was seen as vital.

This highlights the need to grow social and organisational responsibility for the physical and mental wellbeing of a *diversity* of children, instead of pathologising and targeting psychological services to children and young people suffering the outcomes of social structural harm. Alongside this observation about the need for cultural and organisational change, it was also noted that intergenerational trauma and family conflict related to sexuality and gender diversity are uniquely powerful causes of unaccompanied homelessness and mental ill-health for children and young people. A lack of access to culturally safe GPs and housing and homelessness services and a lack of understanding of the likely life experiences of humanitarian entrants into Tasmania were also raised as key issues.

Whilst the specific experiences and service barriers of Tasmanian aboriginal children, children with migrant and refugee backgrounds and children from the LGBTIQ+ community did not emerge in the majority of interviews with children, young people and professionals, it remains unclear if this reflects potential exclusions and limited engagement with these communities across the youth, homelessness, health and mental health service system in Tasmania. Broader research certainly suggests different experiences of mental ill-health and hidden pathways into and through homelessness within these communities.⁹ Further research is required to appropriately ensure the unique dynamics of unaccompanied child homelessness within these communities are made visible in Tasmania.

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9 See for example publications from Mission Australia’s Youth Survey which consistently report higher levels of psychological distress and homelessness amongst Aboriginal and Torres Strait and LGBTIQ+ young people, including Hall et al. 2020 and Brennan et al. 2021. See recent US research linking homelessness and mental ill-health in the experiences of LGBTIQ+ young people (The Trevor Project 2022) and also research exploring the hidden pathways into and through homelessness for refugee young people in Australia, including a distinct lack of service use (Couch 2017).

PART I
**WHAT
CHILDREN
SURVIVE**

"It just goes to show what a family really does for you."



Part I of this report opens engagement with interview material shared by children and young people. It offers insight into how they described and characterised their childhoods and their experiences of unaccompanied homelessness and mental ill-health. Whilst difficult to hear and read, deep listening to these childhood experiences is *the* crucial activity needed to understand and appreciate the intensity of suffering that unfolds from early in children’s lives. There are accounts of lifetime sexual abuse and violence, exposure to and experience of intimate partner abuse, loss and grief, spiralling mental health, loneliness and bullying, self-harm and repeated attempts of suicide.

Also considered are the periods of stability which were developing for some children and young people at the time of their research participation. Currently supported through outreach services and safe in their accommodation, some participants were also connecting with mental health care; these were positive but fragile experiences of diagnosis and support which were arrived at, and held in place, only through the persistent activity of community-based youth outreach workers. Despite these glimpses into the shape and outcomes of better service delivery, however, childhood narratives were overwhelmingly dominated by cumulative adversity and spiralling mental ill-health.

Complex trauma and neglect

As also reported in earlier research *Too hard?* (Robinson 2017), neglect and complex, cumulative trauma are central in trajectories of unaccompanied child homelessness.¹⁰ Of the 15 children and young people who participated, 10 disclosed childhood abuse, including sexual, physical and emotional abuse from parents, step-parents and other family members. This abuse was clearly and graphically described by participants. Included here are just some brief examples of what was described. These edited excerpts are shared to highlight the very serious nature of abuse, but only capture single moments. Each child and young person’s life history was stacked with these, in many cases with each adverse event triggering further vulnerability to the next.

Young participants described severe physical violence inflicted by family members:

Sammy (17): There was a lot of violence. Being strangled to the point where I could barely even breathe at all. And being thrown around the rooms...I couldn’t deal with it.

Gem (18): I was living with my father and my step-mum...They were real bad because, yeah, my dad never really, never took proper care of me. He was always abusive... physically, mentally, fucking financially...Me and my dad just got into an argument one day and he had me on the ground and he said he was going to break my arm and then I said that was enough.

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10 For broader discussion of the relationship between trauma and homelessness, see Robinson 2014.

Renee (18): So December was the big incident where I was absolutely fucking covered in bruises. I went to see me ex-step mum on a walk. He [father] seen me there. Went absolute chaotic. I wouldn't keep my mouth shut. He belted the fuck out of me and the neighbour come across the road, from across the road and down three houses, and she's like, what the fuck's going on? I can hear you from across the road. And he's like oh yeah, I slapped her 20 odd times and stuff, and she's like there's obviously been more than that, because I had right away instantly welted up bruised. So I had gone past the point of normal bruising. You could see there was burst blood vessels in my legs. It was welted up about an inch. It was black, purple, fucking red, everything. I had marks all over me. She didn't call the cops which I'm pissed at but at the same time, she was terrified of him as well. Everyone was fucking scared of him.

Experiences of sexual violence also featured in participants' narratives, and were described as being, at times, minimised or dismissed by others.

Jay (16): Yeah from 10 to 13 I was sexually assaulted by my pop...And it got to the point where it got too far of me and him actually doing stuff with each other and stuff like that, and I didn't know any different; how was I supposed to know any different?

Viviana (17): I'm not going to go into it detail, but my step-father, he was pretty disgusting. Not only did he sexually assault my mum, but he also sexually assaulted me. And so mum ended up leaving him finally after three years and moved us up the coast. And then that was when I was a bit like, okay, this is actually real. This stuff has actually happened to me. And when I did try and speak out about it my mum didn't believe me and neither did my dad.

In one extreme case, Lila's mother actually coerced her to 'sleep with a dude so he'd buy the car':

Lila (16): Mum invited this dude over, but she went to bed. And then we started talking and what not and then I was like, 'Yeah, well, I don't want to do it,' you know, don't want to have nothing to do with that. But then she's like, 'No you have to stay with him so he can buy the car.' So it was, like, I wouldn't call it prostitution or nothing, but she was making me sleep with a dude so he'd buy the car.

Participants who experienced early childhood abuse also variously described experiences of neglect (in particular relating to parental drug and alcohol abuse), additional experiences of sexual and physical assault, exposure to the self-harm and intimate partner violence of care-givers, violence in their own teen relationships, and the deaths of family members, including primary carers. Bree's experience illustrated something of the parental chaos and distress experienced in early childhood:

Bree (15): My mum and dad weren't really around because they were on drugs, so my older sister took care of me...She would have been 15 when she was taking care of us...Before we went into care, he [father] was trying to manipulate my mum, so he cut himself, and it was really deep. And then we went back to the house and there was blood all over the walls.

Of the remaining 5 young people, 4 reported a range of adverse events including witnessing parental self-harm, parental alcohol and drug use, family violence and the intimate partner violence of other caregivers. They also experienced intimate partner violence in their own teen relationships, including coercive control and physical and sexual assault.¹¹ Only one young woman did not disclose specific trauma events or discuss family experiences in any detail.

Tara described being caught up in intimate partner violence being experienced by her aunt:

Tara (19): Because when my aunty said that I could move in, she told me he wouldn't be moving back into the house because he wouldn't be allowed to because of the family violence order thing. But they obviously didn't follow that and he got out of jail and he moved back...and then an incident happened...He smashed in the front glass, so he was stalking the house and then he must have knocked on the door...we were watching tv, the kids were in bed and then she wouldn't let him in so he just - the whole front door was just glass, double door glass, and he just punched through the glass and so then obviously he made his way inside, he was screaming...

Tam and Opal both experienced violence in their own intimate teen relationships, with Opal surviving a horrific attack during which she feared for her life:

Tam (18): I was 14 when we were first together and he was a few years older than me and we were together, but I guess I sort of felt as if he sort of, I don't know if you would say sexually assaulted me, or I suppose we were together, but I still said no. So that sort of thing. So not really a safe person; he was like my dad, not a nice person, just a shitty person I suppose.

Opal (15): He head-butted me in the back of the head, kneed me in the arse so I went forward and smashed the glass. He either punched that side of my face or hit that side of my head because I had bruise on that cheek...he pinned me up against the wall by my throat and the towel rack was there so I ended up with...a massive bruise on back...I don't know how to explain it, but it's almost like he moved like a snake as he moved into me...like swaying as he was going in. And I thought he was going to head-butt me...so I turned my head and he was like, 'Oh, do you want me to fucking rape you, girl?'

Despite the level of abuse, neglect and ongoing risk these children and young people experienced, only six participants reported contact with Child Safety Services, two reporting no action taken, two reporting one week orders and two being placed in Out of Home Care for a limited period (approximately 2 years). One young person, currently living in a crisis accommodation facility in Tasmania, was still on an order in Victoria.¹²

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11 For an in depth examination of teen intimate partner violence in Tasmania, see the forthcoming work of Anglicare Tasmania's Carmel Hobbs: <https://www.anglicare-tas.org.au/fired-up/>.
12 Retrospective permission for participation in the research was sought from this young person's Child Safety worker, as at the time of interview the researcher was unaware that a Child Safety Order was still current in Victoria.

Unaccompanied homelessness

At the point of interview, four participants were in short-term crisis accommodation, four in transitional accommodation with outreach support, two were staying with extended family, two with intimate partners, one in a youth foyer, one in private rental, and one in social housing. All participants described unaccompanied homelessness, with most experiencing extended periods of couch surfing following family conflict, abuse and exposure to family or intimate partner violence. Girls typically reported moving in with older male partners who were subsequently abusive. Overcrowding, survival crime and increased drug and alcohol use also featured in children and young people's narratives. Cycling through youth shelters for extended periods was reported by four participants.

Kayla described how escalating physical and emotional abuse from her mum led her to eventually seek safety elsewhere:

Kayla (18): Since my mum got with who she's still with now when I was 12, their relationship's very toxic and very aggressive. Can be physical but mostly verbal and I've been caught up in a lot of that. And mum's very aggressive towards me and very abusive towards to me physically and verbally...When I was about 12/13, when that started happening, once I realise I couldn't cope with it, I started leaving home...I lived with Dad for a bit, lived with Nan for a bit. I've been at friends' places, on people's couches. I've literally slept on the streets several times, literally on the concrete with a blanket...It was horrible. Like really horrible. It was cold, it was uncomfortable, it was embarrassing, it was just shit to be honest...Having to carry around with you everything that you own to make sure it's safe as well, that's hard.

Catherine: So it was just not safe for you to be at home?

Kayla: Not - especially mentally, 'cause I have mental health issues and it really impacts my mental health. Then when stuff gets physical, that's obviously not safe either.

Likewise Issy and Viviana explained that physical and emotional abuse led to couch-surfing and in Viviana's case to a cycle of homelessness which including entrapment with an abusive boyfriend, a return home and then an exit into rough sleeping:

Issy (16): I was self-harming really bad at that time and right before I left home she [mother] was like, 'Just fucking kill yourself. Why are you still here?,' kind of thing. And my older brother was like, 'You need to get out of here.' And I'm like, 'I know.' So packed a bag and left. So I was kind of like couch surfing, so I pretty much would just be like - on my Snapchat story I'd be like, does anyone have somewhere to stay? I don't have anywhere to go. And at that time I didn't really know about the girls' shelter, which I ended up staying at afterwards. But yes, I was kind of like, I didn't have anywhere to go. Please, someone, just let me stay.

Viviana (17): Mum kicked me out of home over a pair of school shoes...she was being very violent, very aggressive...she went and spoke with her partner. And then he ended up being quite aggressive and violent and was getting right up in my face...

And I called my Dad asking if he could come and get me because my mum didn't want me in the house anymore, and I genuinely didn't feel safe there anyway. And he just said that he was too tired...And at the time I'd been dating this bloke for a year and so his family, like I really got along with them well and I felt much more safer with them than what I do with my own. And my dad wasn't really...he's very unreliable and unsupportive...So I moved in with that family and then things happened with me and that bloke a year later...At first it was once off and then for a few months he didn't do it and then after it just continuously happened. He'd do it and then afterwards he'd try and victimise himself and say that the only way that he could get me to listen is if he went and like...hit me...And so earlier this year I moved out of there and tried to go back to my mum's and she kicked me out again... And so that's when I ended up being homeless for a bit...I stayed with a friend for a few weeks and then a few nights I'd go sleep in a paddock somewhere, and then another few nights I'd go chill out on the street in [regional town]...The one shelter that did have room, they couldn't give me because they had a dangerous occupant there.

For Jay, violence and sexual abuse preceded a long-term cycle of crime, shelter-hopping and living 'out like an animal':

Jay (16): Me and my stepdad were violent towards each other. He would protect himself obviously but then it would get a bit too much...It's just that I wanted Dad home and wanted the family we had at home. And then I started experiencing reality at a very young age, and okay, this is what you have to do when you get to a certain age, like you have to start caring for yourself. And then turned to crime. I committed my first offence at 10...and then from there I haven't stopped...It was just I needed food at the time...I did it very angrily; I could have just walked up and said, 'hey can I have some food?' but I did it sneakily and stole it... I've been out like an animal, 'okay let's go through this bin', and 'I want something to eat' or hey let's go to [supermarket] and steal this...I had to go to the extent of that to be able to live... So I started my criminal stages at 10 and then my homelessness at 12. I ended up at [shelter]...I've been to [shelter], [shelter], [shelter], I've been back and forwards through them for - it would be nearly four years.

Striking in most young people's narratives was the chaos and uncertainty of homelessness and their drift through multiple living arrangements with family and friends, even in the case of participants in contact with child protection services:

Olivia (16): Cause after Year Eight my dad kicked me out. Or towards the end of Year Eight. So then I moved in with my friend 'cause they went to the same school. And their mum was fine with me moving in and everything...And then they moved, so I moved with them to a different school...Well then I got kicked out by her cause I got my period for the first time in ages and when I do I get really bad cramps, so I took a bunch of Panadol and then the next day I felt really, really sick. So I told my teacher and she's like, 'You can go to the nurse.' So I did and she's like, 'How many did you take?' I told her and she's like, 'That's pretty much an overdose. Not lethal or anything

but not good.' So then she called my friend's mum...and then later that day at 10pm she kicked me out...she called the cops to take me away....They called CPS [Child Protection] or something...And then I moved into a residential unit...It was a group of us teens...I got in contact with my older brother again and told him what happened with my dad, then with my friend, and that I was in the residential unit. And he was like, I have a spare room down here [in Tasmania], so you can organise with CPS to come live with me or whatever you want'. So I did that and then we kept having falling outs but they were really bad on his half, so I'd have to call the cops cause he was screaming at me and shit and telling me to go kill myself and that he regretted having me down here and that...I told my CPS worker...and she's like, 'You'll just have to work it out with your brother.' But that happened three times. And eventually the police were like, 'This probably won't work out.' And then he kicked me out. He was like, 'You can't come back.' So I'm like to my neighbours because they knew my mum...so they invited me in for a little bit 'cause I went to school with their son. And then they called the police...I explained what happened and they took me to the... shelter...And then I stayed there for six weeks or so and then came here [shelter].

Bree (15): Well I had to go and live with my dad because my mum moved to Melbourne. And then, he is married. He was dating someone that has three kids, so it was a full house. And then we all moved to [tiny rural town]...And then Child Safety started getting more involved. And then I had to leave because it wasn't suitable for my daughter to be there [significant family violence in the house, unsuitable housing]. So I had to give her to my Nan, which left me homeless because my nan has a lot of people living at her house already. So then I got a call from here [shelter] and they said that I could come and live here...I love being here, but you're just not allowed your kids here...It's just, I want to look after [my daughter] because she's my kid and I don't want her to feel like I'm not being there for her.

Schoollessness

The combination of neglect, trauma and chaotic accommodation trajectories significantly undermined the capacity of children and young people to remain engaged in schooling.¹³ Some participants experienced multiple school moves whilst still at home and most participants described missing several years of education during high school whilst experiencing unaccompanied homelessness. Many were still battling to remain connected to some form of schooling. They connected lack of attendance to their trauma, worsening mental health and suicidality, increasing drug and alcohol use and homelessness. Further, for some, school was described as another unsafe place of bullying, sexual harassment and violence which also triggered and compounded past trauma. Participants also experienced reduced school access (allowed part-time attendance only), suspension and expulsion in relation to their own violent or problematic behaviour at school.

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13 For further discussion of how schools can increase their engagement with students experiencing unaccompanied homelessness see Robinson 2018, 2021. For further discussion of how schools can identify and support children's mental ill-health and service referral see Paton et al. 2022.

Kayla (18): I started not to go as often and then part-time did become a thing, 'cause teachers thought well maybe this will be easier for you to commit to. Then part-time became long. And then I just wasn't going at all...I suppose no one there knew to look into things. Because they didn't know home life was bad for me. I mean, I was naughty student, but I wonder why? If I was a teacher I would be looking further into something, like does this kid have anger issues, or maybe a mental health problem, or are things not good at home?

Lila (16): It's just easier to do that, act like a bad kid at school and then cover up for anything else.

Opal (15): I didn't really go to school much in Grade 8. I went a couple of times, but last time I went there I was on ice, stayed up for four days...yeah, never went to [local high school].

For Lila, bouncing between different family members in different states lead to multiple school moves throughout early childhood:

Lila (15): I think there was like, seven schools by the time I was in Grade 7...

From Year 7, however, the chaos of her life and trauma exposure were almost impossible to make sense of; for two and half years, school just faded into the background:

Lila (15): Well the first half of Grade 7, like I was going to class every day. And then I took off and like a whole bunch of shit happened there and just changed everything. And then I came back down and I was dating, like, the wrong people and all this mess. I was never at school in Grade 8. Like auntie'd call me schitzing, 'where are you?' and that. By the end of it she just couldn't be bothered because she just knew. Grade 9 I started going back - somewhat going back, because living in a shelter, it was down at [outer suburb] so it was ages to get to school. And then - so I was going, but when I'd go, I just leave and go have some wacky tobacco, and then go back and then get a phone call, 'Why weren't you in this class?'

For Bree, school stopped after having her first baby when she was twelve years old. Able to return in Year 9 and for part of Year 10, at the time of interview Bree was now pregnant with her second child, staying in crisis accommodation, still recovering from her traumatic childhood, and had again stopped her schooling:

Bree (15): I went to school in Year 9 and Year 10...well, half of Year 10 because now I'm not in school...With [high school] I'd have to go five days a week, all day. And because I'm pregnant and I have panic attacks around large groups of people and when there's fights and stuff, I have panic attacks. And I've been around a lot of fights at [high school], so it's just not suitable to go there...I've never really been good in school. My handwriting's not the best. And I just feel really self-conscious being around other people, because I was bullied...it was pretty bad. And a year later...I found out that the girl that was bullying me killed herself...I don't feel like school is the best place for mental health and stuff. Just because there's a lot of fights.

Like Bree, for Katie, Gem and Viviana, school was another place of trauma and disengagement:

Gem: Someone stabbed me...I can't feel nothing in this hand, I broke all the nerves and I just let it heal myself, so I didn't go to hospital or nothing...I was attacked in the middle of town, didn't even want to school because they went to the same school that I went to.

Catherine: Were you bullied at school?

Gem: Yep. Every day. Punched in the face. Kicked. Shit thrown at me.

