Education (General Provisions) and Other Legislation Amendment Bill 2024

Submission No:	1807
Submitted by:	[redacted]
Publication:	
Attachments:	No attachment
Submitter Comments:	

[redacted]

Committee Secretary
Education, Employment, Training and Skills Committee
Parliament House
George Street
Brisbane Qld 4000
Via email : eetsc@parliament.qld.gov.au

Dear Committee

EDUCATION (GENERAL PROVISIONS) AND OTHER LEGISLATION AMENDMENT BILL 2024

Please accept this submission in relation to the above Bill.

I have attached it as a report-style document on the following pages.

There are also several further documents which form part of the submission which are either attached individually in the same or subsequent emails.

I have used non-standardised referencing throughout as I simply do not have time to produce a bibliography and a professional document. All websites referenced were accessed on 23-24/3/24.

I hope you carefully consider the factors raised in this and other submissions. I would welcome being contacted for further input as you consider this Bill.

Yours sincerely

[redacted]

Submission to: EDUCATION (GENERAL PROVISIONS) AND OTHER LEGISLATION AMENDMENT BILL 2024

Table of Contents

1 Glossary

ACARA – Australian Curriculum - Australian Curriculum, Assessment and Reporting Authority, National Curriculum. For the purpose of this submission these terms are used interchangeably.

The Committee – Education, Employment, Training and Skills Committee

DDG – Ms Kathleen Forrester, Deputy Director-General, , Policy, Performance, International and Intergovernmental, Education Qld.

The Board - Child Death Review Board

2 Harmful Implications of the proposed Removal of Provisional Registrations

The removal of provisional registrations pose significant barriers, challenges and obstacles for families who are considering or have chosen home education. This process serves as an essential pathway for families in the situation where they have needed to unenroll their child from mainstream schooling abruptly for various reasons - it allows them to collate required documents, research a suitable tailored education plan and implement a home-schooling environment around existing commitments. Removing this option could deter families from considering home education altogether, possibly forcing children to remain in volatile situations that can be detrimental to their mental health and depriving children of a valuable educational alternative.

Removing the option for new home educators to transition into the home school process with provisional registration serves no benefit to the child's well-being, and rather is likely to have the opposite effect. Quite often the reasons parents are registering are because things at school have become impossible, possibly after years of struggling to know how to help their child navigate the school system, while that system continues to harm their child's mental health and well-being. Many times home education becomes a necessity due to one failure or another of the mainstream schooling system, often requiring immediate action to remove their child from the school. Under the new proposed changes, it would be seen that those parents were violating the human right of a child to an education if they weren't instantly home educating them the very next day. By some miracle they would need to do what it can take a whole month to organise in order to be done correctly and in the child's best interests - literally overnight. What an unrealistic expectation to put on an already mentally, physically and emotionally draining situation. Removing the provisional registration may lead to damaging situations for the child, having to stay enrolled in a school environment longer than tenable for their mental health. The provisional registration system is working effectively to allow parents new to homeschooling time to adjust and to explore how best to meet their child's needs. This indvidualised approach will not be removed simply because of the proposed mandate of the Australian curriculum as over 60% of homeschooling children leaving education have reported having a disability (The submission of School Can't Australia to the National Senate Inquiry into the national trend of school refusal and related matters), implying that parents would be responsible for identifying and justifying (by what means?) tailored adjustments to their child's curriculum to suit their needs. This is something parents who choose homeschooling do anyway, however they currently have the flexibility to put their child's health first, to unschool, or deschool or to undertake immersive learning opportunities through passionate exploration of a key subject area. Finding and writing any plan worth reading takes time, and parents are not paid for this work, or for the time they spend saving the Education Department money through choosing homeschooling and taking responsibility themselves for their child's education. Do not make the process of beginning the homeschool journey more arduous and difficult than it already is.

3 The Danger of the proposed Mandatory use of Standard Curriculum

The proposed introduction of mandatory adherence to the National curriculum is extremely troubling to me. Home education has long been valued for its flexibility and ability to cater to the individual diverse learning styles, paces and interests of each child. Mandating ACARA not only undermines the fundamental principle of home education and its flexibility but also restricts our ability to provide a customised education that best suits our children's unique learning styles and needs for their learning journey. I do not want to use the National Curriculum, although I find it a useful resource, among many other resources.

I object to the guiding principle of proving that homeschooling is in the best interest of my child because I already know it's in my child's best interest and for many home-educated families, the proposed changes to mandate a school curriculum represents an horrific prospect. Home education is often chosen as an alternative to traditional schooling precisely because it offers freedom, flexibility, and autonomy in learning, as well as addressing learning difficulties, behavioural issues and disabilities. The proposal to require a school curriculum for home-educated children fails to acknowledge the diverse needs and educational philosophies within the home education community. It undermines parental rights, stifles individualised learning, and overlooks the rich learning opportunities available outside traditional classrooms.

Homeschooling offers children with learning and behavioural disabilities a supportive and nurturing educational experience that caters to their individual needs, fosters their growth and development, and empowers them to reach their full potential. The imposition of a school curriculum on home-educated children is not only unnecessary but also potentially detrimental to their educational experience and overall development. Instead of imposing uniformity, policymakers should respect and support the autonomy of families in choosing the educational path that best suits their children. Mandating a school curriculum would also infringe upon the values and principles that drive families to choose home education in the first place, leading to feelings of frustration, anxiety, and disillusionment among home-educated children and their parents. It is essential to consider the perspectives and concerns of home-educated families when discussing potential changes to education policy, ensuring that their voices are heard and their rights respected.

3.1 Enforcing one curriculum - Against human rights

While the Bill and associated documents and the Director-General's representation to the Committee claim that ACARA can be adjusted and allowances made for children with disabilities. It is my recollection that the DDG in her response during the public briefing on 18 March 2024 stated that allowances for homeschooling families of children with disabilities could be “adjusted as they are in schools” (https://tv.parliament.qld.gov.au/Committees?reference=C7873#parentVerticalTab7). This is a laughable claim, as many parents already know, one of the most difficult things about school, and a reason for homeschooling is the lack of adjustments made for individual children.

The submission of School Can’t Australia to the National Senate Inquiry into the national trend of school refusal and related matters (attached) included results from a survey of 441 parents of children with chronic school attendance issues.

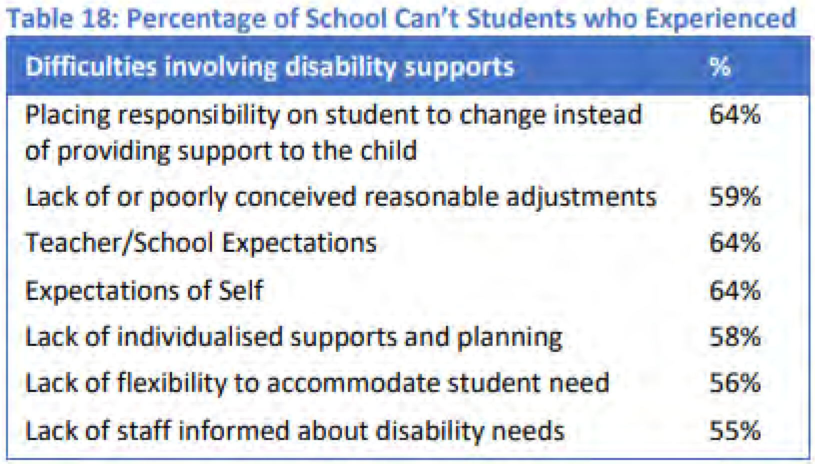


Table 18: Percentage of School Can’t Students who Experienced

Difficulties involving disability supports	%
Placing responsibility on student to change instead of providing support to the child	64%
Lack of or poorly conceived reasonable adjustments	59%
Teacher/School Expectations	64%
Expectations of Self	64%
Lack of individualised supports and planning	58%
Lack of flexibility to accommodate student need	56%
Lack of staff informed about disability needs	55%

This table is extremely relevant to the proposed changes, as the claim made by the DDG that adjustments can be accommodated, just as they are in school is laughable. The list of difficulties that these students had with school include lack of or poorly conceived reasonable adjustments (59%), lack of individualised supports and plannning (58%), lack of flexibility to accommodate student need (56%) and lack of staff informed about disability needs (55%). Schools are not able to adjust for all students!

The Home Education Network’s submission to the National Senate Inquiry The national trend of school refusal and related matters summed up:

About 60% of home educated children who have been removed from mainstream education have exhibited emotional distress related to school attendance (Slater et al., 2022). Children with disabilities are over-represented in the Australian home education community (Slater et al., 2022). The lack of financial support and loss of income therefore disproportionately impact a vulnerable group of children and their families, who are trying to mitigate the effects of School Can’t and provide their children with a quality education that the mainstream education system is unable to provide. I have included the full copy of this submission for your consideration.

If an entire department of 65,045 full-time equivalent teaching staff (in 2022) cannot manage to accommodate children who are gifted, and children with disabilities and still teach them according to the Australian curriculum, what makes you think it is ok to demand that parents, who are not trained in pedagogy, attempt something that your own government cannot manage? (https://www.qgso.qld.gov.au/issues/3646/schools-qld-2022.pdf)

The answer to why homeschooling is successful is in the basic common-sense reality that parents are the ones who care for and love their children most, we are most invested in successful outcomes for our children, and we will never give up on finding the way of learning that most suits our child. We will use instincts, have the flexibility to throw plans out the window to follow a new interest; we will put well-being at the heart of learning. We are the ones listening to our children's dreams and hopes for the future and designing the path towards that future with the most chance of success. This takes time, effort, determination and patience. It is unpaid. But we do this from a place of love first and foremost. We are not teachers but facilitators of our children's learning and growing. With home education we can allow for so many factors, too numerous for me to attempt to list. However I doubt very much if we can all do that as well as provide the documentation you are suggesting to meet not only the Australian Curriculum but also to then document on top of that how each invididual child will vary from that across all the subject areas (some of which to be honest, might be entirely pointless to the individual child's life goals or needs) Requesting this of parents is putting too much of an ardous emphasis on pointless paperwork and likely diminishing the relevance of the homeschool education to the individual. It is also potentially going to return children to a mainstream schooling system which has been proven to be inadequate for purpose for some children. Please refer to https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/SchoolRefusal/Report and take note not only the recommendations in this report but the submissions and data collected, demonstrating how poorly able the existing education system and aderence to ACARA is for many students.

I strongly recommend that before taking the extremely risky step of attempting to duplicate a "school in the home" that you consider the information received from all homeschooling submissions, that show clearly that responses to children in schools are NOT working, which is why many are homeschooling, to be able to provide safety and well being first, meeting fundamental needs which cannot be met while attempting to force a standardised curriculum.

3.2 Irrelevance of a National Curriculum in Homeschooling

The Australian curriculum covers a wide range of subject areas in a very general and relatively simplistic way. This is in theory an effective way to ensure a taste of all possibilities of education for a large number of students in a setting where coverage of general concepts and a 'taste' of opportunities as well as basic requirements for further education and employment are met.

Home education does not seek to provide children with a basic education, or to provide them with a taste of opportunities only. There are some home educators who may do this, and choose home education that may fit within ACARA. This might be the 20% referred to by the DDG in the briefing on 18 March 2024 (https://tv.parliament.qld.gov.au/Committees?reference=C7873#parentVerticalTab7).

This leaves 80% of home-schooling families who are more than likely providing a specialised, individually designed and appropriate educational opportunity, tailored to their child's needs and goals. Why would you seek to change this for the approximately 8,000 students whose needs are not currently being met by the school system? Do you not consider that affected homeschooling families when required to mimic this system might instead return their students in large numbers back into your broken system where their needs will still not be met, and the onus will then be back on your overworked school staff to attempt to accommodate children who the environment was already ill-suited to at best, and life-threatening at worst? (number of students sources: https://tv.parliament.qld.gov.au/Committees?reference=C7873#parentVerticalTab7 and https://www.abc.net.au/news/2024-01-22/homeschool-surges-queensland-post-pandemic-restrictions/102015880)

3.3 Gifted Students Entirely Excluded

As a parent of gifted and twice exceptional (gifted but also with disability) students I am horrified that the proposed standard curriculum has defined the Australian curriculum, senior subject syllabus or vocational education only! This completely ignores the needs of students with exceptional giftedness and passionate interests.

What of the gifted student who is fully enrolled at University aged 14? How will they achieve this through studying such a limiting curriculum in the years preceeding such an achievement? They cannot! What of their completion of the American SAT exam at 13? The study for this would not be found in any of the 'standard' curriculum options mentioned, despite being exactly suitable for that individual child's age and aptitude?

Or a gifted child who demonstrates aptitude in any number of areas not covered by the Australian curriculum who wishes to conduct their career through commitment to their interest and ability area and who is a capable lifelong learner?

Jessica Watson comes to mind here. The Queensland government attempted to shut down her individuality, and to "protect" her. I am incredibly grateful that they were unable to do so, as my young daughter has a strong, incredibly relatable, and passionate Australian young woman to admire. Jessica Watson does not claim to be good at school work, however she had ambition, passion and the working knowledge of sailing to pursue her ambitions, as well as parents and mentors who believed in her. She continues to be a successful woman, conducting herself in the public eye but also completing a Masters in Business Administration and working as a marketing and communications manager as well as writing. None of Jessica's success was due to government oversight and prescription of her homeschooling. I realise that Jessica was schooled using a distance education approach, but back in 2009 there was no Australian Curriculum and even a distance education approach offered a significant flexibility and allowances for students pursuing their passions by comparison to today. (https://www.jessicawatson.com.au/latest/2017/12/12/what-i-learnt-from-my-mba, https://www.acara.edu.au/curriculum/history-of-the-australian-curriculum/development-of-australian-curriculum#:~:text=Teams%20of%20writers%2C%20supported%20by,advice%20from%20the%20ACARA%20Board., http://www.famoushomeschoolers.net/bio_jessica_watson.html)

4 Increased Reporting Obligations

Increasing reporting requirements for homeschooling families will add bureaucratic burden by necessitating additional paperwork, time, and resources to document educational progress. This could be particularly challenging for large homeschooling families, those with additional educational requirements due to learning difficulties and disabilities, those with diverse educational philosophies, those who prioritise non-traditional learning methods or those with additional responsibilities outside of homeschooling - potentially leading to frustration, taking valuable time away from implementing their education plans, hindering the flexibility that often attracts families to homeschooling in the first place and possibly ultimately lead to the inability to continue the quality home education of their children.

5 Reasons for removing children from mainstream schooling to homeschool

Questions I ask you, if the Qld Education System was responsible for ensuring my daughter was taken care of appropriately in her best interests - how would that process look? I adk you when the public schools could never have achieved what I have, so how on earth would an administrative officer in your Home Education Unit in Brisbane manage her best interests? I now ask you, how do you propose to protect the children forced back into the mainstream schooling system under the proposed changes, who had dedicated home educating parents prior to the changes across the Home Education Unit, which has already failed them in big ways? I ask you, where a child does not have learning difficulties, behavioural issues or disabilities that could possibly render them ineligible for homeschooling at the discretion of an administrative officer at the Home Education Unit in Brisbane under the proposed changes, yet are deemed more suitable to homeschooling by their parents - IN THEIR BEST INTERESTS - what would happen to these children? I now ask you what will this new reporting look like?

6 Home Education In the Best Interests of the Child or Young Person

The Bill requires that the home education provided "must be in the best interests of the child or young person" (DDG, Public Hearing 18 March 2024, https://tv.parliament.qld.gov.au/Committees?reference=C7873#parentVerticalTab7)

However, the proposed changes are in direct contradiction to this, as I have outlined above.

6.1 Child mental health service failure a reason to change home education?

The DDG goes on to say that this recommendation reflects the recommendations of the Child Death Review Board, Annual Report 2022. I have read the chapter of this report (full report attached) pertaining to the tragic case of a single young person, a 1 in 10,000 incident (https://www.abc.net.au/news/2024-01-22/homeschool-surges-queensland-post-pandemic-restrictions/102015880)

This terrible story speaks to the failure of a number of government and health agencies, being:

- Queensland Health
- Child and Youth Mental Health Services (CYMHS)
- Department Children, Youth Justice and Multicultural Affairs
- SCAN team, consisting not only of departments listed here but also
    - Queensland Police
    - Department of Education
- Hospital or EQ "School Guidance Officer"
- Department of Education's Youth Engagement Service

None of these services were able to prevent this child's death, despite the multi-disciplinary referral (SCAN team) and multi-agency involvement. (https://www.dcssds.qld.gov.au/about-us/our-department/partners/child-family/our-government-partners/suspected-child-abuse-neglect-scan-team-system)

After the board reviewed the failure of all of the above agencies to successfully intervene to save this child’s life, their concluding paragraph in a scant half page summary of their review of this single case of a child’s death was

“The young person’s experiences led the Board to consider the regulatory oversight of, and support for, children registered for home education in Queensland.” (https://documents.parliament.qld.gov.au/tp/2024/5724T347-DB90.pdf)

No mention is made of considering the hopelessness of the Mental Health Service in improving outcomes (I do not have time to reference this claim, but be my guest and try to prove me wrong, I am willing to be corrected on this point.)

No mention is made of the inadequateness of school to engage young people with severe mental health concerns in a safe and meaningful way. I speak to this from my own experience where schools are woefully unable to successfully conduct even the simplest interactions with highly anxious students without making the situation worse.

How can it be that with all this supposedly “helpful” intervention this child was unable to survive? With all these ‘services’ involved, how can it be that home education is to blame when these apparent experts and specialists could not succeed?

The Board relentlessly pushes on with their one-dimensional appraisal of this single child’s death being the sole responsibility of their status as “home educated”, stating that

“Of the eight school aged children in this sample who died by suicide, five children died within 12 months of disengagement from school.” (https://documents.parliament.qld.gov.au/tp/2024/5724T347-DB90.pdf)

This does not speak to a failure of home schooling. It speaks directly to the failure of the school system to provide a safe place for children, let alone a place where they receive learning. I accept that the children who are not safe at school may be a subset of children, likely those with neurodivergent diagnosis (according to most studies I’ve read), and subsequent mental health challenges are a result of the unsafe environment at school.

Please take the time to read and consider this again. The unsafe environment for a growing number of students is the school environment. Making the home-school environment more like school is the opposite of ensuring the best interests of the child and may lead to terrible consequences.

I would also like to share with you an alternate and entirely fictional presentation of an alternative view of the half-page story which underpins the Board's fascination with overhauling homeschooling. I am aware that I do not possess the facts of this case, but please consider this fictional story alternative:

In 2022-23, the "overseers" considered the case of a child who was known to be at risk of self-harm through assessment of the SCAN Team, consisting of at least for Qld Government deparments: Department of Child Safety, Department of Education, Qld Police Service and Qld Health. These four departments through the SCAN team as well as specific interactions with Child and Youth Mental Health Services (CYMHS), hospital, School Guidance officer and Department of Education's Youth Engagement Service were unable to assist this young person. Their fumbled and heavy handed clumsy interventions may have exacerbated the harm in a delicate and difficult situation.

This young person was diagnosed with multiple mental health conditions and had a history of suicidal ideation and self-harm. They homeschooled at the time of their death, however it is unknown whether homeschooling was a result of leaving school due to mental health reasons, or an unrelated, irrelevant fact in this case. A home visit by CYMHS made the child feel threatened and uncertain, they were scared of being forced into hospital, which terified them as they had a small number of things which made them feel safe, mostly being in their own environment, as all of us do. Having CYMHS on the doorstep made them spiral, especially as these 'visitors' were judging everything around them and then they not only threatened to take the child away but they followed through with that, as well as sending the child's parents into a frenzy of cleaning instead of trying to manage their young persons mental health. The young person was hospitalised among drug users and people with psychosis, many different medications were given to them, none of which made them feel safer or more likely to ever feel ok again. But they were not given a choice and were told they'd not be allowed to leave if they were 'uncooperative'. Parents were being pressured to clean their house rather than being supported to emotionally support their child. Child safety were judgmental and labelling and the whole family were scared and felt judged, on top of existing problems.

In hospital, an education representative “interviewed” the young person, while that young person was vulnerable and not stable (stable people are discharged). They made statements to the young person who eventually agreed with the statements to make them stop, so they would leave. These statements were distressing, because the young person felt isolated by their mental state and the guidance officer only made it worse by saying things like “you’re all alone without school supports”, which given that school was not supportive, triggered a range of mixed and confusing emotions in that young person.

The young person wished that school was a safe enough place to return to *(had they been there, this is unknown, but for this story, this child had been previously at school)*, but knew that it wasn’t. They felt pressured by everyone around them and like they had failed as people kept seeming to say there was something wrong with them that needed fixing. No-one helped them or listened to them and no-one was there for them when they came to the end. But their friends and family grieved for them and for all the hurt caused to them by the “services” supposed to help them.

While I do not claim this is indicative of the child represented by the Child Death Review Board Annual Report 2022-2023, I do say this story, or a variation of it, is very indicative of real world lived experience of young people with mental health conditions. It would be very confronting to have people come into your home when you are vulnerable, and difficult for the cascade of dramatic interventions following this not to lead to a negative outcome. In all of this, in both the real-world and the fictional stories, the fact that the child is home-schooled really does not seem relevant, at least not from the facts presented by the report. The report does not speak to whether the child has been homeschooled all their life, whether they had a rich experience and a wide circle of friends and social supports prior to their decline in mental health, it does not for that matter mention when the onset of known mental health concerns began, or whether there was a known trigger. To conclude from the information presented that somehow homeschooling ought to be reviewed because of this tragedy is ludicrous.

Why not review the school system (that they may have previously left), or the handling of suicide prevention in young people, or the response time or appropriate resourcing of the services involved?

In addition, one of the most difficult to understand aspects of this requirement to standardise curriculum is the leap that is made from this terrible tragedy to a standard curriculum. The report emhasises student physical and mental health, and does not once mention adopting a standard curriculum. So how is requiring adherence to a curriculum providing improvements to the mental health and well-being of students?

6.2 Standardised Curriculum Does not Improve Mental Health

I am concerned that claiming the proposed changes is in the interests of the well being of home schooled students is drawing a long bow, there appears at face value to be absolutely no relationship between positive mental health and curriculum.

6.3 Standardised curriculum does not improve Educational Outcomes

If anything the relationship between well-being and a standardised curriculum is a negative one, adding more pressure to students to ‘perform’ and giving less emphasis to their indivual learning styles and well-being.

Since its introduction, the national curriculum has seen Australia fall behind other countries in English, Maths and Science. (https://www.theguardian.com/australia-news/2019/dec/03/australian-students-maths-performance-falls-to-oecd-average-in-worst-result-since-2000, https://www.theguardian.com/australia-news/2023/nov/27/australian-education-in-long-term-decline-due-to-poor-curriculum-report-says)

The success of one of the highest ranking school systems includes:

‘Estonian students are mostly satisfied with their lives. The assessment of their life satisfaction (average 6.91 points on a 10-point scale) is higher than the OECD average (6.75), similar to Sweden(6.91) and slightly lower than in Finland (7.41).” and feel safe at school “children in Estonia feel safe at school. Students’ sense of security is higher than on average in OECD countries, especially because of the safer way to school. The feeling of safety in the classroom and in other areas of the school is similar to the OECD average. Estonian basic education system supports students to become self-directed learners. Estonia is among the countries where seven out of ten students feel that they are ready for self-directed learning.”

And finally:

Estonia is in first place in the comparison of countries in terms of teachers' freedom in setting up the school curriculum and participating in school management decisions.

So please explain how increasing rigidity is in the well-being interest of students?

6.5 Parents are guardians of their children's best interest

The proposed changes to remove parents' rights to choose home education in the best interests of their children is very concerning. Parents are in the best position to assess their child's needs and make informed decisions regarding their education. By limiting parental autonomy in this regard, the proposed changes not only undermine the rights of parents but also disregard the principle of parental responsibility and involvement in their children's education. I find it offensive that it's being suggested you have the right to overrule parents rights to do what is best for a child in their best interests. I would be very angry and heartbroken if it was decided by a government employee that my child's best interests were being compromised by not attending a mainstream school and be forced to watch them spiral backwards in the education system they were forced out of due to not accommodating their basic safety needs. This would not be acceptable. It is my opinion that the government should stop trying to over reach and cross over with Child Safety, GP's, Qld Health and Allied Services as well as other departments and services responsible for monitoring children at risk with 'compulsory reporting', and leave the best interests of a child to be established by their parent, with the freedom to choose home schooling if it is the most suitable option for that child regardless of their reasons - which is legally their right as the primary care giver and to also choose their Education Plan based around the 8 core subjects as currently required by Qld Home Education Unit, but still be allowed to base their learning around interests and passions, using one on one teaching methods, suitable and engaging resources, conducive learning environments, flexible schedules and essential life-skills to achieve better results than the traditional system - IN THE CHILDS BEST INTERESTS. School dropouts due to bullying and anxiety are unfortunately all too common, highlighting the urgent need for solutions to address these issues within traditional schooling environments.

7 Lack of consultation with Actual Stakeholders

The Department claims that six homeschooling stakeholders were contacted, however those of us in the homeschooling community are shaking our heads to identify who these six might be, how they were consulted and why a wider consultation in the community was not undertaken. Stakeholders who were not consulted may include but not be limited to:

- Teachers and former teachers who understand the challenges of teaching to the Australian curriculum
- Disability advocacy and support groups with lived experience of homeschooling/homeschoolers
- Children who were homeschooled and are now adults
- Parents and children who are not registered homeschoolers but may be considering it
- Parents and children who have homeschooled at some period but no longer do (e.g. for a 2 year travelling stint or during a health crisis, or to sail around the world solo) These individuals may or may not have stories of how they then integrated back into the schooling system

The perspectives from the limited stakeholders consulted appears to have not encompassed those with lived experience of homeschooling, and provided no opportunity for the informal homeschooling groups that exist statewide and around our regions to coordinate and provide comprehensive coordinated feedback.

8 Conclusion

I cannot fathom how after reading submissions from homeschooling families how you could consider agreeing to the amendments proposed regarding homeschooling in this Bill. To adopt these amendments, developed by ill-conceived reports and biased thinking would be to the detriment not only to the homeschooling families directly affected, but would also without a doubt place an even greater strain on the resources of agencies such as Education Qld, the health sector with more doctor and specialist visits required to produce ’evidence’ to justify adjustments being made across the range of subject areas, as it has been established that a greater proportion of students with disabilities find themselves homeschooling.

9 Personal Stories

I have three children, aged 19, 16 and 12. My experience home education began when my eldest child was still a toddler and I explored the pedagogies of Montessori, Steiner and Reggio Emilia. I settled on enrolment at a local independent school for her Prep year as she had not liked Kindy – they had only allowed her a single book at rest time, when at home she would read a stack of 7 or 8 or more books in the same period of time. She was a sociable child who participated in playgroups, Kindergym and saw extended family regularly. During her prep year however she was bored and found the books they were providing as well as the maths too baby-ish. So I enrolled her in Distance Education in year 1, which was also boring, and the school were eventually convinced to grade skip her to year 2 work, which she still found boring. By this time I had three children and I decided that enrolling her in a private Anglican school in year 3 (skipping a grade) would provide her the best educational outcome. She was finally being taught in class at a level more suited to her academic abilities and interests. Meanwhile, her younger brother loved to learn outdoors with physical activity and movement. This wasn't really my style and in hindsight I did not give enough credence to the value of activity and practicality in learning styles, not having a background in understanding neurology and that for my son physical movement was necessary for learning (school never picked this up). He started in a state school where his sensory issues were somewhat accommodated and he flourished in some areas learning the alphabet through stories and relationships in the Letterland phonics approach (https://www.letterland.com.au/) School was too big and despite my concerns raised about dyslexia I was told by Education Qld staff that 'dyslexia didn't exist' and that my son's inability to read or to be able to tell the difference between L and a backwards L was 'normal'. Eventually when he was in grade 2 I had him tested by an educational psychologist, using the WISC standarised test, only to find out he was as gifted as his sister, in the gifted and talented (genius) range, despite near average levels of processing and a further significant identification of severely dsylexic tendencies. I was advised by a private tutor to teach him all spelling words verbally and backwards and within weeks his spelling had improved from 0 out of 10 to 7 out of 10 averages. His teacher however continued to report he was disengaged and not comprehending the latest book they were reading. On the way home in the car he explained the entire plot of the book as well as the morale lesson it intended to portray. He looked out the window in order to concentrate he said. A new class room and teacher and he developed a good friendship group with around 7 other boys which he kept for the majority of primary school. As he got older, he developed asthma which was linked very much to humid weather conditions, and due to his sensory processing difficulties, he found this extremely difficult to manage at school. In hindsight I would have homeschooled him if I knew what would happen next. All I want to say is that for both my elder children, significant emotional harm has come to them directly at the hands of education Queensland staff. Both incidents nothing was done as school principals are like small gods in their school and can wipe away all things with a variety of witness statements designed to intimidate children and parents. It would be nice if these people were held accountable.

Once again I do not have time to tell my family's whole story. You can find more in my attached submission 107 to the Senate Inquiry into School Refusal and related matters. It gives a more detailed account of how the school system and its National curriculum failed my children.

I can however update that my family continue to do 'better' as we follow an unschooling pedagogy where my children are encouraged to follow their passions, to look after themselves mentally and physically and to be well.

My son has an encylopedic knowledge across a broad range of issues. He is an Australian Champion in his chosen team sport. He has attempted and been unable to successfully adapt good study habits for TAFE (who also struggled to make reasonable adjustments) and to overcome his trauma experienced at school. He is currently focussing on his physical health and formulating a plan to study at University of Qld by first completing a course with the Headstart program for school students at university.

My daughter has pursued her love of horses and riding. Being on horseback has assisted her with communicating and taking responsibility for her actions independently.

She has overcome her fears manfested by anxiety through therapy but most of all through going to the beach with her best friend and their dog. Being an animal lover, she is significantly assisted by the presence of the dog when facing her fears. I am now building a case for her to have an assistance dog, a very lengthy, complex and expensive process.

The following was to be my supplementary submission to the Inquiry, however I ran out of time and available hours to submit it, so it remains a draft, now to be included in my submission here:

9.1 Radical Unschooling our way to Happiness.

Submission supplementary to 107. (March 2023)

Thank you for the opportunity to provide a supplementary submission. I welcome this chance with a sense of hope that all the submitters and contributors have been listened to and heard by the Senators, thank you.

An amazing thing happened towards the end of last year, after I had made my submission. A fellow homeschooling Mum mentioned radical unschooling, an ethos I was familiar with from many years ago but had slipped my mind.

Radical unschoolers, or whole life unschoolers, have taken the idea of autonomous learning and applied it to every area of a child's life. **Radical unschoolers do not follow what they call "arbitrary rules" such as bedtimes and chores.** 18 Oct 2016 https://redheadmom8.wordpress.com/2016/10/18/whats-the-difference-between-unschooling-and-radical-unschooling/#:~:text=Radical%20unschoolers%2C%20or%20whole%20life,such%20as%20bedtimes%20and%20chores.

For our family, this was the only way to move forward. To remove all the shame from not being able to attend school, from not being able to regulate sleep, from feelings. I spent an increasing amount of time actively moving towards this model without realizing I was doing so. And it worked, as I slowly tried things, and let things slide if they were not successful.

My daughter attended a very open minded, open to all, opt in or out of all homeschool camp last year. It was life-changing for her. She was anxious and didn’t participate in most activities, I talked with enthusiasm with her about the activities she enjoyed, and didn’t make a big deal out of the things she missed. She spent the whole second night in a huge dorm with the other girls, none of whom she’d known prior to camp. I also attended camp, but more often than not, I was only turning up for mealtimes, which was lovely.

Since then she commented to me that the school system was not really very modern, it didn’t suit kids, and it was outdated.

We have found a lovely local former teacher who takes a small group twice a week into her home. This works for my very sociable daughter, there are less than 10 kids, up to 4 dogs, plus other pets, a park they visit daily and a swimming pool. The dogs make all the difference. I listened to one of the people during the public hearings stating that the first thing they do is make contact with the student to make sure they are ok, and to let them know they are wanted.

As I said to the regional senior guidance officer all it took was a homey environment, plenty of autonomy, dogs and plenty of exercise & fun. I do not think these are unattainable goals.

My daughter now goes to the beach again, and it takes a fair amount of negativity now for her paralising anxiety to kick in.

My son is still playing his sport. He is slowly socializing with the adults with whom he plays. He is also extending his interests into other hobbies involving people. He does not use his NDIS funding as it is restrictive and rarely allows him to spend the money on the things which would help him, as NDIS is very restrictive and insists that children can only access disability specific activities.

He is still entirely unable to attend any kind of formal learning.

9.2 Proposed Changes cannot meet needs

I would like you to please explain how my children could have flourished as they have for the past 18 months under a rigid, school-like curriculum, or how I would have been able to work as I have done while attempting to force them into this unsuitable pedagogy.

The National Trend of School Refusal and Related Matters

Home Education Network

Submission to the Senate Inquiry by
the Home Education Network

Going to school is an expectation that society puts on children and parents. Most children cope with this expectation, but some cannot.

‘School refusal’ (School Can’t) is a common precursor to families choosing to home educate their children. This often comes after years of parents and children persisting in coming up with strategies to mitigate the anxiety and stressors that have led to School Can’t, and/or attempting to reintegrate children back into a school setting (mainstream as well as alternative settings).

About 60% of home educated children who have been removed from mainstream education have exhibited emotional distress related to school attendance (Slater et al., 2022).

Terms of Reference Item (b): Effect of School Can’t on young people and their families, and impacts on employment and financial security

Causes of School Can’t are varied, and include physical and mental health issues (including anxiety), disability and behavioural issues (Watterston & O'Connell, 2019). Children with disabilities are over-represented in the School Can’t cohort (Munkhaugen et al., 2017; Naylor et al., 1994). The implications for possible discrimination in the right to access quality education against children with disabilities is clear.

Home education can provide access to that quality education for children who cannot go to school, but this comes at a high financial cost. Over 85% of Australian home educated children receive no funding to assist with education costs (Slater et al., 2022). The Assistance for Isolated Children (AIC) payment is hard to obtain, and does not cover the education costs for many children (Slater et al., 2022).

In addition to the extra costs that must be covered by families, the majority suffer an additional loss of income, in most cases well over $30,000 per annum, and in at least one third of families in excess of $50,000 (Slater et al., 2022). The financial stress on many home educating families is real.

Children with disabilities are over-represented in the Australian home education community (Slater et al., 2022). The lack of financial support and loss of income therefore disproportionately impact a vulnerable group of children and their families, who are trying to mitigate the effects of School Can't and provide their children with a quality education that the mainstream education system is unable to provide.

Terms of Reference Item (e): Any other related matters

Children who become disengaged from mainstream education and become part of the "School Can't" cohort are at risk of becoming detached from education altogether (Watterston & O'Connell, 2019). Given that we do not have enough alternative schools/settings to pick up detached school aged young people when they detach from school (Watterston & O'Connell, 2019), home education could be recommended as a viable alternative, and as a way to re-engage young people in learning, education, and the wider community. Unfortunately, there is not enough knowledge in the mainstream education system about what home education is, and what it isn't. This often means that it is not suggested as a valid option for families to explore.

Home education is currently not considered, recommended nor supported by mainstream as an option. We have countless examples within the home education community of children who have been disengaged and detached from education, who have thrived when they have settled into home education. Some of these children have remained in home education long term, and others have reintegrated back into the mainstream education system after some time in the home education community.

Home education allows children to rediscover their love of learning, to find what works for them and how they want to direct their own learning. Autonomy is a wonderful, empowering experience. They can pursue their interests, in a calm, relaxed environment, make connections with other families in the home education community, and interact at a level that suits them. This leads to positive outcomes (O'Hagan et al., 2021), and their education trajectory can return to a path that leads to a fulfilling, productive and engaged life (Gray & Riley, 2015).

Conclusions

- Children with disabilities are over-represented in the School Can't cohort
- There is inadequate provision and availability of alternative schools/settings to provide for young people who have detached from mainstream education
- Home education can improve outcomes for young people who are disengaged or detached from mainstream education
- Home education should be recommended and supported as a viable alternative for children in the School Can't cohort
- Home education comes at a financial cost for families, as well as having implications for loss of income
- Broader financial support should be considered for home educating families

Submission prepared by Pavlina McMaster, Secretary
On behalf of the Home Education Network
https://home-ed.vic.edu.au/

References

Gray, P., & Riley, G. (2015). Grown unschoolers' evaluations of their unschooling experiences: Report I on a survey of 75 unschooled adults. *Other Education*, *4*(2), 8-32.

Munkhaugen, E. K., Gjevik, E., Pripp, A. H., Sponheim, E., & Diseth, T. H. (2017). School refusal behaviour: Are children and adolescents with autism spectrum disorder at a higher risk? *Research in Autism Spectrum Disorders*, *41*(3), 31-38.

Naylor, M. W., Staskowski, M., Kenney, M. C., & King, C. A. (1994). Language disorders and learning disabilities in school-refusing adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *33*(9), 1331-1337.

O'Hagan, S., Bond, C., & Hebron, J. (2021). What do we know about home education and autism? A thematic synthesis review. *Research in Autism Spectrum Disorders*, *80*(101711). https://doi.org/10.1016/j.rasd.2020.101711

Slater, E., Burton, K., & McKillop, D. (2022). Reasons for home educating in Australia: Who and why? *Educational Review*, *74*(2), 263-280. 10.1080/00131911.2020.1728232

Watterston, J., & O'Connell, M. (2019). *Those who disappear: The Australian education problem nobody wants to talk about*. The University of Melbourne. https://education.unimelb.edu.au/mgse-industry-reports/report-1-those-who-disappear

How Education failed my children.
I can't write this in a special format, all I can do is the best I can to recount my experience, my thoughts on what could be improved and hope it can be interpreted by the Senate Inquiry and help the government to take action so that other families don't suffer as we did.

My son, who turns next week, and my year old daughter haven't been to a class at school with other children for over 12 months. They both desperately want to go, but there is no system in place to support them to achieve this goal.

Currently they both suffer from anxiety, and their capacity to interact socially in the community fluctuates some, but generally could be considered normal and positive. My son recently started a sport where he plays socially with adults and while reserved he has interacted with them over a period of months both on and off the field. My daughter has regularly engaged positively and warmly with a number of adults.

However when faced with school, or anything that could remotely resemble educational or academic activities, conversations, ANYTHING, a reaction they have I could best describe as trauma and fear. It can send them into a highly stressed, dysfunctional state for days. And every time this happens to one of them, it affects our whole family to see one of us so distressed.

In 2018 I had three children aged who caught the school bus at 8am, and returned home on the bus and walked home together multiple days a week. Only my son, , had any diagnoses, of sensory processing disorder and dyslexia. I had no idea of the chaos my life would descend into.

Previously over the entirety of his education my son has had difficulty. I had been frequently passed off as *helicopter parenting* him, or being incorrect in my concluding that something was wrong by all involved in his education. The word "normal" was frequently thrown in my face over the years. Then when he was in grade 2, I had him tested by an educational psychologist. Her conclusion was that he was gifted and required "advancement and enrichment across the entire curriculum" to ensure his learning met his intellectual capacity. I called this person and said to her "why then is he failing at school and why can't he read?" Another assessment concluded he had the working vocabulary of a 12 year old).

School was delivered this report, with the results of his WISC test. He is now almost so 8 years have passed and he has ***<u>never had any curriculum advancements, despite every school having a copy of this report.</u>***

He was also diagnosed with Sensory Processing disorder, and some limited accommodations were made for him in this regard, but these were often more fraught than practical such as he was allowed to use blue tack as a sensory regulator, but not to stretch it or to roll it on the desk (the regulative activities), only to squish it between his fingers under the desk (providing him with absolutely zero regulatory assistance).

<u>Many and varied were the arbitrarily imposed constraints on the devices supposed to assist him.</u>

I privately obtained tutoring for him and he learned to read using methods designed to assist people with dyslexia. The one thing school did at the end of year 2 was move him to a different class, where in combination with learning to read, he developed a lovely friendship group which lasted him for the remainder of his years at that school. It was his first and only peer friend group and due to the freedom of multi-aged class grouping, included mostly boys older than himself.

Why have I started this tale way back here? Well because frankly, school refusal (stupid terminology, I think it should be school PTSD myself, having witness how affected my family has been), sorry I digress. Chronic not attending school despite best efforts doesn't develop overnight. To my way of looking at it there are significant contributing factors that build to form a terrible unfathomable black hole eventually. For us that black hole eventuated due to COVID lockdown but I'm not sure that is the case for all.

Now that we're talking about it I'm going to skip right to the COVID times. I had influenza in August 2019, and a lingering ill health for over 12 months following this. My children saw me extraordinarily ill and two family friends died at the time I was sick. So COVID arrived while we were still quite raw from severe flu illness and we were naturally very wary. However we do not watch the news and didn't dwell on reports or discussion of the pandemic, but were extremely cautious in our lockdown after such devastating personal experience so recently.

During lockdown, my work, despite having ‘flexible covid hours” refused me the chance to work the extended covid hours of 5am to 10pm (normal workday within these hours), so I was attempting to work full time 9am to 5pm with two children homeschooling who needed significant supervision and assistance. They of course did not get this from me during the day, so they missed any scheduled online lessons, and I made futile attempts to homeschool at 5pm having finished work. It was a nightmare that didn’t work. But peers, the media were all saying “don’t worry, it’s the same for all of us” I now know how much of a fallacy that was. My kids were seriously dysregulated by the whole thing and the very first thing I would go back and change if I could would be the dedication I made to my work. I wish I had not. But it seemed at the time there was no other option for me. My kids needed the regularity of school and without that they needed close and intense support to access their education, which I was not able to provide. There was no support, no one from school reached out to assist, everyone assured me doing absolutely no school work for the duration of lockdown would be fine. They were wrong. They were also not psychologists and should never had made such claims.

Knowing how disruptive lockdown had been, particularly for my son, I attempted to reengage him early in the return to school, however he already displayed anxiety at this point, it was quite profound. My daughter managed to mostly attend at this point, but had many concerns.

During the period following COVID, it became obvious my two youngest were not coping as expected and over a period of time in 2021 were both diagnosed with Autism and my daughter with ADHD.

I am afraid I will run out of time and energy to write this. As I write the situation is unresolved. My son is so disillusioned he does not want to engage in school at all. My daughter wants to attend, but was told just yesterday by the Principal “*name*, you are welcome to go to your classroom” when she arrived. I remind you that my daughter has significant anxiety, ADHD and Autism and is entitled to ‘reasonable adjustments’ to enable to her access her education. Yesterday she was *offered NO ADJUSTMENT at all.* After two years, the Principal could not see fit to provide ANY support to including her on that day. We waited for over an hour for any space to be made available for my daughter, or a person to support her and none were made available (my daughter had brought her own craft and simply wanted to engage in activities in the school environment, a support which was provided in term 2 but suddenly removed in term 4).

As a parent advocating for two children with School PTSD, wishing to be participating but instead being excluded I cannot stress highly enough the following solutions are needed: (I know this isn't what was called for in the terms of reference but it is the only way I can gather my thoughts. Think of it as a list of barriers that made it harder)

Proposed changes to assist students

1. Accountability similar to Grants returns demonstrating how funding for disability has been allocated and used in individual school that is available to the public.
2. Smaller class sizes in all schools
3. Improved amenity in classrooms e.g. air-conditioning, used, refrigerators in primary school classrooms
4. School principals and deputies listening to students and parents advocating for students
5. Total removal of arbitrary, paternalistic restrictions on students self-regulating including timers.
6. Staff who are qualified and experienced in specialised areas of disability widely available. A short course in Autism is not a qualification.
7. Parents and students who are engaging in flexible plans not being excluded from freely accessing all staff normally available to students
8. Principals and deputies not promising one action and then not following through
9. An avenue for parents and students experiencing difficulty accessing their education to seek resolution that does not begin and end with the Principal.
10. Education providers need to trust that parents know their children
11. Consistent recognition that it is not the student or the parents who are failing to fit into the system, but the system is failing our young people.
12. Gender bias

13. Make inclusive adjustments not accommodations. Change the system not the individual.

I would dearly like to extrapolate on the points 8 to 13 however I can’t write further today.

Rationale

1. Accountability similar to Grants returns demonstrating how funding for disability has been allocated and used in individual school that is available to the public.

Our current school receives a significant amount of funding for my two enrolled children (some estimates suggest in excess of $60,000) due to their diagnoses as ‘verified’ by which I was not obligated to agree to, but did not readily so that school would receive more funds.

It is abundantly apparent that although this funding is received, as well as ‘regular child funding’ for normal class attendance, my children have received only a tiny fraction of the overall monies they contributed to the school’s budget. As it stands, the funding received is pooled and used to ‘generally support’ students, but this system is intrinsically flawed as there is no accountability for money to be allocated in a way that even remotely supports the children whose disability have generously provided the extra funds. I am not suggesting that individual funding is necessarily allocated to individual children, but that schools are required to make publicly available the cost of programs and supports received by ‘verified’ children and the funds received applied against their allocation in a way that is similar to existing grants funding returns.

This would provide families with some understanding of how funds are used as well as a significant amount of accountability for schools to allocate funds appropriately. It would also potentially become a useful tool in evaluating what the real cost of adjustments are compared to allocated funding, which I would hope schools would use to lobby for additional assistance for individuals who need it.

2 Smaller class sizes in all schools

Making a significant reduction in class sizes obviously has a major funding and facilities impact for educators. However keeping class sizes under 20 or even better under 18 students has been proven beneficial. Aside from all the peer reviewed research that demonstrates worldwide that smaller class sizes has a significant positive affect on educational outcomes I have also observed the following in my own children suffering from school can't / school based anxiety / school refusal.

- My children have repeatedly found themselves comfortable working in small peer groups as well as small groups of adults despite not being able to enter a classroom for over 12 months.
- It is my observation that managing behaviour in a larger class size takes up more time as the class size increases. My children's inability to attend school happily often stems from a view of negative adult management of behaviour. Smaller class sizes allow more individual and individually appropriate management of behaviour of students.

3. Improved amenity in classrooms e.g. air-conditioning, used, refrigerators in primary school classrooms

Similar to smaller class sizes, improving amenity for students makes it more comfortable, more like both a work and home environment and may produce a greater sense of well being and safety. I know that both my children have significant sensory processing issues and that attempting to obtain decent nutrition from a school lunch box is almost impossible with children who believe hot food needs to come directly from the oven/warmer/microwave and that cold food should be cold from the fridge. Also when students with heightened sensory needs are over heated in classrooms 30 degrees and over, or humid sweaty classrooms, they are entirely unable to learn under those conditions. Increasing amenity makes an improvement for all students. Again, research supports this.

4. School principals and deputies & all staff listening to students and parents advocating for students.

Use the ATP system – ask the person what they need. Then do NOT put barriers in the way of delivering it. Also just listen to students, actually hear what they say, make genuine inquiries of them if they are brave enough to speak. And listen to parents who are more than likely speaking word for word what the student has expressed to them. And keep listening, don’t assume because you listened once that you’ve now ‘heard’ any individuals issues, sometimes things change, and when they do it can be rapid and dramatic so assuming you’re familiar with circumstances is unhelpful. Again, there is everything to gain from this approach and very little to lose. Listening actually does not cost any money, it is free. No huge budget nightmare will be borne from actually listening to people and making sure you are really understanding what they are saying, not making judgements or assumptions along the way.

5. Total removal of arbitrary, paternalistic restrictions on students self-regulating including timers.

Children who need ‘time out’ or time to reset / recover are managing their bodies very real reactions to stimuli. They are attempting to regulate and to be told that they have a time limit to do so is harmful, it erodes their capacity to self-soothe (some children spend the entire length of time a timer is near them in a state of panic!). It sets an arbitrary adult boundary, quashing the child’s autonomy.

Self-regulation is something that can’t be measured or timed.

Put into words better than I can explain is this:

> The reason I think timers can be an issue is because it's putting a time length to something that doesn't necessarily take a specific length of time. For example, I don't always take the same amount of time to drink a glass of water, and if someone hurts me it doesn't always take the same amount of time to recover or feel better.
> When you put a certain time to it, you're telling the person "You should drink water for a certain amount of time" instead of "Drink to quench your thirst and to prevent dehydration". So, by the time the timer is up, you might still more water. Or you might fill up before the timer is up. Then the consequence is that the person doesn't learn to drink when they're thirsty, they learn to drink when they're told, or when they're allowed. They might not drink enough because there's not enough time. They might drink too much because the timer wasn't up yet. They might feel like they can't drink unless the timer is on. They might drink too fast because they're worried they'll run out of time. They might feel rushed or pressured. They might not figure out it works better for them to keep a water bottle with them to drink throughout the day instead of waiting to do it all at once.
> This happens with other needs too, including more abstract needs, or needs that are harder to articulate or access. Putting a timer to it is telling the person their needs aren't what really matters, that what actually matters is doing it on someone else's schedule. It doesn't teach how to recognize when you need something, or how to make sure you get as much as

you need. It can create anxiety. It can tell someone that the timer dictates what they need, or what they deserve.

6. Staff who are qualified and experienced in specialised areas of disability widely available. A short course in Autism is not a qualification.

In all the time my children have struggled they have not been able to access any allied health assistance through school. No speech pathology, no OT, no psychology / guidance officer, no autism expertise (despite regional office having an apparent expert and the availability and willingness of Autism to assist). I spoke with a senior guidance officer in regional office this week and he advised the principal has to request services of the autism expert. There are systemic barriers to accessing supports, and underfunding (apparently) of all of these areas of allied health. If schools can't support kids with high needs they need to stop making excuses and start bringing in genuine assistance so that all students can access an education.

Other notes I’ve kept for your consideration:

School said the right things, and even put some support in place for child 2. But when it came to him gradually improving his situation, and beginning to integrate back into school life they let him (and us) down. On multiple occasions, with catastrophic affects on our household. In 2021 child 1 had her ATAR adjusted by 2.5 points based on the level of disruption and anxiety caused to her directly because of child 2’s school can’t problems and especially the negative impact on his and all of our well being as a result. In 2020 child 2 was encouraged and allowed to spend all day out of class and to return home as needed. This was an excellent step back into school. He did not attend classes. The plan for 2021 was to allow him to continue to use this system while attending classes. He went to school most days for 2 weeks of term1, 2021. Then a teacher aide threatened him, told him he had to go to class in 5 minutes or leave and go home. Somehow, despite this being entirely illegal as a teacher aide has no jurisdiction to make such a request, the student services people (e.g. receptionist staff) backed up this teacher aide and told him I would have to collect him and he couldn’t stay in his safe room. Worse still, no-one at school even apologized for this, or took ownership of the error, it was literally months later that the business manager assured me that individual staff member had been advised to never approach my son (child 2) again. Months. While all this was happening, child 3 was affected by all the days off, special treatment and also her own struggles with how schools handled things. But back to the teacher aide. My son and I both felt unheard and let down by what happened but he returned to school, not to class, too much nervousness and anxiety. And a week later, the same teacher aide did exactly the same thing to him. Told him to either leave for class or leave to go home. And school still didn’t respond. The effect on child 2 was diabolical. He was entirely untrusting. Eventually in 2021 term 3 school put in place a system where the chaplain would spend 9am to 10:30am with him every morning. The chaplain volunteered his time to do this but we were not informed of that until the end of term 4. The time with chappy was so positive that child 2 started to feel more comfortable. Child1 in year 12 suggested he visit her year 12 classes during term 3 as her history teacher was known to them both out of school and her class only had about 12 students. This system worked so well that child 2 was also encouraged to visit year 11 history class with the same teacher and same room and again about 16 students. This system worked really well, however child 2 wasn't getting any engagement with education. His OT wrote to school and recommended he spent one term, term 4 2021 enrolled in the year 11 class, participating in all activities and assessment. The executive principal of the school upon receiving this, then interrupted my daughter's year 12 history class to inform the teacher that child 2 was never allowed in the year 11 class again. I frankly do not care to extrapolate on his motivations, however what he informed me was that the teacher had specifically requested my son not attend the year 11 history class. I was informed of this on the Friday of term 3 at 5pm. One thing the school do with regularity over this entire experience, with terrible consequences for our family, is they leave providing information about the following term until AFTER SCHOOL HAS CLOSED for the preceeding term. E.g. 4pm or 5pm on the last day of term I get an email explaining what the school expect my children to do on the first day of the next term. Between term 2 and term 3 2022, this technique went one step further for child 3 and school would not advise of any term 3 support or partial timetable until the term has started. Child 3 had been accessing support workers to assist her morning transitions to school, and because I did not have the information for the small company supporting her in advance, they too withdrew all supports moving forward and we lost 15 hours a week of assistance with school can't. Back to 2021 and the history situation. My son, child 2 was aware of what happened, that school refused to allow him to participate in the year 11 history (he is gifted and supposed to be extended in his curriculum anyway, but NEVER has been). Somehow despite these setback he attempted re-visiting classes. He succeeded, however upon returning into one class, was informed by a well meaning teacher that he was expected to be elsewhere. Child 2 never went back. I can't even describe more details for 2022, or for child 3. I can't work. My work don't understand, they keep referring to school drop off and pickup despite my explaining so many times that that is not my life now. Child 2 was suicidal for so long. He's come good now, I've worked incredibly hard to build his self esteem back up. He is missing out on enjoying his academic life and on being a teenager at school. He is missing out on finding his tribe. Child 3 is so isolated by all this. Recently, in October, child 3 grew enough confidence to go into a high school transition class, taking me with her. There were 3 other students in the class. In the end it took her about an hour for me to fully disengage and leave her in the class and she was then there alone happily. This is her current standard length of time acclimatizing (in a home school group recently, as well as in a 1:1 class with chaplain). The deputy for inclusion however didn't care that she was making such a huge step, she just came down and rudely told me (thankfully out of earshot of child 3) that I wasn't welcome inside the classroom. I hold a current working with children blue card. Less than a week later, the executive principal stood over myself and child 3 and announced that "other parents volunteer in classrooms, but you are not allowed to" he spoke over the top of my daughter these words at me. She has given up on attending for the rest of the year after this, even though before that she was keen to try to gradually integrate back to class. There is no way to adequately describe how broken we all are as a result of the mistakes school has made, of the gaslighting we've experienced. The broken promises of support.

My other gripe is that child 2 applied to be part of the school leadership team for 2022. He has a strong interest in helping others and interest in the well being committee. He would have been able to participate in the well being committee meetings and activities had he been included and encouraged, giving him confidence to return. Instead he was not assisted at all. And worse, he came to the ceremony for handing out the leadership certificates and badges in week 2 of term 1 2022, but was overwhelmed with anxiety and could not enter the building. He did attend school premises and met with a volunteer support person most days of term 1. They never ever gave him his badge or certificate. I have asked for it multiple times. Most recently via the regional office to the executive principal. There is one week of school remaining and no badge or certificate has arrived. It horrifies me that my children are treated with such contempt.

Child 2 my son was able to secure himself a job, but due to the extreme anxiety of school can't he could not go to the first day of work. He feels like a failure. He wanted to be a doctor and he is intelligent enough to be one. He may still become a doctor, and be a better one for this experience but it has certainly changed the path he is going to have to take to get there. I can't even begin when it comes to child 3. It has affected how I parent, how much capacity I have for parenting. Which in turn affects how both children manage with their lIves moving forward. It is a terrible situation that is very hard to resolve. Both children WANT to be at school.

I already mentioned that child 1's ATAR was adjusted a full 2.5 points based entirely on the anxiety caused to her by the disruption that school can't caused in our household. It has cost us thousands and thousands of dollars in therapy, in creating diversions and extra activities to try to support the children, and more thousands in lost income. I have no career now to speak of as my work were entirely not understanding of the situation. They were incredulous at how hard it was for us with the school. I spend so much time now supporting child 2 and child 3 in their emotional and physical needs because they have shut down and are now less independent and less capable in many ways than they were 4 years ago before this happened to us. In 2018 I had three children who used to catch the school bus at 7:45am go to school for the day, arrive back to the bus stop at 3:30pm, walk home and then I would arrive home at 4:30pm. Sometimes 5 days a week. Now I can't leave child 3 for more than a couple of hours or child 2 for more than a day. I have to spend 2 or more hours a day helping child 3 with her sleeping as she is so dysregulated. I have to constantly monitor child 2's mental well being and ensure he leaves the house sometimes. I get no sleep or rest or reprieve.

The number one thing that reduced school can't was feeling SAFE and IN CONTROL.

What has helped has been the opportunity to engage in smaller group classes, with more mature students (for child 2) and 1:1 support with staff. Being able to attend the physical premises and have an airconditioned room to just spend time outside of home but without the pressure of a classroom. Being able to participate in areas of interest, e.g. child 2 represented the school in a "Readers Cup" regional competition. What has helped both children is having the autonomy to genuinely self- regulate without arbitrary impositions such as timers. Having somewhere to quietly just 'be' and reset (which sometimes takes an entire day) without having to go home was amazing for all of us. Being able to reduce sensory stressors by being in airconditioning. Having a 'next step' ready for when they are suddenly able to step up and do more (rather than what we mostly got which was a school yelping about how they weren't ready and couldn't provide ANY support when either child was ready to increase their engagement. Being listened to! And validated. This NEVER happened from school but others in allied health and support services just listening and validating how myself and both children were feeling was a great support.

What would have helped is teachers being able to engage with either child directly supporting them in their learning. Some wonderful teachers did this off their own bat probably without the knowledge of the principal and child 2 in particular was able to complete adjusted assessments and receive good marks in subjects all without attending a single class for that subject. Having that available across all subjects, and sanctioned would have really helped him stay educated at least! After school tutoring was also good to help child 2 stay engaged without being in class, his school provided this for all students twice weekly.

Everything done to help autistic students in an inclusive way also provides improvements for the wider school community when applied across the board e.g. smaller class sizes for all; making safe spaces available for anyone experiencing school 'can't' can assist students experiencing bereavement or stress.

My son child 2 wanted to be a doctor. He had every likelihood of achieving this. Now he struggles to want to get out of bed. Damaging Autistic students creates dependence, exclusion from society and diminishes the amazing contribution autistic adults can make in society.

What has been the impact on home as well as school, and relationships as well as learning?

This question makes me want to cry. It brings me to the verge of tears and I'm actually trying to respond while not thinking about it as the feelings that come up are so strong and near the surface. You know what made the problem worse? Focusing on what was wrong with my child. Blaming them (sometimes inadvertently) by constantly examining them and their motivations and reactions with a microscope. Expecting others to 'solve' my children so they would somehow magic their way back into the classroom like freshly trained monkeys.

The whole thing is socially isolating, Everyone thinks my kids are in school, I don't know why, they just assume that after two years it has resolved, but it hasn't. Its awful for the kids when at family events, an elderly much loved relative they normally have a warm and friendly relationship with asks "and how is school going?" or even "are you excited for school to finish soon?" neither query is easy to navigate as the grown up parent, and is inadvertently shaming and difficult for a young person to manage.

Even support people get frustrated when it takes so long to resolve.

It affected my work, my workplace was not understanding, they insisted that I was 'the same' as other parents post-lockdown and refused to let me access extended covid flexible work policies on the grounds they had no work I could possibly undertake outside of 9-5 hours (a fallacy).

Even though I work for an organization that ought to be flexible, I was given no understanding, only judgement that I was not behaving correctly. While on for my son (child 2) in 2021 and I requested simply a change in hours so I could better support him while child 1 was working long hours during her school holidays I was denied. This was after being denied holiday leave for that period. My team leader said to me that “I needed to just tell my children I was working and not to disturb me” and they needed to “understand my priority was work, they are old enough not to need supervision”, demonstrating her total lack of understanding of what it is like to have a child who needs surveillance and support to ensure they don’t self-harm. With pressures like that from work I ended up so anxious myself that I entirely changed. I can no longer concentrate on complex tasks, my stamina is exhausted (also no time for self-care). I ended up taking two separate lots of extended leave from work due to my workplaces inflexibility and terrible behaviour towards me. At no point did anyone from my work actually listen to what was happening and attempt to genuinely assist. I did get many many 1000 plus word emails from my manager telling me how I was a terrible employee and ending with a tokenistic suggestion that I could contact the employee assistance service (with whom I was already in contact and they were aghast at the way I was being treated but powerless to help).

Impact on families?

Due to my kids anxiety I can’t even have a holiday. They don’t manage without me and they won’t go away overnight. My husband and adult daughter have just left for a driving holiday to to see Billy Joel in concert. A holiday I planned, for myself, but I can’t take because of the repercussions of school can’t.

My daughter’s anxiety has manifested as fear of nature and natural disasters. Can’t go to the beach, tsunamis. Can’t go up a mountain, falling off. She sees a clinical psychologist for this and it is improved but not reliably so, and we still can’t go to the beach. Just this morning she decided not only was our kitchen burning but she declared she heard ‘sparks’ and now I can’t go to work. She did not even have anxiety before COVID and certainly not before her brother’s school can’t. With her the problems with school coincided with work becoming more desk oriented and she couldn’t manage the academic style of learning. She has ADHD and Autism. So I am here typing this instead of being at work today.

Here's another example of the impact on my family. My exhaustion. I had to type all this in 14 pt font to be able to concentrate on it. I haven’t been able to proof read it. It is unfinished, but getting an extension to submit will just cause me more anxiety.

But also my economic exhaustion as well as emotional. My car has been running a bit off lately, but by my recollection was perhaps not quite due for a service, or not wildly overdue. Also the aircon stopped working. We had no spare money due to my not working and we also missed out on investment opportunities due to my not working. NB I could have remained working had my workplace implemented *its own covid policies for extended covid hours*. So I kept driving my little in the hope that we’d find some extra money to service the car after Christmas. And then Monday it stopped working altogether. Suspected blown automatic transmission – potentially up to $6000 to fix. On a single income. The impact just keeps going. Not only was there the concern of not having the money to service the car, but the practicality of ‘when do I have time now to do this?” while trying to taxi school can’t kids around to school, to alternative activities and appointments. It is exhausting.

School makes it harder.

Last example. My son applied for and was accepted as a “wellbeing leader” in his school this year – beginning of year 9 after entire year 8 unable to attend most classes due to incident of teacher aide sending him home. He dressed in uniform and tried to attend (went into school grounds but could not enter the hall) to receive his badge and his certificate. So he missed that event. I asked if these items could be given to him through the special ed area where he was attending most mornings for an hour with me. I asked multiple times. No response. I asked again in October for it to be available before the end of year and requested this via regional office in response to my making a ministerial request. No feedback. Then I made a comment on a social media post the school made about the end of year approaching and the following day his badge and certificate were available. When he received them, despite all the trauma school put him through he smiled and felt a little better about himself. Now how much more of a difference would that have made for him to receive it at the beginning of the year? He missed out on participating in all manner of well-being projects from handing out flowers on international women's day, to organising lunchtime Kahoot sessions for junior students.

The system and the people running the system are broken and they are breaking our beautiful children.

Child Death Review Board

Queensland **Family & Child** Commission

Annual Report

2022–23

A report on the operations and systemic findings of the Queensland Child Death Review Board

Queensland Government

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty understanding this document, you can contact Translating and Interpreting Service National on 13 14 50 to arrange for an interpreter to effectively explain it to you. Local call charges apply if calling within Australia; higher rates apply from mobile phones and payphones.

Contact for enquiries

For enquiries or further information about this annual report (including to receive a hard copy) please contact:

Secretariat, Queensland Child Death Review Board

Level 8, 63 George Street

PO Box 15217, Brisbane City East QLD 4002

Email: cdrb@qfcc.qld.gov.au

Website: www.cdrb.qld.gov.au/

ISSN 2653-2263 (Print)

ISSN 2653-2271 (online)

Attribution and license

Acknowledgements

The Queensland Child Death Review Board (the Board) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work.

We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

We acknowledge the important role played by Aboriginal and Torres Strait Islander communities and recognise their right to self-determination, and the need for community-led approaches to support healing and strengthen resilience.

The Board acknowledges the difficult and important work of the government agencies that are required to review the services they provided to these children. We are all committed to working together to learn from these reviews and to make the changes needed to promote the safety and wellbeing of children and help prevent future deaths.

The Board relies on the collective knowledge and contributions of government agencies and non-government organisations to inform its systemic reviews. It thanks these agencies and organisations and acknowledges their efforts in protecting Queensland children and assisting their families to care for them.

The Board also acknowledges the work of its Secretariat in analysing child death reports, gathering research, collating data, preparing reports, and coordinating meetings.

Warning

This report may cause distress for some people. If you need help or support, please contact any of these services:

Lifeline: Phone: 13 11 14

Beyond Blue: Phone: 1300 22 4636

Kids Helpline (for 5–25-year-olds): Phone: 1800 55 1800

13YARN [Thirteen YARN] for Aboriginal and Torres Strait Islander people: Phone: 13 92 76

Aboriginal and Torres Strait Islander peoples should be aware that this report contains data about deceased children and information about systemic issues facing Aboriginal and Torres Strait Islander peoples.

Child Death
Review Board
Queensland **Family & Child** Commission

Reference: TF23/714 – DOC23/3525

31 October 2023

The Honourable Yvette D'Ath MP
Attorney-General and Minister for Justice
Minister for the Prevention of Domestic and Family Violence
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 29J of the *Family and Child Commission Act 2014*, I am pleased to provide for presentation to the Parliament the 2022–23 Annual Report for the Queensland Child Death Review Board.

In 2022–23 the Child Death Review Board reviewed the deaths of 60 children. This Annual Report details the key system issues identified in those child death reviews and offers the Child Death Review Board's insights and recommendations to improve the system.

The Child Death Review Board has focused on opportunities to strengthen service delivery in the areas of safeguarding children registered for home education, youth justice, improving responses to the needs of First Nations communities, creating safety for children of parents with problematic alcohol and drug use and increasing visibility of children and young people in the context of coercion and parental deception.

We also include our monitoring of the 16 recommendations made in the prior two years.

Yours sincerely

Luke Twyford
Chairperson
Child Death Review Board

Table of contents

Message from the Chair

All Queensland children should be loved, respected and have their rights upheld. Each year, too many children known to the child protection system die or suffer serious physical injuries.

The loss of any child has long-lasting impacts on family, friends, communities and the professionals who provided support to the child and their family. The Queensland Child Death Review Board (the Board) seeks to honour the lives of children and young people by ensuring that we conduct respectful reviews aimed at preventing future loss of life.

This year, the Board has reviewed the cases of 60 deceased children. From the lives of these 60 young Queenslanders, we have considered the ways in which government services and the community interacted with the young person and their family.

Within this report we have outlined the lives of the young people whose cases we have reviewed. While the Board has seen many examples of great practice which held at its core the safety, wellbeing and voice of children, young people and their families, some opportunities for system improvement stood out. From our review and discussions, the Board has identified five areas where it believes that more action is needed. These are set out in this report and cover the issues of:

- assessing the safety of children who are registered for home education
- reappraising the response to youth crime and the purpose of youth justice
- improving research on the needs of First Nations communities
- strengthening child safety practice in response to parental substance and methamphetamine use
- increasing system visibility of children and young people in the context of coercion and parental deception.

I am hopeful that the delivery of this report, with the details of the cases across these five areas leads to internal consternation and action within and across Government.

This is the third Annual Report of the Child Death Review Board. It represents the last for several Non-government Board members who are appointed to three-year-terms. I would like to specifically thank Deputy Chair Professor Jody Currie and members Bruce Morcombe, Professor Jeanine Young, Margie Kruger and Shanna Quinn for the time they served on the Board. Reviewing the case details of child deaths is not something that can be done lightly and each of these members made profound and significant contributions during their time on the Board. I also thank the government representatives and the Board's staff for their ongoing role in reviewing child deaths to identify opportunities for continuous improvement in systems, legislation, policies and practices.

Yours sincerely

Luke Twyford
Chairperson
Child Death Review Board

Introduction

The Child Death Review Board (the Board) is responsible for conducting system reviews following the death of a child known to the child protection system. The Board undertakes reviews to identify opportunities for system improvements and to make recommendations about the changes needed to keep children safe.

The Board was established on 1 July 2020 and has the power to make and monitor recommendations and publicly report on the outcomes of child death reviews.

Queensland's child death review process is two-tiered. Government agencies that were involved with a child in the 12 months prior to their death undertake an internal agency review of their service delivery to the child. These reviews are provided to the Board for its consideration and to inform its recommendations about whole of system improvement and child death prevention.

This report has been prepared under section 29J of the *Family and Child Commission Act 2014*. It describes the work of the Board in 2022–23 in carrying out its reviews and other functions under Part 3A of the *Family and Child Commission Act 2014* and the Board's *Procedural Guidelines*.

① **Chapter 1** provides an overview of key characteristics of the 60 children and young people reviewed in the reporting period. It looks at the causes of death of the children, basic demographics and cultural status.

Chapters 2 to 6 discuss the key themes and service system issues identified by the Board in 2022–23. These chapters also share relevant case studies and research projects that were undertaken by the Board, and the recommendations the Board made for the reporting period. The key themes and service system issues explored in this report are:

② Assessing the safety of children who are registered for home education.

③ Reappraising the response to youth crime and the purpose of youth justice.

④ Improving research on the needs of First Nations communities.

⑤ Strengthening child safety practice in response to parental substance and methamphetamine use.

⑥ Increasing system visibility of children and young people in the context of coercion and parental deception.

⑦ **Chapter 7** revisits the recommendations that were made in the previous two annual reports and provides an update on the implementation of these recommendations. The chapter presents a summary of key actions, practice reform and changes that the responsible agencies have reported for the years 2020–21 and 2021–22.

⑧ **Chapter 8** considers issues relating to the governance of the Board.

Chapter 1

Cases reviewed by the Board in 2022–23

Cases reviewed by the Board in 2022–23

In 2022–23 the Board received a total of 72 notices of child deaths known to the child protection system and completed reviews of 60 cases. To complete these 60 reviews, the Board assessed 197 agency reviews.

