Early Childhood, Middle Years and Youth

Contents

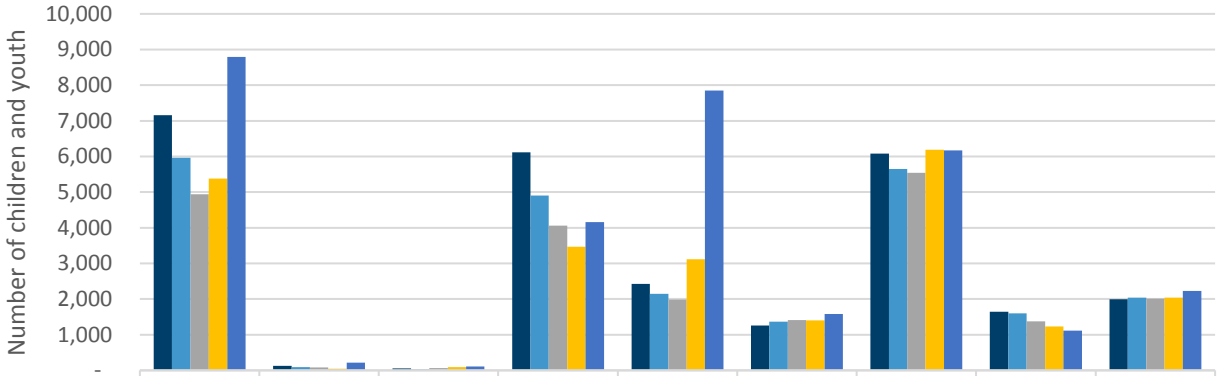
Overview

Health and wellbeing throughout childhood and youth provides an important foundation for positive health status during adulthood. Every child is entitled to opportunities for positive health and wellbeing, which includes physical, social, emotional, cognitive and spiritual health and wellbeing. Children are inherently vulnerable and they face different challenges at different age stages of their life. For this reason, this chapter is split into three sections:

- Early childhood (birth to 8 years)
- Middle years (8-12 years)
- Youth (12-25 years)

In the ACT in 2014, it was estimated that there were 127,324 residents under the age of 25 years, equating to 33% of the population (Australian Bureau of Statistics, 2015a). Belconnen, Tuggeranong and Gungahlin had the highest number of children aged 0-19 years, with North Canberra and Belconnen having the highest number of youth aged 20-24 years, aligned with the major University's in the ACT (Figure 0.1).

Figure 0.1: Estimated number of ACT children and youth (0-4, 5-9, 10-14, 15-19 and 20-24 years) in 2014, by Statistical Area 3



	Belconnen	Cotter - Namadgi	Fyshwick - Pialligo - Hume	Gungahlin	North Canberra	South Canberra	Tuggera-nong	Weston Creek	Woden
0 to 4	7,159	127	58	6,120	2,425	1,257	6,081	1,646	1,997
5 to 9	5,966	94	30	4,907	2,148	1,363	5,647	1,600	2,042
10 to 14	4,944	85	60	4,059	1,983	1,410	5,542	1,373	2,013
15 to 19	5,384	46	87	3,469	3,120	1,402	6,186	1,231	2,038
20 to 24	8,790	221	108	4,160	7,848	1,579	6,174	1,114	2,231

Source: (Australian Bureau of Statistics, 2015a)

Early Childhood

Early childhood is defined as the period from birth to eight years of age. There is clear evidence from Australia and overseas that the early years of a child's life have a profound impact on their future health, development, learning and wellbeing (McKenzie et al., 2014). These early childhood years are a time of rapid brain growth and development and the benefits of exposure to high quality early years learning and development opportunities has lasting impacts both for the community as a whole and to the individual child across their lifetime (Moore and McDonald, 2013).

There is growing evidence for the importance of both the prenatal and postnatal period in children's development and that children's long term outcomes can be compromised directly by adverse experiences during both of these periods. Promoting children's development and learning requires ensuring that the environments in which they spend their time are optimal (Murdoch Childrens Research Institute, 2014). In the case of young children, family and other caregivers are the main providers of the relationships and experiences that make up the child's learning environments.

The environmental factor that has the greatest positive impact on child development and family functioning is social support and social connectedness, while the environmental factor that has the greatest adverse influence on child development and family functioning is poverty (Murdoch Childrens Research Institute, 2014). The consequences of poverty for children are wide-ranging and long-lasting with children from socioeconomically disadvantaged families beginning their lives with a poorer foundation for health (The Marmot Review, 2010).

Discrepancies between children from advantaged and disadvantaged backgrounds are evident from less than one year of age (Nicholson et al., 2012). Development discrepancies are evident across cognitive, social, behavioural and health outcomes with advantages and disadvantages accumulating throughout life and across generations (Najman et al., 2004).

Poorly-resourced families can find the heightened demands of contemporary living and parenting overwhelming and as a result, there has been an increase in the number of families with complex needs, and more pockets of intergenerational disadvantage, underachievement and poor health and developmental outcomes (McLachlan et al., 2013). Although they represent only a small minority, these families and their children subsequently account for a highly disproportionate percentage of the costs and resources for mental health, education services and welfare services.

Children from families who have poor social supports and make limited or no use of early childhood and family services are at increased risk of poor health and developmental outcomes (Murdoch

Childrens Research Institute, 2014). The parents in most need tend to be the ones who are least likely to access support. These include families with limited income, lack of social support, lack of private transport, unstable housing or homelessness, low literacy levels, large family size, personal preferences and beliefs about the necessity and value of services, physical or mental health issues or disability and day-to-day stress (Carbone et al., 2004).

This is further exacerbated by structural barriers, including; lack of publicity about services, cost of services, limited availability, failure to provide services that meet parent's felt needs, inability to respond promptly to requests for help, rigid eligibility criteria, inaccessible locations, lack of public transport, limited hours of operation, inflexible appointment systems, and not having an outreach capacity (Carbone et al., 2004).

The Council of Australian Governments outlined a National Early Childhood Development Strategy in 2009; the Strategy acknowledges the importance of minimising the impact of risk factors in the first years of life before problems become entrenched and reducing the inequalities in outcomes between children (Council of Australian Governments, 2009). This is particularly important for some Aboriginal and Torres Strait Islander children who, on average, have significantly poorer health outcomes than non-Indigenous children, and also for children with a disability with higher rates of abuse and neglect than children and young people without disability.

Key Issues

Vulnerable children

The ACT has a high standard of living when compared to other Australian states and territories, however, there are ACT residents who experience significant levels of disadvantage, including exposure to (or experience of) poverty, social isolation, homelessness, violence, disability, drug and alcohol use, mental health issues, family breakdown, and illness (Shaddock et al., 2015). A nation-wide survey of marginalised young people found that while 'most children report high life satisfaction', a quarter of children 'have a family member who has a disability, chronic illness, mental illness or drug or alcohol addiction' (Flinders University, 2015). These children experience significantly more health complaints than other children (Flinders University, 2015).

Children with complex and challenging behaviours

In 2015, an expert panel reviewed policy and practice in all ACT schools in regards to students with complex needs and challenging behaviours (Shaddock et al., 2015). The report found school populations are becoming more complex because of school retention policies, the preference of

many parents/carers for mainstream placement for their child with a disability, and an increased prevalence of developmental conditions and other issues that affect learning and behaviour.