Katie: I got king hit in the first two weeks of being at [high] school...Then I got the blame for it, so I left, I only had like a term there, so I didn't even do Grade 7 really. And then I went to [a different high school] so I was [there] for Grade 8 and Grade 9 and then I left to go back to [original high school] and the same thing pretty much happened with the principals and everything, belittling me for everything that happened in Grade 7, so I just haven't gone back since.

Viviana's experiences of bullying, physical assault and sexual harassment at school only compounded her cumulative trajectory of sexual harm, school disengagement and deteriorating mental health:

Viviana (17): I did try and seek out help in Year 7. I had an incident at school with boys who were like bashing me up for nude photos and stuff, and it just ended up being a big mess and the school didn't exactly handle it in the right way. And at that point in time I also had an eating disorder...And I tried to go to a counsellor and they didn't really do much for me. The school pretty much just shut down the whole incident...And then in Year 9, Mum made me go to another counsellor who was a male and I felt really uncomfortable around males. In Year 10, like it all just got too much, like it got to the point where if I went to school like I wouldn't go to classes, I didn't know how to get up out of bed, I wouldn't brush my hair for weeks, I wouldn't have a shower. All that kind of stuff. So yeah, I just got sick of it, it was too exhausting for me...

Suicide, self-harm and mental ill-health

Alongside varied diagnoses of mental ill-health, significant self-harm, suicide ideation and one or more suicide attempts were bound up in the muddle of complex trauma, neglect, unaccompanied homelessness and schoollessness outlined above. Participants clearly detailed mental, emotional and physical exhaustion which seemed linked to their experiences of lifetime adversity:

Olivia (16): Cause sometimes I feel like it's [mental health] pretty okay, and then other times I'll go through a three month long depressive episode, where I won't do anything. That happened with I was living with my brother and I just wouldn't go to school. I couldn't. And everything else. I'd barely leave the house. Normally I'd walk from his place all the way into town and then back. But I couldn't.

Viviana (17): I was just sick of like always feeling mentally exhausted, to the point where like, even if I got heaps of sleep, it wouldn't change anything. And I was really over always crying and just feeling helpless.

For Viviana, this exhaustion culminated in a suicide attempt during Year 10. As she made clear, facing unaccompanied homelessness for a second time, together with the mounting pressure of cumulative trauma and conflict at both home and school, became unbearable:

Viviana (17): She [mother] kicked me out the second time because after everything else that had been going on, like I just felt trapped and I didn't know how to process the other sexual assault that I had gone through with that boyfriend, and how to cope with the abuse and everything else that was going on, and basically completely having to change my life again. And I tried to take my life...Mum didn't even want to take me to the hospital...She was speaking to every nurse like shit...she was aggressive, she didn't want to cooperate...she was getting pissed off at me and said how like she was really embarrassed that I was in there and that's making her look like a shit parent when she's not a shit parent...And then CAMHS came and saw me and we tried to find me some crisis shelter cause Mum said in there that she didn't want me home and I didn't feel safe going back home either. And then there ended up being no accommodation available at all, so I was messaging my friends seeing if like I could stay at any one of their houses. And thankfully I did find a house to stay for the night.

Like Viviana, Issy's suicide attempt triggered homelessness; the family friends with whom she had been staying no longer felt able to have her in their home and she did not feel safe returning home due to the family conflict and emotional abuse she experienced there. Further, as her suicide attempt took place on school grounds, she also experienced delayed school re-engagement, difficulties managing the reactions of her peers, a shift out of the mainstream classroom and part-time schooling.

Issy (16): I did it [attempted suicide] at school and that caused a whole lot of other problems...I got discharged from the hospital and went back to [girl's shelter]...That was probably one of the worst days of my life because it was a suicide attempt and that was the day I also became homeless again, and it was terrible, and I didn't want to be in a group home with other girls...I was there for about a month and wasn't going to school because it was like a whole safety issue [post-suicide attempt at school]. And I was trying to do work from home [shelter]...They had to contact the Department of Education and get risk and safety plans done and after that I had to push them, I was like 'Please let me go to school'...it was like oh yeah, we'll bring you back part-time...And then it was a bit too much for me, because the people were kind of just like - everyone heard about it in some way, shape or form, and the rumour mill had turned it into some insane thing as it does. So yeah, you kind of just people saying, oh my God, it's Issy, like urgh...It was just terrible.

More broadly, central to participants' discussion of mental ill-health was the clear connection they made between their cumulative experiences of extreme adversity, their suicidality and other experiences of mental ill-health.

Jay (16): It's my worst enemy, mental health. It's like you get onto a drug, you get addicted to it or I got onto a drug, I got addicted to it, and all of sudden I hear high pitched noises, screams, shit like that, and I don't know if it's trauma or what, but it scares me...My head was hurting, I was hearing shit and, yeah, it was getting to the point of me just over the hurt and shit in my head and I just wanted to kill myself.

Lila (15): Well, I ended up getting PTSD because of the shit that happened with Dad. And anyway, I guess, just the same with Mum as well. And then I've got bipolar but I guess, like it was just the situation where I had to leave...yeah so I wouldn't say my soul because if my soul left my body I'd die, but you know, I don't know what it's called, but like, you're in your body, but you're not. So, like, you can see it happening but you can't like, feel it, you're like, dissociated or something? Is that what it's called?

Bree (15): The violence with my dad and my uncle was probably when I was about eight and my pop had died...They broke my auntie's foot...And then, the first thing that I can't really remember, but I can, was when I was at least five, six or seven and they were fighting and my uncle pushed dad through a sliding glass door...There was blood everywhere...It was just like violence, there's people fighting. My sister was hitting herself in the head. My dad and my step-mum almost broke up so my brother kicked a wall, and I just had a panic attack...Well, it's normally only around violence that I get a panic attack. I cry. I can't breathe. I shake. Yeah. And it's usually just around violence, because I was around my dad and uncle fighting a lot when I was younger.

Opal (15): [My boyfriend] bashing me, that really sent me down to one of my lowest points...Like he was my first love and then having someone who you think is first love, growing up you watch movies, fairy tales and stuff like that, then they bash you, your whole world comes crashing down. You're at rock bottom...But yeah, looking back at it now, like how bad my mental health was, like I was, like, at the point where I was probably two months away from ending it if I stayed any longer on the streets, if I stayed any longer with [him].

Participants also emphasised the young age at which they started experiencing severe mental distress. Katie and Gem discussed a long history of mental ill-health eventually building to suicide attempts in their teens:

Katie (16): My mental health has been shit ever since Grade 5. I was like extremely bullied from Grade 3 to Grade 6 and then moved into Grade 7 and my mental health just collapsed, like my mental health just went downhill horrifically. I started the self-harming and all that kind of stuff. I had no support at all during Grade 7 and halfway through Grade 8 I had nothing and then in Grade 9 I had my second [suicide] attempt...I struggled with moving to a completely new place...[Primary school] did not build me up to any good aspect at all to be ready for high school. And then your family, there was no support at all either. It was kind of like, I was just my own little person in my own little world.

Gem (18): It's [mental health struggle] always been - like ever since primary school I remember it was always there. But I started really, really badly struggling with it to the point where I couldn't, I just couldn't...I wanted to fucking kill myself. And I've always sort of felt like but I've never actually acted on it. And I started sort of acting on it from just, just by my driving alone. Like I just didn't give a fuck. It was a hundred mile an hour everywhere...I wasn't sure if I was ever going to come back when I went out for a drive. I wasn't ever sure.

The dual experience of adversity and mental ill-health

Given the overwhelming nature of children's narratives of both adversity and mental ill-health, the table below offers an additional route to understanding the profound pattern of these experiences across the lives of all participants. Whilst on one hand the table is clearly a reductive view of the experiences of children and young people, on the other it offers expanded and clarified insight into the shared, repetitive presence of trauma and adversity and suicidality and mental ill-health in their lives.

Name	Current age and sex	Self-disclosure of childhood trauma/ abuse	Self-disclosure of mental ill-health
Sammy	Male, 17 years	Physically abused by step-father, victim of violence at school, bullying, suicidal death of primary carer (grandmother)	ADHD Suicide ideation
Gem	Male, 18 years	Physically abused by father	Anxiety, depression, emotional numbness, lack of empathy Suicide ideation including high risk-taking behaviour, AOD misuse
Bree	Female, 15 years	Witness to father's self-harm, parental AOD misuse and family violence, placed into Out of Home Care for 2 years (aged 10-12), victim of school bullying	?PTSD Self-harm
Tara	Female, 19 years	Witness to caregivers' intimate partner violence (IPV)	Anxiety, depression, anti-psychotic medication prescribed, AOD misuse Multiple suicide attempts
Marie	Female, 17 years	Witness to caregiver IPV, sexual abuse by step-father, victim of school bullying including sexual/ physical harassment, teen IPV (sexual assault)	Eating disorder, emotional numbness Suicide attempt
Neve	Female, 20 years	Teen IPV (coercive control), threats of violence from household member	ADHD, anti-depressants prescribed
Kayla	Female, 18 years	Witness to caregiver IPV, physical/ emotional abuse by mother, parental and extended family AOD misuse, teen IPV (physical abuse, coercive control), Child Safety contact	Anxiety, depression, recent bipolar diagnosis Suicide attempt

Olivia	Undecided, 16 years	Death of mother, witness to caregiver IPV, Out of Home Care placement, emotional abuse by sibling, Child Safety Order current (VIC)	Anxiety, depression Suicide attempt
Lila	Female, 16 years	Neglect, 1 week Out of Home Care placement as a baby, parental AOD misuse, witness to IPV, physical abuse by care givers, sexual abuse facilitated by mother	?ADHD, PTSD - Prazosin prescribed for nightmares, experiences dissociation, bipolar, anti-depressants prescribed, AOD misuse
Opal	Female, 15 years	Involved in and exposed to crime-related violence, teen IPV (coercive control, physical and sexual assault)	Anxiety, PTSD High-risk, coerced AOD use Suicide ideation and ongoing self-harm
Issy	Female, 16	Emotional abuse by parents, sexual assault	Anti-depressants prescribed, AOD misuse, suicide ideation, ongoing self-harm, multiple suicide attempts
Tam	Female, 18 years	Sexual abuse by a family member, emotional abuse by father, parental AOD misuse, multiple experiences of teen IPV (sexual assault, emotional abuse)	Autism, AOD misuse Multiple suicide attempts
Jay	Male, 16 years	Neglect, physical abuse by step-father, sexual abuse by step-grandfather	Schizophrenia, anti-psychotics prescribed Suicide ideation, high-risk AOD misuse, including IV drug-use
Katie	Female, 16 years	Limited mention of family, victim of school bullying	Self-harm, multiple suicide attempts
Renee	Female, 18 years	Emotional and physical abuse by father, victim of school bullying, Child Safety involvement, 1 week order	Bipolar disorder Ongoing self-harm, multiple suicide attempts

Together with the narratives of children and young people, this snapshot aligns with research findings linking childhood adversity, poor mental health and suicidality in particular (for example, see Sahle et al. 2021).¹⁴ These findings also echo those of Canadian research linking high suicide rates and experiences of homelessness during childhood under age 16 (Gaetz et al. 2016, p. 65). Given most participants traced their earliest memories of poor mental health to their primary school years, commonly around Grades 3 to 6, these findings also point to the critical role that early intervention into childhood adversity could play in preventing *dual* trajectories of mental ill-health and unaccompanied homelessness.

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14 See also Anthony Jorm's (2021) discussion of recent AIHW (2021c) data highlighting childhood abuse and neglect as a modifiable leading risk factor contributing to the burden of suicide and self-harm in Australia.

The struggle for mental health support

Four key issues were highlighted in participants' discussions about their search for and interaction with mental health services and professionals across a range of settings. A struggle to connect with GPs and allied health professionals was reported - this was a practical and financial struggle, but also a struggle to retain any continuity of care and develop the depth of professional engagement participants were hoping for. Further, in desperate periods of suicide ideation and attempted suicide, participants felt that their pleas for assistance with much broader safety issues were ignored. A deep conflict was also reported between the urgent need to seek help and the negative, even dangerous, consequences of professionals' ensuing dialogue with parents and caregivers. Finally, participants perceived a complete mismatch between the very serious mental health issues they were presenting with - in particular trauma related to sexual abuse and violence - and the kind of 'light touch' advice being offered by mental health professionals.

POOR SERVICE ACCESS

In cases where some participants had been lucky enough to access stable accommodation with associated support, the search for mental health services was very actively facilitated by outreach workers. Even with such dedicated advocacy and practical support such as transport, identifying a GP or psychologist with capacity for new clients was a battle:

Kayla (18): I've already tried a fair few different things. I've had referrals sent to a couple of places, and I've tried to get back in [private psychology practice] but they're full now apparently. And everywhere's just either full or they can't take you on, or it's just the same thing over and over...It's been that hard to actually find a service to link with to start with, before I start making any progress.

As Tam explained, this difficulty of access was particularly stressful in the context of needing ongoing access to prescription medication:

Tam (18): It is quite hard to get into most doctors just because they're so booked up and everything especially with mental health medication. If you script anything you can't really just - well most of them you can't abruptly stop taking.

Currently living with her aunt, Lila had emotional support and transport for appointments, but it was continuity and affordability of care which remained key issues:

Lila (16): With my psychologist, I don't see her anymore, but with my psychiatrist, she ended up moving as well and she doesn't bulk bill and my auntie can't afford it. So I have to speak to a new one in November, but it's a bloke. So I don't know how I'll go. And where my old one, she knew what the go was, what not to do and what to do, and with this new fellow, I'm going to have to say it all over again, and then I don't know if he's going to try and change my medication or if he's going to try - and just, I don't know what's going to happen. So it's just like, I don't know how that will go.

Alongside the struggle to actually access a bulk-billing GP or psychologist, participants also described seemingly random or brief interactions with a range of health and mental professionals, and a lack of engaged, ongoing support:

Sammy (17): My GP's overseas, so in Australia. We do a Zoom call every now and then...So he prescribes...all my ADHD medication that I don't even take...So I'm just stocking up on it. It's good shit to sell. It's expensive when you sell it.

Gem (18): So I went and saw the doctor and he didn't help me all; just put me on pills...I was diagnosed with depression and anxiety. The doctor's a fuckwit though. I literally went in there for only five minutes [and] walked out with a fucking bunch of pills in my hand. Yeah, that's a fucking smart thing to give to a depressed person, isn't it?

Viviana (17): They don't actually give us the right resources. Like they give us simple, online fix kind of things. They don't actually give you something that's going to be long-term and useful.

Kayla's best option was eventual access to online psychiatry and while she highly valued the opportunity for clinical engagement and diagnosis, she did find online diagnosis disconcerting:

Kayla (18): Well my doctor, she can't really do much around my mental health 'cause she's not a professional obviously. And I can't find a psychologist for my life, so I'm seeing a psychiatrist on Dokotela [tele-health service] from Sydney. So I only see him on Skype a couple of times. And that's who I've had the diagnosis from. Which sounds a bit crazy because they don't even know me...

A LACK OF EMERGENCY RESPONSIVENESS

Participants were particularly scathing in their description of hospital emergency department care, with children and young people commonly reporting they felt their concerns about their mental health were not taken seriously enough.¹⁵ Issy, despite multiple suicide attempts requiring hospitalisation, felt her requests for help at hospitals were not listened to and she was quickly discharged:

Issy (16): So I went there, and as always with lots of hospitals, sit around for hours and hours and hours and then got into this room, kind of, just talk to them about how I was feeling and everything like that and they gave me a prescription for antidepressants. But then they were kind of just like, yep cool you're good to go. And I'm like - I just told you all this stuff and...That's how it's been with my other hospital trips as well. They're kind of just - oh yeah, you're fine. I'm like, 'I'm really

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15 Whilst the experiences of children were widely echoed by professionals participating in this research, further research investigating emergency department interactions with unaccompanied homeless children and young people is needed. Ideally, any further research would also include the perspectives of CAMHS hospital-based staff.

not...It's exhausting. And then after that just went, got antidepressants, and then just back to school, back to how it was, and just on antidepressants. It didn't really change anything.

Likewise, Tara felt quickly dismissed following her overdose and emergency admission:

Tara (19): I went to hospital, it was 2019 I think it was Christmas, I went to hospital. I was really bad for those few months at the end there and I starting smoking pot and I just had a really, really bad breakdown and tried to overdose...I took a bunch of different antidepressants and clonidine...I had alcohol as well, so I was like really just out of it for the whole ride and the whole hospital trip. I stayed there overnight and then I think after that they didn't really do anything...I was there overnight and then they sent me home the next day and then a bit later on I had another breakdown.

After hearing voices and feeling suicidal, Jay was given two anti-psychotic tablets during a hospital visit but was left to return to couch surfing, seemingly with no follow-up in place. Further, as his youth outreach worker subsequently described, they were unable to access a bulk-billed GP appointment for another two weeks:

Jay (16): I went to the hospital because I did need [help] but yeah, they still done nothing...My head was hurting, I was hearing shit and yeah, it was getting to the point of me just over the hurt and shit in my head and I just wanted to kill myself...I've sat down and had psychiatric, or whatever it is, consultations in a little room, like it's just off the emergency room. Went in there and sat there for hours upon hours it felt like, telling them what was wrong. And he's like, 'Okay you've definitely got something wrong but we're going to put you on this for now. He put me on quetiapine, anti-psychotic for [thinking] people [were] after me wanting to kill me and shit like that. That night they gave me a white box with two meds in it, and they sent me home with that. They let me walk out the door because I sat in there for long enough. I sat in there for nearly a day without losing my shit...It didn't help...I left with two [tablets], that was just to get me through the day...My [hospital] social worker came out and said, 'Hey Jay, are you right to go?'...And then I said, 'I'm over this'. I said, 'You motherfuckers ain't helping me'.

Youth outreach worker: Now I feel really sorry for Jay because he's like 'Can you please get me some tablets?' I rang headspace, 'We'll give him an appointment in two weeks' time', and then poor Jay's like, 'Well what do I do with no medication when I've been told that I need to be on it for the next two weeks?'

Jay summarised the experiences of many participants:

Jay (16): They sit you down, put you on medication, their job's done.

THE HIGH RISKS OF DISCLOSING MENTAL ILL-HEALTH

Alongside the potential for dismissive health care experiences, children and young people discussed facing risks from intimate partners and caregivers when unwell or seeking help for mental ill-health. Conflict and abuse was reported when parents discovered self-harm or suicide attempts themselves or when they were followed up by professionals.

For Renee, multiple suicide attempts were not only undertaken in the context of ongoing physical and emotional abuse but also became flashpoints for the *intensification* of her abuse:

Renee (18): I tried to kill myself again. So I slit my wrists, which is that one [scar] there. I missed the vein just. So I was lucky. And when he [father] found me doing that, I was sitting on the toilet, blood pissing out me arm. He threw me to the ground, slapped me around a million times. There was fucking blood splattered everywhere. You're attention seeking again, little fucking bitch. How dare you do this to us, and then I ran. I was like, fuck I need to get out of here and it was at my nanna and pop's old farm and there were chickens everywhere. They used to run free. So I went down the stairs, it was double storey, and he slammed me into the ground and he put me in a hold and my open fucking cut, which was like gaping wide, is just squished into the ground full of fucking chicken shit and dirt...They called a fucking ambulance.