Completing the review of 60 cases is an increase of five cases compared to the 2020–21 and 2021–22 years when 55 cases were reviewed. The increase in cases reviewed by the Board reflects an increase in the total number of child deaths known to the child protection system during the same reporting period.[1,2]

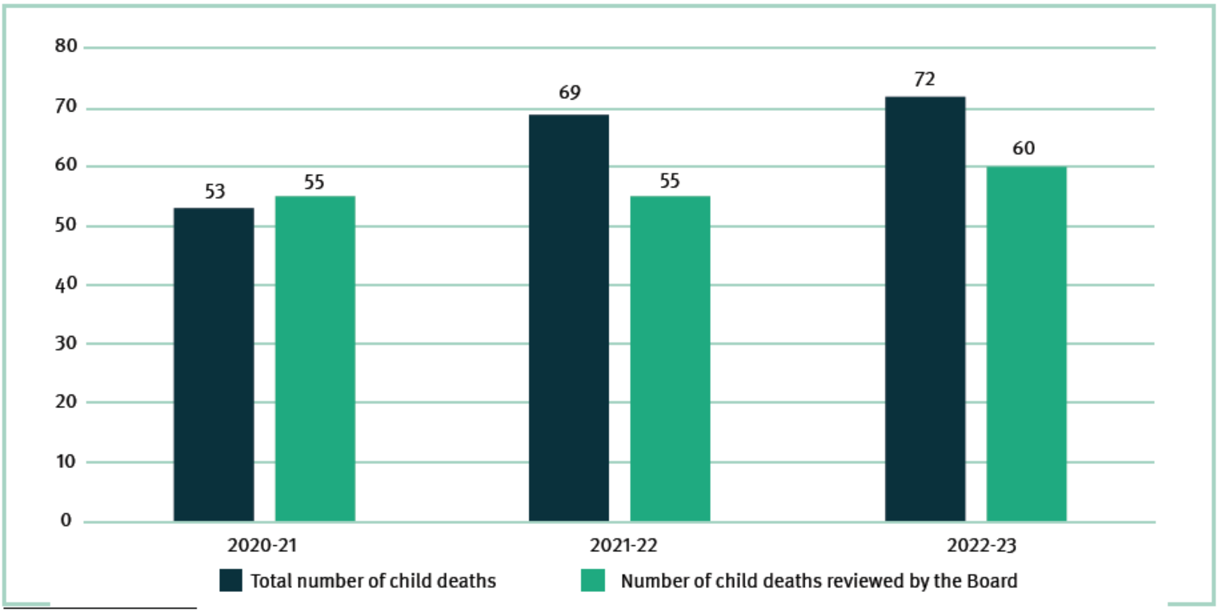
In the financial year 2022–23, 72 children died who had been known to the child protection system in the 12 months prior to their deaths. This is the second year that the Board has not reviewed as many cases as it has received. Consequently, there are 68 cases awaiting review by the Board. Ideally, it takes less than 12 months to review a case (reflecting the legislated six month period for agencies to review their own service delivery, and a further six months for the Board to review the agency findings and identify broader system issues).

After the Board receives all agency review reports and supporting information for a case, a three-tier categorisation framework is utilised to determine the terms of reference and depth of analysis required for each review.[3]

The categorisation framework is based on the extent to which systemic learnings and opportunities can be identified from a case, with those categorised to a Level 3 presenting the most significant opportunities for improvements and requiring in-depth review by the Board. Level 2 reviews are primarily focused on practice improvements, where agencies might have correctly identified areas of improvement in their own reviews. Level 1 cases contain minimal opportunities for learning or child death prevention mechanisms. Cases across all three levels of reviews are monitored to identify recurring issues and trends.

To improve its efficiency and impact, in 2022–23 the Board agreed that matters may be included in a themed collective review. This means that when deemed appropriate by the Chair, matters will be grouped into similar themes and considered together to highlight opportunities for system improvement and child death prevention. This can lead to further collaboration with subject matter experts and ongoing information exchange to support the making and monitoring of recommendations.

Graph 1: Number of child deaths known to the Queensland child protection system and reviewed by the Board by year, 2020–21 to 2022–23[4]



---

[1] The Queensland Family and Child Commission (QFCC) 2023, *Annual Report: Deaths of children and young people 2022–23*.

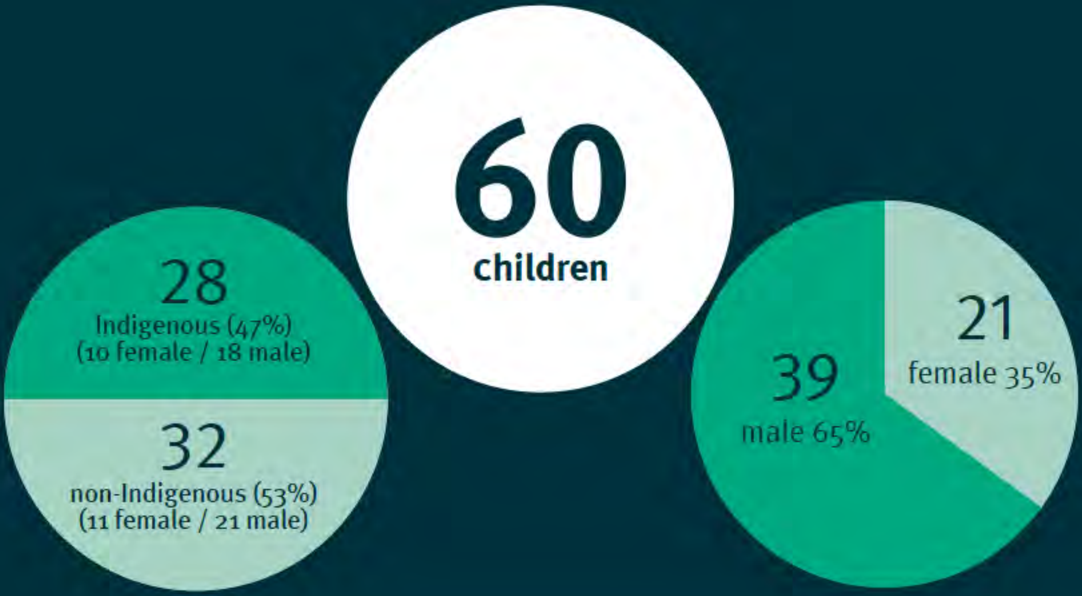
[2] Seventy-two child deaths were known to the child protection system in the 2022–23 reporting period.

[3] For further information, see the *Child Death Review Board Procedural Guidelines*, https://www.cdrb.qld.gov.au/wp-content/uploads/2023/09/Procedural-Guidelines-version-1.4-August-2023.pdf for accessibility

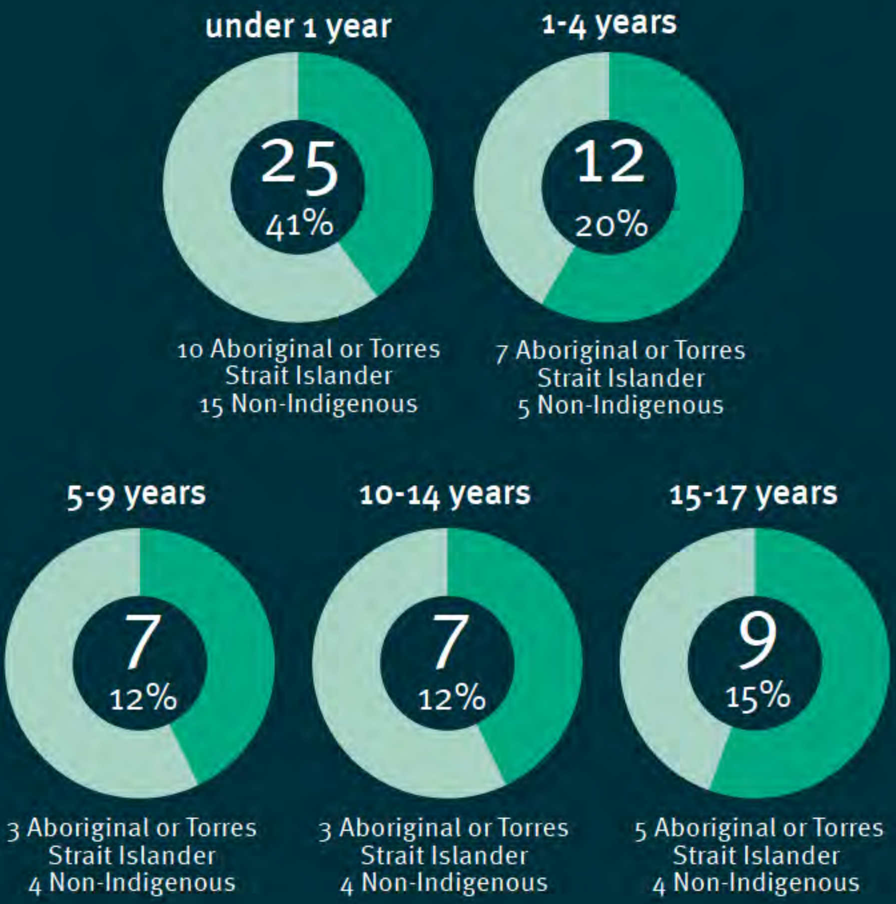
[4] In its first year of operation, the Board reviewed two additional cases that had previously been reviewed by the former Child Death Review Panel, due to new information becoming known.

Demographics

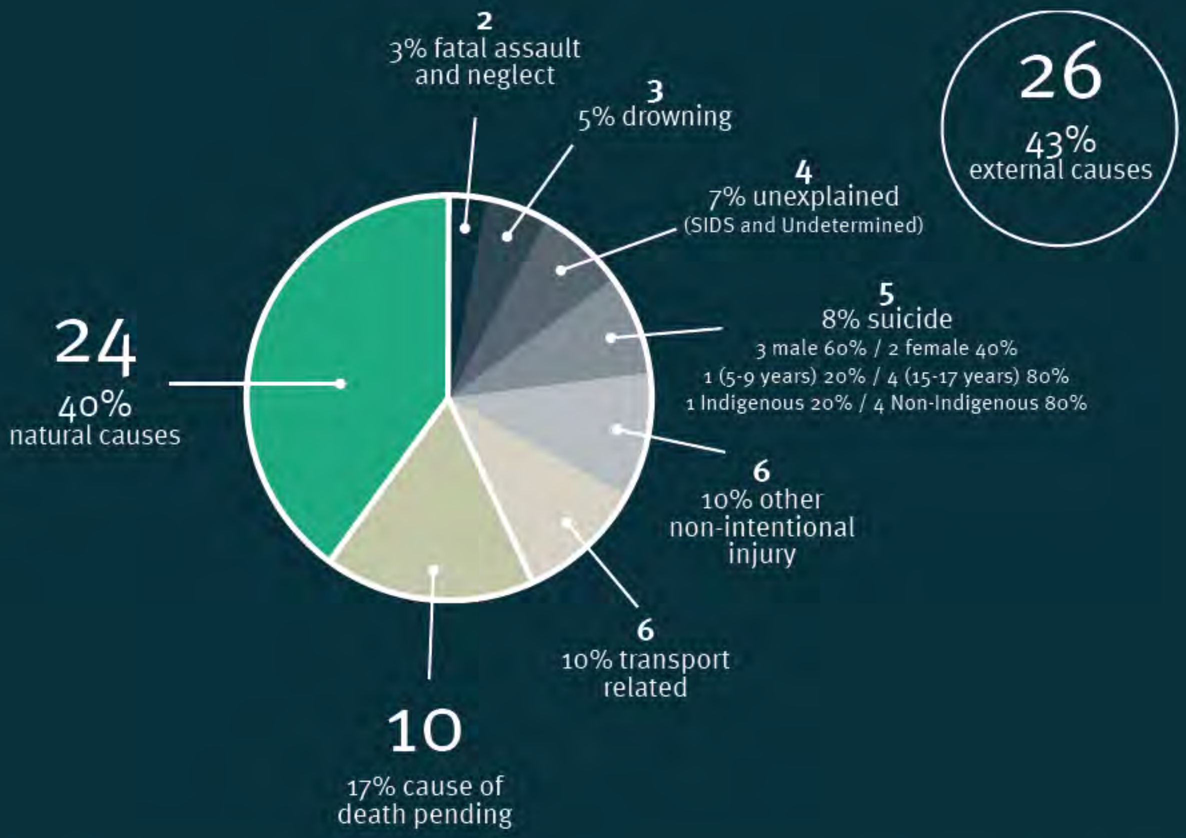
In 2022-23, the Board considered the deaths of



The number of deaths reviewed in each age group



Category of deaths reviewed by the Board



Sudden Unexpected Death in Infancy[5]

11 (18%) deaths fell within the SUDI research classification (**4** Aboriginal or Torres Strait Islander / **7** Non-Indigenous)

Care circumstances

49 (82%) were living with family or friends or independently at the time of their death
10 (16%) were in foster or kinship care or on a permanent guardianship order[6]
1 (2%) was in residential care

Agency reviews considered by the Board (197)

60 The Department of Child Safety, Seniors and Disability Services (Child Safety)
95 Queensland Health[7]
18 The Department of Education (Education)
12 The Queensland Police Service
6 The Department of Youth Justice, Employment, Small Business and Training (Youth Justice)
6 The Director of Child Protection Litigation (DCPL)

Case Review Classification

Level 1 **28** (47%)
Level 2 **17** (28%)
Level 3 **15** (25%)

---

[5] This is a research classification rather than a cause of death where an infant dies suddenly, usually during their sleep, and with no immediate obvious cause.

[6] One child was in hospital at the time of their death with a plan to place them with approved foster or kin carers upon discharge.

[7] The higher number of review reports from Queensland Health (compared to the number of child deaths) is reflective of multiple Hospital and Health Services undertaking reviews for some children.

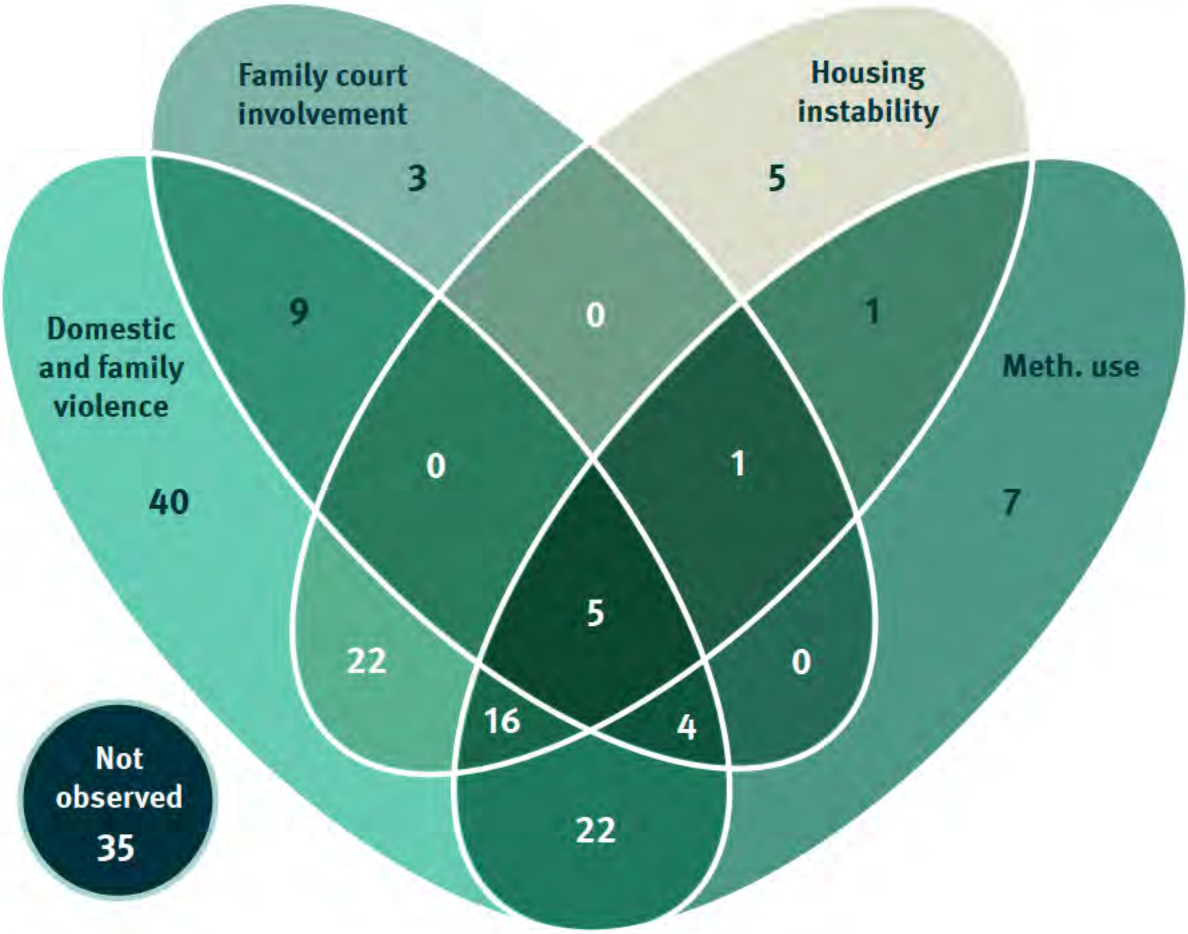


Figure 2: Characteristics from the Board case reviews for the period 1 July 2020 to 30 June 2023.

Case Characteristics 2020-23

Since its inception in July 2020, the Board has recorded the number of cases where select characteristics were noted by the Board. Four characteristics were recorded across a total of 170 cases: family court involvement, presence of domestic and family violence, methamphetamine use and housing instability.[8]

Characteristics	Cases	Per cent
Family court involvement	22	12.94%
DFV presence	118	69.41%
Methamphetamine use	56	32.94%
Housing instability	50	29.41%

Table 1: Characteristics from the Board case reviews for the period 1 July 2020 to 30 June 2023.

This reporting shows the high prevalence of domestic and family violence across cases, and the co-occurrence of multiple safety risks in the families within the Board's remit.

---

[8] For the purposes of this report, housing instability includes homelessness (sleeping rough and couch surfing), multiple families sharing a single dwelling for non-cultural reasons, financial insecurity regarding housing costs, and incidents where women were left without stable accommodation in the context of domestic and family violence.

Summary of recommendations

Recommendation 1

Assessing the safety of children who are registered for home education

The Board recommends the Department of Education:

1.1 Initiate a regular process of data sharing with the Queensland Police Service and the Department of Child Safety, Seniors and Disability Services to identify home-schooling students who may benefit from in-school support services.

1.2 Pursues legislative changes to strengthen oversight of children registered for home education in Queensland, with a focus on upholding the child's rights, best interests, safety and wellbeing at all stages of a child's home education.

Recommendation 2

Reappraising the response to youth crime and the purpose of youth justice

The Board recommends the Department of Youth Justice, Employment, Small Business and Training:

2.1 Takes immediate action to articulate Queensland's Detention Operating Model, and Government commits to publishing this model.

2.2 Produce a workforce strategy for Queensland youth detention centres for immediate effect, and for inclusion into the Detention Operating Model for Queensland's new detention centres.

Recommendation 3

Reappraising the response to youth crime and the purpose of youth justice

The Board recommends the Queensland Government:

3.1 Immediately fund and introduce improved reporting on youth detainees time out of cells (in alignment with the Report on Government Services reporting that already occurs for adults) and agree to champion this measure for inclusion in nationally consistent reporting with other jurisdictions.

3.2 Commission the Board to utilise its review process to review a sample of cases of young people on the Serious Repeat Offender Index and advise Government on the common system issues and opportunities to prevent and reduce reoffending for young people in this cohort.

Recommendation 4

Improving research on the needs of First Nations communities

The Board recommends the Queensland Government strengthens its policies and commits to ensuring that research seeking to understand the needs of First Nations families is designed, procured, coordinated and conducted involving First Nations professionals.

Recommendation 5

Strengthening child safety practice in response to parental substance and methamphetamine use

The Board recommends the Queensland Government invests in a practice guide that will support frontline practitioners in their risk assessments of children whose parents' substance use is problematic. This practice guide should cover:

- clear definitions of the thresholds for intervention types
- a framework of identifiable markers of risks
- the safety planning mechanisms and wraparound services that must be implemented to ensure a child's safety.

Recommendation 6

Assisting workers to recognise and respond to parental deception

The Board recommends the Queensland Government invest in measures to help frontline practitioners across agencies identify and respond to attempts at parental deception in the context of domestic and family violence (the frontline practitioners involved should include child protection, health services, education, law enforcement, courts staff and secondary services).

Chapter 2

Assessing the safety of children who are registered for home education

Assessing the safety of children who are registered for home education

Home education in Queensland

Under the *Education (General Provisions) Act 2006*, home education is a legally recognised alternative to school enrolment in Queensland.

In 2022–23, the Board considered the case of a child who was homeschooled. This young person was diagnosed with multiple mental health conditions and had a history of suicidal ideation and self-harm.

The young person was a client of Child and Youth Mental Health Services (CYMHS) and presented as highly anxious, scared and suicidal during a home visit by CYMHS. The young person's living environment was considered unhygienic and there were worries their basic care needs were not being met. The young person was subsequently admitted to an adolescent mental health unit in hospital, where they remained for three weeks, and Child Safety was notified of concerns about the young person's living situation and the impact on their health, functioning, mental health, and sense of connectedness to others. The young person's case was referred to the Suspected Child Abuse and Neglect (SCAN) team.[9]

While in hospital, the young person expressed to a school Guidance Officer that they felt worried about their missing out on education and wished to return to school. They reported feeling socially isolated and not being actively engaged in their home education program during the six months prior to their death. The young person was referred to the Department of Education's Youth Engagement Service for further support to re-engage with schooling or an alternative education program.

After the young person was discharged from hospital, there were further suicide attempts and the young person died two weeks later. Child Safety had not yet commenced an Investigation and Assessment of the child protection concerns and the Department of Education's Youth Engagement Service had not yet been initiated at the time of the young person's death.

The young person's experiences led the Board to consider the regulatory oversight of, and support for, children registered for home education in Queensland.

---

[9] The purpose of the SCAN team system is to enable a coordinated response to the protection needs of children. See: https://cspm.csyw.qld.gov.au/procedures/investigate-and-assess/consider-a-suspected-child-abuse-and-neglect-team

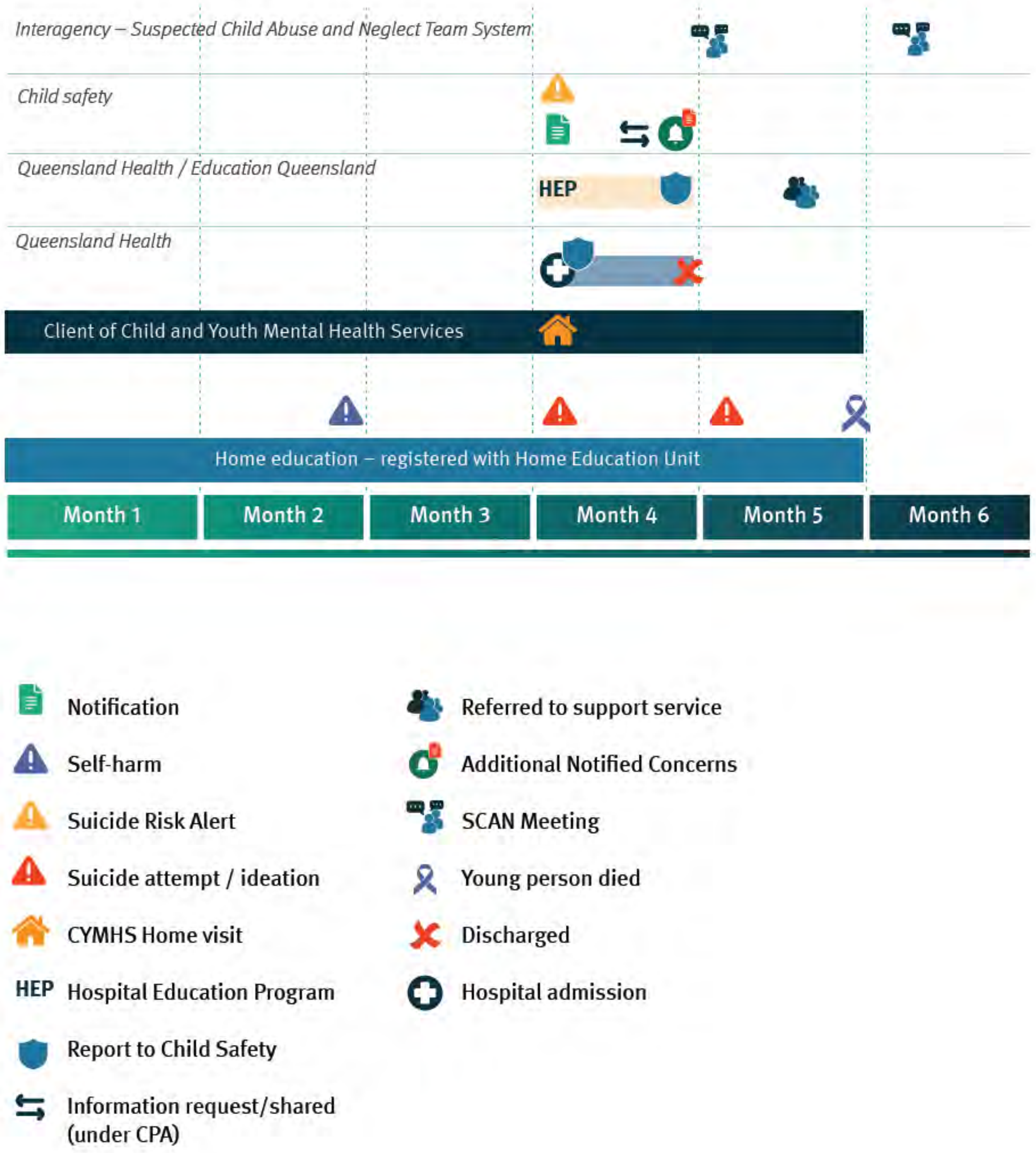
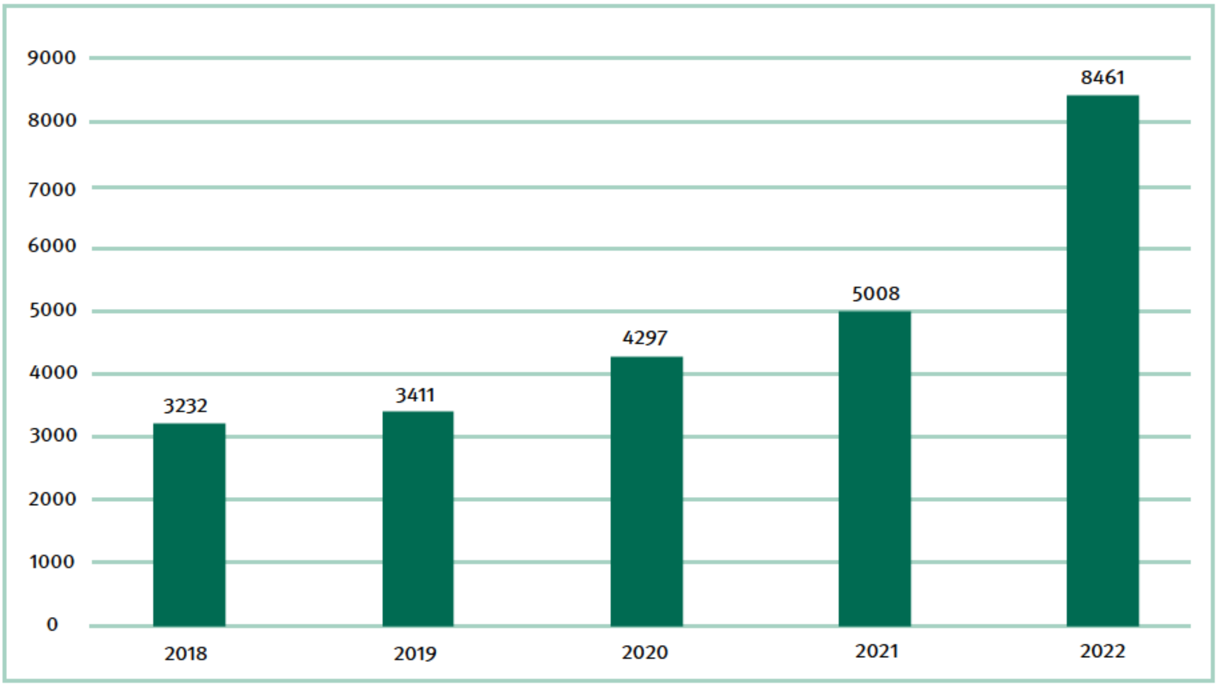


Figure 3: Timeline of system touchpoints for the Young Person

The growth of home education

In recent years, home education has become an increasingly popular option for learning in Queensland. As of 5 August 2022, 8,461 students were registered for home education in Queensland, an increase of 69% from the 5,008 students registered in 2021 (see Graph 2). By comparison, only 722 students were registered for home education in Queensland in 2011.



Graph 2: Students registered for home education 2018—2022 in Queensland

The Department of Education will publicly release the August 2023 census data for home education registrations in late 2023. The Board has been informed that home education registrations in 2023 are likely to have continued on a growth trajectory.

Home education application process

In Queensland, a parent must apply for and be granted registration to educate their child at home.

The registration process consists of documentation submission and review. Applications for registration must provide a summary of the educational program to be used or learning philosophy to be followed. The application must satisfy the Home Education Unit that the home-educated child will receive a high-quality education.[10] The guiding principles for assessment of a high-quality education are detailed as follows:

Standard conditions of registration for home education in Queensland

The education program should show evidence of a high-quality education that:

- is responsive to the changing needs of the child as indicated by the short and long term educational and personal goals
- has regard to the age, ability, aptitude and development of the child concerned
- is conducted in an environment conducive to learning
- is responsive to the child's need for social development
- utilises suitable and relevant teaching strategies to deliver the educational program to the child
- engages the child in a range of rich and varied learning experiences
- is supported by sufficient and appropriate resources; and
- uses strategies for monitoring educational progress.

If the Chief Executive is satisfied the standard conditions of registration will be complied with, registration is granted and a certificate of registration and notice is issued to the parent.[11]

---

[10] Department of Education 2020, *Home education in Queensland procedure*. Accessed 14 December 2022. https://ppr.qed.qld.gov.au/attachment/home-education-in-queensland-procedure.pdf

[11] Ibid.

Once a child is registered for home education in Queensland, the parent is legally responsible for providing the child with a high-quality education. Compliance with the standard conditions of registration is monitored via an annual self-report of the child's educational progress. If the parent does not report as required or if the chief executive is not satisfied with the educational progress of the child, a show cause notice is issued to the parent to demonstrate within 30 days why the registration should not be cancelled.[12]

Home education regulation in other Australian states and territories

The Board compared the regulatory frameworks for home education across Australia (see summary at Table 2). It considered Queensland's regulatory powers to be more limited than most. Most notably, Queensland does not have the ability to undertake home visits or to request contact with a child where there may be concerns about a parent meeting the child's educational needs. Home Education Unit staff do not sight or speak to the child being registered for home education, nor do they visit the residence where education will usually take place. Moreover, there is no legislated requirement to speak to the parent or registered teacher who will be undertaking home education.

The regulatory frameworks in some other states appear to enable a more robust assessment of registrations and a child's educational progress, while also giving more explicit attention to the registered child's rights, best interests, and wellbeing. For example:

- South Australia's regulatory body may consult with the Department for Child Protection and other agencies/professionals about a home education application. The information obtained may determine that home education is not in the child's best interest and therefore a home education exemption may be refused or revoked on these grounds.[13]
- In South Australia, the Principal of the child's most recent school is notified of the intention to home educate a child and invited to provide relevant information to support the assessment of an exemption for home education.[14]
- In Victoria, there is explicit consideration of the child's rights: *When assessing your application, we consider all the relevant rights of the child. This is done in accordance with Victoria's Charter of Human Rights and Responsibilities.*[15]
- In Western Australia, Home Education Moderators may request to meet the child as it is reasonably necessary to enable them to evaluate the home education program and the child's educational progress.[16]
- In New South Wales, Authorised Persons conduct a home visit to review the current and/or proposed educational program for the child. Authorised Persons are mandatory reporters. Mandatory reporters have a legislated obligation to report to Family and Community Services if they have reasonable grounds to suspect that a child is at risk of significant harm.[17]

As a result of its review of other jurisdictions, the Board wrote to the Director-General of Education advising of concerns about the apparent lack of powers and oversight in Queensland's jurisdiction. This included the inability to undertake home visits, to sight or speak to the child registered for home education, or to engage with child protection authorities and previous schools to assess suitability for home education.

To explore this issue further, the Board requested that the Queensland Family and Child Commission (QFCC) lead a system review into the regulation of home education in high-risk home environments in Queensland. This project seeks to *work with agencies to match data to identify the number of children in home education living in high-risk home environments (including those with concerning child protection and domestic and family violence histories).*[18] The QFCC is now working with the Department of Education to develop a cross-agency reference group to collect and link this data. The Department of Child Safety, Seniors and Disability Services and the Queensland Police Service are partners in this project. Information about this review has been included in the QFCC 2023–24 Oversight Forward Workplan.[19]

---

[12] Ibid.

[13] Government of South Australia, Department for Education 2023, *Guide to Home Education in South Australia: Information for families considering applying for exemption from school attendance*, 6. https://www.education.sa.gov.au/sites/default/files/guide-to-home-education-in-south-australia.pdf

[14] Ibid., 21.

[15] Victorian Registration and Qualifications Authority 2022, *Registering for home education.* Accessed 14 December 2022. https://www.vrqa.vic.gov.au/home/Pages/hsregister.aspx

[16] Government of Western Australia, Department of Education 2020, *Home Education Procedures*. Accessed 14 December 2022. https://www.education.wa.edu.au/web/policies/-/home-education-procedures

[17] New South Wales Government 2019, *Registration for Home Schooling: Authorised Persons Handbook*, 10. Accessed 14 December 2022. https://educationstandards.nsw.edu.au/wps/wcm/connect/460a8280-ff57-402f-89e1-3835adabb891/authorised-persons-handbook.pdf?MOD=AJPERES&CVID=

[18] Taken from an unpublished QFCC Terms of Reference document provided to the Board.

[19] See QFCC 2023-2024 *Oversight Forward Workplan*. https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/oversight

State or Territory	Regulatory body	Legislation	Registration process	Child sighted	Home visits
QLD	Department of Education – Home Education Unit	*Education (General Provisions) Act 2006*	Documentation review only	No	No
NSW	NSW Education Standards Authority	*Education Act 1990*	Documentation review and home visit	Yes	Yes
VIC	Victorian Registration and Qualifications Authority	*Education and Training Reform Act 2006*	Documentation review only	No	Possible
WA	Department of Education – Home Education Moderators	*School Education Act 1999*	Documentation review and home visit	Yes	Yes
SA	Department of Education – Home Education Unit	*Education and Children's Services Act 2019*	Documentation review and home visit	Yes	Yes
TAS	Office of the Education Registrar	*Education Act 2016*	Documentation review and registration visit	Yes	Possible
NT	Department of Education	*Education Act 2015*	Documentation review only	No	Possible
ACT	ACT Government – Home Education Team	*Education Act 2004*	Documentation review and video conference	No	No

Table 2: Comparison on home education regulatory frameworks across Australian states and territories

Actions taken by the Department of Education

The Department of Education has also advised that it has recently undertaken a review of the *Education (General Provisions) Act 2006*. This has included a re-examination of the provisions relating to home education. Key issues raised through this review related to opportunities to enhance the regulation of home education and streamline aspects of the home education registration process. The outcomes of this review are yet to be made public.

In 2022, the Department of Education commissioned research to better understand the factors that influence a family's decision to home educate their child/ren. The research, involving 565 parents or guardians registered (or previously registered) for home education in Queensland, found the following factors were key:

- a belief that home education provides a better learning environment for their child/ren
- the ability to provide more personal, flexible and individual learning at the child's pace
- educational philosophy, faith or personal beliefs of the parent
- the ability to better support a child's health or disability needs
- concerns about negative influences on the child or bullying
- COVID-19 related issues, including worries about transmission or alternatively a positive experience during lockdowns/isolation.[20]

Two thirds of the parents or guardians advised in the survey the children they were educating at home had a disability or health issue. Most commonly, these were children who were neurodivergent (e.g., Autism, Attention Deficit Hyperactivity Disorder), or had social emotional or behavioural difficulties, learning disabilities or mental health issues.

Wellbeing supports for children registered for home education

School-based learning environments afford children a level of informal monitoring, social connection, and access to wellbeing support. For children enrolled in state schools, the Department of Education's *Supporting students' mental health and wellbeing* procedure outlines specific responsibilities for school staff, guidance officers and principals. This includes:

- building staff capability to support the mental health and social and emotional wellbeing of all students
- building capacity for mental health promotion and intervention by linking with local agencies and health providers–including key local specialist mental health services such as the Child and Youth Mental Health Service (CYMHS) and headspace centre
- ensuring schools have clear processes for referring children to internal and external supports
- ensuring school prevention and postvention response plans are developed and available.

---

[20] Department of Education 2022, *Home Education Unit: Parent with child/ren registered for home education research insight report.* Accessed 28 September 2023. https://education.qld.gov.au/schools-and-educators/other-education/Documents/research-insight-report.pdf

State and non-state schools can also engage Ed-LinQ[21] to facilitate early access to mental health advice.

The risk and benefit of school attendance was further demonstrated by research the QFCC undertook in a small sample review of commonalities in child and family trajectories of cases considered by the Board, *Lessons from the life-story timelines of 30 Queensland children who have died*. The review highlighted the protective factors that engagement in education can bring to the lives of children and young people, and conversely, that school disengagement often coincided with children and young people's display of increasingly complex behaviours.[22]

The QFCC report found that *all school-aged children who died by suicide had disengaged from education and learning; children were either totally absent from school or were attending for administrative supports only* and that *disengagement from school can lead to a breakdown of social connections and create barriers to accessing additional supports to manage health and wellbeing. Of the eight school aged children in this sample who died by suicide, five children died within 12 months of disengagement from school.*

The high rates of suicide within the school aged, disengaged cohort reflects the need for robust mental health and wellbeing supports to be integrated when risk of school disengagement is first identified.

Children registered for home education are completely reliant on their parents or caregivers for their educative, social, health and wellbeing needs. While most children who are home educated will have these needs met, there is a risk that others become invisible to society and their needs go unmet.

In consulting with Government departments on the proposed recommendation, the Board was advised that this issue is also significant for children who are enrolled in schools of distance education, noting that enrolments in distance education are also increasing at a significant rate. Children who participate in distance education are also isolated from protective factors that attendance at a physical school can provide. While these students do have periodic access to a teacher virtually, there is a potential for these students to be exposed to similar risks as their peers in home education.

Concluding comments

The number and rate of children registered for home education in Queensland continues to rise. These children require oversight mechanisms to ensure their safety, including social development and overall wellbeing, are protected.

The Board holds concern that:

- the existing regulatory system for home education in Queensland lacks necessary rigour, powers, and accountability in relation to registration processes to ensure that a child's educative, social, health and wellbeing needs are considered, monitored, and upheld throughout the course of their home education
- there is currently an absence of the child's views and wishes captured and considered throughout a child's home education registration
- there is a lack of visibility of the children registered for home education. For example, there is no legislative requirement to conduct regular home visits or hold discussions with children or parents/educators.

Recommendation 1

Assessing the safety of children who are registered for home education

The Department of Education:

1.1 initiate a regular process of data sharing with the Queensland Police Service and the Department of Child Safety, Seniors and Disability Services to identify home-schooling students who may benefit from in-school support services; and

1.2 pursues legislative changes to strengthen oversight of children registered for home education in Queensland, with a focus on upholding the child's rights, best interests, safety and wellbeing at all stages of a child's home education.

---

[21] The Ed-LinQ Program was established in 2009 to improve linkages and service integration between the education sector (Department of Education, Catholic Education, and Independent Schools), primary care, community and mental health sectors to support the early detection and collaborative care of school-aged children and young people at risk of – or experiencing – mental health problems or mental illness. See https://www.childrens.health.qld.gov.au/service-statewide-ed-linq-program/

[22] The QFCC 2023, *Lessons from the life-story timelines of 30 Queensland children who have died: A small sample review of commonalities in child and family trajectories considered at the Child Death Review Board*. Accessed 28 September. https://www.qfcc.qld.gov.au/sector/monitoring-and-reviewing-systems/lessons-from-life-story-timelines-of-30-children-who-have-died

Chapter 3

Reappraising the response to youth crime and the purpose of youth justice

Reappraising the response to youth crime and the purpose of youth justice

Over the 2022–23 period, the Board discussed the deaths of six young people who were known to both the child protection and youth justice systems. All six were boys, and four were Indigenous Australians.

Two of these cases drew the Board's attention to an in-depth exploration of the youth justice system. One boy identified as Aboriginal, and the other as Aboriginal and Torres Strait Islander. The boys had extensive contact with Youth Justice, which included periods of time spent in youth detention. The stories of these boys are set out below to bring awareness of the circumstances of some of the young people who are known to the Queensland youth justice system.

Common circumstances in life of the two boys involved in Youth Justice

The stories of these two boys feature experiences of in-utero exposure to violence, alcohol and illicit substances, chronic child abuse and neglect, periods in care, and separations and disconnection from family. Furthermore, the boys had poor educational engagement, attainment, and subsequently left school early; they experienced cognitive and language impairments (unrecognised until adolescence), mental illness, substance use, associations and friendships with antisocial (and highly visible) peer groups, ongoing contact with police from an early age, criminal offending, and periods in detention.

Both boys, though not related, shared similar challenges and trajectories in their short lives. Both were the second child born to young mothers (first child born at 16 and 17 years) and were exposed to substances in-utero. Both were raised by extended family members under family arrangements, as their mothers were unable to meet their care and protection needs. This was due to concerns which included exposure to domestic and family violence, problematic substance use, criminal offending, and mental health issues. Their fathers were absent from their lives. Consequently, Child Safety had significant involvement in the lives of both boys. However, there was no ongoing intervention because they were in the care of kin.

Their families found it hard to manage these behaviours and as a result both boys experienced instability as they moved between family members. One was returned to the care of his mother at age 11 for the first time since being an infant, and the other was moved between his cultural mother and cultural aunts (and possibly cultural grandmother) across towns with significant distance across Queensland. Despite these challenges, the records do not show evidence of support being provided to the extended families to help with the care of either child.

Themes of parental rejection and disconnection from family and culture were significant for both boys. For one boy, his paternal family had chosen not to have any contact with him and the records state that he felt rejected because of this. As he identified as Indigenous on his paternal side, this formed a barrier for connecting with his cultural identity. He also experienced rejection by his mother, who in the weeks prior to his death had relinquished her care of him and blamed him for the problems in the family. The other boy equally had a mostly absent relationship with his mother, while his father had chosen not to be involved in his life at all. As an adolescent, the boy disclosed that his transient childhood resulted in him feeling disconnected.

Against this shared background of complex trauma, abuse and neglect, family dysfunction, disrupted attachments, parental rejection, and disconnection, both boys sought to find connection and meaning through peer groups who carried with them a negative influence, contributing to their entry into the youth justice system and detention.

In early adolescence, both boys began displaying more challenging and complex behaviours. This included criminal offending (property, stealing and motor vehicle offences), anti-social and dysregulated behaviours, disengagement from school, substance use (alcohol, illicit drugs, and chroming), self-harm and suicidal behaviours. These behaviours brought both to the attention of Police and Youth Justice, ultimately resulting in significant periods in detention.

Despite the youth justice system existing to try and help young people address the disadvantage and circumstances that contribute to offending, the system appeared ineffective at achieving improvements in safety and wellbeing for either boy. Arguably, their experiences in detention served to cause further trauma, disconnection, and hopelessness.

Boy 1

One boy became known to Police and Youth Justice at the age of 11 due to property-related, theft, and fraud offences. His offending behaviours continued until his death, leading to eight separate periods of detention and multiple youth justice orders. This boy had a history of suicidal ideation, self-harming, and suicidal behaviours. Between 2017 and 2020, there were nine Suicide Risk Alerts.

The boy's engagement with education during this period was sporadic, with some limited attendance. His enrolment ultimately ended due to his threatening behaviours and periods in custody. He was enrolled with schooling while in the detention centre, but his engagement was interrupted by the significant periods of separation.

The boy disclosed regular substance use in the community, which included alcohol, cannabis, MDMA and methamphetamines. Attempts were made to refer him to the Adolescent Forensic Mental Health Service for support around his substance use; however, he declined the referral.

In the year before he died, this boy's offending and high-risk behaviours continued. Despite curfews and the conditions of multiple statutory youth justice orders, he was frequently identified by Police engaging in anti-social and criminal behaviours, and was the subject of 25 court appearances, resulting in four separate periods in youth detention. He spent a total of nine nights in Police watchhouses and 128 nights in detention during the year of his death.

Boy 2

This boy's household consisted mainly of family members who are known to Youth Justice and Queensland Police, and records indicate he "...was unable to identify any family members or peers that may have a positive impact on him". At age 13, he disengaged from school and had his first contact with the youth justice system for minor offending behaviour. During this time the boy was sexually assaulted in a public place on more than one occasion. Both his offending and substance-use (including methamphetamine use) significantly increased at this time. From this point he demonstrated an escalation in anti-social behaviour, resulting in regular contact with Youth Justice. This included episodes of community-based supervision, and four admissions to youth detention. His charges included stealing, fraud, receiving stolen property, unlawful use of motor vehicles, possession of a knife in a public place, entering premises with intent, and dangerous driving. There are reports he made several suicide attempts around this time also.

While in detention, Boy 2 was verified as having a mild intellectual disability, a moderate to severe delay in receptive language and a mild delay in expressive language. Due to demonstrated impulsivity and attention difficulties, he was suspected to have attention deficit hyperactivity disorder (ADHD). He was not formally diagnosed, and he was unwilling to engage in an assessment for a NDIS referral.

Boy 2 disclosed he engaged in alcohol use, sniffing/chroming, cannabis, and methamphetamine use prior to entering detention. He declined ongoing support to help him manage his substance use, identifying he intended to return to substance use upon his release from detention.

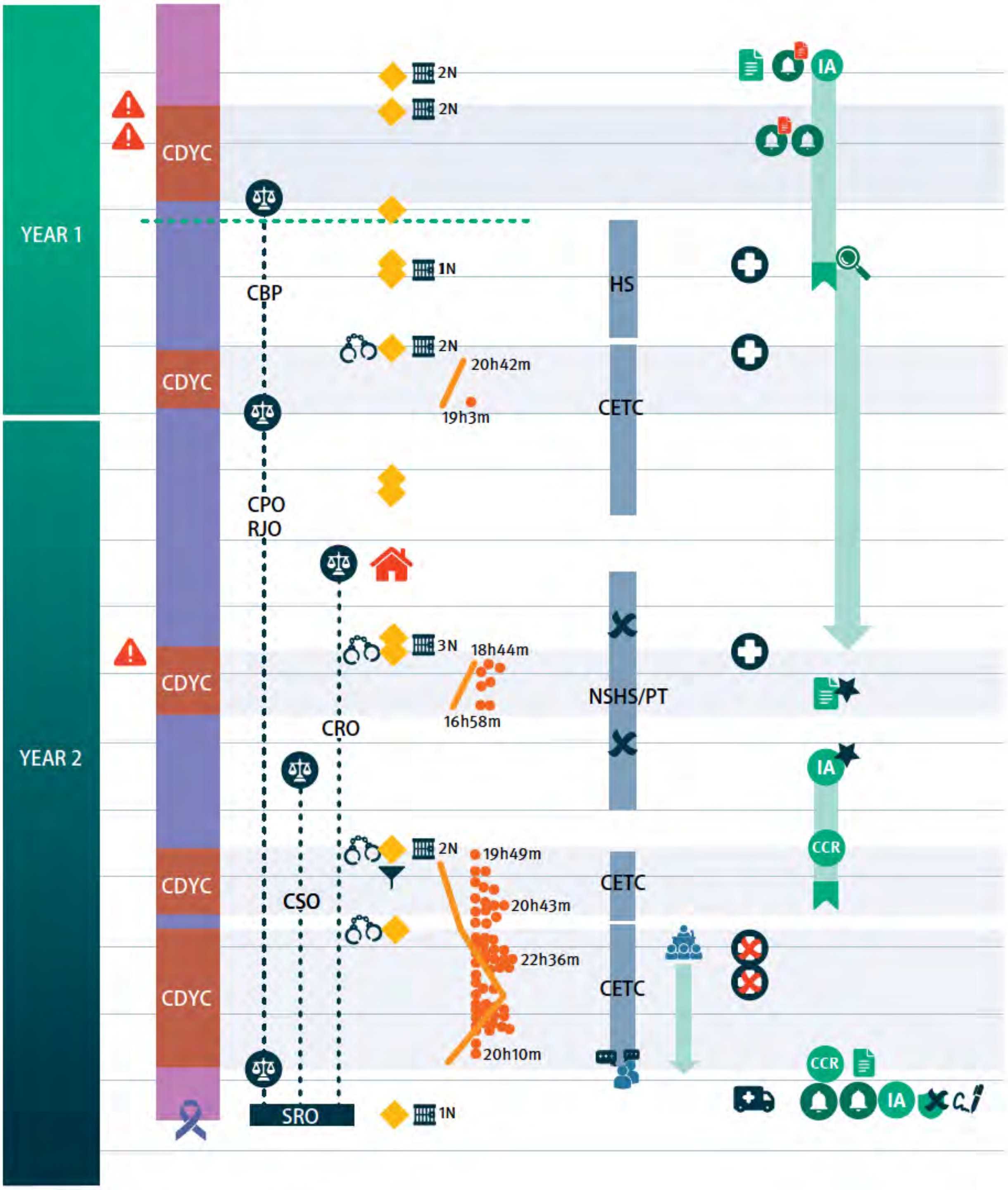


Figure 4: Timeline of system touchpoints for Boy 1

JUSTICE SYSTEM

⚖	YJ order
◆	Mother arrested / charged
⛓	Remanded
▦	Watchhouse
⌂	YJ Home visit
▬	Average hours in separation per 24-hour period
●	Occurrences noted in CDYC (behavioural)
⚠	Suicide Risk Alert
▼	YJ risk assessment (re-offending) - VERY HIGH

EDUCATION

▬	Enrolment
💬	Education planning post-release
👥	Coordinating Care of Vulnerable Young People Forum
✖	Suspension
HS	High school
CETC	Cleveland Education and Training Centre (CETC)
NSHS/PT	Non-state high shool - part time

LIVING ARRANGEMENTS

🟪	Mother
🟦	Extended family
🟥	Cleveland Youth Detention Centre (CYDC)

QUEENSLAND HEALTH

✚	QH/Mental Health services accessed / referred
⊗	QH/Mental Health services declined
🚑	QAS response
🎗	Young person died

CHILD SAFETY

📄	Notification
CCR	Child Concern Report
IA	Investigation and Assessment
🔍	Home visit
✖	Safety assessment - UNSAFE
🔔	Additional notified concerns - Child Concern Report / Notification
🔖	I&A outcome substantiated - CNINOP
✍	Mother signs Assessment Care Agreement
N	Number of nights
h / m	Hours and minutes
★	Other child
CBP	Conditional Bail Program
CPO	Current Probation Order
RJO	Restorative Justice Order
CSO	Community Service Order
CRO	Conditional Release Order
SRO	Supervised Release Order

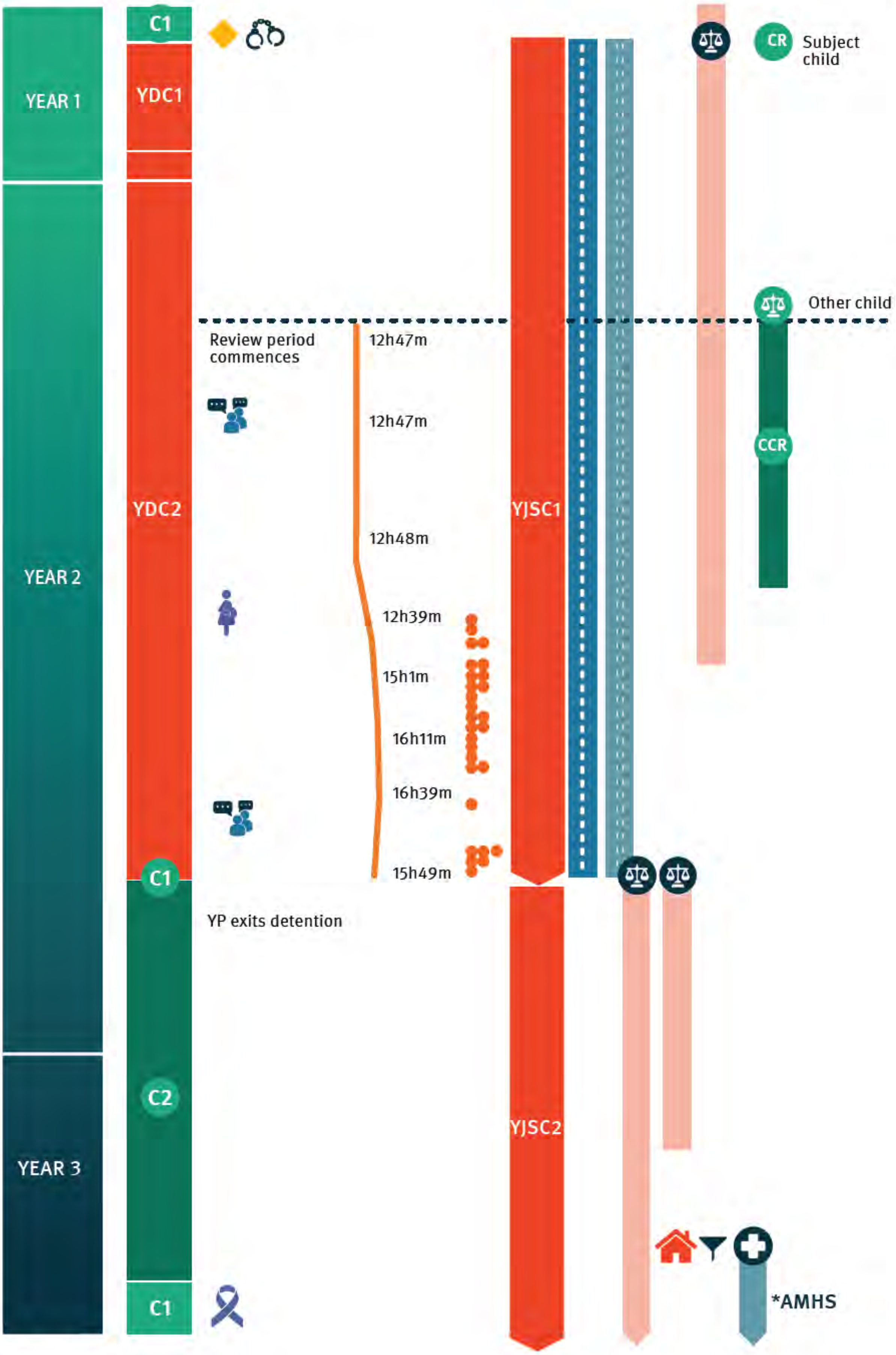


Figure 5: Timeline of system touchpoints for Boy 2

🟥	**JUSTICE SYSTEM**
⚖	YJ order
◆	Arrested / charged
⛓	Remanded
💬	SMART Panel
🏠	YJ Home visit (Final)
━	Average hours in separation per 24-hour period
●	Occurrences noted in CDYC (behavioural)
▼	YJ risk assessment (re-offending) (final)
✚	Referral QH/Mental Health service
▨	YD order type - Probation Order
YDC2	Youth Detention Centre 1 or 2

🟩	**CHILD SAFETY**
CCR	Child Concern Report
⚖	Child Protection Order
🤰	Mother pregnant
C1 C2	Residing in City1 or City2
*AMHS	*AMHS (Adolescent Forensic Mental Health Service)

	QUEENSLAND HEALTH
✚	QH/Mental Health services accessed / referred
🎗	Young person died
▨	Prison Health Services (West Moreton HHS)

	EDUCATION
🟦	West Moreton Education and Training Centre

In its 2021–22 Annual Report, the Board reported on a cohort of children and young people with complex needs who display challenging behaviours–such as substance use, use of violence, criminal offending and suicidal ideation or attempts. Among this cohort of children and young people (aged 12–17 years), the Board identified several common features in many of their life trajectories, including:

- disengagement from, or limited engagement with, education or school
- use of illicit substances
- regular contact with the Queensland Police regarding offending behaviours or involvement with Youth Justice services
- unstable housing, with many not living with their families or frequently leaving their family home
- significant child protection involvement from a young age, mostly due to reports about their families' experiences of domestic and family violence, parental substance use, physical harm or neglect
- while several had suspected or confirmed intellectual disabilities and mental illnesses by the time they became involved with statutory Child Safety and Youth Justice services, there were distinct gaps in assessments and service delivery when their behaviours first emerged in early childhood.[23]

These factors are also reflected in the below figure.

	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8	Child 9	Child 10	Child 11	Child 12
Child protection concerns (from young age)	●	●	●	●	●	●	●	●	●		●	●
School disengagement or low attendance	●	●	●	●	●	●	●	●	●	●	●	●
Substance use	●	●	●	●		●	●	●	●	●	●	●
Poor mental health or suicidal behaviours	●	●	●	●		●	●	●		●	●	●
Diagnosed or suspected intellectual disability	●									●		
Current child protection intervention	●								●			
Current youth justice intervention	●	●		●								
Contact with youth justice services	●	●		●	●	●	●	●	●	●	●	
Contact with police	●	●	●	●	●	●	●	●	●	●	●	●
Risk-taking behaviours relevant to death incident	●	●	●	●	●	●	●	●	●		●	●

Figure 6: Common features in the life trajectories of a cohort of 12 children and young people (aged 12–17 years) identified by the Board

The Australian Institute of Health and Welfare (AIHW) notes avoidable deaths are those that can be prevented when timely and effective healthcare is provided, including by interventions that are targeted at the population-level.[24] The deaths of the two boys were recorded as suicide and drug overdose. Both deaths were preventable, and the Board sought to understand how contact with the youth justice system was both an indicator of broader risk, and an opportunity to address risk, in the lives of Queensland children.

---

[23] Child Death Review Board 2022, *Annual Report 2021–22*.

[24] The Australia Institute of Health and Welfare (AIHW) 2018, *Aboriginal and Torres Strait Islander adolescent and youth health and wellbeing 2018*, 111. Accessed 28 September 2023. https://www.aihw.gov.au/reports/indigenous-australians/atsi-adolescent-youth-health-wellbeing-2018/contents/summary

Children in Youth Justice in Queensland

In Queensland, youth justice services and detention centres are established under the *Youth Justice Act 1992* (the Act). The Act recognises the importance of services designed to rehabilitate and reintegrate children and young people who have offended. The youth justice system exists to reduce criminal offending by young people, to improve community safety, and to provide opportunities for young people to turn their lives around and live productively in the community.[25]

Queensland locks up more children than any other State and leads the nation for the number of nights our young people spend in custody. Queensland children and young people comprise 21.7% of the national population of people who are aged 10–17-years but represent 66.1% of the national population of 10–17-year-olds under youth justice supervision. On an average day in 2022, 267 Queensland young people aged 10–17 years were in youth justice custody, 256 were in a youth detention centre and 227 spent time in a youth detention centre on unsentenced detention.[26] During 2021–22, Queensland had the second highest rate of young people in youth justice custody on an average day (4.8 per 10,000) and the second highest rate of young people under community-based supervision on an average day (16.6 per 10,000) behind the Northern Territory.[27]

During 2021–22, Queensland children spent the most nights in custody (100,425 total), followed by 68,172 total custody nights in New South Wales and 44,129 total custody nights in Victoria. As such, more than a third of the national nights in custody were served by Queensland children.[28]

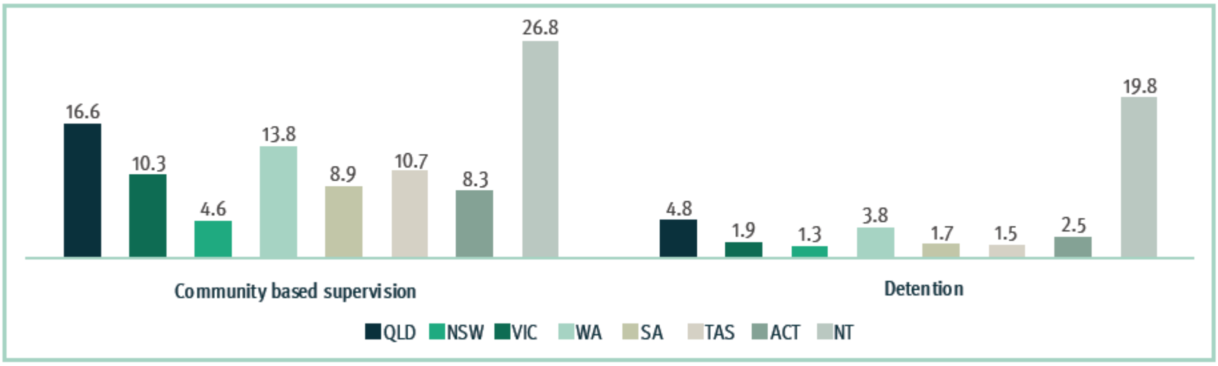
Of the young people completing a period of unsentenced custody in 2021–22, 60% completed a period of 30 nights or longer (62% for First Nations young people and 56% for non-Indigenous young people).[29] Across the cohort of Queensland young people in the youth justice system, First Nations children were significantly over-represented. On an average day in 2021–22, in Queensland 64% of 10–17-year-olds under youth justice supervision and 66% in detention identified as Aboriginal or Torres Strait Islander (compared to 7% of the general population).

Indigenous young people aged 10–17 are 21 times more likely than non-Indigenous young people to be under youth justice supervision (175 per 10,000 compared with 8.2 per 10,000) and 23 times more likely to be in detention than their non-Indigenous peers.

The high degree of commonalities in the cases reviewed by the Board where youth justice involvement existed caused the Board to consider key themes and outcomes that may improve the protection of our young people. In conducting this work, the Board has chosen to present its discussion and findings against four areas of note. These are:

1. improving the social and emotional wellbeing of young people to prevent crime and save lives
2. poor educational engagement amongst children in the youth justice system.
3. the impacts and effectiveness of the current youth detention model.
4. over-representation of First Nations children in the youth justice system.

Graph 3: A comparison across Australian jurisdictions of the rate of young people aged 10–17 per 10,000 in community-based supervision and youth justice detention (2021–22).Source: Productivity Commission, 2023 Table 17A.1[30]



---

[25] Queensland Government 2022, *Basics of youth detention.* Accessed on 28 May 2023 https://www.qld.gov.au/law/sentencing-prisons-and-probation/young-offenders-and-the-justice-system/youth-detention/about-youth-detention/basics-of-youth-detention

[26] Department of Youth Justice, Employment, Small Business and Training (Youth Justice) 2023, *Community supervision, unsentenced custody and all custody*, unpublished data request.

[27] The AIHW, 2022, *Youth justice in Australia 2021–22*. Accessed 5 October 2023. https://www.aihw.gov.au/reports/youth-justice/youth-justice-in-australia-2021-22/contents/summary

[28] Youth Justice 2023, *Unsentenced custody and Indigenous status*, unpublished data request.

[29] Ibid.

[30] Australia Government, Productivity Commission 2023, *Report on government services 2023: Youth justice services*, Table 17A.1. https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/youth-justice

Improving the social and emotional wellbeing of young people to prevent crime and save lives

In Queensland, the *Working Together Changing the Story: Youth Justice Strategy 2019–2023* (the Youth Justice Strategy) acknowledges that prevention programs – such as those that improve parenting, strengthen community, support families at risk, address mental illness, disability and substance use and respond to childhood delay and education problems – are not only effective but are extremely cost-effective.[31] The cases reviewed by the Board highlight the tragic outcomes when service systems do not prioritise prevention and early intervention to promote the safety, health and wellbeing of at-risk children and young people.

Intervene early is the first of the 'four pillars' recommended by Mr Bob Atkinson AO APM in his *Report on Youth Justice*, delivered to the Queensland Government at the conclusion of his independent review into the Queensland Youth Justice System in June 2018. The 'four pillars' were adopted by the Government and underpin the Youth Justice Strategy. The four pillars of the Youth Justice Strategy are:

1. Intervene early
2. Keep children out of court
3. Keep children out of custody
4. Reduce re-offending.

Very early in the lives of two young people reviewed by the Board (arguably from in-utero), it was apparent their parents and families would need additional support to help meet their needs. Both children were exposed to disadvantage and multiple adverse childhood experiences. They and their extended families were left to navigate these challenges largely on their own. It was only after the impacts of their experiences became behaviourally challenging that the service system became more involved. By this stage, the response was often punitive and in reaction to their offending or anti-social behaviours.

There were multiple missed opportunities for targeted early intervention to support the boys and their families in their infancy and childhood, to prevent their escalation into the child protection and youth justice systems. This included:

- **Screening and diagnosis of Foetal Alcohol Spectrum Disorder –** Both boys' mothers were known to have used alcohol to excess during their respective pregnancies, with agency records identifying the possibility of Foetal Alcohol Spectrum Disorder (FASD) for both. Despite these worries, no formal exploration of these concerns manifested in the records. Appropriate screening and diagnosis of FASD provides opportunity for multi-disciplinary support and early interventions for children and their families. This is particularly important given young people with FASD are over-represented in youth justice settings and are at increased risk for mental health issues including suicidality.[32]
- **Trauma-informed support for informal family care arrangements –** Both boys experienced neglect, physical and emotional abuse in their parents' care. Following child safety interventions and periods of detention, both boys were returned to family care arrangements with very limited support or a trauma-informed response.[33] There is little evidence of Child Safety considering the carers' ability and willingness to protect and meet the boys' safety and wellbeing needs and it appeared that there was reliance on Youth Justice services to do this.
- **Early identification and response to speech and language disorders –** Both boys were identified as having language disorders during their admissions to youth detention. Boy 1 was diagnosed with a mild developmental language disorder and Boy 2 was diagnosed with a severe receptive language delay and mild expressive language delay. Boy 2's verbal IQ was found to be extremely low and he was verified with a mild intellectual impairment. These language difficulties and intellectual impairment were likely evident well before their diagnosis in youth detention. Given the noted correlation between oral language competence in early life and the risk for engagement in anti-social behaviours in adolescence, early identification of speech and language delays in early childhood education or school settings, with therapy and targeted supports, must be a priority for the service system.[34]
- **Supporting mental health and wellbeing in childhood –** At seven years old, Boy 1 was referred to mental health support by a paediatrician after exhibiting self-harming behaviours (self-strangulation), anti-social behaviours and socialisation issues. It was reported his family was provided with community-based support information to meet his needs. These behaviours were a significant red-flag and opportunity for more specific trauma-informed and culturally appropriate therapy.

---

[31] Queensland Government, Department of Child Safety, Youth Justice and Multicultural Affairs (Child Safety) 2019, *Working Together: Changing the Story*, 8. https://www.cyjma.qld.gov.au/resources/dcsyw/youth-justice/reform/strategy.pdf

[32] McLean S 2022, *Foetal Alcohol Spectrum Disorder (FASD): An update on policy and practice in Australia,* Australian Institute of Family Studies. https://aifs.gov.au/resources/policy-and-practice-papers/fetal-alcohol-spectrum-disorder-fasd-update-policy-and

[33] The only evidence of 'support' identified in ICMS records (page 257) provider to the Board was checking that maternal grandmother had sufficient food to be caring for the children (four of mother's children in her care as of February 2021), subsequent provision of food vouchers and a phone call after Police had attended the home in response to a fight between the children.

[34] Snow P & Powell M 2012, 'Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence', *Trends & issues in crime and criminal justice*, 435. Australian Institute of Criminology. https://www.aic.gov.au/publications/tandi/tandi435

Without appropriate efforts to engage with families, early diagnosis and early intervention, the system is incapable of appropriately supporting children and providing the remedial services they need to achieve their potential. Since the early 2000s, compelling evidence has emerged about the ways in which the social determinants of health (SDH) explain disparities in health outcomes between groups within society. Research has established that those who experience social, economic, political, and environmental disadvantages are more likely to experience poorer health outcomes. Within the realm of justice, McCausland and Baldry note that the majority of prisoners in Australia come from highly disadvantaged backgrounds.[35] In 2020–2021, 10–17-year-olds from the lowest socioeconomic areas were five times more likely to be under youth justice supervision than those from the highest socioeconomic areas.

In 2022, a total of 1,605 young offenders were surveyed in the Youth Justice Census. Of these, it is estimated that:

- 45% had disengaged from education, training or employment
- 53% had experienced or been impacted by domestic and family violence
- 30% had been living in unstable and/or unsuitable accommodation
- 27% had at least one parent who spent time in adult custody
- 19% had an active child protection order
- 27% had a disability (diagnosed or suspected), including 17% who had a cognitive or intellectual disability
- 33% had a least one mental health and/or behavioural disorder (diagnosed or suspected).[36]

It is clear that there is some level of predictability to the young people who will come into contact with the Queensland Youth Justice system, and that holistic family support services are likely to be a more effective crime prevention strategy than current 'tough on crime' approaches.

> *It is the responsibility... of adults, not vulnerable young people themselves, to ensure that a risky start in life does not result in social marginalisation and offending.*[37]

Transactional justice responses

To address youth crime and change youth offending, we must understand the root causes and motivations that are present in the young people's lives and tailor our responses to be effective. When considering the cases involving youth justice contacts, the Board noted that the individualised and risk-focused models used within our systems are narrow, issue-specific, siloed, and fail to capture the complexity of the drivers of social and emotional wellbeing for children, young people, and families. Youth justice is a highly transactional system; its services primarily and predominantly attach to an episode of offending and a court matter. Youth justice services are therefore transactional, or episodic, often leading to superficial, time-limited exchanges. This is counter to the evidence of what works, which is relational or relational-based interactions that have a longer-term, more personal, and deeper engagement with the young person.