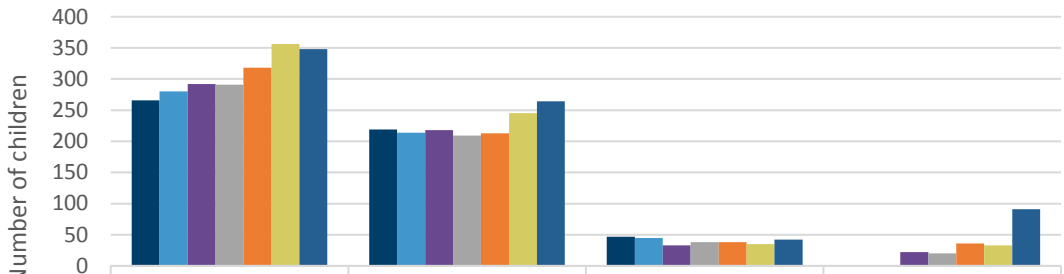
Many of the challenging behaviours exhibited by students at school have a much longer history, often developing in early childhood, before starting school (Shaddock et al., 2015). The experiences that children have during their lives before school enrolment have significant impact, and sometimes determine a child's future development and behaviour. To minimise the negative impact of these issues on children's behaviour and development, appropriate interventions must start as early as possible (e.g. at the time of their recognition or diagnosis) (Shaddock et al., 2015). Supports offered should be tailored to meet the individual needs of children and should be available early, when help is most likely to be beneficial, and before challenging behaviours become entrenched. The report suggests there's a lack of knowledge about the use of referral and diagnostic services for potentially vulnerable children attending various child care facilities across the ACT, and therefore children with complex needs and challenging behaviour may not have their needs recognised or acknowledged (Shaddock et al., 2015).

Out-of-home care

Children in out-of-home care are a vulnerable and at-risk group in the population, and although existing data is limited, they are likely to have poorer physical, mental and developmental health than their peers (Royal Australasian College of Physicians, 2006). All children who enter care have suffered trauma as a consequence of both the circumstances that led them to enter care and the loss of familiar relationships and environments (ACT Community Services, 2014). They may have already been exposed to multiple traumatic experiences including abuse, neglect, domestic violence, a family history of mental health issues, drug and alcohol abuse and family involvement with the criminal justice system. Negative outcomes for the children can include anxiety, depression, post-traumatic stress, attachment problems, sexual behaviour problems, hyperactivity, anger and aggression, suicidal behaviour and other serious mental health issues (ACT Community Services, 2014).

As seen in Figure 0.2**Error! Reference source not found.**, the majority of children in out-of-home care in the ACT are in home-based care (e.g. relative/kinship care and foster care). The number of children in out-of-home care has continued to rise in the ACT, with a total of 748 children in out-of-home care at 30 June 2016, up from 671 at 30 June 2015 (Australian Institute of Health and Welfare, 2016b, Australian Institute of Health and Welfare, 2017).

Figure 0.2: Number of ACT children (0-17 years) in out-of-home care, by type of placement, as at 30 June 2010, 2011, 2012, 2013, 2014, 2015 and 2016



	Kinship care	Foster care	Residential care	Other home-based care
2010	266	219	47	0
2011	280	214	45	1
2012	292	218	33	22
2013	291	209	38	20
2014	318	213	38	36
2015	356	245	35	33
2016	348	264	42	91

Source: (Australian Institute of Health and Welfare, 2016b, Australian Institute of Health and Welfare, 2017)

Of the 748 children in out-of-home care in the ACT in 2016, approximately three out of five (61%) were aged 0-9 years (Table 0.1), with 54% of children overall being boys and 46% girls (Australian Institute of Health and Welfare, 2017). At 30 June 2016, 4 in 5 children (80%) had been continuously in out-of-home care for 1 year or more, with 2 in 5 children (40%) in out-of-home care for 5 years or more (Australian Institute of Health and Welfare, 2017). In 2015-16, 208 ACT children were admitted to out-of-home care, while 137 were discharged.

Table 0.1: Age of ACT children in out-of-home care, as at 30 June 2013, 2014, 2015 and 2016.

	Years of age					
	< 1	**1–4**	**5–9**	**10–14**	**15–17**	**Total**
2013	15 (3%)	118 (21%)	184 (33%)	155 (28%)	86 (15%)	**558**
2014	30 (5%)	124 (20%)	188 (31%)	181 (30%)	83 (14%)	**606**
2015	27 (4%)	151 (23%)	229 (34%)	183 (27%)	81 (12%)	**671**
2016	34 (5%)	173 (23%)	247 (33%)	194 (26%)	100 (13%)	**748**

Source: (Australian Institute of Health and Welfare, 2016b, Australian Institute of Health and Welfare, 2017)

Nationally, the rate of Aboriginal and Torres Strait Islander children in out-of-home care is 10 times the rate of non-Indigenous children (Australian Institute of Health and Welfare, 2017). In the ACT this rate is higher, at 12.7 times (i.e. 79.8 per 1,000 Aboriginal and Torres Strait Islander children compared to 6.3 per 1,000 non-Indigenous children). As at 30 June 2016, the ACT had the second highest rate per 1,000 Aboriginal and Torres Strait Islander children in out-of-home care nationally.

The ACT Government (Community Services Directorate) has developed the Out of Home Care Strategy 2015-2020 to guide the delivery of services for children and young people who cannot safely live with their parents (ACT Community Services, 2014). A number of new services and initiatives, including ACT Together, a consortium of Australia's leading organisations in child protection, began in 2016. ACT Together brings together all the services designed to support children and young people in care and means children will have just one organisation responsible for their care over the course of their time in care.

The ACT appears to have had limited success in identifying a child development system of care that provides a streamlined, accessible, affordable and well-connected pathway of care for families and their young children and has been unsuccessful in ensuring that the most vulnerable children are able to participate fully or achieve equitable health, social and educational outcomes (ACT Medicare Local, 2014). A consultation workshop between ACT Medicare Local, ACT Health and the ACT Local Hospital Network Council, in 2013, raised system of care issues around early childhood. These issues included (ACT Medicare Local, 2014);

- GPs not sufficiently aware of services available and/or access issues for these services, e.g. 9 month waiting list for community paediatrician appointments.
- Disconnect between primary/GP care and services in the community which are required for effective intervention and follow up over time.
- Equity issues between families – those who cannot afford private follow up face access issues to hospital clinics.
- Coordinating within community across campaigns/interventions.

As recognised, there is a need for GPs to identify vulnerable children in the ACT and promote the free services offered at ACT's Child and Family Centres. The Child and Family Centres located in Gungahlin, Tuggeranong and West Belconnen aim to positively influence the development pathways and life trajectory of children, build capacity and resiliency of families to support their children and strengthen the linkages and connections of families to supportive communities (ACT Community Services, 2016b). They achieve this by providing free professional services to all children and families, including, early intervention and mental health assistance, structured group sessions for vulnerable groups of the community, as well as tailored support and health services (ACT Community Services, 2016a).

Strategy

- CHN conducted a Paediatric Symposium in the first half of 2017, which included a session focusing on vulnerable children and the ways in which GPs can support families and identify and refer children to appropriate services (e.g. Child and Family Centres).
- There will be continued development and promotion of paediatric HealthPathways to assist GPs with assessment, management and referrals. Priority paediatric pathways include; Child or Young Person at Risk, Behavioural Concerns in Children, Developmental Concerns in Children and Child Development Milestones.

Access to early mental health intervention services

It has been recognised by the ACT government that identification and access to early intervention services around developmental delay and mental health is complex and difficult to navigate for consumers. The introduction of the NDIS and the reduction of services provided by the Child Development Service (formerly Therapy ACT) has contributed to this complexity.

Difficulties with child behaviour such as tantrums, aggression and frequent night waking are common in the first few years of life. For some children, these behaviours are transient and part of normal development, but for others they persist and lead to significant behavioural problems. It has been reported that up to 50% of preschool behaviour problems evolve into childhood mental health problems (Prior et al., 2001, Campbell, 1995).