Issy described how difficult it was having her emotionally abusive mother present at hospital following her suicide attempt:

Issy (16): They're [hospital staff] like, your mum has to be here with you. I'm like, for fuck's sake, kind of thing. She doesn't care. And afterwards she just got so mad. She was like, 'You've dragged me out of work just to do that', kind of thing. And it like yeah, all the people are like, you must have good parents because you're so well mannered, things like that. And I'm like, 'Not really. I was kind of bullied into being the way I am now'. And they were like 'Oh, your mum is so nice.' I'm like, 'Yeah. No.'

She also discussed her frustration with disclosing her experiences of emotional abuse, only for the school nurse to contact her abusive mother:

Issy (16): I had a social worker/school health nurse person at my old school, and I was like, yeah, my mum did this...And I told them the next day I was like, 'I am so close to suicide, it's so bad.' And then he [school nurse] was like, 'Well, because you're thinking about hurting yourself, we have to call your mum.' I'm like, 'She's the one that's the problem,' kind of thing. I get there's the whole confidentially and having to tell parents or whatever if it's like they're going to harm - if you're thinking of harming yourself or someone else, but it's fucked. Like the fact that she's the whole entire problem and...the school health nurse, he knew it would be just bad when I got home. And he's like, 'Oh, no I have to talk to your Mum.' And I'm like 'Please, please don't'. And he's like, 'I have to, as of law'.

Lila stopped her counselling sessions after the school counsellor contacted her abusive father and conflict ensued:

Lila (16): I actually went to the school counsellor and was telling her shit and then he [father] turned around and said, 'Oh if you're going to keep going I'll put you in the psych ward' rah-rah-rah. And so I stopped going and shit and I started stealing his alcohol and his cigarettes...It (counselling) was alright at first but then [school counsellor] kept calling Dad and shit, telling him, like, everything, and then he turned around and was like 'Oh, you think everything's my fault,' rah-rah-rah. So then I just stopped going...There was help, it was just I couldn't go because if I did [father] would get phone calls and then I'd get schitized at...and I'd be trapped in my room because if I walked out I just felt, like, hatred everywhere. So there was just no point really.

Kayla was told by her abusive boyfriend that she could no longer attend her counselling service after she was allocated a male practitioner:

Kayla (18): My first worker, she was great. But then she moved. And then I had a male worker who my abusive boyfriend at the time, who was domestically violent with me, told me I wasn't allowed to see.

Whilst Renee continued to engage with school counselling sessions as 'a break from life' as she described it, she didn't disclose all that was happening because she knew there would be violent repercussions if her father was to find out:

Renee (18): I was still talking to [school] counsellors...I didn't tell them what exactly happened...or about actual problems because I was terrified that they would tell dad, because I knew that anything to do with self-harm, I think he was just going to abuse the fuck out of me...I think I did end up opening up some stuff. I would never go too deep because I didn't want my dad to know because it was just make shit so much worse at home...So I'd go in there for a break from life...There was a worker from [after-school youth program]...and I trusted her pretty well. I'd speak to her about my mental issues and stuff and she was good with it, but I knew if I told her about self-harm and stuff, she'd have to tell my dad.

For Renee, Issy and Lila there was a clear impediment to their self-disclosure of poor mental health with little alternative pathway for help-seeking available. As Renee argued, there is a catch-22 situation in disclosing poor mental health to professionals when current caregivers are negatively implicated in the conflict or trauma being reported:

Renee (18): I get that obviously the safety of the child but then again, you don't know if that safety is going to be made worse for telling them.

NEEDING SUPPORT FOR 'ADULT PROBLEMS'

Another key issue participants reported was feeling as though the extremity of their experiences was not accounted for by GPs or in the counselling approaches they experienced. As outlined above, many of the children and young people participating had experienced early childhood abuse, exposure to intimate partner violence, early parenthood and experiences of adversity including the deaths of caregivers, physical and sexual assault and intimate partner violence in their own adolescent relationships. Participants reported feeling frustrated about receiving condescending advice on wellbeing, perhaps due to a lack of information and understanding, when they wanted more in-depth and clinical responses to the complex trauma and emerging mental illness they experienced.

Renee (18): If you go and get help, you know you're fucked up in the head. You don't need to be treated like you're a child, especially with people being homeless and especially through shelters.

Viviana, a survivor of lifetime sexual trauma, struggled with a CAMHS group program provided alongside individual counselling for her eating disorder. Whilst she found the counselling invaluable, she found the group activities patronising and pitched for a much younger age group:

Viviana (17):...and they put me in a group program with other girls who suffered from eating disorders. And I found the counselling helpful but I didn't find the group therapy helpful at all. They treated us like we were 8-12 year olds. They weren't actually giving us like, I guess, adult solutions for the adult problems we did actually have, even though we shouldn't have had them, we were only kids. And we sat down watching Lego videos on how to deal with depression and stuff like that. And I was like, this aint going to do shit for me.

Currently a homeless client of Victorian child safety services with a history of grief and complex trauma, Olivia recalled being scored highly by a GP for depression, anxiety and stress, 'cause of everything's that happened'. Olivia reported limited help offered by the GP - melatonin for sleep and blood tests. Further, she said that despite reporting the high scores for depression, anxiety and stress to 'every [professional] person I've talked to since Year 7', she felt she only received very basic advice from mental health services and her moods were most often explained by reference to expected adolescent hormonal change:

Olivia (16): And I've said that to every person I've talked to since Year 7. And they're [professionals] like, All right, well, you're correct, but just do meditation, drink water, stay hydrated. That sort of thing. And they're like, 'That'll work.' Cause every time I bring up my mental health to someone at headspace, they're like 'Have you tried doing meditation or yoga?' Like, mindfulness activities. Have you tried eating healthy? Like, stay hydrated...I think it's sort of to do with my age 'cause even though I'm nearly 17 and nearly an adult, they're sort of like, 'Well, you're still a kid, so you're just going through puberty or whatever. It's normal to feel down 'cause your hormones are all over the place.' Even though I started puberty when I was 10, 11. A lot of years ago.

Lila objected to what she saw as irrelevant attempts of outreach workers to engage her in reflecting on her emotions through participation in childish activities:

Lila (16): I think it was outreach workers come to the school and that, but they were just making me draw on a piece of paper, like, how I felt and that, and it's just like, how old was I at the time? 14. So I don't want to be drawing on paper.

For Kayla, mindfulness techniques were far from useful when in fact she was searching a diagnosis and clear insight into her mental ill-health:

Kayla (18): I don't know if we ever got far enough into the process [of counselling]...I feel like a lot of working on my mental health is do mindfulness colouring ins and meditate and do mindfulness colouring ins and meditate. And I know things like that help, but doing mindfulness colour ins and meditating isn't going to help me really figure out what's going on, or really work on things...I'd rather find out what's - I don't know how to say it - what's wrong with me, or what triggers me, or what bothers me, and then find out strategies to use for those things so that that doesn't happen, if you know what I mean? Like I don't know, I have a lot of issues. I have a lot of self-esteem issues, and anxiety issues, and depression issues and yeah understanding and having some more strategies would probably help. And having someone who might have a better idea of what's actually going on with me to help me.

Through the advocacy of her accommodation support worker, Kayla was finally supported to access a GP and online psychiatry. Despite her reservations about online help discussed above, Kayla felt positive about her bipolar diagnosis and the research she had been able to do in order to understand its effects and how to manage these:

Kayla (18): Maybe getting the right - well, what is probably the right diagnosis at the moment, that probably helped as well. To more help understand what's going on with me...understanding why I feel the way I do...cause I don't think I'm crazy or something's wrong with me, why do I feel like this?...Cause I understand what bipolar is and what it does so I can understand what's going on with me more and not freak out so much.

What she was also looking for, however, was face-to-face support from a psychologist which she had experienced in the past:

Kayla (18): You need to be able to have a psychiatrist who can do the diagnosis and stuff and then the psychologist who can do the talking side of stuff...Like [psychologist] who I was seeing, that was working well, because I was getting to talk to her and get things off my chest and she was giving me good strategies and helping me understand things and teaching me things like cognitive behavioural therapy.... We started looking at self-esteem issues and that type of stuff. And I don't know, she was just - it was really great, the way she was working with me.

Following multiple hospital presentations, it was only through the advocacy and support of a youth outreach worker and the eventual prescription of anti-psychotic medication by a headspace GP that Jay received 'the only help, mental health-wise'. For Lila, it was working out a diagnosis of PTSD and bipolar, with current consideration of ADHD, that helped her fit together a whole range of disturbing experiences including dissociation, depression, anxiety and hypervigilance. With the advocacy of a youth outreach worker who connected her to a proactive, youth-friendly, bulk-billing GP, Lila was supported to access a psychiatrist and psychologist in Sydney through tele-health. Though she was unable to have continuity of care with either professional, she said 'It was good knowing what's wrong' and in practical terms - such as for her social housing application - she had a clearer way of communicating recognised mental ill-health to others rather than having to provide personal descriptions of symptoms.

Self-management: 'Weed is my ice'

Through the struggle to find effective, ongoing mental health support, children simply adopted alcohol and other drugs to help manage symptoms of mental ill-health. Despite trialling a random prescription of anti-depressants, for example, Gem decided that marijuana worked better, especially in the context of needing to manage his violent temper in a shared bedroom in a youth crisis shelter:

Gem: After work, yeah I fucking go and smoke about 30 grams. Sometimes I smoke, like, three or four grams in a night.

Catherine: So pretty much every night you'd...

Gem: Every night. Like pretty much every night without fail.

Catherine: And why do you reckon you do that?

Gem: Oh because I'd go to jail and end up killing someone.

Catherine: Helps you keep a lid on things?

Gem: Yeah, helps me calm me nerves and whatever else. Not think about things...

If I had good enough stuff going in my life, I wouldn't need to smoke fucking cones. Like if I had my own house that I could go and relax after working, I wouldn't need to go smoke 40 cones. But after coming back [to the shelter], fucking deal with all these fuckwits, and that's why I have to smoke 40 cones. Otherwise if I don't, I'd lose my nut.

For Opal marijuana use also helped her to manage dysregulated behaviour and hypervigilance:

Opal (15): I could not stop that [marijuana]. That's - like, weed is my ice, definitely. It's - that, like one thing - if I ever go dry, I'm to go schitz like a crackhead's going to do when they don't have crack. Like, it's my thing that I rely on. Like how other people rely on ice.

Catherine: What do you think it does for you?

Opal: It just puts me in a place where - where I can actually live with myself. Like, I'm very full on like, I'm a bit much, I do talk a lot, I do talk really fast. It's like, well, now I need to learn how to slow down and regulate myself and it just helps me. If I don't have weed in my system I feel I can't regulate myself when I get heightened.

Lila and Jay likewise described their current reliance on marijuana and its calming effects:

Lila (16): I can go without dope for a couple of days, but you know, it's meant to help me sleep, that's the only reason I am allowed to smoke it...I rely on dope now to help me, like - put me in the mood to, like make me lazy to the point where I want to go to sleep...sometimes it does the job, sometimes it doesn't, depending on my mood...

Jay (16): It slows my thoughts down as well as just myself in general.

Lila also explained how marijuana and alcohol use were earlier normalised in her family, with both parents injecting ice users:

Catherine: So have you always used dope?

Lila (16): No. When I was living with Mum it was more alcohol because that's what she was getting. So yeah, she was using her shit [methamphetamine]. So what she said to me when I moved up there, 'I'll smoke my shit and you smoke yours', like her talking about crack and yeah, me my dope. And then so she'd get alcohol and that I'd rather be drunk and because she was on the shit, when you're on the shit you don't drink as much...So yeah, I'd drink a lot and then when there wasn't any I'd schitz because you know, she's had her shit...I'm on the alcohol. So when we had no money, it was a bit, 'Go ask the neighbour for money because I want a drink'.

Alternatively, Jay and Opal linked their drug use with homelessness:

Jay (16): When they [youth crisis shelter] said to me, 'You're out'...I shat myself, I didn't know where I was going; I had nowhere to go apart from places where I was constantly on drugs. I was on methamphetamine due to homelessness for six months. I was hanging with a friend at the time - they got it every day, I was smoking it every day. I OD'd on it twice and didn't give a shit because I was homeless. My mum or dad should have been there, like, 'Fuck, you need to go to hospital'. No.

Both Jay and Opal had previously found a lifestyle in drug use and crime, including stealing, home invasions, 'meat runs' (stealing meat from supermarkets to sell on) and 'bottle runs' (stealing alcohol from bottle shops to sell on). For these children, drugs seemed to provide a functional gateway into an immediate subculture which connected them to accommodation, purposeful activity and promised something like belonging.

Opal (15): After that I went and stayed at this guy's house with the guy from the shelter and we ended up couch surfing...I stayed there for a couple of nights and then we did a home invasion because we thought they had drugs there...Me and [friend from the shelter] did a couple of like, meat runs, just for money...So the people I was around with, they all smoked ice and stuff like that.

Jay was clear, however, that it was the lack of intervention in his mental health that was a key factor in his long history of offending:

Jay (16): Youth Justice is shit. 'Come in, do a sentence report, we'll give it to your judge, it'll be okay.' I don't know, now lost my licence for two years; they're not really much help. Like, they could have said, 'Hey, like, he just needed his medication and then he'll be on the right road'.

And for Opal, it was the terrifying violence of this subculture and her boyfriend that lead her to realise she was not experiencing belonging but entrapment and spiralling mental health:

Opal (15): When it started getting to...the real stuff [serious drug-related crime], I had that feeling I didn't belong anywhere...like, I didn't feel I had a purpose, I just kind of felt like I was there...But I think that night when [boyfriend] bashed me is the one thing that opened up my eyes the most...I was already deep into a relationship that I couldn't get out of.

Finding a 'foundation' and 'that second voice'

Whilst the life story narratives of participants in this research often spoke darkly of an urgent need for and absence of mental health supports, productive interactions with school counsellors (participants did not distinguish whether psychologists or social workers) and with CAMHS were also scattered through some interviews. Kayla and Tara reported a period of support (approximately three weeks) from CAMHS following suicide attempts and hospitalisation; for Tara this only came after her second hospital presentation. Following several suicide attempts with hospitalisation, Tam recalled positive support from CAMHS with a focus on diagnosis for autism. Katie also mentioned seeing CAMHS 'for a little bit'. Viviana reported a close connection to a CAMHS eating disorder counsellor, with the referral to CAMHS the outcome of the efforts of a school counsellor who 'really fought for me to get the help I needed'. Following several years of emotional abuse, unaccompanied homelessness, chronic suicidality and self-harm, Issy had been seeing CAMHS for the previous 12 months for support, though she described this as only valuable once she was able to stop her mother attending.

Earlier in childhood or where participants retained contact with parents (mothers) or other family members (grandmothers, aunts, stepmothers), sessions with various private psychologists, psychiatrists and counsellors were also facilitated. For example, Sammy and Neve reported early childhood diagnosis with ADHD, Olivia attended grief counselling briefly after the death of her mother, Viviana's mother 'made' her attend a counsellor, Tara and Tam had contact with multiple psychologists and psychiatrists coordinated by their mothers, and Lila recalled some form of private counselling in Year 7 organised by her aunt. Participants also reported some contact with community-based youth mental health services and suicide aftercare.

Most commonly, however, assistance from schools, CAMHS, hospitals, private practitioners and community-based services were fleeting, vague interventions in children and young people's broader narratives of continuing abuse, violence, adversity, family chaos and conflict, unaccompanied homelessness and escalating mental ill-health. Such fragmented care did not match the at times overwhelmingly complex mental health issues children and young people described. For example, Viviana described her experience of receiving specialist support for her eating disorder at a time when she was also homeless following the emotional abuse and aggression of her mother and mother's partner:

Viviana: Everything was a mess, and I didn't - like I didn't even know how to go get help...Like you kind of sit there and you're like, I'm cold and I want food. I want somewhere to sleep. I want to be with somebody. And you can't be with nobody. And it's even harder when you don't have your parents to cry to. Like they're meant to be your two biggest supporters in life, and then if you don't have them then you're a bit like, well what do I do? And the only thing that my counsellor wants to talk about is what I've been eating for the week, even though I can't get food because I don't have a home to go to, to get food. Then it's like, what do I do?

Whether or not participants had also experienced some positive interventions from school professionals, CAMHS, private or community-based practitioners, whilst they were unaccompanied and mobile, moving between shelters, couch surfing with strangers, friends and intimate partners and occasionally rough sleeping, their mental health continued to rapidly decline. It seemed they were then caught in a sickening snowball of the impacts of early childhood trauma, emerging mental illness and compounding additional adversity, including the stress and loneliness of homelessness, exposure to drugs, violence and further abuse.

As Renee described, this was a seemingly unstoppable cycle of trauma, ill-health and homelessness. Having escaped the intense physical abuse inflicted by her father, Renee returned to the care of her mother - but soon found herself alone, back in the shelter system, and struggling to engage with mental health support:

Renee (18): And then when I come back down to Tassie, I moved in with mum again, and then obviously I had the additional trauma plus all the other mental health issues. So I was back at being a cunt. I was smoking, being just a fuckhead and then I think we were constantly arguing again, like we always did, and one day she was like, you know what? You may as well fucking leave and don't bother fucking coming back...and then she called the cops on me...the cops found me and they let me go and I went to Nan and I'm like, what about the shelter that I was at before I left? So I went back to shelters...I think I still had a few periods where I had a private counsellor or something I had two sessions with and I was, I can't be fucked going anymore. Seeing headspace on and off a few times...I couldn't be fucked, fuck you, and just didn't go back.

Once living this spiral of adversity and ill-health, the most powerful, positive change in participants' trajectories seemed to fundamentally pivot on their *concurrent* access to stable, safe accommodation and youth outreach. It was when they were finally living in contexts of relative safety *and* with access to the very persistent support of an outreach

worker that some children and young people reported finally feeling on the cusp of breakthrough engagement with mental health services. These participants commonly described being in the early stages (for example, up to two or three sessions) of access to responsive GPs, tele-health psychology and psychiatry, community-based mental health outreach workers and sexual assault counselling services. They spoke of emerging plans to connect with additional mental health specialists or to investigate appropriate diagnoses and medications. They also highlighted the crucial enabling role played by outreach workers, including intensive support with advocacy, identifying and pursuing all relevant referral pathways, providing transport and in-person support during appointments.

Following her eventual suicide attempt, for example, CAMHS referred Viviana to a transitional accommodation service which offered outreach support:

Viviana: When I first moved there I was still going to CAMHS and still seeing them. And then I felt that I'd progressed and I didn't suffer from the eating disorders anymore, so then my beautiful counsellor...said goodbye...And then after that I had my little vent to [outreach worker] when we have our weekly check-ups. And then I still go to my school counsellor and she helps a lot...and I also see another lady at [sexual assault counselling service]...Like [outreach worker] she organises things like [sexual assault counselling service] that I can go and talk to them about what's been going on.