The cases of two young people highlight the system's focus on risk and deficit (health & illness/criminogenic/ child protection) and how each system can take a transactional approach to 'delivering its statutory process'. While much was known about the problems and difficulties faced by these young people, it was not apparent that any system had accountability for understanding and addressing the root cause issues present in these boys' lives.

In the Board's attempts to understand and make sense of the constellation of factors contributing to the deaths of the boys, it identified that different foci, theories, and frameworks are used within each service system.

---

[35] McCausland R & Baldry E 2023, 'Who does Australia lock up? The social determinants of justice', *International Journal for Crime, Justice and Social Democracy*. https://www.crimejusticejournal.com/article/view/2504

[36] Child Safety 2023, *Youth justice census summary statewide*. Accessed 28 September 2023. https://www.cyjma.qld.gov.au/resources/dcsyw/youth-justice/resources/census-summary-statewide.pdf

[37] Snow P & Powell M 2012, 'Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence', *Trends & issues in crime and criminal justice*, 435. Australian Institute of Criminology. https://www.aic.gov.au/publications/tandi/tandi435

- **Youth Justice, Youth Level of Service/Case Management Inventory (YLS/CMI) and Criminogenic Risk –** The YLS/CMI is a risk/needs tool based on the 'big four' criminogenic factors and more broadly the 'central eight' criminogenic factors in predicting offending and re-offending to assist in case planning. The 'big four' are antisocial attitudes and cognitions, antisocial peers, history of antisocial behaviour and an antisocial personality pattern. The 'central eight' adds problematic family circumstances, problems at school or work, problems with leisure activities and substance use.
- **Child Safety: Structured Decision Making, Child Strengths and Needs (SDM CSN) –** The SDM CSN is a tool to assess across 12 individual domains to assist in case planning. These are behaviour, emotional wellbeing, alcohol and drug use, family of origin relationships, peer relationships, cultural identity, physical health, child development, education or employment, preparation for independent living, relationships with carer family or with residential placement, and an option to add a unique identified strength.
- **Queensland Health, Mental Health Services: Biopsychosocial Assessment –** The biopsychosocial model grew from dissatisfaction with traditional and sometimes reductionist biomedical approaches to health and illness.[38] The biopsychosocial model recognises that illness and health are the result of an interaction between biological, psychological, and social factors. In the context of Queensland mental health services, anecdotally, the consideration of biological and psychological factors predominates. Social factors beyond the individual's personal social context and participation, like the structural and systemic barriers faced by First Nations peoples, are not as well integrated into assessments and intervention plans as considerations for the individual.
- **Adverse Childhood Experiences (ACE) –** The original Adverse Childhood Experiences (ACE) study was conducted at Kaiser Permanente (California) from 1995 to 1997. Seven categories of adverse childhood experiences were examined: psychological, physical, or sexual abuse; violence against mother; or living with household members who used substances problematically, were mentally ill or suicidal, or ever imprisoned. The researchers found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.[39] More recently, 'ACE scores' are available to be used as assessment tools.[40]

It is tempting to remain focused on individual risk factors and illness models, particularly because suicide and overdose deaths are often considered in the realm of health and healthcare. While valid and valuable, these frameworks guide practitioners toward individualistic and risk-based approaches to understanding and intervening. For example, it could be concluded that with timely access to quality drug detoxification and rehabilitation services, one boy would not have died from an overdose; or with earlier treatment of mental ill health the other would not have died from suicide. While possibly not untrue, these conclusions infer 'drug abuse' and 'mental illness' as the causes of the boys' deaths, and this would not present the truth of their life and the broader social, political, and cultural contexts in which they lived.

In Table 3, Boy 1 and Boy 2's experiences are mapped against social and emotional wellbeing domains. This demonstrates the significant risks that impacted them across their life spans.

---

[38] Wade D and Halligan P 2017, 'The biopsychosocial model of illness: A model whose time has come', *Clinical Rehabilitation*, 31(8).

[39] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS 1998. 'Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine*, 14(4), 245-258.

[40] National Centre for Injury Prevention and Control, Division of Violence Prevention 2021, *About the CDC-Kaiser ACE Study*. Accessed 29 September 2023. https://www.cdc.gov/violenceprevention/aces/about.html#:~:text=The%20CDC%2D Kaiser%20Permanente%20adverse,two%20waves%20of%20data%20collection.

Boy 1	Boy 2
Connection to body: Physical health – feeling strong and healthy and able to physically participate as fully as possible in life.	
• Substance use (methamphetamine use from age 13, alcohol, marijuana, MDMA) • Enjoyed fishing, basketball, football and computer games.	• Substance use (methamphetamine, alcohol); consumption rapidly increased following experiencing sexual assault/s • Enjoyed playing football.
Connection to mind and emotions: Mental health – ability to manage thoughts and feelings.	
• In utero exposure to alcohol and maternal stress domestic and family violence • Mild language disorder • Possible FASD – late recognition • Low self-esteem • Poor emotional regulation and problem-solving skills • School disengagement from 14 years • Self-reported feelings of anxiety • Self-harm, suicidal behaviours and suicide attempts • Anti-social behaviours from age 11 resulting in nine periods in youth detention. Ongoing offending behaviours and contact with Police and YJ from age 11 until the days before his death.	• In utero exposure to alcohol, illicit substances, and maternal stress domestic and family violence • Behavioural concerns through childhood that family found difficult to understand/manage • Overall, very poor engagement with education from Prep Year onwards; 10 school enrolments • Cognitive and language impairments (intellectual disability and speech and language disorder) – late recognition of same • Possible ADHD – late recognition • Possible FASD – late recognition • Received mental health support for self-harming and behavioural concerns • Victim of sexual assault/s when aged 14 • Suicide attempts reported • Antisocial/pro-criminal attitudes with multiple subsequent convictions • Help-rejecting • Withdrawn, isolating, possibly depressed in the months post exit from detention.
Connection to family and kinship: Connections to family and kinship systems are central to the functioning of Aboriginal and Torres Strait Islander societies.	

Table 3: Boy 1 and Boy 2's experiences mapped against domains of social and emotional wellbeing

Criminogenic responses to young offenders show an issue-specific mindset and target single events, rather than considering a holistic response that utilises both the strengths and developmental needs of children and young people. The punishments and sanctions given to young people must have context and relevance to their circumstances if they are to be effective. Narrowly focused, risk-based and issue-specific responses to youth justice within key government agencies represents a collective failure to prevent youth crime and to rehabilitate young offenders.

Table 4 provides a summary of Boy 1 and Boy 2's interactions with the Youth Justice system in the twelve months prior to their death.

In the twelve months prior to their death:	
Boy 1	**Boy 2**
• Held in watchhouses four times, for a combined nine nights • Arrested and/or charged 10 times • 25 court appearances including 19 adjournments, nine appearances resulting in custody and 15 finalised outcomes • Four admissions to detention (of a total eight admissions in his lifetime) • Subject to ten statutory orders, including: – Two Reprimands, – One Community Service Order – Three Conditional Release Orders – One Supervised Release Order paired with one Detention Order, – One Probation Order – One Restorative Justice Order • Subject to a Conditional Bail Program.[44]	• Two court appearances • One admission to detention (of a total of six admissions in his lifetime) • Subject to three statutory orders, including: – two Probationary Orders – one Court Diversion Referral.

Table 4: Boy 1 and Boy 2's interactions with the youth system in the twelve months prior to their death

For Queensland to make a difference to protect the community, change young people's offending behaviour and prevent crime, it must recognise the factors contributing to offending, and preventing each individual's behaviour change. Our collective response across government should be to prioritise a system of engagement with young people that builds and maintains relationships, trust, and understanding, and provides hope and opportunity. Transactional justice responses for young people that leave them in the same life circumstance are unlikely to lead to significant change.

---

[44] Conditional Bail Program targets young people who the court believes are unlikely to comply with bail, by engaging them in program activities, which become a condition of their bail undertaking.

Poor educational engagement amongst children in the youth justice system

School disengagement is a known risk factor for a young person's entry into the youth justice system. The 2021 Youth Justice Census identified that 52% of the 1642 young offenders surveyed were disengaged from education, training, or employment.[45]

The school enrolment records for the two young people highlights the challenges they experienced in terms of movements between family members and subsequently their schools, sporadic attendance, behavioural challenges, and lack of engagement with schooling, training or employment.

	Boy 1	Boy 2
Enrolments	15 school enrolments: • two state primary schools • four state high schools • eight Education and Training Centre (in detention centre) • one non-state school	Ten school enrolments: • three state primary schools • three state high schools • one flexi-school • three Education and Training Centre (in detention centre)
Behaviour	Decline in school functioning, and disruptive and anti-social behaviour from age 11.	Self-harming and anti-social behaviours, and socialisation issues from age seven. Non-compliance and withdrawal from age 13.
Attendance	Poor engagement in learning in high school. Attended school programs in detention however significantly impacted by lockdowns and separations.	Attendance at school from Prep onwards, sporadic. No school attendance in community post age 13 years. Attended school programs in detention, though engagement limited at times.
Suspensions	Two recorded	One recorded
Verifications	Mild developmental language disorder. Not verified until after school disengagement.	Cognitive and language impairments (intellectual disability and speech and language disorder). Not verified until after school disengagement.
Enrolment status at time of death	Not engaged in education, training, or employment.	Not engaged in education, training, or employment.

Table 5: Summary of school enrolments and education issues for Boy 1 and Boy 2

Both young people went through their schooling without their challenging behaviours being explored from a developmental perspective. The result was that their language and learning difficulties remained unaddressed during their schooling, likely contributing to behavioural escalations, increasing frustration, disconnection, and ultimate disengagement from schooling.

---

[45] The QFCC 2023, *Policy Submission: Strengthening Community Safety Bill 2023*. https://www.qfcc.qld.gov.au/sites/default/files/2023-02/QFCC%20Submission%20to%20Strengthening%20Community%20Safety%20Bill.pdf

> *Boys with unidentified language difficulties who display disruptive and uncooperative tendencies in the classroom will, of course, be identified as 'behaviour problems' rather than as at-risk for unidentified language impairment and their management thereafter typically reflects this characterisation.*
>
> *Keeping all children engaged academically has significance for health and wellbeing at a community level and it is vital that educators position their work within a broader public health context.*[46]

Another key factor observed was the use of suspensions by schools in response to difficult behaviours. School suspension is recognised as contributing to academic failure, dropout, and a range of negative behavioural outcomes, including violent and antisocial behaviour and tobacco use.[47] It also increases the risk of young people who are marginalised and excluded entering the youth justice system and eventually adult incarceration.[48] Suspended students can become alienated from school, impacting what for many disadvantaged and vulnerable students is a key protective factor in their lives. This was again shown in the QFCC research mapping the life trajectories of 30 Queensland children published this year.[49]

The current model of youth detention

The Government recognises the youth justice system must ensure the young people in detention are provided with health, rehabilitation services and programs, are supported to develop education and vocational skills and are assisted to transition effectively back into their families and communities, and to adulthood.[50]

Both boys' experiences in youth detention was far from this ideal – either in terms of their life outcomes, or community safety. One boy served his periods of detention at Cleveland Youth Detention Centre (Townsville) while the other served his time at West Moreton Detention Centre (Brisbane).

Collectively, Boy 1 and Boy 2 spent a combined 600 days in detention during their lifetimes. Boy 1 had eight admissions for a total of 217 days, while Boy 2 had six admissions for a total of 383 days. Table 6 provides the number and duration of each of their admissions.

	Boy 1	Boy 2
Admission 1	11	1
Admission 2	6	4
Admission 3	28	50
Admission 4	44	25
Admission 5	20	80
Admission 6	23	159
Admission 7	27	-
Admission 8	217	-
Total	**376**	**319**

Table 6: number and duration in days of Boy 1 and Boy 2's admission to youth detention.

During these repeated entries into detention, the boys received health, education and wellbeing services, and case management that was otherwise missing in their external world. The effectiveness of these services however was hampered by low and changing staffing numbers in the facilities, frequent periods of separation and an operating culture within detention centres that did not contribute to sustained behaviour change.

---

[46] Snow P & Powell M 2012, 'Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence', *Trends & issues in crime and criminal justice*, 435. Australian Institute of Criminology. https://www.aic.gov.au/publications/tandi/tandi435

[47] Hemphill S, Broderick D, Heerde J 2017, 'Positive associations between school suspension and student problem behaviour: Recent Australian findings', *Trends & issues in crime and criminal justice*, 531. Australian Institute of Criminology. https://www.aic.gov.au/publications/tandi/tandi531

[48] Snow P & Powell M 2012, 'Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence', *Trends & issues in crime and criminal justice*, 435. Australian Institute of Criminology. https://www.aic.gov.au/publications/tandi/tandi435

[49] The Queensland Family and Child Commission 2023, *Lessons from the life-story timelines of 30 Queensland children who have died: A small sample review of commonalities in child and family trajectories considered at the Child Death Review Board*. Accessed 28 September 2023. Lessons from the life-story timelines of 30 Queensland children who have died (qfcc.qld.gov.au)

[50] Queensland Government, Child Safety 2019, *Working Together: Changing the Story*. https://www.dcssds.qld.gov.au/resources/dcsyw/youth-justice/reform/strategy.pdf

> *Youth detention centres, in their current design and operation, have proven to be ineffective in addressing the root cause of offending, evidenced by the high rates of repeat offending. Youth detention centres are highly expensive to operate and maintain, and persistent workforce pressures can contribute to sub-optimal outcomes for children.*[51]

Youth Justice recognised in its review of Boy 1 that detention centres manage young people with high levels of complexity, with many young people entering detention with significant mental health, disability, psychiatric and social disorders. Their offending behaviours are symptomatic of the significant trauma and disadvantage experienced in their lives.

The records of a young person's time in custody largely show the transactional exchanges with the system. This includes records of incidents, separations, and service events – such as attendance for medical assessment or treatment. What is not apparent in the records for the boys at this time was the long-term planning for their life and re-entry into the Queensland community with prosocial intent.

One boy experienced incidents of bullying and victimisation from other young people while in detention. Records show he was spat on by other young people, punched in the head, had water thrown on him and was bullied because of his size. Records show this boy requested to move cells *because he feels he is being bullied ...[and]... that he is sick of the sexualised behaviours and inappropriate comment[s] by some of the other young people in the unit.*[52] When he considered that this move was not actioned quickly enough, he tried to flood his cell and his access to water was turned off. He reported spending additional time in his cell by choice because he felt unsafe.

Both boys' time in detention (in the year prior to their deaths) was significantly impacted by extended periods of separation. In the Queensland context, separation is defined as placing *a young person in a locked room by themselves for a purpose defined in section 21 of the Youth Justice Regulation 2016.*[53] International human rights prohibit the use of solitary confinement on children and young people. [54] The United Nations defines solitary confinement as the *confinement of prisoners for 22 hours or more a day without meaningful human contact.* [55]

---

[51] The Queensland Family and Child Commission 2023, *Policy Submission: Strengthening Community Safety Bill 2023*, 9. https://www.qfcc.qld.gov.au/sites/default/files/2023-02/QFCC%20Submission%20to%20Strengthening%20Community%20Safety%20Bill.pdf

[52] Youth Justice records provided to the Board, *Attachment 5 – Client records for Boy 1*, 5214.

[53] Youth Justice 2023, *Youth Detention centre operational policy: YD-3-8 Youth detention - Separation.* Unpublished document provided to the Board.

[54] The United Nations, Office of the High Commissioner for Human Rights 1990, *United Nations Rules for the Protection of Juveniles Deprived of their Liberty*, Rule 67: "All disciplinary measures constituting cruel, inhuman or degrading treatment shall be strictly prohibited, including corporal punishment, placement in a dark cell, closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned...". See https://www.ohchr.org/en/instruments-mechanisms/instruments/united-nations-rules-protection-juveniles-deprived-their-liberty

[55] The United Nations, Office on Drugs and Crime 2015, *United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules)*, Rule 44. See page 14 of https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

> *We cannot dismiss our obligation to provide quality education, health, disability and other universal supports and services because a young person has committed an offence.*[56]

During a routine day in detention, young people are locked in their cell between 7.30pm and 7.30am – known as a 12-hour overnight lockdown. Youth detention operational procedure specifies routine overnight lockdowns are excluded from the total count of hours of continued separation.

Both boys experienced periods of separation during the day in addition to and often adjoining the 12-hour overnight lockdown. Boy 2 was confined to his cell for more than 22 hours of the day (cumulative and including the 12-hour overnight lockdown period) on 55 of the days he was in detention. On 22 days, he was in his cell for more than 23 hours. The Youth Justice report identified three occurrences of Boy 2 spending 24 consecutive hours in his cell without a break and a further consecutive period of 31 hours and nine minutes.[57]

Table 7 outlines the additional hours of separation experienced by both boys. Youth Justice reports these separations were undertaken in line with current youth detention centre policy and procedures.[58]

In the twelve months prior to their death:	Total hours in detention	Hours spent in separation during the 12 hour daily overnight lockdowns	Additional time spent in separation	Total time spent in separation	Percentage of their time in detention spent in separation
Boy 1	3,072 hours (128 days)	1,536 hours	875 hours and 57 minutes	2,411 hours and 57 minutes	78.51%
Boy 2	4,920 hours (205 days)	2,460 hours	208 hours and 41 minutes	2,668 and 41 minutes	54.24%

Table 7: Additional in-cell separation time experienced by Boy 1 and Boy 2 in the 12 months prior to death.

Critically, extended separations significantly impacted Boy 2's access to education, therapeutic and cultural programs, social and leisure activities, exercise, fresh air, and sunlight. Youth Justice noted separation periods directly led to Boy 2 having *limited ability to engage in criminogenic programs during his time remanded.*[59] While the number and length of separations experienced by Boy 1 were not as significant, he too had his programs, education and activities interrupted by staff shortages and separations.

These separations were for a variety of reasons, including in response to incidents, for staff meetings, and at the young people's own request, but predominantly there was significant separation due to staff shortages. It was noted for the separation in Cleveland Youth Detention Centre authorised on 17 July 2021 there were 23 detention youth worker positions vacant, and eight detention youth workers reported as "did not work".[60] Staff shortages of between ten and 23 detention youth workers were a common occurrence during the boys' admissions.

Periods of separation, isolation, or solitary confinement can impact a child's health and wellbeing in severe, long-term and irreversible ways.[61] Many of the children and young people in detention have experienced a life of significant disadvantage and marginalisation, with many being the victims of abuse and neglect. Being confined in a cell for extended periods of time, without interaction with peers, family, culture, and support networks creates an environment of re-traumatisation. Research has shown pre-existing mental health problems are likely exacerbated by experiences during incarceration, such as isolation, boredom and victimisation.[62]

---

[56] The QFCC 2022, *Yarning for Change*. https://www.qfcc.qld.gov.au/sites/default/files/2022-11/Yarning%20for%20Change.pdf

[57] Phone records (page 15) provided by Youth Justice to the Board suggest Boy 1 made five phone calls during this period, the longest 9 minutes in duration, which suggests records of separation on this occasion were not accurate.

[58] Youth Justice records provided to the Board, *System and Practice Review for Boy 1*, 35.

[59] Ibid., 14.

[60] Youth Justice records provided to the Board, *Attachment 1 – Client Records for Boy 1*, 6602.

[61] Baldry E & Cunneen C 2019, 'Locking up kids damages their mental health and sets them up for more disadvantage. Is this what we want?', *The Conversation*. Accessed 5 October 2023. https://theconversation.com/locking-up-kids-damages-their-mental-health-and-sets-them-up-for-more-disadvantage-is-this-what-we-want-117674

[62] Dudgeon P 2022, *Locking up kids has serious mental health impacts and contributes to further reoffending*. Accessed 29 September 2023. https://www.uwa.edu.au/news/Article/2022/November/Locking-up-kids-has-serious-mental-health-impacts-and-contributes-to-further-reoffending

As children are still in the crucial stages of developing socially, psychologically, and neurologically, there are serious risks of solitary confinement causing long-term psychiatric and developmental harm.[63]

As First Nations adolescents, separation and solitary confinement likely had additional and compounding impacts. The Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory recognised the psychological effects of isolation can be amplified for First Nations children and young people due to their specific cultural needs.[64] Furthermore the 1991 Royal Commission report found solitary confinement causes "extreme anxiety" and has a particularly detrimental impact on Aboriginal and Torres Strait Islander prisoners, many of whom are already separated from family, kin, and community.[65]

The practice of detention that these boys experienced were more likely to increase, rather than address, feelings of hopelessness, worthlessness and low self-esteem.

Separation is counter-productive: rather than improving behaviour, it creates problems with reintegration and fails to address the underlying causes of behaviour.[66] Both boys experienced heightened emotions and behaviours as a direct result of extended periods of separations and the associated reduction in access to activities and programs. Youth Justice identified 17 Incident Reports recorded in relation to Boy 1's behaviours during the review period. One recorded that he "appeared extremely agitated and it was clear that [he] was frustrated being in the unit and with minimal activities".[67] Records relating to Boy 2 identify multiple behavioural escalations where he voiced separation periods were a precipitating factor in his behaviours:

- In December 2020, Boy 2 was verbally abusive and kicking the cell door. He said he was triggered by frustration about when he would be let out.
- In March 2021, Boy 2 verbally abused staff because he was not allowed out of his cell.
- In July 2021, Boy 2 threw a cup around the room as he did not want to go back to his cell. This was in response to being asked to return to his cell after 51 minutes out for day.
- Also in July 2021, Boy 2 was assessed as part of a Suicide Risk Assessment. He identified his main emotions as boredom and frustration.
- In August 2021, Boy 2 armed himself with a broom. Post-incident, Boy 2 voiced he had not wanted to return to Continuous Cell Occupancy (the young people had only been out of their rooms for one hour and 12 minutes of the day). Some of Boy 2's personal belongings were confiscated in response to the incident. He requested their return the following day, and was denied, resulting in another behavioural incident.

A number of behavioural incidents were noted for Boy 2 over his four admissions. Like Boy 1, there is a trend with the number of behavioural incidents increasing as his time locked in his cell per day increased. Figures 4 and 5 outlines the system touchpoints for each boy and illustrates this trend.

One of the boys was charged with criminal offences relating to incidents in youth detention and the police watchhouse, including common assault and wilful damage. Youth detention is intended to be a place of rehabilitation. Responding to behavioural incidents in custody with criminal charges further punishes young people who are being triggered by isolation and denial of pro-social services.

---

[63] Ibid.

[64] Royal Commission into the Protection and Detention of Children in the Northern Territory, 'Isolation', *Volume 2A, 285*. https://www.royalcommission.gov.au/system/files/2020-09/Volume%202A.pdf

[65] Human Rights Watch 2020, *"He's Never Coming Back": People with Disabilities Dying in Western Australia's Prisons*. Accessed 29 September 2023. https://www.hrw.org/report/2020/09/15/hes-never-coming-back/people-disabilities-dying-western-australias-prisons

[66] British Medical Association 2021, *Solitary confinement and children and young people*. Accessed 29 September 2023. https://www.bma.org.uk/advice-and-support/ethics/working-in-detention-settings/solitary-confinement-and-children-and-young-people

[67] Youth Justice records provided to the Board, *Attachment 1 – Client Records for Boy 1*, 278.

The Youth Justice Department acknowledged the flow on effects of extended separation in its report to the Board, including:

- escalated behaviours
- fractured relationships and breakdown of therapeutic alliances
- reduced compliance and commitment to programs
- additional workload placed on staff in a therapeutic position required to support young people
- lack of privacy due to speaking with young people through their doors.[68]

Children and young people need a youth justice system that can provide trauma-informed responses to address their underlying beliefs and behaviours. Instead, we have a system that can too easily fall into providing a negative cycle of more punitive practices and escalating behaviours that trap young people into anti-social and risk-taking behaviours that led to a cycle of incarceration.

In 2018, the British Medical Association (BMA), the Royal College of Paediatrics and Child Health (RCPCH), and the Royal College of Psychiatrists (RCPSYCH)[69] published a joint position statement on solitary confinement of children and young people. In agreement with international organisations such as the United Nations Committee on the Rights of the Child, the European Committee for the Prevention of Torture, and the United Nation's Special Rapporteur on Torture, the statement condemned the practice for its serious risks of *causing long-term psychiatric and developmental harm* and exposed the practice as counter-productive, as it *fails to address underlying causes [of youth crime] and creates problems with reintegration.*

Across Australia each jurisdiction's youth justice system uses terms such as 'separation', 'lockdown', 'confinement' and 'segregation' to explain times when young people are confined to their cells. No jurisdiction acknowledges it uses 'solitary confinement'. The Board recognises that there are times when safety drives operation – this may include times when young people are 'isolated' due to the threat they pose to others; or alternatively when young people are 'isolated' for their protection from others. These two instances are distinct from the use of 'isolation' to manage the overall safety of a centre because there is insufficient staffing – including using 'lockdowns' when staff are having lunch, or when insufficient recruitment has occurred. Labelling each of these situations with the same word, and then failing to properly record and report on the instances and solutions should not be acceptable. Youth Justice centres across Australia, including Queensland, claim that there are system limitations impacting the accurate and more nuanced reporting of lockdown periods. This limitation does not apply to adult corrections – which transparently report into a national data base on detained adults "time out of cell". The Board joins calls made by Australia's Childrens Commissioners and Guardians to: "ensure that the Report on Government Services (17 Youth Justice services) at least includes jurisdictional data about "time out-of-cells (average hours per day)" as currently is done for Adult Corrections (8 Corrective services)".

Exits from detention as a measure of success of detention

Boy 1 and Boy 2 left detention on eight occasions and six occasions respectively. The time between Boy 2's last exit from detention was less than five months. Boy 1 died 20 days after his last exit from detention.

Data released in 2022 indicates that for the 12-month period ending 30 June 2021, over 90% of young people that completed a detention period in Queensland committed another offence in the 12 months following their release.[70] The cases of these two boys, and the data confirm that the current model of youth detention is failing to meet its goal to "rehabilitate and reintegrate children and young people who have offended" and to "reduce criminal offending by young people, to improve community safety, and to provide opportunities for young people to turn their lives around and live productively in the community".[71]

It is not acceptable for any system to fail in its intent so significantly. It highlights that our current model of detention is not working as intended.

Following the *Royal Commission into the Detention and Protection of Children in the Northern Territory*, the Northern Territory Government committed to a public articulation of its Youth Justice model, philosophy, standards and service requirements. Following significant community input and co-design the 'Model of Care in Detention' was published. The model of care is publicly available with an associated Evaluation Plan.[72]

The Northern Territory Detention Model of Care is built around the needs of young people. It consists of three parts:

---

[68] Ibid., 13.

[69] The British Medical Association (BMA) is a registered trade union for doctors, the Royal College of Paediatrics and Child Health (RCPCH) is the professional body for paediatricians, and the Royal College of Psychiatrists is the main professional organisation of psychiatrists in the United Kingdom (UK).

[70] Queensland Parliament 2022, *Question on Notice No. 1270.* https://documents.parliament.qld.gov.au/tableoffice/questionsanswers/2022/1270-2022.pdf

[71] Queensland Government 2022, *Basics of youth detention*, accessed on 28 May 2023 https://www.qld.gov.au/law/sentencing-prisons-and-probation/young-offenders-and-the-justice-system/youth-detention/about-youth-detention/basics-of-youth-detention

[72] The Northern Territory Government, Department of Territory Families, Housing and Communities 2023, *Youth Detention Centres Model of Care.* Accessed 5 October 2023. https://tfhc.nt.gov.au/youth-justice/youth-detention-centres/model-of-care

1. An operating philosophy based on six core principles.
2. An organisational framework that articulates the resources that will be employed to bring the model of care to life, translating the operating philosophy into the service model.
3. A service model that defines service standards for each element: connected to culture, family and community, connected to support, connected to opportunity and safe and secure.

The publicly available model articulates key youth justice service standards including how:

- the clear philosophy directly shapes the organisational design and service model features – from which infrastructure design is then derived
- young people being 'connected to opportunity' and 'connected to culture, family and community' whilst in detention is the overarching aim of critical importance
- a standard day for detainees occurs, including a commitment to 13 hours of unlock time per day, and how this is linked to a published evaluation and monitoring framework including independent oversight
- detention occurs within a broader continuum of Youth Justice service delivery with an emphasis on family focused interventions that address the life circumstances of young people
- a dedicated emphasis on the people that are employed and operate within the facilities meet key competencies aligned to the Youth Justice philosophy – covering their skills, capabilities and motivations (with nine 'personal attributes' providing a standard for all staffing decisions)
- clear expectations on detention centres to have partnerships that mean they are part of the community service delivery landscape where support and relationships follow young people back into community to provide enhanced 'through care' and long-term case management
- an understanding of the importance in separating relational and procedural security, as well as positive behaviour support, in the context of physical and dynamic security – so that safety is not delivered through increasingly punitive and counterproductive responses.

There is no comparable public document available in Queensland, with detention centre operations and broader Youth Justice services operating under a myriad of laws, policies, procedures, frameworks and commitments.

There is significant opportunity for Queensland to make advancements in its response to youth offending behaviours and crime if it were to define its operating model more holistically and transparently – including the connections between the various services that young people such as the two boys experience. A clearly articulated purpose statement for the state that flows into tangible and pragmatic operating guides, role descriptions, procedures and training across multiple systems is necessary.

Other matters

Commencement of the *Inspector of Detention Services Act 2022*

On 1 July 2023, the *Inspector of Detention Services Act 2022* (IDS Act) and the *Inspector of Detention Services Regulation 2023* commenced. Staff from the Office of the Queensland Ombudsman has committed to supporting the Inspector's functions under the IDS Act. *The IDS Act seeks to improve detention services with a focus on promoting the humane treatment of detainees and prevention of harm. The IDS Act sets out a framework for review of detention services, inspection of places of detention and independent and transparent reporting. This preventative focus will examine the systems and the lived experiences of people detained. Specific IDS functions include:*

- *inspecting places of detention in Queensland, including youth detention centres, adult prisons and watch-houses*
- *preparing and publishing standards for inspections*
- *reporting to the Legislative Assembly on inspection visits and making recommendations for improvement.*[73]

Staffing pressures

The cases reviewed by the Board highlight the significant challenges detention centres face in attracting and retaining the staff required to function in accordance with current policies and procedures. Staff shortages directly led to isolation and treatment that ran counter to the objectives and principles of the Youth Justice and Human Rights Acts. The two boys were denied the opportunity for a rehabilitative and transformative experience in detention. Instead, their experiences are likely to have caused further harm and impacted their physical and social and emotional wellbeing.

The Queensland Government has committed to building two new youth detention centres – one in Cairns and another in Southeast Queensland. It is important for the system to consider how staffing issues will be overcome to ensure young people receive youth detention services that are vastly improved from their current quality.

The Board considers that a clearer articulation of the role and purpose of the youth justice workforce is required to ensure Queensland attracts, supports and retains valued employees that can make tangible positive differences to the lives of young people. Workforce reform is needed that values key capabilities likely to drive behaviour change in young people.

---

[73] The Queensland Ombudsman 2023, *Detention inspection: About this service*. Accessed 5 October 2023. https://www.ombudsman.qld.gov.au/detention-inspection/about-this-service

Concluding comments

Children and young people subject to child protection and youth justice interventions are often experiencing marginalisation and recriminalisation by a system that should protect and support them. As a result, young people known to the youth justice system have poorer outcomes, and the community's frustration with repeat offending is increasing.

Young people in detention are experiencing confinement and extended separations because of staffing shortages. This is directly restricting their access to human connection, education, rehabilitative programs, exercise, fresh air and sunlight, and is contributing to escalating behaviour patterns. Punitive responses to these behaviours contribute to the recriminalisation of children and young people with lifelong negative impacts. Through its work over the last two years, and specifically in the case of these two boys, the Board has found:

1. the need for clearer early-intervention support services for young people that would prevent their escalation into the youth justice system. This includes the need for clearer accountability for youth justice prevention across all elements of our community and government service systems. Specifically, the education, health, housing, child safety and justice systems must work together on this accountability to identify and prevent young people's offending
2. the need for an improved, or more explicit, detention model of care. This would recognise how 'detention services' address trauma and correct causes of offending. It would recognise how poor internal detention processes contribute to escalated behaviour, further criminalisation of young people and a loss of hope that is driving anti-social behaviours and loss of lives
3. the need for improved workforce design in youth justice – including the skill mixes, capabilities and values of detention centre staff, as well as the attraction and retention strategies for the workforce
4. the need for improved support structures for young people that exit detention – across multiple life-domains and portfolios of government and particularly for children such as these two boys who had limited or absent family and community connections.

The Board also finds that its process of building cross-agency life-story timelines for these boys has shed light on significant missed opportunities to address youth offending. It is unfortunate that these boys' stories only came to light because of their deaths. If Queensland sought to better understand how to prevent reoffending, it would be entirely possible to replicate the Board's process for young people in the youth justice system. Selecting a sample of the current or past young people on the Serious Report Offender Index and conducting a system and practice review would lead to critical learnings and confirmation on this cohort of young people that could drive systemic changes.

In consulting with Government Departments on the proposed recommendations, the Department of Youth Justice, Employment, Small Business and Training advised that it would *continue to publish comprehensive information about the youth detention centre operating model and policy framework, noting there is substantial information available on both the Department's website and the Your rights, crime and the law website*. This information includes the youth detention philosophy which flows into a series of operational policies, frameworks and procedures. The Department undertook that *This information will be expanded upon as the Department continues to implement its practice reform agenda*. This practice reform agenda includes ongoing work on a range of workforce strategies and plans to support the safe and capable operations of Queensland youth detention centres.

Recommendation 2

Reappraising the response to youth crime and the purpose of youth justice

The Department of Youth Justice, Employment, Small Business and Training:

2.1 Takes immediate action to articulate Queensland's Detention Operating Model, and Government commits to publishing this model.

2.2 Produce a workforce strategy for Queensland youth detention centres for immediate effect, and for inclusion into the Detention Operating Model for Queensland's new detention centres.

Recommendation 3

Reappraising the response to youth crime and the purpose of youth justice

The Queensland Government:

3.1 Immediately fund and introduce improved reporting on youth detainees time out of cells (in alignment with the Report on Government Services reporting that already occurs for adults) and agree to champion this measure for inclusion in nationally consistent reporting with other jurisdictions.

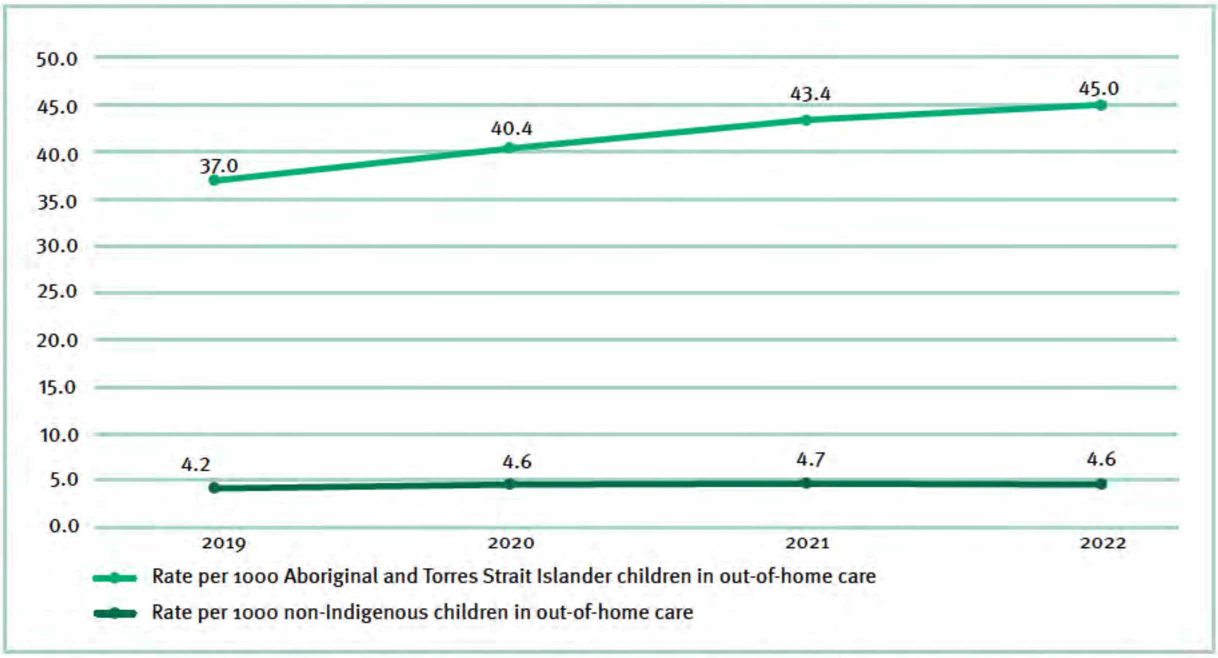
3.2 Commission the Board to utilise its review process to review a sample of cases of young people on the Serious Repeat Offender Index and advise Government on the common system issues and opportunities to prevent and reduce reoffending for young people in this cohort.

Chapter 4

Improving research on the needs of First Nations communities

Improving research on the needs of First Nations communities

Aboriginal and Torres Strait Islander young people and children were over-represented in the cases reviewed by the Board during 2022–23. Of the 60 cases, 28 (47%) identified as Aboriginal and Torres Strait Islander. Since the commencement of the current child death review model in July 2020, First Nations children and young people have been consistently over-represented. This reflects the wider over-representation in Queensland's child protection system.



Graph 4: Rate per 1000 children in Queensland in out-of-home care as of 30 June 2019 to 2022. Source: *Report on Government Service 2023*, 16 Child Protection Services, Table 16A.

In previous years, the Board has made recommendations that sought to address over-representation of First Nations children and young people in the child protection system. The aim has been to improve the cultural responsiveness of service delivery to First Nations children and their families. Over the course of its meetings throughout 2022–23, the Board identified the need for culturally safe research into best practices for working with Aboriginal and Torres Strait Islander families that is either led by or conducted in partnership with Aboriginal and Torres Strait Islander people and incorporates the voices of children, young people, their families and communities.

Of the 28 cases, 19 children and young people had active involvement by Child Safety at the time of their deaths. This included Investigation & Assessment (I&A), support services cases, Intervention with Parental Agreement (IPA), and various child protection orders. The nine remaining children had involvement with Child Safety in the 12 months prior to their deaths but not at the time they died. Twenty of the 28 children had been living at home with their families or guardians.

The case records reviewed by the Board commonly noted concerns about socio-economic disadvantage, domestic and family violence and substance misuse, including alcohol misuse and parental mental health as compounding challenges. The Board has observed in line with the Australian Institute of Family Studies (AIFS) that the drivers of over representation of First Nations children and young people in the child protection system are often multi-faceted and connected to the legacy of colonisation, and past assimilation policies and practices.[74] Cultural disconnection, identity disruption, isolation from communities and intergenerational trauma are significant contributing factors. Furthermore, discrimination, poverty, and lack of access to services, in particular in rural, remote, and discrete communities can have disproportionately negative impacts on Aboriginal and Torres Strait Islander people.[75]

Appropriate alcohol and drug intervention strategies must be sensitive to this context and respond to an individual's cultural needs. The Board notes that there is a significant lack of research into the drivers of problematic alcohol and drug use within Aboriginal and Torres Strait Islander families. While these issues occur across all cultures, research and responses need to be tailored and safe for intended audiences.[76] The Board believes that a stronger evidence base is needed that has been led, created, and designed by First Nations professionals and champions the voices of First Nations children, young people, their families, and communities.

---

[74] Australian Institute of Family Studies 2020, *Child protection and Aboriginal and Torres Strait Islander children*, https://aifs.gov.au/resources/policy-and-practice-papers/child-protection-and-aboriginal-and-torres-strait-islander

[75] The Australian Bureau of Statistics has published data pertaining to the 10 most disadvantaged Local Government Areas (LGA) are: Woorabinda (Queensland), Cherbourg (Qld), Belyuen (NT), West Daly (NT), Yarrabah (Qld), Kowanyama (Qld), Wujal Wujal (Qld), East Arnhem (NT), Doomadgee (Qld) and Central Desert (NT). See Socio-Economic Indexes for Areas (SEIFA), Australia, 2021 | Australian Bureau of Statistics (abs.gov.au)

[76] See Chapter 5: *Strengthening child safety practice in response to parental substance and methamphetamine use* for further detail on this topic.

The need for First Nations-led research

Aboriginal and Torres Strait Islander peoples are a heavily researched cohort and are considered to be the most researched peoples in the world.[77] There are concerns that, despite this, there have been limited to no corresponding benefits or improvements for Aboriginal and Torres Strait Islander peoples.[78] Research methodologies and practices often derive from Western concepts, which can mean that the *researcher maintains control of the depth and type of interaction and manages data gathering and analysis.*[79] Research led by Aboriginal and Torres Strait Islander people allows determination of what the purpose and objectives of the research are, how it progresses, and how research outcomes will be of benefit to Aboriginal children, young people, their families and communities.

The Board raised the need for tailored research to better understand the dynamics, impact and best practice responses for working with First Nations families. Not enough research available to the Board was conducted by, or in partnership with, Aboriginal and Torres Strait Islander people. The Board found that *policy responses to Aboriginal and Torres Strait Islander disadvantage have too often been focused on responding to the symptoms of trauma, rather than prioritising healing to address the cause.*[80]

In the health sciences, the Board noted that there is strong commentary on the need and benefits for research that is conducted by and for Aboriginal and Torres Strait Islander peoples. Significant groundwork has been achieved in the development of guidelines for undertaking ethical research in partnership with Aboriginal and Torres Strait Islander peoples, including but not limited to the work of the Lowitja Institute and the National Health and Medical Research Council. These principles and guidelines can readily inform research in other domains.

Children and young people have often been excluded and their voices left unheard within research. The Board observed that some research designs seem to imply that children and young people are unable to participate in making important decisions that affect them.[81]

A recent example of First Nations-led research is that by Australia's National Research Organisation for Women's Safety (ANROWS) in partnership with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP). This research examines the impact of domestic and family violence on First Nations families in contact with the Queensland child protection system, and how services can better support families *to heal from their experiences and break the intergenerational cycle of distress*.[82] The experiences of children and young people are also included in this research, being mindful that service delivery can often be focused on adults.

This research is led by Aboriginal and Torres Strait Islander researchers using a participatory action research methodology, a collaborative and iterative process that aims to *elevate Indigenous voice and self-determination by generating knowledge by and for Indigenous people, families, and communities.*[83] This ensures that there is focus on cultural safety and inclusion of cultural values and protocols in research processes. The Board looks forward to the findings of this research project upon completion.

Having Aboriginal and Torres Strait Islander peoples involved in all aspects of research is crucial to achieving successful and meaningful outcomes.

---

[77] The Queensland Government, National Health and Medical Research Council 2018, *Ethical guidelines for research with Aboriginal and Torres Strait Islander peoples*. Accessed 5 October 2023. https://www.nhmrc.gov.au/research-policy/ethics/ethical-guidelines-research-aboriginal-and-torres-strait-islander-peoples

[78] Ibid.; Bainbridge R, Tsey K, McCalman J, Kinchin I, Saunders V, Lui FL, Cadet-James Y, Miller A & Lawson K 2015, 'No one's discussing the elephant in the room: contemplating questions of research impact and benefit in Aboriginal and Torres Strait Islander Australian health research', *BMC Public Health*, 15, 696.

[79] Biin D, Canada D, Chenoweth J & Neel L 2021, *Pulling Together: A Guide for Researchers, Hiłk'al*. BCcampus. https://opentextbc.ca/indigenizationresearchers/

[80] Healing Foundation, *Leading Our Way: Queensland Aboriginal and Torres Strait Islander Healing Strategy 2020-2040*. https://www.dcssds.qld.gov.au/resources/campaign/supporting-families/leading-healing-our-way.pdf

[81] Langhout R and Thomas E 2010, 'Imagining Participatory Action Research in Collaboration with Children: an Introduction'. *American Journal of Community Psychology*, 46: 60-66. https://onlinelibrary.wiley.com/doi/10.1007/s10464-010-9321-1

[82] Australia's National Research Organisation for Women's Safety, *New Ways for Our Families: Designing an Aboriginal and Torres Strait Islander cultural practice framework and system responses to address the impacts of domestic and family violence on children and young people.* https://anrowsdev.wpenginepowered.com/wp-content/uploads/2022/04/Morgan-et-al-RR1_NewWaysOurFamilies.pdf

[83] Ibid.

> *...self-determination starts by empowering Aboriginal and Torres Strait Islander peoples to make decisions about the things that affect them directly, about their trauma and healing. Governments need to allow the community to lead solutions. This requires governments and other service providers to relinquish control and share decision-making power with Aboriginal and Torres Strait Islander peoples.*[84]

In response to consultation, the Department of Child Safety, Seniors and Disability Services confirmed its commitment to *Breaking Cycles – An action plan: co-designing, developing and implementing services with and for Aboriginal and Torres Strait Islander children and families 2023–25*. Breaking Cycles was co-designed with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) and commits the Department to work with QATSICPP to address Aboriginal and Torres Strait Islander data sovereignty and establish a Safe and Supported data sovereignty working group with subject matter experts across the Department. Representatives of DCSSDS regularly attend national Safe and Supported meetings to share progress made under the relevant action plans and to coordinate a nationally consistent approach to data sovereignty. Through this work the Department of Child Safety, Seniors and Disability Services is working to implement the principles of Aboriginal and Torres Strait Islander data sovereignty in the child safety research program. The Board commends the Department for this work and recommends broader adoption of this approach across Government.

Concluding comments

The over representation of Aboriginal and Torres Strait Islander children in the child protection system and child death statistics remain a significant focus for the Board. The Board is calling for culturally safe research into best practices for working with Aboriginal and Torres Strait Islander families and addressing the multiple complexities some Aboriginal and Torres Strait Islander families are facing.

Recommendation 4

Improving research on the needs of First Nations communities

The Queensland Government strengthens its policies and commits to ensuring that research seeking to understand the needs of First Nations families is designed, procured, coordinated and conducted involving First Nations professionals.

---

[84] Healing Foundation, *Leading Our Way: Queensland Aboriginal and Torres Strait Islander Healing Strategy 2020-2040*. https://www.dcssds.qld.gov.au/resources/campaign/supporting-families/leading-healing-our-way.pdf

Chapter 5

Strengthening child safety practice in response to parental substance and methamphetamine use

Strengthening child safety practice in response to parental substance and methamphetamine use

Problematic alcohol and drug use[85] was regularly identified as a child protection concern in the cases the Board has reviewed.[86] Of the 170 cases reviewed by the Board from 1 July 2020 until 30 June 2023, methamphetamine use was prevalent in 32.94% of cases. The Board also observed a high prevalence of polysubstance use by parents.

Children are impacted by a parent or caregiver's problematic alcohol and drug use in profound ways. Direct exposure can significantly harm a child's physical, emotional and mental health. Moreover, indirect and environmental exposure can pose significant secondary risks to children. Children who were exposed to problematic alcohol and drug use often became known to the child protection system, repeatedly for a combination of concerns that the Board commonly observed across cases. Housing instability and domestic and family violence were often among such common experiences.

While practitioners often articulated awareness of parental polysubstance use and concerns about their capacity to parent safely, this did not always trigger effective responses towards mitigating risk to children.

The consequences of parental methamphetamine use can include impaired decision making that results in children's exposure to unsafe environments with access to drugs or drug paraphernalia, unsafe driving while under the influence, exposure to poor ventilation or unsafe temperatures for extended periods, unsafe sleeping practices, and basic care needs not being met (i.e., nutrition, hydration, hygiene, clothing, medical care). Parents who regularly use methamphetamines can show extreme and unpredictable mood fluctuations, violent behaviours, and lack of impulse control. This pattern of behaviour has been shown to impede parent-child attachment and reduces parents' emotional availability.

The Board received evidence that parents using methamphetamines experience high levels of parental and psychological distress, which can persist even during abstinence. They also display depressive symptoms and dysfunctional parenting practices (e.g., indifferent and overreactive tendencies). Although they can experience strong feelings of guilt and self-doubt towards their children, they also tend to perceive their children as highly demanding. Consistent with the typical binge and crash cycle of methamphetamine use, parents cycle through periods of euphoric-wakefulness, irritability and volatility, and lethargy and depression. Additional vulnerabilities include financial strain, unemployment and periods of incarceration. There is also an inter-generational component, whereby their children learn dysfunctional behaviours and relationships.

The Board observed that children whose parents regularly used substances were harmed or were at unacceptable risk of harm. This occurred as a result of the following factors:

- exposure in utero and/or environmental exposure to harmful substances
- exposure to criminal activity, especially drug-related offending
- not meeting basic care needs such as food, drink, shelter, appropriate clothing, personal hygiene, and medical care
- not enough age-appropriate supervision
- unsafe sleeping practices
- inconsistent, erratic, and dangerous parental behaviour
- emotional unavailability of parents to their children, resulting in emotional neglect
- developmental delays from limited stimulation
- insecure attachments to parent/caregiver.

Children of parents who use alcohol and drugs did not always have access to safe and protective care, severely impacting their physical and emotional development. Parents consistently prioritised funding, obtaining and using alcohol and drugs over the needs of their children.[87] In several cases, children were in the care of a parent who was driving under the influence, exposed to unsafe persons during drug deals, had access to dangerous drugs, and lived in proximity to drug paraphernalia.

---

[85] The terminology problematic or harmful drug and or alcohol use, as used throughout this report, is consistent with the terminology recognised in the *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022-2027*. See https://info.qmhc.qld.gov.au/queensland-alcohol-and-other-drugs-plan

[86] Alcohol and drug foundation 2023, *Polydrug use*. Accessed 5 October 2023. https://adf.org.au/reducing-risk/polydrug-use/

[87] Child Safety 2023, *Living with alcohol and other drugs use*. Accessed 5 October 2023. https://cspm.csyw.qld.gov.au/practice-kits/alcohol-and-other-drugs/working-with-parents-1/seeing-and-understanding-1/living-with-aod-use

Polysubstance abuse by parents can result in the exposure of a child to inconsistent and unpredictable parenting behaviours. As a result of their using, a parent's presentation can oscillate between manic, impulsive and overly attentive behaviours and emotional withdrawal, flat affect, and limited to no responses towards their child.[88] Such lack of emotional regulation can substantially impact a child's developing ability and competency to regulate their own emotions and significantly disrupt attachments with parents and caregivers.[89] Problematic alcohol and drug use is not only a risk factor for emotional abuse. The Australian Childhood Maltreatment Study (ACMS) found that family substance problems double the risk for multi-type maltreatment.[90]

Cumulative harm

Exposure to parental substance use can have lifelong impacts on a child. Young children are particularly vulnerable to emotional harm, with exposure to parental substance use before age three linked to insecure and disorganised attachment[91] and delayed speech and language development.[92] Even minor exposure can have compounding effects over time, resulting in cumulative harm.[93]

Heightened vulnerability of infants and very young children

Infants and very young children, due to their absolute dependence on their caregivers, are especially vulnerable to the harms of problematic alcohol and drug use. The Board reviewed cases of infants going without food and water, left in dirty nappies, confined for extended periods in cots, not given attention or physical touch, and missing medical appointments. Such neglect, even over relatively short periods of time, can be fatal. Therefore, it is vital that care is provided by a safe adult who is consistently responsive to the infant or young child's needs.[94]

Practitioners must consider how the necessities of life might be met for an infant or child if the parent's capacity to keep the child safe is impaired due to their substance use.

Newborn baby's story: exposure in utero and unsafe neonatal period

Newborn Baby was born to a mother who had been experiencing multiple complex issues including methamphetamine (ice) addiction, untreated mental health issues, homelessness and limited family and social supports.

Newborn Baby's mother had been referred to multiple health services in relation to antenatal/postnatal care and concerns about substance use. However, the services reported difficulties engaging her.

At birth, Newborn Baby did not have signs of withdrawal but soon developed feeding and breathing difficulties and remained in hospital for several weeks. During this time, Newborn Baby was assessed as 'Safe' due to the increased visibility at the hospital. However, hospital staff had been voicing concerns for Newborn Baby's safety due to Mother's sporadic visitation and non-engagement with specialised feeding education.

Newborn Baby was eventually discharged from hospital into their mother's care. Two weeks later, Newborn Baby passed away after reportedly being unsettled and having difficulties feeding. At the time, Mother had been visiting a known drug associate.

---

[88] Ibid.

[89] Shadur J and Hussong A 2020, 'Maternal Substance Use and Child Emotion Regulation: The Mediating Role of Parent Emotion Socialization', *Journal of Child and Family Studies* 29, 1589–1603. https://link.springer.com/article/10.1007/s10826-019-01681-5

[90] Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 2023, *'The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report', Australian Child Maltreatment Study,* Queensland University of Technology. https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/

[91] Barnard M and McKeganey N 2004, *'The impact of parental problem drug use on children: what is the problem and what can be done to help?', Addiction,* 99(5), 552-559.

[92] Dunn MG, Tarter RE, Mezzich AC, Vanyukov M, Kirisci L & Kirillova G 2002, 'Origins and consequences of child neglect in substance abuse families', *Clinical Psychology Review,* 22(7), 1063-1090.

[93] Broadley K 2014, 'Equipping child protection practitioners to intervene to protect children from cumulative harm: Legislation and policy in Victoria, Australia', *Australian Journal of Social Issues*, 49(3), 265-284.

[94] Child Safey 2022, *Safety Planning*. Accessed 5 October 2023. https://cspm.csyw.qld.gov.au/practice-kits/alcohol-and-other-drugs/safety-assessment-and-safety-planning

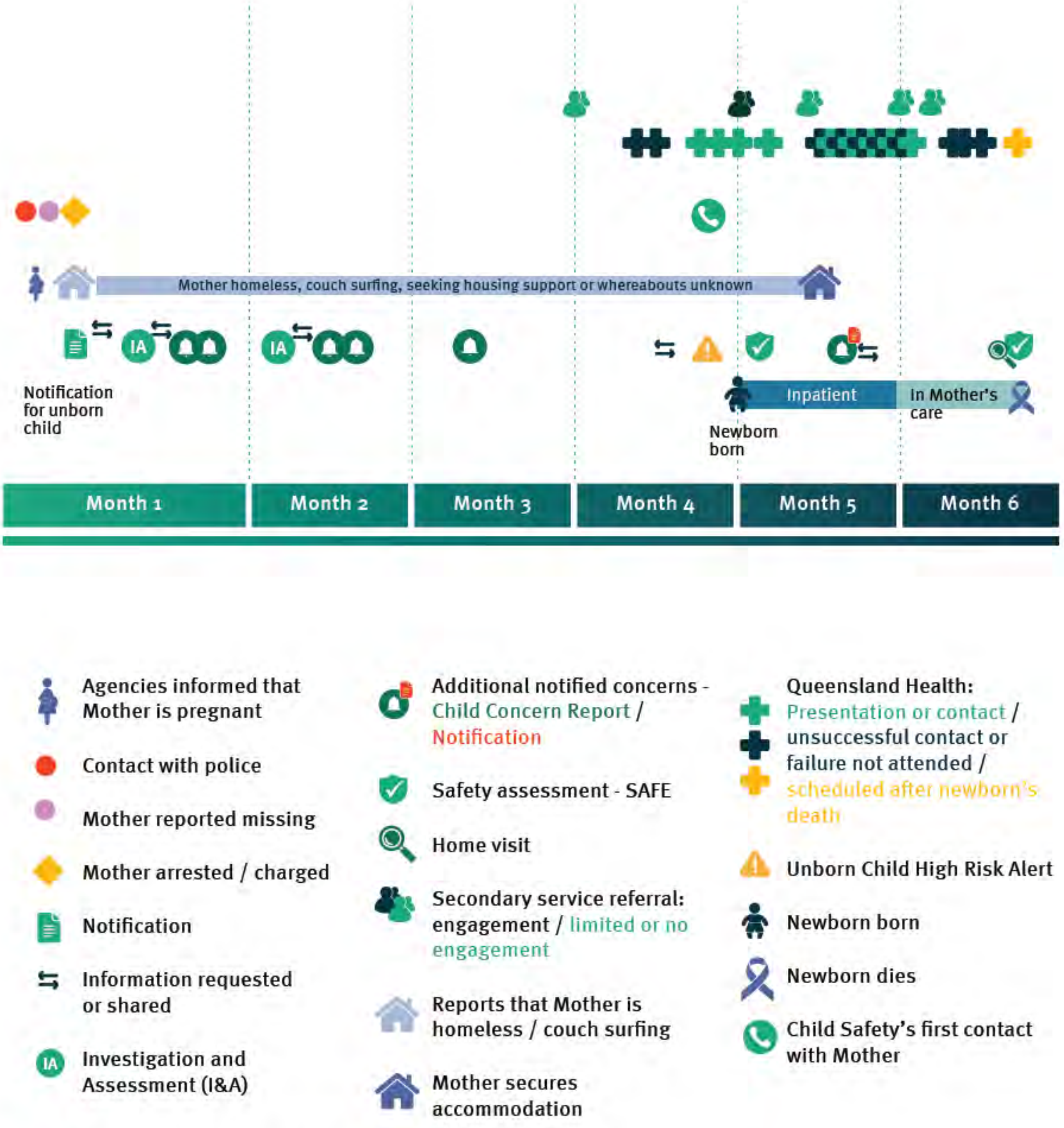


Figure 6: Timeline of system touchpoints for Newborn Baby

Demographic overview and prevalence of methamphetamine use in Queensland

Methamphetamines are one type of a class of drugs called amphetamines. They have a stimulatory effect on the central nervous system, with the most potent form of methamphetamine known as crystal methamphetamine, or ice. Consequently, people using methamphetamines are much more susceptible to developing dependence and experiencing a range of associated harms. Australia ranked third highest for consumption of methamphetamines globally.[95] The prevalence of methamphetamine use in Queensland is on par with national use in Australia and its use is associated with more social marginalisation and disadvantage, compared to parents who use other drugs, such as alcohol, tobacco, and cannabis,[96,97] higher likelihood of polysubstance use, and co-occurring mental health concerns.[98]

The proportion of people in Queensland aged at least 14 years of age who reported having used methamphetamines in the previous 12 months for non-medical purposes fell from 2.9% in 2001 to 1.5% in 2016 to less than the national average of 1.3% in 2019.[99] The Australian Criminal Intelligence Commission's National Wastewater Drug Monitoring Program (NWDMP) Report noted that although national data showed that the average excretion of methamphetamine in wastewater was higher in cities, relative to regional areas, this pattern was reversed in Queensland.[100] Nevertheless, the level of detection of methamphetamine in regional wastewater remained steady in regional Queensland from the second half of 2020 to the end of 2022, compared to a consistent increase in metropolitan areas of Queensland.

In Queensland, data collated in March 2021 showed that an estimated 42% of children in Out of Home Care had at least one parent who had a record of methamphetamine use.[101]

In Australia during 2021, methamphetamines accounted for 8.2% of all drug-related hospitalisations (12,400)[102] and were the principal drug of concern in 24% of treatment episodes.[103] The most common cause of methamphetamine-related death was accidental drug toxicity, although suicide and accidents comprised more than half of all these deaths.[104] Although methamphetamine-related harms occur across the population in Australia and globally, these harms are disproportionately high for people and communities from lower socio-economic backgrounds.[105] In the Australian context, First Nations people are disproportionately impacted by lower socio-economic factors: an estimated one-third of the health gap between First Nations people and non-First Nations people is attributable to lower levels of schooling, employment status, hours of employment, housing adequacy and income.[106] For First Nations Australians, these structural risk factors are further aggravated by the individual-level risk factors that apply to all individuals regardless of their cultural identity, such as adverse childhood experiences, trauma, grief and loss.[107]

---

[95] Australian Criminal Intelligence Commission 2023, *National Wastewater Drug Monitoring Program, Report 19*. https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports

[96] Semple, S Grant I & Patterson TL 2005, 'Utilization of Drug Treatment Programs by Methamphetamine Users: The Role of Social Stigma', *The American Journal on Addictions*, 14(4), 367–380. https://onlinelibrary.wiley.com/doi/abs/10.1080/10550490591006924

[97] Ward B, Kippen R, Reupert A, Maybery D, Agius PA, Quinn B, Jenkinson R, Hickman M, Sutton K, Goldsmith R and Dietze PM 2021, 'Parent and child co-resident status among an Australian community-based sample of methamphetamine smokers', *Drug Alcohol Review*, 40(7), 1275-1280. https://onlinelibrary.wiley.com/doi/10.1111/dar.13155

[98] National Centre on Substance Abuse and Child Welfare 2021, *Supporting children affected by parental methamphetamine*. https://ncsacw.acf.hhs.gov/files/meth-tip-sheet-children.pdf

[99] AIHW 2020, *National Drug Strategy Household Survey*. https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/contents/summary

[100] Australian Criminal Intelligence Commission 2023, *National Wastewater Drug Monitoring Program, Report 19*. https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports

[101] The Queensland Cabinet and Ministerial Directory 2021, *Demand increases for family support and child protection.* https://statements.qld.gov.au/statements/92939

[102] AIHW, 2023, *Illicit drug use*. Accessed 5 October 2023. https://www.aihw.gov.au/reports/illicit-use-of-drugs/illicit-drug-use

[103] AIHW, 2023, *Australia's mothers and baby: Maternal Age.* Accessed 5 October 2023. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/overview-and-demographics/maternal-age

[104] Darke S, Kaye S and Johan D 2017, 'Rates, characteristics and circumstances of methamphetamine related death in Australia: a national 7 year study', *Addiction*, 112(12), 2191–2201. https://onlinelibrary.wiley.com/doi/10.1111/add.13897

[105] United Nations Office on Drugs and Crime 2020, 'Drug use and consequences', *World Drug Report 2020*. https://wdr.unodc.org/wdr2020/field/WDR20_Booklet_2.pdf

[106] AIHW, 2022, *Determinants of health for Indigenous Australians.* Accessed 5 October 2022. https://www.aihw.gov.au/reports/australias-health/social-determinants-and-indigenous-health

[107] Lee WC, Fang SC, Ying-Yeh C, Liu HC, Huang MC & McKetin R 2023, 'Exploring the mediating role of methamphetamine use in the relationship between adverse childhood experiences and attempted suicide', *Addictive Behaviors*, 123, 107060–107060. https://www.sciencedirect.com/science/article/abs/pii/S0306460321002458?via%3Dihub

Alcohol and drug informed practice

Both National[108] and Queensland[109] strategies to address problematic alcohol and drug use advocate a harm minimisation approach. The approach aims to reduce 1) demand, 2) harm and 3) supply.[110] The second aim, harm reduction, is about providing support services to people, their families and their communities to minimise the negative effects of alcohol and drug use.[111]

From the child protection system's perspective, the priority for any intervention is to ensure that children are safe. Harm reduction in this context means first and foremost that risk to the child must be minimised and continually managed. This means that a child's short- and long-term safety is the primary objective when working with a family impacted by parental substance use. This is in accordance with the *Child Protection Act 1999's* Paramount Principle:

> *The main principle for administering this Act is that the safety, wellbeing and best interests of a child, both through childhood and for the rest of the child's life, are paramount.*[112]

Ensuring a child's safety in the context of parental substance use does not always need to result in the child's removal from their parents' care. There are many Australians who engage in substance use – particularly alcohol – where there is no evidence available that they are posing safety risks to their children, for example because they have utilised their safety and support networks (e.g., arranging alternative supervision from a family member). Where concerns exist in the child protection system, skilled practitioners must conduct robust risk assessments to determine the likelihood a child might suffer harm which will inform decision making about ongoing child protection interventions.

Once a child's safety needs have been determined, the intervention for parents should focus on both reducing substance use and improving parenting skills.[113] Evidence suggests that such dual treatments are more effective in a child protection context than approaches that address drug use alone.[114,115]

In the cases it reviewed the Board noted that children did not always receive the support and intervention they and their parents needed to help keep them safe, despite the best intentions of the systems around them. The child's interests were not always held at the centre of practice. This resulted in the children continuing to be exposed to hazardous parenting practices in dangerous environments without additional supports, where the significant risks of ongoing harm were not fully understood, and as such were insufficiently mitigated and addressed.

A significant number of cases involved children under three years old whose parents had engaged in methamphetamine use (38% of the 170 cases reviewed by the Board in its three years of operation). From reviewing these cases, the Board noted that further research is needed to better understand how behaviours indicative of methamphetamine use might be recognised and responded to effectively in frontline practice.

---

[108] Australia Government Department of Health and Aged Care 2017, *National Drug Strategy 2017–2026*, 13. https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf

[109] The Queensland Mental Health Commission (QMHC) 2022, *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022-2027*, 17. https://info.qmhc.qld.gov.au/queensland-alcohol-and-other-drugs-plan

[110] The QMHC 2022, *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022-2027*, 17. https://info.qmhc.qld.gov.au/queensland-alcohol-and-other-drugs-plan

[111] Ibid.

[112] *Child Protection Act 1999*, Section 5A: Paramount Principle.

[113] Ward B, Moller C, Maybery D, Weimand B, Krause M, Dietze P, Harvey P, Kippen R, McCormick F, Lloyd-Jones M & Reupert A 2022, 'Interventions to support parents who use methamphetamine: A narrative systematic review', *Children and Youth Services Review*, 139.

[114] Neger E & Prinz R 2015, 'Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations', *Clinical psychology review*, 39, 71-82.

[115] Ward B, Moller C, Maybery D, Weimand B, Krause M, Dietze P, Harvey P, Kippen R, McCormick F, Lloyd-Jones M & Reupert A 2022, 'Interventions to support parents who use methamphetamine: A narrative systematic review', *Children and Youth Services Review*, 139.

Baby's story: the dangers of limited safety planning

Baby lived with their mother and two siblings. Baby's parents had a long history of polysubstance use, poor mental health, and criminal offending, which included drug trafficking and lead to periods of imprisonment.

Soon after Baby's birth, Child Safety opened an Intervention with Parental Agreement (IPA) with the family. As part of the casework, child protection practitioners developed an ongoing safety plan with the family which requested that Baby's mother would not use or deal drugs while caring for Baby. The plan, however, did not spell out how mother might achieve this goal and what assistance she may require. Baby's death occurred during a night their mother was using drugs at her home alongside several other adults. It appears that the safety plan did not help to increase the safety of Baby as it relied too heavily on mother's capacity to independently change her long-established patterns of substance use.

The Board noted the following themes and patterns in child protection risk assessments and associated Impacts on children from their parents' drug use:

- **Challenges identifying cumulative harm** – chronic emotional abuse and neglect caused by repeated exposure to parental drug use often remained unaddressed. Cumulative harm is often less visible and takes additional effort to identify, including direct observations of the child. In consideration of resourcing constraints, the Board noted that practitioners do not always have the resources to pursue this.
- **Difficulty recognising impacts on children from patterns of problematic substance use by parents** – behaviours were evaluated as individual incidents rather than repeated habits.
- **Missed opportunities to investigate extent and type of drug use and associated impacts** – where parents disclosed polysubstance use, follow up conversations about the extent and type of drug use often did not go beyond eliciting superficial information and did not sufficiently explore the impacts on children.
- **Acceptance by workers when parents advised they were unwilling to address their substance use** – many parents were pre-contemplative about addressing their alcohol and drug use and denied any negative impacts on their child/ren.
- **Acceptance of information from parents at face-value** – working with parents who use substances at levels that present harm to their children requires practitioners to use a level of scepticism.[116] Accounts from the parents were often given more weight than the accounts from members of the safety and support network.
- **Overreliance on inadequate family arrangements or support networks** – informal arrangements with family members or friends were considered sufficient to care for a child when their parent was intoxicated. Often practitioners did not confirm that people who had agreed to care for a child were safe and sober to do so.
- **Overly optimistic practice** – a parent's ability and willingness to adhere to established safety plans was frequently overestimated. Some safety plans did not sufficiently take into account a parent's past behaviour in the context of problematic substance use.

The systemic difficulties to accurately ascertain risks to children from problematic alcohol and drug use as outlined above require greater education and resources across the child protection system to increase children's safety and protection.

---

[116] Hader Clinic Queensland, *Why addicts lie and how to deal with it*. Accessed 5 October 2023. https://haderclinicqld.com.au/why-addicts-lie-and-how-to-deal-with-it/

Young Boy's story: safeguarding children facing multiple household challenges

Young Boy was the only child born to young parents. The family resided with several family members and friends while they were facing challenges to obtain stable accommodation. The records state that Young Boy had been present while the parents used and dealt drugs and had witnessed his father perpetrate domestic and family violence against his mother.

In the year prior to Young Boy's death, several child protection risk assessments identified all of the above challenges in relation to concerns about Young Boy's immediate safety. However, the records contained little information on how practitioners considered the impacts these potentially traumatic experiences might have had on Young Boy. There was also limited information on what strategies and interventions could have been deployed to increase the family's safety. During the time Child Safety was working with Young Boy and his parents, multiple extended family members offered to care for him.

No ongoing intervention was open in the months prior or at the time of Young Boy's death. Young Boy remained in the care of his parents without any support to scaffold his safety, nor did his parents receive targeted support to help address the challenges that they were facing, which likely had been caused at least in part by their ongoing substance use. Young Boy died in a car crash where his father may have been driving while under the influence of drugs.