Distinguishing between transient behaviours and early mental health problems can be difficult (Campbell, 2006). Behaviours that are frequent and transient in most young children can also indicate more serious problems that may merit mental health intervention. Therefore primary/universal service providers (e.g. GPs, community nurses, child care providers, early childhood educators/teachers) should always explore any concerns that parents raise about their child's behaviour or emotional development. Referral for specialist intervention may be necessary when there is a cluster of persistent symptoms across settings or relationships, when symptom severity is likely to impede the child's ability to achieve developmental tasks, and where it affects day-to-day functioning (Campbell, 2006).

Behavioural (externalising) problems affect around 14% of Australian children, this includes aggression, hyperactivity and oppositional defiance disorder. Emotional (internalising) problems affect up to 15% of Australian children, which include anxiety, fears and phobias in younger children,

and depression and anxiety in school-aged children (The Royal Children's Hospital Melbourne, 2012). The incidence of mental health problems is even higher for those from disadvantaged backgrounds, including Aboriginal children (24%) (Zubrick et al., 2005), children residing in 'out of home care' (55-60%) (Tarren-Sweeney and Hazell, 2006) and children with a learning disability, who are up to four times more likely to have mental health problems than children with no disability (Witt et al., 2003).

The younger the child, the more vulnerable their brain is to environmental influences. Experiences in the early years shape the development of young children's brains in ways that have long lasting effects. Mental health problems can develop at any stage of life, including infancy and pre-school age. Children's mental health problems are the result of interactions between genetic-biological vulnerabilities (e.g. temperament in infancy) and environmental stress (Beardslee et al., 1997, Beidel and Turner, 1997). There are a number of family environmental factors that contribute to children developing externalising and internalising problems, which are potentially modifiable. These include (Royal Children's Hospital, 2006):

- parenting practices (e.g. low warmth, harsh discipline, over-protective parenting)
- insecure parent-child attachment relationship
- parents' mental health problems (e.g. depression)
- family stress and trauma.

Many parents respond to their young children's challenging behaviours in ways that reinforce and entrench the very behaviours that cause them concern in the first place (e.g. harsh physical punishment in response to aggressive child behaviour) (Sanders et al., 2000). Cultural context should also be carefully understood, since culture may influence parents' help-seeking strategies, care-giving practices and perceptions of child behaviour as problematic (Royal Children's Hospital, 2006).

Good mental health is essential for children's learning, social development, self-esteem and resilience to stress (Royal Children's Hospital, 2006). The best chance of preventing mental disorders or providing early intervention to minimise the impact of mental illness across the lifetime is during childhood. Untreated conduct disorders in childhood significantly increase the social and economic costs to the individual and the community later in life. Childhood mental health problems often continue into adolescence and then adulthood, adding further costs related to areas such as school dropout, substance abuse, poor employment outcomes, family violence and suicide, along with sick leave, unemployment and crime (Royal Children's Hospital, 2006). This can then affect the next generation of children.

The effectiveness of early intervention is poorly recognised in the current system and schools and early childhood services are generally ill-equipped to identify problems early and intervene effectively. Additionally, the child mental health services in Australia that do exist can struggle to bridge the gaps between health and the settings where children spend much of their time – education or child care (Department of Health, 2011).

Only twenty-five per cent of young people with mental illness access services, and for most there is a long delay between the start of symptoms and when they receive help (Department of Health, 2011). Young people are hard to reach, as they don't necessarily make regular visits to health services.

Government funding for initiatives such as Better Access, Headspace and suicide prevention has had some success, but young Australians still need better access to more services to minimise the toll of mental illness on their lives and their families.

Please refer to the mental health section for more information about access to early mental health intervention services.

Priority Issues

Healthy growth and development

Childhood overweight and obesity impacts around 26% of ACT children in the 5–17 year age range and this figure has remained relatively stable between 2007 and 2014 (ACT Health, 2016b), which is comparable with other Australian states and territories. Younger children (5-6 years) represent a smaller proportion of children in the ACT who are overweight or obese, with this figure remaining stable at around 15-16% (ACT Health, 2016b). In 2014-15, 16% of kindergarten children in the ACT in were measured as overweight or obese (ACT Kindergarten Screening Program) compared to 15.7% in 2012, 17.3% in 2011 and 15.7% in 2010. While rates of overweight and obesity in children have remained reasonably stable, significant numbers of children will continue to be at risk of developing serious disease and chronic health conditions in adulthood if action is not taken early in life to prevent childhood overweight and obesity.

A physically active childhood is important for healthy growth and development and sets up healthy behaviour patterns which are likely to continue on into adulthood. It also improves the child's social and emotional development and wellbeing and increases mental awareness and boosts confidence and self-esteem. In the ACT, 19% of primary school aged children are meeting the National Physical

Activity Guidelines of 60 minutes or more of physical activity each day (ACT Health, 2016b). Boys were more likely to meet the national guidelines than girls. Less than a third of ACT parents were aware of the recommendation made by the National Guidelines (ACT Health, 2013). In addition to this, around 35% of children aged 5–15 years spend more than 2 hours a day engaging with electronic media, with boys more likely than girls to exceed the guidelines of 2 hours or less a day (ACT Health, 2016b). The relatively low numbers of children who meet the physical activity guidelines is in line with the Australian average, however, it is concerning that the number of parents aware of the Department of Health guidelines is also quite low. These low results are significant in the sense of long term chronic disease prevention as it is well documented that good nutrition and a solid grounding in physical activity in the early years (amongst other things) are considered to be protective factors that play a role in long term health, development and wellbeing (Center on the Developing Child at Harvard University, 2010).

Encouraging children to eat vegetables on a daily basis is a task seen as difficult by many caregivers. In the ACT only around 5% of children aged between 2 and 17 years are meeting the minimum NHMRC dietary guidelines for vegetable consumption (National Health and Medical Research Council, 2013). However, fruit consumption among children in the age range sits at around 68% indicating that about two thirds of children were eating 1–2 serves of fruit each day (ACT Health, 2016b, National Health and Medical Research Council, 2013). It is encouraging to see that sugary drink consumption by children aged 5-15 years in the ACT is on a downward trend, reducing from around 50% in 2007 to around 30% in 2014 (based on children who consume more than 2 sugary drinks per week) (ACT Health, 2013).

Physical inactivity, poor fruit, vegetable and sugary drink consumption are considered to be risk factors for the development of cardiovascular disease, cancer, diabetes, obesity as well as mental health conditions (specifically depression and anxiety).

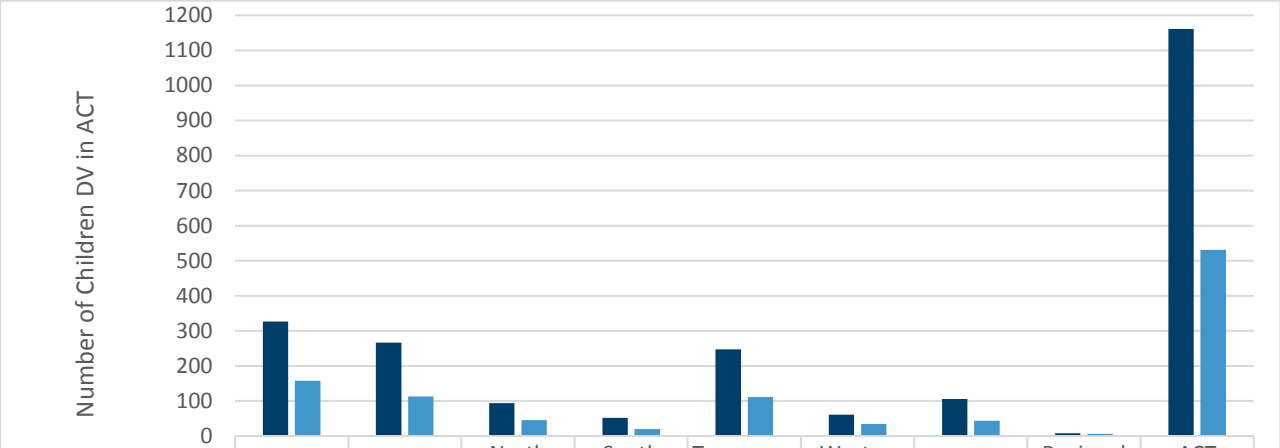
Australian Early Development Census

Successful transition to school is greatly shaped by children's attainment of the basic skills for life and learning in the early years. Children's development in the years before school has an impact on both their ability to be ready to learn at school entry and their social and economic outcomes over the course of a lifetime. The quality of the relationships, environments and experiences in the early stages of development are crucial in shaping a child's health, wellbeing and developmental outcomes. The Australian Early Development Census (AEDC) provides a population measure of children's development as they enter school. The AEDC questionnaire is completed by teachers for children in their first formal year of schooling every three years (2009, 2012, and 2015), results are