Catherine: So do you think would have been able to reach out to [sexual assault counselling service] without [accommodation outreach worker]?

Viviana: I didn't even know they were a thing until [accommodation outreach worker] told me.

Tara similarly described the crucial advocacy role of the outreach support provided with her transitional accommodation:

Tara (19): If I didn't have [outreach worker] I probably would really, really, really, really struggled with a lot of things, just because I guess my mum doesn't do those things for me anymore, like taking me to appointments and stuff like that, so she's got other kids, she's got problems, other stuff in life...Ever since I moved in [outreach worker] has helped me literally with everything from going to school, signing up for TAFE, finding...a drug and alcohol counsellor, she's helped me get the psychiatrist that I have, the psychologist that I have...If [support worker] didn't take me to a lot of appointments I probably just wouldn't go.

As Tara powerfully identified, her outreach worker provided her with a 'second voice':

Tara (19): Because we're young and we're moving out of parents, but I certainly don't know how to - I struggle with lots of adults' stuff that you have to do - they help you with all the things that you can't do by yourself, like they advocate for young people. [Outreach worker] will take me to my job appointments, she takes me to my psychiatrist's doctor [for tele-health appointments], she takes me to [regional centre] for my psychologist appointment. So she does a lot for me...If I had to get my own

way or catch the bus I'd think, no one's there telling me I have to do it, but I know that I should because I should be like, I have to do those things [medical appointments, job agency appointments]. But yeah, it's just so hard when you have really bad anxiety, you just overthink it, whereas I'm really comfortable with [outreach worker] so I just think, oh it's an appointment with [outreach worker]...I think it's amazing... having that second voice so that people listen to you, so that you have the right things for you.

For Viviana, Kayla and Issy, alongside the 'second voice' of outreach workers, having access to a safe home was also crucial:

Viviana (17): Like I said, there's no point in giving a kid counselling sessions at school or making them go out to places like [sexual assault support service] and stuff like that if they don't even have a stable, warm home to come home to, to actually sit down and process that. Because whilst I was still trying to juggle school, and go to counselling appointments at school, later on I'd have to pack my shit and I'd have to go find somewhere to sleep, and I'd just forget about that and I wouldn't have time to do it, 'cause you get into survival mode when you're out there and you're having to look out for yourself. You don't have the time to sit down and think about 10 things to be grateful for every morning and that kind of thing. Like you don't have time to do that. So yeah, definitely without having that basis of home, then everything else just isn't really going to fall into place.

Issy (16): I've always wanted to get into there [youth foyer] since I moved out of home...it's nice because it's having two years - because you can stay there for about two years of stability. Because when I was with [friend and family] I didn't quite know when it was going to start-end, and especially at [youth shelter] as well and transitional [units], you're only supposed to be there for three to six months...I'm lucky to have had accommodation but it's still kind of scary with being so unstable and not knowing what's going to happen when.

Kayla (18): I started seeking help for myself from [youth outreach service]...I tried to start learning things and looking into things, to make things better for me. And what I was taught is if you don't have a foundation you can't build anything else on that. So like if I don't have a stable place to live, and an environment, then I can't be going to school, or doing this, or doing that. So the first thing I had to do was get a stable house. So I was on the housing list for a long time, and eventually got a house.

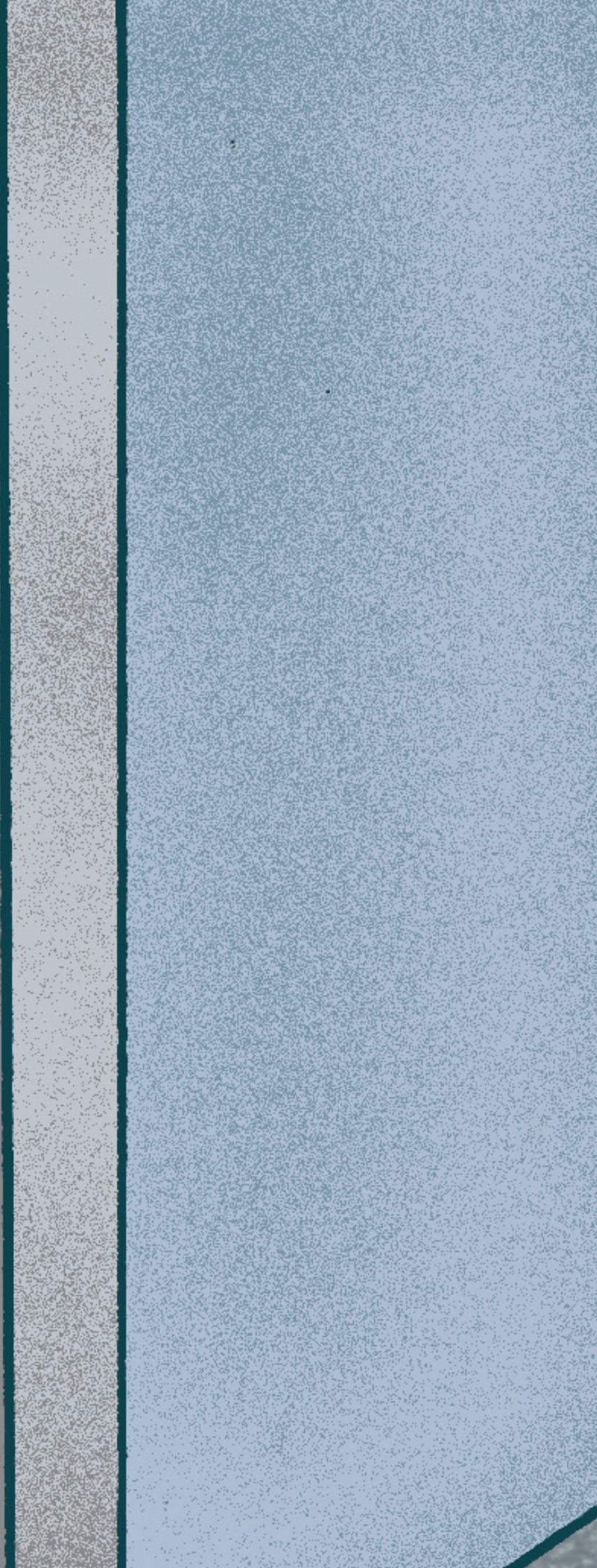
Conclusion

Life-changing experiences of safe accommodation and youth outreach support were the positive ending point in the narratives of only some of the children and young people participating in this research. As evidenced in their life histories, concurrent access to such safety and intensive support coordination came only after years, mostly lifetimes, of extraordinary experiences of adversity and escalating mental ill-health. Apart from Renee, who was engaged with a community-based outreach mental health service, access to positive mental health supports was described by participants as only resulting from the sustained, persistent advocacy of youth outreach workers, and continuity of care was extremely fragile. Nonetheless, outreach workers were in place to continually advocate for access to services and did their best to patch together the mental health care children and young people needed.

With the exception of Issy (16), safe, stable housing was first accessed independently by participants on the cusp of adulthood – Tara (19), Viviana (17), Neve (20), Kayla (18), Tam (18) and Renee (18) – and by those children, Lila (16) and Opal (15), with access to safe care in the homes of extended family members. This leaves an uncomfortable question about the physical and mental wellbeing of Katie (16) and Jay (16) living with intimate partners and those participants still in short-term crisis accommodation: unaccompanied children Bree (15) and Olivia (16) and unaccompanied young people Sammy (17) and Gem (18) who were without obvious entry points into independent housing.

Overall, where longer-term support was encountered, participants' life stories did reveal some emerging experiences of stability and mental health care. These experiences begin to clarify the core elements of responses needed once unaccompanied children experience homelessness and mental ill-health: youth outreach support, long-term accommodation and accessible mental health practitioners. Also revealed, however, were common experiences of cumulative harm and mental ill-health snowballing largely unchecked through unsafe childhood homes and into the chaos of unaccompanied adolescent homelessness. The struggle with complex trauma, emerging mental illness and the repetition of suicide ideation and suicide attempts across these life stories were striking.

In Part II, the experiences of professionals offer a broader account of the systemic context which more often *suspends* unaccompanied homeless children in compounding adversity and deteriorating mental health. They make clear that any experiences of housing stability and access to appropriate mental health services are extraordinarily difficult to achieve. They offer another perspective on a fragmented adolescent service system in Tasmania which is clearly ill-equipped to respond to extreme and complex adversity in the lives of highly vulnerable children.





PART II

WHAT PROFESSIONALS BATTLE

"There's no mental safety net for them ... there's no one to pick them up when they fall down."

Drawing from the experiences of relevant professionals across state, Part II of this report traces an account of a profound mismatch between the presenting complexity and extremity of unaccompanied children's experiences and a blunt system of mental health care available in Tasmania. Clinical, youth and social work professionals from youth health services, youth mental health services, homelessness, youth outreach and school-based student support services all laid out an overwhelming picture of unaccompanied homeless children's observed need for mental health care, their struggle with clear service gaps and barriers, and their poor experiences with services never designed to meet their needs.

As well as the clear negative impacts of this system mismatch on children, also evidenced was the widespread distress and vicarious trauma of professionals. This stemmed from experiences of being left to provide under-skilled and under-resourced support to children experiencing at times overwhelming risk. As such, they interpreted their own practice and the wider service system as further perpetuating the suffering of this vulnerable group while also reducing their capacity to work with a range of other children and young people also experiencing serious need.

One overarching outcome of the inadequate mental health system they described seems to be the entrenched beliefs many professionals held about the *necessary* conditionality of mental health service provision. In short, professionals claimed that mental health services could not, and should not, be provided to unaccompanied homeless children until they had achieved stability of general care and accommodation in their lives. As is further discussed, it is likely this conditional approach to service provision is another product of an incomplete adolescent mental health system in Tasmania.

The presenting mental health issues of unaccompanied homeless children

All professionals in contact with children experiencing unaccompanied homelessness described the significant presentation of mental ill-health amongst this group. Professionals specifically working with unaccompanied homeless children in youth shelters or through outreach commonly described the majority of their clients as experiencing mental ill-health:

Catherine: Would you say that experiences of mental ill-health are present for your clients?

Youth outreach worker: For me, 100% of my clients

Youth outreach worker: Same, it's 100%. Every single one of them that I have had.

Youth outreach worker: Yeah, mine as well.

Youth outreach worker: The majority of them do have mental health issues. Caused by whether it be trauma or family or bullying at school. Their mental health goes way downhill.

Youth shelter worker: Most children that come through our shelters have some form of mental illness, whether it be anxiety, depression, emerging BPD.

Youth shelter and outreach workers noted the central experience of childhood trauma and high rates of suicide ideation and attempts amongst their clients:

Youth outreach worker: All of these kids have had significant trauma before seven. Physical abuse, mental, emotional abuse and sexual abuse, sometimes all of them.

Youth shelter worker: It's what's happened in their home which has led to all of their mental health and homelessness...I absolutely agree that [childhood trauma] is there, and that it's the main contributor.

Catherine: Is [self-harm/suicide ideation] common amongst your kids?

Youth outreach worker: Yeah. All of them bar three. So yeah, seven of them have had hospital admissions for suicidal ideation at some point...That is seven human beings who want to end their life...And they're only the ones that I'm working with.

Youth outreach worker: Like last week or maybe the end of last month, I think three of the [outreach] workers all had someone who had been in hospital for attempted suicide...It's everyone who has these clients are having these issues...

Clinical professionals also described the complex presentations of mental ill-health they expect to see from unaccompanied homeless children, with childhood trauma likewise understood as a central driver of ill-health:

Clinical social worker: So my expectation is all of them will have some overlay of a relational trauma, they've got some reason why they can't be at home. It's usually some parenting issue or relationship issue; you don't just leave home for no reason. There's usually some sort of personality development issue, emerging personality disorders along the spectrum, whether that's borderline anti-social - the conduct disorder stuff. Again, if you can't, in those formative years, have that key relationship that's safe and stable and supportive, you're going to have some sort of attachment disorder, which probably leads to all this. And then I think, because you've got the overlay of drugs, homelessness, poor diet, and as I said earlier, the trauma - I think the impact on your axis one diagnosis is...schizophrenia, psychosis. So the homelessness leads to all of those issues [but] it's not just being homeless, it's that unaccompanied, the isolated disconnect which usually has some fairly significant impact on attachment.

Clinical social worker: I would say it's really rare for a young person not to have a trauma background.

Community-based psychologist: Yeah, trauma and self-harm, suicidal ideation and attempts. And that trauma can often look like a lot of significant family violence throughout childhood, whether it's witnessing or experiencing, sexual abuse, neglect, and that real difficulty with attachment of parental figures.

Professionals gave comprehensive descriptions of the hopelessness and disenfranchisement unaccompanied homeless children experience. They illustrated how children's young age, lack of guardianship and homelessness paradoxically contribute to the worsening of poor physical and mental health and barriers to receiving basic health care:

Registered Nurse/AOD Clinician: Because they are under 18 and homelessness - they often have really limited access to services. I mean, you can't even get a Medicare card until you're 15, so those 12-15 year olds, it's really challenging. They often come with a real fear of services, a lot of stigma, discrimination, and multiple complex issues. They have a limited ability to navigate services, they're got a lack of health literacy merely because of their age, lack of finances, lack of transport. It's really hard for them to access a bulk-billing GP, especially if they haven't got a Medicare card...They come with all these diagnoses. Sometimes they might have been treated early on in life and that that treatment drops off and I guess really, it's the trauma that is most significant. There's often interactions with the law, charges of stealing, breaking and entering as a means to try and get some finances to survive, they're exploited by other people, they're often victims of physical abuse and sexual abuse. Nutritionally they're often really impacted. I mean where do you stop? The issues are so complex, often their sleep patterns are really poor, if they are able to find somewhere that's half comfortable, good luck with that. But then they develop that hypervigilance because how do you sleep; if you haven't got that level of safety, how do you actually sleep? So I think, from a physical point of view, there's a lot of disadvantage and then of course the mental health - fear, anxiety, anger. A lot of these young people are very angry, and then of course they are using substances as a way of trying to deal with some of that. I think trauma is the underlier...There also are those other young people who are just so depressed, that are so depressed, and come with that sense of hopelessness... There are some that come with signs of emerging psychotic illnesses. They are the minority. The majority come with anxiety, depression trauma...It is a really complex cohort...I think there's a heck of a lot of work that needs to be put in place to support such young people.

General Practitioner: It's the 14, 15, 16, up to 18 year olds whose health literacy is poor, they're suspicious of their family GP, if they ever had one, they are reluctant to seek help for a heap of different reasons. A lot of them have a bewilderment about how they're feeling. They're vulnerable from the point of view of nutritional deficiency, sexual predation, isolation and the psychological issues which come with that...Because they are homeless, it's not unusual for them to have a history of family violence or family coercive control issues, there's a lack of financial support, there's lack of psychological or social support, they bounce around from maybe no accommodation to couch surfing and they basically go down a very slippery slide very quickly. They're vulnerable to having to sell themselves for financial support, which it turn puts them at risk of sexually transmitted diseases.

Catherine: Would you expect clients who experience homelessness who are under 18, would you expect them to present with a mental health issue of some kind?

General Practitioner: Yes I would. Mild to severe, yes I would. And sometimes it can be as mild as - and as appropriate as - anxiety, situational induced anxiety, post-traumatic stress, and sometimes it can be as severe as extreme paranoia, extreme depression, risk of self-harm, risk of suicide because it all feels so hopeless...They need more than pastoral care.

Unresponsive health and mental health service systems

Alongside articulating unaccompanied homeless children's clear need for 'more than pastoral care', professionals also emphasised the system gaps and barriers which prevent this cohort from receiving adequate health care. They described a landscape in which every form of mental health care available, from primary to acute and emergency care, involved significant barriers or limited capacity resulting in the predominant ongoing exclusion of this cohort and the normalisation of their experience of mental ill-health.

POOR ACCESS TO PRIMARY, ALLIED AND EMERGENCY HEALTH CARE

Nearly all professionals raised the desperate struggle statewide for GP access. Professionals doubted that unaccompanied children would ever be able to coordinate or afford GP access on their own unsupported by a guardian or service provider. Even in their own efforts to identify and support a client to access a GP, professionals experienced enormous difficulty and long wait lists of between one and three months.

Youth shelter worker: So that access, the cost is a complete barrier. We have very limited bulk-billing services here. So if we can't get into one of them, our young ones just don't go to the doctor.

Professionals also raised significant concerns with the quality of GP care provided, including what they perceived as a distinct lack of skill and training in child and youth engagement and in trauma-informed care provision. Issues encountered included the blacklisting of children and young people from medical practices due to failing to present for previous appointments, limited continuity of care, and a quickness to prescribe in the context of a lack of ongoing support and a lack of awareness that children and young people may not be able to afford medication.

General Practitioner: I don't think a lot of practices are youth friendly. And just the very fact they have to have an appointment. Now, if you are living a chaotic life and you haven't got any money to catch a bus, you're couch surfing with a friend who's out at [outer suburb], you can't get in to see anybody and someone tells you that you've got to be there at 11 o'clock tomorrow morning, one, you might not even be awake because who knows how chaotic your life is, but secondly, how on earth are you going to get there?

Registered Nurse: GP practices - they won't say they'll blacklist them, but they do. So if the GP is the first port of call [for a mental health service] that is really hard.

Clinical social worker: We do a lot of work quite often trying to get a GP for a young person, but then they might not even be able to book in with that same GP, they'll be in a centre and they just go and see a different one each time, so that continuity of care isn't there.

Most importantly, professionals emphasised how debilitating wait times were to the overall process of support provision and unaccompanied children's help-seeking. The length of wait times was incongruent with the timeframes of children's support periods in other services and, given how quickly their lives and circumstances change, with the brief windows of time in which they felt ready and able to access clinical support. Such barriers to service provision are particularly concerning given professionals also said that GPs were often their key or only route for mental health care access for their clients.

Youth accommodation worker: It's a huge issue, GP access in Tassie at the moment, so I guess the huge barrier for these isn't even the mental health; the main barrier - the first barrier, the primary barrier is actually even getting into a GP to actually get referral to a psychologist or any service. They're just not there.

Where GP access and mental health care plans were eventually facilitated for children by some professionals, the subsequent battle was trying to identify bulk-billing psychology and psychiatry appointments, with the same array of barriers as accessing GPs:

Clinical social worker: With private psychologists, that's got its own barriers, the cost, the waitlists, the appointment-based system, the fact that they don't offer outreach and then finding ones who know about trauma and emotional regulation, who have that knowledge and support the young person with that and who are happy to work with a young person who doesn't have a parent supporting them...Gosh, there's so many things.