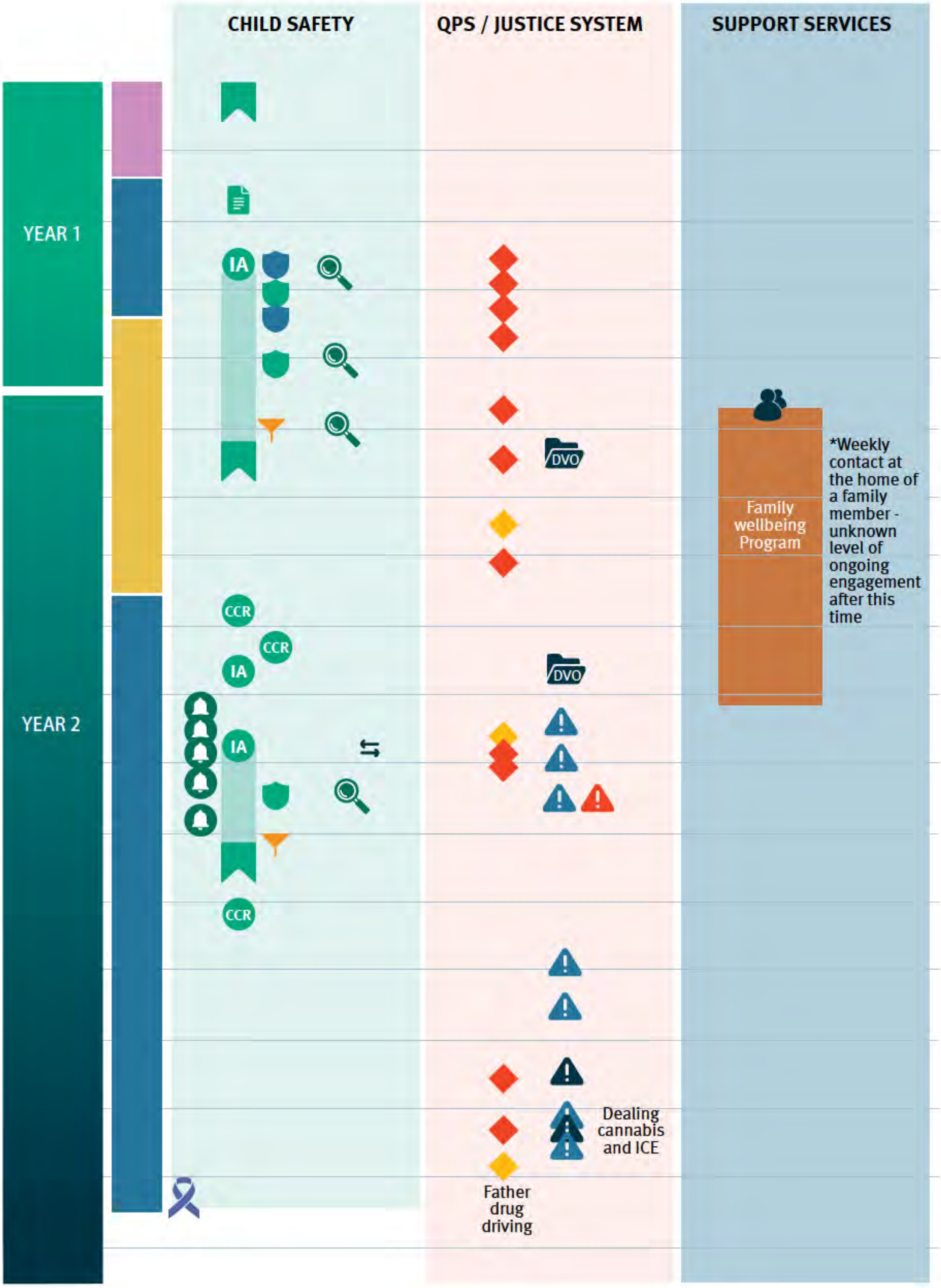


Figure 7: Timeline of system touchpoints for Young Boy

CHILD SAFETY

📄	Notification
CCR	Child Concern Report
IA	Investigation and Assessment
🔍	Home visit
🛡 🛡	Safety Assessment – Safe/ Safe with Immediate Safety Plan
🔔	Additional notified concerns - Child Concern Report / Notification
🔖	I&A outcome substantiated
▼ ▼	Risk evaluations: moderate / high
✓ ✗	Safety Assessment: Safe with plan / Unsafe
⇆	Information requested or shared
🎗	Young Boy died

QPS / JUSTICE SYSTEM

DVO	Domestic Violence Order
◆	Arrested / charged
◆	QPS street check / caution
⚠	DVO breach / incident with QPS response
⚠	Drug intelligence
⚠	Mother suicidal

YOUNG BOY'S LIVING ARRANGEMENTS

🟪	Maternal family's house with mother
🟦	Friend's house with both parents
🟨	Paternal family's house with parents

🟧 SUPPORT SERVICES

👥	Family wellbeing program

The Board's case observations suggest that practitioners require greater support to determine a threshold at which problematic substance use means there is no parent able and willing to care for and protect their child. In some cases, this may mean that there is ongoing intervention to address the child protection concerns and, in some instances, the child may need to be removed from their parents' care while safety concerns are addressed.

Recent system responses to alcohol and other drug use

On 14 October 2022, the Queensland Government released *Achieving balance: The Queensland Alcohol and Other Drugs Plan (2022–2027) (Achieving balance).* It is a whole-of-government plan that puts into action the Queensland Government's commitment to preventing and reducing use of alcohol and drugs.

Achieving balance includes some priority actions which focus on the needs of families. These include:

- improvement in coordination across systems to build capacity and increase culturally appropriate, evidence-informed family supports and interventions
- improvement of prevention and early intervention through earlier identification and provision of appropriate child, youth and family services for children and young people experiencing vulnerabilities associated with parental alcohol and other drug use.[117]

Responding to methamphetamine use and harms

In 2023, the Board commissioned the University of Queensland's Poche Centre for Indigenous Health to conduct a literature review and present findings in a research report that examines the demographics and impact of methamphetamine use on infants and young children, with particular consideration of the Queensland context. The research report details what is known about methamphetamine use within families who have been in contact with the child protection system and comments on how the child protection system in Queensland could engage in a whole-of-system effort to recognise and respond to the care and protection needs of young children in families with parental methamphetamine use.

The Board provided 33 de-identified case reviews to identify how best practice interventions could be applied to prevent child deaths in the future. The research report aims to generate tangible guidance to practitioners in relation to assessment of parental capacity in the context of methamphetamine use and the implications for targeted intervention programs. Findings from the report are summarised briefly in the below section.

The research confirmed that recognition of parental methamphetamine use, and its impact on children, is difficult for practitioners. Where methamphetamine use was identified in the 32 cases studies, there was often little recorded evidence showing how practitioners might have responded to or address the concerns. Possible reasons for this include:

- underappreciation of the risk of parental methamphetamine use to children
- insufficient information about the extent and patterns of the parent/s' use
- a lack of understanding about how methamphetamine use is compounded by other challenges
- unaddressed stigma towards parents and families who use methamphetamines.

This then resulted in missed opportunities to intervene. The research suggests that there are opportunities for stronger and more effective system responses to families where methamphetamine use by parents has been identified. This can include:

- ongoing guidance and support to frontline staff to develop a better understanding of the impacts and harms on children from parental methamphetamine use
- investment in time-effective and collaborative information sharing
- minimising stigma by leveraging existing resources, programs and initiatives
- considering the development of a stepped approach response across the child protection system, including the development of a Queensland-specific model of therapy that is based on current best evidence family therapies.

---

[117] The QMHC 2022, *Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022-2027*, 24. https://info.qmhc.qld.gov.au/queensland-alcohol-and-other-drugs-plan

Parents who use methamphetamine are often engaged in a set of behaviours that include staying awake, having multiple sex partners, exhibiting erratic and bizarre behaviours, and experiencing extreme euphoria followed by painful withdrawal symptoms, such as depression, paranoia, irritability or delusions. In addition to these risks associated with the use of methamphetamine itself, parents who use methamphetamines become exposed to increasingly risky situations over time, such as being out late at night while seeking or dealing drugs, engaging in criminal activities to support drug use, or involvement in prostitution.

A relatively unique feature of methamphetamine use is that the trajectory from initial, or low risk, use to highly problematic use and dependence is often rapid.

Modifying the trajectory of parental methamphetamine use is difficult, especially for parents who are using ice. One natural history study found that the only an estimated 5% of people who had been using ice had been able to maintain sobriety for three years without a form of treatment or formal rehabilitation program.[118] The success with which abstinence from methamphetamines can be achieved does appear to improve with treatment, with one study showing 39% of people maintained abstinence for 12 months after treatment.[119]

Appropriate alcohol and drug interventions must also respond to people's cultural needs. Such responses cannot be implemented effectively without self-determination. For First Nations families, some of the ongoing impacts of colonisation can contribute to multiple adverse experiences. This can include engagement in substance use and experiences of homelessness.[120] Cultural disconnection, identity disruption, isolation from communities and intergenerational trauma are significant contributing factors which are perpetuated by ongoing discrimination, poverty and lack of access to services.[121]

Concluding comments

The Queensland Government's *Action on ice plan of 2018* has invested more than $100 million over five years to address the impact of ice on Queensland communities. The overall intent is to reduce the burden imposed by ice use on emergency services, community services, law enforcement and the health system, and the staff that work within them, across the public, private and non-government sectors. The key features of this plan are:

- Increased community awareness about the consequences of ice use, along with a dependable and reputable information hub for guidance on seeking assistance and support.
- Improved availability and augmented funding for efficient, adaptable, and culturally fitting services for treatment, recovery, and support for both individuals and families. This included $1.7 million over three years to Lives Lived Well for residential recovery units, improved co-ordinated outreach and intensive care management support for families in Logan and its surrounds engaged in the child protection system.
- A criminal justice system attuned to the requirements of those impacted by ice, encompassing stringent penalties for those involved in supplying alcohol and other drugs (AoD) substances.

---

[118] Campillo, R 2022, 'My Experience and Recovery from Meth Addiction', *Missouri Medicine.* 119(6): 500. https://pubmed.ncbi.nlm.nih.gov/36588652/

[119] Breckt M & Herbeck D 2015, 'Time to relapse following treatment for methamphetamine use: a long-term perspective on patterns and predictors', *Drug and Alcohol Dependence*, 139, 18-25

[120] AHIW 2016, *Exploring drug treatment and homelessness in Australia: 1 July 2011 to 30 June 2014.* https://www.aihw.gov.au/reports/homelessness-services/exploring-drug-treatment-homelessness-2011-2014/notes

[121] Australia Government Department of Health and Aged Care 2017, *National Drug Strategy 2017–2026*, 26-7. https: //www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026.pdf

The *Queensland Alcohol and Other Drugs Plan 2022–2027* translates the Queensland Government's dedication into concrete steps for preventing and decreasing problematic alcohol and drug use. It recognises that the consumption of substances is integrated into the lives of many individuals, spanning a spectrum from occasional usage to high levels of dependency. While the majority of use adheres to responsible and recommended standards, injurious utilisation can emerge at any stage, impacting communities and people of various ages. The repercussions of harmful use extend to individuals, families, communities, and the economy.

The Queensland plan also acknowledges, however, that the extensive ramifications can be averted or lessened. It recognises that successfully minimising AoD-related harm in Queensland will require a multi-level approach across the three pillars of supply reduction, demand reduction and harm reduction. To that end, it specifies five priorities and three focus areas for investment. The five priority areas are:

1. prevention and early intervention
2. enhanced treatment and support systems
3. expanded diversion programs
4. reducing stigma and discrimination; and
5. reducing harm.

The three focus areas aim to address: vulnerabilities at the individual and family level; harm and safety at the community level; and increased impact at the systems level. The stated focus of this plan on vulnerable families and improving system-level impacts means that there is a clear opportunity to specifically explore how the child protection system might more effectively engage with a range of other systems.

In consulting with Government on the proposed recommendation, the Department of Child Safety, Seniors and Disability Services advised that it has integrated a Drug and Alcohol Practice Kit within the Child Safety Practice Manual. This kit aims to provide practitioners with expert advice and guidance to inform their practice with parents who are using drugs and alcohol. The Department further advised that the Drug and Alcohol Practice Kit is currently being reviewed to ensure it contains contemporary information and advice. The Board considers this a good opportunity for its recommendation to be implemented in this Department, but considers more work, and consistent work, is required across other human services.

Problematic alcohol and drug use is a significant concern for Queensland children. The complexity of issues that occur alongside substance use can make it difficult for practitioners to accurately assess the ongoing risk to children. This is particularly important when working with young children. Understanding the direct and indirect risks while accounting for each child's individual circumstances, is essential to keeping children safe.

Recommendation 5

Strengthening child safety practice in response to parental substance and methamphetamine use

The Queensland Government invests in a practice guide that will support frontline practitioners in their risk assessments of children whose parents' substance use is problematic. This practice guide should cover:

- clear definitions of the thresholds for intervention types
- a framework of identifiable markers of risks
- the safety planning mechanisms and wraparound services that must be implemented to ensure a child's safety.

Chapter 6

Increasing system visibility of children and young people in the context of coercion and parental deception

Increasing system visibility of children and young people in the context of coercion and parental deception

Exposure to domestic violence is a significant issue for Australian children and families. It *occurs when a child sees or hears acts of violence towards other family members in the child's home*.[122] Typically, these acts are attributable to a parent or caregiver, or another family member. They are often physical, but they may also be verbal, sexual, or involve threats or coercion. The *Australian Child Maltreatment Study* (ACMS) published in April 2023 found that 39.6% of Australians aged 16 years and over had experienced exposure to domestic and family violence when they were children.[123] Among 16–24-year-olds surveyed in the study, this rate rose to 43.8%.[124]

In 2022–23, 37 (62%) of children whose deaths were reviewed had experienced domestic and family violence.[125] Almost always underpinning the experiences of these children and their families was coercive control, a repetitive and insidious pattern of abuse and behaviours used to create a climate of fear, isolation and intimidation.[126] The Board noted cases where the system did not effectively respond to the needs of children and young people where parents and family members actively sought to keep their protection needs invisible. The Board observed that parents had used methods of parental deception and disguised compliance to mislead the system and keep intervention at a minimum. In his independent report to the *Inquest into the death of Mason Jet Lee*, Andrew Whitaker defined disguised compliance as:

> *A parent or carer giving the appearance of cooperating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.*[127]

---

[122] Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 2023, 'The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report', *Australian Child Maltreatment Study*, Queensland University of Technology, 7. https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/

[123] Ibid.

[124] Ibid.

[125] For most children, no direct correlation was established between their experience of domestic and family violence and their death.

[126] Hill, J 2020, *See what you made me do: The dangers of domestic abuse that we ignore, explain away or refuse to see,* Sourcebooks.

[127] Coroners Court of Queensland 2020, 'Report of Dr Andrew Whitaker', *Inquest into the death of Mason Jet Lee*, 58. https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/651636/cif-lee-mj-20200602.pdf

Child's story

The Board reviewed the case of a 11-year-old boy who died after not receiving medical support. His parents were no longer in a relationship and the boy had been spending time between both parents' households. Child protection reports had been received about the boy and his brother from infancy across both households. Both parents were reported to have been avoidant of authorities, transient and dismissive towards offers by support services to engage with them. Concerns included domestic and family violence (DFV), parental alcohol and substance use, mental illness, criminal activity, transience, forcing the child to engage in animal cruelty, physical and emotional abuse of the children, and insufficient supervision. The Board noted the extent of the emotional trauma the boy had suffered throughout his life.

For the time period the boy lived with one parent, records often noted conversations between workers and the parent in which they minimised and outright dismissed the workers' concerns by declaring that things were fine, and that workers should instead be talking to the other parent as they had been the one who posed a safety risk. This was interspersed with aggressive, hostile, and threatening responses towards staff. Records indicate that this parent successfully minimised and dismissed concerns in response to attention from Child Safety, the primary school, QPS, and Queensland Health, as detailed below:

- Two Investigations and Assessments (I&A) were unsubstantiated by Child Safety following verbal statements by the parent and their new partner that dispersed concerns about the children's safety. In the course of the second I&A, the children were interviewed three months after an incident of domestic and family violence, but they did not disclose any information and instead said they were not going to talk about what happened. The time lapse may have allowed for the parent to ensure that the children did not disclose abuse and for physical injuries to heal. Ongoing intervention did not eventuate after the parents advised that they would not be accepting support from a service.
- QPS visited the household more than 20 times in the year prior to the boy's death. This included alerts about domestic and family violence, animal cruelty, drug activity, and noise complaints. The parent was reported to display aggressive and antagonistic behaviour towards Police – leading to dynamics that made it more difficult to assess the child's wellbeing.
- Throughout his life, the boy had been enrolled in more than 10 different primary schools. The boy had been observed to be unable to sit still and concentrate in class. Erratic and disruptive behaviours that indicated emotional trauma had been noted by staff, who also reported that the boy had disclosed feelings of being scared of their parent, especially when they were drunk. The school reported these concerns to Child Safety once, and later confirmed that the boy had been mentioning almost daily that he felt worried or scared at home.
- Queensland Health had also been involved, mainly through treatment of "accidental" injuries, including failures to address medical issues where in one case the referral was closed.

At the time of death, there was no open child protection intervention. The Board considered that concerns had been assessed in isolation, that evidence from professional notifiers was disregarded, and the voices of the children were missed or minimised. Where opportunities to identify the safety and wellbeing of the boy existed, records suggest the parent had used distractions, delays and aggression to hinder investigation.

Those who perpetrate coercive control upon their family create a *web of rules or codes, rituals of defence, modes of enforcement, sanctions and forbidden places*. Those subjected to it often report complete isolation from their family, friends, and other support networks, and are *frequently deprived of money, food, access to communication or transportation, and other survival resources*.[128]

Parents often extend the use of coercive tactics and control strategies to the systems designed to keep children and families safe. The climate of fear can result in children too afraid to disclose harm or to speak to trusted adults. Parents can use deceptive strategies by appearing, on the surface, to be jovial and open to engaging with agencies, only to minimise the reported concerns so as to maintain unmitigated control of what happens *behind closed doors* of the family home. Others might create and reinforce control by isolating the family, moving frequently, preventing contact with extended family, changing schools or daycare centres, or repudiating engagement with support services.

In 2021–22, the Board analysed a sample of cases to identify recurring issues and improvements in responses provided to families who are known to the child protection system and experiencing domestic and family violence. The Board's findings were detailed in its report: *Reviewing the child protection system's response to violence within families: Findings from an analysis of child death reviews involving domestic and family violence.* Learnings from the cases considered by the Board in 2022–23 show that the key findings from the report (see below) remain highly relevant. This year the Board saw that:

- All forms of domestic and family violence and lethality indicators are not always recognised or understood by agencies and therefore the associated risks to children may not be obvious.
- Children's voices and views are not always appropriately sought or heard when the system responds to parents, thus minimising the harm the children may have experienced.

Cross agency collaboration and information sharing is important for maintaining 'visibility' of perpetrator behaviours, understanding and minimising risks their behaviours pose to children, and addressing comorbid risk factors. This is particularly important in considering that children, young people and their families impacted by domestic and family violence can often experience other types of maltreatment. The ACMS found that two out of three children who have suffered maltreatment experience more than one type of maltreatment, and one in four Australians experience three to five types of maltreatment.[129]

While the household might have received a response from government – that is Police, Child Safety, health services, crisis accommodation housing and a whole range of services – too often systems geared their responses towards parents, while the children were seen as a third party. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability found in its public hearing 33 that a *[father's] behaviours were explained away, excused or accepted because he had the care of two children with disability*. For example, it was suggested that [father] was doing a *good job of parenting* but *had a different standard to others*,[130] while the boys themselves were often not directly consulted.

> *We know that children are impacted simply by living in a household of fear, and a household with stress; it impacts them deeply.*[131]

The needs of children experiencing coercive control as part of domestic and family violence are not always recognised astutely by practitioners. While overt acts of violence and physical harm may be easier to identify, the subtleties of coercive control and its impacts on a child can be overlooked if staff are not attuned to recognising warning signs and common behavioural patterns indicate that the children might be fearful. This can include a child's inability to regulate emotions, frequent behavioural escalations, high levels of anxiety and stress, nightmares or inability to sleep, emotional withdrawal or numbness, reluctance to talk about what is happening at home for fear of retribution, and an inability to learn at school.[132] The infographic below illustrates some of these observations for a case the Board has reviewed.

---

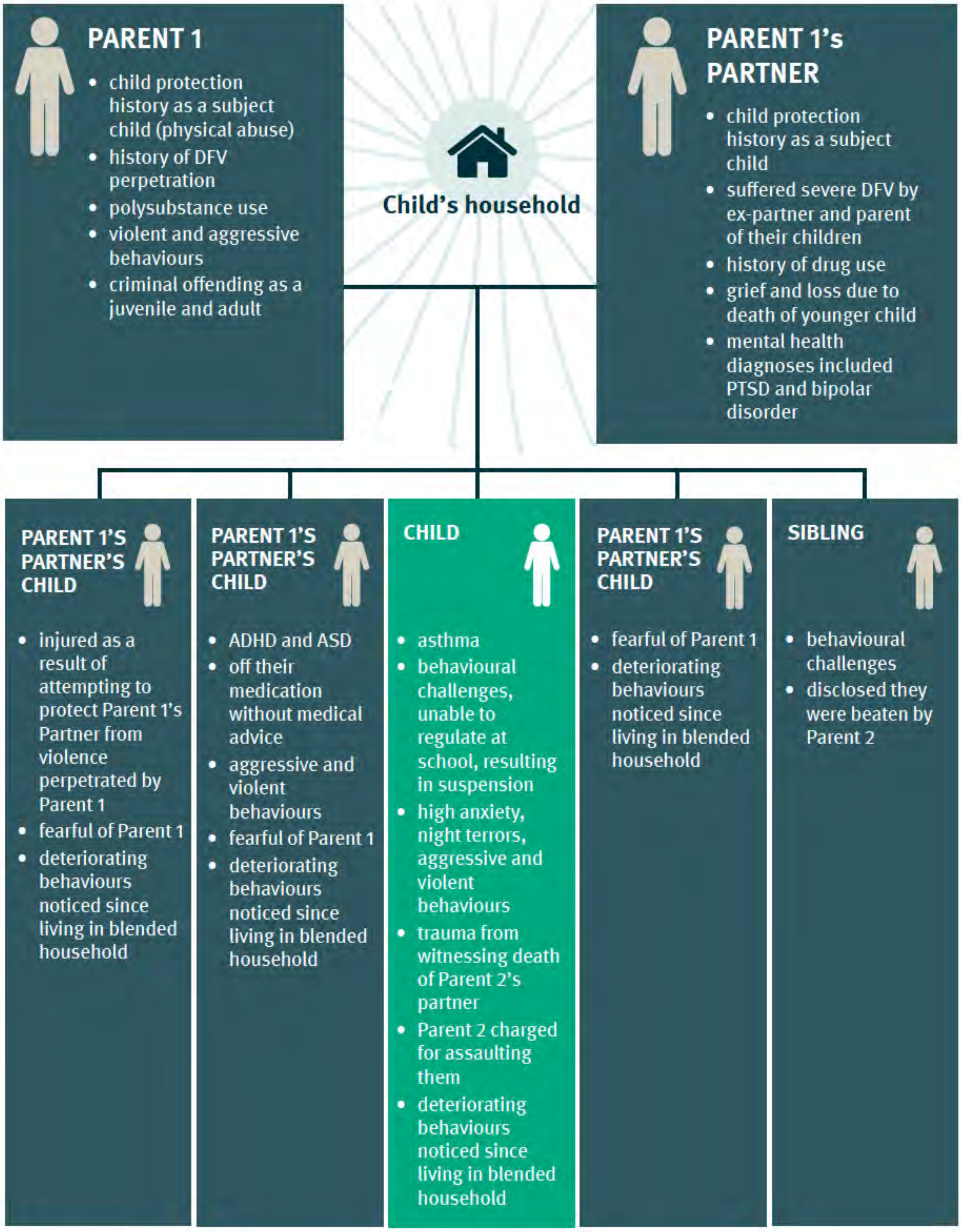
128 Ibid.

129Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 2023, 'The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report', *Australian Child Maltreatment Study*, Queensland University of Technology. https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/

130 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability 2023, *Report on public hearing 33: Violence, abuse, neglect and deprivation of human rights: Kaleb and Jonathon (a case study)*, 121. https://disability.royalcommission.gov.au/publications/report-public-hearing-33-violence-abuse-neglect-and-deprivation-human-rights-kaleb-and-jonathon-case-study

131 Luke Twyford, Child Death Review Board Chairperson quoted by ABC News Brisbane, 8 December 2022, *Report shows 69 children known to Queensland's child protection system died between 2021-2022*, Accessed 5 October 2023. https://www.abc.net.au/news/2022-12-08/qld-report-69-children-known-to-sustem-died-2021-2022/101750996

132 Government of Western Australia, Department of Communities 2021, *Child Development and Trauma Guide*. https://www.wa.gov.au/system/files/2021-11/Child-Development-And-Trauma-Guide.pdf



Child's household

PARENT 1

- child protection history as a subject child (physical abuse)
- history of DFV perpetration
- polysubstance use
- violent and aggressive behaviours
- criminal offending as a juvenile and adult

PARENT 1's PARTNER

- child protection history as a subject child
- suffered severe DFV by ex-partner and parent of their children
- history of drug use
- grief and loss due to death of younger child
- mental health diagnoses included PTSD and bipolar disorder

PARENT 1'S PARTNER'S CHILD

- injured as a result of attempting to protect Parent 1's Partner from violence perpetrated by Parent 1
- fearful of Parent 1
- deteriorating behaviours noticed since living in blended household

PARENT 1'S PARTNER'S CHILD

- ADHD and ASD
- off their medication without medical advice
- aggressive and violent behaviours
- fearful of Parent 1
- deteriorating behaviours noticed since living in blended household

CHILD

- asthma
- behavioural challenges, unable to regulate at school, resulting in suspension
- high anxiety, night terrors, aggressive and violent behaviours
- trauma from witnessing death of Parent 2's partner
- Parent 2 charged for assaulting them
- deteriorating behaviours noticed since living in blended household

PARENT 1'S PARTNER'S CHILD

- fearful of Parent 1
- deteriorating behaviours noticed since living in blended household

SIBLING

- behavioural challenges
- disclosed they were beaten by Parent 2

Figure 8: Child's Household

Paying careful attention to a child's voice and behaviours – including what they are not saying – and assessing if there is presence of cumulative harm due to ongoing exposure to domestic and family violence requires significant skill and resourcing. Alertness to the controlling tactics a parent may use, be it against their own children, stepchildren, partner, ex-partner or extended family members, and indeed child protection staff, comprises an essential element of a holistic child safety assessment.

When a child is not talking, workers must reflect on what might be stopping them from engaging in a free narrative about their lives and home. What is it they are not saying and what do their behaviours suggest? Besides careful consideration of a child's behaviours, it requires talking to extended family and other important people in their lives such as teachers, therapists or medical professionals who can provide collateral information and identify if the child's behaviours have changed over time. The observations by teachers and school staff who often see children regularly are valuable for informing assessments about the impacts of coercive tactics as part of domestic and family violence, and the safety and wellbeing of a child more generally.

In several cases the Board reviewed, extended family and friends had voiced concerns about the parents' situation and their capacity to care for the children, as had been asked of them in the safety and support plan. In response, parents had then been able to placate the system through disguised compliance. In one example, by agreeing to adhere to a safety plan with professionals while at the same time telling family members or friends, they had no intention to do so and were only telling workers what they thought they wanted to hear.

The Board has observed that professionals, family members and friends who raise concerns about the safety and wellbeing of children are often also willing to offer strategies for workable interventions and actively offer to help find an alternative solution.

System coercion by parents

The Board considered cases where parents had used tactics of parental deception to shape and control the dominant narrative, and to successfully downplay the concerns of the child protection system. In one case, this occurred despite evidence from Police and a teacher who had repeatedly witnessed the children's fear responses and agitated behaviours. Instead, the child protection system focused on limited verbal disclosures by the children which created the illusion of an absence of concerns. Inadvertently, this may have contributed to the children's invisibility: while superficial engagement and platitudes by parents were accepted at face-value, children often remained in environments of ongoing harm and unmitigated risk.

Parents who are skilled at deception often seek to preserve a closed family system and limit external responses, including offers of support. In this and in other cases, the Board found that children had complied with a parent's coercive control tactics. For example, fear generated from a parent's use of threats can prevent a child from making disclosures about their experiences or seeking help. In one case, a child, after being interviewed by officers, said they were worried about what they had disclosed and about their parent getting *mad*. Parental deception in the context of coercive control can prevent children and young people from getting the help they need early. As ACMS data shows, an experience of maltreatment is associated with a 2.8 times increase in the odds of developing one of four common mental disorders and an increase in health service use across life, including a 2.4 times higher chance of being admitted to hospital for a mental disorder.[133] Early and appropriately targeted support for children raised in physically or emotionally unsafe homes has the potential to positively change the mental health trajectory of a child. The system must ensure that children are not deprived of access to support by parental deception.

---

[133] Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E 2023, 'The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report', *Australian Child Maltreatment Study*, Queensland University of Technology. https://www.acms.au/resources/the-prevalence-and-impact-of-child-maltreatment-in-australia-findings-from-the-australian-child-maltreatment-study-2023-brief-report/

Deny, Attack, and Reverse Victim and Offender

DARVO, meaning “Deny, Attack, and Reverse Victim and Offender,” summarises a consistent reaction and manipulation tactic used by perpetrators of abuse or other types of wrongdoing. It works by shifting the focus away from the original issue and attacking the actual victim. It attempts to switch the roles of victim and perpetrator to allow the actual offender to receive sympathy and compassion, publicly or privately, as well as to avoid consequences for their actions.

The formalised DARVO meaning was first introduced by a psychologist named Jennifer J. Freyd in the 1990s. Freyd worked to build an understanding of how and why those accused of abuse respond to these accusations. Individuals can use DARVO as a reaction, but entire institutions may employ the strategy as well. Elements of the process can be formally or informally integrated into corporate policy.

In DARVO, the abuser will deny, minimise, and justify their actions and use a process shown to sway personal and public opinion quickly. The use of these manipulation techniques can happen so subtly that many people will miss the warning signs. Instead, they will fall into the pattern of manipulation where all evidence is criticised. An abuser may use DARVO in the following ways:

1. Deny

The first step of the process is for the abuser to deny whatever wrongdoing they are accused of. They will completely refuse that any element of the abuse happened in the way they are accused. They will remain steadfast in their assertion. Depending on the abuse in question, an abuser might say these things:

- “This situation never happened.”
- “I never did that.”
- “This is a lie.”
- “I’m a good person who couldn’t engage in this kind of behaviour.”
- “I’m a friend to women, and people know this isn’t me.”

At this point, the denial is clear and simple.

2. Attack

Once the denial is established, the accused goes on the offensive. Here, the abuser does everything in their power to attack the other person. One way to achieve this is by questioning their motivation, mental health, and stability, attacking their intelligence, honesty, and morality, and attacking their actions (past and present). The abuser could attack the victim in countless ways by saying:

- “You’re crazy.”
- “You’re a psycho.”
- “You’re an alcoholic or a drug addict.”
- “You’ve made these claims before.”
- “You asked for this/wanted me to do it.”
- “You never said ‘no.’”

The victim will never be treated with respect or value. They will be demeaned and disparaged.

3. Reverse Victim & Offender

At this point, the perpetrator will attempt to switch roles with the victim. Rather than accepting responsibility for their actions, they aim to make the original victim into the perpetrator. This reversal is done in many ways depending on the situation and accusation. At times, the attempt seems to lack outward validity and rationality, but that part seems unimportant. Many aspects of DARVO rely on feelings more than facts.

Ultimately, frontline workers can find themselves entangled in the perpetrator's manipulation if they are not skilled and experienced in identifying the signs of coercive and controlling behaviours.

While at times applying deception and disguised compliance, parents who use coercive control in their personal relationships can be equally intimidating, avoidant, controlling, aggressive and potentially violent towards frontline child protection practitioners, health professionals, police officers, teachers, and support workers. For example, records describe a parent as *aggressive, antagonistic, immediately uncooperative, unwilling to provide information, very hostile, and trying to goad police into a fight.*

Coercive control can involve repeated attempts to threaten and intimidate and, more insidiously, it can involve manipulation and gaslighting.[134] The Board has observed parents using agencies' complaint mechanisms, family court and custody processes to exert control over the narrative and by extension, an ex-partner and co-parent. Frontline child protection practitioners can feel significantly challenged, vulnerable and fearful for their own safety when attempting to engage parents who use tactics of coercive control as part of domestic and family violence. This can impact workers' ability to confidently assess the safety and wellbeing of a child. The Board noted in one case that a family support service had closed a referral because the workers feared for their safety when attempting to engage Father, who was a single parent of several children. As a result, the children did not receive the support they likely needed to experience increased safety in the home.

The system holds a responsibility to ensure that frontline child protection staff are regularly upskilled, appropriately resourced, safe within their locations where they are required to work, and supported to respond to the challenging and controlling behaviours that people who have perpetrated domestic and family violence may exhibit. Therefore, worker safety must be prioritised and addressed.

System responses unintentionally enabling coercive control by the offending parent

The Board noted the system at times unintentionally enabled parents to maintain control of the family through coercive practices that could include deception and disguised compliance. This resulted in less attention on children's behaviours and voices, and in particular, when the children seemed guarded and reluctant to talk freely about their families and their lives together.

Child and their sibling's stories

The Board reviewed a case in which two children and their mother were at high-risk of serious harm or lethality from the father's violence. There had been multiple physical assaults, emotional and verbal abuse, non-lethal strangulation, threats to kill the mother and the children if she left, isolation from others, financial abuse, and deprivation of liberty by barricading/locking mother and the children in rooms. Mother had a Police Protection Notice and Domestic Violence Order, the child's paternal grandmother had a Police Protection Notice and the maternal grandfather had an Apprehended Violence Order (NSW). Despite displaying such extreme violence, the father was able to deceive the system and as a result was assessed as the 'safer' parent. For example:

- Following a short period of time living in their mother's care, the children started living with their grandparents, in the same household as father. The family's living arrangements (supported throughout Child Safety's involvement) and no contact conditions under the Domestic Violence Order (DVO) which prevented the father from approaching the mother now restricted the mother from regularly seeing the children. This disempowered the mother and reinforced the father's control.
- The father kept reporting that the mother had intellectual impairments and mental health diagnoses, creating a narrative of her diminished parenting capacity; however, health professionals had advised there were no diagnoses and that her issues likely stemmed from the impact of the father's abuse. Despite their advice, the father's perspective was prioritised throughout child protection records and impacted the children's opportunities to be with their mother.

A visualisation to the timeline of service delivery to Child and their sibling can be found at Figure 9.

---

[134] Hill, J 2020, *See what you made me do: The dangers of domestic abuse that we ignore, explain away or refuse to see*, Sourcebooks.

A responsibility exists to ensure that interactions with parents and families do not unintentionally enable and allow deceptive and controlling patterns of behaviour to continue.

The Queensland Government has acknowledged the need to address coercive control as part of recent initiatives to reduce rates of domestic and family violence in Queensland:

- In December 2021, The Women's Safety and Justice Taskforce released their first report *Hear her voice – Report One – Addressing coercive control and domestic and family violence in Queensland.* Eighty-nine recommendations were made in the report, including a recommendation to criminalise coercive control. The Queensland Government supported the recommendations in principle and since then, legislative reforms have been introduced into Parliament to address coercive control. The Board acknowledges that this needs to be reflected in the practice guidance child protection practitioners regularly access.
- The *Domestic and family violence common risk and safety framework (CRASF)* has been designed for government and non-government agencies to enhance the safety of Queenslanders. It seeks to support the self-determination of those who have experienced domestic and family violence and acknowledges that subjection to coercive control can impact the self-confidence and self-determination of victim-survivors. The CRASF was revised in 2021 to include coercive control factors in its risk assessment and safety planning tools. This framework provides a foundation that can enable frontline practitioners to identify and respond to parental deception.

Concluding comments

Domestic and family violence continues to be one of the most significant challenges that children and families experience. The Board has noted cases where parents were able to extend their power and control to the very system designed to try and protect their children and support their families. Despite system involvement, often they continued to maintain closed family systems, where their children were left invisible and exposed to environments of violence, abuse, and neglect. Even where parents did accept offers of support, the Board noted ongoing issues with workforce capacity, including a lack of timely access to behaviour change programs and suitable domestic and family violence accommodation options. Individual review agencies continue to note opportunities to strengthen domestic and family violence informed practice in the workforce. The Department of Child Safety, Seniors and Disability Services confirmed that it has engaged Social Care Solutions to deliver a state-wide forum in November 2023 in relation to decision making in practice (with links to issues relating to cognitive bias, halo effect, confirmation bias, difficult conversations, noise impacting decision making and disguised compliance). The forum will also provide participants with a session in relation to domestic and family violence practice and mental health, with a focus on parental deception and the use of systems in coercion and control.

Ongoing reform work must continue to focus on building the capacity of the system to respond collectively and collaboratively to the varied needs of children and families experiencing domestic and family violence. This includes efforts towards upskilling and resourcing staff and supporting individual worker safety.

Recommendation 6

Assisting workers to recognise and respond to parental deception

The Queensland Government invest in measures to help frontline practitioners across agencies identify and respond to attempts at parental deception in the context of domestic and family violence (the frontline practitioners involved should include child protection, health services, education, law enforcement, courts staff and secondary services).

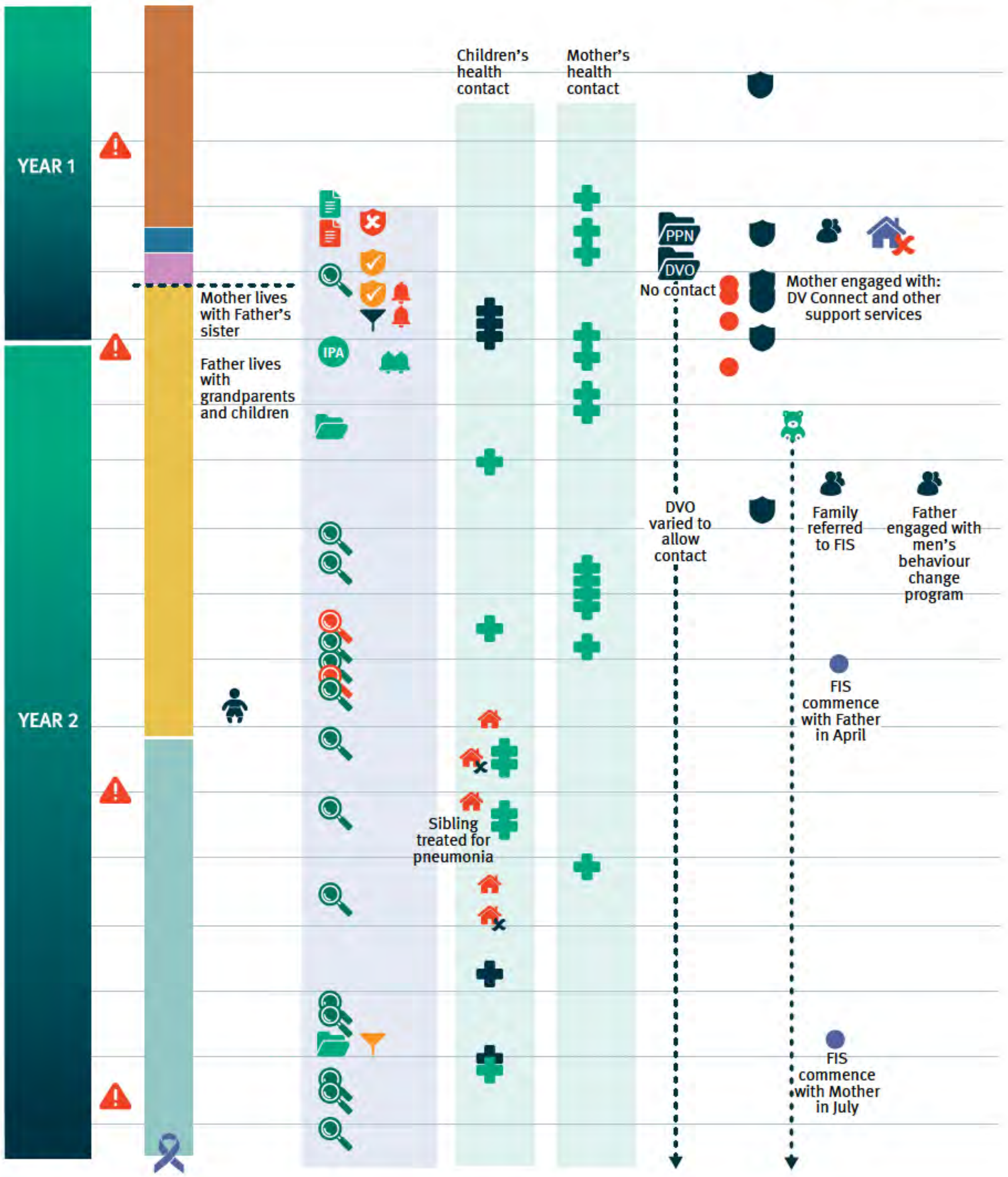


Figure 9: Timeline of service delivery to Child and their sibling

- Notification
- Temporary orders granted
- IPA Intervention with parental agreement
- Case plan developed
- Home visit successful / unsuccessful
- Family discussed at High Risk Team meeting
- Children attend day care
- ⚠ Mother expresses self-harm or suicidal behaviours
- Risk evaluations: moderate / high
- Drug screen: meth / cannabis negative
- ● Family Intervention Service (FIS) activity
- ● Police response / contact
- Safety Assessment: Safe with plan / Unsafe
- Police-lodged protection order
- Health home visit: Family declines follow-up
- Health appointment / ED presentation
  - engaged
  - does not engage
- Service engagement
- Mother secures short-term accommodation at shelter
- Sibling born

CHILDREN'S LIVING ARRANGEMENTS

🟧	Both parents
🟦	Foster care
🟪	Mother
🟨	Father and grandparents
🟩	Both parents and grandparents

Chapter 7

Monitoring recommendations

Monitoring recommendations

The Board monitors the actions taken in response to the recommendations it has made in the previous years. This chapter reports on the 16 recommendations made by the Board.

The Board made six recommendations in 2021–22. These were tabled in Parliament in the *Child Death Review Board Annual Report 2021–22*, on 8 December 2022. The Government provided its response on 9 August 2023.

In its response, the Queensland Government "commends the valuable work of the Board" and acknowledges "that it is the collective responsibility of more than one government department to promote the safety, wellbeing and best interests of children and young people".[135]

Five recommendations were supported or supported in principle. *Recommendation 3. Continuity of care for children with complex needs* was designated for 'for further consideration'.

The Board made ten recommendations in 2020–21. These were tabled in Parliament in the *Child Death Review Board Annual Report 2020–21*, on 17 February 2022. The government response tabled on the same day accepted or accepted-in-principle all ten recommendations.

Copies of the two previous the Board annual reports and respective government responses are available from https://www.cdrb.qld.gov.au/reports-and-publications/.

As part of the Board's monitoring functions, the Chair wrote to the Chief Executives of agencies on 1 September 2023 requesting an update on the implementation of any recommendation on which they were identified as lead agency. The relevant agency responses largely pertain to how they intend to implement the recommendations, rather than provide a progress update. The Board intends to seek further implementation update in mid-2024 for inclusion in *Child Death Review Board Annual Report 2023-24*.

The Board is pleased to report that eight of the ten recommendations from the Annual Report 2020–21 have now been completed. One (recommendation 5) is in progress, and one (recommendation 10) has been closed without implementation. For the Annual Report 2021–22, one of the six recommendations (Recommendation 4) has been marked as 'complete'. All other recommendations from the Annual Report 2021–22 remain 'in progress'.

---

[135] Queensland Government 2023, *Government Response to the Child Death Review Board 2021–22 Annual Report*, 3.

Annual Report 2021–22 recommendations

In 2022–23, the Queensland Government provided a response to the six Recommendations tabled in the Board's 2021–22 Annual Report. Full versions of the *CDRB 2021–22 Annual Report* and government response are available from https://www.cdrb.qld.gov.au/reports-and-publications/.

Workforce reform to ensure service accessibility and delivery (Recommendation 1: 2021–22)

The Board recommended that the Queensland Government implements reform across the human services workforce to ensure it can meet the needs of children and families. This reform should:

- examine and address the shortages in core skills areas that are projected to become more pronounced over the coming decade, particularly in regional and remote areas
- recognise the overlap and competition that exists between departmental portfolios, and establish ways (such as exploring joint commissioning and pay parity) to help children, families and carers receive quality support
- promote place-based approaches, particularly in the early intervention and secondary services areas, to address local workforce issues
- include a focus on foster and kinship carers, with a view to increasing the number and expertise of carers.

Status: In progress

Government response

The Queensland Government supported this recommendation in principle, noting the significant role the non-government sector plays regarding the human services workforce, alongside government. It stated that it would consider how best to give effect to the intent of Recommendation 1 particularly in relation to recognising the overlap and competition that exists between departmental portfolios, and establish ways to help children, families and carers receive quality support. This will be considered in the context of the current industrial relations framework set out in the *Industrial Relations Act 2016*, which promotes collective bargaining as the primary mechanism for setting wages and conditions; and noting there is already a level of wage parity that exists among a number of Queensland Government agencies.

The Queensland Government acknowledged the significant workforce issues impacting the human services sector across the country. It pointed to *Good People. Good Jobs Queensland Workforce Strategy 2022–32* as the first whole-of-government workforce strategy produced by the Queensland Government. The Strategy identifies the workforce pressures faced by Queensland and will be delivered through three, multi-year action plans. The Queensland Workforce Strategy highlights the shared responsibility between all levels of government, employers, industry, individuals, education and training providers and communities.

The Queensland Government reported that at a national level, the Community Services Ministers are working collaboratively to address the workforce pressures facing child protection and family support systems across the country through the delivery of *Safe & Supported: the National Framework for protecting Australia's children 2021–2031* (Safe & Supported), and implementation of the associated Action Plans. The First Action plan includes work to develop a national approach or strategy for a sustainable and skilled children and families services workforce.

The Board's observations

When the Board approached Government for an update on the actions in September 2023, we received individual agency workforce actions – which although necessary and important – are counter to these recommendations' explicit focus that Government must work holistically to address workforce shortages. While it is evident that leading agencies Youth Justice and Child Safety have reflected on how they can reform their internal workforces, the intent of Recommendation 1 was to inspire a whole-of-government response to workforce challenges. The Board hopes future implementation updates addresses the need for workforce reform at the State and National level. Recommendation 1 will remain 'in progress' at this time.

Workforce reform to ensure service accessibility and delivery (Recommendation 2: 2021–22)

The Board recommended that the Queensland Government implements reform across regional and remote communities of Queensland, particularly First Nations communities, to ensure there is a present human services workforce that can engage with the local community, particularly in culturally safe and engaging ways. This is to include:

- investigating how statutory roles can be redirected to local Community-Controlled Organisations to enable local employment and service delivery
- empowering Aboriginal and Torres Strait Islander peoples through diverting funding to Community-Controlled Organisations for para-professional and innovative service delivery solutions that address persistent gaps in government workforces
- investigating and repurposing unspent funding for long-term vacant positions to support place-based service design and delivery in regional and remote communities to address the departmental and portfolio silos that are impacting on the ability to deliver holistic family support and early intervention.

Status: In progress

Government response

The Queensland Government supported Recommendation 2 recognising the importance of local community and culturally safe responses in building a strong human services workforce to ensure service accessibility and delivery. It stated that for Aboriginal and Torres Strait Islander communities, this requires working in partnership with First Nations peoples and organisations to design and deliver services that meet identified needs and priorities.

Key initiatives currently supporting the intent of this recommendation include:

- Local Decision Making Bodies (LDMBs) are being established by DTATSIPCA as part of the Local Thriving Communities reform with the aim of empowering First Nations communities to influence and co-design how services are delivered to communities. Engagement with LDMBs across Queensland will inform development of regional and remote workforce strategies.
- As a key action under the Queensland Government's *Workforce Strategy 2022–32* (noted above), the Queensland Government is implementing *Paving the Way – First Nations Training Strategy* and is supporting the development of Queensland's Aboriginal and Torres Strait Islander workforce and improving job outcomes through training and skills development.
- DCSSDS is implementing *Our Way: a generational strategy for Aboriginal and Torres Strait Islander children and families 2017–37*. Principle 2 of Our Way is 'ensuring that Aboriginal and Torres Strait Islander peoples and organisations participate in and have control over decisions that affect their children, and includes building the capacity of community-controlled organisations; facilitating the participation of Aboriginal and Torres Strait Islander families and children in decisions; delegating one or more statutory child protection functions or decisions in relation to an Aboriginal or Torres Strait Islander child to the Chief Executive Officer of an Aboriginal or Torres Strait Islander entity when certain requirements are met; and recognising the role of Aboriginal and Torres Strait Islander communities to drive local solutions to local issues.
- The Queensland Government has committed to ensuring that Aboriginal and Torres Strait Islander children, young people or families can access their supports through an Aboriginal and Torres Strait Islander community-controlled organisation (ATSICCO) if they wish to do so. There is a 10-year timeframe for transitioning investment to that sector to enable this to occur. The Department will work closely with the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP), regions, Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCOs) and mainstream providers to plan and execute the transition of investment. This includes collaboration with QATSICPP to develop a workforce strategy for the ATSICCO sector.
- The Queensland Government is also developing a new, whole-of-government First Nations Economic Strategy, planned to be released in 2023–24, to support economic participation and self-empowerment for Aboriginal and Torres Strait Islander Queenslanders. The strategy will link with workforce, skills and training strategies and identify emerging opportunities, working in co-design with a First Nations Economic Committee, to support workforce development across the state, including at a regional and community level.

The Board's observations

The Board welcomes the actions being taken and would like to see how these specific efforts address workforce shortages in regional and remote communities of Queensland. The Board encourages further investigation into the repurposing of unspent funding for long-term vacant positions to place-based service design as part of the *First Nations Economic Strategy*, planned to be released in 2023–24.

Recommendation 2 remains 'in progress' reflecting that the Board will continue monitoring efforts towards achieving a culturally safe, local workforce available to all children and families living in regional and remote Queensland.

Continuity of care for children with complex needs (Recommendation 3: 2021–22)

The Board recommended that the Queensland Government develops a fit-for-purpose model that provides a continuum of care for children with high-risk behaviours that recognises that multiple government departments come into contact with these young people, and there is no single responsible owner for the assessment and response required to address the complex needs. The model should:

3.1 Be informed by a study of child death, serious injury or other relevant cases where the children were identified to have complex needs manifesting in high-risk behaviours to establish:

- commonalities with their trajectory into tertiary systems
- touchpoints with universal, secondary and tertiary systems that provide greatest opportunity for an entry point into the model.

3.2 Include an early intervention stream that provides a pathway for professionals working closely with children and families, such as schools, to trigger a case management response. The response should focus on:

- addressing the social, emotional, cultural and health and wellbeing needs of children and their families which contribute to their behaviours
- supporting the child's family and carers for the continuation of positive family functioning, behavioural guidance and treatment at home
- coordinating health-based assessments and treatments
- working with the child's school to ensure the child is engaged in education; and
- providing access to informal and formal respite for children and families.

3.3 Include a tertiary stream that provides a specialised accommodation service for children that meets the underlying causes of high-risk behaviours that are a danger to themselves or others that is:

- underpinned by a culturally appropriate case management response addressing the social, emotional, health and wellbeing issues of children and their families contributing to the behaviours
- authorised by a clear and appropriate legal framework that clarifies if, when and how restrictive practices can be used, and how the system will be monitored with effective oversight to ensure decisions and actions are in the best interests of the young person; and
- integrates ongoing access for the child to family, culture and education.

Status: In progress

Government response

The Queensland Government designated Recommendation 3 as *for further consideration*. It recognised that children with high-risk behaviours require specialised support, together with the importance of early interventions to support the social, emotional, health and wellbeing needs of children, young people and their families before their behaviours escalate or reach a crisis point.

The Queensland Government stated that it provides a range of supports for children with complex needs who are engaging in high-risk behaviours through the health, education, child protection, and youth justice systems and that a number of initiatives are currently underway to improve the responses to children and young people with complex needs, including from a continuum of care perspective, and that it recognises that more can be done.

The Queensland Government outlined a strong interest in working with the Queensland Family and Child Commission and Child Death Review Board to further explore this recommendation over the next 12 months, with a particular focus on:

- better understanding the trajectories of children and young people
- providing for more coordinated and integrated responses
- considering which targeted early interventions could best support children, young people and their families.

Child Safety continues to utilise Intensive Family Support (IFS) services for case management of children who are at risk of entering the child protection system or families with complex support needs. Some IFS providers are trialling two evidence-based models: Functional Family Therapy-Child Welfare and Functional Family Therapy-Case Management. Three trial sites are demonstrating positive outcomes for families with complex needs that require a therapeutic response to address multiple challenges within family relationships. IFS providers also participate in Local Level Alliances to bring together agencies working with vulnerable families and identify gaps in support services within local communities.

Government is currently reviewing the authorisation framework for the use of restrictive practices with NDIS participants under the *Disability Services Act 2006* (Qld), including the potential expansion of that framework to include the use of restrictive practices with NDIS participants who are children. A key aim of the framework is limiting the use of restrictive practices to circumstances where it is necessary to protect a person from harm. It is expected that the NDIS Review and the Disability Royal Commission will produce recommendations of relevance to working with children with complex needs. Child Safety will work with Queensland Government Agencies as required once the final reports are released.

Child Safety is also working with Youth Justice and other responsible agencies to consider opportunities to improve supports for children with disability who are at risk of intersecting with the youth justice system.

The Board’s observations

The Board acknowledges the Queensland Government’s concerns about restrictive practices and shares Child Safety’s value in safeguarding the rights of people with disabilities, including children, by limiting the use of restrictive practices.

The Board would like to see insight that children may be exhibiting complex needs for reasons other than a disability or mental health concern. Evidence suggests trauma, maltreatment and other adverse childhood experiences are significant contributing factors in the manifestation of high-risk behaviours. These children are often ineligible for NDIS support and need alternative support mechanisms to help keep them, their families, and their communities safe.

The Board is committed to working with the QFCC and the Queensland Government to improve support for children with complex needs. As such, Recommendation 3 remains ‘in progress’ at this time.

Responding to domestic and family violence (Recommendation 4 2021–22)

The Board recognises there is significant reform occurring in the area of domestic and family violence. *The Board recommended* that within this reform, the Queensland Government include a focus on:

- children as specific victims of domestic and family violence in their own right
- culturally appropriate responses or services for children displaying problematic or violent and aggressive behaviours in the context of their own experiences of domestic and family violence
- the role of fathers and fathering, as promising points for behaviour change intervention.

Status: Complete

Government response

The Queensland Government supported this recommendation noting there is significant reform being undertaken to improve responses to domestic and family violence.

The Department of Justice and Attorney-General (DJAG), as the agency leading the implementation of Recommendation 4, has completed the following actions:

- Improving service system responses through the revised *Domestic and Family Violence Common Risk and Safety Framework*, which recognises children as victims of domestic and family violence in their own right.
- Enhancing High Risk Teams to improve the safety of victim-survivors at high risk of harm of domestic and family violence, including funding for six new Victim Assist Queensland roles.
- *The Domestic and Family Violence Protection (Combatting Coercive Control) and Other Legislation Amendment Act 2023* commenced on 1 August 2023. Among changes to support adult victims, the *Youth Justice Act 1992* has been amended to provide a mitigating factor for child offenders who are victims of domestic violence or have been exposed to domestic and family violence.
- In 2022–23, $6.6 million was provided to 24 organisations for counselling children impacted by domestic and family violence. This funding will increase to $7.7 million in 2023–24.
- Administrating $4.355 million over 2020–25 for the Legal Aid Queensland Youth Legal Advice Hotline and $6.225 million over 2020–25 for the Legal Aid Queensland and Aboriginal and Torres Strait Islander Legal Service Youth Justice Legal Advocacy Program to deliver free youth specific legal assistance.
- From 1 July 2023, staged trials of specialist perpetrator intervention programs have commenced roll out, including a second youth perpetrator intervention program and programs designed for Aboriginal and Torres Strait Islander people.
- From 2023–24, $2.4 million per annum will be allocated to Men's Support Services to provide culturally appropriate support to Aboriginal and Torres Strait Islander men to address concerns related to the use of violence.

DJAG has several additional activities underway including establishing three new High-Risk Teams in Townsville, Redlands and Rockhampton. The new teams will have a First Nations Cultural Advisor embedded in each. A standalone Domestic and Family Violence Perpetrator Strategy is currently being developed – the whole of government strategy will be the first of its kind in Australia. DJAG also intends to facilitate a community-led project to design and pilot a perpetrator intervention program specifically tailored to meet the needs of Aboriginal and Torres Strait Islander peoples through an embedding healing approach.

The Board's observations

The Board acknowledges the Queensland Government's actions to improving domestic and family violence responses and the multi-faceted approaches taken to date. The Board welcomes the support of co-designed, community-based, culturally safe prevention and intervention programs. The delivery of the *Domestic and Family Violence Common Risk and Safety Framework* and supported prevention and intervention programs is ongoing. The Board looks forward to following their success, particularly for where they result in benefits for children and families.

The Board records Recommendation 4 as 'complete' on the basis that focus has been given to the issues raised to the extent possible within the reforms to date.

Ongoing improvements in Queensland's response to, and prevention of, Domestic and Family Violence will continue to be an area considered by the Board.

Promoting the safety of infants and unborn children (Recommendation 5: 2021–22)

The Board recommended that the Queensland Government:

- extends health home visiting programs across the state as a priority to focus on parents with complex needs, with a view to:
  - supporting and monitoring the wellbeing and development of an infant within the family home; and
  - addressing families' health and psychosocial needs and wellbeing as they arise.
- implements or expands initiatives to create safer sleep environments for all priority Queensland populations by:
  - supplementing home visiting with tiered support strategies using the family's existing resources
  - upscaling multimodal safe sleeping programs to provide an acceptable, feasible, safe, and culturally appropriate initiative for families
  - implementing evidence-based and practical messaging around safe sleep practices and finding ways to achieve consistency of messaging across decentralised service systems.

Status: In progress

Government response

The Queensland Government supported Recommendation 5 in principle noting the alignment with the existing *First 2000 Days* program. It reported that as of August 2023, there are two Hospital and Health Services that have been funded to execute a home visiting program. These programs demonstrated increased parental capacity to support their child's early development. It also confirmed that two safe sleeping initiatives (Connecting2U and Pepi-pod) have been trialled and further roll-out is being considered.

Since accepting Recommendation 5 in principle, Queensland Health has begun considering activities in response to the recommendation as part of the *First 2000 Days* program. The *First 2000 Days* program of work includes the extension of health home visiting programs and the promotion of safer sleeping initiatives.

The Board's observations

The Board welcomes the extension of health home visiting programs and the implementation of two safe sleeping initiatives trials.

The Board notes that Queensland Health has begun consideration of the recommendation and expects the outcomes of this consideration in the 2023–24 financial year.

Recommendation 5 remains 'in progress'.

Promoting the safety of children with disability (Recommendation 6: 2021–22)

The Board recommended that the Queensland Government engages with the Commonwealth Government to improve access for vulnerable children and families to the NDIS by:

- demonstrating the cost benefit of establishing state-based positions across Queensland to help vulnerable children and parents with disability access the NDIS system and receive services – these positions need to be based in universal or secondary services with which children and parents engage
- improving the mechanisms by which children and parents with complex needs can enter and access the NDIS – including consideration of an appropriate agreement that allows prescribed state professionals to refer children and parents to the NDIS on their behalf.

The Board expects the outcomes of the engagement to be reported back to it by August 2023.

Status: In progress

Government response

The Queensland Government supported Recommendation 6 in principle, noting that:

- supporting access to the NDIS is primarily the responsibility of the Commonwealth Government
- implementation of the recommendation is reliant on working with the Commonwealth Government on access to a national program
- there is a strong likelihood of significant recommendations of relevance arising from the Independent Review of the NDIS, which is due to report in October 2023 and that therefore a report back to the Board by August 2023 will not be able to be achieved
- the Queensland Government has already committed funding to the Assessment and Referral Team (ART) Program, which continues to support at risk children and young people to access the NDIS, as well as building the capability of Queensland Government agencies to navigate the NDIS access pathway more effectively.

The Government confirmed that it continues to work with the Commonwealth Government and other NDIS governing partners to improve NDIS access and to advocate for simpler and more effective access processes that ensure vulnerable and complex cohorts can access the NDIS and receive the supports they need. It stated that the Independent Review of the NDIS is currently underway, and that DCSSDS has a role in supporting Queensland Government engagement with the Commonwealth Government through the Disability Reform Ministerial Council and the NDIS Executive Steering Committee to improve access for vulnerable children and families to the NDIS. This advocacy will continue and is a key priority for Queensland, including during the NDIS Review.

Government outlined how as part of the 2023–24 Queensland Budget, government invested a total of $16.2 million over four years and $2 million per annum ongoing to:

- support at-risk-children and young people to access the NDIS until December 2024
- establish and maintain a specialist disability assessment team to support people with complex needs navigating multiple mainstream services systems to access NDIS services from January 2025.

The Board's observations

The Board has noted the Queensland Government's ongoing advocacy for the Commonwealth Government to create simpler and more effective access processes.

The Board specifically notes that the funding announced by Government is necessary to ensure Queensland children can access the NDIS but that this funding is time limited. Keeping track of this expenditure, and the NDIS plans created for young people during this time, would constitute the cost-benefit/return-on-investment assessment called for in the Board's recommendation.

The Board agrees that the outcomes of the Independent Review of the NDIS is likely to shape how the Queensland Government might best support vulnerable children and their families, and strong Queensland advocacy in relation to the improving the mechanisms by which children and parents with complex needs can enter and access the NDIS would meet the Board's recommendation.

Recommendation 6 will remain 'in progress' at this time.

Annual Report 2020–21 recommendations

In 2021–22, the Queensland Government provided a response to the ten recommendations tabled in the Board's 2020–21 Annual Report. Full versions of the 2020–21 Annual Report and government response are available from https://www.cdrb.qld.gov.au/reports-and-publications/.

2020–21 Recommendation 1:

The Board recommends: The Department of Children, Youth Justice and Multicultural Affairs[136] strengthens its model of funded secondary services. This is to:

1.1 determine whether the model meets the needs of referred children and families by reviewing the:

- efficacy of services in terms of improving outcomes for children and families and diverting them away from needing Child Safety intervention
- equity of access for the families who are intended to benefit from these services.

To do this, the perspectives of children, families and communities should be gathered and used to inform findings. For example, in implementing Recommendations 1 and 2 of the Queensland Audit Office's report, this can be done by speaking with communities and Aboriginal and Torres Strait Islander peoples to identify barriers and enablers to equitable access and active efforts (such as cultural safety and practical supports) to help families to participate.

Findings from the agency's evaluations of these services and the Queensland Family and Child Commission's evaluations of the reform program could also inform this work.

The Board also recommends: The Department of Children, Youth Justice and Multicultural Affairs strengthens its model of funded secondary services and:

1.2 develops and implements best practice and culturally responsive strategies to improve outcomes for children and families

1.3 supports and strengthens referral and reporting pathways for professional and mandatory notifiers by:

- developing guidance for relevant agencies and services about responding to concerns for a child if a referred family is not successfully engaged by these services
- requiring a referrer from a mandatory reporting agency to be advised by these services of case closure because of a family's non-engagement.

Status: Complete

Government response

The Queensland Government accepted Recommendation 1.1 and 1.2. A review of secondary services was regarded as timely, particularly the delivery of services for Aboriginal and Torres Strait Islander Queenslanders. The Queensland Government noted that delivery of Recommendation 1.2 would be guided by *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families*.

Recommendation 1.3 was accepted in principle, noting that at the time, Child Safety was reviewing how it might respond to reported concerns about children through its intake processes. This included working with mandatory notifiers.

In the Board's 2021–22 Annual Report, Child Safety reported:

- Intensive Family Support (IFS) services had transitioned to an outcomes-focused performance framework on 1 July 2022, which included evaluation of consent rates and achievement of family case plan goals.
- The Aboriginal and Torres Strait Islander Family Wellbeing Services (FWS) program was subject to an evaluation, completed in December 2021.
- Continued monitoring and reporting of the proportion of families who receive support from IFS and FWS services who subsequently become the subject of an investigation by Child Safety.

---

[136] The then Department of Children, Youth Justice and Multicultural Affairs is now the Department of Child Safety, Seniors and Disability Services. This report refers to child safety function as 'Child Safety' throughout, irrespective of the current department name.

- Funds had been identified to implement a workforce development strategy for the Aboriginal community-controlled organisation sector. This includes reform of workforce profiles of service providers to reflect the communities they serve.
- Child Safety, through Family Matters Queensland, was continuing to implement *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037 (Our Way)* to eliminate the disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system.
- Expansion of the email feedback mechanism regarding family engagement to both IFS and Family and Child Connect (FaCC) services to Queensland Health and Department of Education referrals.
- A review of the services available to refer families subject to intake reports to ensure that families have access to early intervention.

2022–23 Actions and agency response

In 2022–23, Child Safety reported new data against the outcomes-focused performance framework for IFS. While the target had been set to 40%, the data report stated that 50.4% of eligible families are closing cases following intervention with an IFS with all or the majority of their case plan goals marked as "achieved". This figure is similar for both First Nations families (50.7%) and non-Indigenous families (50.3%). Voluntary engagement with an IFS has also improved, with 71.3% of eligible families agreeing to engage. A higher percentage of First Nations families (75.7%) agreed to engage with an IFS service than non-Indigenous families (69.9%).

Child Safety continued to partner with Family Matters Queensland to deliver *Our Way* and address the over-representation of Aboriginal and Torres Strait Islander families in the child protection system. One action implemented throughout the last year is delegated authority: one or more functions or powers in regard to an Aboriginal or Torres Strait Islander child that had been the delegation of the chief executive (Child Safety) under the *Child Protection Act 1999* is now transferred to a Chief Executive Officer (CEO) of an Aboriginal or Torres Strait Islander entity. The second implementation phase of *Our Way,* which is called *Breaking Cycles* (2023–2031), has commenced. This whole-of-government action plan was co-designed with key First Nations entities, including the Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP) and aligns with key government commitments including *Closing the Gap*, *Path to Treaty* and *Local Thriving Communities*. Guided by the *Our Way* Strategy and the Aboriginal and Torres Strait Islander Child Placement Principle, organisations have been supported to develop Cultural Practice Frameworks and to trial and implement the Family Matters Reflective Practice Toolkit.

(1.3) FaCC and IFS models are being updated to require services to report back to professional reporters on whether families have engaged or not following a referral to their service, to ensure information sharing and determine the need for any further responses. This is similar to the way that secondary services report this information back to Child Safety.

The Board's observations

Child Safety has transitioned to outcomes-focused evaluation of its funded secondary services. Results from this initial year of monitoring appears positive, especially in regard to equity of access. The Board records Recommendation 1.1 as 'complete'.

Work towards completion of Recommendation 1.2 included efforts made towards participation and partnership by engaging First Nations peak bodies and secondary service providers. Noting Child Safety's ongoing commitment to continuous improvement for best practice and culturally responsive strategies to improve outcomes for children and families, the Board records Recommendation 1.2 as 'complete'.

The new requirement to report engagement outcomes back to professional notifiers is expected to fulfill Recommendation 1.3. The Board records Recommendation 1.3 as 'complete' pending the implementation of the new referral requirements.

2020–21 Recommendation 2:

The Board recommends: The Department of Children, Youth Justice and Multicultural Affairs improves its ability to undertake effective child protection history reviews at intake to support decisions about whether a child is suspected to be in need of protection. This must include strengthened intake processes to make sure staff are able to give proper consideration to:

- complex or lengthy child protection histories (information about a family recorded on the data system)
- indicators of cumulative harm (refer Recommendation 3), particularly when frequent child concern reports are recorded
- patterns of parental behaviour (acts or omissions– refer Recommendations 3 and 4)
- cultural factors.

To support this, Child Safety's *Workload Management Manual* should include guidance on reasonable workloads for intake.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting that Child Safety was reviewing its intake processes, particularly different ways of reviewing previously recorded information about the child or family. In 2021–22, Child Safety reported it had undertaken a Multiple Event Review trial where a third consecutive intake received within 12-months would prompt four additional questions to aid an officer's decision making. Staff reported a positive impact on their ability to understand the cumulative impacts of child protection history, and improved confidence and capabilities in risk assessment. Child Safety were seeking to further embed Multiple Event Review questions and improve visibility of child protection histories in the new IT system (known as Unify) under development. The mandatory training on intake processes for new Child Safety Officers was reported to be under review.

2022–23 Actions and agency response

In 2022–23, Child Safety has continued to develop guidance to support risk assessment decision making at intake. This guidance will be available to staff at the time of the Unify system launch in mid-2024. Once implemented, Unify will also present a child's departmental history in a timeline formation to assist staff in identifying cumulative harm. The review of mandatory training for the Child Safety Officer (CSO) role has also been completed. Formerly two-weeks long, the training is now three-weeks in duration and includes four days dedicated to assessing risk and safety. Non-mandatory training on cumulative harm continues to be available and delivered across the State.

The Board's observations

The Board acknowledges the multifaceted approach Child Safety has taken to strengthen its practitioners' ability to undertake effective child protection history reviews at intake. This includes the opportunity to engage in a more nuanced consideration of cumulative harm in the context of multiple intake events, via the guidance provided through four targeted additional questions. Furthermore, Child Safety's approach has incorporated an extension of the mandatory training for CSO's with a strong focus on assessing risk and safety and made available ongoing professional development. The incorporation of visual timelines to illustrate child protection histories has capitalised on technological solutions.

The Board considered that Child Safety has taken sufficient action in response to Recommendation 2 and will consider the recommendation 'complete' noting the launch of Unify in 2024.

2020–21 Recommendation 3:

The Board recommends: The Department of Children, Youth Justice and Multicultural Affairs develops additional guidance for assessing cumulative harm. This is intended to:

- assist staff to decide whether a notification should be recorded on the basis of cumulative harm
- make sure screening and response priority decision-making tools adequately reference indicators of cumulative harm
- be used in developing information technology platforms.

This work should take into account the reviews by Child Safety and interstate jurisdictions on decision tools and cumulative harm. Any updates to decision tools must take into account intergenerational trauma for Aboriginal and Torres Strait Islander families as a result of past policies and the legacy of colonisation.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting that Child Safety had delivered additional training to staff about assessing cumulative harm and were exploring new approaches to reviewing multiple reports of concern during the intake process. In 2021–22, Child Safety revised practice and guidance training resources following an internal review paper on cumulative harm. Risk assessment guidance for staff had been updated in mid-2022 and included strengthened content on cumulative harm. This was in the context of the discontinuation of the Structured Decision-Making tools to allow staff greater application of their expertise and interpretation of a child's history in their risk assessment decision making. Several training products had also been updated to improve practitioner knowledge and identification of cumulative harm.