presented based on the postcode in which the child resides. The ACT has a smaller population size than all of the other states and territories, therefore it is important to consider the AEDC data for the ACT in terms of the numbers behind the percentages.

The latest year of data for the AEDC (2015) indicates that overall, the majority of children in the ACT are developmentally 'on track' (in the top 75% of the national AEDC population) and doing well. The proportion of ACT children developmentally vulnerable (children whose domain score is below the 10th percentile of the AEDC national population) on one or more domains (22.5%) is similar to their Australian peers (22.0%) and the proportion developmentally vulnerable on two or more domains (10.3%) is slightly less than their Australian peers (11.3%) (Australian Early Development Census, 2015). Results in the ACT from 2009, 2012 and 2015 have remained relatively stable with little change in vulnerability on one or more domain(s) (22.2%, 22.0% and 22.5% respectively) as well as vulnerability on two or more domains (10.9%, 9.8% and 10.3% over time) (Australian Early Development Census, 2015).

Figure 0.3: Number of children developmentally vulnerable (DV) in the ACT, by sub-region, AEDC 2015

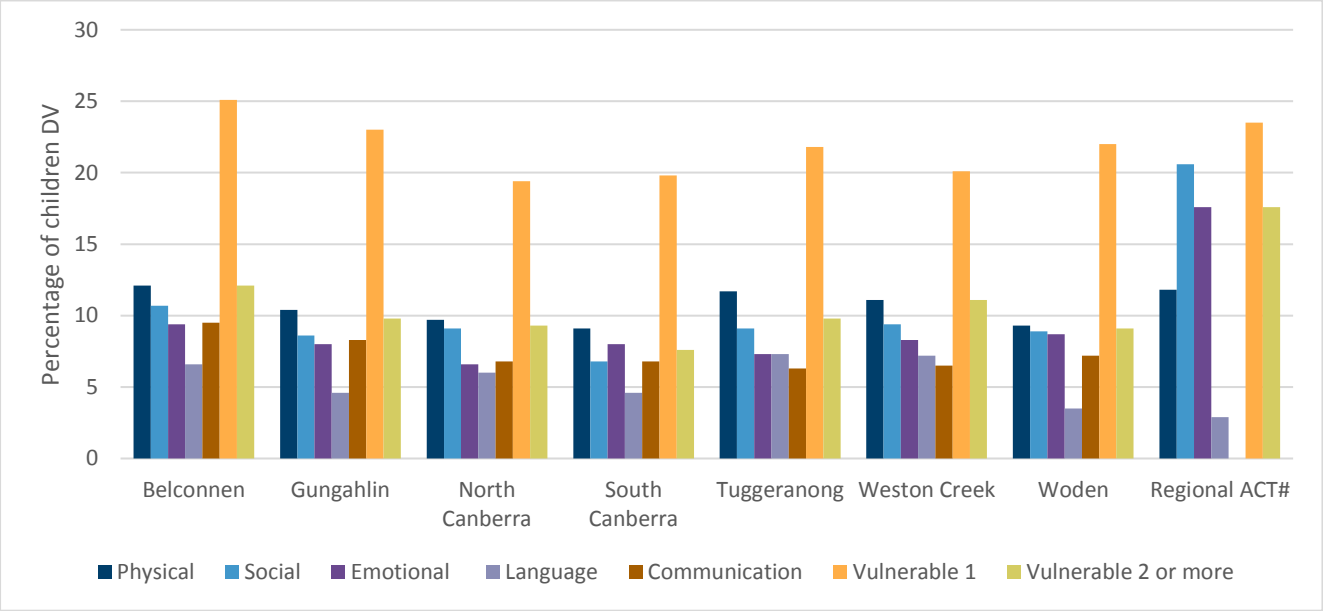


	Belconnen	Gungahlin	North Canberra	South Canberra	Tuggeranong	Weston Creek	Woden	Regional ACT	ACT Whole
DV in 1 + Domain	327	266	94	52	247	61	106	8	1,161
DV in 2+ Domain	158	113	45	20	111	34	44	6	531

Source: (Australian Early Development Census, 2015)

The Belconnen region has seen the greatest rise in developmental vulnerability in each of the domains between 2012 and 2015 with an increase in developmental vulnerability in all domains except physical health (Australian Early Development Census, 2015). Physical health remains the domain where children demonstrate the highest proportion of developmental vulnerability across all sub-regions of Canberra. Figure 0.4 demonstrates the proportion of children developmentally vulnerable by domain in the sub-regions of the ACT in 2015.

Figure 0.4: The proportion of children developmentally vulnerable (DV), by domain, in sub-regions of the ACT, in 2015



Only a very small number of children reside in Regional ACT therefore percentages may not be comparable to other Canberra regions. Source: (Australian Early Development Census, 2015)

When comparing the proportion of ACT children to Australian children in 2015, results are quite similar for those children developmentally on track, at risk and vulnerable on each domain (Table 0.2). The biggest discrepancy was seen in the Physical health domain, with 5% less children developmentally on track in the ACT (72.7%) when compared to Australia (77.3%) (Australian Early Development Census, 2015).

Table 0.2: The proportion of ACT and Australian children developmentally on track, at risk and vulnerable on each domain of the AECD, 2015

Domain	Developmentally on track (%)		Developmentally at risk (%)		Developmentally vulnerable (%)	
	ACT	Australia	ACT	Australia	ACT	Australia
Physical health	72.7	77.3	16.4	13.0	10.9	9.7
Social competence	74.5	75.2	16.2	15.0	9.4	9.9
Emotional maturity	75.9	76.4	15.9	15.3	8.2	8.4
Language and cognitive skills	83.5	84.6	10.6	8.9	5.9	6.5
Communication	75.5	76.3	16.8	15.1	7.7	8.5

Source: (Australian Early Development Census, 2015)

Strategy

CHN coordinated the 'Connect Up 4 Kids' Initiative which has provided support to primary care and community sector professionals focussed on optimising healthy growth and development to families with children aged 3-7 years to both general practice and the community sector.

Middle Years

The middle years of childhood can be categorised using varied age ranges (from as early as six years, until as late as fourteen), however, for this report we have classified the middle years as 8-12 years of age (Kennedy, 2010). Blume (2014) acknowledges the considerable debate surrounding the age parameters of this period but describes the characteristics that “at the beginning of this stage, emergent cognitive abilities are enabling children to handle more complex intellectual problem-solving and to better understand reciprocal social relationships than they could in early childhood. By the end of middle childhood, greater self-regulation and the consolidation of problem-solving skills, allow children to extend their abilities to tasks requiring flexible, abstract thinking, and the maintenance of close relationships."