Clinical social worker: Primary level care - that's what we're not seeing here. It's hard to get one [GP] and when you do, you're not going to get bulk-billed. You also can't get bulk billing psychiatry in Hobart. There's no one that can do that...Unless you're going to get in to see CAMHS or ACMHS, you're not going to get access to that. There might be telehealth through psychology and psychiatry, but how many unaccompanied kids have got the option to logistically sit down and be linking on their laptop to telepsychiatry or telehealth?

Clinical social worker: There's a handful, if even, of private psychologists who are willing to bulk bill but then the pressure on them, you're very conscious of how many young people that you can send and their wait lists are four to six months to get in

Professionals argued that a lack of ready access to GPs or allied health practitioners contributed to the normalisation of unaccompanied children's mental ill-health:

Youth shelter worker: But yeah, I think another barrier is around validation of their mental health. Like if they're not travelling well, it's actually someone sitting down and saying, the way you're feeling is not normal. You don't need to feel like this every day.

Youth outreach worker: And it's really hard because when they're willing to be vulnerable, you need to capitalise on that, it's only there for a short period of time because something can happen at school or they can have an argument with a family member or their boyfriend or a friend or whatever it might be, and they're like, 'Well, fuck it. I'm not fucking doing anything. I'm never going change. This is always going to feel this way,' so then they shut themselves down again. So that is really hard.

Poor service access and long wait times meant that some professionals ultimately hoped that the mental ill-health of their clients would acutely escalate and result in hospital admission and subsequent hospital referral to mental health services:

Youth outreach worker: I just think it's really hard to get them their support, unless it gets to a point where they are admitted to hospital...it takes a lot for it to be noticed or for them to be a high priority.

Youth accommodation worker: It's the hospitalisation, it sort of forces things to happen. But unfortunately, that's when you get to the acute end of things.

Youth outreach worker: So I think the most success I've had is because the clients have gone to hospital, and then, from the hospital, they've been referred through to headspace. So I think that has a lot more weight coming from the hospital rather than a referral [from] myself through to headspace.

Youth outreach worker: The assessment will only come if they've presented at hospital, I've never been able to get somebody into CAMHS unless they've gone through emergency first...

In many cases, however, professionals found emergency department responses to their clients deeply frustrating and also potentially dangerous. They raised concerns with the lack of specialist care provided to unaccompanied children and young people presenting to hospital; they argued that they were commonly offered generic care by emergency registrars, were rapidly discharged with unrealistic support in place, if any at all, and potentially due to pressure to clear patients, were returned in taxis to wherever they may be staying.

Student support coordinator: One day, we were high-fiving each other - we'd managed to get one of our extremely unwell [unaccompanied] young people into hospital, only for her to be sent home with a safety plan with a school psychologist, who works two days a week.

School social worker: We did a lot of work around getting [student] to the place where he was okay to get to hospital, when he was willing to accept that support and felt like it was a positive. I followed up with the hospital at night, just from home, just calling them and making sure that they had all of the information. But yeah, they had already discharged him. And so, then he comes back [to school] the next day and we start from scratch again.

Youth accommodation worker: Look, often they get released that night, get sent in a taxi back to the shelter.

Youth accommodation worker: If we get a referral from the hospital, it may not also really talk about the severity of where a young person's at. They just want to get them out. So we may not get the full picture, they maybe say they've been assessed. But they've been assessed by a Registrar at A&E, they haven't been assessed by a mental health professional. They haven't been assessed by a psychologist. They've been seen by a new registrar that asks a couple of basic questions and doesn't probe further and realise that the client's actually still actively suicidal and sending them to a communal living environment isn't the best option.

Youth outreach worker: CAMHS aren't there [in the emergency department] because if you attempt to kill yourself outside the hours of 9 to 5, it's really inconvenient. But a general doctor will ask a list of questions, 'Are you planning on killing yourself in - how are you feeling? Do you have a plan? The young person says no. They're discharged.

AN 'UNTOUCHABLE' CAMHS

Statewide, professionals overwhelmingly described CAMHS as a severely limited service. Many professionals struggled to recall their last successful referral to CAMHS. When referral was successful, significant collaborative advocacy across multiple services and government agencies seemed to be involved, alongside acute presentations of children to emergency departments.

Professionals understood this limited access as a result of the under-resourcing of CAMHS and its subsequent evolution as a niche service.¹⁶ Nonetheless, they described this as damaging for unaccompanied children and as placing enormous pressure on the rest of the mental health service system, leaving those services which had ongoing contact with unwell children feeling demoralised.

Registered Nurse: Now, as far as CAMHS go, CAMHS will only see young people who are the more acute end of mental illness. In the past they wouldn't see any young person unless a parent was supporting them. With the recent review I'm not 100% sure on what's happened with that but I'm hoping that that review has made that not a mandatory thing. Because again, if we've got a young person who is acutely unwell or has more of a severe level of mental illness, if we can't refer them to CAMHS, where do we refer them to?

.....

16 This is consistent with the national picture of a lack of equity and access to mental health services specifically for those children and young people unable to meet the threshold of CAMHS services - triaged to high severity due to lack of capacity - and unable to afford private care (*The National Children's Mental Health and Wellbeing Strategy 2021*, p. 56).

School youth worker: CAMHS. I just don't bother. I don't do a referral to CAMHS because they just won't take it. And if I have got a young person that's been with CAMHS, it's only a very short period of time before they discharge them.

Youth outreach worker: Unfortunately we don't have any interaction with CAMHS...A lot of ours, they're not hitting that top 5% - we just don't have access through that way. And that even through child health nurses. CAMHS is not on our radar.

Youth outreach worker: I've had nothing to do with CAMHS here [Tasmania]. Purely because I have never been able to reach them. They've not been on the radar. They're just this untouchable service I suppose.

School social worker: CAMHS is our biggest one that we get pushback from, absolutely.

Youth outreach worker: Just someone saying, how about we try CAMHS? You just have an inner feeling of defeat.

Professionals argued that experiencing childhood trauma as a key presenting issue, being homeless, being unaccompanied, being suicidal or using drugs and alcohol were all key grounds on which their clients were commonly refused a service from CAMHS:

Catherine: And what are the key barriers that you perceive to being able to access CAMHS?

School youth worker: A parent. A parent. Because they won't work with someone that doesn't have a parent/guardian supporting them. And they're either - they're not severe enough or they're too something, or they're too old. They're always too something, Catherine....Too pointy ended or not pointy ended enough. Or not a mental health issue; it's more behavioural, it's a behavioural thing, we can't deal with that.

Youth outreach worker: If you're bringing a kid to [CAMHS] and they don't have food, they don't have shelter, they don't have care and protection, they don't have education they don't have all these things; bring them back when they have all these things, and we will work with them, otherwise it is a waste of time. All of our young people will never have those things, that doesn't exist...And the families don't have capacity.

Youth outreach worker: So when they [CAMHS] first see a young person, they do an assessment with the young person, an assessment with the parents. And then then they do their own little assessment. And then they go, we'll take this client on. So he didn't have a guardian, so they could do [the assessment] - so they didn't accept him...Even if he did get through, childhood trauma, we don't deal with that.

Youth outreach worker: Like our only specialised mental health service for youth is CAMHS. They say they take the top 6% of high-risk youth. They're not our top 6%. They won't hardly take our clients. This is the issue, they're very quick with saying, that's behavioural issues or that's drug and alcohol, that's...

Clinical social worker: So we try and engage with CAMHS and I know this has probably come up a million times; that it's quite difficult when that young person, the model they use as family therapy that if that young person doesn't have that supportive family member they can't engage because they've got no family...I think the CAMHS current model is quite a middle class service where you're working as a family and there's definitely a place for that, but for these people that are really high risk, it's not appropriate for them or they can't access it because they don't fit the criteria.

With CAMHS understood and experienced as an 'untouchable service', professionals were left scrabbling to piece together occasional GP appointments, community-based mental health services and private practice. Given the extraordinary struggle professionals faced to connect children and young people with community-based or private options, they felt the situation for children and young people without advocates was truly hopeless. Even advocates watched their clients spiral towards suicide and hospital presentation in the absence of other pathways:

Youth outreach worker: I don't want to go on a CAMHS bashing tirade, but CAMHS is probably my key frustration. They're supposed to be free. It's free, right? They block access to the young people that I'm working with because they don't fit a certain criteria of mental health. They're a child and adolescent mental health service, that is literally their fucking name, but they pick and choose who they work with. And I get it, to an extent, but employ more people, employ more staff. Employ more staff and have PTSD-specific clinicians and bipolar-specific clinicians, and have sexual-assault; do you know what I mean? It's the access. It should be easily accessible for young people to get mental health [care], and it's not. It's actually really hard. So if I'm struggling as their worker, and qualified, educated, I consider myself relatively smart, if I struggle to get them support, what actual hope do young people have on their own when they're experiencing significant mental health issues?

Youth outreach worker: I had one young person say, 'Is my life not fucked up enough? What else do I need to do to get help? And she had it - is trauma not enough? Is trauma not enough? That is bad enough. And she deserves everybody throwing everything that they can at her to support her. But because she isn't presenting in a certain way...she did attempt to kill herself in the end.'

THE MISSING MIDDLE BETWEEN HEADSPACE AND CAMHS

Unfortunately for unaccompanied children, not only did professionals statewide predominantly describe CAMHS as an inaccessible service, but headspace was too.

Catherine: How do kids find headspace? How do they manage, because I know it's appointment-based?

Youth shelter worker: Yeah. The ones who are most stable succeed. The high-risk challenging ones - it's not a thing. So if I don't go to every single one, which isn't always doable and it's not sustainable, I'm not their key person, I find yeah, without external support like TYSS or something like that, taking them, they're not doing it.

Youth outreach worker: Our kids won't access headspace, they think it's very middle class and you go to headspace when you get bullied. Our kids will not access headspace, they hate it.

Clinical social worker: Headspace will say that their cohort is low to medium; they won't take people with high risk...We really feel like it's really limited.

Youth outreach worker: We've got headspace, they've just got this fantastic new space, it's really great. Do I have clients who would go there? No. No I don't. This is middle class, maybe working class. This is not low socio-economic background, high trauma. That's not what it is. It's not going to work on this most complex tier. Because they do not feel like they belong in that space. This is not familiar in any way, shape or form. This is a community that has shunned me from birth. I don't fit in.

Alongside difficulties in accessing both headspace and CAMHS, professionals also focused on the widespread experience of children with complex needs falling *between* the gaps of early intervention and acute service provision. This was commonly framed by professionals as the problem of the 'missing middle' of services targeted to children and young people experiencing moderate to severe and complex mental ill-health; as one clinical social worker described it, 'the middle space is blank'. Professionals characterised this as the problem of the headspace-CAMHS dynamic in Tasmania - with unaccompanied children being deemed as too complex for early intervention through headspace but not acute enough for a limited CAMHS:

Community-based psychologist: That missing middle...[They're] considered too complex for mild to moderate care such as headspace or private psychology but maybe not fitting or meeting criteria for tertiary care.

Registered nurse: I find this kind of, 'we'll do mild to moderate', 'we'll only do the pointy end' But what happens in the middle? And what happens to those - the young people that really fall through the gaps are the ones with that moderate mental health and/or drug and alcohol issue, because they're too hard for the mild to moderate, they're not ill enough for the more severe; they are the ones that really fall through the gaps.

General Practitioner: It's this falling between the gaps...people who are not so extreme seem to be okay, the people who are really, really extreme seem to be ok. It's this interim group that you have trouble reaching and who have trouble reaching us, not just because of physical access issues, although that's a major issue, but because they're suspicious - not suspicious because we think we're going to hurt them, but nobody can help me, I've lived like this for a long time now, it's all my fault.

Youth outreach worker: This will sound terrible to say but it feels like headspace, like CAMHS, they are services built for the children of families who are reasonably high functioning, middle to upper class, working, engaged, responsive. Those services aren't really there to meet the needs of our [outreach service's] children. They're not there for the kids who do not have a family who have a car, who do not have the

people who will gather round them, because headspace, the majority of their young people that actually engage in real therapeutic work have all those people around them, they have supports, they have school, they have family, they have people getting them there. Very few of my kids have ever engaged in headspace. They can't. [CAMHS] is really great if you are young and you're going into psychosis but if you have trauma, if you have factors resulting from trauma symptoms, you're not getting into [CAMHS], you're not getting anything.

In summary, professionals around the state painted a picture of mental health services that, at all levels and in multiple ways, either shut their doors to unaccompanied homeless children or were just too difficult to access, even with the persistent advocacy of youth outreach workers. Barriers were faced in access to early intervention services, acute services including CAMHS, hospitals, and school-based and private psychologists. This meant both professionals and children received inadequate support and were left potentially feeling that 'there's no one out there'.

Youth outreach worker: And they're often in the middle, between mild to moderate and severe and complex. Because they can't get a mental health care plan, or if they don't, if they've seen a few psychologists in the area and they've run out of options there. We can't refer them to headspace because they might be too complex for headspace and then they're not complex enough CAMHS. And then we find that sometimes the young people that end up going to emergency will get seen and then discharged the same day with a sleeping tablet. Go and sleep it off. It's a bit of a shit show, isn't it?

School psychologist 1: CAMHS have the family model...So then you have kids who cannot have their parents in there and it just doesn't fit.

School psychologist 2: And they're very reluctant to take them on if the parents aren't involved. But the parents can't be involved because the kids aren't living with their parent.

School psychologist 1: Or I mean we've recently referred to headspace, and we're told they're too serious for headspace.

School psychologist 2: Or if they're at all suicidal they can't go to headspace. Well, that rules out three-quarters of them. That rules out quite a large number of our kids.

School psychologist 1: It does. Absolutely. So yes, so we're just left with, where do you go?

School youth worker: It's difficult, it is really, really, really difficult. There's no one out there; there is no one.

Conditional mental health care: Maslow's hierarchy versus high-risk kids

Alongside the immense service pressure and scarcity of mental health care resources described by professionals in Tasmania, an additional, overarching barrier to mental health service provision also emerged in the narratives of professionals: the necessary conditionality of mental health service provision. Both mental health practitioners and youth support workers in various settings wrestled with their sense that unless unaccompanied homeless children were physically safe and experiencing stability of general care, then psychological support was not only inappropriate, but potentially dangerous.

Interestingly, this conundrum was repeatedly discussed with unprompted reference to Maslow's (1943) theory of human motivation, with professionals asserting the priority of meeting physiological over psychological need:

Community-based psychologist: I guess we look at it that, like Maslow's hierarchy, and without that stability, security, basic needs of home, food, shelter, we have such a minimal degree to be able to jump in with therapy and run with it because they're thinking about where their next meal's going to come from so why would they sit there and talk about cognitive change?

Clinical social worker: So in that chronic stress mode surviving to even the idea of dropping their guard to be able to do anything therapeutically is just, is too much.

School psychologist: You feel a bit helpless really. You see these kids struggling and you what they need, but you can't give it to them. And then I guess, from my perspective, knowing that they need mental health intervention but they're probably not in that space. Because again, their basic needs are not being met. They can't even consider their mental - the psychological level if you think about the Maslow's hierarchy of needs. That's just not a priority.

School support teacher: I think our greatest concern is maybe foremost trying to find some accommodation for them before we address their mental health.

School psychologist: And when the kids that are at risk of homelessness won't engage with me, because their basic needs aren't being met, then they're not high on my list.

Some mental health practitioners worried about pathologising children rather than addressing their distressing life circumstances; some retained doubt about the value of delivering mental health services in broader contexts of risk, and indeed about the need for mental health intervention at all:

Clinical social worker: I know there's mental health issues but how significant would those issues be if they had stability here? It wouldn't be. I think they're reacting to their life circumstance, so mental health services is fine, but how much can you do when people's life circumstance - you're still sending them back to a life circumstance

that's wrong...So the distress I think we put down to mental health, there's an element of mental health in there, but it's emotional distress at life circumstance.

Community-based psychologist: If we do therapy and say this is okay that you're in these terrible circumstances, we won't do anything about it, we're showing them that we're abrogating our responsibilities as caregivers...and you're going to make them less able to benefit from therapy later. They're better experiencing the trauma and finding a stable place, and then have the treatment...Kids need a roof over their head and food, before they need therapy. And then, if the stress is persisting after those basic needs are met, then it's about mental ill-health.

For others, it was apparent that a stepped approach to increasing mental health service 'readiness' in children would not alone make any difference to their mental ill-health and their persistent, potentially long-term, need for mental health care:

Youth outreach worker: CAMHS don't seem to like messy. The homeless, they're like oh well, you [youth outreach service] find them a house because then it will be fixed. No it won't be. You can still find them a house. One issue. But the issues are still there. It doesn't mean it goes away. Housing is one issue of a huge thing. It might make them easier to engage with mental health services but it doesn't mean the mental [ill-] health goes away. They need specialised mental health [care].

Clinical social worker: I find in my experience where young people are transients, when they've not had a stable, connective home for their life, like they don't have this pattern - it does not just get better and it takes years of support to reach that stable base, if you ever do reach it. And I say that as someone who worked with a lot of adults who'd been through this and then were trying to change so their children didn't go through the same thing that they went through. So if someone was working with young people like working with this group in particular, it's like you really hope that you can make some impactful change but it's really difficult.

With the overwhelming majority of mental health service provision being appointment based and requiring significant, ongoing advocacy and practical support for access, it seemed that the 'obvious' conditionality of stability first, treatment second actually resulted from a system with limited capacity to meet children earlier in their trajectories of harm. It was also suggested that simply due to lack of contact with children with complex needs, the extremity of some children's mental ill-health may not be understood and practitioners may not be trained in innovative approaches for successful work with this cohort.

Clinical social worker: I think a lot of mental health professionals, depending on where you work, would not have contact with young people who are transient, so I think that is just a case of not knowing...it's almost like this hidden, invisible side of the world that people don't know about unless you're directly working with them.

For a range of reasons, some clinical professionals did not imagine themselves as having a role in helping children to achieve stability. It seemed most often assumed that this stability and safety would and should come from somewhere else first, in particular

from the specialist homelessness services sector. Creating further complexity, however, is the historical legacy of the *reverse* conditionality in the homelessness sector, which, traditionally and likewise due to service and funding specifications, has operated with an approach of treatment first, stability second.¹⁷ As one youth shelter manager explained, youth SHS services are funded to provide basic supported accommodation which requires any additional needs to be met by external services:

Youth shelter worker: This model is funded for a low-level need, that's just the parameters of what we're working within. It's really, really challenging to provide support for young people with complex mental health challenges when they aren't being adequately supported. Our facility [youth SHS] is not a mental health facility. We're not equipped to be able to deal with complex and persistent mental health, the constant suicidality. We're not a 24 hour facility. We are a sleep-over model so the staff go to bed at 11 o'clock and wake up at 7 the next day. The service model and the funding for this service is not suited to be able to cater for young people with complex mental health challenges. And when they're not getting support from CAMHS, when they're not getting support from the ED, sometimes we actually have to say, I'm sorry, but we are actually unable to support this person due to their level of mental health and that's a young person's that missing out on services through no fault of their own but for a fault of the system.