2022–23 Actions and agency response

In 2022–23, Child Safety has increased mandatory and non-mandatory cumulative harm training for staff and incorporated visual depictions of child protection histories into its forthcoming IT system, Unify, which aims to illustrate and make more visible cumulative impacts of harm on children, young people and their families. In addition, Unify will generate a prompt if a third (or more) intake event has been generated for a child or young person within 12 months. This functionality seeks to prompt practitioners to consider the impacts of cumulative harm on the child.

The Board's observations

The Board notes Child Safety's ongoing actions to improve the assessment of cumulative harm. The Board anticipates that the mandatory training Child Safety provides to staff on identifying and responding cumulative harm will help staff to will better assess and articulate harm, and unacceptable risk of, to children. The Board notes the design functions to improve risk assessment, particularly the identification of cumulative harm, being built into Unify.

The Board considers that Child Safety has improved its capability to identify and assess cumulative harm and will consider the recommendation 'complete' noting the launch of Unify in 2024.

2020–21 Recommendation 4:

The Board recommended the Department of Children, Youth Justice and Multicultural Affairs builds the capability of Child Safety Officers on assessing whether a parent is ‘able and willing’, as it applies to making decisions about whether a parent can keep their child safe. This is to:

- build understanding about cultural differences in parenting, family structures and child-rearing practices
- promote consistency in its application across decision points at intake, during investigation and assessment, and for interventions with parental agreement
- address how to identify and respond to patterns of concerning parental behaviour (acts or omissions – that is, continuing to act in a way that harms a child, or not taking reasonable action to protect a child)
- address ongoing practice issues with failing to apply perpetrator pattern-centred domestic and family violence practice (including by misidentifying victims of violence as failing to protect their child)
- (separately to parents who actively avoid or disengage from services) strengthen assessments of, and responses to, parents who do not engage with services due to:
  - limited supply of, and timely access to, supports and services in regional and remote areas
  - (for Aboriginal and/or Torres Strait Islander families) a lack of cultural safety within services or lack of active efforts taken by services to help families overcome barriers to their participation
- recognise the importance of children’s views about the safety of their home environment and their parents’ willingness and ability to meet their needs.

The findings of the Board and the Queensland Family and Child Commission’s systemic review of intervention with parental agreements may be used to develop this training.

Status: Complete

Government response

The Queensland Government accepted this recommendation acknowledging the need to encourage consistent practice in assessing a parent as ‘able and willing’. The Queensland Government noted that Child Safety had commenced a review of its Child Safety Officer training. This largely related to risk assessment, particularly responding to specific risks posed by exposure to domestic and family violence. The review will also look at guidance on the Aboriginal and Torres Strait Islander Placement Principle to ensure cultural factors are considered during the risk assessment process.

In 2021–22, Child Safety reported the Child Safety Practice Manual had been updated to include greater guidance regarding the assessment of a parent as ‘able and willing’. Child Safety recently made a decision to move away from the use of structured screening tools such as the Family Risk Evaluation and the Family Risk Revaluation tools. To promote greater flexibility for practitioners in the application of their professional assessment skills, *Cultivating Risk Assessment* learning circles had been completed by all senior team leaders and senior practitioners, with the program to be rolled out to all Child Safety Officers by December 2022. Child Safety also advised that several training programs had been updated in response to this recommendation, particularly training for Child Safety Officers in their first year of practice and training in domestic and family violence-informed practice.

2022–23 Actions and agency response

In 2022–23, Child Safety completed its review of mandatory training for the Child Safety Officer role. The training is now three-weeks in duration and includes a dedicated day focusing on domestic and family violence-informed practice. Non-mandatory training on domestic and family violence-informed practice is also available to all staff.

The Board’s observations

The Board notes that across the two reporting years, Child Safety has taken action to increase the capacity of staff to assess whether a parent is able and willing to care for and protect their child from harm. Efforts have primarily taken the form of increased training for staff. Within this training, attention has been given to domestic and family violence-informed practice.

The Board will close Recommendation 4 noting that Child Safety has taken multiple actions to improve its workforce’s risk assessment decision making abilities, however, the Board caveats that quality risk assessment is essential to child protection practice and is likely to be an ongoing matter for continuous monitoring and improvement.

2020–21 Recommendation 5:

The Board recommended the Department of Children, Youth Justice and Multicultural Affairs and Queensland Health addresses the ongoing barriers and enablers to seeking, weighting and engaging expert advice from health professionals (including Aboriginal and Torres Strait Islander community-controlled health services). This is to include:

- mapping the structural and relational barriers and enablers. This will be informed by discussions with frontline workers and findings from the Board, Queensland Health and Child Safety internal agency review reports and other sources of external review
- developing actions to address the findings and act on opportunities to improve inter-agency coordination more broadly
- increasing the capacity of the Child Safety Officer (Health Liaison) positions to:
  - facilitate access to expertise from health professionals about the health needs of children and the impact of parental mental illness on a child's safety
  - work with Child Safety regional intake services to educate staff on health systems and to facilitate local relationships with hospital and health services and Aboriginal and Torres Strait Islander community-controlled health services
  - support coordinated and joined-up responses to children of parents with mental illness who are receiving ongoing health intervention.

Status: In progress

Government response

The Queensland Government accepted this recommendation, noting Child Safety and Queensland Health's commitment to collaboration towards continuously improving inter-agency coordination and responses to children and their families with specific health needs.

In 2021–22, Child Safety and Queensland Health reported the establishment of a cross-agency working group to define, design and implement key activities that meet the intent of Recommendation 5. At this time, the working group had progressed a mapping exercise that captured the enablers and barriers to seeking, weighting and engaging expert advice from health professionals. Four priority areas were identified: Hospital Liaison Officer capacity, maternity/neonatal, child health and mental health, alcohol and other drugs.

At the time, the Board received information that future activities of the working group would be determined through stakeholder engagement, which included a co-agency workshop which was to be held in September 2022, and consultation with Aboriginal and Torres Strait Islander community-controlled health services.

2022–23 Actions and agency response

In 2022–23, Child Safety and Queensland Health's cross-agency working group facilitated a state-wide focus group session on the four identified priority areas at the Queensland Health *13th Annual Child Protection Liaison Officer and Child Protection Advisor Conference*. The focus group's subsequent paper*, Seeking, weighting and engaging health findings,* was released internally in December 2022 with the aim to promote local Hospital and Health Service and Child Safety Service Centre awareness.

Queensland Health activities in the past 12 months have included:

- Publishing an internal Queensland Health interactive child protection contact list (including a map) to improve inter-agency coordination between Queensland Health employees and their local Child Protection Units and Child Safety Regional Intake Services (RIS) and Child Safety Service Centres (CSSC).
- In consultation with Child Safety, Queensland Health is currently updating their *Responding to an Unborn Child High Risk Alert guideline* and accompanying *High Risk Alert* forms to strengthen communication and joint agency coordination processes to enable a more effective response for unborn children who are "reasonably suspected to be in need of protection after their birth".
- On 4 September 2023, Children's Health Queensland officially launched the *Supporting all Families Everyday* (SaFE) Child Protection online education modules, designed to address the child protection education training needs of all Queensland Health staff.
- Continued cross-agency collaboration and implementation of Child Safety's Unify system.

Board's observations

The Board notes both agencies have taken steps to identify barriers and enablers to seeking, weighting and engaging expert advice from health professionals. The actions taken to date speak to improvements in relationships between agencies at an officer-level and appear likely to improve inter-agency coordination more broadly, however, the Board would like to see evidence of strengthened practice before closing this recommendation. Further activities may need to be taken to address the following parts of the recommendation:

- Promoting advice seeking from Aboriginal and Torres Strait Islander community-controlled health services and further embedding of cultural expertise in practice.
- Deep consideration and response to the recommended changes to Child Safety Officer (Health Liaison) positions.

The Board would like to see evidence that efforts have been made towards growing the stakeholder relationship between CSSC's and the Aboriginal and Torres Strait Islander community-controlled health services in their catchment, as well as changes to CSO (Health Liaison) role descriptions reflecting proposed duties.

The Board will continue to record Recommendation 5 as 'in progress' at this time.

2020–21 Recommendation 6:

The Board recommended the Queensland Mental Health Commission's *Shifting minds* Strategic Leadership Group (SLG), as the senior cross-sectoral mechanism with oversight of mental health, alcohol and other drugs and suicide prevention reform in Queensland, developed a targeted response to youth suicide.

This group, with the support of the Queensland Suicide Prevention Network (once formed), should consider the findings of the research commissioned by the Board into suicide prevention and effective child protection and mental health systems, specifically to:

- establish a shared professional development program on the acute and long-term effects of adverse childhood experiences
- provide Queensland data that can be rapidly given to agencies
- map pathways to services to identify structural barriers to delivering an accessible, comprehensive and integrated continuum of care
- identify the need for new investment to expand services for infants and pre-school children with mental health presentations (and their carers)
- promote service models designed by Aboriginal and Torres Strait Islander communities to effectively engage Aboriginal and Torres Strait Islander children and their families
- investigate multisystemic therapy (MST) for consumers who currently do not have their needs met by child and adolescent mental health services or Evolve Therapeutic services
- undertake routine reviews of policies and procedures of agencies providing services to children to make sure they promote inter-sectoral collaboration and consistency in responses.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting the shared priority focus area of child and youth mental health identified by the cross-agency *Shifting minds* Strategic Leadership Group. The Queensland Government also flagged that, at the time, the Queensland Suicide Prevention Network was under formation and a review of *Every life: A Queensland Suicide Prevention Plan 2019–2029* (*Every Life*) was due for review. The Queensland Government envisioned that the development of a targeted cross sectoral response to youth suicide would support a phased implementation of suicide prevention in Queensland.

In 2021–22, the Queensland Mental Health Commission (QMHC) reported they were continuing to progress the coordination and oversight of whole-of-government suicide prevention priorities. This included the collaborative renewal of *Shifting minds*, and development of phase two of *Every life*. Scoping and preliminary consultation was reported to have commenced to inform a project plan to support the cross-sectoral development of a targeted response to youth suicide prevention. Concurrently, work was reported to be underway to address specific areas identified by the research into youth suicide which had been commissioned by the Board previously: *Highly vulnerable infants, children and young people: a joint child protection mental health response to prevent suicide*. This was to include the development of a workforce competency framework for the human services and education workforce.

2022–23 Actions and agency response

In 2022–23, the QMHC continued developing a targeted response to youth suicide, with activities undertaken against each of the recommendation's criteria. Activities included:

- In October 2022, the delivery of a capability framework for non-health workers and volunteers engaging with young people who are experiencing vulnerability.
- Conducting an analysis to identify gaps in the available professional development resources to identify what is needed to address the acute and long-term effects of adverse childhood experiences.
- In September 2023, phase two of *Every life* was released, which contains actions aligned with Recommendation 6. Shared objectives relate to increased monitoring and reporting of suicide data, mapping of locations with a higher frequency of suicide, promoting service models designed and delivered by First Nations people and promoting supports that use a whole-of-family and kin approach.
- Commenced the *Reforming Suicide Surveillance Project*, which aims to enhance the availability and accessibility of data for suicide, suicide attempts and crises. This will enable government agencies and other services to mobilise supports, monitor trends, and investigate and respond to localised risk factors for suicide.
- Undertook a range of community consultations to understand the barriers and challenges to accessing services and supports. Findings regarding structural barriers were reported in the *Every life Phase Two Consultation* report. Identified issues are also being addressed through the implementation of *Better Care Together: A plan for Queensland's state-funded mental health, alcohol and other drug services to 2027* (*Better Care Together*).
- Significant new investment in expanding services for infants, pre-school children and their parents across the continuum of care to reduce barriers and increase accessibility, including over the next five years through *Better Care Together*. Investment is intended for expanded community-based perinatal and infant mental health treatment services and new public mother and baby beds to increase access to state-wide specialist inpatient treatment for severe perinatal mental health disorders.
- Partnered with DTATSIPCA to deliver community-led initiatives under the *Thriving Local Communities* initiatives. Initiatives aim to improve mental health, social and emotional wellbeing of First Nations peoples.
- Funding an evaluation of *Pinangba*, an Aboriginal and Torres Strait Islander-led service delivery which takes a holistic, all-family approach to alcohol and other drug rehabilitation.
- Continued investigation of Multisystemic Therapy (MST), including reviewing existing research and evidence on the effectiveness of MST and consultation with interstate counterparts. While QMHC advises the evidence for MST is strong, their initial investigation suggests implementation can be challenging and resource intensive, particularly in regional and rural areas.
- Driving continuous improvement and consistency of response across government through the *Suicide Prevention Strategic Oversight Group* and the *Queensland Suicide Prevention Network.*

The Board's observations

The Board welcomes the efforts taken by the QMHC to address all aspects of Recommendation 6. It is beneficial to see that the QMHC has collaborated across government departments to promote a targeted, consistent response to youth suicide. Noting that several initiatives are ongoing or long-term strategies, the Board will record this recommendation as 'complete'.

2020–21 Recommendation 7:

The Board recommended: The Department of Children, Youth Justice and Multicultural Affairs:

7.1 immediately examines why less than 60% of young people under community supervision by Youth Justice considered eligible for a medium- to long-term suicide risk management plan have not had one developed.

7.2 reviews its suicide risk management policies and procedures to:

- address barriers to developing and implementing medium- to long-term culturally responsive suicide risk management plans (examining the results from 7.1)
- establish mechanisms similar to the Suicide Risk Assessment Team approach used in youth detention centres to assist Child Safety and Youth Justice community supervision staff to better identify and respond to suicide risk. This is intended to provide staff with expert, multidisciplinary support when responding to a young person at risk of suicide
- ensure the suicide of a peer, family or community member is adequately recognised as a risk factor for suicide, and that culturally responsive supports are provided to children who experience the suicide of a person known to them.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting an independent audit of all aspects of the approach to managing youth suicide risk was recently conducted within the Youth Justice portfolio. The review was expected to result in procedural updates and additional training opportunities for staff to strengthen suicide risk management with the youth justice system.

In 2021–22, Child Safety reported they had progressed scoping and engagement with internal and external stakeholders regarding suicide prevention. A suicide prevention working group had been established to develop an action plan for Child Safety, including review of policies and procedures. For the same period, Youth Justice reported the completion of a 2020 independent audit of suicide risk management within the portfolio. The findings revealed significant practice opportunities to improve their response and management of suicide risk. Key areas for review included clarifying timeframes for risk management plan completion, establishing processes to review and refer to existing medium to long-term plans, developing improved information sharing processes between detention and community staff and reviewing practice resources for staff. A working party had been formed to assist with the implementation of the audit's recommendations.

2022–23 Actions and agency response

In 2022–23, Child Safety informed the Board that staff now have access to non-mandatory eLearning training courses on understanding suicide and non-suicidal self-injury. Youth Justice reported undertaking the following actions to improve the resources and policy framework regarding suicide prevention:

- Updates to the *Identifying, recording and managing suicide risk operational policy and procedure* occurred in April 2022, requiring all staff who have contact with young people to complete the approved online suicide risk training within one month of commencing work and renew the training every two years.
- A new two-part eLearning module 'Working with Young People: Understanding Suicide' and 'Responding to Suicide Risk' has been developed for all youth justice roles including restorative justice staff.
- Development of a practice resource, *Suicide Prevention Toolkit for Youth Justice staff*, in October 2021.
- Restorative Justice Convenor training now includes specific guidance about maintaining a focus on mental health and suicide prevention throughout the conference process.

The Board's observations

The Boards recognises that since Recommendation 7 was made, an immediate review of medium- to long-term suicide risk management plans for young people under community supervision was undertaken. The review has led to improved suicide prevention policies and practice resources, supplemented with accompanying training for staff. The Board will close Recommendation 7 at this time but would appreciate the provision of data showing the percentage of eligible young people under community supervision on a medium- to long-term suicide risk management plans.

2020–21 Recommendation 8:

The Board recommended the Queensland Mental Health Commission and the Queensland Family and Child Commission develop and deliver youth-friendly messages to raise awareness about mental health services for children and young people, and about their right and ability to consent to and access these.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting that both Commissions would co-design strategies to meaningfully engage young people about available mental health services and their right to access these. The process for this would centre around consulting young people directly. The increasing wait times for mental health assessment and support was raised as a possible barrier to the success of this recommendation, noting that increased help seeking would need to be matched with timely and appropriate service provision.

In 2020–21, the QFCC and QMHC reported an agreement to deliver this. At that time, actions taken by the QFCC and QMHC included:

- Stakeholder consultation with the mental health support sector and young people.
- Contracting headspace to run a social media campaign on young people accessing and consenting to have their own Medicare card. The QFCC ran a supporting digital media campaign to promote headspace's campaign.
- QFCC staff and youth advocates worked with an external animator to develop two videos to raise awareness on mental health supports through a 'Let's have this convo, together' campaign.
- A third digital animation had been drafted addressing consent and parental access to information by mental health services providers.

The QFCC and QMHC reported their intention to conduct evaluations of the above campaigns.

2022–23 Actions and agency response

In 2022–23, the QFCC and QMHC delivered a third animation to help young people understand more about youth mental health support services and their ability to access them. As with the previous two animations, storyboard concepts were created by young people. A webpage was created to support the animations' key mental health messages, available at https://www.qfcc.qld.gov.au/mentalhealth. The QMHC funded the QFCC $3,000 to promote the animations through a social media advertising campaign. Engagement with the campaign over its 26-day duration was positive, with 268,957 users reached through Facebook and Instagram and 9,137 link clicks to the supporting Mental Health webpage. Key stakeholders, including the Department of Education, Headspace, Stride, and Youth Justice also circulated the animations on their own public-facing websites and digital platforms. Stakeholders provided the QFCC with positive feedback about the content.

The Board's observations

The Board notes the creation of three animations and accompanying media campaigns towards the delivery of Recommendation 8 over the two reporting periods. The Board commends the seeking of input of young people into the creation process and thus amplifying their voices across multiple digital platforms. The level of engagement with the content will likely have increased awareness about mental health services for children and young people, and about their right and ability to consent to and access these services.

The Board will record this recommendation as 'complete'.

2020–21 Recommendation 9:

The Board recommended: The Department of Education undertakes an audit of a sample of schools to make sure:

- suicide postvention plans are up to date and comply with departmental policy, part of which is having an Emergency Response Team that includes a representative from the local mental health service
- plans are tailored to meet the specific cultural needs of the individual school community
- the suicide of a peer, family or community member is adequately recognised as a risk factor for suicide and culturally responsive supports are provided to children who experience the suicide of a person known to them.

Status: Complete

Government response

The Queensland Government accepted this recommendation noting Education's commitment to continue strengthening its approach to suicide prevention and postvention. Improvement will inform the recommendation audit of suicide postvention plans in a sample of schools. A number of other strategies within Education's coordinated approach to reducing suicide were acknowledged, including Suicide Prevention and Postvention Training for guidance officers and alerts from the QFCC when there is a suspected suicide of a child in Queensland.

In 2021–22, Education reported Recommendation 9 as complete, following an audit of 42 suicide postvention plans from schools across the state. Learnings from the audit will be used to inform DoE's resources (including the Student Learning and Wellbeing Framework and Supporting Students' Mental Health and Wellbeing procedure) and the support available to schools around the development and ongoing review and implementation of their plans. Education committed to providing the findings of the report into a report to be provided to Board by August 2022.

2022–23 Actions and agency response

- In 2022–23, Education provided a further update on the implementation of the audits' recommendations, including the development of a new Suicide Postvention Plan template for use by Queensland state schools. Education has been working with Be You[137] to develop the new template which includes an overarching statement that the suicide of a peer, family or community member is a risk factor for suicide
- space for schools to indicate key cohorts in their student community who may be at greater risk (i.e., Aboriginal students and Torres Strait Islander students)
- links to key Be You fact sheets specific to postvention responses for Aboriginal students and Torres Strait Islander students to ensure a school's postvention response is culturally responsive
- a requirement to include all members of the Emergency Response Team and their contact details.

When finalised and approved, the new template will be published for use by school staff in response to suicide risk and events. An accompanying communication plan had been developed to ensure schools know how to access advice and support when updating their Suicide Postvention Plan. Education committed to providing the Board with a copy of the Suicide Postvention Plan template when it has been finalised. This is expected to occur in late 2023.

The Board's observations

The Board is satisfied that Education has taken appropriate action to deliver Recommendation 9. The Board appreciates Education's commitment to sharing a copy of the new Suicide Postvention Plan template and will record this recommendation as 'complete'.

---

[137] Be You a national mental health initiative led by Beyond Blue with delivery partners Early Childhood Australia and Headspace. Be You supports education providers to support children's and young people's mental health in early learning services and schools. More information about Be You is available at their website: www.beyou.edu.au

2020–21 Recommendation 10:

The Board recommended that the Queensland Family and Child Commission extends its suicide notification process about children enrolled (or previously enrolled) in state schools to also include children enrolled in Catholic or independent schools. This will require consultation with, and the support of, the non-state schooling sector.

For children not enrolled in either a state or non-state school, opportunities to notify the agency most closely linked with the family should also be explored as part of this work.

Status: Closed – not implemented

Government response

The Queensland Government accepted this recommendation in principle, noting that implementation is reliant on the support of the non-state schooling sector. The QFCC would consult with the non-state schooling sector to extend its suicide notification process and explore opportunities to notify other agencies with close links to families not enrolled in state or non-state schools.

Previous agency response

In 2021–22, the QFCC reported consultation had commenced with the Department of Education, the Queensland Catholic Education Commission (QCEC) and Independent Schools Queensland (ISQ) on the approach to implement this recommendation and the perceived benefits of the model for students in non-state schools.

2022–23 Actions and agency response

In 2022–23, the QFCC continued consultation with the Department of Education, the QCEC and ISQ. Consultation raised the following barriers to implementing Recommendation 10:

- There is no central register for enrolment of children at non-state schools. This means that the QFCC is unlikely to have access to accurate information about the correct school to notify of a student suicide.
- The operation of non-state schools is not centrally directed by the QCEC and ISQ, meaning that individual memorandums of understanding (MOUs) would need to be developed with each non-state school governing bodies or boards, and individual notification and referral systems established.
- schools are often already aware of student suicide through contact with police, families and communities.

QFCC advised that it would not be able to progress with the implementation of Recommendation 10 without significant new resources for the Commission and likely for independent schools. On this basis it recommended the closure of Recommendation 10.

The Board’s observations

The Board acknowledges the actions that the QFCC has undertaken to determine the feasibility of implementing Recommendation 10.

The Board will record Recommendation 10 as ‘closed – not implemented’.

Chapter 8

Governance

Governance

The Board held six meetings in 2022–23. The Chair presided at all meetings and a quorum[138] was present at all meetings. Meetings were:

- **Meeting 12** – 24 August 2022. At this meeting, the Board reviewed 13 cases.
- **Meeting 13** – 2 November 2022. At this meeting, the Board reviewed 12 cases and received a presentation on recent and ongoing QFCC initiatives by Jaime Blackburn, Executive Director, Government Relations and Corporate Services, QFCC.
- **Meeting 14** – 7 December 2022. At this meeting, the Board reviewed 5 cases and received a presentation of the QFCC's Intervention with Parental Agreement (IPA) Project by Zara Berkovits, Director, System Reviews, QFCC. Presentation followed by questions and discussion.
- **Meeting 15** – 15 February 2023. At this meeting, the Board reviewed 10 cases.
- **Meeting 16** – 26 April 2023. At this meeting, the Board reviewed 14 cases.
- **Meeting 17** – 21 June 2023. At this meeting, the Board:
  - reviewed 6 cases
  - received a presentation on findings from the Australian Child Maltreatment Study by Dr Divna Haslam PhD, MPAS, Queensland University of Technology
  - received another presentation regarding the interim findings of the Board's commissioned research into service delivery to young children whose parents use methamphetamine by Professor Anthony Shakeshaft, Professional Research Fellow, Poche Centre for Indigenous Health, University of Queensland
  - Natalie Lewis, Commissioner, QFCC attended the meeting and contributed to discussions.

Child Death Review Board members

The Board consists of a Chair and 11 members. Members include both government and non-government persons with a requirement that government members not constitute a majority. The *Family and Child Commission Act 2014* sets out requirements for the Board's composition, such as the appointment of an Aboriginal or Torres Strait Islander person as the Chair or Deputy Chair, and membership that comprises specialist knowledge in relevant fields.[139] In 2022–23, the Board members held professional expertise across child protection, family law, maternal, family and child health and mental health, education, justice systems and child advocacy.

---

[138] See *Family and Child Commission Act 2014*, s. 29ZF.

[139] *Family and Child Commission Act 2014*, s. 29W-29Y.

The Child Death Review Board Chair: Mr Luke Twyford

Mr Luke Twyford was appointed as the Board Chair in March 2022. Luke's career spans more than 20 years across Commonwealth, New South Wales and Northern Territory governments in the areas of reform, research and evidence, integrity, audit, governance and complaints management. Prior to joining the QFCC, Luke worked for nine years with the Northern Territory Government, leading critical reform of the child protection and youth justice system and its legal frameworks.

Luke holds a Bachelor of Laws with Honours from the University of Wollongong. He has extensive experience providing evidence to courts, inquiries and commissions. Luke's parents fostered a number of children throughout his childhood, with his own lived experience and those of his foster brothers and sisters profoundly shaping the perspective he brings to his work and his passion in advocating for the safety and wellbeing of children and young people.

Deputy Chair: Professor Jody Currie

Professor Jody Currie is a Professor of Practice (Indigenous Health) at QUT. Jody was most recently Chief Executive Officer of the Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane. Jody established ATSICHS Brisbane as a Nationally Registered Early Childhood Education provider, a Nationally Registered Housing Provider, and a Registered National Disability Insurance Scheme Provider.

Jody is a Yugambeh person with traditional ties to the country between the Logan and Tweed Rivers. Since attaining her Bachelor of Arts (BA) in Gender Studies, Jody embarked on her career in health and human service delivery. Jody has a particular focus in child protection and health, working in several senior positions in both the community and government sector.

Ms Simone Jackson

Ms Simone Jackson is a proud Kamilaroi woman from Southwest Queensland and an accomplished Government Executive with over 20 years' experience as a public servant and over the past 11 years has worked in Senior Government roles. Simone has worked in roles relating to justice and human services across two jurisdictions (Queensland & Northern Territory). Simone is currently the Chief Executive Officer, Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu Health) and is responsible for the Aboriginal community-controlled health response operating across West Moreton, over three clinical sites, Ipswich, Booval, and Laidley. Kambu Health also has Amaroo Kindergarten and a Long Day Centre, Children, and family services as well as operating programs funded through numerous state and commonwealth departments. Simone has been a member of the Queensland Parole Board since 2017.

Ms Margie Kruger

Ms Margaret (Margie) Kruger is a solicitor and practises in the area of family law and child protection law. Margie has worked in the area of child protection in service delivery to children and families, policy and the Court, both as a social worker and lawyer for 36 years. Margie was admitted to practice as a Barrister of the Supreme Court of Queensland in May 2000 and was subsequently admitted to practice as a Solicitor in October 2000. Margie is also admitted as a practitioner to the High Court of Australia.

Margie is the Deputy Chair of the Queensland Law Society Family Law Committee and has previously been a member of the Queensland Law Society Children's Committee. Margie was a Board Member of the Child Protection Practitioners Association of Queensland (CPPAQ) from 2010 to 2020 and Chair of CPPAQ from 2014 to 2016. Prior to commencing practice as a lawyer in 2000, Margie was a social worker with the Queensland Government working in the area of child safety.

Mr Bruce Morcombe OAM

Mr Bruce Morcombe OAM is the co-founder of the Daniel Morcombe Foundation which he established with his wife, Denise, after the abduction and murder of their son in December 2003. The Foundation's vision is *Today we build a future where children are free from harm and abuse.* The Morcombes advocate passionately for the education of children and young people on how to stay safe in both physical and online environments and for the support of young victims of crime. They continue to drive to deliver child safety messages to as many Australian schools as possible. The Day for Daniel is held annually as a national day of action to educate children about personal safety. In 2012, Bruce and Denise were recognised as Queensland's Australian of the Year nominations, and both received Medals of the Order of Australia in 2013. In 2020, they were named as Queensland Greats for their tireless dedication to child safety advocacy.

Ms Shanna Quinn

Ms Shanna Quinn is a barrister, mediator and trainer with experience across Australia and Asia, specialising in family law. With extensive experience as a forensic social worker and counsellor, Shanna has focused her career on family law matters (parenting and property), domestic violence and child protection, including clients from diverse cultural, socio-economic and religious backgrounds. Shanna's multi-disciplinary background provides a unique and integrated approach to all areas of her work. As a barrister and mediator, her background as a forensic social worker makes her particularly equipped to deal with sensitive and complex child-related matters.

Professor Jeanine Young AM

Professor Jeanine Young AM is Professor of Nursing, University of the Sunshine Coast. Jeanine is a registered nurse, registered midwife and qualified neonatal nurse. Jeanine has worked in Australia and the United Kingdom in midwifery, neonatal intensive care, paediatrics and community child health. Jeanine's primary focus as an academic researcher is public health in the early years and specifically strategies to reduce mortality and improve health outcomes for children and families experiencing social vulnerabilities. Jeanine has a special interest in infant care practices; in particular breastfeeding and safer infant sleep, including parent-infant bed-sharing which formed the basis of her doctoral studies.

Jeanine works in partnership with government, industry, safety and regulatory bodies, and communities in translating evidence into practical advice for parents. Recently this included the Queensland Health Safer Infant Sleep Clinical Guideline (2022), which Jeanine co-led in collaboration with the Queensland Paediatric Quality Council and Queensland Clinical Guidelines Unit, and the Best Practice Guide for the design of safe infant sleeping environment. Jeanine was made a Member of the Order of Australia for her work in June 2020.

Government members

Government appointments to the Board are based on a position rather than the person. As different officers occupy the nominated Board position within an agency, they automatically become the agency's Board member.

Child Safety

The Board position within the Department of Children, Youth Justice and Multicultural Affairs, Queensland (Child Safety) is the Chief Practitioner. Dr Meegan Crawford is the Chief Practitioner for the Department of Children, Youth Justice and Multicultural Affairs, Queensland. After graduating as a social worker, Meegan commenced her career over 30 years ago as a Child Safety Officer. Meegan has worked in a variety of roles in the department including Senior Team Leader, Senior Training Officer, Manager, Director and Executive Director and has worked as an academic and research assistant for Griffith University. As the Chief Practitioner Meegan reports directly to the Director General and has oversight of the teams responsible for child death and serious injury reviews; child safety complaints; child safety training; operational policy, practice development and guidance; delegated authority; NDIS interface; sexual abuse and exploitation, and partnerships and projects.

Youth Justice

The Board position within the Department of Children, Youth Justice and Multicultural Affairs, Queensland (Youth Justice) is held by the Assistant Chief Operating Officer, Youth Justice Statewide Services, Operations and Commissioning. Mr Darren Hegarty held the role of Assistant Chief Operating Officer and the Youth Justice representative on the Board for meetings 7, 8, 10 and 11, while Youth Justice existed within the Department of Children, Youth Justice and Multicultural Affairs. Darren has led a number of positive and significant reforms for children and young people in both the youth justice and child protection systems. These include the Youth Justice Strategy and Action Plans, Out of Home Care Reinvestment program, including Queensland's first Mental Health Recovery Residential, improved service delivery frameworks within Child Safety, targeted outcomes for Aboriginal and Torres Strait Islander families, stronger engagement with community Elder groups and Aboriginal and Torres Strait Islander service providers, and the re-focused investment in Intensive Family Support for children and young people. Darren has extensive experience in providing innovative approaches to solving complex problems within the human services sector.

Queensland Health

The Board position within Queensland Health is held by the Medical Director of Child and Youth Mental Health Services, Children's Health Queensland. Dr Stephen Stathis held the position of Medical Director of Child and Youth Mental Health Services, Children's Health Queensland and was the Queensland Health representative on the Board throughout 2021–22. Stephen obtained a dual fellowship in paediatrics and psychiatry, with certificates in Child & Adolescent Psychiatry and Forensic Psychiatry. Stephen is currently the Medical Director of Child and Youth Mental Health Services, Children's Health Queensland. He also acts as the Clinical Advisor to the Mental Health Alcohol and Other Drugs Branch for child and youth mental health. Stephen has extensive experience working among vulnerable and marginalised young people within the community. His clinical interests include 'bridging the gap' between paediatrics and psychiatry, mental health policy and strategic planning, gender dysphoria, consequences of early childhood trauma and abuse, and adolescent forensic psychiatry.

Department of Education

The Board position within the Department of Education is held by the Executive Director for Student Protection and Wellbeing. Ms Hayley Stevenson has held a number of roles since commencing with the Queensland Department of Education in 2002 and is currently the Assistant Director-General for Disability, Inclusion and Student Services. In this role, Hayley is responsible for leading the development and statewide implementation of key initiatives related to Student Wellbeing, Behaviour, Engagement, Respectful Relationships, Student Protection and Suicide Prevention, Disability Strategy and Inclusion. Hayley is committed to providing schools with the resources they need to embed support for student safety wellbeing into their everyday work.

Queensland Police Service

The Board position within the Queensland Police Service is the Detective Superintendent Child Abuse and Sexual Crime Group. Detective Superintendent Denzil Clark commenced with the Queensland Police Service (QPS) in January 1988 and has served the past 33 years as a detective in various positions across the QPS. Denzil has worked as an investigator in regional child protection units, criminal investigation branches, various units within Crime and Intelligence Command and at the Crime and Corruption Commission. In 2018 Denzil was promoted to Detective Superintendent, Child Abuse and Sexual Crime Group which includes the key roles of State Child Protection and Investigation Unit (CPIU) Co-ordinator and QPS Child Safety Director. Denzil has twice been awarded the Commissioner's Certificate and has also received a number of other operational and corporate awards in recognition of his contribution to policing. In 2021 Denzil completed a Graduate Diploma of Executive Leadership.

Attendance

Member	Agency	Meeting 12 24/8/2022	Meeting 13 2/11/2022	Meeting 14 7/12/2022	Meeting 15 15/2/2023	Meeting 16 26/4/2023	Meeting 17 21/6/2023
Luke Twyford	QFCC (Chair)	Present	Present	Present	Present	Present	Present
Prof. Jody Currie	Non-government (Deputy Chair)	Present	Present – via video call	Apology	Present	Present	Present
Simone Jackson	Non-government	Present	Present – via video call	Present	Present	Apology	Present
Bruce Morcombe OAM	Non-government	Apology	Present	Present – via video call	Present	Present – via video call	Present
Prof. Jeanine Young AM	Non-government	Present	Present	Present	Present	Present	Present
Shanna Quinn	Non-government	Present – via video call	Present – via video call	Present – via video call	Present – via video call	Present – via video call	Present – via video call
Margaret Kruger	Non-government	Present	Present	Apology	Present	Present	Apology
Dr Meegan Crawford	Child Safety	Present	Present	Present	Present	Present	N/A
Charmaine Matebau		N/A	N/A	N/A	N/A	N/A	Present
Hayley Stevenson	Education	Present	Present	Present	Present	Apology Proxy – Lisa Shields	Present
Dr Stephen Stathis	Queensland Health	Present	Present	Present	Present	Apology Proxy – Ross Alcorn	Present
Darren Hegarty	Youth Justice	Apology Proxy – Pele Ware	Apology Proxy – Pauline Zardo	Apology	Apology Proxy – Pauline Zardo	Apology Proxy – Elizabeth Howe	Present
Denzil Clark	Police	Present	Present	Apology Proxy – Glen Donaldson	Present	Apology Proxy – Stephen Blanchfield	Apology Proxy – Stephen Blanchfield

Table 8: Attendance at the Board in 2022–23

Conflicts of interest

The Board members disclosed a personal interest relating to a review as required by legislation[140] on three occasions. Examples of interests disclosed included non-Government members being appointed to another board that pertains to children or families, and Government members' participation in the agency's internal review process. After consideration of each disclosure, the Board agreed that there was no conflict of interest arising in relation to the matter, and the member was able to participate.

No members were asked to be absent from the case discussion for which they declared a potential conflict of interest.

Stakeholder engagement

The Board continued to maintain professional relationships with a range of stakeholders throughout 2022–23. Stakeholders supported the Board by:

- providing insights into the experiences of individuals, families or communities or contributed expertise on matters that affect them
- contributing data, research or expertise to inform the Board's work
- undertaking internal agency reviews and provided insights into relevant legislation, policies, procedures and practices
- carrying out similar review functions in other Australian jurisdictions
- implementing, or assisting in the implementation of, system change recommended by the Board
- sharing the Board's key messages to a wider audience.

A cross-agency working group was established in 2020 to develop operational guidelines for agency reviews following the death or serious physical injury of a child. Chaired by the Board Secretariat, the group met twice during 2022–23 to monitor the number of upcoming internal agency reviews and discuss death review processes and emerging issues.

The Board is also a member of the Australian and New Zealand Child Death Review & Prevention Group. Through this group, the Board is able to engage and share learnings with similar interstate entities.

In 2022–23, the Board commissioned one research contract. The research focused on best practices for practitioners working with children whose parents use methamphetamine. The findings of this research contributed to *Chapter 5: Strengthening child safety practice in response to parental substance and methamphetamine use* and the research is expected to be released in full in late 2023.

---

[140] *Family and Child Commission Act 2014*, s. 29ZJ.

Promoting our work

The Board maintains a website at www.cdrb.qld.gov.au which provides information about its structure, functions and work.

In the past year, the Chair issued two media releases discussing research previously commissioned by the Board. The two research pieces were about Sudden Unexpected Deaths in Infancy, and Domestic and Family Violence. Full versions of both media releases are available at www.cdrb.qld.gov.au/news-and-updates

Information requests

Pursuant to S29P of the *Family and Child Commission Act 2014*, the Board Chair is able to request information to support the Board to carry out its reviews.

The Chair used S29P information request powers on two occasions in 2022–23:

- The Chair wrote to Child Safety requesting the child protection history relating to a young person's cultural family.
- The Chair wrote to a foster carer agency:
  - seeking a summary of the service delivery offered to a child and their foster carers, including respite opportunities
  - requesting details of the foster carer agency's engagement with Child Safety during their service delivery to a child
  - inviting the provider to raise any specific issues they felt critical for foster carer support agencies.

On both occasions, the entities supplied the requested information within timely manner.

Risk management

The Secretariat, on behalf of the Board, maintains the Board strategic risk register in compliance with the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2019*. These require that all accountable officers and statutory bodies establish and maintain appropriate systems of internal control and risk management. The Board strategic risk register captures and monitors strategic and operational risks for the Board. For purposes of accountability, it is presented quarterly to the QFCC's Audit and Risk Management Committee.

Member farewell and recruitment

Board members are appointed for a term of three years. Several Board members' terms concluded on 30 June 2023. Non-Government members Professor Jeanine Young, Margie Kruger, Shanna Quinn, and Bruce Morcombe finished their term with the Board following the conclusion of Meeting #17. Deputy Chair Professor Jody Currie also retired at this time.

With the next three-year appointment terms commencing July 2023, the QFCC partnered with the Department of Justice and Attorney-General between January and June 2023 to undertake a significant recruitment process. There was a strong aspiration to increase Aboriginal and Torres Strait Islander membership on the Board. The QFCC led a digital and media campaign to encourage applications from across Queensland and provided advice to the Department of Justice and Attorney-General to support assessment of applicants' expertise and knowledge.

Appendices

Appendix 1–Child Death Review Process

Internal agency reviews

The purpose of internal agency reviews is to facilitate ongoing learning, promote accountability and improve child protection services to children and young people. Agencies promote collaboration by sharing learnings and recommendations from their reviews.

Chapter 7A (Internal agency reviews following child deaths or injuries) of the *Child Protection Act 1999* outlines the legislative responsibilities of reviewing agencies.

The agencies required to undertake reviews are:

- the Department of Education
- the Department of Child Safety, Seniors and Disability Services (Child Safety)
- the Department Youth Justice, Employment, Small Business and Training (Youth Justice)
- Queensland Health (Hospital and Health Services)
- the Queensland Police Service
- the Director of Child Protection Litigation (DCPL).

The reviews conducted by the DCPL have a different scope to those conducted by other review agencies.[141,142]

Focus, purpose and processes of the Child Death Review Board

The focus and purpose of the Board's reviews is to identify opportunities for continuous improvement in systems, legislation, policies and practices. The Board receives and considers all internal agency review report findings and adopts a high-level focus to identify system improvements that can increase children and young peoples' safety and wellbeing and prevent future child deaths. [143] It does not investigate the deaths of individual children or make findings about the actions of individuals.[144]

In 2022–23, the Board met six times to review trends and emerging system issues across 60 cases. For 15 of these cases, the Board conducted in-depth reviews (categorised and referred to as Level 3 reviews), where it was identified that children's experiences of the system provided the greatest opportunity for learnings and recommendations about improvements to systems, policies, practices and legislation.

For these reviews, the Board collates multiple agencies' information and findings to develop visual timelines of childrens' engagement with the system in the 12 months prior to their death. Timelines provide a narrative infographic of the child's experiences and aim to stimulate rigorous and in-depth discussions about system collaboration and improvements. Cases that were categorised as Level 1s and 2s are reviewed by the Board to monitor and report on recurring issues and trends within the Queensland child protection system.

---

[141] See *Child Protection Act 1999*, s. 245H and 245I for details of requirements for reviews, and s. 245K for further details on the scope of a relevant agency review.

[142] See *Child Protection Act 1999*, s. 245J for details of requirements for the Director of Child Protection Litigation reviews and s. 245L for further details on the scope of those reviews.

[143] *Family and Child Commission Act 2014*, s. 29A.

[144] *Family and Child Commission Act 2014*, s. 29A(3) and 29H(5).

Appendix 2–Glossary of terms and acronyms

Term or acronym	Meaning
Agencies and organisations	
Board members/ members	Members of the Child Death Review Board
The Board	Child Death Review Board
DCSSDS/Child Safety	Department of Child Safety, Seniors and Disability Services. Previously the Department of Children, Youth Justice and Multicultural Affairs or DCYJMA.
DoE/Education	Department of Education
ODCPL	Office of the Director of Child Protection Litigation. The ODCPL supports the functions of the Director of Child Protection Litigation (DCPL) including by conducting the child death and serious physical injury reviews.
QAO	Queensland Audit Office
QFCC	Queensland Family and Child Commission
QH/Health	Queensland Health
QMHC	Queensland Mental Health Commission
QPQC	Queensland Paediatric Quality Council
QPS/Police	Queensland Police Service
Review agencies	These are the agencies required to undertake reviews following the death or serious physical injury of a child as defined in section 245B – see *relevant agency* - of the *Child Protection Act 1999*. These are: the Department of Education (DoE), the Department of Child Safety, Seniors and Disability Services (Child Safety), the Department of Youth Justice Employment, Small Business and Training (Youth Justice), Queensland Health (Hospital and Health Services) and the Queensland Police Service. The term 'review agencies' also includes the Director of Child Protection Litigation defined in section 245J of the *Child Protection Act 1999* (noting its review scope is different to that of the other review agencies).
DYJESBT/Youth Justice	The Department of Youth Justice, Employment, Small Business and Training. Previously the Department of Children, Youth Justice and Multicultural Affairs or DCYJMA.

Term or acronym	Meaning
Child protection terms See www.csyw.qld.gov.au/childsafety/child-safety-practice-manual/quicklinks/glossary-terms	
Child concern report (CCR)	A child concern report is a record of child protection concerns received by Child Safety that does not meet the threshold for a notification.
Child in need of protection	This is a child who has suffered harm, is suffering harm, or is at unacceptable risk of suffering from harm, and does not have a parent able and willing to protect the child from the harm (*Child Protection Act 1999*, section 10).
Aboriginal and Torres Strait Islander Child Placement Principle	The Aboriginal and Torres Strait Islander Child Placement Principle aims to keep children connected to their families, communities, culture and country and to ensure the participation of Aboriginal and Torres Strait Islander people in decisions about their children's care and protection. The Principle centres on five elements: prevention, partnership, participation, placement and connection.
Child Safety Officer (CSO)	A child safety officer is authorised, under the *Child Protection Act 1999*, to: • deliver statutory child protection services, such as investigating and assessing allegations of suspected child abuse and neglect • intervene to ensure the safety and wellbeing of children subject to ongoing intervention, in accordance with legislation, policies and procedures.
Cumulative harm	This refers to harm to a child caused by a series or combination of acts, omissions or circumstances that may have a cumulative effect on the child's safety and wellbeing. The acts, omissions or circumstances may apply at a particular point in time or over an extended period, or the same acts, omissions or circumstance may be repeated over time.
Domestic and family violence	Domestic and family violence is behaviour by a person towards another person with whom the person is in a relevant relationship. It includes behaviour that is: physically or sexually abusive; emotionally or psychologically abusive; economically abusive; threatening; coercive; or in any other way controls or dominates the other person and causes them to fear for their safety or wellbeing or that of someone else.
Family and Child Connect (FaCC) service	Family and Child Connect is an easily accessible referral point for agencies working with families who may need support. Families can also contact FaCC services directly for advice and help. A principal child protection practitioner is based at each FaCC service to identify and respond to serious concerns that may need Child Safety intervention. A specialist domestic and family violence practitioner also works with each FaCC service to advise on and assist with domestic and family violence matters.
Family Wellbeing Service (FWS)	The Aboriginal and Torres Strait Islander Family Wellbeing Service is a program co-designed with the community-controlled sector and the Queensland Aboriginal and Torres Strait Islander Child Protection Peak. Family Wellbeing Services are designed to make it easier for Aboriginal and Torres Strait Islander families across Queensland to access culturally responsive support to improve their social, emotional, physical and spiritual wellbeing, and to build their capacity to safely care for and protect their children.
Harm	In this context, harm refers to any detrimental effect of a significant nature on a child's physical, psychological or emotional wellbeing. Harm can be caused by physical, psychological or emotional abuse or neglect, or sexual abuse or exploitation. Harm can be caused by a single act, omission or circumstance; or a series or combination of acts, omissions or circumstances (*Child Protection Act 1999*, section 9).
Intake	Intake is the first phase of the child protection continuum and is initiated when information or an allegation is received from a notifier about harm or risk of harm to a child or unborn child, or when a request for departmental assistance is made.
Intake enquiry	An intake enquiry may be a request for information or relate to child wellbeing issues or child protection concerns. It is one type of departmental response to information received at the intake phase.

Term or acronym	Meaning
Intensive Family Support (IFS) programs	Intensive Family Support programs provide case management to families at risk of entering the statutory child protection system.
Intervention with parental agreement (IPA)	This refers to ongoing intervention with a child who is considered in need of protection, based on the agreement of the child's parent/s to work with the department to meet the child's safety and protection needs.
Investigation and assessment	Investigation and assessment is the second phase of the child protection continuum. An investigation and assessment is the departmental response to all notifications and is the process of assessing the child's need for protection where there are allegations of harm or risk of harm to a child (*Child Protection Act 1999*, section 14).
Non-government organisation	In this context, this refers to a not-for-profit organisation that receives government funding specifically for the purpose of providing community support services.
Notification	A notification is recorded when information is received about a child who may be harmed or at risk of harm that requires an investigation and assessment response. A notification is also recorded on an unborn child if there is reasonable suspicion that they will be at risk of harm after they are born.
Out-of-home care	This refers to placements of children, subject to statutory child protection intervention, using the authority of the *Child Protection Act 1999*, section 82(1). Out-of-home care includes placements with a licensed care service, an approved or kinship carer, or another entity.
Parent able and willing	This refers to a parent who has both the ability and willingness to protect their child from harm (*Child Protection Act 1999*, section 10). A parent may be willing to protect a child, but not have the means or capacity to do so. For example, a parent with a diagnosed mental illness may express a willingness to protect their child; however, due to factors related to the mental illness, may not be able to do so. Alternatively, a parent may have the means and capacity to protect a child but may not do so. A child safety officer must clearly assess the parent's motivation and ability to protect the child. In circumstances where a child resides across two households, the ability and willingness of both parents to protect the child needs to be assessed.
Placement	This refers to when a child is placed in an out-of-home care living arrangement due to intervention by the department.
Regional intake service	This is the contact point for reporting concerns about a child. There are seven regional intake service locations across Queensland. They receive incoming calls and reports, assess the information and decide how to respond.
Other	
Adverse childhood experience (ACE)	Adverse childhood experiences can include abuse, neglect and household dysfunction. 'Adverse childhood experience' is generally seen as a mental health term, where the more a child experiences, the greater the likelihood of negative impacts on the child's physical and mental health. These include negative impacts on gene function and brain structure.
Child Death Register	The Queensland Child Death Register records the deaths of all children and young people who die in Queensland. It is maintained by the QFCC.
Post-traumatic stress disorder (PTSD)	Post-traumatic stress disorder is a treatable anxiety disorder that occurs when fear, anxiety and memories of a traumatic event remain and interfere with how people cope with everyday life.
Sudden unexpected death in infancy (SUDI)	Sudden unexpected death in infancy is a category of death where an infant dies suddenly, usually during sleep, and with no immediately obvious cause.

Appendix 3–Remuneration of the Child Death Review Board

Child Death Review Board (the Board)					
Act or instrument	Family and Child Commission Act 2014				
Functions	Undertake systemic reviews following the deaths of children connected to the child protection system and make recommendations to improve the child protection system and to prevent the deaths of children.				
Achievements	The Board met on six occasions in 2022–23. A total of 60 child deaths were reviewed in this period. One research project was commissioned.				
Financial reporting	The Board is audited as part of the Queensland Family and Child Commission. Accounts are published in the annual report.				
Remuneration					
Position	Name	Meetings/ sessions attendance	Approved annual fee	Approved sub-committee fees if applicable	Actual fees received
Chair (government)	Luke Twyford	6	$0	N/A	$0
Deputy Chair (non-government)	Jody Currie	5	$4500	N/A	$4500
Member (non-government)	Simone Jackson	5	$4500	N/A	$4500
Member (non-government)	Margaret Kruger	4	$4500	N/A	$4500
Member (non-government)	Bruce Morcombe OAM	5	$4500	N/A	$4500
Member (non-government)	Shanna Quinn	6	$4500	N/A	$4500
Member (non-government)	Jeanine Young AM	6	$4500	N/A	$4500
Member (government)	Meegan Crawford	5	$0	N/A	$0
Member (government)	Charmaine Matebau	1	$0	N/A	$0
Member (government)	Hayley Stevenson	5	$0	N/A	$0
Member (government)	Lisa Shields	1	$0	N/A	$0
Member (government)	Stephen Stathis	5	$0	N/A	$0
Member (government)	Ross Alcorn	1	$0	N/A	$0
Member (government)	Darren Hegarty	1	$0	N/A	$0
Member (government)	Pele Ware	1	$0	N/A	$0
Member (government)	Pauline Zardo	2	$0	N/A	$0
Member (government)	Elizabeth Howe	1	$0	N/A	$0
Member (government)	Denzil Clark	3	$0	N/A	$0
Member (government)	Glen Donaldson	1	$0	N/A	$0
Member (government)	Stephen Blanchfield	2	$0	N/A	$0
Number of scheduled meetings/sessions	6				
Total superannuation paid (non-government)	$2835.12 ($472.52 per non-government member)				
Total out-of-pocket expenses	$828.51 (accommodation, meal allowances and member taxi fares/parking)				

Child Death
Review Board
Queensland **Family & Child** Commission

PARENT PERSPECTIVES ON SCHOOL CAN'T: Implications for Health, Welfare, Disability and Education

A submission to the 2022 Federal Senate Inquiry into School Refusal

Abstract:

School-Can't (School Phobia, School Refusal) Australia is a national peer support community of parents/carers, supporting children and young people through school attendance difficulties. In this document we: share the group's framework for understanding school refusal, discuss the role of stressors including those which are: school based, COVID related and experienced within the family and community contexts. We describe the impact on children/young people, and parents/carers of school refusal and the difficulties and barriers associated with seeking help and support. Our response is informed by the collective lived experience of the group, results from a survey conducted for this inquiry, and our research. This report contains distressing information about students (many with disability) who have experienced trauma connected with their experience of schools and the significant impacts on parents/carers mental and physical health.

Written by:

Louise Rogers, Bsc/BE (Hons). MTeach (Primary), &
Tiffany Westphal, BSocWk, BA, Grad Dip Bus Mgmt.
on behalf of School Can't (School Phobia/School Refusal) Australia

Table of Contents

List of Tables

List of Figures

ACKNOWLEDGEMENTS:

Preparation of this document was informed by the lived experience of parents/carers from the School Can't Australia group, and pending members, who have completed our survey. We would like to thank the 441 parents who took time before Christmas 2022 to share their experiences with us in the survey, and the parents from School Can't (SPSR) Australia who have provided testimonials. Thank you to Sophie Black of the Guardian Newspaper for bringing this issue to the public's attention. We would like to thank Senator Penny Allman-Payne for bringing this issue to the Federal Senate and proposing a Senate Inquiry into School refusal. We are excited to be able to share our experiences, the findings of our research and our knowledge about school can't. We would like to extend thanks to those group members who volunteered to work on creating and analysing the results of our survey, including Charlotte Fitzgerald, Rebecca Gelsi, Katrina Benton, Katrina Scurrah, Leigh Wedding and others who wish to remain anonymous. We must also thank our families for shoulder massages, cups of tea and coffee, cooked dinners, and more than a usual number of takeaway meals, as we redirected out attention to conducting the SC Survey-22 and writing this submission.

1. Executive Summary:

This report, prepared for the 2022 Senate Inquiry into School Refusal details the findings of research into the experiences of parents and carers with children experiencing school refusal, conducted by School Can't (School Phobia School Refusal) Australia, along with the lived experience knowledge of the group.

School Refusal refers to a child's inability to attend or participate in formal education.

The language of "**School Can't**" is preferred as it recognises that this is symptom of stress, not a behavioural problem.

There is a spectrum of school can't from mild (where a child might still attend school but be unable to complete work) to severe (where they are unable to attend at all for at least 6 months and show signs of severe distress or nervous system shutdown).

This submission includes results from the School Can't Survey (December 2022, with 441 completions, "SC Survey-22") as well as insights and experiences as shared amongst the School Can't (SPSR) Australia group over the last 8 years.

We have responded to the following terms of the Senate Inquiry:

1. **The increasing number since the COVID-19 pandemic, of young people and their families who are experiencing school refusal.**

Key concepts from Section 6:

- School Can't (SPSR) Australia is not able to say that there is an increasing number of students experiencing school refusal since the onset of the COVID-19 pandemic.
- The group membership has grown consistently since 2014.
- The SC Survey-22 found 46% had experienced school can't before COVID-19. As many factors contribute to school can't, it can't be concluded that the pandemic caused the remainder.
- There is no reliable formal data on school can't across Australia, with no formal definition and current methods of collecting and classifying details on school absences.
- Social stigma and poor levels of awareness impact on parental identification of school can't and early signs.

Recommendation 1:

That state and territory DOEs work towards establishing agreement about defining "school can't" and create a set of guidelines regarding recording school can't absences that is consistent across all states and territories. Furthermore, information about absence reasons should be made publicly accessible and should be published in relation to each school. Improved data collection will assist to identify trends relating to school can't absences and can be used to track effectiveness of intervention and preventative measures.

Recommendation 2:

That state and territory Departments of Health and Education, in conjunction with School Can't (SPSR) Australia, develop and promote public health messaging about school can't to improve community understanding that it is a stress behaviour and not misbehaviour. That awareness raising include information about early warning signs, and how to respond and support students experiencing school can't. Such action will assist in breaking down stigma and shame and assist parents and carers to feel able to report signs of school can't to schools. These actions must be done to support collection of data which more accurately reflects the incidence of school can't in the community.

2. How school refusal is affecting young people and their families and the impact it is having on the employment and financial security of parents and carers.

Key concepts from Section 7.1- **The Impact on Young People:**

- There is very little research into the perspectives and experiences of students with school refusal and impacts on their long term wellbeing, future earnings, career or life prospects.
- Parents/carers describe their children as experiencing distress, frustration, anger, loss of hope and trust. Their children feel: misunderstood, judged, shamed and not listened to. They are frequently socially isolated, and excluded from school activities and experiences. They may be self-harming, have suicidal ideation, or be in a nervous system state of flight, fight or shutdown.
- Collaborative and Proactive Solutions (CPS) supports students and adults to explore the difficulties a student is experiencing without shame or judgment.
- School can't is experienced by students across all year levels, with an increase at 6-7 years and 13-14 years, indicating increasing vulnerability following primary and secondary school transition points.
- Most parents / carers in SC Survey-22 described their child as experiencing severe school can't. Almost a quarter of these students had been absent from school for more than 80% of the previous 12 months.
- An overwhelming majority (73%) of these students were diagnosed with a disability—mostly autism and ADHD. Another 10% are suspected or awaiting diagnosis.
- For those with anxiety and depression, most were diagnosed **after** school can't onset. These diagnoses are seen as responses to the chronic unresolved stress.
- Exposure to ongoing stress can result in a trauma response and ongoing physical and mental health issues. The source of stress must be identified and reduced to calm the child's nervous system. Early identification is critical to recovery. Use of rewards and consequences, continued expectations of attendance at school or increased demands on the student can add more to the student's stress load, further preventing the student's nervous system from being able to return to a "safe" state.

- Parents are often left with no option but to remove the child from the source of stress. That may mean moving to another school, home schooling, distance education, or enrolling in an alternative school.
- The lack of awareness and viable alternatives means some students remain in situations where their health continues to be impacted and they do not

experience a reduction in their exposure to stress for long enough to reset the nervous system.

Recommendation 3:

That the Federal DOE recommend that state and territory DOEs mandate the rolling out of Collaborative and Proactive Solutions (CPS) across all schools in order to equip teachers with collaborative communication skills to assist them in working with students and parents/ carers to identify problems and find solutions or ways to remove the barriers that lead to school attendance difficulties. CPS is a powerful tool which assists in amplifying student perspectives and voice in the problem-solving process.

Recommendation 4:

That State and Territory based departments of Families / Human Services fund Collaborative Proactive Solutions parenting programs to assist parents and carers to prevent school can't and to understand and support children experiencing school can't. CPS is a powerful tool which can be used to help understand what is happening for our children and identify supports and accommodations that will promote engagement with learning.

Recommendation 5:

That consideration be given to funding research (informed by lived experience) to unpack factors associated with increased student stress leading to onset of school can't at age 6-7 and age 13-14 to understand how to better support students in these age groups.

Recommendation 6:

That DOE **policies** are reviewed to support students and parents/carers to take time off work or time out of school, while parents/carers work with the student, school and clinicians to identify underlying issues and address the mental health concerns of the student, in order to facilitate recovery via an individualised plan. This should be communicated to families so that they understand that this is possible. This will reduce parent/carer and student stress.

Recommendation 7:

That state and territory DOEs provide positive messaging about forms of schooling other than formal schooling and ensure messaging that normalises that there are many different ways to engage with learning. Such that families and students are aware that there are a range of options available to them should they require them.

Recommendation 8:

That state and territory DOEs provide positive and more frequent messaging about the variety of pathways that exist to higher education outside of mainstream school. So that schools, parents/carers and students are aware that there are many options and successful completion of year 11 and 12 are not the only ways to access tertiary studies. This will help reduce stress in the final years of school if young people experience school can't at this time.

Recommendation 9:

That State and territory DOEs fund an on demand free health and wellbeing check with parents prompted about the service in year 1, year 4, year 7, and year 10, to identify any previously unidentified diagnoses, mental health issues and support needs. This service should provide referral to funded assessments and supports. This will reduce barriers to accessing costly diagnoses leading to more timely identification of childhood illness and developmental conditions and ensure parent/carers support in their effort to seek help for their child.

Key concepts from Section 7.2 - **How is School Refusal Impacting on Parents / Carers**:

- The impact of caring for a school can't child on the parent/carer's ability to work is significant—only 3% of parents reported no impact on their ability to work over the last 5 years.
- Employment impacts include the amount of work parents or carers undertake (with most wanting to work more hours), the type of work, and the location of work. They may need flexibility around the unpredictable and varying nature of school can't and what is required to support their child, whilst also managing their own stress levels. Carers Leave is limited in its application.
- The financial stress of school can't impacts on families in both the short and longer term, with increased costs, reduced earnings and impact on savings. A third of families stated they are coping for now but their long-term financial security is impacted. 15% felt that they were struggling to afford essentials such as food, housing, transport, health, and basic needs.
- Limited school and practitioner awareness about school can't means early signs are ignored and parents/carers experience difficulty finding help and support. Over 90% of parents surveyed said that School Can't (SPSR) Australia's lived experience and support assisted them to focus on their child's mental health and wellbeing.
- Parents and carers make use of a range of supports, but face barriers in finding, obtaining and accessing them, leading to further frustration and stress. (Supports are discussed further in Sections 8.1, 8.2, and 8.3).
- There is significant impact on parent/carer social connections, with feelings of isolation, shame and judgment often rooted in differences in beliefs about how to respond to their child's needs (assuming poor parenting vs an invisible stressor).
- Two-thirds of surveyed parents / carers reported that exhaustion and overwhelm limited their ability to access supports for themselves. They were also impacted by limited free time, the unpredictability of school can't, and waiting lists.
- The burden of care is substantial, and the lack of school can't awareness among service providers adds to the complexity. Many survey respondents suggested that it would help to have supportive case management that was trauma aware, independent, and focussed on wellbeing rather than school attendance.
- Negative and frequently unfounded narratives about engagement with school and learning (eg "school to prison pipeline", "every day counts" and views of non-compliant children as lazy and manipulative), all perpetuate parental /carer anxiety and difficulties in them accessing formal and informal supports.
- Parents/carers surveyed experienced substantial negative impacts to their mental and physical health and their perception of themselves as a parent.

Recommendation 10:

That federal parliament review the financial supports delivered by Services Australia for parents who are caring for school can't children, in consideration of the substantial impact on the finances of parents and carers. That consideration be given as to provision of a 12 month "school refusal package" in addition to carers payment and carers allowance, and/or access to Assistance for Isolated Children, where children are recovering at home from school can't. This will assist parents who are unable to maintain employment to manage the cost of living on reduced income, whilst paying for allied health and other supports including: psychology, social work, psychiatry, paediatricians, private tutors, support workers etc as required.

Recommendation 11:

That state and territory DOEs fund independent case management for students with school can't which has wellbeing as its first priority. Case management would assist parents and carers to access: timely and appropriate medical and allied health supports, build a team of supports around the student, determine factors underlying school can't, communicate with schools, assist schools to remove barriers and accommodate the student's needs, identify alternative education options or flexible ways to engage with learning if necessary, and collaborate to create recovery focussed plans. This will assist in reducing parent/carer stress.

Recommendation 12:

That the federal government fund School Can't (SPSR) Australia to create and deliver professional development materials for school staff and for wellbeing and clinical services in order to improve knowledge about school can't, including: how to prevent school refusal, how to identify risk factors for school refusal, how to identify underlying issues and collaborate with and support students and their parents or carers where a student is experiencing school can't. Building awareness and knowledge about school can't at the school and clinical level will lead to reduced carer stress and will result in students receiving assistance in earlier stages of school can't.

Recommendation 13:

That federal parliament review financial supports for parents who home-school. Many have been forced into home schooling as a result of their child's disability/mental health needs not being met previously in formal schooling. We request that consideration be given to: helping families meet the additional cost of living associated with home schooling, provision of additional funds when families are home-schooling a child with disability, increasing Assistance for Isolated Children payments (broadening eligibility criteria to include students experiencing school refusal).

3. The impact and demands of the increasing case load on service providers and schools to support these students and their families.

Key concepts from Section 8 - Services Accessed for School Can't Children, Helpfulness of Services, and Barriers to Accessing Services

- Parents/carers are struggling to access helpful supports for their school can't children.
- **Helpful supports are trauma aware and share an understanding of school can't. They are focused on the child's wellbeing, seek to identify and address the underlying causes of distress; and demonstrate patience and compassion.**
- SC Survey-22 respondents overwhelmingly (85%) indicated that their experience of parent peer support groups was helpful. Support workers and OTs were also rated as helpful, though to a lesser extent.
- Concerningly, school-based supports were rated as unhelpful by many, perhaps reflecting the conflict of their position with a focus on attendance versus wellbeing. Even wellbeing/school counsellors were rated as not helpful by nearly 60% of those who had accessed them. Year level coordinators and class teachers were rated as not helpful by nearly 55% of respondents.
- Many of the difficulties in accessing external supports link back to poor understanding of disabilities within schools; gaps between what is covered by education, health and disability sectors; and long waiting lists and costs of accessing supports. There were also limited practitioners with an understanding of school can't.
- Within schools, many surveyed parents/carers reported difficulty finding supportive people; the school being willing to explore underlying issues; and poor access to communication between teachers and parent/carers.

- **Small numbers of parents/carers surveyed report having experienced punitive threats and actions from Australian education departments and schools in order to force their children to attend school. Some students were also threatened with loss of privileges based on their attendance.**
- **46% of surveyed parents/carers felt their child's mainstream school had pushed them out, that they were left with no choice but to leave a school. Many parents/carers described becoming reluctant home schoolers because they had no other options.**
- **Parents/carers reported that accessing support for their child was also impacted by the severity of and unpredictable pattern of the child's distress.**

Recommendation 14:

That the senate committee undertake an investigation to review the impact of the siloed structure of funding (education, health, disability) on the ability of families to access help, with a view to reducing barriers to accessing help and supporting families with the costs associated with seeking help and supporting their children to recover.

Recommendation 15:

That state and territory DOEs ensure that intervention from authorities, (when low attendance results in mandatory referral to an organisation outside the school, such as the HSLO in NSW) not escalate parent or student stress, but instead seek to identify underlying issues and work collaboratively with stakeholders to develop recovery plans rather than attendance plans.

Recommendation 16:

That State and territory DOEs ensure that student supports and funding are able to seamlessly move between different contexts. A social worker, psychologist, occupational therapist, support worker or tutor who works at home with a student, needs to also be able to work or support the student at school and vice versa, as students transition between these environments.

Recommendation 17:

That all state and territory DOEs establish and resource an external independent complaints service, for parents and carers of students with disability or mental health difficulties, to self-refer to. This service would assist families when parents/carers have been unable to work with their child's education provider (State, Independent or Catholic) to obtain the support they feel is required to enable their child to access education with their education provider. That such a service provider mediation/advocacy service on behalf of families and report to state parliaments about the number and nature of complaints.

Recommendation 18:

That all state and territory DOEs provide a mechanism through which parents and carers can initiate a request for an immediate formal review of a student's support needs if there are signs of increasing student distress. This will initially involve a PSG meeting and should involve referral to a fast-track service for relevant assessments by psychology, occupational therapy or speech therapists to help identify underlying issues so that students can be better supported. This will enable intervention at an earlier stage and reduce the number of severely distressed students requiring help later.

Recommendation 19:

That state and territory DOEs change **messaging** around school refusal to reflect the need for wellbeing to be prioritised over compliance with attendance expectations. Messaging should recognise that sometimes staying home is necessary to support wellbeing and should also inform parents/carers about how to access supports if a student's wellbeing needs are impacting their attendance at school regularly or persistently. This change in direction will involve removing fines and threatening letters and changing messaging in school newsletters and on DOE websites. This will empower parents to focus on addressing their child's wellbeing needs.

4. How relevant state, territory and federal departments are working to monitor and address this growing school refusal challenge.

Key concepts from Section 9:

- There is a lack of consistency in the understanding of school can't and how it is recorded.
- Once data is available, school can't should be correlated with other data on disability, indigenous status, inclusion, use of exclusionary practices and school discipline practices.

Recommendation 20:

State parliaments be encouraged to legislate and provide funding to enable the collection of data on parent reported reasons as to why a student has exited from a school to seek an alternative enrolment. That this data be reported to their respective parliaments annually. Data should also be collected regarding reasons for seeking enrolment in alternative education environments such as distance education, home-schooling or specialist/therapeutic education environments. This data should include information about the student's disability status, exclusion, restraint, and school refusal history. This will enable a better understanding of the factors impacting students with disability and those with a history of school can't and assist in identifying and responding to barriers to inclusion.

5. Stressors

Key concepts from Section 10.1- School-based stressors:

- Many parent-nominated school-based stressors reflect known difficulties (that could be proactively addressed) for autistic and ADHD students around sensory needs, flexibility, attendance expectations, following interests, using CPS, and neuro-affirming social emotional learning.
- 71% of survey respondents nominated a lack of safe people as problem for their school can't child. The students in this cohort are struggling with relationships and connection with both teachers and peers at school.
- Poor school and teacher understanding of stress and distress impedes students being heard and getting the support they need.
- Neuro-normative expectations, shaming and non-inclusionary school cultures see many students masking to fit in. Masking adds to a student's stress load by cutting off avenues to reduce, avoid or recover from stress.
- Schools are often overstimulating and distressing to neurodiverse students and those impacted by trauma. Sensory acoustics, uniforms, classroom temperature, lights and visual clutter all impact on this and could be improved at a school or classroom level and with increased flexibility.
- Difficulties with schoolwork were also seen as stressors. Work not of interest, executive functioning difficulties, difficulties with specific subject areas, execution of the curriculum, group work and processing speed were all significant.
- The length of the school day, number of transitions and early start times all contribute to the school stress load for many students.
- Universal supports and individualised supports are needed to meet the range of complex needs in the classroom. This requires a culture of inclusion, increased disability training and mentoring for teachers, providing reasonable adjustments, and flexibility to meet a range of needs.

Recommendation 21:

That state DOEs identify and remove barriers (including examining funding structures and policies) which prevent students from: easily moving between face-to-face learning, distance education and home schooling or combining enrolments across different types of learning contexts when needed. This will allow students to access a wider variety of options for engaging with education.

Recommendation 22:

That state DOEs identify and remove barriers which prevent enrolment in an out of zone school when the student no longer feels safe and supported at the zoned school, in circumstances where a student experiences or is a risk of School Can't.