Despite the debate around the age parameters of the middle years, it is widely understood that middle childhood is the developmental stage between early childhood and adolescence, in which children undergo dramatic social, emotional and physical changes (Blume, 2014). These developmental changes occur at somewhat differing times for different individuals, as a result of both psycho-physical factors and differing social, cultural and environmental experiences (Healthy People 2020, 2016).

Compared with early childhood and adolescence, young people in their middle years have received relatively little attention from academics and policymakers, other than in the space of academic achievement. Yet there is growing recognition that this is a critical time when children experience rapid physical and mental development, in addition to facing a significant transition from primary to secondary school (Redmond et al., 2016).

Development of children during the middle years

Families and communities play a central role in facilitating childhood development. The environments that a child is raised plays a critical role in laying the foundations for healthy development and success in adulthood, as do the opportunities that a child is given (Blume, 2014).

According to renowned child psychologist, Jean Piaget, the ages of 8-12 years fall into the third stage of Cognitive development, "The Concrete Operational Stage" (Piaget, 1983). This stage is a major turning point in a child's cognitive development, because it marks the beginning of logical, organised, 'operational' thought and the gradual disappearance of egocentrism (McLeod, 2010). During this period a child matures the ability to use logical thought or operations (i.e. rules), however, can only apply this logic to physical objects (hence the name concrete operational) (Piaget,

1983). Furthermore, the child develops the ability of conservation; an ability based on the understanding that an object can change in shape or appearance, but it can still be the same (McLeod, 2010). The ability of reversibility is also developed; which constitutes the child's capacity to understand that actions and roles can be reversed. However, although children during this stage develop the ability to solve problems in a logical fashion, they are typically not able to think abstractly or hypothetically (Piaget, 1983). Despite this, during this phase children begin to learn that things are not always as they seem, and are able to approach matters and situations from several angles, rather than only reacting to a stimulus based on outward appearances (Cherry, 2016). The other major development identified by Piaget during this stage is that children begin to envision different scenarios, in which they develop the skill to analyse 'what if' something were to happen (Piaget, 1983). This is due to the fact that they now have a more 'operational' thought process. Children are also advancing more towards adolescence, in which peer friendships become more important, and they have a growing sense of independence, confidence, self-evaluation and emotional expansion (Cherry, 2016).

Physical development for children in the middle years vastly differs depending on the individual, however, most children during this phase:

- Increase body strength and hand dexterity through physical activities
- Improve coordination and reaction time
- Increase in large-muscle coordination, leading to success in organised sports and games
- Increase in small-muscle coordination, allowing them to learn complex craft skills
- Have refinement of finger control
- Have increased physical stamina
- Show signs of puberty, particularly in girls
- Perform a variety of activities that promote social interaction and self-expression
- Develop manual skills and interest in things such as cooking and carpentry
- Have slow and steady physical growth

Key Issues

There is much evidence to support the theory that a child's experiences and surroundings in middle childhood are extremely important in sculpting their development and lifelong learning. During the middle years, these changes include physical growth, cognitive development, moral development, environmental changes, development of peer-relationships and relationships outside of the family sphere, and the development of oneself. How a child develops during this time affects future

cognitive, social, emotional, language, and physical development, which in turn influences school readiness and later success in life (Healthy People 2020, 2016). Without the appropriate environment, a child can be significantly delayed in emotional regulation and attachment, language development, cognitive development and motor skills (Healthy People 2020, 2016). Inadequate caregiving, environmental stressors, and exposure to negative risk factors can significantly affect the brain and may seriously compromise a child's development into adulthood, especially in school success, health literacy, self-discipline, the ability to assess decisions around risky situations, eating habits, conflict negotiation and resolution, and the development and maintenance of healthy relationships (Healthy People 2020, 2016).

Mental health in the middle years

Mental health disorders impact individuals in various ways, and to varying extents. The exact cause of most mental illnesses is still largely contestable, however, research suggests that a combination of factors, including heredity, biology, psychological trauma, and environmental stress, may be involved (Bird and Lawson, 2006). However, the cause is not always the most important factor when dealing with mental illness, as often the origin of the illness cannot be altered or cured. Thus it is important that families, educational providers, health providers and all stakeholders in a child's life, are all aware of the mental health problems that can form during childhood and adolescence, and have resources available to them to help the child if it appears that a mental illness is forming (Bird and Lawson, 2006). The most important factor in mental illness is early detection, as once a mental illness develops, it can quickly become a regular part of a child's life, which makes treatment an even more difficult task (Lawrence et al., 2015). A child in the middle years is exposed to a myriad of change and development, particularly in their transition to high school, and if a child is suffering from a mental illness during this time and it is not appropriately treated, is highly likely that this illness will continue into adolescence (Bird and Lawson, 2006).

A large Australian study, conducted in 2013-14, found around one in seven (13.9%) children and adolescents (4-17 years) experienced a mental disorder in the previous 12 months (Lawrence et al., 2015). The four most common mental disorders seen in children and adolescents were:

1. Attention-Deficit/Hyperactivity Disorder (ADHD) – 7.4% of children and adolescents
2. Anxiety disorders (social phobia, separation anxiety, generalised anxiety and obsessive-compulsive disorder) – 6.9%
3. Major depressive disorder – 2.8%
4. Conduct disorder – 2.1%

As seen in Table 0.3, similar rates of anxiety disorders and conduct disorders were seen between those aged 4-11 years and those aged 12-17 years, while there were higher rates of ADHD and lower rates of major depressive disorders in the younger age group when compared to the older children (Lawrence et al., 2015).

Table 0.3: 12-month prevalence of mental disorders among 4-17 year olds by sex and age group, 2013-14

Disorder	Males 4-11 years (%)	Males 12-17 years (%)	Females 4-11 years (%)	Females 12-17 years (%)	Persons 4-11 years (%)	Persons 12-17 years (%)
Anxiety disorders	7.6	6.3	6.1	7.7	6.9	7.0
Major depressive disorder	1.1	4.3	1.2	5.8	1.1	5.0
ADHD	10.9	9.8	5.4	2.7	8.2	6.3
Conduct disorder	2.5	2.6	1.6	1.6	2.0	2.1
Any mental disorder	**16.5**	**15.9**	**10.6**	**12.8**	**13.6**	**14.4**

Source: (Lawrence et al., 2015)

Consultation has highlighted that there is a lack of mental health support for children in their middle years in the ACT, with a high demand on available services.

Healthy growth and development

Ensuring that a child is able to learn, grow and thrive in a setting that encourages optimum development is a difficult task. The interaction of factors and context for development can be extremely complex and individualistic, making it difficult to come up with a standard strategy for childhood development. However, recently there has been much evidence to support a range of factors in families, communities, society and health and education sectors, that can be readily influenced to promote positive childhood development, and encourage families to engage in healthy lifestyles that will ensure optimal psycho-physical development of children (Kennedy, 2010). Throughout the middle years, it is extremely important that children are surrounded by role models that can support and encourage them in their journey towards independence (Tassoni, 2008). Because children during this age are very influenced by older individuals, it is very important that the adults in a child's life are engaging in healthy and productive lifestyles, and that the influence they provide is positive and supportive (Tassoni, 2008). The child needs to be provided a safe and secure environment, in which meaningful praise and encouragement is regularly provided by the child's care-givers. The child also needs to be given the opportunity to engage in new experiences, develop new skills, gain confidence in their abilities and be encouraged to use a wide range of communication strategies (Tassoni, 2008). A child also needs to be provided the opportunity to solve

their own problems, assess risks, set their own boundaries and be encouraged to talk through the problems, and potential problems they are experiencing.