It was also clearly argued that the inherent short-term model of crisis accommodation is not designed for the support of those with complex needs:

Youth shelter worker: A lot of shelter are saying every six weeks, so this is not long and so kids get bumped around the state which of course doesn't give enough time to build rapport with people, to get things started, to try and get ID; it just falls apart because they're going to be leaving.

Professionals illustrated an environment in Tasmania where access to stable care and housing - whether through the homelessness sector or through Child Safety - can be a slow, even unlikely, outcome for unaccompanied homeless children. This was thus seen as the clearest sign of the need for mental health service intervention 'to step in now' and be *part of the journey* towards achieving stability:

Youth outreach worker: I have worked in [outreach service] for the last 10 years and I can think of three clients that were accepted by [CAMHS] and had regular therapeutic intervention.

Catherine: What's the barrier?

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17 This stepped approach to homeless service provision has been fundamentally brought into question through the Housing First movement which promotes the integrated provision of stable, long-term housing and clinical care. There is scope to more radically broaden the implementation of mental health reforms in Tasmania to increase cross-agency and cross-sector service integration and coordination for children and young people.

Youth outreach worker: Family. Family, security, Maslow's hierarchy of needs...If you're bringing a kid to [CAMHS] and they don't have food, they don't have shelter, they don't have care and protection, they don't have education, they don't have all these things; bring them back when they do and we will work with them otherwise it's a waste of time. All of young people will never have those things, that doesn't exist... and their response is well, Child Safety should do it, well the school should do it, well this should happen. But it doesn't and it won't. And families don't have the capacity.

Catherine: Do you believe that mental health care is a waste of time if all that other stuff is not in place?

Youth outreach worker: No. No, it's absolutely essential. No, not at all. That's exactly when it's needed. That's critical, I mean, fuck, how many of us go see a psychologist when everything is going really well? None of us, none of us wait until we've got a really good, solid relationship, our house is paid off and garden looking fucking great; no we don't. We go when everything is falling apart, and we don't have Maslow's hierarchy of needs. We have none of it. That's why we go, because we're fucked. I need someone to step in now.

Indeed, for one professional, the inflexible adoption of Maslow's ideas about a hierarchy of needs is an outdated legacy to be 'overthrown'.

Clinical social worker: Maslow's hierarchy of needs is totally outdated and needs to be overthrown. Homeless people will never get a mental health service if being housed and stable is a requirement of service provision.

Risk-holding and vicarious trauma

In the context of limited mental health care availability, those left holding this cohort of high-risk children were predominantly professionals in youth homeless services, youth outreach services, student support services and youth health services (community-based and state operated). These professionals collectively felt the negative impacts of the lack of access to complex mental health care and the ongoing battle to connect their unaccompanied homeless clients to any form of specialist mental health care.

In particular, specialist homeless service staff and school social workers and psychologists routinely struggled as they remained accessible, low-barrier contacts for unaccompanied children in need and shouldered a duty of care for children accessing their organisational sites whether or not the issues children presented were in their scope of service provision. The result of this, however, was pressure on staff and on other clients also needing assistance.

'COULD I GO TO SLEEP AT NIGHT?': THE STRUGGLE OF COMMUNITY-BASED YOUTH SERVICES

With the constraints of group residential settings operating with a sole-worker and sleepover model of care, youth SHS staff described their inability to perform basic care

tasks for unaccompanied children experiencing mental ill-health. This included being unable to transport and accompany children to hospital in response to self-harm and suicidality, being unable to transport and accompany children to medical or counselling appointments, and being unable to effectively monitor suicidal children. Legally contracted, funded and staffed to provide a safe residential environment, SHS staff were nonetheless forced to provide whatever additional care they could.

Youth shelter worker: So we had a young person at [the shelter] who had suicidal thoughts and we took him to the hospital and it was on a Friday, of all days, but he was sent home in a taxi by the hospital without even notification that that's happening, back to [shelter's] door. This kid, just a little kid, I think he was 13 maybe, 12 or 13, didn't have an assessment by CAMHS because crisis only happens Monday to Friday 9-5pm for young people.¹⁸ So he went back to [the shelter] and the issue is that when they turn up at our door, we can't say no. We can't just turn a child away and say, oh sorry. It makes it really, really difficult for services. It puts us in a hugely difficult situation because we want to support the young person but also, we can't carry that level of risk in our organisation. But of course, our services are focused on the young person, that's how we should operate, but being realistic and being honest, it is a huge risk and because we're not equipped to be able to deal with that; we're not equipped to be able to support young people with those issues... Again, through no fault of their own; through a fault of the actual system. And there is no mental health supported accommodation facility for young people and our services aren't equipped to deal with that...They need constant and quite ongoing psychological support. They need that support and they're not getting that in SHS services because we're not funded for it...If you've got someone who's literally, constantly suicidal and constantly trying to kill themselves, we can't do it. We just can't do it. There was one person, one of the staff one night found her in a bath of blood...Are we actually providing the best level of service to a young person if they're coming in here? We're obviously doing everything we can to get them that support, which is a challenge... but we're not equipped for that...When we get those tricky referrals, ethically for me, can I keep this young person safe? That's what I think. Could I go to sleep at night while that young person was in my service?

Youth shelter worker: When you've got a kid with high mental health needs in your house, your time is greatly taken up by those individuals at the expense of the other kids. It's also really difficult. You have to tailor your behaviour approach, your processes even. If they are little, and they have acute needs, and they have behavioural issues, and they are diagnosed et cetera, you're working with some kids who can't reason, you can't build connection with them. So you have to treat everything you do completely different and it takes a lot more time. It's exhausting. Like, there are some kids, like the one I described, like working with him usually is

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18 Frustration with the limited availability of CAMHS hospital teams was a common theme in the narratives of professionals, as in their experience acute suicidality or other mental health crisis usually occurred outside of weekday office hours.

two, three incident reports a day...Like here's a young person who needs a one-to-one, step by step residential placement where you work through a lot of this trauma behaviours along with his diagnosed [illness]. And you're trying to replicate the level of care because he is just a little kid and no other shelter will touch him.

Youth outreach worker: So when I was working at the shelter, often we would have to have the ambulance come and pick up the young person, because of, you know overnight one worker, you've got six other people who are in bed, so you have to either rely on the ambulance to come...Often they get released that night, get sent in a taxi back to the shelter. It's really hard. When we had clients who continuously presented with suicidality, all of this mental health stuff, it then became too high needs for the worker and the shelter itself, in that model. We've got so many other people that we have to attend to, and we're not able to do that because we're focusing on this one person every night...Then they are forced, basically, to go back home or find somewhere else to stay or to go to another shelter and this continues to happen - the same thing happens at that shelter, and then it's like who know what happens after that...I think one of the main issues is that there's not a homelessness shelter for people with mental health [problems].

Specialist homeless service staff described the stress and vicarious trauma resulting from attempts to support children experiencing extreme ill-health and suicidality in facilities and program models never designed to enable appropriate responses. These impacts were felt by both staff and other children and young people in the shelters. For children and young people this involved exposure to additional stress, trauma, self-harm and suicide contagion, and for staff, increased stress, trauma and difficulties managing the behaviours of other residents, including their bullying of those experiencing mental ill-health.

Youth shelter worker 1: It's confronting seeing someone come in with their arm sliced from wrist to shoulder, it's confronting seeing all that blood and cuts, and someone's done that to themselves...But the impact that having someone that self-harms constantly in the house has on other residents who have struggled with self-harm, it triggers them. It can really compound in the house and the next thing you've got a house full of young people who are all self-harming. And it's hard on staff. And especially around suicide. Like if someone's suicidal, it's really hard to carry that risk. It's really hard to sit with that on a night shift knowing you've done everything you can. But sitting with that level of risk is stressful

Youth shelter worker 2: Your heart pounds when you walk down the hallway towards the bedroom door, you're like, what am I walking into...

Youth shelter worker: I think after a few nights of the same thing repeating it does get draining...Like you then have a run of all these mental health issues. If it's night time they [young residents] can all hear what's going on. So then you might have another client who like, all of this talk is bring on all of these thoughts of self-harm for myself. So then you've got to deal with two cases of it. And then you might have another client who doesn't like it, might not have any thoughts themselves, but then they start

to get angry, because all this stuff is going on and it makes them uncomfortable. And so then you've all of these things happening at once. It definitely, I think, it affects other people in the residence. Definitely.

School youth worker: The kids that do live at the shelters, they do have really bad mental health, like schizophrenia and unusual outbursts and things. They struggle because the kids hate them because they're weirdos, they're disruptive. So they often get hated on because they just don't fit in, and I've seen it. And the staff can't manage them either a lot of the time. Which is fair enough, because we're youth workers, not psych nurses.

Youth shelter worker: I think for the other kids who are in emotional distress, they can be really difficult to watch as a worker. I feel, well, the vicarious trauma for staff can be quite high. Because especially if you're unable to link them [kids] with support or they don't identify as having a mental health issue, showing quite bizarre behaviours which then leads to other young people, potentially, bullying them. And sort of targeting them. Because we're not a mental health facility and it isn't a psych ward, when you get kids who should be in those situations it can be really difficult to manage them around others. And change the entire service to fit them which we're not technically meant to do but we kind of have to do because it means they're going to be homeless otherwise and some of them are really vulnerable.

'LEFT HOLDING THAT RISK': THE STRUGGLE OF SCHOOL-BASED SERVICES

Similarly to specialist homeless services professionals, school-based student support professionals – predominantly psychologists, social workers and nurses – struggled to connect children with complex mental health needs to appropriate, skilled, intensive responses. These professionals described working in an extremely limited service in which psychologists work weekday school hours in school terms and social workers struggled to maintain contact with students during extended school breaks. Further, students completely lost access to any support staff when leaving high school and then again when leaving college.

At the same time as operating in limited services, school-based professionals reported receiving huge numbers of referrals, with one college reporting nearly 400 hundred referrals in 2021. With this scale of referrals and a substantial focus by psychologists in high schools on learning assessments and in colleges on assessments for exam adjustments, individual follow up for any students was described as difficult. For many children already experiencing barriers to school access and engagement, access to overwhelmed student support teams seemed even more unlikely. Indeed, as staff discussed, where they did establish connection with children experiencing high-risk, given the volume of referrals and responsive nature of their on-site roles, they struggled to provide follow-up and find external services to connect children into.

School psychologists: I don't know how many kids this year that have just really fell through the cracks, because we were getting like 10 new referrals every week. And so I'm trying to keep the ones that I've first seen...but when I've got 10 new referrals every week I can't follow them up. And so there are kids that would really benefit from support but I haven't got time to follow them up...And I think we just see, just because of the work - how many we're getting, we feel like we're scraping the surface.

School nurse: Because we're only here term time, it's actually the external support that we need because we can't be here all the time.

Support teacher: Because we're here for a short period of time. So we can't continue on their journey with them. We need to really set them up. [Referrals] often don't arrive until the middle of Year 11 or end of Grade 11. So we really want to set them up with someone that's going to be there long-term. So an external service provider around mental health...

Student support service manager: Often what we're getting when we've got kids who are suicidal, kids who have been in ED, we're saying your safe person is your school counsellor, so that's your protection. These people are directed to have their phones off at five o'clock. They don't work on weekends. And over the summer holidays, there's no one around for six weeks. And you can appreciate that if it takes you six months to even make a referral to the psych, and then school [is finished], the kids are done, they're transitioning from Year 12 in this unknown world.

Similarly to SHS professionals, school-based professionals described getting 'stuck' with unaccompanied homeless children when they were unable to identify an appropriate external service to support them:

School psychologist 1: We normally call the parents when [students] are suicidal, but there's no one to call.

School psychologist 2: There's no one to call with them [unaccompanied homeless students]. So now we're stuck with well, we don't know where this kid is going on the weekend.

School psychologist 1: We don't know what they're doing on the weekend.

School psychologist 2: We don't know how safe they'll be. You ask them, they say they're not sure. You send them to a hospital, they send them back.

School social worker: Like we're not a therapeutic service, full stop. We don't have the capacity to do that...But when you've got a young person who's in crisis and they're feeling down or they're self-harming and you've got a six/eight week wait [for external service provision], you're holding them anyway. Even if you've done the referrals somewhere else, you're still providing that support in the meantime. That's a really unique thing about working in schools. There is no other workspace like it. The client base have access to you.

School social worker: There's a lack of services and there's a lack of handover there's no one there to carry the risks. So like, when we handed this young person over the police, it ended up being in the end, not the ambulance, we handed over then, that responsibility for them to take care of that young person and then they handed it on to the hospital. And then, the hospital did nothing and then [student] was back at the shelter again. And the shelter are in the same position as us...It seems that the school is consistently left holding that risk...The school support sits in that early intervention space but really, what we're finding more and more is that we're sitting with the more complex ones because we can't get them in anywhere. And that's not our remit. That's not what we're equipped for.

Conclusion

Mental health, homelessness and outreach professionals alike described a current pull to incorporate the 'missing middle' of moderate to severe and complex mental health service provision in their work. As one early intervention mental health service professional explained, 'we see a lot more complex presentations because there's often nowhere else for people to go'.

Whilst the primary need of unaccompanied children to have basic needs met and stability of care was seen by some as the key threshold for access to mental health services, it also seemed that this threshold was more a reflection of what was needed to access the clinical, appointment-based services on offer, rather than a true test of what kind of mental health service provision would be valuable for high-risk children. For those witnessing and 'left holding' the extremes and complexities of unaccompanied children's presenting mental ill-health, it was also clear that overwhelming complex trauma, attachment disorders and emerging mental illness would not be addressed by an improvement in life circumstance alone. For one clinical social worker the issue was obvious: 'We're not set up, we're not set up for these kids'.

Addressing 'life circumstances' and providing timely access to specialist mental health services clearly emerged as *concurrent responses* needed to address the mental ill-health experienced by unaccompanied homeless children. Ultimately, and as discussed in Part III, professionals were clearly hitting the limits of siloed service provision and were reaching for a new model of care. For many, this was about cutting through agency, service and program specifications to centre on unaccompanied children, the reality of their presenting needs, and on what mental health specialists *could* immediately contribute to collaborative efforts to ensure their survival and wellbeing.



PART III

DREAMS

"Just someone to be there for all of us."



Part III of this report provides a space in which to hear advice, ideas and dreams for a more just system of care, including mental health care, for unaccompanied homeless children in Tasmania. Without significant system and service change, professionals deeply feared for children's futures. As one clinical worker social bluntly commented, 'Where does that kid graduate? Into prison, or into childhood pregnancy or into major mental illness. That's the three options these kids have got and you can follow their trajectory.' Despite the often overwhelming harm, abandonment and ill-health they experienced, children and young people shared exciting goals they were focused on achieving and articulated their hopes for future careers. They also had a clear vision of the kind of supports that would most help them to progress these hopeful trajectories. Though worn down by the impacts of system fragmentation and missing services, professionals too offered a consistent picture of how unaccompanied children could best be supported towards the positive outcomes they dreamed of.

What children dream of

Deep listening to the compound adversity unaccompanied children described in Part I throws into relief the remarkable strength they retained through the ordeals of both home life and homelessness. Their survival and their ability to hold on to and articulate positive dreams for themselves offers professionals positive and future-focused ground to protect and nurture. Included in the narratives of children and young people were dreams for their own personal futures and also dreams for services responsive to their needs and those of other unaccompanied homeless children and young people around them. They sharply observed structural inequality, system and service gaps, and needed interventions; as might be expected, these were both bluntly and poignantly expressed.

'BIG THINGS OUT THERE IN LIFE': GOALS, CAREERS AND SELF-EXPRESSION

Children and young people described a range of goals for themselves and also linked working on their mental health with recovery, securing pathways out of unstable housing and making steps towards newly established dreams. Sammy wanted to work on his resume and was after a job in a phone shop, Gem had clear goals of regaining his lost driver's license and trying to manage his anger to ensure he stayed out of jail. Bree wanted to explore alternative education options so she could continue to work towards her dream career in midwifery; she was also hoping for a social housing breakthrough and the return of her toddler to her care before giving birth to her second child. Issy was determined to excel in college and move towards a Defence Force career as a nurse or medic.

With access to the support of a youth outreach worker, Tara and Kayla were also working hard to bring together multiple elements of support in their lives, trying to manage mental health, reduce drug and alcohol use, attend TAFE and also work. Between them they showed extraordinary resourcefulness and courage in their help-seeking:

Tara (19): I've been doing really well this year with following through in going to appointments and continuing to help myself and even reach out for help that I just didn't think that I would.

Kayla (20): Due to my mental health I missed a lot of school, so they unenrolled me and would not let me back. It's their loss though I feel, 'cause now I'm working at Hungry Jacks doing a great job...There's no point letting things that go on define who I am. I need to be the best person I can be. And I don't know how good that is yet, because I'm still trying...Maybe getting what is probably the right diagnosis helped as well.

Like Kayla, Jay was determined not to be held back in his life by the extraordinary adversity he had experienced and continued to face in his current search for stable housing and support with emerging schizophrenia. Soon to be a father of two, he had plans to step into a career and increase his capacity to provide care for his children:

Jay (16): My plans are very big and very out there, only because of what I've done in my life and because I'm homeless; that's not going to stop me from becoming a diesel mechanic. And I've now got a beautiful girl in the world and she's seven months old.

Outreach worker: So Jay's a dad and his current girlfriend is pregnant so he'll be a dad again.

Jay: Yeah, I've got big things out there in life that I need to be here for and support.

Also supported through a youth outreach service, Lila and Opal were making strides towards crafting purposeful lives through making clear goals, improving schooling and undertaking structured activities such as participating in the Duke of Edinburgh awards program and returning to dance classes:

Lila (16): So even though I'm in Grade 10, I'm doing Grade 11 English, to boost me for when I'm in Grade 11 and my Duke of Ed. We were talking yesterday that I could do my silver. I'm going to do my first aid course.

Lila was also planning to undertake a beautician course:

Lila (16): I've applied for this course, like nails and that, like to set up a business and that.

Opal had escaped a culture of drug use, drug-related crime and violence in which she felt purposeless. Now she was currently working on a solo dance routine that would tell the story of some of these past experiences, including her survival of brutal intimate partner violence:

Opal (15): Now it's like, thank god, because now I have a purpose in my life. I am now doing the things I love to do. I go to dancing every Saturday. It's just, life is so much better now...Dance is the way I find to express myself...So this time I've got my first solo...So the whole dance is just basically going to be about this story, so I can express my story. I messaged my dance teacher and I was like, 'you watch. You're going to be in tears because I'm going to make sure I'm being heard louder than I have ever been heard before in my dancing'...I am a role model now.

'MAKING THE TRAUMA OR THE PAST A BIT MORE EASIER': STABLE, SECURE HOUSING WITH SUPPORT AND INTENSIVE MENTAL HEALTH CARE

Many of these young research participants were currently in a place of relative safety and able to offer a reflective account of the supports they felt were most useful in their own journeys. They also offered their advice on what was most needed by other children and young people experiencing homelessness and mental ill-health alone.