Recommendation 23:

That state and territory DOEs ensure that options exist, particularly in high school, for students to choose the way they would like to engage in a subject i.e. online, face to face, live or watch at another time. This will enable students flexibility to engage in ways that meet their wellbeing/ recovery needs.

Recommendation 24:

That state and territory DOEs build capacity of teachers to have in depth knowledge about adjustments and accommodations required to support students with disability / mental health difficulties. Especially in relation to collaboratively creating supportive learning plans, regulation plans, and mental health support plans. This will ensure students are better supported and will reduce student stress.

Recommendation 25:

That State and territory DOEs and University Teacher training courses work to develop awareness around the importance of teacher wellbeing and supporting teacher's nervous systems. This is to ensure that teachers have the capacity to be with distressed students and can co-regulate and share their calm with the student. Teachers who have highly aroused nervous systems may unintentionally arouse the nervous systems of their students.

Recommendation 26:

That state and territory DOEs mandate trauma or nervous system informed practice training for staff at schools and examine ways to support teacher wellbeing and regulation in the workplace at an institutional level, because the wellbeing of students is closely related to the wellbeing and regulation of teachers.

Recommendation 27:

That Federal and State parliaments legislate to ensure that according to Article 24 of the United Nations Conventions on the Rights of Persons with Disabilities, to which Australia is a signatory, students with disability will have their right to access inclusive (non-segregated) education upheld.

Recommendation 28:

That in conjunction with legislation recommended in Recommendation 27 state and territory DOEs will mandate the upskilling of teachers in relation to inclusive educational practise and universal design, through professional learning and mentoring for teachers already employed and in teacher training courses. This will support the desegregation of our education system so that all students are supported in mainstream contexts regardless of diagnosis and fewer students with disability are left as casualties of their engagement in mainstream education.

Recommendation 29:

That university teacher training courses be mandated to include units on disability and cultural awareness in relation to attitudes towards disability.

Recommendation 30:

Given the positive response that many young people (24%) had to remote learning, we recommend that State and territory DOEs make access to distance education more readily available and easier to access.

Recommendation 31:

That State and territory DOEs resource and make available, remote learning facilities to help students who cannot attend school in person, retain connection to their schools (including peers), and remain connected to their learning.

Recommendation 32:

State and territory DOEs review and amend policies in relation to the following supports for students with anxiety:

- Permission for parents or support workers to be on site as a support person to provide reassurance to an anxious young person.

- Permission for the young person to carry a mobile phone on their person at school as part of a safety plan, so they can alert a support person when in distress.

- Permission for a young person to access and use any supports that assist them to feel calm so long as these do not disturb other students (e.g. listening to music, use fidgets, use break cards, ability to move, visit a favourite teacher).

Key concepts from Section 10.2- School based, COVID related stressors

- **COVID-19 did bring a range of additional school-based stressors related to unpredictability, interrupted routines, transitioning back to the classroom, meeting remote work expectations, lack of contact with peers, and missed learning.**

Recommendation 33:

That state and territory DOEs be required to proactively develop an emergency plan for students with disability, involving funded supports and creation of resources, should remote learning be required again. The nature of these supports and resources should be developed in consultation with students with disability and their parents and carers, and should reflect feedback about recent past experiences of remote learning. This will reduce the experience of remote learning as a stressor which impacts a students' ability to engage with learning and their perception of themselves as a capable learner.

Key concepts from Section 10.3- Family and Non-School Stressors Impacting on School Can't

- **There are a wide range of stressors which impact children and young people both directly and indirectly through the family unit. It is important to consider how we as a society, support families when they experience stressful events.**

Recommendation 34:

That state and territory Departments of Health improve access to mental health services that specialise in trauma recovery. Current access to psychological care through the Better Access to Mental Health Care initiative is inadequate to meet the needs of those with PTSD and to care for those that live with or care for them. Trauma impacts more than just the individual who experienced the trauma. Long term impacts on mental health and physical health of untreated trauma and PTSD are concerning.

6. Disability as a risk factor for school can't - Autism and ADHD

Key concepts from Section 0- Disability as a risk factor for school can't

- **SC Survey-22 results indicate that disability is a significant risk factor for experiencing school can't - 73% had a confirmed diagnosis and a further 10% were suspected or seeking diagnosis.**
- **Autism, including the PDA presentation, and ADHD were the most significant diagnoses. These were followed by sensory processing disorder, academic**

giftedness, specific learning difficulties (eg dyslexia, dysgraphia, dyscalculia), and auditory processing disorder.

Also see related recommendations above:

- Recommendation 9 regarding diagnoses and supports,
- Recommendation 13 regarding funding home-school supports and cost of living,
- Recommendation 14 regarding funding silos between education, health and disability,
- Recommendation 16 regarding transition supports bridging education, health and disability,
- Recommendation 17 regarding complaints, advocacy and mediation,
- Recommendation 18 regarding a review of student support needs,
- Recommendation 20 regarding data collection when enrolling or terminating an enrolment with an education provider,
- Recommendation 27 regarding alignment of state and territory law with human rights obligations to provide an inclusive education,
- Recommendation 28 regarding training and upskilling teachers in inclusive practise,
- Recommendation 29 regarding training and upskilling teachers in disability and cultural awareness around disability,
- Recommendation 30 regarding proactive disability support planning for remote learning.

Recommendation 35: That State and Territory DOEs acknowledge and provide for the needs of students whose nervous systems require: smaller schools, smaller classrooms, buildings that are designed and outfitted to account for sensory needs, pedagogy that accommodates interest based or self-directed learning, no uniforms, shorter days, later start times in secondary schools, low demand and low arousal environments in order to maintain student wellbeing and capacity for learning.

7. Power imbalances, cultural beliefs and frameworks of understanding

Key concepts from Section 12- Power imbalances, cultural beliefs and frameworks of understanding

- Power imbalances impact on the relationship between young people and their parents/carers, as well as between parents/carers and those who are attempting to gain compliance, intervene or assist (e.g. educators, clinicians and authorities)
- School can't is complex and can only be understood through a collaborative approach that involves parents/carers and students.
- Ableism contributes to the experience of school as a trauma for the child with a disability or for the child with school can't.
- Blame and shame culture when students don't fit the system, causes more stress for parents/carers and children, and impacts on attachment and help seeking.

Recommendation 36:
That at all levels of government and across all sectors: health, education, welfare, and disability a commitment is made to collaborate in a way that validates and amplifies the voices of those with lived experience in order that research, policy, and design reflect the needs of those who have in the past been othered. "Nothing about us without us"

8. School Can't Australia not for profit organisation

Key concepts from Section 13 - School Can't Australia Not For Profit Organisation

- School Can't (SPSR) Australia is a volunteer-run parent peer support group that is providing much-needed support that has been rated by families as helpful.
- The group is growing fast and plans to register as a not-for-profit organisation to access funding, expand the range of supports, and manage the risks of providing this type of service.

- **Expansion opportunities include offering advocacy support services; educational materials and programs for educators, parents and professionals working with school can't; programs for young people; and expanding on the parent programs**

Recommendation 37:

That the federal government acknowledge the excellent work that School Can't (SPSR) Australia's volunteers have been doing to provide a valued national parent peer led intervention service and that they provide funding for this service in order to sustain it to meet the needs of the growing school can't community over the coming years.

2. School Can't (School Phobia, School Refusal) Australia

Key concepts:

- School Can't (SPSR) Australia is a peer support group for parents and carers of children who are experiencing school attendance difficulties that was established in 2014.
- As at February 2023, there were 7,600 parent/carer members of the group, and a further 700 waiting to join.
- The group meets online (via Facebook) and in person, in capital cities across Australia.
- The group is currently run by four parent volunteers, but with the size of membership and work involved it is looking to move to a Not For Profit organisation with paid staff.
- Over the last 8 years the parents in the group have been involved in an informal action research project, co-creating knowledge about school attendance difficulties.

2.1 About School Can't (SPSR) Australia:

School Can't (SPSR) Australia is a peer support group for parents and carers of children who are experiencing school attendance difficulties. The group was established in 2014. Since 2014 the parents in our group have been involved in an informal action research project, co-creating knowledge about school attendance difficulties. By sharing what has worked and what hasn't worked for our children over this period we have developed knowledge and a set of shared understandings about supporting students with school attendance difficulties. Our strength has come from sharing what we know with each other.

We currently have a membership of 7,600 parents/carers with a further 900 waiting to join (**Error! Reference source not found.**). We meet both online (using Facebook), and in person, in capital cities around Australia. The support we offer each other online is accessible 24 hours a day, 7 days a week and is available for 48 weeks of the year (the group takes a 4 week recess during the summer school holidays). School Can't (SPSR) Australia is currently run by four parent volunteers, but with a membership in excess of 7,600, this is no longer sustainable, and we are seeking to move from a volunteer run organisation to one that is a registered Not for Profit organisation with paid staff. This is discussed further in Section 14.

> "I was so fortunate to be informed about this group by a family friend. In the 5+ years that my daughter has been experiencing a range of mental and physical health challenges and has been diagnosed (late) as autistic (PDA profile) and ADHD, it has been a key source of excellent information and sharing for people going through similar, yet unique challenges.
> The reality is that currently school staff and health professionals usually don't have the knowledge and skills to adequately support students with very complex needs and this group has developed a wealth of expertise through lived experience and drawing on the work of worldwide leaders in the field.
> It can be very isolating for parents who lose their networks when their child isn't able to attend school (and sometimes other activities), and having this group is so beneficial.
> I would love to see further advocacy, education and resources available to all, not just to the lucky ones who happen to know someone who is in this group."
>
> *Parent of autistic School Can't child, age 17y*

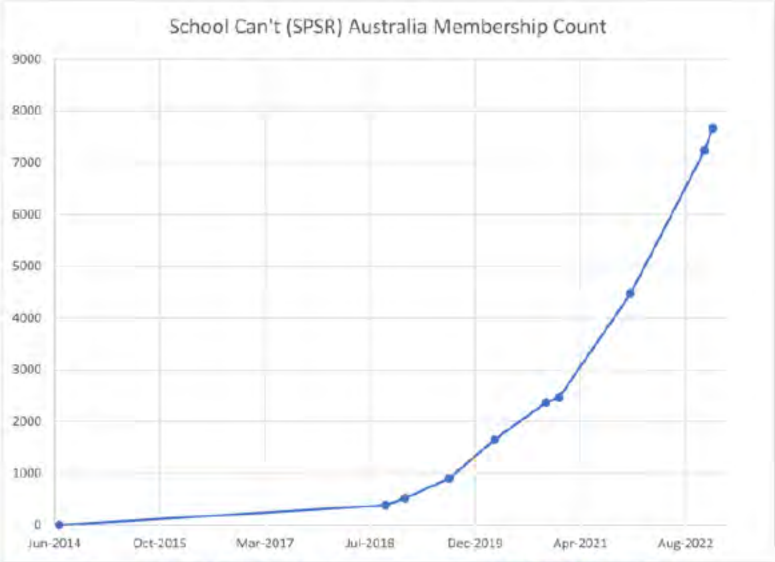


Figure 1: Source: Facebook analytics for School Can't (SPSR) Australia

2.2 Parent Experience:

Parents and carers who join our group report high levels of personal distress and high levels of distress in the children they care for. They are frequently very invested in seeking help but either help is not forthcoming, is unhelpful or is even harmful. Many professionals focus efforts on returning the child to school as soon as possible without identifying and addressing the underlying issues outside of the immediate context of the child and family. Child and adolescent mental health issues such as anxiety and depression are frequently diagnosed after onset of school refusal. Children and their parents and carers are closely linked and the wellbeing of one, impacts the wellbeing of the other over time. Parents and carers report impacts on their personal wellbeing, mental health, physical health, careers, personal finances, and relationships. Parents and carers who find their way to our group report an overwhelming sense of gratitude and relief at having found support and understanding.

"Until I found this group I felt like I was doing something wrong as a parent"
"As a result of this group I realised I wasn't alone"
"I was so fortunate to be informed about this group by a family friend"
"I have learnt so much in this group"
"I no longer feel alone. Instead I feel informed, knowledgeable and supported. I am able to use all I have learnt from this group along with their strength to better advocate for my child and to improve their outcomes"
"With the support of this group I have been able to seek the right professional help and advocate for my sons disability"

Testimonials provided by members of School Can't (SPSR) Australia 2022

2.3 Our Values:

At School Can't (SPSR) Australia we value and hold important:

- Knowledge gained through lived experience.
- The well-being of both parents and students.
- Protection of the parent child relationship and attachment.
- "Felt safety" as a neurobiological precursor to learning engagement.
- Parent/adult self-regulation.

- Co-regulation between parents/carers and children/young people.
- Individualised supports and accommodations.
- Learning can happen in many places and many ways.
- Belonging and connection.
- Inclusive and neurodivergent affirming practice.
- Collaborative approaches to identifying problems and solutions.
- Shared power and the amplification of the child's voice.
- "Kids do well if they can" (Greene 1998)

2.4 Our Vision:

The end goal for our group is to ensure that school attendance difficulties become a thing of the past, and that families no longer find themselves needing the support of School Can't (SPSR) Australia. To achieve this there is a need, both for action that meets the needs of those currently impacted by school can't as well as for action that prevents or reduces the rate at which school can't occurs. The recommendations we suggest in this document describe the actions we consider necessary at a government and institutional level to achieve this.

3. Defining School Refusal:

Key concepts:

- School Refusal refers to a child's inability to attend or participate in formal education.
- There is a spectrum of School Can't from mild (where a child might still attend school but be unable to complete work) to severe (where they are unable to attend at all for extended periods and show signs of severe distress or nervous system shutdown).
- The language of "School Can't" is preferred as it recognises that this is symptom of stress, not a behavioural problem.

School Refusal refers to a child's inability to attend or participate in formal full-time education and may occur in the context of: mainstream, specialist, distance education, remote learning and even home school environments.

Alternative terms often used include:

- School Can't
- School Phobia
- Emotionally Based School Avoidance
- School Attendance Difficulties
- Truancy

Often a distinction is made between School Refusal and Truancy. School Refusal is when parents are aware that their child or young person is not attending school. Truancy is when a child is missing school without their parent's knowledge, such as when a child wags.

School Can't (SPSR) Australia would argue that the distinction between truancy and school refusal requires further investigation as the key difference may be related to the degree to which a student:

a) senses they are likely to be met with adult judgement and disapproval in relation to difficulties they are having attending school, or
b) believes that the problems at school have no solutions and so flight from or avoidance of school is the only solution, or
c) experiences learned helplessness and is unable to resolve issues that impact the way they experience school, or
d) feels so ashamed of themselves or a situation at school that they can't seek help or remain in the learning environment.

The language and social constructs around "truancy" presume that a child is wilfully misbehaving, and that the solution is to promote compliance and more socially acceptable behaviour through punishment, bribery, or use of rewards, rather than identification and resolution of difficulties the student may be experiencing. **"School Can't"** is our group's preferred term for "school refusal" and we will be using this term when we talk about school attendance difficulties.

3.1 Presentations of School Can't:

"I found this group early in our journey, when I was struggling to get Ms 9 to school, but still

Signs of school can't may include the following in relation to attending school:

- an expressed reluctance to attend school,
- physical signs of anxiety such as stomach upsets and headaches,
- sleep disturbance,
- not wanting to go to bed or get out of bed
- not wanting to get dressed or eat, or to get in the car, or to get ready,
- anger, crying, begging, or other distress about attending school,
- being late to school, missing school, missing particular classes,
- avoiding or refusing work or homework,
- hiding when at school rather than going to class or out for lunch or recess,
- unable to move physically or to talk: flight, fight, freeze, shutdown,
- absence from school for single days at a time over many weeks,
- absence from school for many days at a time, or extended absence from school.

> insisting she go unless demonstrably ill. This was the rule when I was a kid, after all. Reading the stories and approaches here, I realised my error, and changed the way I parent. We now work together to understand and overcome the barriers, and if that's not possible, well, sometimes a doona day is good for both of us.
>
> Our relationship was suffering from my fixed idea of what was 'acceptable', but a few months later, she is relaxing and opening up to me again. She is far less anxious about school and more open to learning, too. ***We are also both now being assessed for ASD and ADHD***, partly thanks to information I learned in this group!
>
> Without this kind of peer support, I may have permanently dmanaged my kid's relationship with both me and with school and learning. Thank you for existing."
>
> Mother of 9 year old School Can't child (used with permission)
> *Published School Can't (SPSR) Australia's Facebook page 2022*

We consider any of these presentations as manifestations of school can't.

School Can't occurs on a spectrum from mild to severe:

1. **Examples of mild school can't:** A child with mild school can't might express a desire not to go to school but is still able to attend school most days. They might have several days a term where they cannot go to school. They may be persistently late to school because of their reluctance to go. They may report feeling unwell (tummy ache or headache). They may feel anxious on Sunday nights as the school week is about to start. They may be unable to complete school work either at home or at school.
2. **Examples of severe School Can't:** A child with severe school can't might be unable to attend school at all. Duration is often for more than 6 months. They may not be able to leave their bedroom or the house. They show signs of severe distress and or a nervous system shutdown response. They may develop atypical sleep patterns often awake all night and asleep during the day. They may show signs of self-harm, clinical depression, or severe anxiety.

3.2 Conceptualisation of School Refusal: misbehaviour or stress behaviour?

School Can't (SPSR) Australia believed that a child's inability to attend school is a symptom of a problem. It is not "the problem" to be fixed. The way the problem is conceptualised shapes parents/teachers/clinicians responses to it. School Can't (SPSR) Australia invites parents/carers to reframe "school refusal" and consider it from a neurobiological perspective rather than from a behaviourist perspective. We invite readers of this submission to do likewise. Kristin Wein's illustration demonstrates the impact of this lens shift. (See Figure 2)

When school refusal is viewed as a **behaviour problem**, then students are perceived as refusing to go to school. The student is viewed as wilful or defiant and adults are more inclined to respond with rewards and consequences. Clinicians and education professionals are more likely to view the problem as residing with in the child or the family. In responding they are more likely to make demands of the family or the student, that either focus on remedying a fault within the child or family or focus on gaining compliance with the expectation of attendance. These lead the parents/ carers and student to feel judged, ashamed, and experience increasing distress. This conceptualisation of the problem does not lead to exploration or identification of the issues underlying school can't.

Figure 2: "Reframe the Behaviour" Visual by Kristin Weins. Used with permission. Source: https://northstarpaths.com/

The risks associated with this conceptualisation include:

- Increased feelings of stress leading to feelings of helplessness for the student and/or parents/carers,
- Continued and deepened student disengagement,
- Damage to the parent child attachment,
- Damage to the student – school relationship,
- Student distrust of adults and withdrawal from engaging with them to identify what is impacting the student.
- Worsened mental health of the student,
- Failure to identify how to assist and support the student,
- Parents / carers left with no choice but to exit mainstream schooling to protect the child's mental health and wellbeing.

Reframing school refusal as "school can't" helps adults instead, to conceptualise school refusal as a response to **stress**. It leads them to be curious and to look for underlying reasons why a student might be having difficulties attending school. Adults are more likely to identify and remove barriers and to install accommodations and supports that meet the student at their point of need, reducing student stress in the process. Teachers and clinicians are more likely to work collaboratively with students and their parents/carers to assist them. Students and their carers feel understood, supported and safe in their interactions with teachers and clinicians who approach school can't in this way. Parents who join School Can't (SPSR) Australia report that the change in the way the problem is conceptualised empowers them: to connect with their child, to seek assessments that assist them to understand the difficulties and to find solutions and supports enabling their children to recover and thrive (see Section 7.2.3).

It is, fundamental when considering school can't that shared understandings are developed across the community, in clinical, school, parent, and research contexts in order to effectively address the issues that lead to school can't. Failing to do so puts our young people at risk.

4. Models that support our framework of understanding:

Key concepts:

- Leading research-based practices that are helpful in understanding and helping with School Can't include Collaborative and Proactive Solutions (CPS) by Dr Ross Greene; Dr Stuart Shanker's Self-Reg; Dr Stephen Porges' Polyvagal Theory; Bronfenbrenner's Ecosystems perspective; and trauma informed and inclusive education practices.

4.1 Collaborative and Proactive Solutions

Collaborative and Proactive Solutions (CPS), created by Dr. Ross Greene (1998, 2008), is a problem-solving model for identifying and addressing the barriers and stressors impacting our children and causing them difficulties. We use this model to look for underlying drivers of school refusal behaviour.

4.2 Shanker Self–Reg

"The key to changing a child's trajectory is to identify and reduce their stress load, rather than trying to teach better self-control. The latter emerges naturally as a result of improved self-regulation." (Hopkins, Shanker & Leslie, 2017)

The Shanker Method (Shanker, 2021) is a 5-step process for identifying and reducing stressors impacting children and adults, thereby promoting self-regulation.

1. "Read the signs of stress and Reframe the behaviour
2. Recognize the stressors
3. Reduce the stress
4. Reflect, enhance stress awareness
5. Restore Energy "

We can use this process to address the stressors contributing to a child's stress behaviour.

From Shanker we learn that self-regulation is about managing energy use and recovery. We learn about the extraordinary power of the adult nervous system to influence the nervous system of a child and facilitate the development of the child's ability to regulate their own arousal levels. This process is referred to as co-regulation by Mona Delahooke (2019).

4.3 The Polyvagal Theory

The Polyvagal Theory, proposed by Dr. Stephen Porges (1995) (2011), describes how the state of the autonomic nervous system (ANS) impacts human behaviour. The theory explains that the capacity for social engagement behaviours (including sociability, creativity, curiosity, playfulness and flexibility) emerges when ANS detects safety. We see protective behaviours such as fight or flight when ANS detects threat, or a freeze response when ANS detects threat with no way to escape.

"Safety is in the Eye of the Beholder" – Mona Delahooke

Source: Psychotherapy Networker (2020)

A threat may be physical such as: a growling dog or a house fire. A threat may also be to our sense of self such as: getting in trouble with the teacher, or be a threat to our connection with others such as: fighting with a friend or going against the group. Even consideration as to whether we have enough internal resources to meet a challenge, such as being hungry, tired or unwell can be a threat. We pick up signs of safety or threat unconsciously; from the environment, from the nervous systems of those around us, and from the internal state of our own body. Our ANS responds automatically. Please refer to Appendix 19.1 "The Autonomic Nervous System" for further information about the Autonomic Nervous System.

Porges writes for medical professionals. We recommend these authors who have applied Porges' work to other fields of study: Mona Delahooke (parenting) (2019), Deb Dana (mental health) (2018, 2021), Lori Desautels (teaching) (2020).

Trauma informed education is built on understanding the nervous system and applying this knowledge to the way we interact with others in the context of school.

4.4 Ecological Systems Theory framework – Bronfenbrenner

Bronfenbrenner's Ecosystems perspective (1979) makes an essential contribution to understanding school can't. His approach directs us to consider the student within the context of school, family, the education system, the local community, and the wider socio-political environment. Bronfenbrenner outlines five environmental systems that interact with each other: microsystem, mesosystem, exosystem, macrosystem and chronosystem. The ecosystems framework highlights the complex nature of understanding and addressing school attendance difficulties and the need to consider a wide range of variables that might impact a student's capacity to attend school not just at the parent/carer or child level. See Tobias (2019) for a description of the application of ecosystems theory in understanding and supporting students with school can't.

4.5 Trauma Informed and Inclusive Educational Practices

Trauma informed educational practise and inclusive educational practises provide insight into understanding and preventing school can't. Trauma informed education practises recognise, and are responsive to, the potential impact of traumatic experiences on student wellbeing, and learning. They are informed by neuroscience, pertaining to the Autonomic Nervous System. Examples include: The Berry Street Model (Brunzell, & Norrish (2021) and The Neurosequential Model in Education (Perry 2020).

Educators may be unaware of traumatising experiences that students may have had. The Adverse Childhood Experiences (ACES) list was created for an epidemiological study and lists potential traumatic events which may result in adversity later in life. The study found that the more ACES a child has experienced the greater the risk of trauma responses (Center for Disease Control and Prevention, 2021).

It is important that schools are not only responsive to the potential trauma that students carry, but also that schools minimise the possibility for students to have traumatising experiences at school. Students with disability are impacted by ableism, barriers to access and participation, increased risk of bullying (Cappadocia, MC, Weiss, JA, Pepler, D, 2012), and increased exposure to punitive and exclusionary discipline practises (Graham, L, McCarthy, T, Killingly, C, Tancredi, H, & Poed, S, 2020) which all have the potential to generate a trauma response in these students.

It is important to remember that one person may be traumatised by the event, while the another is not. Van der Kolk, B. A (2014) reminds us of the subjective nature of a trauma response. Two people may be subject to the same experience, but it is mediated by each person's own nervous system.

The hidden nature of some student's disabilities means that the disability is not necessarily known. School Can't (SPSR) Australia values inclusive teaching practises such as Universal Design for Learning (UDL) and differentiated teaching (Cologon & Lassig 2020:179-207) as a means to safeguard students with disability. Differentiated teaching practices are required under AITSL Professional Standards for Teachers 1.5 and 1.6. (AITSL 2018). An inclusive education is a human right as outlined in Article 24 of the United Nations Conventions on the Rights of Persons with Disability (United Nations: 2006), to which Australia is a signatory.

Inclusive education practices seek to reduce barriers to access and participation and subsequently reduce the stressors that the student is experiencing. Creating an inclusive educational environment is crucial to the wellbeing and education of students with disability. Educational environments which rate higher on measures of inclusivity show higher attendance rates and fewer issues with discipline (Anderson, K. P., 2021).

5. School Can't Survey 2022:

Key concepts:

- The School Can't Survey was conducted in December 2022 with 441 completions.
- Most survey respondents were members of the closed parent peer support group.
- Most respondents identified as female, were well educated and resourced, and were parents of children or young people with a severe expression of school can't.
- This submission includes results from the Survey as well as from the wider experience as shared amongst the group over the last 8 years.

To assist our response to the Senate Inquiry into School Refusal, School Can't (SPSR) Australia undertook research into its members' experiences and the experience of others in the community who have children with school can't. There is very little research that has been conducted into the experiences of parents who have children with school can't so we felt it was important to conduct this research in order to inform our report to the Senate Inquiry.

The School Can't Survey 22 (SC Survey-22) was administered to both members of School Can't (SPSR) Australia and non-members. The survey contained 75 questions. Two questions regarding participant's experience of our group were omitted for non-members. Refer to Appendix (Section 19.2) for a copy of the survey questions.

Most participants took between 30 and 66 minutes to complete the survey which was open from 7th December 2022 until midnight on 21st December 2022. 371 group members completed the survey. 70 non-members completed the survey.

The member survey was advertised within our closed parent peer support group. Members were invited to register an email address to receive a personalised link to complete the survey. This enabled them to complete the survey anonymously across multiple sittings if required. A total of 441 people attempted the survey. 371 completed most questions in the survey.

The survey for non-members, was shared by members of School Can't (SPSR) Australia with those outside our Facebook group. A total of 84 non-members attempted the survey. We did not actively promote this survey but provided it as an option for those who were not members of our group who wanted their experiences reflected in our submission. 80 parents / carers used the option to receive a personal link by email to complete the survey. 70 completed most questions in the survey.

All participants opted-in to complete the survey. They were not compensated for their time. Their completion of what was a lengthy survey administered at a busy time of year (in the lead up to Christmas) is demonstrative of their strong desire to be heard and seen.

The survey asked a range of questions, starting with demographics. While many of our respondents have more than one child (n.118 had 2 children and n.17 had 3 children) with school can't, we asked that parents select one of their children about whom to answer the questions.

Survey respondents identified as female and were well educated and resourced. Few respondents (4%) identified as First Nations peoples. The survey respondents were people who likely have 'help finding' and research skills. It is probable that they value education, as they themselves have been educated at a tertiary level. They most likely see value in participating in research to build knowledge about school can't. Results of the survey show a high incidence of parents and carers caring for children with more severe expressions of school can't. It is difficult to know whether this is representative of other members of our group. There are a variety of factors that influenced

whether people completed the survey on not with several people expressing on our Facebook page that they didn't have any spare time or were too overwhelmed with their caring responsibilities. Parents and carers whose children have less severe expressions of school can't, may be less active in our group and may have been less likely to either know about the survey or may have been less inclined to participate in the survey. **It is not known the extent to which the profile of the typical survey respondent reflects the demographics of our peer support group** as Facebook does not provide us with very many demographic details of group members to enable a comparison.

The typical survey respondent:

- Aged 40-59 (85%)
- Well educated: 24% postgraduate qualifications, 68% bachelor's degree or higher
- Identified as female or woman (96%)
- Married (63%)
- Parents of a school can't child (98%)
- Born in Australia (82%)
- English as primary language at home (99%)
- Lived in a metropolitan area (66%)
- Lived in either NSW or Vic (61%)
- Had a household income of $100k+ (54%)
- Mean age of their children is 12.5, with a range from 5 to 17 years old
- Their school can't child missed an average of 41-50% of school in the 12 months prior to December 2022

We are aware that the fact that our group's main presence is on Facebook means that literacy skills and access to the internet or Facebook are by default a prerequisite to participation and present a barrier to many people. We would like to become more accessible so that we can offer peer-based support to a more diverse group of people.

In responding to the terms of reference we have supported our perspectives and recommendations with information obtained from both SC Survey-22 and from our 8 years of shared lived experience knowledge.

6. On the increasing number since the COVID-19 pandemic, of young people and their families who are experiencing school refusal:

Key concepts:

- School Can't (SPSR) Australia is NOT able to say that there is an increasing number of students experiencing school refusal since the onset of the COVID-19 pandemic.
- The group membership has grown consistently since 2014.
- The SC Survey-22 found 46% had experienced school can't before COVID-19. As many factors contribute to school can't, it can't be concluded that the pandemic caused the remainder.
- There is no reliable formal data on school can't across Australia, with no formal definition and current methods of collecting and classifying details on school absences.
- Social stigma and poor levels of awareness also impact on parental identification of school can't and early signs.

School Can't (SPSR) Australia is NOT able to say that there is an increasing number of students experiencing school refusal since the onset of the COVID-19 pandemic. The data we have access to indicates: that our membership continues to grow, that School Can't was a significant problem even before COVID, and that there are complex issues in relation to the measurement of school can't.

6.1 Our growing membership:

While our membership numbers have grown considerably in recent years (Figure 1, page 17) our growth rate has remained relatively consistent since we began in 2014. We fitted Poison regression models to our membership data to estimate the incidence rate ratio (IRR), as a measure of the growth rate of the group. The estimated IRR per year was 1.86, with a 95% confidence interval of 1.77-1.96 and a p-value < 0.001. This indicates that on average, the group size increases by 1.86 times every year - that is, it almost doubles in size. We can be 95% confident that the true increase is at least 1.77 (a 77% increase) and the increase could be almost equal to 2 (1.96). Given this incidence rate ratio, the time period taken to double in size is approximately 410 days or a little more than a year. Using this growth rate to forecast the future size of the group we can see that it is likely that School Can't (SPSR) Australia will have 15,400 members in just 410 days time.

6.2 School Can't prior to and since COVID:

The SC Survey-22 did show that many children experienced school attendance difficulties prior to the COVID-19 pandemic. Of those with children enrolled prior to 2020, 46% (165/359) indicated that onset of school can't was prior to 2020 and 54% (194/359) indicated that onset was during the pandemic. This figure alone, however, does not tell us that COVID caused onset of school can't for 54% of students just that it occurred in those years. There are many factors that contribute to school can't (discussed in sections, 10.1, 10.2 and 10.3). It is not possible to say from this figure alone that the experience of the COVID pandemic caused school can't for 54% of survey respondents children. A discussion about COVID related stressors that have impacted school can't can be found in Section 10.2 pg80.

We did not ask in SC Survey-22 whether the experience of COVID played a significant role in member's children's school can't and in their subsequently seeking membership of School Can't (SPSR) Australia. As our growth rate is unchanged and we have no evidence to determine whether

the growth of School Can't (SPSR) Australia is due to a growing trend of school refusal or due to other factors we are unable to confirm that there is an increasing trend and we suggest that more evidence should be gathered to determine if there is an increasing trend in school can't.

6.3 Factors Relating to Measuring School Can't:

To our understanding there are no nationally consistent guidelines in place across states and territories and across schooling types in relation to the recording of absence due to school can't. This makes it extremely difficult for the Government to understand what is happening. Members of our group report that absence due to school can't is recorded variously as: "Parent Choice", "Illness", "Explained absence" or "Truancy". When asked in our unpublished 2019 School Can't survey (30 % of respondents did not know how their child's absence was recorded and 21% indicated their child's absence was recorded by the school as "illness". Lack of a distinct category for school can't means that we don't know how many students are experiencing school can't and are unable to distinguish them from students who might be home for other reasons.

School Can't (SPSR) Australia would like to highlight that collecting data about school can't is complex. Parents/carers sometimes do not realise that the child is experiencing school can't until a pattern of reduced capacity for school is evident. Parents may also feel ashamed or afraid of having their parenting judged and are sometimes reluctant to report what is happening to the school. In order to successfully begin to collect data we first need shared understandings about school can't. Clear guidelines across jurisdictions about recording school can't absences would need to be supported by a public messaging campaign to reduce stigma and raise awareness at both parent/carer and school levels.

Recommendation 1: That state and territory DOEs work towards establishing agreement about defining "school can't" and create a set of guidelines regarding recording school can't absences that is consistent across all states and territories. Furthermore, information about absence reasons should be made publicly accessible and should be published in relation to each school. Improved data collection will assist to identify trends relating to school can't absences and can be used to track effectiveness of intervention and preventative measures.

Recommendation 2: That state and territory DOEs in conjunction with School Can't (SPSR) Australia develop public health messaging about school can't to improve community understanding that it is a stress behaviour and not misbehaviour. That awareness raising include information about early warning signs, and how to respond and support students experiencing school can't. Such action will assist in breaking down stigma and shame and assist parents and carers to feel able to report signs of school can't to schools. These actions must be done to support collection of data which more accurately reflects the incidence of school can't in the community.

7. How school refusal is affecting young people and their families and the impacts it is having on the employment and financial security of parents and carers

7.1 The impact on young people:

Key concepts:

- There is very little research into the perspectives and experiences of students with school refusal and its impact on long term wellbeing, future earnings, career or life prospects.
- Parent and carers describe their children as experiencing distress, frustration, anger, loss of hope and trust, and feeling misunderstood, judged, shamed and not being listened to. They may be socially isolated, and excluded from school activities and experiences that are "rewards". They may be self-harming, have suicidal ideation, be stuck in flight, fight or shutdown.
- Collaborative and Proactive Solutions (CPS) is an approach that supports students and adults, to explore the difficulties a student is experiencing without shame or judgment.
- School can't is experienced by students across all year levels, with an increase at 6-7 years and 13-14 years, indicating increasing vulnerability at the primary and secondary school transition points.
- Most of the parents / carers in SC Survey-22 described their child as experiencing severe school can't. Almost a quarter of those students had missed more than 80% of school time in the previous 12 months.
- An overwhelming majority (73%) of these students were diagnosed with a disability – mostly autism and ADHD. Another 10% are suspected to have a neurodevelopmental disability.
- For those with anxiety and depression, most were diagnosed after school can't. These diagnoses are seen as responses to the chronic unresolved stress of the situation. Of the 193 students diagnosed with depression, 77% occurred after school can't began.
- Exposure to ongoing stress can result in a trauma response and ongoing physical and mental health issues. The source of stress must be identified and reduced to calm the child's nervous system. Early identification is critical to recovery. Use of rewards and consequences, continued expectations of attendance at school or increased demands on the student can add more to the student's stress load, further preventing the student from being able to return to a "safe" state.
- In the absence of being able to work with a school to identify and reduce the stress the child is experiencing at school, parents are left with no option but to remove the child from the source of stress. That may mean moving to another school, home schooling, distance education, or enrolling in an alternative school (such as Community schools, specialist therapeutic education environments, private special education schools).
- The absence of awareness and viable alternatives means some students remain in situations where their health continues to be impacted and they do not experience a reduction in their exposure to stress for long enough to reset the nervous system.

There is very little research into the perspectives and experiences of students with school refusal and very little research that tracks students with school can't over time to show how it impacts long term wellbeing, future earnings, career or life prospects. As School Can't (SPSR) Australia was unable to survey students about their experiences, our knowledge about the impacts on students is seen through the lens of our perspectives as parents and carers. School Can't (SPSR) Australia argues that it is more important to learn about the demographic characteristics of students experiencing school can't and to identify factors in the environment that contribute to school refusal. Anxieties about the future of our school can't students often result in fear-based responses rather than in responses that seek to identify and remove the barriers to school attendance. Consequently, in responding we would like to draw attention to:

1. Student experiences of school can't as perceived by parents, and

2. Data from SC Survey-22 that indicates demographic characteristics of students with school refusal.
3. Information about the Autonomic Nervous System (ANS) and associate health impacts of school related trauma.

This information will assist the Senate Committee to identify what is happening and who is being impacted.

7.1.1 Student Experiences:

Parents and carers share in our parent peer support group about their children's experiences of school can't. We have observed from the sharing in our group that those experiencing school can't may:

1. Feel frustrated with themselves that they are unable to successfully meet expectations to attend school,
2. Either be able to tell us what the issues are, or they may be unable to communicate about what they are struggling with. Their ability to understand and communicate about the problem can be impacted by their limited life experience, and/or the state of their nervous system or any communication disabilities they may have. These factors can make it hard for them to make sense of what is happening.
3. Feel distressed, or even lose hope that the issues that led to them being unable to attend school will be identified or addressed.
4. Feel frustrated and angry that no-one seems to understand how to support them.
5. Feel angry that their concerns are invalidated or dismissed.
6. Feel frustrated with their school that understanding, accommodations or supports they needed were not available or that the school lacked the capacity to flexibly meet their needs.
7. Feel judged, ashamed and confused from messaging that blames them for school can't: "try harder", be "more resilient", or "you just need to change your thinking" being common messages. This may lead to internalised shame and self-blame
8. Experience adults (including: parents/carers/teachers/clinicians) who are unable to show compassion, or curiosity, or to see things from the student's perspective and who may be focussed on behaviour management.
9. Feel that adults are against them or that there is no hope or way to resolve their situation and lose the ability to trust adults to assist them and may withdraw from contact with them.
10. Experience adults (including: parents/carers/teachers/clinicians) who are anxious about them and focussed on "worst case scenarios" such as this child will: never get an education, never live independently, never grow up, never be able to get a job, never be able to go to university, never amount to anything, or is headed for prison unless we get them back to school. The anxieties of these adults lead the child to become increasingly stressed and anxious.
11. Be aware of the adult community's anxieties about completion of year 12 and doing well in year 12. This anxiety exacerbates the student's own anxiety about themselves.
12. Experience stress and feel dysregulated for extended periods of time due to the lack of resolution or relief from the people, situations, or things that are causing them stress.
13. Become socially isolated from peers. This may be due to reduced proximity to peers, lack of flexible options for engagement at school, and exclusion by peers both intentional or unintentional in nature. Even peers who are sympathetic to the student who would like to connect can after a while struggle to find shared experiences around which they can socialise.

14. May engage in self harming behaviour or experience suicide ideation.
15. May frequently appear to be in either a state of fight, flight or shutdown.
16. May experience exclusion from experiences and activities at school that they might enjoy because school views these things as a reward for attendance.

The above list details signs of distress and experiences of students with school can't. It is important to support students, so their voices and perspectives are heard. In doing so we can come to a shared understanding about the factors impacting their sense of 'felt safety" where safety is viewed in a broad sense. We recommend Collaborative and Proactive Solutions as an approach that is useful in supporting students and adults to explore the difficulties experienced by the student and to listen to the student's perspective, without shaming or judging. CPS can be used as a preventative tool in the early stages of school can't and plays a key role as an intervention for more severe cases of school can't.

Recommendation 3: That the Federal DOE recommend that state and territory DOEs mandate the rolling out of Collaborative and Proactive Solutions (CPS) across all schools in order to equip teachers with collaborative communication skills to assist them in working with students and parents/ carers to identify problems, and find solutions or ways to remove the barriers that lead to school attendance difficulties. CPS is a powerful tool which assists in amplifying student perspectives and voice in the problem solving process.

Recommendation 4: That State and Territory based departments of Families / Human Services fund Collaborative Proactive Solutions parenting programs to assist parents and carers to prevent school can't and to understand and support children experiencing school can't. CPS is a powerful tool which can be used to help understand what is happening for our children and identify supports and accommodations that will promote engagement with learning.

7.1.2 Survey Findings:

The SC Survey 22 asked parents to complete a series of questions about one of their school can't children. The age of these students is shown in Figure 3. The data sample shows an increasing number of students in each age group peaking at age 14 with a declining number in each cohort after age 14. Notably 43% of the sample population was aged between 13 and 15 years old. 93% of respondents' children were born in Australia.
50% of the students in the survey sample identify as male, 37% identify as female and 7% identify as non-binary with the remainder of respondents not providing a response.

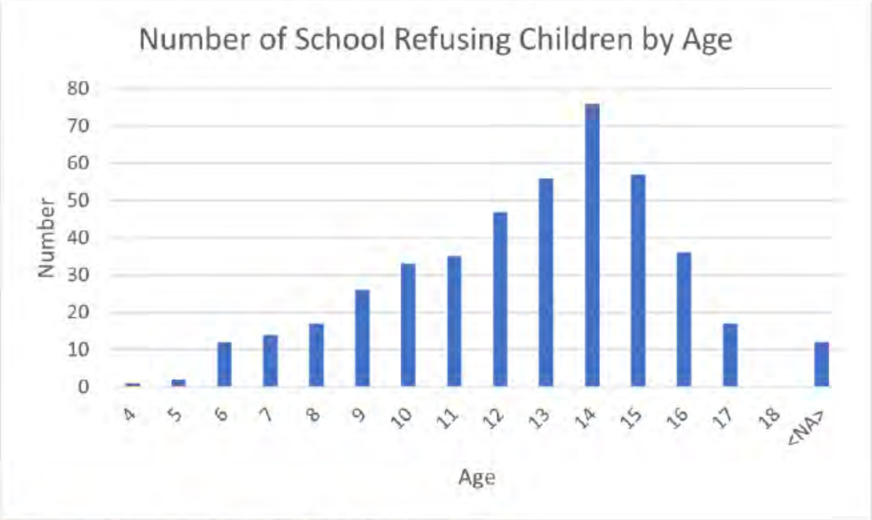


Figure 3. SC Survey-22 School Can't Children by Age.

Age of onset of school can't data from our survey sample (see Figure 4) shows that onset of school can't happens across year levels from the first year of school until students are no longer required to engage in compulsory schooling. There are noticeably more students however, in the sample who experienced onset at age 13 and age 14 with a slight increase in the number experiencing onset of school can't at the age of 6 and 7. This trend is consistent with data collected by School Can't (SPSR) Australia prior to COVID in December 2019, which also showed a higher rate of onset in those age groups. This suggests that there is a vulnerability to onset of school can't shortly after students transition into primary school and again when they transition from primary school to high school.

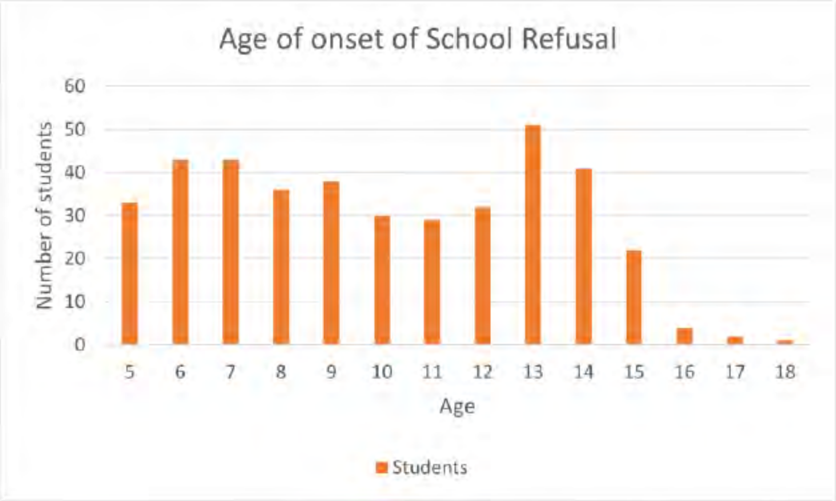


Figure 4. SC Survey-22 Age of onset of School Refusal as reported by Parents/Carers.

Recommendation 5: That consideration be given to funding research (informed by lived experience) to unpack factors associated with increased onset of school can't at age 6-7 and age 13-14 to understand how to better support students in these age groups.

Question 32 of the survey asked: "If your child is enrolled in distance education or mainstream school, how many weeks of schooling do you estimate that your child has missed in the past 12 months?" Results are shown in Figure 5. 24.9% of parents and carers whose children were enrolled at either a mainstream school or with a Distance Education provider indicated that their child had been absent for more than 80% of the school year in the past 12 months and 64.8% had been absent for more than 40% of school year. The average amount of school missed for those surveyed was between 41 and 50% of the school year in the 12 months prior to December 2022.

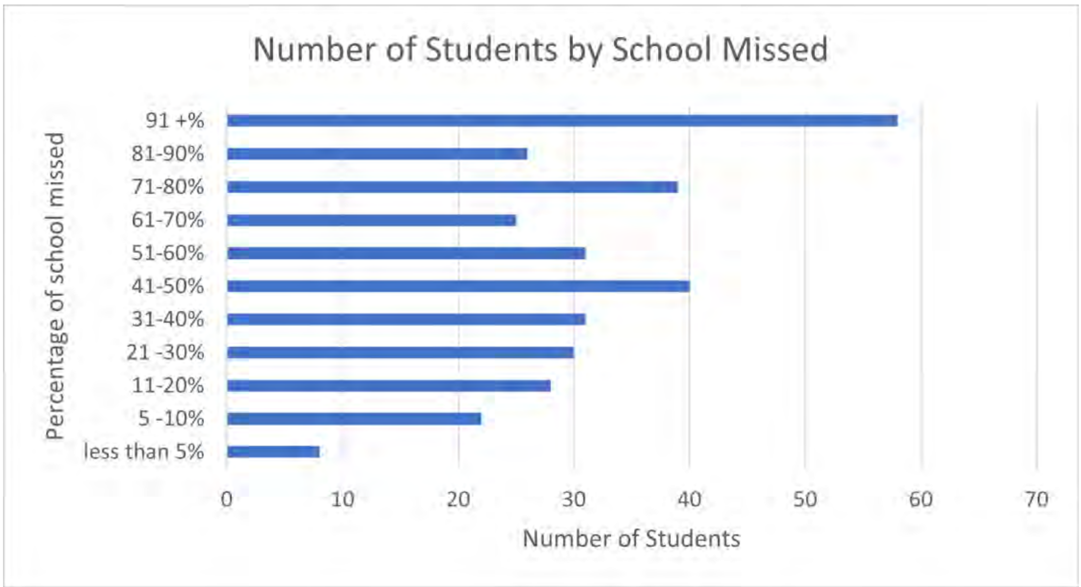


Figure 5. SC Survey-22 Percentage of School missed in past 12 months by School Can't children.

The SC Survey 22 also asked about the severity of the school can't child's most recent or current episode of school can't. Parents/carers were asked to rate their child's experience using a scale from 1-5 =where 1 was considered mild and 5 was considered severe. 421 Parents and carers provided a rating and of these 52.4% scored the most recent or current episode as severe. Only 5% scored the experience as mild. Results are displayed in Figure 6. It is unclear whether this experience can be generalised to the rest of our School Can't community.

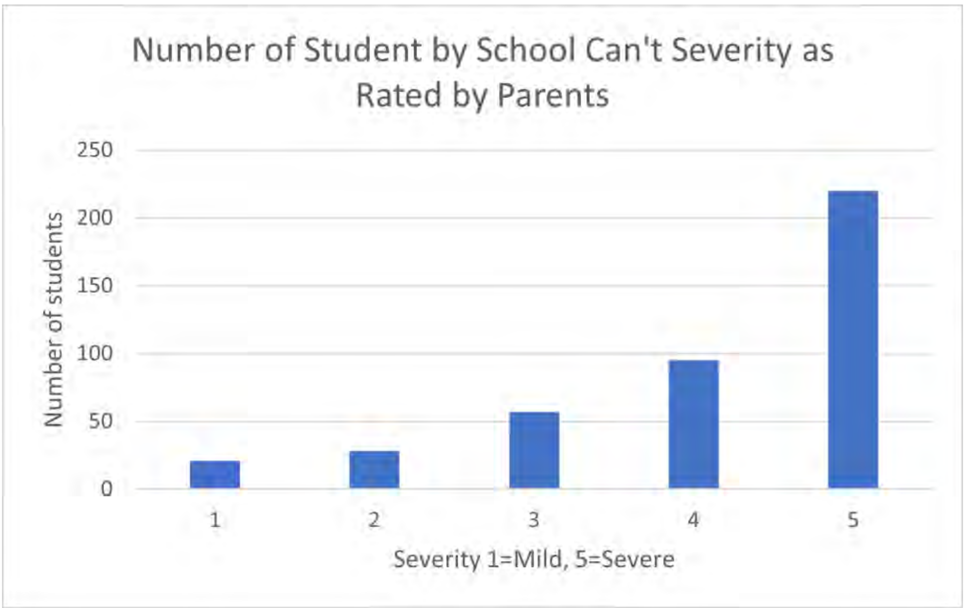


Figure 6. School Can't severity as rated by parents.

The measure of severity of the most recent episode of school can't is subjective. As such, responses may be influenced by a range of factors such as:

1. How long the child has been experiencing school can't.
2. Signs of and degree of student distress.
3. The degree of distress felt by the parent about the situation.
4. Past parental experience of school can't.

More investigation is recommended to determine characteristics of students with more severe school can't, compared with peers with milder school can't experiences. Little is known about the characteristics of the experiences of these students.

The SC Survey 22 showed that the most common enrolment type for those with one schooling type was mainstream government (49%), followed by mainstream independent (13%) and mainstream catholic (11%). In 2019 for those with one schooling type, the most common enrolment type was mainstream government (68%), followed by mainstream independent (16%) and mainstream catholic (12%). The data shows a move away from enrolment within a mainstream government education for students with school can't (68% enrolled in 2019 and 49% enrolled in 2022). The most frequent change was from enrolment in a mainstream government school in 2019 to Distance Education enrolment in 2022 (1% enrolled in Distance Education in 2019 and 9% enrolled in Distance Education in 2022).

Notably the survey showed that 73% of children had a confirmed diagnosis of a neurodevelopmental disability with parents/carers indicating they suspected or were seeking a diagnosis for an additional 10% of children. The mean and median for the survey population was two confirmed diagnoses (with a range of 0-8 diagnoses). The vast majority of diagnoses were for ADHD and autism (including Aspergers and PDA). See data on disability status in (insert cross ref to table/graph). The correlation between school can't and diagnosis will be explored further in Section 0.

Anxiety and Depression are the two most common mental health problems experienced by students with school can't. The experience of members of School Can't (SPSR) Australia suggests that these are not factors that cause school refusal but rather that they occur as a response to the lack of resolution and chronic nature of stress factors that contribute to school refusal. Of the 193 children with confirmed depression diagnoses, more than three quarters (77%) of diagnoses occurred after the onset of school can't. Similarly, of the 190 children with a confirmed diagnosis of generalised anxiety disorder, 60% of diagnoses occurred after school can't. There is also considerable overlap between these conditions, with 105 children (60%) diagnosed with both depression and generalised anxiety disorder after school can't, in contrast to 35 children (20%) diagnosed with either condition after school can't began, and 36 children (20%) diagnosed with both conditions before school can't.

7.1.3 The Autonomic Nervous System and School Can't:

Viewing school refusal through the Polyvagal framework of understanding (Porges 2011) assists us to understand what is happening for the child. Seen through this lens school can't is a symptom of chronic unresolved stress. Usually when faced with a stressor our bodies automatically (without thinking) respond in order to attempt to resolve the situation and help us quickly return to a relaxed and regulated state often referred to as a state of homeostasis. This automatic response usually results in either a fight or flight response. If the threat is so significant or if a fight/flight response has been unsuccessful in the past then a shutdown or freeze response in more likely. A freeze response sometimes occurs also after a fight or flight response in order help transition back to a relaxed state. When children/young people experience something particularly threatening or stressful or they are exposed to repeated stress or stress that remains unresolved over a period of time, this impacts their ability to return to a relaxed state. Normally a stressor is resolved by some action and we are able to quickly return to a resting state. However, when students are exposed to ongoing stress, then a trauma response occurs. This relationship between the ANS and trauma is discussed by Levine (2015:43-46). A trauma response leads the baseline resting state to shift from one of low arousal to one of high arousal. The student's nervous system stays alert instead of returning to a low arousal resting state. This becomes their new normal resting state. They seem to escalate more quickly when faced with a threat and are often diagnosed at this point with anxiety or PTSD. When this goes on for too long then the Autonomic Nervous System becomes ineffective at regulating and Autonomic Nervous System Dysregulation (ANSD) occurs. There is considerable research that links stress to a range of physical health impacts which require ongoing medical care. (Please refer to Section: 19.1 for a more detailed explanation of the Autonomic Nervous System and ANSD)

Use of rewards and consequences, continued expectations of attendance at school or increased demands on the student can add more to the student's stress load, further preventing the student from being able to return to a "safe" state. Over time this impacts the student's mental health and puts the student's physical health at risk as well. School Can't (SPSR) Australia's position is that it is crucial to the wellbeing of the student that we identify and reduce stressors and support the student's nervous system to reset back to its default "safe" state as soon as possible. Early identification of and resolution of stressors is crucial to ensuring recovery and to mitigating protracted mental ill health and prolonged experience of school can't. In the absence of being able to work with a school to identify and reduce the stress the child is experiencing at school, parents are left with no option but to remove the child from the source of stress. This is both a sensible and often a necessary protective response. Options include removing the student in order to: Register to home educate, enrol in distance education, attend an alternative school (such as Community schools, specialist therapeutic education environments, private special education schools), or to obtain a medical exemption from school.

Parents/carers are frequently limited in the choices available to them when they choose to leave a school:

- Home schooling, for instance is an option only readily available to those with access to sufficient financial and personal resources.
- Proximity to alternative schools may limit choices.
- Access to supportive and understanding medical practitioners who can support an application for medical exemption.

The absence of viable alternative options means some students remain in situations where their health continues to be impacted and they do not experience a reduction in their exposure to stress for long enough to reset the nervous system.

Recommendation 6: That DOE **policies** are reviewed to support students and parents/carers to take time off work or time out of school, while parents/carers work with the student, school and clinicians to identify underlying issues and address the mental health concerns of the student, in order to facilitate recovery via an individualised plan. This should be communicated to families so that they understand that this is possible. This will reduce parent/carer and student stress.

Recommendation 7: That state and territory DOEs provide positive messaging about forms of schooling other than formal schooling and ensure messaging that normalises that there are many different ways to engage with learning. Such that families and students are aware that there are a range of options available to them should they require them.

Recommendation 8: That state and territory DOEs provide positive and more frequent messaging about the variety of pathways that exist to higher education outside of mainstream school. So that schools, parents/carers and students are aware that there are many options and successful completion of year 11 and 12 are not the only ways to access tertiary studies. This will help reduce stress in the final years of school if young people experience school can't at this time.

Recommendation 9: That State and territory DOEs fund an on demand free health and wellbeing check, with parents prompted about the service in year 1, year 4, year 7, and year 10, to identify any previously unidentified diagnoses, mental health issues and support needs. This service should provide referral to funded assessments and supports. This will reduce barriers to accessing costly diagnoses leading to more timely identification of childhood illness and developmental conditions and ensure parent/carers support in their effort to seek help for their child.

7.2 How is School Refusal impacting parents and carers?

Key concepts:

- Detailed data was collected on the wide range of difficulties experienced by parents and carers in caring for their child with school can't.
- The impact of caring for a school can't child on the parent/carer's ability to work is significant - **only 3% of parents reported no impact on their ability to work** over the last 5 years.
- Employment impacts on the amount of work parents or carers undertake (with most wanting to work more hours), the type of work, and the location of it. They may need flexibility around the unpredictable and varying nature of school can't and what is required to support their child, whilst also managing their own stress levels. Carers Leave is limited in its application.
- The financial stress of school can't impacts on families in both the short and longer term – with increased costs, reduced earnings and impact on savings. For a third of these families, they are coping for now, but it is impacting on their long-term financial security. **Nearly 15% of respondents felt that they were struggling to afford essentials such as food, housing, transport, health, and basic needs.**
- Limited school and practitioner awareness of school can't sees early signs ignored and parents and carers having difficulty finding help and support. School Can't (SPSR) Australia is a source of lived experience and support that over 90% of surveyed parents have found helpful in finally focusing on their child's mental health and wellbeing.
- Parents and carers make use of a range of supports, but face barriers in finding, obtaining and accessing them, leading to further frustration and stress. (Supports are discussed further in Section 7.2.3)
- There is significant impact on parent/carer social connections, with feelings of isolation, shame and judgment often rooted in differences in beliefs about how to respond to their child's needs (assuming poor parenting vs an invisible stressor).
- Two-thirds of the surveyed parents / carers reported exhaustion and overwhelm as limiting their ability to access supports for themselves. They were also impacted by limited free time, the unpredictability of school can't, and waiting lists.
- The burden of care is substantial, and the lack of school can't awareness adds to the complexity. Many survey respondents suggested that it would help to have supportive case management that was: trauma aware, independent, and focussed on wellbeing vs school attendance.
- Whilst these children are needing radical acceptance, this is challenging for adults in the face of negative and frequently unfounded narratives about engagement with school and learning. "School to prison pipeline", "every day counts" and views of non-compliant children as lazy and manipulative, all perpetuate parental /carer anxiety and difficulties in them accessing formal and informal supports.
- Parents/carers surveyed experienced substantial negative impacts to their mental and physical health and their perception of themselves as a parent. 80% rated moderate to severe impact on their mental health.

Parents and carers surveyed reported a wide range of difficulties related to caring for their child. These difficulties play a role in impacting the parent/carers experience of stress. Difficulties experienced by parents are categorised and reported on as follows:

1. Maintaining and managing employment,
2. Managing financial stress whilst caring for a school can't child,
3. Finding help, building skills and knowledge to support our children, and ourselves,
4. Identifying, obtaining / accessing professional supports and managing if none is available,
5. Negative Impact on the parent/carer's social and relational needs
6. Having time, energy and opportunity to access and action self-care,
7. Balancing, planning and managing often unpredictable demands,
8. The need to become the child's case manager,
9. Regulating their own nervous systems especially in relation to ongoing worries about their child/children,

In addition to the difficulties above which impact parents/carers' wellbeing, parents/carers are also face challenges in relation to:

1. negotiating power imbalances in relationships with schools and clinicians,
2. reconciling clashes in frameworks of understanding used to understand their child's difficulties.
3. ideological and cultural understanding which impact the way mental health and disability are perceived and responded to.

These three issues will be explored in section 12.

7.2.1 Maintaining and Managing Employment:

Out of 338 survey respondents surveyed in SC Survey-22, 34/6% worked part time, 24.4% worked full time, and 21% were engaged in home duties. The next most common form of employment was self-employment (9.5%), followed by casual employment (6.2%). See Table 1 below.

Table 1. SC Survey-22 Respondents Stated Employment Type

Full time	Part Time	Casual	Self employed	Seeking work	Studying Full time	Studying Part time	Home Duties	TOTAL
86	117	21	32	3	2	6	71	338
24.4%	34.6%	6.2%	9.5%	0.9%	0.6%	1.8%	21.0%	100.0%

The impact of caring for a school can't child on the parent/carer's ability to work is significant. In response to a question about the impact of their caring responsibilities on their employment in the past 5 years, **only 3% of parents reported no impact on their ability to work.** 54% reported that they felt stressed about their ability to maintain their employment. Other impacts on employment are reported in Table 2:

Table 2. SC Survey-22 respondents' impact on caring in the past 5 years

Impact of caring on employment in past 5 years	
Felt stressed about their ability to maintain their employment.	54%
Indicated that their career progression had been impacted	47%
Worked fewer hours than they would have liked.	44%
Changed their work hours due to caring responsibilities	41%
Were unable to work at all for a period	30%
Had to take unpaid leave from their employment	28%
Had to ask family or friends to care for their school can't child so they could work	28%
Changed work roles due to caring responsibilities	24%
Resigned from a job because of caring responsibilities	20%
Reported that they have worked in casual employment in place of permanent work.	14%
Found themselves working in less secure work due to their caring responsibilities	11%
Reported no impact on their ability to work.	3%

In SC Survey-22 survey we asked about the number of hours that parents and carers usually worked in a week. We selected a population of parents and carers aged 40-59 years of age, from our survey respondents, who indicated that their work status was employed (part time, full time or casual) for comparison with the number of hours worked by same age peers in the Australian population. 187 parents from our December survey were compared with data released by the ABS regarding the number of hours worked in November 2022 (the closest month for which we could obtain data). The data shows that females who were parents or carers of children with school can't reported working less hours than their same aged peers in the Australian population. See Figure 7.

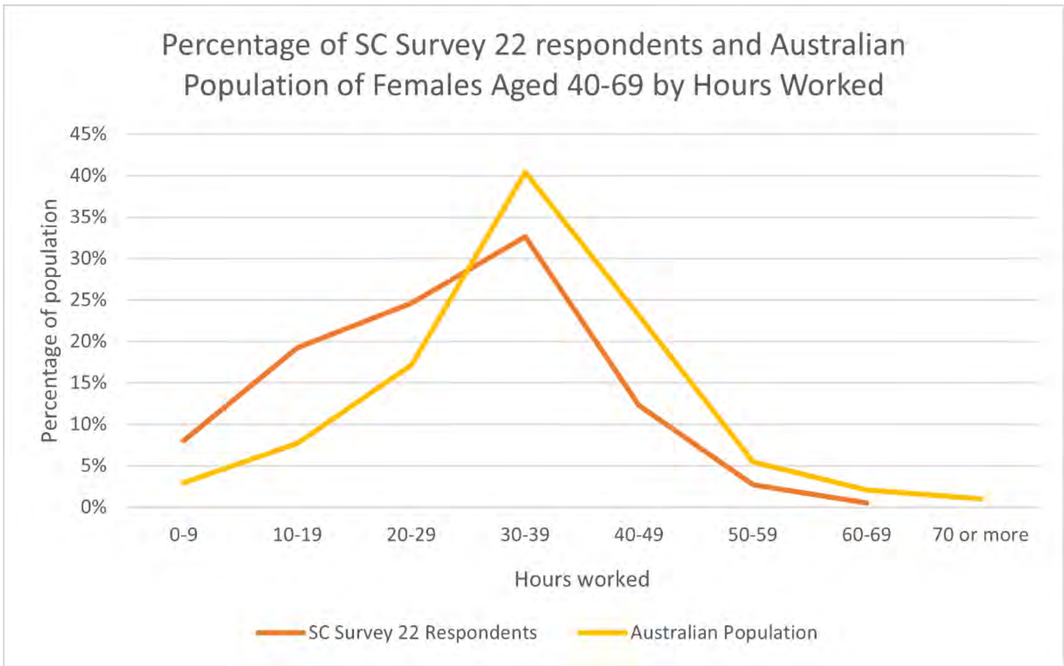


Figure 7. Weekly hours worked. Comparison of SC Survey-22 respondents and same aged peers in Australian population.

SC Survey-22 also asked about how many hours respondents would prefer to work if school attendance difficulties were not an issue. Figure 8 below shows the number of hours currently worked (on the horizontal axis), plotted against the preferred number of hours (on the vertical axis). The straight line represents equality, when the actual and preferred number of hours are equal. The majority of respondents would prefer to work more hours as represented by the red circles above the line, although some are happy with their current hours (green triangles on the line). A minority would prefer to work less (blue squares), most only a few hours less but some substantially less (including a preference for not working at all from one respondent currently working 50 hours per week). Notably, most respondents currently working 40 or more hours per week would prefer to work less.

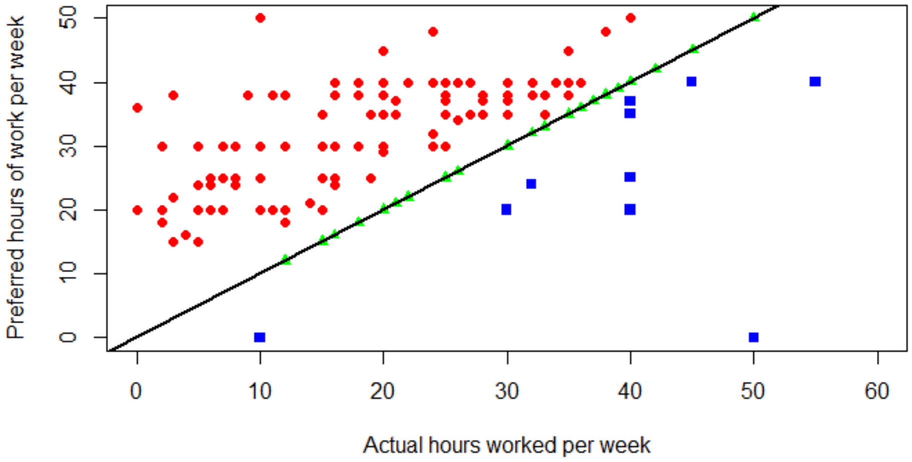


Figure 8. Actual hours worked per week compared with preferred hours of work as indicated by employed SC Survey-22 parent/carer respondents.

Reasons parents struggle to work centre around the need to care for the school can't child. There are many challenges parents experience that impact on their ability to work:

- They may find it hard to get to work on time.
- They may need to leave work to pick up a distressed child during the day.
- Their child may be attending reduced hours leaving few hours child free to attend work.
- Their child may be old enough to stay home without adult supervision but be too mentally unwell to be left unattended.
- Their child may need to stay home for an extended period as part of a recovery plan
- They may find that their child needs to be home schooled or to attend distance education and therefore they need the full-time supervision of a parent.
- Time required to attend appointments in relation to your child and meetings at school can impact on available time to work or use up carers leave quickly.

The ability of a parent or carer with a school can't child, or children, to engage in and maintain employment is also impacted by **the availability of work that is flexible** in relation to:

- **Start times**: work that has a fixed start time can be challenging since school drop offs may be difficult in the mornings and may not go to plan. School Can't is often unpredictable in nature making planning difficult.
- **Location of the place of employment** (home based employment can be easier),
- **The nature of the employment** (eg. employment can become untenable if clients are depending on you to be at appointments on time but you can't reliably get to those appointments due to the distress your child feels in relation to attending school),

Other employment related challenges include:

- **Access to carers leave**. The frequency and duration of episodes of school can't varies. Severity ranges from being late to school, missing 1-2 days per week, to missing a week here and there through to missing upwards of 12 months of school. The National Employment Standards (Australian Government: Fair Work Ombudsman n.d.) provide for full-time and permanent employees to get a minimum of ten days of sick and carer's leave each year. Part-time employees are entitled to the same amount of leave in proportion to the number of hours they work each week. Casual employees are not entitled to carer's leave.

- **Energy available for paid work.** The amount of emotional labour that is involved in supporting a child with School Can't can also impact both the type of work and the amount of work that a carer is able to perform as parents and carers seek to balance their personal stress burden in a sustainable way.

7.2.2 Managing Financial Stress Whilst Caring:

The financial wellbeing of parents and carers of children with school can't is impacted by a variety of factors including:

- Increased household expenses due to having a child at home (eg. aircon, heating)
- Lost earnings from having to take unpaid leave or being unable to work.
- Reduced earnings from having to work reduced hours or in less secure employment or not at all.
- Interruption to career and impact on career progression which impacts future earnings potential. 47% of respondents in SC Survey-22 indicated that their career progression had been impacted.
- Costs involved in identifying what is going on for the child including assessment by Psychologists, Speech Therapists, Occupational Therapists, a Paediatricians, or Psychiatrist.
- Costs associated with home schooling: materials, tutoring, activities, internet connection, heating and cooling.
- Costs involved in recovery/therapy/ongoing care commonly cost of appointments involving: general practitioner, psychology, speech therapy, occupational therapy, paediatrician, psychiatrist, social worker, support workers, tutors.
- Reduced savings, and superannuation which impact savings into the future due to compounding and limit lifestyle choices later on.
- Reduced ability to repay mortgages which means families end up paying interest for longer on loans.

In the SC Survey 22 we asked respondents to tell us about the ways that their financial situation had been impacted. Of 336 respondents 33.9% indicated that although they were coping, their long-term financial security was being impacted. Concerningly nearly **15% of respondents felt that they were struggling to afford essentials such as food, housing, transport, health, and basic needs**. See Table 3 below for more information.

Table 3. Parent / Carer report on impact of caring on personal/family finances

Impact on Financial situation	Percent	Number
Coping but impacting longer term financial security	33.9%	114
Limiting their ability to participate in usual family activities such as holidays	17.3%	58
Impacting on their ability to afford essentials eg. food, housing, transport, health, and basic needs	14.9%	50
Coping but living frugally	12.8%	43
Minimal impact	8.9%	30
Other (described)	6.3%	21
No impact	6.0%	20
Total	100.0%	336

Recommendation 10: That federal parliament review the financial supports delivered by Services Australia for parents who are caring for school can't children, in consideration of the substantial impact on the finances of parents and carers. That consideration be given as to provision of a 12 month "school refusal package" in addition to carers payment and carers allowance, and/or access to Assistance for Isolated Children, where children are recovering at home from school can't. This will assist parents who are unable to maintain employment to manage the cost of living on reduced income, whilst paying for allied health and other supports including: psychology, social work, psychiatry, paediatricians, private tutors, support workers etc as required.