There are a range of problems that arise when a child is not provided with the appropriate environment for them to grow and develop healthily. For instance, the most important factors in a child's physical development is that a child is provided with a healthy nutritious diet, is appropriately exercising, and is engaging in an overall balanced lifestyle.

Living a healthy, active lifestyle is one of the most important factors in middle childhood. A child needs physical activity to build strength, coordination, and confidence and to understand the groundwork for a healthy lifestyle that continues well beyond childhood (Tassoni, 2008). Furthermore, there are health risks associated with not engaging a healthy lifestyle. Obesity, one of Australia's biggest public health concerns, is often a condition formed through lack of physical activity, and is a disease that dramatically increases the risk of developing a range of health problems later in life, including Type II diabetes, high blood pressure, cardiovascular disease, osteoarthritis and certain cancers (Better Health Channel, 2013). In the ACT in 2014-15, 22.6% of children aged 8-11 years were overweight and 2.6% of the population in this age parameter were considered obese (Australian Bureau of Statistics, 2015b). Evidence suggests that lifestyle diseases like obesity are often established through an exposure to an unhealthy lifestyle as a child, which then matures and manifests into an unbalanced lifestyle as an adult (Better Health Channel, 2013). It is becoming increasingly important given the rising risk of many lifestyle related diseases, that all children in the middle years are educated about the significance of a healthy lifestyle.

Puberty and pressures from peers and society

Children develop at different speeds, therefore not all children in the middle years of childhood experience the changes puberty brings. However, for the majority of girls, the onset of puberty begins in the middle years, with the growth of breasts followed by the onset of the menstrual period (Pickhardt, 2010). For boys puberty starts with the enlargement of the testicles, which usually only begins towards the end of the middle years, with most other puberty-related phenomenon in boys starting after the middle years, thus their issues with physical puberty throughout this stage is usually not as significant as girls (Pickhardt, 2010).

For many children puberty catches them at an awkward time in their life, a time in which they are separating from childhood, and beginning to strive towards establishing social belonging and a place in their social group (Better Health Channel, 2014). Many children experience feelings of being overwhelmed and confused, and when the onset of puberty occurs these feelings can lead to anxiety, low self-esteem and social problems. Furthermore, the middle years is often an age of

intolerance, in which perceived differences or straying from the dominant or desired norm are not treated kindly, thus the social pressures during these years can become overwhelming and troublesome (Pickhardt, 2010). Many children experience bullying associated with factors surrounding puberty, which further increases vulnerability to anxiety and low self-worth (Better Health Channel, 2014).

In society, children are over-exposed to an immeasurable amount of stimulus that can influence a child's perception of how they are supposed to be and behave (Better Health Channel, 2014). If older siblings and parents are unable to provide salient, positive examples to follow, many children can easily fall into the trap of being caught in the array of cultural values that attempt to define what it is to be a man, woman and young person. Ideals indoctrinated in society and stereotypes portrayed in the media and entertainment outlets, can negatively influence a child during puberty, and can often lead a child to question their self-image, their sexuality, their body image, their sex-role definition and their social behaviours and interests (Pickhardt, 2010). If a child is not encouraged to be the person they want to be, the exposure to these external influences during puberty can be very overwhelming, and can lead to a range of problems, for example, mental health problems, like anxiety, depression and eating disorders, and social problems such as bullying and exclusion (Pickhardt, 2010). In attempts to avoid these negative outcomes, it is important that a child's care-giver and the other role models in a child's life are encouraging and empower the child to make their own decisions and express their own desired needs. It is also extremely important that a child is adequately educated on the process of puberty, and is given multiple outlets to express their feelings and their presumed personal issues (Better Health Channel, 2014).

Transition to high school

A child's transition from primary school to high school is both an exciting and daunting part of their life. Often children have mixed feelings about starting high school, based upon excitement to make new friends, be more independent, be exposed to new experiences and learn new things as well as nervousness and worry about learning new routines, not making new friends, not being able to handle the increased workload and being bullied (Raising Children Network, 2015). Experiencing these mixed emotions is completely normal, however, for many children these feelings can become a real problem, and their worries can often become a reality. The most common and influential problem many children face during their transition into high school is bullying and exclusion (National Centre Against Bullying, 2017). According to the Australian national 'Bullying No Way!' campaign, bullying and exclusion can reduce a child's participation, learning and enjoyment of school and can lead a child to feel unsafe and unable to focus in the school environment (Bullying No Way!,

2017). If these experiences are endured over a long period of time, a range of negative long-term impacts can manifest. Some of these impacts include physical health complaints and fatigue, mental health impacts such as depression and anxiety, social implications including self-doubt and reluctance to participate in group activities and educational difficulties and can lead a child to skip school in an attempt to avoid being bullied (Bullying No Way!, 2017). Although Australia implements a variety of anti-bullying programs, it still continues to be one of the major problems children experience in the middle years, both in their transition to high school, and in their primary school years (National Centre Against Bullying, 2017).

Another issue that occurs during a child's transition to high school, is problems concerning educational and behavioural difficulties. With the increasing shift towards independence, many children with educational and behavioural problems struggle to adjust to this drastic change (Raising Children Network, 2015). According to the Australian Psychological Society, it is likely that two to three children in each Australian classroom will experience problems with learning (Australian Psychological Society, 2017). However, what makes learning and behavioural difficulties so complex, especially during the middle years of childhood, is how unique each case is, and how complex overcoming these difficulties is. What is most important is that if an educational or behavioural issue is being displayed by a child, it needs to be detected and addressed as early as possible (Australian Psychological Society, 2017).

One of the ACT Youth Coalition's recommendations in their submission to the 2017-18 Budget was to provide targeted support to children and young people, particularly those aged 8-12, to successfully transition from primary to high school. The Youth Coalition acknowledge that it is well established that this transition is a crucial time for young people and their continued engagement with education (Youth Coalition of the ACT, 2017).

Priority Issues

Identification of children in their middle years in primary health care and the issues associated with them

Primary health care professionals need to be aware of issues that are associated with children in their middle years, including the challenges that puberty and transitioning to high school can bring. Young people in marginalised groups are at higher risk of low wellbeing. This includes young people with disability; young carers; materially disadvantaged young people; Indigenous young people; culturally and linguistically diverse young people and young people in out of home care. Early

identification of mental health issues and healthy growth and development are the most important issues in this period of childhood.

This should be supported well through a newly announced ACT Government initiative for year 7 students in ACT schools to receive a free health check from 2018-19. This program will provide the opportunity for early interventions for students who are showing signs of mental and physical health issues and who may benefit from additional support and should result in a more integrated approach to the wellbeing needs of students (Public Service News Network, 2017). The checks will also complement the work of school youth nurses, school psychologists and community services provided in schools, resulting in a more integrated approach to the wellbeing needs of students. ACT Health and the education sector will determine how the health checks will be rolled out to Canberra high schools to complement existing health services provided to this cohort of students through other programs, such as the High School Immunisation Program. While full details of the initiative haven't yet been released, it would be ideal for feedback from this program to be given to the young person's GP for follow-up.

Strategy

- Support GPs to identify children in the middle years and to be aware of the issues and challenges these young people may be experiencing that could have an impact on their health and wellbeing. These issues include lack of school engagement; bullying; mental health problems; puberty; transition to secondary school and significant disadvantage and marginalisation.

Youth

Youth is defined as the period between childhood and adulthood/maturity, regularly categorised as those aged 12-25 years. It is a significant period of transition in a person's life. Many modifiable behavioural risk factors that can affect current and future health and wellbeing either emerge or accelerate during this time (Australian Institute of Health and Welfare, 2016a). Addressing health concerns and choices early can improve the immediate quality of life for youth and is socially and economically more effective than dealing with enduring problems in adulthood.