Sammy and Gem focused on the fact that if they had had different childhoods, their trajectories may have been more positive:

Gem: Maybe if my dad actually gave a fuck it would have been different. But he didn't and now I am here [crisis accommodation]. That's probably what I wish. I was my dad fucking actually gave a fuck. Yeah, that's probably it. And my mum didn't fucking leave. Then it probably all would have been different.

Catherine: Thinking back to that time [earlier childhood], what help do you wish you'd had?

Sammy: Friends and actual family that cared, around me to support with that shit, and get me out of that place.

Alongside wishing early family life had been different, participants focused on the key need for intensified, earlier supports. Viviana discussed her wish for 'a normal person's emotions' and made a case for early intervention to prevent cumulative trauma. Sammy and Jay discussed how important care and accommodation were for unaccompanied children who struggled to be able to care for themselves or access safe accommodation without assistance. Jay expressed particular anger at how he felt only those under aged 12 received a proper care response from Child Safety.

Viviana (18): I wish sometimes - like I'm glad that I'm strong and I don't take any shit now, but like sometimes I do sit back and I'm like you know, it would be nice to have a normal person's emotions and be able to feel things the way that other people do. So that's another thing, like if people receive the right kind of help before it drags on too late, then they still have that chance to still be a very strong person but be able to experience things that people who haven't been traumatised their whole life [can] experience.

Sammy (16): Just someone to be there for all of us. Someone that can support us through everything that all of us are going through. Down times, and that. Help us out with clothes because none of us really have the money to buy our own clothes. Just someone there to talk to.

Jay (16): There needs to be help, there needs to be a better child safety services. Like I'm going through court and I can't be going and doing my community services hours when I'm living on the street. I can't be healthy, I've always got to be looking around for my dangers, like who's around me or when am I going to get food or when am I going to have a bed next. Like, they only do shit for people under the age 12. What about us? We still need help. Like there's 12 year olds out there that get everything but then there's us and we're down in the gutter...Child safety are nothing but dog shit. I'll sit here and

say that. There needs to be a better place for youths to go or just kids than Child Safety. Child Safety is nothing but shit. Somewhere better and bigger and stronger.

As Jay argued, not only did there need to be 'somewhere better and bigger and stronger' than Child Safety, but there also needed to be increased capacity in the youth shelter system:

Jay (16): And somewhere where there's more than six beds, because even though when I was in a shelter I was still seeing a lot of youths come to the door and say, 'Hey, is there a bed?' and there wasn't a bed. There needs to be a big fuck me off hotel where youths can go and just crash.

Further, Jay powerfully described how young homeless people need access to stable, *secure* and unconditional accommodation accepting of the young homeless people's challenges - in his case anger, violence, self-harm and emerging mental illness:

Jay (16): It needs to be more a long term accommodation out there; they can't just 'okay, we'll put you here for three months or you can stay at this shelter for six weeks'. It's like hey, you can be here for as long as you need, that's what the word and saying should be, 'you can be here for as long as you need', to make that youth feel safe and secure. Because for me, when they said 'You're out', I shat myself, I didn't know where I was going...It's all because of just my mental health though. Like I'm very angry and I guess that's why people are like, no, or like, 'Hey you just harmed this young youth' or 'You just harmed yourself', 'we can't be around that'. Like shelters are shelters, they're shelter for people who need shelter. They're not shelters for people to be able to be goodie two-shoes or 'you need to do this right? You've got to attend this appointment today.' It shouldn't be like that.

Catherine: So would you say you've often been asked to leave the shelter because of stuff you've done?

Jay: Because I can't get a doctor's appointment or because I don't have any more meds or just because some dickhead has turned around and called me a dickhead and I've just snapped and punched him in the face or something. It's just my constant mental health issues.

Renee described the catch-22 of being required to have mental health support in place in order to maintain her accommodation:

Renee (18): At [youth shelter] they were like, you need to get help. It's a condition of being here and I'm like, help me get the help then. What do you want me to do? Go to fucking headspace with a fucking six month wait list? They're like if you're not getting help, you can't be here. I'm like yeah well I can't get the help for this certain amount of time because there's a fucking wait list and to get actual fucking help, that's going to cost a fuck load of money, but I'm homeless so I can't afford that shit. So what are you going to do? Even with private psychs you've got such long wait lists.

Plus the money. To get a psychologist it take ages, but to get a psychiatrist? Near fucking impossible.

As Jay and Renee argued, the short-term and conditional nature of crisis accommodation did not enable the level of security and support they needed. Further, as Tam pointed out, the problem of accommodation access was a particular issue for unaccompanied homeless children under the age of 16 for whom, outside of Child Safety, long-term supported accommodation is not available in Tasmania.

Tam (18): I suppose I probably wish - well especially being younger and when I was not 16 yet it was hard because I was originally looking at - and they were helping me look at going into some housing for myself and because I wasn't having anywhere to go and there wasn't really many options for anywhere to go. When you're under that certain age there's not a lot of options for that...

For other participants a lack of knowledge of basic homeless support services was a barrier which they argued could easily be solved through much earlier and more extensive information being made available through schools. Participants also seemed to suggest that this first involved adults more actively recognising that significant adversity and need for help is experienced by *young* children and information and resources need to reflect this:

Lila (16): One thing I wished, before I went on the streets, is that I knew about these sort of places that could help. Because a lot of people who are on the streets now, at some point they never knew they were going to be on the streets. So I only learnt that stuff, when - I only learnt about like places I could go get vouchers from to go get groceries and go get clothes - I only found out about that stuff when I was already deep in a relationship I couldn't get out of. They need to be out there more. Like young kids need to know a bit more about them, like you know, going around schools...Like even just going around like that to give out pamphlets and be like, 'This is a place you can go if you don't ever want to be home', that sort of thing.

Jay (16): Why isn't there some sort of [place] where a kid can go and just hop into a warm bed and have a nice warm Weetbix or something like that? Why do they have to be homeless for six months and then offend on the streets?

As already discussed in Part I, stable, secure housing and the provision of outreach care and support in the early stages of independent living were identified as core elements of recovery. Currently living in transitional housing, Viviana articulated the crucial value of the stability this gave her. Neve, also in transitional housing, landed on the need for 'more support workers *with* the houses':

Viviana (18): [Youth service] providing me a house to be in is the biggest thing for me. Like I don't think that any amount of counselling over anything else that affects you is even going to be really helpful if you don't even have a stable home to be in, like it's as simple as that.

Neve (20): [There] should be more houses. There should be support workers. More support workers with the houses.

Jay (16): They [kids aged over 12] still need to be able to have that help to be able to live until they get that job or until they get that unit or something like that...

The reflections of Tam and Renee, who both had stable housing but did *not* have associated outreach support, suggest the value of extending youth outreach for older children and young people who are living independently to a *wider range* of accommodation settings. As Tam described, living alone in private rental 'does get isolating when you don't have a huge circle and struggle with mental health' and for Renee, having just moved into a social housing unit after nearly five years of cycling through shelters, the adjustment to being alone was very challenging:

Renee (18): It's good because I finally got what I wanted for so fucking long, but then there's also the aspect of I'm so used to having the 24/7 support around me. It's like when I do get in those really dark spaces, I don't have anyone to stop me from doing anything. No one's going to notice because I live by myself.

Participants also considered what kinds of mental health care they wished they had or thought was needed for children and young people. For Tara and Viviana, having *early* access to mental health services was crucial. For Tara this translated into her efforts to ensure her younger sister had access to the kinds of mental health services she had found useful:

Tara (19): I have a young sister and she struggles a lot with a lot of the same things that I do. And I've helped her, I tell her about all the things that - because she was really, really against going to talk about her feelings with psychologists and stuff like that, like she thought it was ridiculous. But I was able to tell her what they do and how it's helped me and how it's nice to have someone that's not your family to talk to and someone that can be on your side.

Viviana argued that children need more in depth information about how to access mental health services:

Viviana (18): Everything was a mess and I didn't even know how to go get the [mental health] help. Like we weren't educated on what to actually do. We're just not really educated about what other resources we have at school. Like we're only given like helpline or headspace and stuff like that. And the most education we have on that is literally on a few bits of pieces of paper behind a toilet door. Every now and then they're like sit there and like tell us that we have options and stuff like that, but they don't give us the right resources. Like they give us simple, online simple fix kind of things. They don't actually give you something that's going to be long-term and useful.

As discussed in Part I, participants most commonly emphasised a desire for more *intensive* mental health service provision, with access to more counselling support for longer. It was clear, however, that the potential risks of mental health practitioners' engagement with

parents needed closer scrutiny and management – children needed to be safe in their disclosures and heard when they raised concerns about practitioner contact with their parents. Where they experienced it, participants valued access to specialist mental health care including psychology and psychiatry and the opportunity to explore diagnosis and trial medication where needed. It was in hospitals in particular that they reported feeling as though there was little engagement or listening to their concerns.

For Jay, support to address the impacts of children and young people’s trauma was critical – this included ‘drug and alcohol help’ as well as mental health care to ‘just make the trauma or the past a bit more easier’:

Jay (16): Some sort of drug and alcohol help and mental health is the big one because they’re going to be affected from being 10 until whenever they die of what they’ve been through. So just to be able to give them that help to forget or push back what’s happened, because with me, my big thing is my past; I feed off it and I hate it. But just make the trauma or the past a bit more easier I guess.

For Tam, Kayla, Neve and Renee it was increased access to specialised mental health practitioners able to work with severe and complex mental health issues and offer longer-term treatment that was most needed:

Neve (20): When people reach out for mental health...I’ve just seen them for a few short sessions. Why can’t it be longer term?

Tam (18): I know that there is headspace for people because CAMHS only does, you’ve got to be in a crisis I think, to be able to go there. So I think it would be good if there is more because there is headspace but it’s just so overrun isn’t it? It would be good if there were more public services like that, like CAMHS.

Kayla (18): The first time I probably accessed mental health help was probably [community-based service] to be honest, which was only last year.

Catherine: Do you feel [youth outreach worker] offered you mental health support?

Kayla: She did the best she could with the knowledge she had. Like she’s not a professional mental health worker but she did the best with what knowledge she had. I felt she was a great worker. But I need someone who is professional and has more knowledge because I don’t even know what’s going on with me, so I need someone else to understand.

Renee (18): If you’re under 18 you’ve got headspace and you’ve got private, which you can get a few [appointments] under the mental health plan and the Youth Health Fund will cover three sessions. Three sessions isn’t enough to fucking get help and most minors don’t have three, four hundred dollars an hour to go spend to talk to someone about their problems, especially if you’re fucking homeless. They need more. It’s like headspace, yeah it’s good. But [headspace practitioner] was honest with me, he’s like, you’re too complex for us. They’ve got something for youth. They can deal with basic stuff. Depression, anxiety, some eating disorder stuff. They don’t

have the training or qualifications to deal with people like me with serious fucking issues. Personality disorders, intense trauma. They can give them basic talk therapy but not the actual help that they need... Obviously I'm not trying to downgrade mental illness because it's all fucking bad. If you've got a bit of depression but you haven't been through shit, yeah, Headspace can help you. You've been through trauma, you've been abandoned, you've had shit thrown at you, you've got trust issues. You need someone to really push it and go above and beyond to show that they do actually give a fuck about helping you. When you've constantly had the bare minimum or below your entire life from people that are meant to support you, those people going above and beyond make all the difference. You need a true passion with mental health support.

Finally, participants also raised the high value of peer support. Jay suggested that children and young people would appreciate the support and connection and understanding of people their own age. Renee and Viviana emphasised the potential power of meeting with peers who had survived similar trajectories of complex trauma and unaccompanied homelessness. They described the great hope that would come from connecting with 'experiential' peers who had not only survived similar adversity but who could show them it was also possible to flourish and create positive futures.

Jay: There's not enough help out there for youth; they might say, okay, you've got Headspace, you've got Kids Helpline, you've got this, you've got that. No. There's not enough help out there and there's not proper help out there. To be honest, I think go out there, get some respectable head screwed in youth and take them out talking to youths, or something like that. Like, give youths what they want, more youths or something like that. Like if you're going to be bringing older people or something, like, I don't know. If you want to get a word out of the youth, a proper word, like what's the serious issue, I reckon get another youth to be able to sit down, have a conversation, do things that the youth wants to do.

Renee: I feel like more people in these services that actually have dealt with this shit themselves so they can relate. And I know counsellors aren't actually allowed to be, 'this is my story', but it would be nice for them to be, you know what? I've dealt with similar stuff. It doesn't have to be heavy detail, but to show that they can relate and understand what a person is feeling. Goes so far...to see that someone has been able to overcome that shit and how good they're doing and how happy they are in life.

Viviana: I guess what I wanted is I wanted someone to sit there and tell me what they've been through, and so I know that like it is actually possible to go through it and do it and end up being a happy person that's got a lot going on for them.

'TREAT GIRLS LIKE HUMANS': ADDRESSING EQUITY AND SAFETY FOR GIRLS

Several participants drew attention to the gendered nature of the violence they experienced – a clear issue that was reflected across the narratives of nearly all female participants. The need for increased awareness of the ongoing impacts of child and

adolescent trauma in which boys and men play a central role was highlighted by participants' discomfort about seeing male mental health practitioners and by the conflict Kayla experienced with her abusive boyfriend after seeing a male counsellor.

Viviana very passionately raised the need to address the negative and disrespectful cultural attitudes to girls which she saw directly reflected in her lifetime history of sexual abuse and sexual violence. Further, and again reflecting her own experience, Tam argued for the need to increase accommodation options for unaccompanied girls under 16 to avoid them having to rely on male partners for access to accommodation.

Catherine: Through your journey, what would you want more of you think? Or wish that you had had earlier in life?

Kayla: Just simply having a bit more equity, like with females and males. Like that's where most of my problems have arised from. Like just how things are at school. Like for instance the other day, girls at my school were told to go down on their knees to have their skirts measured because it's distracting to male teaching staff and older boys in the school. And that's that same attitude that's always been there. And it's just really disappointing because it shouldn't be about a girl's skirt, like the length of a girl's skirt. It should be about educating young men on how to actually be decent and respectful and treat girls like humans and not just sexualised objects that are them for them to look at.

Tam (18): It would definitely be good to have more [accommodation] options I suppose, for young girls. To avoid, yeah...I think it is a quite vicious cycle, young girls, I suppose, feeling like they can't be at home and then from there moving on to men who just aren't very nice, and it is a bit of cycle I think.

What professionals dream of

The diverse professionals participating in this project had a wide range of dreams for system and service change across the education, homelessness, child protection, health and mental health sectors. This section reports in depth on just three of the most central frustrations shared by all participants. These are the 'missing middle' of moderate to severe and complex mental health service provision in Tasmania; the limited provision of accommodation for unaccompanied homeless children; and the need for assertive outreach and care coordination. Professionals dreamed of responsive, mobile mental health services, age-appropriate accommodation and a collaborative approach to the provision of holistic outreach. For several, holistic outreach was imagined as a distinct multi-disciplinary, multi-agency, cross-sector team contributing specialist expertise to key workers providing care coordination on the ground.

'I HEAR YOU, I HEAR YOU NEED HELP, AND WE'RE HERE': A COMPLEX MENTAL HEALTH SERVICE FOR CHILDREN AND YOUNG PEOPLE

When thinking outside the current siloed operations of the adolescent mental health system in Tasmania, professionals identified the clear responsibility of specialist mental health

practitioners to respond immediately to the mental health needs of children and young people experiencing unaccompanied homelessness. As will be discussed further below, they also saw a vital role for specialist mental health practitioners in both initiating and delivering a collaborative holistic care response for unaccompanied homeless children.

Access to a complex mental health outreach service for their unaccompanied homeless clients was undoubtedly the shared ideal of professionals statewide. Given the need for relational engagement with children and young people, the complexity of issues they experience and long wait times across the mental health system, professionals identified the provision of not only outreach but long-term outreach – for example, a minimum support period of two years. They dreamed of a mental health outreach service explicitly authorised and designed to respond to the complex need being experienced by unaccompanied children and young people. They dreamed of access to a service that said ‘yes’ to their referrals, responding in a timely way that matched the urgency of children’s needs and the brief windows of opportunity for connection with them.

Youth shelter worker: When you’re looking at service design for vulnerable people, we need to be able to meet them where they’re at, and that goes for adults as well. You go out to them where they are because for this cohort of people you need to have outreach capacity. You need to go to them. That’s just the reality of it. So the services like CAMHS or even headspace to be honest, need to be place-based; they need to come out to where they’re at and actually provide that direct intervention and support and then wrap everything else around them as they need it.

Youth outreach worker: That would be the first thing is you’d do assertive outreach. It’s relationship, it’s relationship, it’s relationship because relationship failed them in the first place so it’s going to be relationship that gets it back.

Clinical social worker: These transient young people need that mental health service that goes to them, that has that flexibility.

Clinical social worker: Definitely services to refer to that you knew wasn’t going to be a really long wait period. For those people that can really work intensively with young people who have got severe mental ill-health, the ones that just feel so heightened and so unable to deal with their strong emotions that they’re always self-harming, they’re going into hospital weekly. Flexible services who can work in the medium- to long-term at an intensive level.

Youth outreach worker: Ideally, I would love to be able to call, I don’t know if it’s CAMHS, but I would love to be able to a youth specific mental health service and say, I have a young person who is presenting in this way and has agreed for me to this referral. When can you see them, and their turnaround time be less than two weeks. Ideally under two weeks for the first appointment because then it’s validating, that first connection, ‘I hear you, I heard you need help, and we’re here’. Two weeks. So assertive outreach for counselling would be amazing because you’ve got to meet them where they’re at. And then I envision it over a period of time transitioning to maybe coming into offices because later on, and when they’re adults and hopefully still accessing counselling or whatever mental health support they need – it’s

ongoing, it doesn't just stop, there's no quick fix. I think if the transition into an office space or counselling room or therapy room towards the end, it might be beneficial just because obviously, later on in life if they ever go to access again, chances are they won't have that assertive outreach.

Youth outreach worker: Outreach, I really think it needs to be outreach. Because you know, then it's just - I've never met a client at the office, never. Not once. And they don't want to either. They don't want to go to some big office where a million other people are. And for it to be a 24 hours service, because that's what you need. Otherwise the option is hospital if it's really high level. So outreach, 24 hours, many more providers, so many more providers.

SECURE, STABLE, AGE-APPROPRIATE ACCOMMODATION

As discussed throughout this report, children, young people and professionals all articulated the need to concurrently fill the significant gap in moderate to severe and complex mental health service provision *and* address the 'life circumstances' and 'basic needs' creating barriers to the provision of and engagement in mental health care. Professionals discussed enormous frustration with the current limits of the care and accommodation options - either offered through Child Safety or the Specialist Homeless Services. They wrestled with what they most commonly experienced as a lack of response from Child Safety and children's needs for appropriately supported residential care which outstripped the capacity of youth shelters. They raised the ideal of additional longer-term accommodation options, in particular for unaccompanied children under 16.¹⁹ This was not about providing the current crisis accommodation model for longer time period, but about developing *new* models of age-appropriate care.