7.2.3 Finding Help and building skills and knowledge:

When parents find themselves in a novel situation, they often find themselves needing new skills and knowledge. They refer first to prior knowledge, skills and understandings in order to try to understand, and help their school can't children. Parents often resort to the application of rewards and consequences to begin with, to gain compliance with attendance expectations. This approach may work if a child has very mild or recent onset of school can't, however if the difficulties the child is having in relation to school are significant for that child, then this approach will not result in enduring change. Parents may ignore early stages of school can't, until the child is experiencing significant distress. Once they determine that they have exhausted all known methods of getting their child back to school, parents and carers begin the search for more information to try to assist their children. The difficulties parents and carers experience in relation to finding help, and building skills and knowledge are substantial and varied.

Anecdotally, parents new to School Can't (SPSR) Australia, report that they have difficulty:

- Making sense of what is happening for their child.
- Understanding why their child is resisting going to school.
- Identifying suitable supports at the school and in the community.
- Finding resources and information.
- Being an advocate at school.
- Knowing what help to ask for and who to ask.
- Knowing their legal rights and responsibilities.
- Knowing how to repair their relationship with their child.
- Knowing how to connect and collaborate with their child.
- Navigating and applying for government supports.
- Understanding how to apply new frameworks of understanding to their lives (e.g. learning how to use Collaborative Proactive Solutions or Shanker Self-Reg).
- Finding alternative education pathways.
- Processing feelings of shame and blame.

In question 61 of SC Survey-22 we asked our survey respondents to indicate how much they felt School Can't (SPSR) Australia has helped them with a range of skills and knowledge. 91.9% of parents/carers indicated that the group had assisted them to focus on their child's mental health and wellbeing. Commonly parents are told by schools and clinicians that the focus should be on getting their child to comply with the expectation that they attend school. A shift to focussing on wellbeing marks a significant change in approach. 91.6% of parent/carers indicated the group had helped them with understanding that their child was doing the best they could, and 88.4% indicated that the group had helped them "see school refusal differently". Both these items testify to a conceptual change that takes place when parents join our group. School Can't (SPSR) Australia's unique environment provides a place for parents new to school refusal difficulties to learn and benefit from the experiences of those who have travelled the road before them.

Table 4. School Can't (SPSR) Australia has helped me:

School Can't (SPSR) Australia has helped me:	Affirmative	Sample size
To focus on my child's mental health and well being	91.9% (308)	335
Understand that my child is doing the best they can	91.6% (307)	335
To see school refusal differently	88.4% (296)	335
To be a better advocate for my child	84.2% (282)	335
To see education differently	79.7% (267)	335
To reduce conflict with my school can't child	78.2% (262)	335
Focus on identifying the problems underlying school can't	78.2% (262)	335
Support my child better	77.4% (260)	336
Identify alternatives to mainstream education	76.4% (256)	335
Identify potential solutions to the problems impacting my child	74.9% (251)	335
Learn more about mental health and wellbeing	70.7% (237)	335
Identify appropriate supports	65.0% (217)	334
Connect with my child better	64.7% (216)	334
Learn skills I need to support my child	62.9% (210)	334
Know what support I can expect from my child's school	57.6% (193)	335
Engage my child's school in finding ways to support my child	48.7% (163)	335

School Can't (SPSR) Australia asserts that improvements in knowledge about identifying and responding to school can't would lead parents to:

1. Be able to identify school can't in earlier stages,
2. Be able to identify suitable supports more efficiently rather than learning from their own trial and error.
3. Have confidence about what to do
4. Have skills to work with their child and their child's school
5. Quickly orient themselves to appropriate supports.
6. Prevent damage to their parent-child attachment
7. Protect their child's mental health

Schools should be the first place a family can receive evidence-based assistance; however, this has not been the experience of our members. Nor is it the experience of School Can't (SPSR) Australia's members that clinicians external to schools such as: psychologists, counsellors, paediatricians, general practitioners, or psychiatrists are providing support that aligns with the 8 years of lived experience of School Can't (SPSR) Australia's members. More information about the range of supports accessed for children and young people can be found in section 8.1. and detail regarding parent/carer perceptions as to the helpfulness of those services can be found in section 8.2.

Recommendation 11: That state and territory DOEs fund independent case management for students with school can't which has wellbeing as its first priority. Case management would assist parents and carers to access: timely and appropriate medical and allied health supports, build a team of supports around the student, determine factors underlying school can't, communicate with schools, assist schools to remove barriers and accommodate the student's needs, identify alternative education options or flexible ways to engage with learning if necessary, and collaborate to create recovery focussed plans. This will assist in reducing parent/carer stress.

Recommendation 12: That the federal government fund School Can't (SPSR) Australia to create and deliver professional development materials for school staff and for wellbeing and clinical services in order to improve knowledge about school can't, including: how to prevent school refusal, how to identify risk factors for school refusal, how to identify underlying issues and collaborate with and support students and their parents or carers where a student is experiencing school can't. Building awareness and knowledge about school can't at the school and clinical level will lead to reduced carer stress and will result in students receiving assistance in earlier stages of school can't.

7.2.4 Finding, obtaining and accessing supports:

Parents and carers make use of a variety of supports. These are detailed in 8.1: Services Accessed by SC Survey-22 Participants to Help Child.

A range of barriers exist in finding, obtaining and accessing supports which increase parent/carer frustration and stress.

> "I would have loved for the school to give me a guide as to what to do when we were going through all this… If there was a number or checklist of what to do next, I feel that would of helped. I had never heard of mental health care plans etc. Before this and until I found the School Can't FB page that's when I learnt what to do and where to start"
>
> *SC Survey 2022 respondent*

Finding supports is impacted by:

1. Not knowing what to do or who to seek help from.
2. Whether you view school can't as a behavioural problem or a stress problem. This perspective influences the kind of support you might look for and whether it is likely to be effective or not.
3. Limited number of clinicians who share your understanding of school can't.
4. Limited number of schools who understand and are resourced sufficiently to support your child.
5. Knowing few (or no) other parents whose children have a similar problem who can recommend supports. People often don't disclose their children's difficulties due to shame.
6. Feeling overwhelmed and not being able to make decisions.

Obtaining and accessing supports is impacted by:

1. Availability of suitable supports that are accessible at a time and place that is suitable
2. Whether you and your child can leave the house to attend an appointment
3. Lengthy or closed wait lists.
4. Affordability of consults while unemployed or one reduced income.
5. Where you live. Parents in rural and regional areas have fewer local services available to them than those in metropolitan areas.

The inability to access supports impacts both the child and the parent/carer. More is written about barriers to obtaining and accessing suitable supports for children/young people in sections 8.3 through to 8.3.8**Error! Reference source not found.** and in relation to supports for parents/carers in section 7.2.6.

7.2.5 Impact on parent/carers social and relation needs:

Parents and carers of children with school can't experience significant impact on their social connections. They often report feeling socially isolated. They frequently experience conflict between themselves, their partners, their wider family and their friends in relation to beliefs about how best to respond to the child's needs. Many people believe that school refusal is a behavioural issue or due to poor parenting, rather than due to a child's experience of an invisible stressor.

In addition to the jarring difference in shared understandings about school refusal, parents are also impacted socially due to:

> "(We) were treated by our son's school as if we were stupid, terrible, weak parents who really didn't understand the importance of education and what we were 'doing to' our son by letting him miss school."
>
> *SC Survey 22 Respondent*

Feelings of shame which cause them to withdraw socially to avoid scrutiny.

- No longer physically being on a school campus where they would usually socialise with other parents.
- Their child being too anxious to be able to leave home.
- Their child being so mentally unwell that they cannot be left home without supervision.
- Their child being so mentally unwell or socially anxious that they are unable to be cared for by another adult.
- Their physical absence from workplaces.
- Having no energy left - "nothing left for socialising"
- Feeling disconnected from the interests and experiences of peers
- Being "on a road less travelled" and living a life that has diverged from those their peers are leading.

Sometimes there is uneven distribution in the parental role of helping children get ready for the school day and off to school, meaning that one parent may be experiencing first hand, all the difficulties and distress involved in school attendance difficulties while the other does not. The task of seeking help is also often the role of one parent and not the other. The different experiences of help seeking and supporting the child often results in parents not being on the same page.

In the SC Survey-22 we asked whether having a school can't child had impacted on a relationship with a partner and whether this impact had been positive, negative, or whether there had been no impact. 66.9% of 396 respondents indicated that their relationship with their partner had been impacted in a negative way. See Table 5

Table 5. Q 54. Has having a School Can't child impacted on your relationship with your partner?

	Impacted in a positive way	Impacted in a negative way	No impact	Not applicable	Total
Number of respondents	21	265	32	78	396
Percentage	5.3%	66.9%	8.1%	19.7%	100%

Table 6. How has having a school can't child impacted on your relationships with your wider family, friends and informal support networks?

	Percent (number)
I've learned that I can't discuss my child's school attendance with some people	65.3% (n=288)
I've had to reduce contact with some family and friends	50.3% (n=222)
There are very few people in my social network that I can talk to about school can't	45.6% (n=201)
I've lost contact with the social connections I had at my child's school	41.0% (n=181)
I've had to cease contact with some family and friends	24.0% (n=106)
I've found new friends who are understanding and supportive	17.7% (n=78)
There is no one in my social network that I can talk to about school can't	11.6% (n=51)
School Can't has led me to have a closer relationship with some family and friends.	11.6% (n=51)
I don't feel that my social relationships have been impacted much	5.4% (n=24)

Responses to the question: "How has having a school can't child impacted on your relationship with your wider family, friends and informal support networks?", revealed significant impacts for many on their social relationships with only **5% indicating that there had been no impact on their social relationships**. 65% of parents who responded to the question indicated that they have learned to not discuss their child's school refusal with some people. This is done in order to protect themselves from criticism, judgement, from receiving unhelpful advice or from having to explain and justify the actions they were taking to support and help their child. 50% of respondents indicated that they had consciously reduced contact with family and friends. 45.6% indicated that they had very few people in their social network that they could talk to about school can't. 41% indicated that they had lost contact with other parents and carers at their child's school.

7.2.6 Having time, energy and opportunity to access and action self-care

One of the key messages from our parent peer support group is that parents must put on their own parachutes first. By filling our own tanks, not only can we buffer ourselves against our children's stress and but coregulate with them to down regulate their arousal levels when they are distressed. Additionally, this restores capacity for seeking help, advocating, and making and attending appointments and so on.

In SC Survey-22 three questions were asked about support for the parent/carer. Question 58 asked "What support for yourself have you accessed in the past 12 months?" we also asked whether they experienced difficulties accessing any of these supports. Question 59 asked "What kinds of supports not listed above would you like to be able to access?" and Question 60 asked "What barriers to accessing carer support have you experienced?"

The most accessible support for parents seeking assistance with self-care was a visit with their General Practitioner 66% were able to access this service and 12% indicated that they wanted to access this service but were unable to. The next most frequently accessed support for parents/carers was a consult with a psychologist with 41% accessing this service and 31% indicating that they had wanted to access the service but were unable to. These were the only two forms of support where the proportion of respondents indicating that they had been able to access the service was more that those who had wanted to but had been unable to access the support.

The biggest discrepancy between actual and desired engagement was in relation to engaging in regular exercise which was accessed by 33% of respondents but was unable to be accessed by 51% of respondents. This is a significant concern in relation to the wellbeing of parents and carers. Access to regular exercise is impacted by cost and by the ability of the parent/carer to leave the house without the child with many indicating that they are required to be with their child 24 hours a day and 7 days a week.

51% of respondents desired but were unable to access regular exercise

SC Survey 2022 Finding

A significant percentage of parents/ carers also indicated inaccessibility and a desire for: Support with house cleaning 41%, Access to Chid Respite Care 40%, Access to a support group 38%, and access to in home support worker 30%. See Figure 9 below.

67% of parents said overwhelm and exhaustion played a major role in not being able to access personal supports

SC Survey 2022 finding

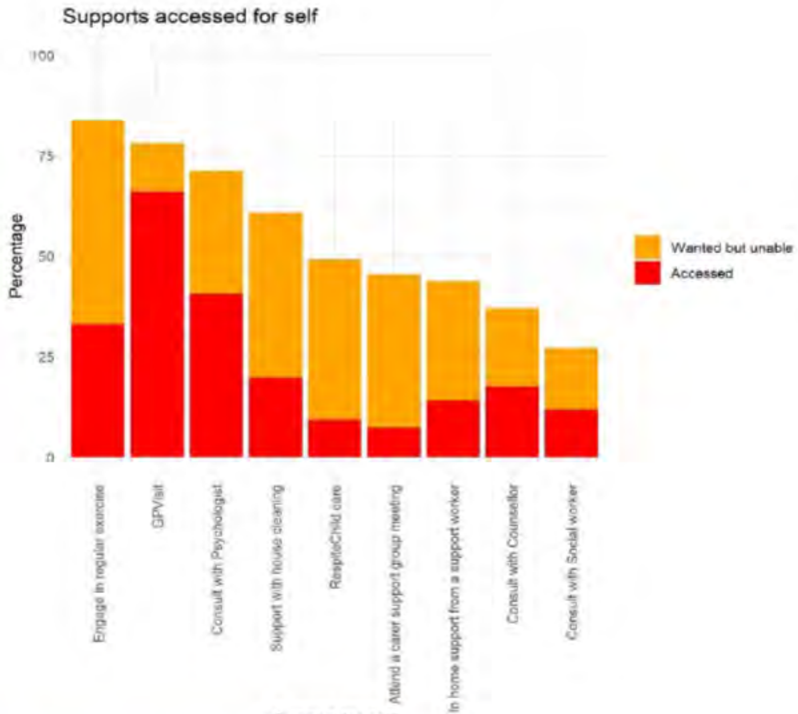


Figure 9. Carer Supports Accessed for self.

Suggestions for other supports desired by survey respondents included access to an advocate / case manager that is wellbeing focussed and access to legal advice. A number of respondents indicated that they would like to attend local school can't carer support groups.

Concerningly 67% of parents describe overwhelm and exhaustion as playing a major role in being able to access personal supports: "I'm so tired and burned out I can't initiate that support" Other barriers included lack of free time, unpredictability of school attendance, waiting lists for carer support, needing to also care for other family members (many are also juggling caring for ageing parents) cost of supports and being unable to afford a gym membership or the out of pocket fee for a psychologist, being unable to leave their child unattended, feeling unsure who to ask for support, or being a single parent. Other things mentioned in the open ended question included: being consumed with and unable to finding help for their child and this being a first priority, being told that they don't qualify for support from carer support agencies.

Table 7. Barriers to accessing carer support.

Barriers to Accessing Carer Support:	
Overwhelmed and just surviving	67%
Lack of free time	54%
Unpredictability of school attendance	49%
Waiting lists to access support	46%
Caring for other children or family members	43%
Unable to afford supports or activities	40%
Unable to leave my chid unattended to access support	37%
Don't know who to ask for help	33%
Single parent with sole custody (no down time)	20%
None	3%

7.2.7 Planning and managing unpredictable demands:

Typical parents/carers can usually predict how their day will go and expect that routines will be followed, but this is not the case for parents/carers of a school can't child. Parents/carers with school can't children are exposed to larger amounts of unpredictability. Consequently, they work harder, from day to day, expending more mental energy having to consciously plan and arrange logistics only to have to rejig those plans later if their child is unable to attend school. 49% of SC Survey-22 respondents indicated that unpredictability of school attendance impacted their ability to access and engage in self-care, we know it also impacts their ability to plan and manage day to day life.

Anecdotally we know that at the beginning of the year parents/carers face the following unknowns:

1. Will their child go to school or not when school resumes?
2. What will their child's capacity be like for full time, part time, distance, or face to face schooling?
3. What supports will be in place at school?
4. Will the support personnel this year be the same or different?
5. Will the support personnel at school listen and collaborate or will they make demands and be directive?
6. Will it be easy or hard to form a working relationship with the new team?
7. What will the child's mental health be like once school is underway and pressure of school returns?
8. Will the parent/carer be able to work?
9. Will the parent/carer be able to get some of their personal needs met?
10. How much energy will they need to get through the year?

It can be difficult to know whether a child will be able to go to school as planned.

On a day-to-day basis parents/carers often describe experiencing hypervigilance in relation to the state of their child's nervous system. Parents/carers describe a state of constantly waiting to see whether:

1. They will be able to get to work or to an appointment on time.
2. They will be able to get a sibling to school on time.
3. Their child will be able to get ready to leave the house independently or whether they will need assistance or prompting to: eat, brush teeth, dress, pack a bag or even to get out of bed.
4. They will be able to accomplish a household task or not while their child gets ready for school.

The parents/carers surveyed describe a state of being constantly on edge, waiting to see what will happen. They are aware that if they become agitated themselves it will add to their child's dysregulation. They juggle expectations about their day, the expectations of others and the expectations of the school. They may wait patiently in a car for an hour to see if a child will be able walk through the school gate. They may sit outside a classroom to see if their child will settle and to provide reassurance. They co-regulate and calm their child knowing that doing so can't happen to a schedule and can't be forced.

Whether they finally get their child to school (or not) and return home, they collapse from the exhaustion of the effort it took, pulling into the driveway they sit on their phones scrolling unable to summon the energy to move on and adjust the rest of their day.

From month to month and year to year there is also unpredictability. School can't is often episodic in nature. The parent is challenged because even if the child returns to learning it is difficult to predict when or if it will happen again. This makes long term planning challenging.

7.2.8 Case managing our children:

Parents/Carers are required to simultaneously juggle caring for a distressed, unwell child and seeking and building a support team around their child and themselves. They spend hours searching for information, in the absence of being directed to it. Parents/carers of school can't children engage in a range of activities relating to case managing their children's needs including:

> "It took a long time, and a lot of heartache for me to set up a support network of counsellors, friends for us, as well as a long time to get a diagnosis on my child's condition (ADHD and anxiety). Months of phone calls, waiting for responses, waiting for appointments"
>
> *SC Survey 2022 Respondent*

- Engaging in advocacy on their child's behalf at school.
- Educating school staff about supporting their child.
- Searching for and identifying alternative pathways for education.
- Navigating closed and lengthy wait lists.
- Interpreting and making sense of reports and assessments.
- Arranging supports only to discover that: the support is not suitable (e.g. not trauma aware), their child is too unwell to engage or he/she has recovered somewhat and no longer requires support. Or they discover that the support cannot be accessed at home or the school will not support access on the campus.

Fluctuating capacity of the child makes it hard to put supports in place as many privately engaged supports require you to make a regular ongoing booking for support.

The burden of care is substantial and overwhelm often impairs their ability to carry out this role. Many survey respondents suggested that supportive case management that was: trauma aware, independent, and wellbeing focussed rather than attendance focussed would help reduce their overwhelm. Parents/carers expressed that they didn't know how to advocate for their child or what support to ask for. Findings from SC Survey-22 (See Table 8) indicate high rates of overwhelm (already mentioned above), 46% of respondents described not knowing who to contact to assist their child, 43% indicated that their own mental or physical health issues impact their ability to seek help, 37% indicated that they had insufficient time to access supports for their whole family, 25% said they were not sure about other education options. Respondents suggested that an initial point of contact such as a helpline would have assisted them to know what first steps to take.

Table 8. Barriers to accessing supports due to parental distress.

Difficulties with case management activities in the past 12 months:	
Not knowing who to contact	46%
Parental mental or physical health issues impacting help seeking capacity	43%
Insufficient time to access supports for a whole family	37%
Cost of time off work to access supports	34%
Not sure about other education options	25%

7.2.9 Regulating Parent/carer worries about their school can't children:

Parents/carers frequently report feeling anxious about their children. They are exposed to messages about the importance of attendance regularly in school newsletters and other communications from school. Parents/carers feel anxious about things happening now and things that may happen in the future including:

1. their child's mental, and physical well-being,
2. loss of academic progress and keeping up with peers academically,
3. impacts on the child's social relationships and connections,
4. the impact on their child's future education opportunities,
5. whether their child will ever be able to return to school/learning,
6. whether their child will be able to one day get a job.

They are impacted by a range of narratives in the community which fuel anxiety such as:

1. School to prison pipeline – they will be headed for a life of crime.
2. Home schooled students don't develop social skills.
3. Every Day Counts: students who miss school won't have a future.
4. Non-compliant children are: lazy, manipulative, and no good.
5. They will never be able to care for themselves or be independent.
6. A high ATAR means you are a success, and your parents did their job successfully.

It is important that parents/carers are encouraged to maintain calm and optimism about their school can't children and are assisted to counter the negative narratives listed above. Parent anxieties about school attendance can:

1. Interfere with being able to work with the child collaboratively to identify the underlying issues.
2. Increase the child/young person's distress about themselves and their situation which can lead to depression.
3. Lead parents/carers and schools to push attendance at the expense of well-being.

Calm begets calm. Parents/carers who stay calm can connect and co-regulate with their child. Adults at school who communicate calm, help the student feel safe at school. At School Can't (SPSR) Australia we frequently discuss "radical acceptance". This is the act of accepting the child where they are at now rather than communicating disappointment or frustration at their current situation. Radical acceptance communicates safety, but is challenging for adults in the face of such negative and frequently unfounded narratives about engagement with school and learning.

The study (Hancock et al 2013) underpinning the "Everyday Counts" narrative shows a correlation between attendance levels and NAPLAN results for those from disadvantaged backgrounds but it shows that "more advantaged children had relatively high achievement levels irrespective of their level of attendance at school. This pattern is particularly evident in the primary school years, and suggests that more advantaged children have alternative and effective resources that help them achieve learning objectives, both at school and in the home, during the early years of school." (Hancock et al, 2013:vi)

7.2.10 Impact on physical, mental health and perception of self as parent

In summarising the impact on parents/carers of caring for school can't children the most concerning figures are in relation to the impact on parent/carers physical and mental health and on their perception of themselves as a parent/carer. The implications for the long-term health outcomes of

the surveyed parent/carer cohort is concerning, considering their ongoing experience of chronic stress. Chronic stress in the context of negative perceptions of self as well as self-assessed mental health and physical health decline can lead to feelings of hopelessness.

Question 56 of the SC Survey-22 asked to what extent has having a School Can't child impacted on your physical health, your mental health and your perception of yourself as a parent over the past 12 months. Parents/carers were asked to score each item using a 7 point scale from Positive (0) to Negative (7) with a neutral mid-point. Results can be seen in

> "We have experienced trauma. Possibly we have PTSD now as a result of school can't and how we have been treated or neglected by schools, education dept, health professionals. It has changed everything about my life and the life of my child. I feel like we have been in a war. It has changed me irrevocably."
>
> *SC Survey 2022 respondent*

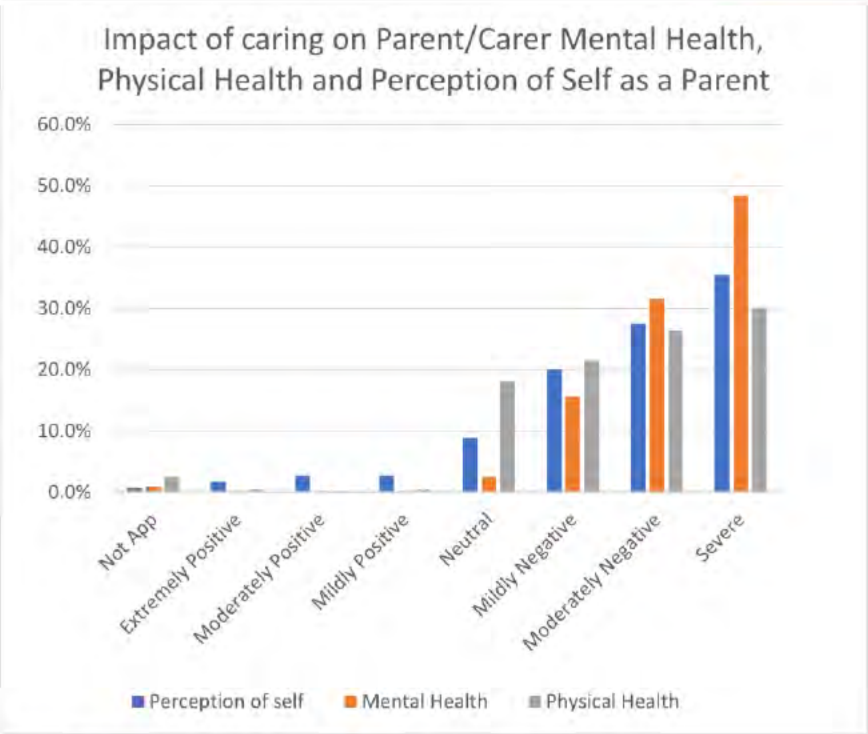


Figure 10.

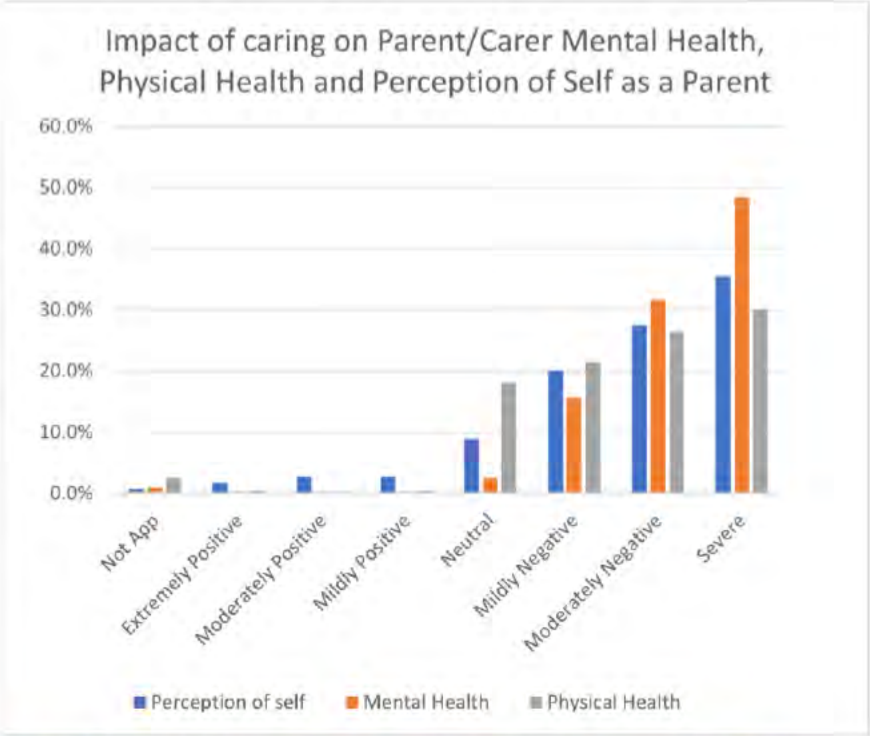


Figure 10: Impact of Caring on Parent/Carer Mental Health, Physical Health and Perception of Self as a parent

Parents/carers surveyed experienced substantial negative impacts in all three domains: mental health, physical health and perception of self as a parent. The biggest negative impact on parent/carer wellbeing was in relation to their mental health: 95% indicated a negative impact across the spectrum of mild to severe with 80% indicating moderate to severe impact. Impact on parents/carers perceptions of themselves as a parent was the second most significant area of negative impact with 83% indicating a negative impact ranging from mild to severe and 63% indicating the impact was moderate to severe. Impact on physical health showed 78% scored a negative impact across the spectrum of mild to severe with 56% showing moderate to severe impacts. These findings are concerning given the possible long term health impacts of parents/carers having experienced lengthy periods of distress while supporting their children.

> "My daughter's School Can't is more stressful than my cancer diagnosis."
>
> *SC Survey 2022 Respondent*

Recommendation 13: That federal parliament review financial supports for parents who home-school. Many have been forced into home schooling as a result of their child's disability/mental health needs not being met previously in formal schooling. We request that consideration be given to: helping families meet the additional cost of living associated with home schooling, provision of additional funds when families are home-schooling a child with disability, increasing Assistance for Isolated Children payments (broadening eligibility criteria to include students experiencing school refusal).

8. The impacts and demands of the increasing case load on service providers and schools to support these students and their families.

A child or young person who is struggling lies at the epicentre of school attendance difficulties. Comforting the child and addressing the underlying causes of their distress must be the top priority of families, schools, allied health and remediation programs. Patience and compassion is required. The process cannot be rushed. Engagement with education can only be built on a platform of 'felt safety', accessibility, and belonging. Parents and carers are looking to access services from education professionals, clinical services and other support services that are trauma aware and share their understanding of school can't. Often, parents/carers are also looking for providers who are also neurodiversity and/or LBGTQI+ affirming. Many families surveyed reported difficulty finding suitable supports. Data from SC Survey-22 indicated that many families have found supports to be unhelpful. Section 8.1 outlines the services accessed by parents/carers who were surveyed and section 8.2 describes the helpfulness of these services as reported by SC Survey-22 respondents.

Recommendation 14: That the senate committee undertake an investigation to review the impact of the siloed structure of funding (education, health, disability) on the ability of families to access help, with a view to reducing barriers to accessing help and supporting families with the costs associated with seeking help and supporting their children to recover.

Recommendation 15: That state and territory DOEs ensure that intervention from authorities, (when low attendance results in mandatory referral to an organisation outside the school, such as the HSLO in NSW) not escalate parent or student stress, but instead seek to identify underlying issues and work collaboratively with stakeholders to develop recovery plans rather than attendance plans.

Recommendation 16: That State and territory DOEs ensure that student supports and funding are able to seamlessly move between different contexts. A social worker, psychologist, occupational therapist, support worker or tutor who works at home with a student, needs to also be able to work or support the student at school and vice versa, as students transition between these environments.

Recommendation 17: That all state and territory DOEs establish and resource an external independent complaints service, for parents and carers of students with disability or mental health difficulties, to self-refer to. This service would assist families when parents/carers have been unable to work with their child's education provider (State, Independent or Catholic) to obtain the support they feel is required to enable their child to access education with their education provider. That such a service provider mediation/advocacy service on behalf of families and report to state parliaments about the number and nature of complaints.

Recommendation 18: That all state and territory DOEs provide a mechanism through which parents and carers can initiate a request for an immediate formal review of a student's support needs if

there are signs of increasing student distress. This will initially involve a PSG meeting and should involve referral to a fast-track service for relevant assessments by psychology, occupational therapy or speech therapists to help identify underlying issues so that students can be better supported. This will enable intervention at an earlier stage and reduce the number of severely distressed students requiring help later.

Recommendation 19: That state and territory DOEs change messaging around school refusal to reflect the need for wellbeing to be prioritised over compliance with attendance expectations. Messaging should recognise that sometimes staying home is necessary to support wellbeing and should also inform parents/carers about how to access supports if a student's wellbeing needs are impacting their attendance at school regularly or persistently. This change in direction will involve removing fines and threatening letters and changing messaging in school newsletters and on DOE websites. This will empower parents to focus on addressing their child's wellbeing needs.

8.1 Services Accessed by SC Survey-22 Participants to Help Child

Key concepts:

- Parents/carers are **struggling to access helpful supports** for their school can't children.
- Helpful supports are trauma aware and share an understanding of school can't. They are focused on the child's wellbeing, seek to identify and address the underlying causes of distress; and demonstrate patience and compassion.
- SC Survey-22 respondents overwhelming **(85%) indicated that their experience of parent peer support groups was helpful**. To a much lesser extent, support workers (59%) and OTs (51%) were rated as helpful.
- **Concerningly, school-based supports were rated as unhelpful by many**, perhaps reflecting the conflict of their position with a focus on attendance vs wellbeing. Even wellbeing/school counsellors were experienced as **not helpful** by nearly 60% of those who had accessed them. Year level coordinators and class teachers likewise, were experienced as **not helpful** by nearly 55% of those who sought help from them.
- Many of the difficulties in accessing external supports link back to poor understanding of disabilities within schools; gaps between what is covered by education, health and disability sectors; and long waiting lists and costs of accessing supports. There were also limited practitioners with an understanding of school can't.
- When trying to work with schools, many surveyed parents/carers reported difficulty finding supportive people within the school and the school being willing to explore underlying issues. **Poor access to communication between teachers and parent/carers was reported by 42% of respondents** as a factor that contributes to the child's school can't.
- Small numbers of parents/carers surveyed report having experienced punitive threats and actions from Australian education departments and schools in order to force their children to attend school. Some students were also threatened with the loss of privileges based on their attendance eg excluded from a significant school event or not being eligible for leadership positions.
- 46% of surveyed parents/carers felt their child's mainstream school had **pushed them out.** They describe scenarios where they were left with no choice but to leave a school. Many parents/carers describe becoming reluctant home school parents because they had no other options.
- Parents/carers reported that one of the biggest impediments to accessing support for their child was related to the severity and unpredictable pattern of the child's distress.

Over the past 2 years SC Survey-22 participants accessed a wide range of clinical services, community-based services and supports from schools, to support their school can't child or young person. See Figure 11 below.

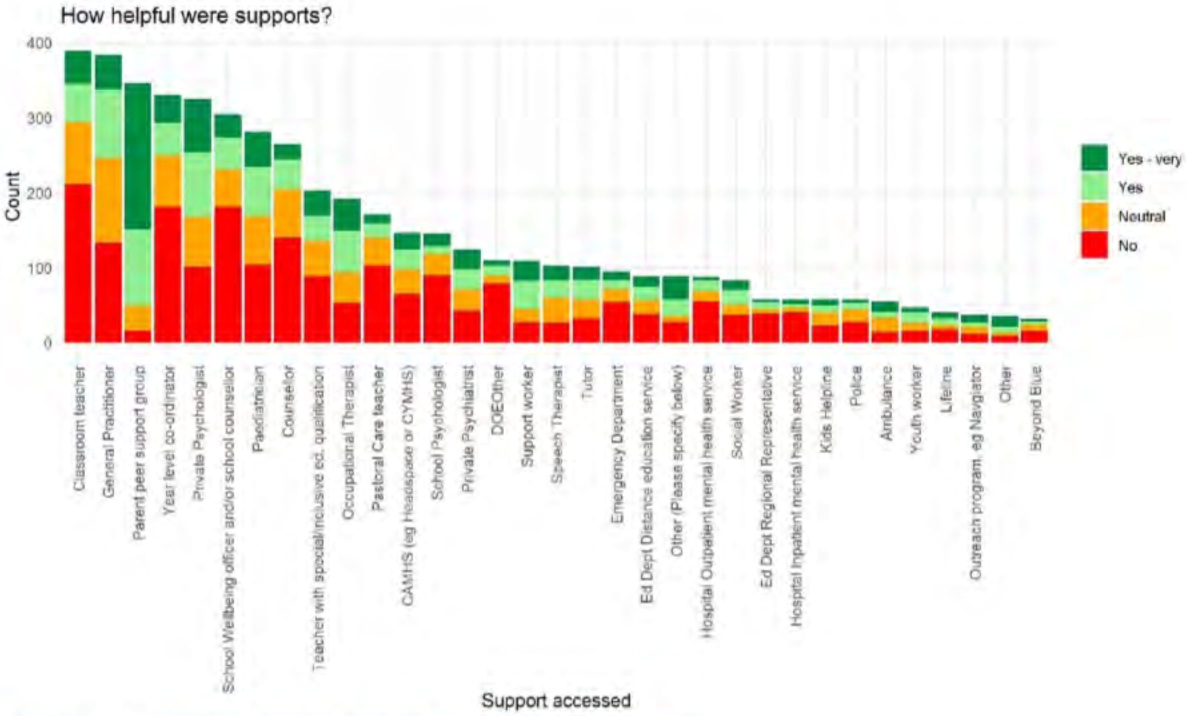


Figure 11. SC Survey-22 - Services Accessed by number of respondents.

More than 50% of respondents indicated they had accessed support from a class teacher, general practitioner, parent peer support service, private psychologist, year level co-ordinator, paediatrician, wellbeing / school counsellor, other counsellor or a teacher with inclusive or special education skills during the past 2 years (see Table 9).

Table 9. Most popular supports accessed by SC Survey-22 participants.

The most popular supports accessed by survey participants for children and young people.	% Participants Accessed
Class teacher	94%
General Practitioner	93%
Parent Peer Support	85%
Private Psychologist	80%
Year level Co-ordinator	81%
Paediatrician	70%
Wellbeing / School Counsellor	75%
Other Counsellor	66%
Teacher with Special or Inclusive Education skills	51%

8.2 Helpfulness of Services Accessed to Help Child:

SC Survey-22 participants were asked to rate the supports they accessed for their children indicating those that were very helpful, helpful, neutral, unhelpful and very unhelpful. Figure 12 displays the range of supports accessed, and the helpfulness of each service. The graph shows the following categories: Very helpful, helpful, neutral and a combined category of unhelpful responses.

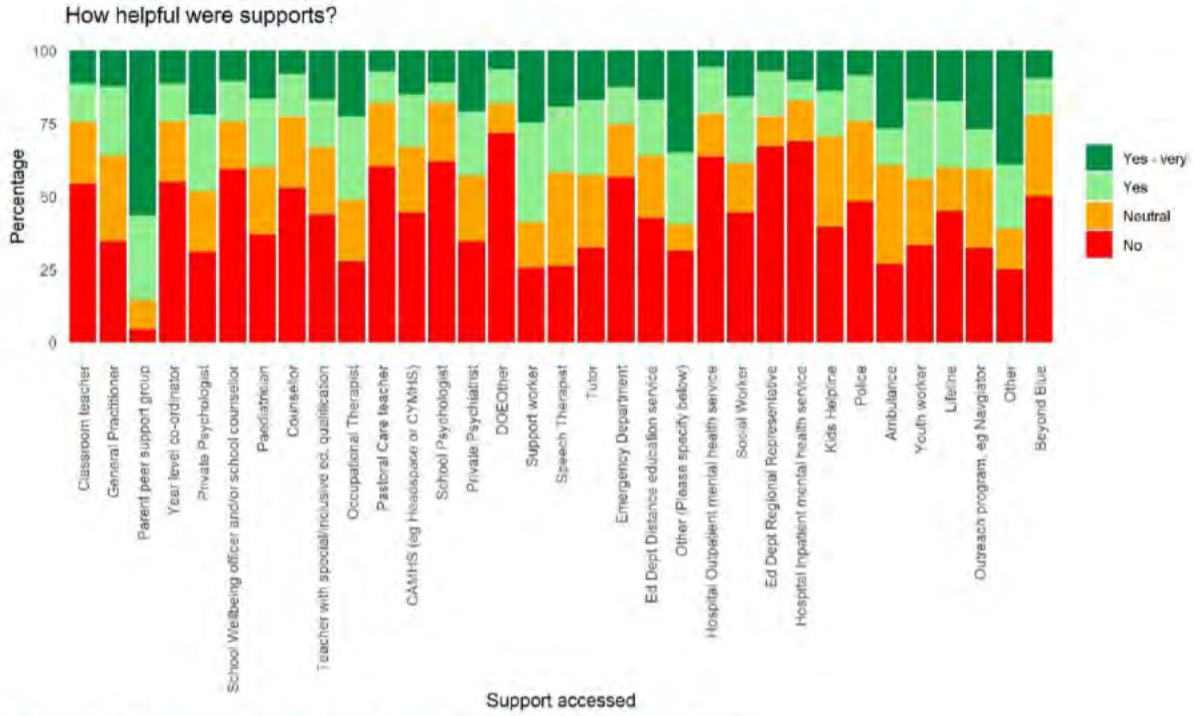


Figure 12. SC Survey-22 Parent/carer report on how helpful supports were.

In the open question asking about supports not listed in the questionnaire a number of parents/carers mentioned the following supports had been helpful: art therapy, music therapy, play therapy, equine assisted therapy, tutor, support worker.

Of supports accessed, the following supports were rated as most helpful by more than 50% of the respondents who accessed them: Parent Peer Support group was accessed by 85% of the respondents and 85.5% of respondents who accessed the service indicated it was helpful, Support Workers were accessed by 27% of the respondents and 58.7% of these rated the service as helpful, Occupational Therapy was accessed by 47% of respondents and 51% of those who accessed the service indicated that it was helpful for their child. Results can be seen below in Table 10.

Table 10. Supports Accessed by more than 50% of respondents that were helpful.

Accessed Supports:	% Participants said service was helpful	% of Total Participants who accessed service
Parent Peer Support	85.5%	85%
Support Workers	58.7%	27%
Occupational Therapists	51%	47%

Parent Peer Supports was the category with the lowest negative and lowest neutral responses overall.

It is a concern that there are not more services listed in Table 10. This indicates that **parents/carers are struggling to find and access helpful supports.** SC Survey-22 respondents indicated that 48% experienced difficulty finding clinicians who understood school can't. This is consistent with what parents tell us in the School Can't (SPSR) Australia parent peer support group. Most supports seem to lack an understanding of how to make sense of and provide support to a school can't student. They also describe other barriers to accessing support which are described and discussed in section

8.3, 0, 8.3.8. In order to improve the ability of existing service provider to better meet the needs of parents/carers School Can't (SPSR) Australia recommends that:

1. more training in relation to how to understand school can't and provide support is needed for service providers, or
2. service providers need increased awareness so they can understand enough about when to refer families on and who to refer them to, or
3. more community awareness is needed so that parents/carers can more quickly identify and locate appropriate supports.

Of the supports accessed by more than 50% of respondents, the following supports were rated as least helpful: wellbeing/school counsellor, year level co-ordinator, class teacher and counsellors external to school. Please see Table 11 for details.

Table 11. Supports accessed by more than 50% of respondents that were rated as unhelpful by more than 50% of respondents who accessed the support.

Type of support	% who found this support unhelpful	% Participants who accessed this support
Wellbeing / School Counsellor	59.3%	75%
Year Level Co-ordinator	54.8%	81%
Class teacher	54.5%	94%
Counsellor	52.8%	66%

As schools are usually the first port of call for parents and carers seeking assistance, feedback about how families have experienced education supports has been isolated from Figure 12 and is shown in Figure 13

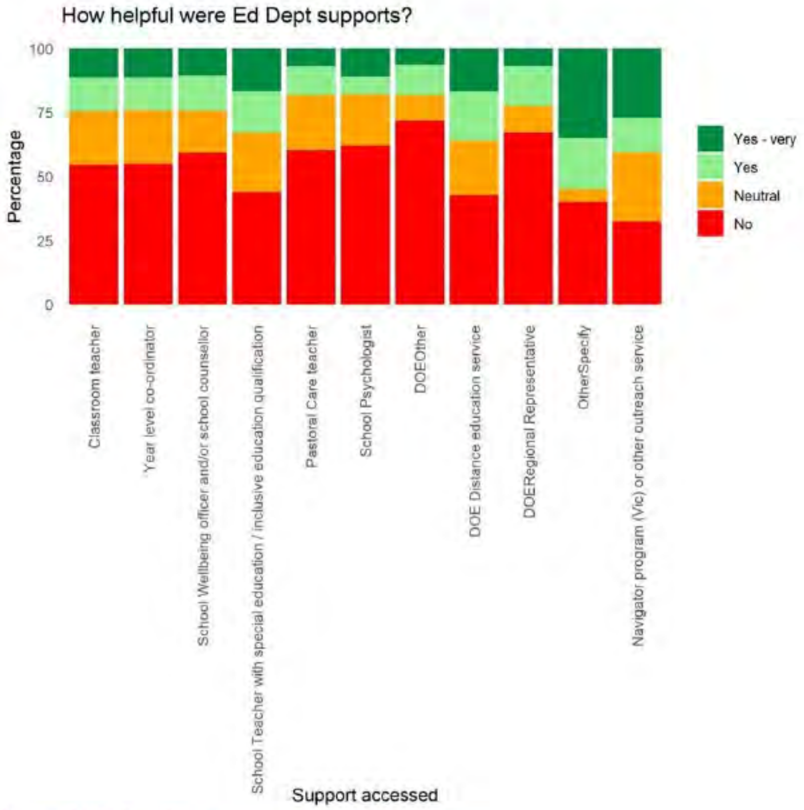


Figure 13: Education supports by helpfulness

With the exception of the Navigator program or similar, all department of education services received negative reports. Navigator and similar programs received at 40% favourable report however only 9% of those surveyed had interacted with a program such as Navigator or similar. This is an indication that the services of similar programs should be made more widely available. Although parents/carers have indicated that the limitation of such programs is often that they are funded through Departments of Education and therefore their primary objective is to get students back through the school gate as quickly as possible. Parents/carers have expressed that these programs should be more recovery and wellbeing focussed and that they would value assistance to explore alternative learning opportunities such as home schooling and distance education when the child is ready to engage with learning again and be supported to transition to these types of education.

"… in Perth WA. All child and Adolescent psychiatrists have closed their books."

"We have sought help and received GP referrals but extended wait times and being triaged as a low priority case means we are still waiting to see paediatrician and psychologist."

"We used one psychologist who was atrocious, and one that was quite good but it took us 18 months to get into her. She did a full report regarding my daughter but didn't see the point in seeing her any more than that as she doesn't really respond to talk therapies. She does do play therapy now and that is going really well."

"Unable to access suitable reengagement programs because we are rural and nothing which is on offer is close by."

Quotes from parents/carers in SC Survey-22

8.3 Barriers to Service Provider Access for a Child or Young Person

We asked SC Survey-22 participants to nominate the barriers they experienced in finding support for their children and young people in the past 12 months. Services availability, suitability and cost were of particular concern to our survey respondents.

Table 12. Barriers relating to service availability, suitability, and cost.

Barriers relating to Service Availability, Suitability and Cost	Percentage:
Lengthy wait lists preventing timely access to assessments	56%
Gaps between education, disability, and family support services	55%
Cost of accessing privately funded supports	55%
Difficulty finding clinicians who understand school can't	48%
Lengthy wait lists preventing timely access to medical or psychological care	37%
Difficulty finding clinicians who are trauma aware	30%
Lengthy wait lists to access external to school re-engagement programs	21%
Unable to access suitable re-engagement programs near us	19%
Waiting on a diagnosis to access supports	19%

8.3.1 Waitlists for assessments and medical/psychological care:

56% of respondents indicated that lengthy wait lists preventing timely access to assessments inhibited them from accessing care for their child. The ability to access assessments is important because they assist in understanding why a student is struggling to attend school. School Can't (SPSR) Australia observes that many parents/carers only discover after things fall apart at school, that their child had a previously undiagnosed disability. The identification of a disability helps provide information that clarifies the nature of the difficulty the student is experiencing and is one of the first steps School Can't (SPSR) Australia recommends when parents/carers are seeking to understand what is happening for their school can't. 19% of respondents indicated that the wait for a diagnosis was a barrier to accessing supports. 37% of respondents indicated that they had experienced lengthy waitlists for medical or psychological care. Assistance with finding psychiatrists with open books is a topic that members of our group regularly request help with.

8.3.2 Issues with funding gaps across education/health/disability:

Gaps between funding for education, health, welfare, and disability are also of significant concern for 55% of SC Survey-22 respondents. The following funding sources (aside from private funding) are used by members of School Can't (SPSR) Australia to assist them to fund and access treatment and support for their child:

- The National Disability Insurance Scheme (NDIS)
- Mental Health Care Plans
- Chronic Disease Management Plans
- Carers Payment
- Carers Allowance
- Assistance for Isolated students

Funding in schools includes:

- Funding under Nationally Consistent Collection of Data on School Students with Disability (NCCD)

- Funding for individual students with disability in school (this varies across Australia but examples include the Program for Students with Disability & Disability Inclusion Funding programs in Victoria, and Integration Funding Support in NSW)

Key issues:

- The siloed nature of funding creates impacts on the flexibility with which supports can be used and means some supports don't exist.
- School Can't children need flexible supports that can be used across both home and school contexts.

38% of SC Survey-22 respondents access NDIS for their school can't child. This number equates to close to half of the survey sample who indicated their child had a disability. Having NDIS funds does not mean you can access the funds you need to assist you to get back to school or recover from school can't. Barriers include not being able to access supports across multiple environments and not being able to access psychological supports to assist with being able to access the school environment.

Parents and carers of children with NDIS plans are told by NDIA representatives that they can't use their funds to provide a support worker to accompany their child to attend school or to employ tutors to build capacity for learning reengagement in a safe and supported way. Parents/carers are told these things should be funded by schools. Funding at schools is insufficient however, to cover these supports and these supports often need to cross over between home and school.

Families report that they require supports that are flexible and able to be accessed in both the home, community and school environments. Sometimes support workers or tutors who are privately funded by parents/carers are prevented from attending the school site if a principal feels it is not a necessary support, they may also find that there is a lack of a suitable room or space at the school.

NDIS does not cover supports for the mental health of those with a disability, even though their mental health has deteriorated as a result of their engagement in contexts (such as schools) that are not inclusive and understanding of their needs and even though anxiety is considered to be a common co-occuring condition in some disabilities.

Meta analyses suggest that 39.6% of autistic young people under the age of 18 meet conditions for a co-occuring anxiety disorder under DSM-IV (van Steensel et al, 2011). Rates of co-occuring anxiety in people with ADHD are estimated to be at 25% (D'Agati et al 2019). Rates of anxiety disorders are estimated at only 6.5% for non-autistic young people under the age of 18 (Polanczyk et al, 2015).

Access to psychology should be available on the NDIS to support autistic children with co-occurring anxiety, as these children require support from mental health professionals who understand Autism.

Rates of access to Carers Payment and Carers Allowance among SC Survey-22 respondents was low with 14% of respondents accessing Carers Payment and 29% accessing Carers Allowance. Parents and carers who have a student with school can't that does not have a disability or is awaiting an assessment for a disability, are currently unable to access support from Carers Payment/ Carers Allowance. They are also unable to access Carers Gateway for counselling support. They financially unsupported while waiting for assessments, having to pay privately for those assessments and at a time when they are unable to work.

Access to the federally funded Assistance for Isolated Children (AIC) is restricted to those who live in an isolated area, have a disability or have special health needs. Parents/carers whose children are home schooled or attend Distance Education for medical reasons or whose child is unable to attend their nearest state school due to geographical distance are able to access AIC funding. Currently students who are too mentally unwell to attend school due to school can't, and who stay home from school as part of a recovery plan are unable to access AIC funding.

8.3.3 Cost of accessing privately funded supports

Cost of privately funded supports was identified as a barrier by 55% of respondents. We have reported earlier (see 7.2.2) about the impact on family finances of having a parent or carer unable to work. This directly impacts their ability to afford services. The cost of psychological assessments for ADHD, Autism, or Specific Learning Difficulties averages $1500 - $2,200 and are not covered by Medicare.

A recent report evaluating the "Better Access Initiative" showed that "Affordability was consistently raised as an issue by consumers and providers who contributed to the various studies in the evaluation. In 2021, 65% of Better Access treatment services attracted a co-payment compared with 53% in 2018. The median co-payment for these services was relatively stable at around $74 per session between 2018 and 2021 but increased significantly in the first half of 2022 to $90. (Pirkis et al 2022:14). This is consistent with the experiences of our members seeking psychological care for their children or themselves. Many state that with reduced income they struggle to afford the substantial co-payments for fortnightly mental health care that they may need to access. They also worry about the number of subsidised sessions they can access being inadequate.

8.3.4 Other barriers to accessing supports for the child:

48% of SC Survey-22 respondents indicated that they experienced difficulties in finding clinicians who understand school can't and 30% indicated they experienced difficulty in finding clinicians who are trauma aware. In relation to accessing re-engagement programs: 21% of respondents indicated that had experienced lengthy wait lists to access external to school re-engagement programs and 19% indicated they were unable to access suitable re-engagement programs near them.

8.3.5 Barriers to School Based Support Access for a Child or Young Person

Many of our survey participants nominated barriers relating to difficulties in collaborating with schools and school personnel. This is a point of some concern as School Can't (SPSR) Australia considers that collaboration between parents/carers and school personnel is essential in order to:

1) identify and address the underlying difficulties contributing to school can't,
2) establish conditions that support a child or young person in their wellbeing, and
3) ensure the student's sense of felt safety and belonging such that they might be able to return to school.

These factors are all critical in setting the scene for reengagement with education.

Parents rate parent-teacher collaboration and communication as one of the most helpful interventions for supporting autistic children with anxiety a school (Adams, Young, Simpson & Keen, 2019). Difficulties collaborating and communication with school, are characteristic of a breakdown in crucial supports for these students.

SC Survey-22 participants identified a range of difficulties that impeded their efforts to access support at their child's school (refer Table 13). **38% found it difficult to find supportive people at their child's school**. Discussing school can't is challenging for parents due to many narratives in our culture that blame children and families for their distress (discussed Section 12). Parents can often be dismissed or are given advice that is inappropriate or unhelpful. **36% experienced difficulties in engaging their school in exploring underlying issues** related to their child's school can't. This frequently happens due to a widespread belief that the problem and therefore the solution lies within the family or the child.

Table 13. Barriers relating to difficulties collaborating with the school.

Barriers relating to Difficulties Collaborating with the School	
Difficulty finding supportive people within the school	38%
Difficulty engaging the school in exploring underlying issues	36%
School difficult to communicate with	33%
Feel uncomfortable attending meetings at school	30%
School not following recommendations from experts	29%
School refusing access to external supports	19%
School denies there is a problem and won't provide access to school based supports	18%

33% of respondents found the school difficult to communicate with. Poor access to communication between teachers and parent/carers was reported by 42% of respondents as a factor that contributes to the child's school can't. Communication difficulties included: not being allowed to have the email address for the teacher, having to use a general email address and related concerns regarding privacy. They also include meetings that are infrequent, too short or only available at times when the parent is the only one home to look after the school can't child. 30% of respondents indicated they felt uncomfortable attending meetings at the school. Parents/carers often feel outnumbered or threatened by the presence of a large number of staff or by the presence of senior staff.

Parents/carers also experienced difficulties with schools not following recommendations of experts (29%), refusing access to external supports (19%) and others indicated they had experienced school's denying there was a problem and refusing to provide access to school-based supports (18%)

SC Survey-22 participants indicated that there were issues which had impacted their child's school can't pertaining to **the need for training of staff in relation to being informed about the child's disability when there was one (55%), making reasonable adjustments (59%), and provision of individualised supports and planning (59%).**

See also discussion of structural difficulties which have contributed to school can't section:6.5.1

These findings highlight a need for case management and advocacy services, that can mediate between families and schools and service providers.

Difficulties in collaborating with schools and school personnel may reflect:

1. the stress that schools and teachers are under,
2. the lack of training and resources available to schools to work with complex cases, and
3. the emotional load of working with distressed people.

Schools require needs-based funding, and education systems and school communities must prioritise teacher wellbeing. Addressing stressors in the system, providing training and resources will grow teacher capacity to meet student need.

8.3.6 *Impact of use of power and threats to induce attendance:*

Small numbers of parents/carers surveyed report having experienced punitive threats and actions from Australian education departments and schools in order to force their children to attend school, ranging from letters outlining the negative impacts of non-attendance, letters threatening legal action and fines, threats to terminate enrolment, threats to refer a family to Child Protection, threats that school employees or police come to the family home to escort a child to school. Some of these threats were followed through. There were also threats and actions directed at children such as excluding the child from a significant school event due to their attendance (6% threatened and 10% report having been excluded), or not allowing them to apply for leadership positions (7% threatened, 6% report this happened to their child). **School Can't (SPSR) Australia strongly advises against such measures** as they damage relationships between families and schools and add to the stress that children and families are experiencing while failing to address the underlying causes of school attendance difficulties.

8.3.7 Ignorance or Systemic Exclusion?

School Can't (SPSR) Australia is extremely concerned that 46% of SC Survey-22 parents/carers indicated that they felt that their child's mainstream school had pushed them out. They describe in private messages and on our Facebook page a range of scenarios where they were left with no choice but to leave a school. We have permission to share these de-identified scenarios. In some cases parents/carers described being excluded or directed away from enrolment and others described situations where they just didn't get the support or understanding they needed and were left with no choice but to exit.

Scenarios described included:

- A young person with school can't being told they would have to withdraw from the school if they don't meet an attendance expectation as there are other students who would happily take their place and attend on time.
- Being directed by principals to take their enrolment elsewhere and told that the school could no longer cater to their child's needs.
- A 17 year old who wanted to return to school, after being unable to attend the year prior. He was told he could not access the VCAL program and reminded that he no longer "had" to be at school, despite his desire to give it a go.
- Schools that had no idea about how to support students with severe anxiety, other than to advise parents to just get their child to school and to make life unpleasant at home so they come to school, leaving the family to choose between further harm to their child or leaving the school.
- A school whose focus on attendance led them to insist that a family sign an attendance plan in the form of a contract, that the family knew they would not be able to action, because the child was not well enough. This left them with no choice but to leave and home school.
- Stories of schools who have used power/authority including threats of legal action to intimidate and humiliate parents. Parents felt that they could not work with school staff, and determined that it would be easier to find another school who understood that they weren't dealing with a behavioural issue but with a mental health issue.
- Being told to transfer the child's enrolment to Distance Education or home education or else the school would pursue legal action.
- School's not understanding the length of time that recovery from school can't takes. A parent described a school agreeing to a 3-week partial attendance plan but then expecting full time attendance at the end of that period.
- Lack of flexibility on the school's part / insisting their way of doing things would fix the school attendance problem, despite the parent/carer presenting information about what had worked in the past to support the child.
- Lack of responding in a timely manner to a parent's early expressed concerns, leading to increased student distress, until the child displayed signs of trauma and worsened mental health, preventing their return.

- Failure of schools to provide previously agreed accommodations and modifications, leading to the child feeling severely distressed, experiencing panic attacks and being unable to stay at the school.
- Schools that believe the solution to anxiety is to push through it. "Keep sending her to school. All kids this age feel this way", said a school principal to a mother, whose daughter was so distressed by school that she had become suicidal.
- One parent described a counsellor at their child's old school who labelled the child as lazy and manipulative despite knowing of a diagnosis of anxiety. Staff at school physically dragged their crying / fearful child into the school ground in front of peers saying that they knew best as they were the professionals. The experience was traumatising for both the parent and the child and led them to lose trust in the school's capacity to assist and to look for another school.

Many parents/carers describe becoming reluctant home school parents because they had no other options, or having to find an alternative to the school their child was enrolled in previously.

8.3.8 Barriers to Accessing Support due to Severity and Pattern of Child's Distress

SC Survey-22 participants indicated that one of the biggest impediments to accessing support for their child was the severity and pattern of the child's distress. (See Table 14 below). 66% of participants indicated their children was too anxious to engage with any supports and 47% indicated their child was too traumatised or too shut down to engage in supports. They described children who may be any or all of the following: shut down, withdrawn, unable to trust or connect with adults, unable to leave home, unable to leave their bedrooms, or suffering other signs of burn out. 48% of participants indicated that the unpredictability of school can't made accessing assistance difficult. Their child might be ok for a term and then not be able to attend school. This unpredictability makes it difficult to commit to regular supports and creates challenges in maintaining continuity of supports.

Table 14. Barriers to accessing supports due to severity and pattern of child's distress.

Barriers to Accessing Supports due to Severity and Pattern of Child's Distress	
Child / young person is too anxious to engage with supports	66%
Unpredictability of "school can't" – seems OK and then suddenly not OK	48%
Child too traumatised / shutdown	47%

9. How relevant state, territory and federal departments are working to monitor and address this growing school refusal challenge

Key concepts:

- There is a lack of consistency in the understanding of school can't and how it is recorded.
- Once data is available, school can't should be correlated with other data on disability, indigenous status, inclusion, use of exclusionary practices and school discipline practices.

According to feedback from members of School Can't (SPSR) Australia there is a lack of consistency in the way that school can't absences are recorded in schools. There is much to be done to create conditions within which data can be collected which truly represents the reality of the situation can be collected. Please refer to our discussion about this issue at section 6.3

School Can't (SPSR) Australia recommends that data in relation to school can't is examined to see how it correlates with other data such as:

- disability status
- indigenous status
- whether a student is in foster care or out of home care
- measures of inclusive practice in schools
- rates of informal exclusion used by schools such as restricted attendance, and early dismissals initiated by a school
- rates of detention
- rates of use of seclusion and restraint practices in schools such as holding a child so they can't leave with a parent or using an isolated locked "calm down space" to manage a meltdown) and
- School discipline practices

School Can't (SPSR) Australia knows from its recent survey that rates of diagnosis are very high in the population of student whose parents and carers were surveyed (see Section 0). **School Can't (SPSR) Australia suspects that schools with practices that prioritise compliance over connection and who have poor inclusion practices will have higher rates of students with school attendance difficulties. The demographics of SC Survey-22 indicate that students with disability are significantly adversely impacted by their experiences in schools.**

Recommendation 20: State parliaments be encouraged to legislate and provide funding to enable the collection of data on parent reported reasons as to why a student has exited from a school to seek an alternative enrolment. That this data be reported to their respective parliaments annually. Data should also be collected regarding reasons for seeking enrolment in alternative education environments such as distance education, home-schooling or specialist/therapeutic education environments. This data should include information about the student's disability status, exclusion, restraint, and school refusal history. This will enable a better understanding of the factors impacting students with disability and those with a history of school can't and assist in identifying and responding to barriers to inclusion.

10. Stressors

School Can't (SPSR) Australia has come to understand that that school refusal is a stress behaviour rather than a "misbehaviour". In responding we must identify the sources of stress and seek to reduce the stress in order to prevent school can't and in order to create school environments within which students can be sustained in ways that allow them to engage with learning from kindergarten through to year 12. To assist the Senate Inquiry to understand these sources of stress the SC Survey-22 asked parents a range of questions in relation to stressors. These explored school based, COVIID-school related factors and family stressors and their impact on school can't.

Questions 39 – 45 asked parents/carers for information about stressors which had impacted their child's school can't experience:

1. **Question 39-42: "Are difficulties with any of the following linked to your child's school can't?" asked about 57 different stressors grouped under the following headings: environmental, sensory, emotion, social/communication, cognitive, academic, disability accommodations, structural, and physical.**
2. **Question 43 asked "In the past 2 years, have the following COVID related stressors impacted your child's attendance at school..." and respondents were presented with a list of 19 potential COVID related stressors.**
3. **Question 44 was an open ended question and asked: "What, if any, further details would you like to share about how the school- based factors / stressors in the previous questions contributed to school can't?".**
4. **Question 45 asked: "Have there been family and personal impacts outside of the school environment (excluding disability or child's mental health) that have impacted your child's school can't? (eg loss of a family member, parental illness, impacted by natural disaster?" This question gave parent/carers the opportunity to provide a text based response.**

In the following sections: (10.1, 10.2, 10.3) we report on the findings relating to these questions.

10.1 School Based Stressors:

Key concepts:

- Surveyed parents nominated many school-based difficulties that contributed to their child's school can't. Many of these reflect known difficulties (that could be proactively addressed) for autistic and ADHD students around sensory needs, flexibility, attendance expectations, following interests, using CPS, and neuro-affirming social emotional learning.
- 71% of survey respondents nominated a lack of safe people as a definite problem for their school can't child. The students in this cohort are struggling with relationships and connection with both teachers and peers at school, and feeling safe.
- Poor school and teacher understanding of stress and distress impedes students being heard and getting the support they need.
- Neuro-normative expectations, shaming and non-inclusionary school cultures see many students masking to fit in. Masking adds to a student's stress load by cutting off avenues to reduce, avoid or recover from stress.
- Schools are often overstimulating and distressing to neurodiverse students and those impacted by trauma. Sensory acoustics, uniforms, classroom temperature, lights and visual clutter all impact on this and could be improved at a school or classroom level and with increased flexibility.
- Difficulties with school work were also seen as stressors. Work not of interest, executive functioning difficulties, difficulties with specific subject areas, execution of the curriculum, group work and processing speed were all significant.
- The length of the school day, number of transitions and early start times all contribute to the school stress load for many students.
- Universal supports and individualised supports are needed to meet the range of complex needs in the classroom. This requires a culture of inclusion, increased disability training and mentoring for teachers, providing reasonable adjustments, and flexibility to meet a range of needs.

School Can't (SPSR) Australia asked SC Survey-22 respondents to nominate the school-based difficulties connected to their child's school can't. See Figure 14 below. A range of difficulties were selected and categorised under the headings: environmental, sensory, emotional, social/communication and cognitive, academic, disability accommodations, and structural. Interestingly most difficulties on the list were nominated as being applicable by at least 26% of parents/carers. These results are congruent with difficulties commonly experienced by children with Autism and ADHD in our school system and given the demographics of our SC Survey-22 population this result is not surprising although it is concerning.

The full table of results for the data displayed in Figure 14 below can be found in the appendix at section 19.4.

The top 10 stressors identified included difficulties with:

- Limited safe people and places at school
- School staff unable to identify signs of distress
- Communicating student distress to the teacher
- Masking
- Teacher or school expectations
- School work that is not of interest
- School placing responsibility on the student to change instead of providing supports
- Meeting expectations of self
- Lack of trauma informed staff
- Length of the school day

See **Error! Reference source not found.** below.

Table 15: Top 10 School-based stressors impacting School Can't

Top 10 difficulties impacting school can't:	% Yes:	% Maybe:
Limited safe people	71%	13%
Staff unable to identify signs of distress	69%	13%
Communicating Student Distress to teacher	68%	15%
Masking	67%	14%
Teacher / school expectations	64%	11%
Work not of interest	64%	16%
Placing responsibility of student to change instead of providing support	64%	10%
Expectations of self	64%	15%
Lack of trauma informed staff	62%	9%
Length of school day	61%	16%

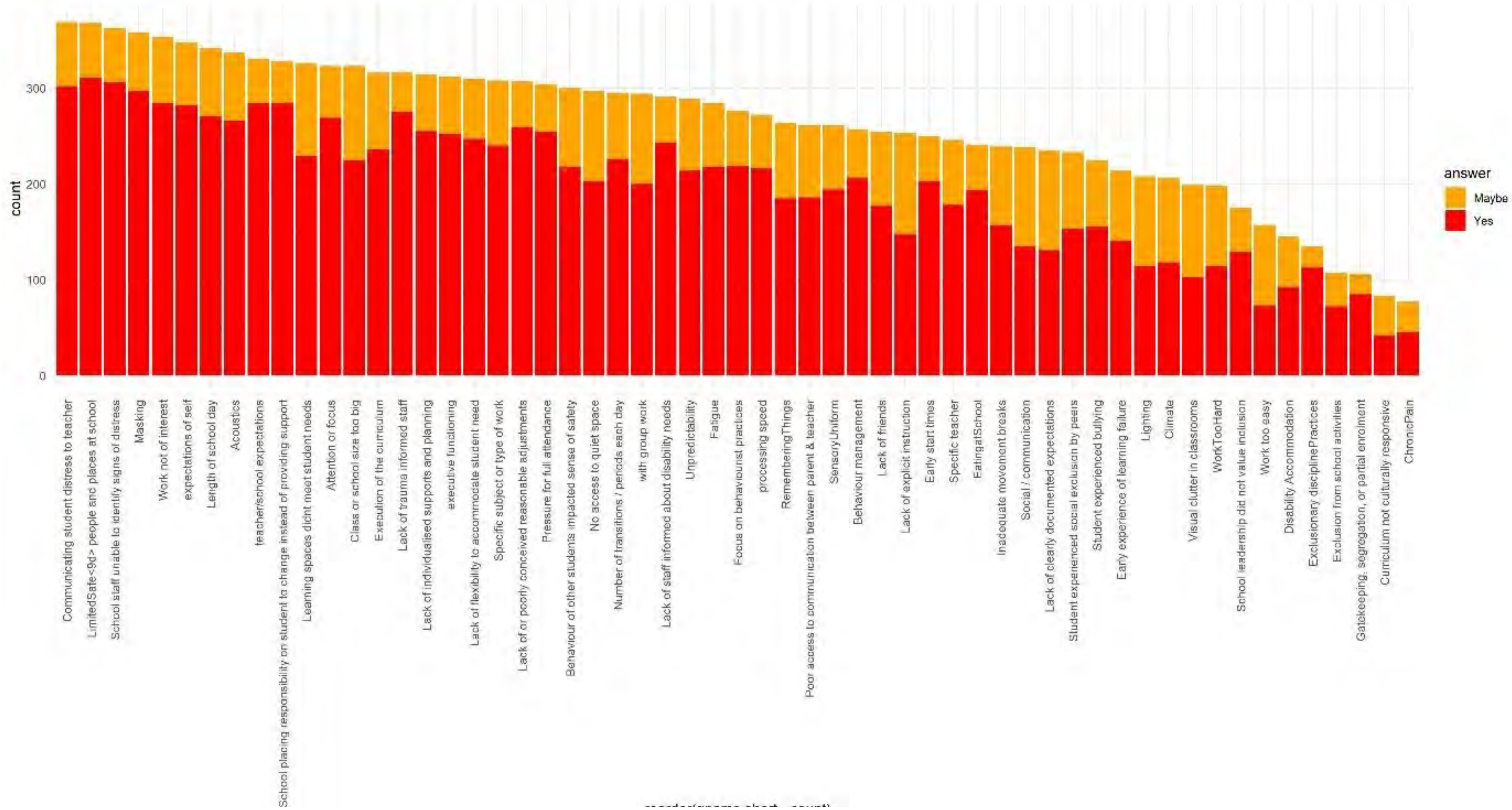


Figure 14: SC Survey-22: School Based Difficulties Contributing to School Can't as Identified by Parents/Carers

Many of these stressors can be proactively addressed by adjustments to the way we do things in schools such as:

- Designing our schools and classrooms to meet sensory needs,
- Adjusting timetables and attendance expectations,
- Facilitating interest-based learning,
- Reconsidering the use of competitive timed activities,
- Use of Collaborative and Proactive Solutions, low arousal, and de-escalation approaches, and
- Social emotional learning that is neurodiversity affirming,
- Ensuring that learning support plans focus on accessibility by removing barriers, making adjustments and providing support.

As you can see from Figure 14, there are many stressors impacting on children and young people. School Can't (SPSR) Australia's lived experience knowledge and research has led us to have much to say about what works and what doesn't work to reduce the experience of these stressors and help create learning environments that would better support our children. We have selected just seven areas to write about in detail:

1. Felt Safety,
2. Recognition and acknowledgement of student stress by school staff
3. Masking
4. Sensory sensitivities
5. Problems with school work
6. Structural difficulties
7. Disability supports and inclusion

Recommendation 21: That state DOEs identify and remove barriers (including examining funding structures and policies) which prevent students from: easily moving between face-to-face learning, distance education and home schooling or combining enrolments across different types of learning contexts when needed. This will allow students to access a wider variety of options for engaging with education.