Young people go through a range of changes and challenges during their youth, including but not limited to, becoming more independent (e.g. moving out of home, traveling, being responsible for themselves), dealing with youth pressures (e.g. those associated with puberty, relationships/sex, alcohol and drugs, body image), study/schooling/transitioning to the workforce, as well as remaining healthy (e.g. exercise, eating healthily, good mental health).

In 2014, there were approximately 68,000 youth aged 12 to 25 in the ACT, accounting for nearly one in five of the ACT population (Australian Bureau of Statistics, 2015a).

Aboriginal and Torres Strait Islander youth

Aboriginal and Torres Strait Islander children and youth are over-represented in statistics that include living in poverty, statutory child protection, out-of-home care, juvenile justice and leaving school early, compared to their non-Indigenous Australian peers.

Nationally, the rate of Aboriginal and Torres Strait Islander children in out-of-home care was 10 times the rate of non-Aboriginal and Torres Strait Islander children (Australian Institute of Health and Welfare, 2017). In the ACT this rate is higher, at 12.7 times (i.e. 79.8 per 1,000 Aboriginal and Torres Strait Islander children compared to 6.3 per 1,000 non-Aboriginal and Torres Strait Islander children). Trauma in these children and youth (as a result of being removed from families, family violence and family breakdown) is an issue often overlooked.

Domain four of the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (the Implementation Plan) focuses on adolescent and youth health (including ages of approximately 12-24 years) (Department of Health, 2015). This Domain contains four strategies that support Aboriginal and Torres Strait Islander youth to increase health literacy and make healthy choices, identify and address health issues early and excel in areas such as sport, music, art and education to achieve their aspirations. One of these strategies refers to young people being able to

access culturally appropriate and non-racist services that address health and risk behaviours (Department of Health, 2015).

Gugan Gulwan Youth Aboriginal Corporation is an Aboriginal youth centre located in southern Canberra and works with its clients through a range of programs. These programs include an arts program, school holidays program, lunch program, StreatBeat youth outreach program and a young mums program that offers opportunities for young mothers to engage in the learning and development of life skills, nutrition and receive practical parenting support (Gugan Gulwan Youth Aboriginal Corporation, 2017).

Key Issues

Homelessness and housing affordability

On any given night, an estimated 100 youth in Canberra are homeless (YouthCARE Canberra, 2016). Some 'couch-surf' with friends, others face a night on the street or in bushland. According to the 2011 Census, the under 25's made up approximately two in five (42%) of those experiencing homelessness, with 28% being under 18 years (Australian Bureau of Statistics, 2012). It is possible that this is an under-representation of the actual number of young people experiencing homelessness in the ACT as there is no reliable data on those who are sleeping rough or living with relatives and friends.

When family support is weak or non-existent, young people are much more likely to experience homelessness and long-term disadvantage. If young people leave home early, they find it very difficult to gain sufficient income to live independently. The experience of homelessness is fraught with insecurity, a lack of safety, exposure to drugs and alcohol, more health and medical issues and the likelihood of greater contact with the criminal justice system (MacKenzie et al., 2016). Many homeless youth experience mental health issues and the incidence of self-injury and attempted suicide is much higher than the general population or other disadvantaged young people.

Many youth experience challenges associated with housing affordability and availability as they have a strong desire to live independently, yet barriers including high market rental costs make this desire unattainable for many (The Australian Youth Affairs Coalition, 2013). Difficulties include finding affordable, quality housing in a reasonable location, often on a minimal wage and having other financially restricting commitments like full time study.

General Practice at the Deep End Canberra, a group of GPs who work with vulnerable populations in the ACT, identified housing as the key issue for the marginalised populations in Canberra (Deep End

Canberra, 2017). A person's housing situation can drastically affect their health needs, and often people who spend the majority of their money on housing then can't afford the health services they require. During previous consultation (2014), many expressed the need for a focus on coordination and collaboration across government and non-government sectors to address homelessness, particularly youth homelessness.

A recent report found the cost of youth homelessness in Australia was enormous and preventing young people becoming homeless in the first place was the critical policy implication from the research (MacKenzie et al., 2016).

For more information about people who are homeless or who are at risk of being homeless in the ACT please see section on Vulnerable populations (People who are homeless or at risk of homelessness).

Alcohol and drugs

In Mission Australia's 2016 Youth Survey of nearly 22,000 young people in Australia (aged 15-19 years), the top issue identified as most important in Australia today was alcohol and drugs, consistent with their 2015 results (Bailey et al., 2016). In the ACT, where 475 young people completed the survey, males identified alcohol and drugs as their top issue, while for females it was number three, behind mental health and equity and discrimination (Bailey et al., 2016).

Data from the Australian Secondary School Alcohol and Drug (ASSAD) survey found that in 2014, 71.6% of students aged 12-17 years in the ACT had ever drunk alcohol, 44.5% had drunk alcohol in the last year, 22.2% in the last month and 11.9% in the last week (ACT Health, 2016a). These were all less than the reported alcohol consumed by students in the ACT in 2012. There has been a statistically significant decline in alcohol consumption since 1996. Similar alcohol consumptions rates were seen in the ACT in 2014 for both males and females, however, a significant difference was seen between 12-15 year olds and 16-17 year olds, with older students more likely to consume alcohol than the younger teens (ACT Health, 2016a).

In 2014, cannabis was the most commonly reported illicit drug among secondary school students in the ACT with 15.1% of students reporting that they used in the previous year (16.7% of students reported to have ever used it and 4.2% reported using it in the last seven days) (ACT Health, 2016a). This was followed by ecstasy with 4.0% of secondary school students reporting that they used it in the previous year (4.7% reported ever having used it and 0.5% reported using it in the last seven days) and hallucinogens with 3.4% of secondary school students reporting that they used it at least

once in the previous year (4.8% reported ever having used it and 0.8% reported using it in the last seven days).

Tranquilisers (used for other than medical reasons) were the most commonly reported other drug used among secondary school students with 16.2% reporting that they used it in the previous year (24.1% of student reported to have ever used it and 4.0% reported using it the last seven days), followed by inhalants with 9.3% of secondary school students reporting that they used it in the previous year (14.8% reported ever having used it and 2.8% reported using it in the last seven days) (ACT Health, 2016a). Inhalants are defined are substances deliberately inhaled from spray cans, glue, paint, petrol or thinner (it excludes white-out, liquid paper, textas, markers or pens).

For more information about alcohol and other drugs in the ACT please see section on Alcohol and Other Drugs.

Sexuality/LGBTIQ

The ages of 12-25 years are a critical period for the development of identity, and uncertainty and questioning regarding gender identity and sexual preferences are common (Headspace, 2011). However, many same sex attracted young Australian's experience homophobia, through verbal abuse (61%), physical abuse (18%) and other forms of homophobia (26%) (Hillier et al., 2010). Young men and gender questioning young people reported more abuse than young women, with the most common place for the experience of abuse being the school (80%).

The study found strong links between homophobic abuse and feeling unsafe, excessive drug use, self-harm and suicide attempts (Hillier et al., 2010). Young people who had been physically abused had worse mental health indicators than those who reported verbal abuse or no abuse. Drug use (often about self-medication) was higher in these young people than young people in general and young women were more likely to use drugs than young men. For more than half of the participants, homophobic abuse impacted negatively on aspects of their schooling, however, for 42%, homophobia had no impact at all.

The largest study conducted on the mental health and care pathways of trans and gender diverse young people in Australia found that around three-quarters (74.6%) of trans young people aged 14-25 years reported ever being diagnosed with depression and 72.2% with anxiety, compared with approximately 7% in the general adolescent population (Strauss et al., 2017). An alarming 48.1% had attempted suicide at some point in their life.