Youth outreach worker: It is always going to sit with you that when we've got kids out in the community that are unaccompanied, 15 years old or younger, potentially with some serious mental health presentations and other stuff. And we can't get those mandated services or these protective services to step up and do anything. They're kind of just like, 'Yeah, well, whatever. We can't do much until something really goes pear-shaped.' That's something I'm quite passionate and get quite angry about because I mean, I'm not going to take it on if something happened to that kid, obviously I would be distraught, but I don't take it on personally. But where can I go? Like what can I do as a worker, as somebody that supports and advocates for them, when I'm getting courts, police, Child Safety kind of washing their hands? Like that to me is infuriating and I don't know yet how we would kind of change that but it does sit alongside these kids because this is the complex kids we're talking about.

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19 Professionals also acknowledged the recent developments in this space, including a new Youth-at-Risk Centre in Launceston for unaccompanied homeless children 12-15, and the announcement in 2021 of significant investment in a residential care pilot for unaccompanied under 16s experiencing homelessness, see https://www.premier.tas.gov.au/site_resources_2015/additional_releases/tackling_under_16_youth_homelessness.

Youth shelter worker: It needs to be a different model. It needs to be a completely different model, you'd actually want that family-focused therapeutic support and actually apply that in a home. At the moment [in crisis accommodation] it is a short-term shelter, so regardless of how long they are there, we are still putting these young kids in a short-term shelter model...[Alternatively, in some models of out of home care] - it's very much, once they're there, they're there. And there is a person that lives on site and actually provides support to the young people, they've got that continuity of care and they develop those strong working relationships with carers. But it is a little bit more than you're given in a service like a SHS or a crisis facility. It is much more of nurturing, parenting type role and kids at that age need that. All children need that. So in order to really provide that level of support that children need, for extended periods of time, that's the kind of model that we're needing, not a crisis model where kids are kept at arm's length.

School social worker: Therapeutic Residential Care. So that is a service that you need. So it's not just a kid in a shelter, it's a kid in a shelter with a support network around them.

A CARE COORDINATION SERVICE FOR CHILDREN AND YOUNG PEOPLE WITH COMPLEX NEEDS

Whilst both a complex mental health service and long-term accommodation were seen as the critical gaps needing filling in the care landscape for unaccompanied homeless children, many professionals also identified the high value of a mobile care coordination service. Separated from static accommodation-based care, such a service was imagined to have scope and flexibility to work with children and young people in a range of accommodation services or other settings, in particular couch surfing and rough sleeping. Given homeless children under 16 cannot access housing support workers and yet were accommodated in youth SHS services which cannot provide age-appropriate care, professionals argued that key workers for unaccompanied homeless children would be ideal:

School psychologist 1: They need to be allocated a case worker who actually overviews them from the minute they fall out of that home. Someone to check, so that we have communication both ways between us and them. And also to make those transitions.

School psychologist 2: And just things like navigating the forms and the stuff of even living independently, how to do that.

Clinical social worker: Young people who are transient or traumatised, they don't need a million services, a million people coming into their lives; they've had enough of that. They need some stable people who they can form a relationship with.

Youth shelter worker: I think having a key, holistic support for the young person going through homelessness. There needs to be a shift to having for kids who fall into the high-risk cohort, having specialised youth workers who are holistic case managers. And they work - they do everything, so they are the referrers of drug and alcohol, mental health, housing, everything. And we [SHS services] all drop in and out at

different times, depending on where they're at. But having that one person who does all of that. But that would mean funding key workers to take on the high-risk cohort... In an ideal world that would be what I would envisage; there's a holistic, wrap-around support. Key people for you, so they're not getting fobbed off to here, this person, that person that person.

School youth worker: So if these kids had a case worker, and it doesn't need to be called a case manager, a key worker, or a support worker, whatever it is, I'm looking after you. I'm your person that when shit hits the fan, you've got one key person. What do you need done and I'm here, I will walk beside you. That's what our kids need, Catherine, especially the homeless ones. That's what I would love.

Clinical social worker: The problem is, if you look at the system, a lot of people are there to refer [unaccompanied homeless children] to somebody else. There's a bunch of all people who are there to just do the work. Your job is engage with this kid and that's it, that's your KPI, engage with them, keep them alive. Yeah you might have some KPIs of improved education outcomes, possibly getting a job, finding ongoing housing. They're your tertiary level outcomes of this, but your primary role is to engage. And we need a cohort of workers just doing that...We need a new team that straddles child safety, youth justice and homelessness. Let's have a team that sits over this.

Professionals reflected on a possible future in which a complex mental health service would be able to augment the efforts of such a care coordination service. This approach, it was suggested, would maximise and mutually leverage different skills and roles.

Clinical social worker: If you're tagged as unaccompanied or homeless there should almost be the flag that goes, this is a young person who's flagged and this is the type of team that should go around them. And in that what you need is a longer-term option for mentoring or case management. So if you're doing some mental health support and some therapeutic work and you don't have a family but you need someone to help you keep on track and to go, do you know, I think maybe you need to see a GP or you've got this major health thing or this presentation, maybe you need to see a paediatrician. Because no one is saying that to you when you're unaccompanied. There's no protective person. So if you can have a service that could be long-term, case management, mentoring, not tied to bloody timeframes...The therapeutic work would be enhanced from doing that.

Clinical social worker: You need to create some sort of accommodation and safety; you need to create a relationship and then you need to do the mental health work. Now, ideally, we just need the safe accommodation and relationships stuff - the mental health worker sits over the top and so it's a supervision support, helping make sense role. It's holding that worker who is on the ground to do that work. I think that's the most important element of any intervention from a tertiary mental health service is actually contributing to the care, the care team that's sitting on the ground who is actually providing care to that young person.

They imagined how effective a mobile care coordination service could be if key workers not only had a complex mental health service to refer to, *but also* had a broader senior cross-sector, multi-agency specialist team to call on and escalate to, in which specialist mental health practitioners also played a role. It was argued that such a team would address the key service provision barrier of risk aversion by actively working to collaboratively acknowledge and manage the risk children present:

Clinical social worker: When these guys on the ground are meeting, these other specialists are there overlaying them and providing direct supervision practice support and that could [also] go out. If you're a mental health professional, how about you got out and see these kids with that worker - the relationship is built. 'Hey Bobby, this is Jon he's from mental health services. I just asked him to come on board because of that last conversation we had - do you mind?' And you've already framed it up with that young person so it's not a shock, we just want to talk about that a little bit more, let's talk about safety planning. And then you can the mental health guy who is doing an assessment as he's going, 'Yeah, look, I think you've got this going on, let's keep working in it, we can hold risk that way.'...It helps mitigate and manage the risk because it's shared not just with that team but with these specialists that sit about them. That specialist doesn't just sit there in isolation, no they're in the field too they're jumping in the car and they're going to do a home visit, but they're focusing on the kids who need it most, at any given time. And they're doing training and education as they go. Then we start to build a systemic, sort of growth in that team that starts to get more and more skilled working with these young, high-risk people.

One youth outreach worker had previous experience of collaborating with CAMHS in Melbourne in a similar way to the ideal model being described by the clinical social worker above. In this case, CAMHS provided secondary consultations for key workers supporting high-risk and homeless children and young people. The worker highlighted the accessibility and high value of this collaboration for children and young people and also noted the professional benefit of being able to personally learn from working closely with, and in support of, mental health specialists:

Youth outreach worker: I really have found in the past, secondary consults from Melbourne CAMHS was hugely helpful. And we'd obviously come with a client in mind and just absolutely unpack whatever was going on at that point and get some clear direction from the psych or whoever it was who came out to give that. And I found that really helpful. And I think there needs to be more of that. To have that secondary consult as a team, for all staff, to be on the same page to have the same response and approach. They would often sit on care teams and were extremely accessible which I think is the big contrast to here. They were really involved and you could always call any of the clinics. They gave really explicit instruction on how to manage stuff. Like one of the girls had some really severe, like flashbacks where she would just dissociate and it was something I hadn't really dealt with to these intense levels before. So they were really good in guiding me in sort of sitting with her and what I could do to support her through those things. So they'd be up, on the phone, potentially at the same time, trying to guide us both through it. So just, yeah, super educational from a professional point of view. Just accessible, I think is the word.

Conclusion

There were many overlaps in the dreams of children, young people and professionals, in particular on the need for more accessible, intensive mental health care and stable long-term supported accommodation both for unaccompanied children and for young people transitioning to independence alone. There was common critique of the lack of child protection involvement for older children as well as of the provision of crisis care largely through Specialist Homeless Services - never properly designed or resourced to provide intensive, age-appropriate care for children.

Children and young people also emphasised their needs for more meaningful *education* - not just information - about available supports and about the practical process of help-seeking. They expressed a desire for peer support - from peers their own age and peers with similar experiences - which they thought might offer avenues for being heard and understood and to see that recovery might be possible. Finally, two young women raised their concerns about poor cultural attitudes to girls, gendered violence and the need for further accommodation support for girls to prevent their over-reliance on, and potential entrapment by, abusive older partners.

Professionals' dreams of system and service change were overwhelmingly focused on having access to timely, responsive complex mental health care that could match the intensity and longer-term support needs of high-risk children experiencing homelessness and mental ill-health alone. Specialist mental health intervention was *never* imagined as a siloed service in the lives of this particular cohort; professionals dreamt of new models of age-appropriate supported accommodation alongside the efficiencies of mental health practitioners collaborating with mobile key workers providing stable, relational care and coordination on the ground. Further, an opportunity for secondary consultation was imagined in which mental health specialists were part a *broader* specialist team including, at minimum, senior professionals from all children's statutory agencies - Education, Child Safety and Youth Justice.

In short, children, young people and professionals all had powerful dreams for change - from increased access to 'warm weetbix' and 'a warm bed', to a new efficient system of mobile care coordination supported by a multi-disciplinary specialist team, to equity for girls and a reduction in the cycle of violence they experience. There was also no mistaking that such dreams were being driven by astute, critical observation and traumatic experience of a current service system with limited capacity to hear and respond to the calls for help issued by unaccompanied homeless children and the professionals working with them.



CONCLUSION BETTER, BIGGER, STRONGER

"When you've constantly had the bare minimum or below your entire life from people that are meant to support you ... those people going above and beyond make all the difference."

Unaccompanied homeless children in Tasmania need a response that is ‘better and bigger and stronger’ than what they currently experience. This report provides additional evidence and nuance to our understanding of what unaccompanied homeless children in Tasmania need from mental health services in particular. Alongside the recommendations below, this report provides a vehicle for recording the experiences, insights and suggestions of children and a range of professionals whose voices on the issue of unaccompanied child homelessness and mental ill-health are rarely, if ever, heard. The inclusion of extended excerpts from their experiences is deliberate; it is these voices which enable a picture to be built of the specific Tasmanian context in which children experience homelessness and mental ill-health and in which better, bigger and stronger care – including mental health care – is urgently needed.

Recommendations

BETTER INTERVENTION INTO CHILDHOOD ADVERSITY

This research revealed that both unaccompanied homelessness and poor mental health were direct outcomes, and the presenting symptoms, of childhood adversity. Participants recalled being aware of poor mental health during their primary school years, before they subsequently also experienced unaccompanied homelessness as older children. If identified and responded to, children’s early experiences of mental ill-health represent a ‘red flag’ opportunity to explore additional supports for children and their families, potentially preventing children’s trajectories towards unaccompanied homelessness and intensifying mental ill-health.

An expansion in school social work capacity *in primary schools* – as the first universal statutory service setting for Tasmanian children – is one key vehicle for the early identification of childhood adversity and for the prevention of cumulative adversity into adolescence. Professionals identified that primary schools are a particularly significant service setting for children outside of major city centres. They also argued that due to workforce availability and school psychologists’ focus on providing learning and cognitive assessments, social workers are best positioned to undertake holistic case work with children and their families. Social work expansion should include both increased allocation of staff *and* the adoption of flexible, mobile models of care targeted to children and families experiencing complex needs. It should also include an emphasis on strengthening skills to identify mental ill-health in primary school children and building appropriate external referral networks.

- **RECOMMENDATION ONE:** Strengthen early responses to childhood adversity through expanding social work capacity in primary schools.

BIGGER FOCUS ON ACCESS TO HEALTH CARE FOR CHILDREN AND YOUNG PEOPLE WITH COMPLEX NEEDS.

Primary and allied mental health care was highlighted, particularly outside of city-centres, as critical but extremely difficult to navigate and access. One ready-made route to increase access to primary and allied health care for unaccompanied homeless children and young people statewide is through additional investment in the Youth Health Fund. The Youth Health Fund is currently available in Tasmania for the purchase of a range of medical services for disadvantaged children and young people aged 12-25. The Youth Health Fund was not broadly understood nor consistently utilised by professionals participating in this research.

There is scope to review the practical operation of the Fund, including billing and Medicare rebate processes, as well as to expand its role in ensuring disadvantaged children and young people have improved access to and continuity of health care. The provision of targeted training for practitioners about the Youth Health Fund also presents an opportunity for professional development on child and youth engagement and trauma-informed service delivery.

Finally, statewide expansion of health care delivered through mobile outreach would ensure that homeless children without the practical support and guidance of a parent or guardian could be assertively offered basic health care services.

- **RECOMMENDATION TWO:** Target increased access to primary and allied health care for children and young people experiencing disadvantage through additional investment in the Youth Health Fund and mobile health care outreach.

Whilst children were often already struggling with mental ill-health when living at home, once unaccompanied and homeless their mental health spiralled and they faced many additional barriers in accessing mental health care due to their young age, lack of effective guardianship, lack of income and unstable living circumstances.

Largely excluded from primary health care and private practice and fitting the current criteria for neither early intervention nor acute services in Tasmania, a clear focus for all participants in this research was the need for a mental health service explicitly designed, tasked and authorised to work with children and adolescents experiencing complex needs, including a lack of effective guardianship, homelessness, self-harm and suicidality, and drug and alcohol use.

The role of mobile outreach was emphasised statewide as crucial to overcoming the lack of equitable service provision experienced by unaccompanied homeless children. Service delivery through responsive and assertive outreach and extended operating hours was also seen as key to hospital avoidance. In the current context of mental health workforce shortages, direct collaboration with community service organisations was seen as one cost-effective and practical route to ensuring unaccompanied children and young people with complex mental health needs receive clinical care and therapeutic outreach.

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- **RECOMMENDATION THREE:** Establish a complex mental health service with significant outreach capacity in the Tasmanian Child and Adolescent Mental Health Service.

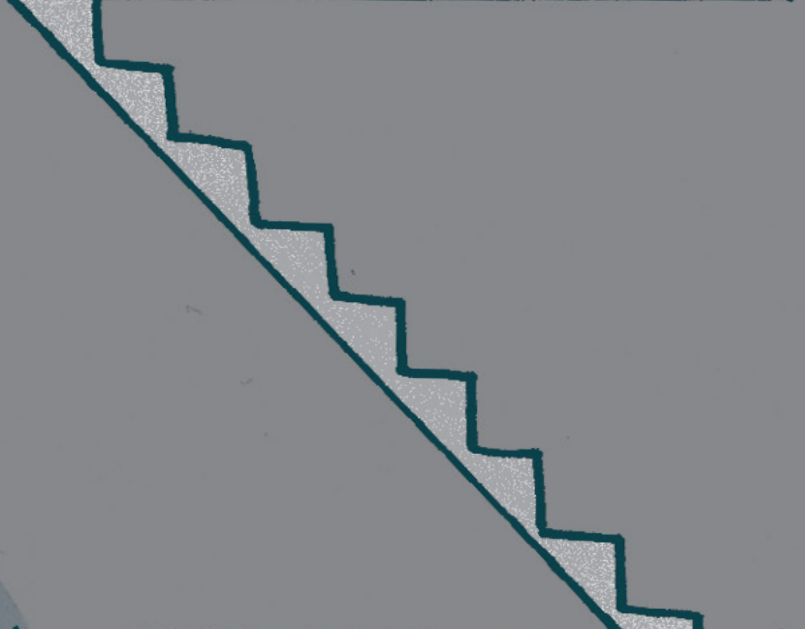
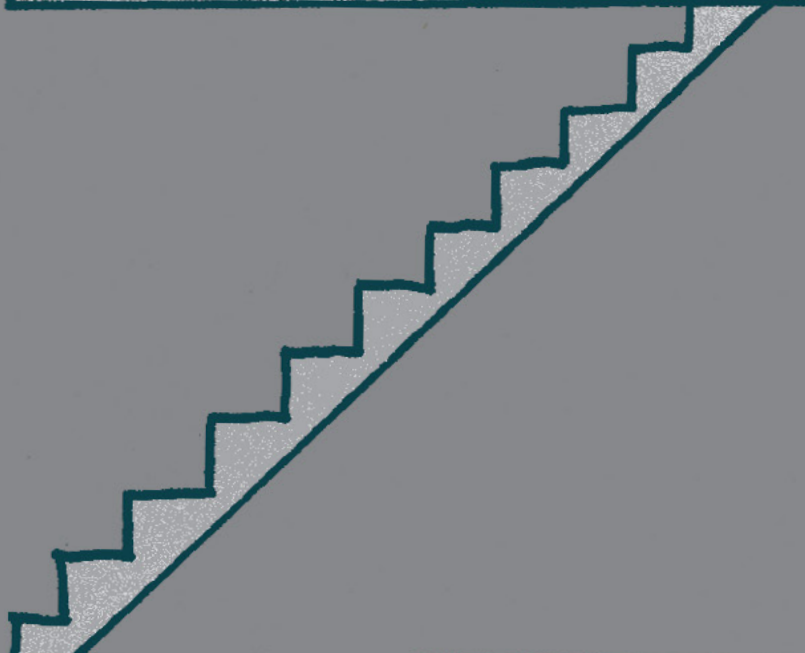
STRONGER CARE COORDINATION FOR CHILDREN AND YOUNG PEOPLE WITH COMPLEX NEEDS

Given the multi-dimensional challenges of unaccompanied homelessness, children, young people and professionals all saw a critical role for community-based youth outreach workers in providing in holistic care coordination for children and young people in a range of settings, such as the homes of parents and carers, couch surfing, shelter accommodation, rough sleeping or independent accommodation. Key components of an efficient care coordination service were discussed, including a mobile youth/social work care team providing relational continuity for children and young people and closely collaborating with a multi-agency specialist practitioner team. This specialist practitioner team was seen as crucial in providing secondary consultation and direct specialist service provision where needed.

Such a service would strengthen the continuum of support currently offered through Children, Youth and Families and ensure children experiencing complex needs, including a lack of effective guardianship and homelessness, remain closely connected to an authorising environment within which their care and guardianship needs can be escalated.

- **RECOMMENDATION FOUR:** Develop a care coordination service through Children, Youth and Families for children and young people experiencing complex needs, comprising mobile care coordination teams and multi-agency specialist practitioner teams.

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