A young person's gender identity and sexual orientation can be fluid, and subject to change over time. A person may have different gender presentations for different situations. A young person may

be reluctant to access health care and support due to a fear of not being understood and supported by health care professionals. In a healthcare setting, it is important for GPs and other primary health care providers to respectfully find out the name, gender identity and gender pronouns of each person receiving care, to ensure they are correctly addressing them and meeting their core needs (ACT Health, 2016c).

For more information about the LGBTI population in the ACT please see section on Vulnerable Populations.

Pregnant teens and smoking

In the ACT between 2009-2014, two in five (42%) of women aged 20 and under reported smoking at their first antenatal visit, significantly higher than those aged 20-34 years (9%) and those aged over 35 years (5%) (ACT Health, 2016b). Aboriginal and Torres Strait Islander women were more likely than their non-Indigenous counterparts to smoke while pregnant. There is a dose-response relationship between number of cigarettes smoked and the likelihood of giving birth to a low-birthweight baby. Infants who are born with low birthweight are at greater risk of poor health, disability and death than other infants and the health effects of low birthweight continue through childhood and into adulthood (Australian Institute of Health and Welfare, 2011).

The ACT Health Smoking in Pregnancy (SiP) project includes the 'Quit for You, Quit for Two' strategy. This strategy aims to prevent smoking uptake amongst all young women in the ACT; reduce smoking rates during pregnancy amongst young women aged 15 to 24, and also support their partners and families in quitting and reduce smoking rates during pregnancy for all Aboriginal and Torres Strait Islander women, and also support their partners and families in quitting (ACT Health, 2017). Capital Health Network promotes these strategies in newsletters to GPs and other primary health care providers to raise their awareness about smoking in pregnancy when dealing with young pregnant women. CHN has approached practices with a high percentage of young pregnant patients and Aboriginal pregnant patients (based on PenCAT data), in relation to training opportunities and the opportunity to participate in a free NRT supplies trial.

Out of home care

In the ACT, the number of children and young people in care has grown on average by around five per cent per annum over the last decade and there are no grounds to believe that this pattern will cease without intervention (ACT Community Services, 2017). The current ACT care system is not delivering the desired quality outcomes for children and young people (ACT Community Services, 2014). Research indicates care leavers experience worse life outcomes than the general population

(Osborn and Bromfield, 2007). The experience of being in care can impact a child or young person long after they have left care in terms of their ability to gain an education, succeed in employment, build meaningful relationships and parent their own children satisfactorily, connect with their community and lead productive lives (ACT Community Services, 2014).

Young people in child protection and under youth justice supervision

In Australia in 2014-15, those aged 10-17 years who were in the child protection system were 14 times as likely as the general population to be under youth justice supervision in the same year (not necessarily at the same time) (5.5% compared with just 0.4%) (Australian Institute of Health and Welfare, 2016c). Aboriginal and Torres Strait Islander children are significantly over-represented in the ACT child protection system as they are in other Australian jurisdictions (ACT Community Services, 2014). Aboriginal and Torres Strait Islander young people in the child protection system were more than twice as likely to be under youth justice supervision as non-Indigenous young people (10.4% compared to 4.3%). The level of dual involvement was 8.0% for those under care and protection orders, 6.3% for those in out of home care and 4.1% for those who were the subject of an investigated notification (Australian Institute of Health and Welfare, 2016c).

Youth mental health

Mental health problems are common in young people and often have their first onset during this period of life. But many affected youth either don't seek or delay seeking professional help. In 2016, the Youth Coalition of the ACT conducted a survey of 2,052 youth (aged 12-25 years) in the ACT and this provides a useful snapshot to identify emerging trends and patterns (Youth Coalition of the ACT, 2016). Overall, the top five issues that were affecting the lives of young people in the ACT and worrying them were:

1. School, work or study (38%)
2. Stress (37%)
3. Feeling sad or anxious (30%)
4. Mental health and wellbeing (24%)
5. Employment (21%)

It is clear from these results that mental health and related issues, e.g. 'stress' and 'feeling sad or anxious', were a significant concern for the respondents. When asked what issues are important to them, 79% of youth responded that mental health and wellbeing was important or very important, listed a close second behind human rights (80%) (Youth Coalition of the ACT, 2016).

For more information about youth mental health in the ACT please see the section on Mental Health.

Priority Issues

Access to mental health services in a timely manner

Access to mental health services is one of the biggest issues faced by children and youth with a mental health issue. Consultation has revealed that there is a lack of service availability for youth with mental health issues (and their parents). This includes psychologists as well as community-run mental health assistance. Stakeholders have reported that people are being discharged from the mental health unit into the community with no follow-up. One of the ACT Youth Coalition's key priority areas identified in their submission to the 2017-18 ACT Budget was mental health. They call for investment that addresses the gap between early intervention and crisis services in the ACT mental health system and increased investment in coordinated strategies and services that address the social determinants of health (Youth Coalition of the ACT, 2017). The Youth Coalition also wants to ensure that young people are involved in the planning and development of suicide prevention activities in the ACT.

There are targeted mental health services at Headspace for youth aged 12-25 years with mild to moderate presentations. The aim of Headspace is to increase early intervention for mental health problems among 12-25 year olds by setting up youth-friendly enhanced primary health services. However, consultation has revealed that access to these services in the ACT is less than optimal, with long waiting times for an appointment.

Strategy

- CHN is facilitating an increase in service delivery of Psychological Interventions to Youth (12-25) through the provision of two full time equivalent mental health clinicians working within the Next Step High Intensity service. An integrated Service Navigation and Vocational Support Service will be available for young people with or at risk of a severe mental illness with complex needs.
- Additionally, youth in the 12 – 25 age range can access psychological intervention via the general Next Step High Intensity service. This service has the capacity to work with people over the age of 5 years through to adults. Youth aged 18 – 25 years can access Low Intensity Psychological Therapy via Next Step Low Intensity service.

- CHN has commissioned Headspace to continue the delivery of appropriately targeted Mental Health Services for mild to moderate presentations aimed at youth aged 12 – 25 years.
- For more information about strategies for youth mental health services in the ACT please see the section on Mental Health.

Identification and management of vulnerable youth in primary health care

At 30 June 2016, there were 748 children (0-17yrs) in the ACT in out of home care (Australian Institute of Health and Welfare, 2017). Children going into care have usually suffered abuse and neglect and have problematic health issues so require an engaged and effective GP. Children in out of home care are more likely, in the long term, to have poorer health, lower education, increased mental illness, have children earlier and increased risk of their children being in out of home care.

Aboriginal and Torres Strait Islander children are over represented in out of home care in the ACT, accounting for 26% of the children in out of home care, but less than 2% of the total population.

Vulnerable children can be identified by schools, GPs, Community Health Centres and other community organisations e.g. Youth Coalition ACT, Families ACT, Diversity ACT. GPs are a critical source of information, referral and support to youth and their parents who may have limited financial means. However, they can have difficulties accessing appointments and finding a GP, particularly a GP who bulk bills. Due to the time constraints of a 15 minute appointment, referrals to other support services are often not forthcoming.

Research indicates that isolated families access the universal service system (Centrelink, Health, Housing and Education). It is after this contact that parents seem to fall through the cracks, often failing to get information or referrals to targeted and intensive support systems designed to help them. Embedding supported linking practices across the service system will greatly increase the ability of targeted services to make contact with families whom those services have found 'hard to reach'. GPs could play a more proactive role and connect parents to formal service support systems.

Strategy

- Provide educational opportunities for focusing on vulnerable children and youth and the ways in which GPs can support families and identify and refer children and youth to appropriate services.
- Provide support for strengthening whole of jurisdiction early intervention initiatives.

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