Recommendation 22: That state DOEs identify and remove barriers which prevent enrolment in an out of zone school when the student no longer feels safe and supported at the zoned school, in circumstances where a student experiences or is a risk of School Can't.

Recommendation 23: That state and territory DOEs ensure that options exist, particularly in high school, for students to choose the way they would like to engage in a subject i.e. online, face to face, live or watch at another time. This will enable students flexibility to engage in ways that meet their wellbeing/ recovery needs.

Recommendation 24: That state and territory DOEs build capacity of teachers to have in depth knowledge about adjustments and accommodations required to support students with disability / mental health difficulties. Especially in relation to collaboratively creating supportive learning plans, regulation plans, and mental health support plans. This will ensure students are better supported and will reduce student stress.

Recommendation 25: That State and territory DOEs and University Teacher training courses work to develop awareness around the importance of teacher wellbeing and supporting teacher's nervous systems. This is to ensure that teachers have the capacity to be with distressed students and can co-regulate and share their calm with the student. Teachers who have highly aroused nervous systems may unintentionally arouse the nervous systems of their students.

Recommendation 26: That state and territory DOEs mandate trauma or nervous system informed practice training for staff at schools and examine ways to support teacher wellbeing and regulation in the workplace at an institutional level, because the wellbeing of students is closely related to the wellbeing and regulation of teachers.

Recommendation 27: That Federal and State parliaments legislate to ensure that according to Article 24 of the United Nations Conventions on the Rights of Persons with Disabilities, to which Australia is a signatory, students with disability will have their right to access inclusive (non-segregated) education upheld.

Recommendation 28: That in conjunction with legislation recommended in Recommendation 27 state and territory DOEs will mandate the upskilling of teachers in relation to inclusive educational practise and universal design, through professional learning and mentoring for teachers already employed and in teacher training courses. This will support the desegregation of our education system so that all students are supported in mainstream contexts regardless of diagnosis and fewer students with disability are left as casualties of their engagement in mainstream education.

Recommendation 29: That university teacher training courses be mandated to include units on disability and cultural awareness in relation to attitudes towards disability.

Recommendation 30: Given the positive response that many young people (24%) had to remote learning, we recommend that State and territory DOEs make access to distance education more readily available and easier to access.

Recommendation 31: That State and territory DOEs resource and make available, remote learning facilities to help students who cannot attend school in person, retain connection to their schools (including peers), and remain connected to their learning.

Recommendation 32: State and territory DOEs review and amend policies in relation to the following supports for students with anxiety:
- Permission for parents or support workers to be on site as a support person to provide reassurance to an anxious young person.
- Permission for the young person to carry a mobile phone on their person at school as part of a safety plan, so they can alert a support person when in distress.
- Permission for a young person to access and use any supports that assist them to feel calm so long as these do not disturb other students (e.g. listening to music, use fidgets, use break cards, ability to move, visit a favourite teacher).

10.1.1 Felt Safety

71% of survey respondents nominated a lack of safe people as a definite problem for their school can't child. The students in this cohort are struggling with relationships and connection with both teachers and peers at school, and feeling safe. Usually this is because the child's nervous system has been sensitized to detect social threat as a result of poor experiences in the past. Students may struggle to determine if a teacher or peer is happy with them or not and the effort of trying to determine this makes them feel anxious. While not attending school itself could be a reason for a lack of relationship, children have generally been to school before school attendance difficulties began and we must consider whether a lack of those relationships in the first instance, or a breakdown in relationship may be contributing factor.

Difficulty with a specific teacher was nominated as a contributing difficulty by 40% of parents/carers. Bullying and social exclusion from peers were both nominated by 35% of parents/carers. Lack of friends was nominated by 40% of parents. Physical restraint by a teacher and witnessing peer to peer violence were also mentioned by parents in our free form text response to this question. One respondent described a situation where a student was shamed by her teacher in front of the class for struggling with a timed task, which resulted in bullying from students who witnessed the exchange. While this will impact a student's sense of belonging, and a student's capacity to call on peers or teachers when they need assistance, this also impacts the nervous system arousal state of the student. Only when students feel safe will their nervous systems enable their brains to attend to learning. Felt safety is a necessary precursor to learning.

Behaviour of peers was also nominated as influencing students' sense of safety at school with 49% of parents reporting that this was a factor in their child's school can't.

Misguided advice from schools on how to address school attendance difficulties is also problematic for the recovery of school can't students (See Table 25 on page 91 for further discussion. Attempts to force students back to school negatively impact student – adult relationships and damage trust. School can't children and young people need to feel heard and supported by their grownups. They need to feel like they have allies not adversaries.

Parents/carers of school can't children also report that some school staff do not know how to interact with anxious students, expecting them to push through their fears, "use their resilience", and just get on with things. The expectation is that the school is safe, there is nothing to be afraid of, it's all in their minds, and the student will experience safety once they are at school, mitigating their fear and interrupting ruminative thought by challenging their negative beliefs. If only it were so easy! This approach may work with students who have very low levels of nervous system arousal but for severely anxious students it only makes them feel more unsafe.

> "The only things that were working was reduced hours days at school. So he would attend anywhere from 2-4hrs instead of 6. This got my son happier about going to school, a lot of his physical symptoms abated and for the first time this year he felt a sense of achievement. However pressure from the school due to their concerns about his education got to me and we slowly worked up to full hours so reversed any positive progress we had made."
>
> *Respondent in SC Survey-22*

Feeling safe is subjective. It is a property of the interaction between a child's nervous system and the environment. As Mona Delahooke reminds us "Safety is in the Eye of the Beholder" (Psychotherapy Networker (2020).

According to the Harvard University Center on the Developing Child (2021 website)

"The science of child development and the core capabilities of resilient adults point to a set of "design principles" that policymakers and practitioners in many different sectors can use to improve outcomes for children and families. To be maximally effective, policies and services should:

1. *Support responsive relationships for children and adults.*
2. *Strengthen core skills for planning, adapting, and achieving goals.*
3. *Reduce sources of stress in the lives of children and families."*

10.1.2 Recognition and Acknowledgement of Student Stress by School Staff:

The next two top difficulties nominated by our parents relate specifically to the ability of staff to notice student stress (69%) and for students to be able to communicate to teachers (68%) about the amount of stress that a student is experiencing. A lack of awareness that a student is struggling, means that a teacher may not recognise a need to make adjustments and provide supports for a child, or may dismiss parental reports that children are not coping at school, believing that the child is fine because they look fine in class.

There are a number of reasons why teachers may not be aware of a student's distress:

- Masking - the student's ability to mask their difficulties, discussed further in section 10.1.3,
- A fight or flight response may result in visible behaviour that is misinterpreted as disruptive or avoidant behaviour
- A nervous system shutdown response may be difficult to detect because at first glance, the student is quiet and may seem to be working. On closer inspection they are sitting quietly, unable to ask for help, or indicate that they need to leave the room, and they won't be able to complete work.

Schools who use traditional behaviour management in the absence of knowing about nervous system regulation tend to position behaviours of concern, (which often stem from student distress), as a problem for the teacher or the class or the school. If a student receives a sanction for behaviour that is inconvenient to others, then there is a good chance that the student's stress load is increased by the imposed consequence, and the underlying circumstance that led to that students' behaviour, and their feelings of distress, remain unaddressed.

50% of SC Survey-22 respondents identified a focus on behaviourist practises as problematic for their young person. 47% identified school behaviour management as an issue. Exclusionary discipline is also problematic (26%), with 16% nominating exclusion from school activities as contributing to their child's difficulties in attending school.

Focussing on behaviours of concern distracts staff from recognising and responding to underlying student distress. Behaviours of concern should be treated as signals of student distress. Models like Collaborative and Proactive Solutions draw attention to the antecedents to behaviour. Self-Reg aims to identify and reduce a student's stress load and thereby improve self-regulation. Both are of huge benefit in assisting staff to understand and identify student distress and to create a sense of safety.

Collaborative Proactive Solutions helps school staff avoid misunderstandings and assumptions about behaviour. It encourages adults to be curious about the student's perspective and to collaborate with the student to find solutions. Students feel heard and validated in response and misunderstandings about behaviour are less likely. See our discussion about Milton's Double Empathy Problem (2012) in section 12.

10.1.3 Masking

Most children don't like to stand out as different. Masking was nominated by 67% of SC Survey-22 respondents. Masking is the name given to the act of camouflaging one's differences. It involves the suppression on one's natural tendencies and conscious modification how one presents in order to fit in. Masking behaviour is more common in autistic people than non-autistic people (Jedrzejewska & Dewey, 2021).

School Can't (SPSR) Australia recommends that attention is paid to creating school cultures which value diversity and make room for difference so that students can feel that the person they are is valued unconditionally and that they have space to be themselves. In the past many aspects of autistic presentation and ways of being, have been portrayed as wrong by our society. Research and therapies have been aimed at normalisation of the autistic person. Cultural beliefs about disability and difference have led to spoken and unspoken rules about how to be, and have been applied to things like: the way autistic children play, the way autistics socialise, and the way they move. Neuro-normative rules impact the way children are expected to be in a classroom: sit still, eyes on the teacher when they speak, raise your hand and wait to speak. These all assume every student has the same capacity for the prescribed behaviour. "Whole Body Listening", is an example of a neuro-normative set of expectations/rules about how children should conduct themselves in class. Its use has led to shaming of autistic children in front of their non autistic peers for things like lack of eye contact and difficulties sitting still. Whole Body Listening has recently been overhauled by its creators as a result of input from neurodivergent people. The "Meet Bumper: a Whole Body Learner" resource, from Autism Level Up, also offers an alternative more neurodiverse affirming approach to the original "Whole Body Listening" resource (Fede & Laurent, 2022).

The need to mask impacts a child's sense of belonging. As Brené Brown (2010) says, "*Fitting in is about assessing a situation and becoming who you need to be to be accepted. Belonging, on the other hand, doesn't require us to change who we are; it requires us to be who we are*".

Masking can also interfere with a student's ability to meet or advocate for their own needs. For example: supressing stimming behaviour due to concerns about the way this behaviour appears to others results in difficulty with self-regulation. Another example of masking might be where a student avoids asking for, or using an accommodation or adjustment, due to fears of being identified as being different. These are examples of how masking adds to a student's stress load by cutting off avenues to reduce, avoid or recover from stress.

Masking is implicated in poor mental health (Cage & Troxell-Whitman, 2019, Ross, Grove & McAloon, 2023, Bernardin, Lewis, Bell & Kanne, 2021).

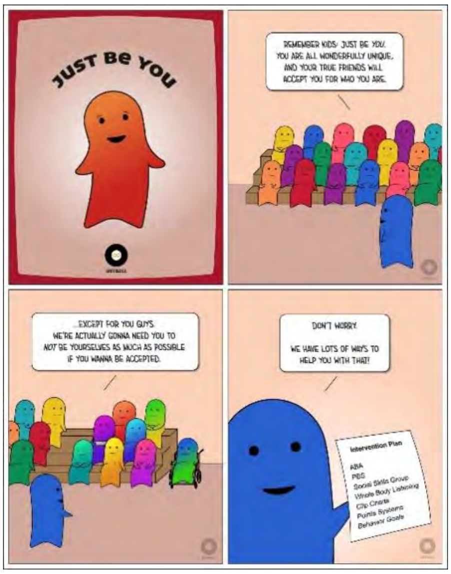


Figure 15. Just Be You.

Comic by Autball

Downloaded from https://www.facebook.com/autball1/photos/pb.100082207851890.-2207520000./126561146753655/?type=3

Permission to use obtained

10.1.4 Sensory Sensitivities

Sensory acoustics were nominated by 60% of SC Survey-22 respondents as problematic for their child or young person and were discussed in the open ended questions on things that could prevent school can't, help students experiencing school can't and re-engaging in learning (see Appendix 19.4 for more). Auditory hypersensitivity is common in autistic children. (Tomcheck & Dunn 2007). Many children experience discomfort or pain in environments where non autistic children deem the noise level to be acceptable.

Trauma itself, can also cause difficulties in sensory processing. Sensory triggers can serve as a reminder to traumatic experiences. (see ACT Government Community Services, 2021)

While aides such as noise cancelling headphones which reduce noise levels for an individual person can be used, consideration should be given to solutions that don't single out individuals such as:

- Design and construction of school buildings to dampen noise,
- providing quiet spaces where students can take a break,
- smaller class sizes, staggered locker times
- planning adjustments for the child at whole school events or excursions that may be particularly crowded or noisy such as sports carnivals,
- Being aware of noise levels for band practise and emergency drills.
- Adjustment of the school intercom to not be too loud.
- Fitting toilet blocks with paper towels, instead of hand dryers.

Often accommodations like the examples listed above benefit all students and lower the stress levels of everyone.

Other sensory difficulties nominated by parents had to do with the school uniform (44%), the climate (27%), the lighting (26%) and visual clutter in the classroom (23%). Smell was also mentioned in response to our open-ended question. We would suggest that schools:

- Consider relaxing or even abolishing uniform requirements so that children can feel comfortable when they learn and play at school, and do not have to endure a uniform that is an uncomfortable distraction.

- Minimise the use of fluorescent lighting in schools and classrooms, using natural light were possible.
- Allow students to wear visors, hoodies or sunglasses that shield the eyes, indoors.
- Minimise visual clutter.
- Consider adopting fragrance free and low fragrance soaps and cleaning agents for use in the school and recommending that staff and families use fragrance free and low fragrance personal products.

> "Encouraging and supporting them, not punishing them for things that don't really matter. Understand that the uniform is a problem for some kids - and don't implement stupid rules like "if you are not wearing the correct uniform you have to wait at the canteen until everyone else has been served". In 10 years time, it won't matter whether they wore the correct uniform, but it will matter that they were punished and made an example of in this way."
>
> *Respondent in SC Survey-22*

It is evident to many parents of neurodivergent children that mainstream environments are frequently overstimulating and distressing for our young people. Children are often excluded for distress behaviour or self-exclude by refusing. Self-exclusion occurs when a student imposes a boundary of their choosing for their own protection from discomfort. Research is needed to determine how school environments can be made more accessible for students with sensory processing challenges without resorting to segregation.

The concept of sensory trauma supports this. This concept is derived from lived experience testimony, that unpleasant and overwhelming sensory experiences are a threat that occur frequently and unpredictably in ordinary everyday life. These experiences are often hidden to non-autistics as they derive from differences in experiencing the world. (Fulton, Reardon, Richardson & Jones, 2020)

It is good practice to give a child agency in the supports they use, rather than simply imposing them. There may be reasons why a child may not want to use supports, such as standing out as different to their peers, or due to a conflict with another sensory need, or it could be that their needs have been misunderstood. Occupational therapists can assess a student in their school environment, to make recommendations for sensory supports and accommodations that may benefit the student. Students however are frequently the experts in what feels safe to their nervous system and their perspective should always be sought and validated.

10.1.5 Problems with School Work

Many parents/carers reported in SC Survey-22 that their children struggled with schoolwork. The reasons for this were varied (refer Table 16). The most common problem nominated by parents was that the work is not of interest (64%), another 62% reported that their child has difficulty with attention or focus.

Parents/carers report that building schoolwork around student interest (e.g. interest based or self-directed learning) increases intrinsic motivation, helps students to focus, and increases the likelihood that students will engage with their learning. Parents report that students with ADHD, Autism and PDA are particularly benefited by this approach and this is often the approach taken by parents who turn to home schooling to enable their child to engage with learning.

> "Less assessment. Less time pressure. More choice. Time for creative and deep learning."
>
> *Respondent in SC Survey-22*

Difficulties impacting student engagement with school work:	%

Work not of interest	64%
Difficulty with attention or focus	62%
Difficulty with executive functioning	57%
Difficulty with a specific subject or type of work	54%
Execution of the curriculum	54%
Processing speed difficulty	49%
Difficulty with group work	45%
Difficulty remembering things	42%
Inadequate movement breaks	36%
Lack of explicit instruction	34%
Early experience of learning failure	32%
Work too hard	26%
Difficulty accessing disability friendly textbooks, online content and handout	21%
Work too easy	17%
Curriculum not culturally responsive	10%

Table 16: Difficulties impacting student engagement with school work

Interest based learning takes advantage of hyperfocus, often reported as a feature of ADHD (Hupfeld, Abagis & Shah, 2019) and attention tunnels in autism (Murray, Lesser, & Lawson, 2005), wherein autistic people are able to concentrate for long periods of time on topics of interest.

Interest in learning, may also be impacted by a child's nervous system state. If their brain and body is in survival mode or busy processing an adverse experience they will not have capacity to focus

57% of survey respondents indicated that difficulty with executive functioning was impacting their school-can't child or young person. Executive functions consist of thinking skills and cognitive processes that help a person to plan and follow through to achieve their goals. Executive functions include paying attention, working memory, self-control and the ability to problem solve. They impact a person's capacity to plan, organise and sequence ideas, tasks or belongings, to prioritise, to initiate or complete tasks, control impulses and focus (Psychology Today Australia, 2023).

Individuals with ADHD and Autism frequently experience impaired executive functioning. (ADHD and Executive Function - Barkley, 2010), (Autism: Lai et. al, 2017). Given that 58% of our SC Survey-22 cohort had a diagnosis or suspected diagnosis of ADHD and 66% of the cohort had a diagnosis or suspected diagnosis of Autism, it is not surprising that impaired executive functioning was listed by d 57% of parent/carers as impacting their child's school can't. Students with Autism and ADHD require executive function supports to be built into their learning plans and provided in order to help them access the curriculum and demonstrate their learning.

54% of respondents indicated that difficulty with a specific subject or type of work was a problem for their child. While this may be related to interest, it could also be related to: how well a child gets along with a subject specific teacher, a gap in subject specific learning, or to a specific learning disability directly impacting that child's ability to understand and process the subject matter (input related difficulties), or to respond to or action a learning task (output related difficulties). While a gap in subject skill or knowledge may be addressed with tutoring for example, those relating to a learning difficulty will require targeted supports and accommodations.

Execution of the curriculum was nominated by 54% of respondents as a stressor impacting school can't. The way a subject is taught directly impacts a student's ability to engage with the content. It is not exactly clear to the researchers what the unmet needs are in relation to this however the following related stressors may shed further light:

1. 34% of SC Survey-22 respondents indicated that a lack of explicit instruction was a stressor for their school can't child. School Can't (SPSR) Australia is aware that some students have specific types of requirements in order to engage with the curriculum and demonstrate learning. Students with learning difficulties impacting their reading and writing for example, require a program including structured synthetic phonics. Many students with executive function difficulties benefit from step-by-step instructions. The "I do, We do, You do" learning model is an example of an evidence based teaching model that includes explicit instruction, modelling, scaffolding and repetition to support student learning (Killian, 2023).
2. Difficulty with group work was nominated as another stressor by 45% of survey respondents. No longer are many classrooms set up with rows of desks facing the front of the classroom with students engaging in solitary study and receiving instruction from the teacher. Working and collaborating in groups is something that is encouraged in many schools however, many students struggle with group work. These students may benefit from more independent work or increased support from the class being supported to learn how to help the child feel included and valued as a group member.
3. Processing speed is the amount of time it takes for someone to process and understand some input prior to responding to it. 49% of respondents nominated processing speed as a stressor for their children. These students find that timed tasks requiring them to think and respond quickly are very stressful and pose a barrier to them being able to demonstrate their learning. Many students with slower processing speed also find that the classroom just moves too fast for them. They try to participate in classroom discussions for instance but by the time they have processed what others have said and thought about what they want to say or ask the discussion has moved on. They take longer to produce work and lament never being able to finish things. They have lower output and feel frustrated that there is never enough time. They frequently feel left behind and need the pace of instruction, and discussions to slowed down in addition to being asked to do fewer tasks compared to their peers.

10.1.6 Structural Stressors:

Structural stressors refer to stressors that are caused by the way that school is organised and operates. SC Survey-22 asked parents/carers whether structural issues such as the length of school day, early start times or the number of transitions or learning periods in a day impacted their child's ability to attend school. 61% of parents/carers indicated that the length of the school day impacted on their child's school can't. 51% indicated that the number of transitions /periods in a day impacted their child's school can't and 46% indicated that early start times were a source of stress. (See Table 17).

Table 17: SC Survey-22, School Based Structural Stressors

School Based Structural Stressors:	%
Length of school day	61%
Number of transitions / periods	51%
Early Start times	46%

Overall length of school day was the 10th most common stressor that parents/carers indicated had impacted on their child's school can't. Many of our school can't children are finding the school day simply too long. High stress levels expend more energy. Those for whom school is stressful find the school day too long. They come home and collapse. Many of our school can't children also have trouble sleeping due to anxiety creating a cycle of exhaustion that is relentless.

Sleep disturbances are reported in conditions such as anxiety (Cox et al. 2020), autism (Morgan et al., 2020) and ADHD (Becker et al., 2020).

Autistic burnout, (discussed in autistic culture), is only recently being considered by researchers. This refers to a state of chronic exhaustion (due to cumulative stressors), resulting in lack of ability to carry out learned skills and a reduced capacity to tolerate stimuli (Raymaker et al., 2020), withdrawal and reduced capacity to think and an amplification of Autistic traits (Higgins et al., 2021). Autistic burnout is thought to be a result of masking and the stress associated with living in a neurotypical world (Higgins et al., 2021).

Furthermore, adolescent sleep schedules are different to those of children and adults, with many preferring to go to bed later and wake up later. In Australia, however, school hours are organised around adult sleep wake times. Kelly (2018) suggests that high school start times be adjusted to a later start time, taking adolescent sleep schedules into account. Early start times were nominated as a school-based stressor by 46% of the SC Survey-22 sample.

The number of transitions during the day was nominated as a school-based stressor for 51% of survey respondents. Transition from one activity to another (Macdonald et al., 2018) or from one educational environment to another (Tso et al., 2017) are known stressors for many autistic students.

Difficulty with transitions can also be linked to processing speed and executive functioning difficulties. The amount of time and energy required to get set up and start working on something for a student with executive functioning difficulties is longer than for their peers. Children who need longer to think about things also find frequent transitions to be stressful.

Other structural stressors such as lack of flexibility to accommodate student need have been covered in other sections.

10.1.7 Universal Supports or Individualised Supports? Both Please!

64% of SC Survey-22 respondents indicated that the practice of placing responsibility on students to change instead of providing support to the child, contributed to their child's difficulties with attendance. Asking a student with a disability to change their ways of being and doing, to fit the established ways that things are done, is not inclusive practise. Inclusion must incorporate both reciprocity and responsivity to need. This requires innovation, flexibility, and sometimes requires a re-evaluation of educational goals and the routes taken to achieve them. We must consider how we can change our systems, environments, pedagogy, processes, and attitudes to be accessible and welcoming of those with diverse needs. Collaboration with parents/carers and children and people with lived experience is a vital part of reimagining education. True inclusion is immersive.

59% of SC Survey-22 respondents nominated a lack of or poorly conceived reasonable adjustments. 58% nominated a lack of individualised supports and planning for their child. 55% nominated lack of staff informed about disability needs. These statistics reflect a lack of understanding about how best to address diverse or complex needs, pointing to a need for additional teacher training in disability support or specialist mentoring to support teachers in supporting the neurodivergent/disabled student. A lack of poorly conceived adjustments, and lack of individualised supports may also be a result of a lack of collaborative and cooperative practises that value input from the parent, child, and allied health team, as partners in problem solving barriers to access. See Table 18.

Table 18: Percentage of School Can't Students who Experienced

Difficulties involving disability supports	%
Placing responsibility on student to change instead of providing support to the child	64%
Lack of or poorly conceived reasonable adjustments	59%
Teacher/School Expectations	64%
Expectations of Self	64%
Lack of individualised supports and planning	58%
Lack of flexibility to accommodate student need	56%
Lack of staff informed about disability needs	55%

56% of SC Survey-22 respondents nominated a lack of flexibility to accommodate student needs as a problem. Is this a reflection of teacher stress, or lack of time and headspace for curiosity and innovation? School Can't (SPSR) Australia recommends an urgent review of stressors impacting teachers. Reducing teacher stress will create the conditions within which children and young people with disability can have their needs met.

School Can't (SPSR) Australia encourages curiosity about barriers to inclusion:

- Is there a support need that is beyond what the teacher is empowered to provide? Is more funding required or does a resource simply need to be requested but its availability wasn't known?
- Are there concerns that if we give the student this one thing, then everyone will want it? Equity does not mean equal. It means giving everyone what they need to be successful.
- Do we need to rethink the notion of success? Who determines what success looks like? Is it OK for success to be pursued at the expense of wellbeing?
- Are beliefs about strong boundaries and being consistent at odds with meeting a child at their point of need and capacity?

64% of SC Survey-22 respondents indicated teacher/school expectations were a source of stress, and 64% nominated student's expectations of self as a stressor that contributed to school can't. A child with a disability or anxiety or one whose been through a difficult experience, may experience barriers to meeting classroom or school expectations, or may have internalised ideas of what they should be able to do, that are contrary to their true needs or are outside their current capacity. The following example is from our open-ended responses.

"The school practiced whole body listening, where the students needed to sit cross legged on the floor, hands in lap and eyes on the teacher… Our child has Joint Hypermobility Syndrome and would benefit from being able to shift positions to avoid pain. Our child was worried for being told off and would sit like a statue."- Parent of School Can't child, from SC Survey-22.

Strong boundaries are of no help to a child who cannot meet an expectation in the first place, or cannot meet the expectation without great cost to the self. Schools must be willing to let go of the established way that things are done and to rethink them in our new collective circumstance. They must ask how do we need to change things so that inclusion can happen? How can we create a space wherein different ways of doing and being are considered perfectly acceptable? Schools must consider having supports available for anyone to use, to normalise their use.

We need conversations that clarify expectations, generate adjustments to expectation, and expose expectations as unrealistic. We have to be prepared to put some expectations on the back burner for now, as others take priority. Collaborative and Proactive Solutions is a great model supporting these types of discussions.

Not all children are diagnosed with their disabilities when they enter a classroom. Universal supports, help to proactively meet the needs of students whether they have a diagnosis or not and reduce the need for individualised supports.

Not all supports will work for all children but universal supports at a Tier 1 Response To Intervention (RTI) will reduce the need for more individualised supports at Tier 2 & 3 RTW. Supports conceived at all levels, tier 1-3 work best when they have been identified collaboratively. Problems identified and solved collaboratively with students mean the student is more likely to elect to use a support, compared with when an adult has imposed a solution on a child.

10.2 School Based Stressors – COVID related:

Key concepts:

- COVID-19 did bring a range of additional school-based stressors related to unpredictability, interrupted routines, transitioning back to the classroom, meeting remote work expectations, lack of contact with peers, and missed learning.

A worldwide pandemic (COVID-19) has impacted our lives in many ways. It has for many been a very stressful experience and has impacted on the mental and physical health of large numbers of people. School Can't (SPSR) Australia sees school can't as a response to stress. COVID has inarguably increased community and student stress. It is therefore not unexpected that it has contributed to the experience of school can't for some students. COVID has increased stress across the whole education system, impacting schools at all levels.

In SC Survey-22 we presented respondents with a list of possible COVID related stressors. Parents/carers were asked to indicate which COVID related stressors had impacted their child's school attendance. (See Question 43 SC Survey-220). An overview of responses to this question can be seen in **Figure 16** below.

The six top responses (seen in Table 19) indicating a stressor had impacted on their child's attendance included: Increased unpredictability, this negatively impacted attendance for most young people (59%), followed by interrupted routines (60%), difficulty transitioning back to face-to-face learning (54%), meeting the expectation to work independently during remote learning (54%), lack of contact with peers (46%) and difficulty due to missed learning (45%).

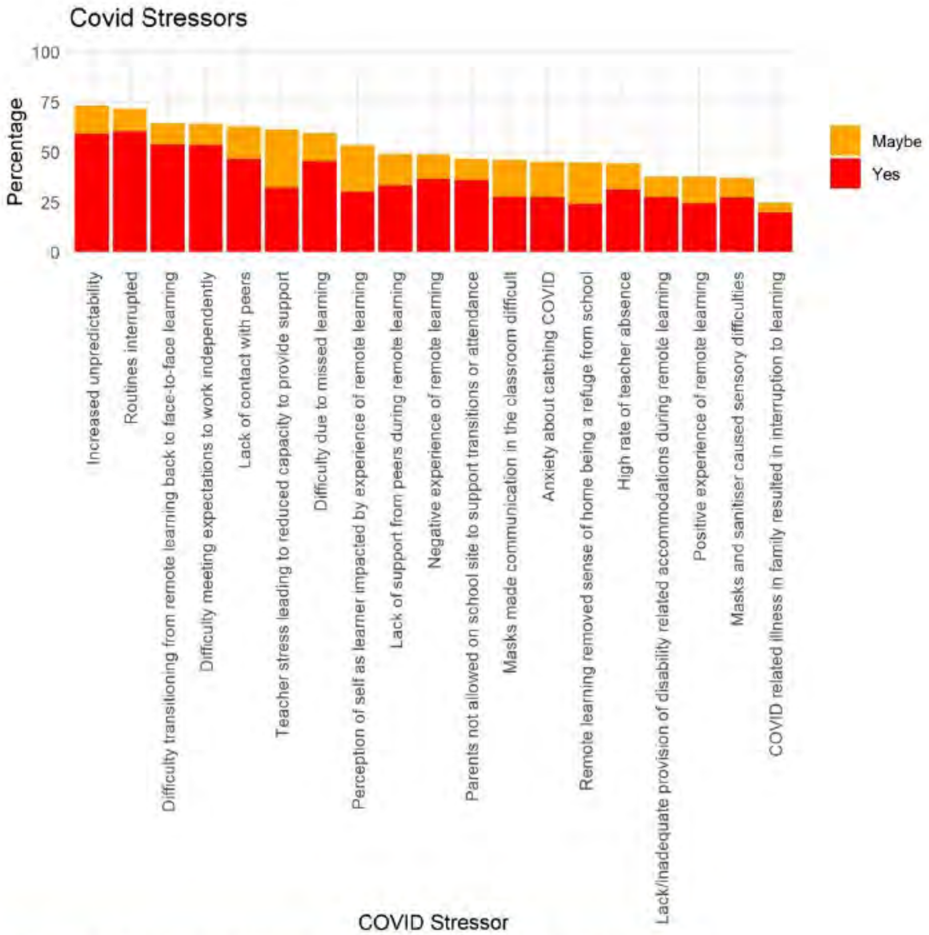


Figure 16: SC Survey-22 COVID related Stressors impacting School Can't

Table 19. Top 6 COVID 19 specific education related stressors impacting school can't experience.

Covid 19 Specific Education Related Stressors:	% impacted on school can't
Routines interrupted	60%
Increased unpredictability	59%
Difficulty transitioning from remote learning back to face-to-face learning	54%
Difficulty meeting expectation to work independently	54%
Lack of contact with peers	46%
Difficulty due to missed learning	45%

In relation to the impact of remote learning: 37% of respondents noted that remote learning had a negative impact on attendance, whilst 24% that remote learning had a positive impact on attendance. This is consistent with findings that some students preferred remote learning to face to face learning due to fewer distractions, and the reduction in social pressures.

Table 20. Perception of remote learning and impact on school can't.

Perception of remote learning experience:	% impacted on school can't
Negative experience of remote learning	37%
Positive experience of remote learning	24%

Other impacts were attributed to:

Table 21. Other COVID-19 specific education related stressors impacting school can't.

Covid 19 Specific Education Related Stressors:	% impacted on school can't
Parents not allowed on school site to support transitions or attendance	36%
Lack of support from peers during remote learning	33%
Teacher stress leading to reduced capacity to provide support	32%
High rate of teacher absence	31%
Perception of self as learner impacted by experience of remote learning	30%
Masks made communication in the classroom difficult	28%
Masks and sanitiser caused sensory difficulties	27%
Inadequate provision of disability related accommodations during remote learning	27%
Anxiety about catching COVID	27%
Remote learning removed sense of home being a refuge from school	24%
COVID related illness in family resulted in interruption to learning	20%

Recommendation 33: That state and territory DOEs be required to proactively develop an emergency plan for students with disability, involving funded supports and creation of resources, should remote learning be required again. The nature of these supports and resources should be developed in consultation with students with disability and their parents and carers, and should reflect feedback about recent past experiences of remote learning. This will reduce the experience of remote learning as a stressor which impacts a students' ability to engage with learning and their perception of themselves as a capable learner.

10.3 Family And Non-School Stressors Impacting School Can't

Key concepts:

- There are a wide range of stressors which impact children and young people both directly and indirectly through the family unit. It is important to consider how we as a society support families when they experience stressful events.

We asked SC Survey-22 parents/carers in Question 45 if there have been family and personal impacts outside of the school environment (excluding disability or the child's mental health), that have impacted their child's school can't? (e.g. loss of a family member, parental illness, impacted by natural disaster). 36% (see Table 22) of respondents answered yes to this question and provided heart breaking details of a wide range of stressful situations in their open-ended responses including: parental separation, divorce, domestic violence, relocation, death of family members, suicide of family members, loss of a pet, friends moving away, parental or sibling ill health or injury, parent/sibling mental health difficulties, adoption, contact from birth family, house damage and flooding, parents/siblings with disability, impact of other siblings also going through school can't, parental alcoholism, parental trouble with police, house broken into, financial stress due to job losses leading to a house sale, floods, storms, threat of bush fires, court appearances and impact of family court orders. A few respondents mentioned impacts related specifically to COVID 19, such as COVID related parental loss or illness.

Table 22: Have Family / Personal factors Impacted Child's School Can't

Have there been family and personal impacts outside of the school environment ?	
Response	**Percentage** (*n=400*)
Yes	36%
No	64%

The list above highlights that there are a wide range of stressors which impact children and young people both directly and indirectly. Parents, and children are closely linked and the wellbeing of one impacts on the wellbeing of the other. Likewise, the wellbeing of siblings also impacts the wellbeing of other siblings in a family. It is important to consider how we as a society support families when they experience stressful events especially in light of epidemiological research about Adverse Childhood Experiences and the impact these have been shown to have on long term health and wellbeing of individuals (Hughes et al 2017).

Recommendation 34: That state and territory Departments of Health improve access to mental health services that specialise in trauma recovery. Current access to psychological care through the Better Access to Mental Health Care initiative is inadequate to meet the needs of those with PTSD and to care for those that live with or care for them. Trauma impacts more than just the individual who experienced the trauma. Long term impacts on mental health and physical health of untreated trauma and PTSD are concerning.

11. Disability as a risk factor for School Can't – Autism and ADHD

Key concepts:

- SC Survey-22 results indicate that disability is a significant risk factor for experiencing school can't—73% had a confirmed diagnosis and a further 10% were suspected or seeking diagnosis.
- Autism, including the PDA presentation, and ADHD were the most significant diagnoses. These were followed by sensory processing disorder, academic giftedness, specific learning difficulties (eg dyslexia, dysgraphia, dyscalculia), and auditory processing disorder.

SC Survey-22 results indicate that disability is a significant risk factor for experiencing school can't. School Can't (SPSR) Australia believes that students with a disability carry a much higher burden of stress connected to being in school environments that are not inclusive of them or responsive to their needs. This is evidenced by the number and range of difficulties/stressors nominated by parents/carers as having impacted their child's experience of school can't (see Section 10.)

Sadly, the prevalence of children with a diagnosis within our parent/carer cohort is so common that it is one of the first things parents/carers are encouraged to consider when they first join our group looking for assistance. Many parents/carers are first learning about ADHD or Autism from hearing other parents talking about the difficulties their child has experienced at school.

- Of a total of 912 diagnoses reported by respondents to the SC Survey-22, 55% were diagnosed prior to onset of school can't. The remaining 45% of diagnoses were received subsequent to school can't commencing.
- **73% of students in the sample had a confirmed diagnosis, with an additional 10% of parents seeking diagnosis or suspecting a diagnosis.**
- The mean and median were 2 confirmed diagnoses with a range of 0-8 diagnoses.
- Most diagnoses were for ADHD and autism (including Asperger's and PDA). 77% of school can't children had a confirmed or suspected diagnosis of one or more of Autism, Autism with a PDA presentation or ADHD.
- 27% of school can't students in the survey sample did not have a diagnosis, however parents/carers indicated that 10% suspected or were seeking a diagnosis.

The most prevalent number of school can't students with diagnoses or suspected diagnoses were: Autism (total including Aspergers and PDA) 66%, ADHD 58%, Autism with PDA traits 38%, Sensory Processing Disorder 33%, Academically Gifted 23%, Specific Learning Difficulty (such as: Dyslexia, Dysgraphia and Dyscalculia) 22% and Auditory Processing Disorder 17%. See Table 23.

47% of the school can't population had a diagnosis or suspected diagnosis of autism (not including those with a PDA presentation) **as well as** ADHD. 27% had a diagnosis of autism with PDA traits as well as ADHD. Only 19% of respondents had a diagnosis or suspected diagnosis of autism but did not have a diagnosis or suspected diagnosis of ADHD. 22% of the population with a diagnosis or suspected diagnosis had a diagnosis or suspected diagnosis other than autism or ADHD.

The SC Survey-22 cohort had a very large number of students who have or are suspected to be autistic and or have ADHD. 77% of the school can't students whose parents/carers completed the survey had one or more diagnosis of autism, autism with PDA, or ADHD.

Table 23: SC Survey-22 Percentage of School Can't students with a Diagnosed or Suspected Disability by Disability Type

Disability diagnosed or suspected	Percentage
ADHD	58%
Total Autism	66%
Autism with PDA	38%
Sensory Processing Disorder	33%
Gifted Academically	23%
Specific Learning Difficulty	22%
Auditory Processing Disorder	17%
Dyspraxia	8%
Communication Disorder	7%
Developmental Language Disorder	5%
Physical Disability - Mobility	4%
Motor Disorder	3%
Intellectual Disability	2%
Tourettes	2%
Physical Disability - Vision	2%
Physical Disability - Hearing	1%

Table 24: Autism and ADHD: Most Common Combined Presentations

Disability diagnosed or suspected	Percentage
One or more of: Autism, Autism (PDA), ADHD	77%
Autism (not PDA) + ADHD	47%
Autism (PDA presentation) + ADHD	27%
other than either Autism or ADHD	22%
ADHD but autism not diagnosed or suspected	22%
Autism but no ADHD diagnosed or suspected	19%
Autism and gifted	19%

Whilst there are other sources of stress (aside from those related to the disabled student's experience of school) such as COVID related stressors and stress experienced within the context of families and the home environment, it is evident from our research that a student's disability status places them at significant risk of experiencing school can't. This should not be the case.

It is clear that the education needs of this cohort are not being met by schools and that they are exposed to chronic stress in the school environment which impacts their sense of "felt safety". Refer to earlier discussion regarding school based stressors (10.1) and universal supports (10.1.7).

An inherent tension exists in the inclusive education paradigm surrounding the needs of school can't children. Many school can't children and young people need predictable environments, that are quieter, have fewer people, less busyness, reduced demands, fewer transitions, increased agency and autonomy, learning that follows interests (facilitating flow), and a lot more flexibility and freedom to be themselves, than our current mainstream system typically provides. The school-based stressors identified in response to SC Survey-22 reflects this. Stress results in reduced productivity, and in the long-term mental health difficulties. The drive for efficiency and throughput in education is generating casualties.

> "We need more SMALL, alternative schools, which offer a less overwhelming environment for kids with these issues. There are so FEW options that these kids have no choice but massive schools. To attend the few alternative schools they have to be on a wait list and I have to give up working to drive them across town to get them there. And - then they feel they are in a "weird" school and feel excluded from normal life because these schools are so rare they're not seen as "normal" to a teen. We need many more alternative schools run by the state govt so that kids everywhere have other options."
>
> *Parent /carer in SC Survey 22*

The current segregated system is at odds with the notion of inclusion. Many environments claim to be inclusive but they conflate accessibility with inclusion. Supports should be available to anyone who feels that they need them. Inclusion means everyone is welcome and catered for. A segregated system has rules on who can go where. Gatekeeping results with schools deciding who is welcome and who they are willing to cater for. Students fall between the cracks in such a system, finding themselves with no school willing or able to take them.

Education environments characterised by centralisation and homogeneity, (large schools that have many students all providing a similar style of education), typically don't provide the low demand, low sensory overwhelm, low distraction, low transition environment that school can't children need. Consequently, children must use ear defenders and visual schedules to counteract the disabling features of a larger, noisier, crowded, high pressure educational environment. School can't children may benefit from a more geographically distributed model, with several additional smaller schools and smaller class sizes, providing different styles of education.

Unfortunately, disabled students are frequently viewed through a deficit lens. They are perceived as being the problem. Those who perceive the child's disability as being the problem are unlikely to consider that the problem is actually a failure of a school or education system to support inclusion. Students with disability generally desire inclusion. Amongst parents/carers there is a tension between desiring inclusion on the one hand and the reality that inclusion is still but a dream and not yet reality. The suffering of their children as a result of poor inclusion often leads parent/carers to desire disability specific places of education or to seek alternative education contexts where their children might experience safety.

Also see related recommendations above:

- Recommendation 9: regarding diagnoses and supports,
- Recommendation 13: regarding funding home-school supports and cost of living,
- Recommendation 14: regarding funding silos between education, health and disability,
- Recommendation 16: regarding transition supports bridging education, health and disability,
- Recommendation 17: regarding complaints, advocacy and mediation,
- Recommendation 18: regarding a review of student support needs,
- Recommendation 20: regarding data collection when enrolling or terminating an enrolment with an education provider,
- Recommendation 27: regarding alignment of state and territory law with human rights obligations to provide an inclusive education,
- Recommendation 28: regarding training and upskilling teachers in inclusive practise,
- Recommendation 29: regarding training and upskilling teachers in disability and cultural awareness around disability,
- Recommendation 30: regarding proactive disability support planning for remote learning.

Recommendation 35: That State and Territory DOEs acknowledge and provide for the needs of students whose nervous systems require: smaller schools, smaller classrooms, buildings that are designed and outfitted to account for sensory needs, pedagogy that accommodates interest based or self-directed learning, no uniforms, shorter days, later start times in secondary schools, low demand and low arousal environments in order to maintain student wellbeing and capacity for learning.

12. Power Imbalances, Cultural Beliefs, and Frameworks of Understanding

Key concepts:

- Power imbalances impact on the relationship between young people and their parents/carers, as well as between parents/carers and those who are attempting to gain compliance, intervene or assist (eg educators, clinicians and authorities)
- School can't is complex and can only be understood through a collaborative approach that involves parents/carers and students.
- Ableism contributes to the experience of school as a trauma for the child with a disability or for the child with school can't.
- Blame and shame culture when students don't fit the system, causes more stress for parents/carers and children, and impacts on attachment and help seeking.

In order to reduce the occurrence of school can't and improve supports for those students experiencing it and their families, it is first necessary to acknowledge and understand the impact of:

1. **Power imbalances** between children/young people and their parents/carers in the first instance, and then also between parents/carers and those who are attempting to gain compliance, intervene, or assist, such as educators, clinicians, and authorities.
2. **The need for shared understandings**. Without shared understandings we cannot collaborate. Without shared understandings we cannot agree on the nature of the problem let alone agree on a solution.
3. **The pervasive nature of and influence of cultural beliefs about disability, mental health, mothering, childhood, behaviour and education.**

Power imbalances can dismiss the voice and experience of the parent and overlook the voice of the child/young person. This results in a failure to understand the nature of their experiences, and results in a subsequent failure in identifying the nature of the problems they experience. Research seeking to understand school attendance difficulties in the past has focused on within child and within family factors and has neglected to explore within school factors. Interventions have emerged from this skewed knowledge base which have had limited effectiveness as a result of missing key information and understandings about the very nature of the problem.

Educators are experts in school-based education. Knowledge and skills required in the field of education is wide, new knowledge is emerging. No educator can be across all aspects of this discipline. The same can be said of clinicians working in fields such as mental health and disability. Each discipline knows what it knows and doesn't always know what it doesn't know.

Parents/carers are experts on their own children. They observe and support their children throughout their education, while their children move in and out of new schools and classrooms, and as they progress through their schooling. Knowledge about parenting is gained from the experience of being parented as a child, from cultural messages about parenting, from our lived experiences of parenting, and from observing peers parenting their children, in addition to more formal learning from books, podcasts and seminars etc. Parents/carers also know what they know and don't always know what they don't know. Parents/carers are, however, the constant in the child's life. They provide a safe landing place and see the child without the mask they wear at school.

Only when parents/carers along with their children and young people are given a position at the table as equals, will we truly be able to collaborate to identify the barriers to school attendance, experienced by children and young people. Only then will schools be able to understand the adjustments, supports and accommodations, required for that child and the circumstances of their difficulties.

The reality is that parents/carers frequently find themselves being told. Being **told** how their child should respond, being **told** that the problem is them and their parenting, being **told** that their child is misbehaving, being **told** all the ways their child should be different: more resilient, less anxious, work harder, pay attention, sit still, attend more. They feel unsafe and unable to share their knowledge as a parent due to the power imbalance and failure of the experts to recognise and value their lived experience knowledge.

Frequently, parents/carers find themselves under scrutiny for their parenting due to their children's difficulties attending school and due to the child's distress.

Parents/carers often change their way of parenting, incorporating new knowledge to parent their children. The way a parent/ carer parents their neurodivergent or school can't child, can look quite different to typical parenting. This leads to being judged by educators and clinicians and others in positions of authority and often the parenting style is blamed for the problem.

The use of rewards and consequences to shape children's behaviour for example, has been found by many parents/carers of neurodivergent children to be ineffective and to add to the child's distress. Many parents/carers have moved away from thinking that the behaviour itself is the problem, to thinking about the antecedents to behaviour and how we can address these with the help of our children in a supportive relationship, that fosters trust and empowers our children to work through the problems they face, with help from adults and their social networks. Parents find that the solutions to problems are more likely to be successful because they have addressed the underlying issue and the child has had agency in arriving at the solution.

Figure 17. Outnumbered? (Used with permission).
Source: https://cdi.uvm.edu/islandora/o=bject/uvmcdi%3A104936/datastream/OBJ/view

Children have the least amount of power across the contexts of school, family and the therapy office. Neurodivergent children frequently find it difficult to feel safe when power is used over them. Children are subjected to rules within their family and to laws which mandate school attendance with no power to vote or choice over whether they attend or not. Children's perspectives are impacted by their age and prior experience, and they often have difficulty understanding adult perspectives. Adults don't necessarily see the child's perspective either, particularly if neurodiversity is involved.

The Double Empathy Problem posits that experiential differences between autistic and non-autistic people may result in lack of empathy for the other which contributes to misunderstandings (Milton, 2012). These misunderstandings can be simple, for example:

1. A teacher observes a child is wriggling. They conclude the child is misbehaving and not paying attention. But seen from the child's perspective—her chair is in direct sunlight and she is hot and uncomfortable in the sun and can't concentrate.
2. A child is greeted by the teacher with "How are we feeling today?". The child doesn't reply. The teacher thinks the child is being rude or has not heard. But seen from the child's

> perspective — she doesn't know how to respond to this collective question because she does not know how the other person is feeling or how to identify and articulate her own emotions. (Examples adapted from Beardon, 2021: Chapter 2 & 1).

The Double Empathy problem highlights the need for people in positions of power to be curious, to listen and to work hard at hearing the voices of lived experience in understanding and solving problems. Collaborative and Proactive Solutions (Greene, 1998) is respectful to the voice and agency of children, using shared power rather than "power over" to address the barriers and stressors experienced by students.

"Regulatory Supports NOT behaviour supports. Collaborative and Proactive Solutions (Dr. Ross Greene). Stop shaming practises in schools such as writing children's name of the whiteboard when they are struggling."

Parent /carer in SC Survey 22

Children with disability and their parents are impacted by ableism.

> "Ableism is a set of beliefs or practices that devalue and discriminate against people with physical, intellectual, or psychiatric disabilities and often rests on the assumption that disabled people need to be fixed in one form or the other. Ableism is intertwined in our culture due to many limiting beliefs about what disability does or does not mean, how able-bodied people learn to treat people with disabilities and how we are often not included at the table for key decisions" (Center for Disability Rights, https://www.cdrnys.org/blog/uncategorized/ableism/, n.d.)

Ableism leads adults to consciously or unconsciously:

- Dismiss the child's perspective, or the parent/carer's concerns.
- Compare the child to typically abled peers and focus on deficits.
- Insist the child change or overcome features and characteristics of their disability.
- Shame the child for things they cannot control due to their disability.
- Attribute disruptive or unusual behaviour to failings of the child, for example, lazy, unmotivated, attention seeking, manipulative, not resilient.
- Be unable to perceive autistic culture and autistic ways of communicating and doing, and accept these as valid.
- Not recognise or support attempts of the child to self-regulate or self-advocate.
- Communicate that the child's needs are burdensome or inconvenient.
- Be inflexible or unwilling to change or adapt the way things are done.
- Be apathetic to understanding the needs of the child/young person.
- Misconstrue the reasons why a child might be struggling with something.
- Encourage children/young people to mask or hide their difficulties.

For example, children with disability often receive individual learning plans that resemble "Behaviour Support Plans" rather than "Learning Support Plans". Behaviour support plans typically contain a list of things the child will do differently or ways the child will be different in order to meet adult expectations. Learning support plans primarily contain a list of things the teacher will do to enable the child to be able to access the curriculum and successfully learn as best they can. One demands the child change, the other assists the teacher to support the child, in ways specific to that child. This is an example of ableism.

> "The system as it stands is literally punishing them for being different, for being unable to do things that they simple cannot do, due to disability &/ or trauma."
>
> *Parent /carer in SC Survey 22*

Ableism contributes to the experience of school as a trauma for the child with a disability or for the child with school can't. School Can't (SPSR) Australia believes that the large number of our parent/carer cohort who have children with disability who are unable to attend school is likely a reflection of a large number who have been traumatised by their experiences of in person school. COVID remote learning gave some of those children and young people a chance to experience a safer learning environment while others were traumatised further by the lack of adjustments to their needs during remote learning.

Narratives that blame a child or parent for their lack of fit, motivation or poor boundaries are particularly problematic for parents/carers of school can't children. Not only do these narratives add to parental stress, but strategies associated with these narratives encourage parents to use power over, instead of collaboration with or support for their child, and have potential to damage the parent child relationship, whilst leaving the source of a child's distress unaddressed. This can leave children in a situation where their concerns and worries are ignored by all the adults. Where is a child to find sanctuary if something at school is causing them distress and parents are encouraged to make home unpleasant?

SC Survey-22 participants indicated that they experienced these blame narratives when seeking support for their children and young people. Risks associated with these narratives include increased feelings of parent and child shame, reduced likelihood of seeking help elsewhere, damage to the parent child attachment when action are taken based on these narratives, and reduced confidence in professionals.

Table 25. Barriers related to Narratives that Blame.

Barriers related to Narrative that Blame	
I've been told that I just have to make life unpleasant at home and they will go to school	39%
I've been told by clinicians/school that it is my fault my child stays home	26%
I've been told by clinicians/school that my child is misbehaving	22%

Recommendation 36: That at all levels of government and across all sectors: health, education, welfare, and disability a commitment is made to collaborate in a way that validates and amplifies the voices of those with lived experience in order that research, policy, design reflect the needs of those who have in the past been othered. "Nothing about us without us"

13. Parent/Carer Suggestions for Prevention, Support and Re-engagement:

The SC Survey-22 asked a series of open-ended questions about what would prevent school can't happening, what would support their child whilst they are experiencing school can't, and what has made a difference in helping their child re-engage with learning.

Analysis of these questions gives further insights into how stressors can be reduced at different stages and reinforces themes that we've explored elsewhere.

Regarding preventing school can't, at the education system level parents/carers suggested:

- Teacher understanding and training around disability, inclusion, mental health and school can't, and particularly understanding masking and connection. Teachers were also seen to need more support, and be given more time for planning.
- Trauma informed and less behaviourist approaches. This included relational safety; CPS; less "controlling"; prioritising engagement over attendance; being compassionate and showing empathy; and not penalising or threatening children who can't attend.
- Working with and listening to parents and experts.
- Being more proactive in addressing disability, inclusion, bullying and school can't.

> "Acting before school cant is established. I could see where we were heading when my child started school. The school and private psychologist didn't/ wouldn't act until things became dire. I was told so many times " we have to wait for things to become really bad before we can do/apply for/ implement that. Then things got really bad and no one knows what to do and now I'm told "you have to apply for the unit class we can't accommodate you and it's only going to get worse. That's the only option left"."
>
> *Parent/carer in SC Survey 22*

Themes regarding **preventing school can't at the school environment level** included:

- Quieter – creating spaces that were less overwhelming. This included other sensory sensitivities in the school environment as discussed in detail in Section 10.1.4. Suggestions included allowing students to access quiet spaces as they need to.
- Smaller – smaller classes and smaller schools.
- More flexibility – specific examples included flexibility of location (allowing for some remote learning); shorter days; reduced subjects; flexibility of teaching styles; and flexibility in relation to school uniforms.

> "Once it's got this point it's very very difficult to alter that trajectory. We need to be reducing the cognitive load of school for all children as the best means of prevention. Once they are experiencing school can't, then it needs to be understood as a form of burnt out in children due to the excessive cognitive stress/cognitive load of school. It's completely predictable."
>
> *Parent /carer in SC Survey 22*

When students are experiencing school can't parents/carers recommend reducing stress though:

- Reduced pressure - this included no pressure around attendance, not calling daily to check on attendance, giving them space, allowing time away from school, and not having attendance reward systems.
- Flexibility –flexibility of reduced hours, reduced subjects, later starting times, early finishing times, attendance without pressure to do any work, no assessments, providing appropriate accommodations, allowing students to engage in subjects they enjoyed, and allowing movement breaks.
  There were many respondents that also described flexible approaches to school delivery including being able to complete work at home, attend their usual class remotely, distance

education options (without having to leave the school), and being able to do assessments from home.

- Being understanding, compassionate and kind – eg taking a trauma informed approach; not judging, shaming or blaming; not using behaviourist approaches; collaborating with students; and putting the child's wellbeing first.

> "Time off from any demands of learning or life in general. Teachers taking time to build a relationship with child that centres around child's interests. Supporting the child to develop new friendships."
>
> *Parent /carer in SC Survey 22*

Parents also stated the following had helped their child to re-engage in learning:

- Acceptance of where the student was at; lowering expectations; giving time and space; time to heal; focus on wellbeing; no pressure. This was relevant to both school and home relationships, and included making home a safe place.
- Reduced hours, subjects and accommodations in the classroom.
- Moving to home schooling, unschooling, de-schooling and distance education.
- Supportive teachers that prioritised relationship building, were trauma-informed and showed additional care and concern.

Further details regarding these thematic analyses can be found in the Appendix: 0

Recommendation 37: That the federal government acknowledge the excellent work that School Can't (SPSR) Australia's volunteers have been doing to provide a valued national parent peer led intervention service and that they provide funding for this service in order to sustain it to meet the needs of the growing school can't community over the coming years.

14. School Can't Australia, Not for Profit Organisation:

Key concepts:

- School Can't (SPSR) Australia is a volunteer-run parent peer support group that is providing much-needed support and has been rated by families as helpful.
- The group is fast growing and plans to register as a not-for-profit organisation to access funding, expand the range of supports, and manage the risks of providing this type of service.
- Expansion opportunities include offering advocacy support services; educational materials and programs for educators, parents and professionals working with school can't; programs for young people; and expanding on the parent programs.

School Can't (SPSR) Australia's online parent peer support group is highly regarded and valued by its members (as indicated by responses to SC Survey-22 discussed in Section 8.2 and Table 10). 85.5% of survey respondents rated it as helpful or very helpful. Reading the personal testimonies listed in the Appendix, see Section 19.3, helps one appreciate the degree to which parents/carers value the group. In view of the fact that many other services designed to support parents/carer and children/ young people are either unavailable or perceived to be unhelpful, School Can't (SPSR) Australia plays a vital role in supporting parents/carers. Up until this point, School Can't (SPSR) Australia has been run entirely by volunteers and has offered its support at no cost to members. As the group continues to grow, however, this is not sustainable and it is the desire of our administrative team to form and launch an NFP in 2023. Creation of an NFP will mean that we are able to apply for grants and move towards developing the parent/carer supports we offer along with a range of other education and support services.

In the past 8 years School Can't (SPSR) Australia has experienced a growth rate which has seen the size of the group double approximately every 410 days. The group is forecast to grow to 15,400 members in just 410 days time (see Section 6.1 for further discussion of this). This means that School Can't (SPSR) Australia expects to be adding 263 new members to the group every week over the course of the coming year.

School Can't Australia is currently run by a team of four active volunteer parent members who juggle their own children's needs for support, and variously juggle home schooling, and/or employment. It is estimated that they collectively spend 45 hours per week moderating and maintaining the group.

Moderation work involves:

1. Reviewing member applications to ensure that each applicant meets our membership criteria (is a parent of a child experiencing school can't).
2. Reviewing posts prior to publishing them to the group. In the past year we have seen an 86% increase in the number of posts to our page when compared with the same time last year. As the group grows, the daily number of posts requiring approval also grows. Posts are reviewed by moderators to reduce the risk of exposing members to content which might be libellous, distressing, or dysregulating. Moderators also review posts to direct parents/carers to seek urgent care when necessary for themselves or their child if there is self-harm, suicidal ideation, abuse or violence disclosed. Posts are also screened to ensure that content is on-topic, and aligns with our group values.
3. Reviewing comments on posts. Once a post hits our page moderators monitor the comments on the post to ensure that engagement is supportive and respectful and that parents and carers are being directed to knowledge which is helpful for their situation. An increased number of members means an increased volume of posts and subsequent

comments to monitor. In 2019 it was possible for an admin team of five to comment on every single post and read all the comments. In 2021 we began using key word filters to screen for comments that require action because we were experiencing difficulty reviewing every comment. The risk of missing something increases as the group grows.

4. Curating content to ensure that new members are exposed to content which informs them about our frameworks of understanding and shared understandings about what works. It is important to monitor the type of content shared to ensure that lived experience knowledge is prioritised.

Our volunteers are at risk of burn out, at risk of vicarious trauma and are exposed to a growing personal liability risk. They should be paid, insured, supervised and supported while they are engaged in the work of running what is a unique and highly valued parent intervention relating to school attendance difficulties.

Our volunteers are passionate about helping support Australian parents who have children with school can't. Volunteering for School Can't (SPSR) Australia is something that our volunteers do flexibly while juggling their own children's needs and employment and other responsibilities. It is hoped that by forming an NFP organisation School Can't (SPSR) Australia would be able to offer flexible employment to staff to enable individuals to carry out this work without the competing need to work elsewhere, thereby reducing their individual stress burden and recognising the value of their lived experience knowledge.

For many years the co-ordinators of our group have wanted to create a similar group for professionals and have wanted to develop course content and professional development offerings in order to share what we have learned and to promote understanding about how to support parents/carers and their children. This has been too difficult to achieve whilst managing a large growing parent peer support group, employment and our children's needs. Approximately 10% applications to join School Can't (SPSR) Australia are from professional applicants who wish to join our group to learn more about supporting students with school can't. There is strong demand for information from professionals, with many frustrated that they seem to be unable to help the young people they come into contact with.

14.1 Proposed activities:

Member of School Can't (SPSR) Australia have identified a number of ways they would like to see the organisation impacting on school can't nationally. They would like School Can't (SPSR) Australia to:

1. Provide information to all stakeholders (including governments, institutions, parents/carers, clinicians, school staff) about school refusal and lived experience knowledge.

2. Provide lived experience consultancy impacting: research directions, public health messaging, government policy and funding decisions relating to the health, education and disability sectors.

3. Provide parent peer support through:
    a. A web-based forum (similar to Facebook)
    b. Small face to face support groups with trained and resourced leaders in capital cities and large regional cities.
    c. Low fee small group or 1:1 mentoring services delivered either online or face-to-face.

4. Provide opportunity for professionals seeking to assist students with school can't to learn from the lived experience voice of parents and students via a web-based forum (similar to Facebook) which is moderated by parents/carers with lived experience knowledge.

5. Provide an advocacy support service staffed by disability inclusion, CPS trained and trauma aware practitioners to assist with the home-school relationship. Supporting parents and students (experiencing or at risk of experiencing school can't) in their efforts to collaborate with schools to identify and address underlying issues contributing to school can't.

6. Provide opportunities for parents, teachers, and clinicians to learn about school can't, including information about: the nervous system, prevention of school can't, identifying early warning signs of school can't, recovery from school can't, and ways to support students and families effectively and prevent further trauma. This will be done through:
    a. Attendance of representatives of School Can't (SPSR) Australia at conferences to speak about school can't
    b. Writing of papers for publication in journals
    c. Hosting in person and online learning opportunities
    d. Hosting an annual School Can't conference
    e. Offering in school or regional professional learning programs for school staff
    f. Engaging with the media

7. Establish a national network of people interested in further developing knowledge about school can't through research which is informed and shaped by lived experience.

8. Offer parents, educators and clinicians training and mentoring in understanding and using Collaborative Proactive Solutions.

9. Explore and develop opportunities for students with school can't to connect with other school can't peers in order to reduce the social isolation and shame associated with school can't.

10. Develop and deliver a psychoeducation program for students to engage with which assists them to understand their nervous systems such that they are empowered to advocate for their nervous system's support needs in the home or school environment.

15. Conclusion:

There are a number of popular narratives about school refusal. The two most often seen assert that school refusal is due to:

1. Parenting failure. Caused by parents who do not set appropriate boundaries or use "tough love" to gain their child's compliance. The cure is to ensure that parents are enforcing rewards and consequences to gain compliance.
2. Children/young people who have anxiety disorders. The cure is to treat the disordered thinking and convince the child that there is nothing to be afraid of through use of Cognitive Behaviour Therapy and Exposure Therapy.

School Can't (SPSR) Australia takes a different perspective. The application of an ecosystems framework of understanding, together with new understandings about the nervous system and the brain-body connection, which lead us to see school refusal as a response to stress. **The cure is simple: if we identify the stressors and reduce the stress, then we can reduce the incidence of school can't and provide effective support to those who are experiencing it.**

In the past, research has neglected to investigate school-based factors contributing to student stress and the subsequent onset of school can't. Psychologists have focused on within child and within family factors instead. This failure to draw a connection between chronic stress and school can't has led schools to blame school attendance difficulties on parents, and psychologists to perceive mental illness as a pathology of the individual. The result has been little interest in identifying school-based stressors.

Society's understanding of school can't, is shaped by cultural beliefs about: education, parenting, disability, mental health and behaviour. School Can't (SPSR) Australia invites the Senate and others examining this issue to consider the way these beliefs influence and shape understandings and responses to school can't. We must challenge beliefs about education: how, what, where, when and why? We must embrace inclusion and listen to neurodivergent voices to do better. We must value the voice and knowledge of parents, as they walk alongside their children year in and year out and seek help for them. We must call out ableism and the role it plays in oppressing and 'othering' those who are different. We must look at this problem through an inclusion lens! Mental health clinicians must look upstream to identify sources of stress, leading to mental health break down, and join in advocating for reductions in student stress to promote wellbeing. Schools need to rethink compliance focussed behaviour management practices and instead focus on regulation, connection and collaboration, to improve "felt safety".

The data from SC Survey-22 is alarming. We must do better! The long-term financial and health impacts on families are extremely concerning. The impact of long-term stress on students, and the fact that so many are experiencing school-based trauma, should concern us all. Trauma that follows them for years to come:

> "***I still sometimes struggle to pick up my siblings from school or go to their school recitals because the fear of school buildings imprinted upon me has impacted my mental health and relationship with the education system for the rest of my life***" (Hayden:2022)

Reducing school-based stressors will also be protective of the teaching workforce. No doubt teachers are also adversely impacted as they struggle to teach and support chronically stressed children and young people. It's important that teachers are equipped with knowledge about the nervous system and are supported to meet their own regulation needs within the context of education communities that care.

Collaboration at all levels is vital and must include: parents/carers, teachers, clinicians, students, researchers, and the government. Collaboration requires a shift in power and shared understandings. The voices of those with lived experience: parents/carers and children and young people must be amplified.

School Can't (SPSR) Australia implores the Senate Committee to advocate urgently on our behalf. The priority is child and family wellbeing.

16. Additional Material that may interest the Inquiry

School Can't (SPSR) Australia formerly known as School Refusal/School Phobia Australia prepared a submission to Victoria's Royal Commission into Mental Health which can be found here:

http://rcvmhs.archive.royalcommission.vic.gov.au/School_Refusal_Australia.pdf

17. References

ACT Government Community Services, 2021. "Sensory Processing: The Ongoing Impact Senses can have on Children affected by Trauma" https://www.communityservices.act.gov.au/ocyfs/therapeutic-resources/sensory-processing-factsheet-the-ongoing-impact-senses-can-have-on-children-affected-by-trauma2

Adams D, Young K, Simpson K, Keen D. "Parent descriptions of the presentation and management of anxiousness in children on the autism spectrum". *Autism*. May;23(4) (2019):980-992.

Anderson KP. "The Relationship between Inclusion, Absenteeism, and Disciplinary Outcomes for Students with Disabilities." *Educational Evaluation and Policy Analysis* 43, no. 1 (2021): 32–59.

Australian Government: Fair Work Ombudsman (n.d.), *National Employment Standards* https://www.fairwork.gov.au/employment-conditions/national-employment-standards.

Australian Institute for Teaching and School Leadership "Professional Standards for Teachers." 2018.

Barkley R. ADHD and Executive Function, Child Mind Institute, 2010, https://www.youtube.com/watch?v=GR1IZJXc6d8&t=4s

Beardon L. *Avoiding Anxiety in Autistic Children: A Guide for Autistic Wellbeing*. Sheldon Press, 2021.

Becker SP, Kapadia DK, Fershtman CE and Sciberras E. Evening circadian preference is associated with sleep problems and daytime sleepiness in adolescents with ADHD. *Journal of sleep research*, 29(1), (2020) p.e12936.

Bernardin CJ, Lewis T, Bell D, and Kanne S. "Associations between Social Camouflaging and Internalizing Symptoms in Autistic and Non-Autistic Adolescents." *Autism* 25, no. 6 (2021): 1580–91.

Brown B. *The Gifts of Imperfection: Let Go of Who You Think You're Supposed to Be and Embrace Who You Are*. Hazelden Publishing, 2010.

Bronfenbrenner U. *The Ecology of Human Development*, Cambridge, Mass: Harvard University Press, 1979

Brunzell T and Norrish J. *Creating Trauma-Informed, Strengths-Based Classrooms: Teacher Strategies for Nurturing Students' Healing, Growth, and Learning*. Jessica Kingsley Publishers, 2021.

Cage E and Troxell-Whitman Z. "Understanding the Reasons, Contexts and Costs of Camouflaging for Autistic Adults." *Journal of Autism and Developmental Disorders* 49, no. 5 (2019): 1899–1911.

Cappadocia MC, Weiss JA, and Pepler D. "Bullying Experiences among Children and Youth with Autism Spectrum Disorders." *Journal of Autism and Developmental Disorders* 42 (2012): 266–77.

Center for Disability Rights. *Ableism* (blog), n.d. https://www.cdrnys.org/blog/uncategorized/ableism/.

Center on the Developing Child. "Three Principles to Improve Outcomes for Children and Families," 2021.

Cologon K and Lassig C. "Universal Approaches to Curriculum, Pedagogy and Assessment." In *Inclusive Education for the 21st Century*, 179–207. Routledge, 2020.

Cox RC and Olatunji BO. Sleep in the anxiety-related disorders: A meta-analysis of subjective and objective research. *Sleep Medicine Reviews*, 51, (2020) p.101282.

D'Agati E, Curatolo P and Mazzone L. "Comorbidity between ADHD and Anxiety Disorders across the Lifespan." *International Journal of Psychiatry in Clinical Practice* 23, no. 4 (2019): 238–44.

Dana D and Porges SW. *Anchored: How to Befriend Your Nervous System Using Polyvagal Theory*. Sounds True, 2021.

Dana D. *The Polyvagal Theory in Therapy: Engaging the Rhythm of Regulation (Norton Series on Interpersonal Neurobiology)*. W. W. Norton, 2018.

Delahooke M. *Beyond Behaviours: Using Brain Science and Compassion to Understand and Solve Children's Behavioural Challenges*. John Murray Press, 2019.

Desautels LL. *Connections Over Compliance: Rewiring Our Perceptions of Discipline*. Wyatt-MacKenzie Publishing, 2020.

English R. "Getting a Risk-Free Trial during COVID: Accidental and Deliberate Home Educators, Responsibilisation and the Growing Population of Children Being Educated Outside of School." *Journal of Pedagogy* 12, no. 1 (2021): 77–98.

Everyday Regulation, n.d., Supporting learners in a neurodiverse world. https://www.everydayregulation.com/?fbclid=IwAR0BbG5i4Z8QvbWLtFbZ9B9jRhYM35KnuSP8N7o4-fHl4K4eMOEUBVwTwp8

Fede J and Laurant A. "Meet Bumper: A Whole Body Learner." Autism Level Up, 2022. https://cdn.sanity.io/files/p6bm7moz/production/99d189ab413e0ccab0329aaa52658ad68b2f7875.pdf.

Fisher AV, Godwin KE and Seltman H. "Visual Environment, Attention Allocation, and Learning in Young Children: When Too Much of a Good Thing May Be Bad." *Psychological Science* 25, no. 7 (2014): 1362–70.

Fulton RE. Reardon RK and Jones R. "Sensory Trauma: Autism, Sensory Difference and the Daily Experience of Fear." *Autism Wellbeing CIC*, 2020.

Gore NJ, Sapiets SJ, Denne LD, Hastings RP, Toogood S, MacDonald A, Baker P, Allen D, Apanasionok M and Austin D. "Positive Behavioural Support in the UK: A State of the Nation Report." *International Journal of Positive Behavioural Support* 12, no. 1 (2022): i–46.

Graham L. *Inclusive Education for the 21st Century*. Crows Nest: Allen & Unwin, 2020.

Graham LJ, McCarthy T, Killingly C, Tancredi H, and Poed S. "Inquiry into Suspension, Exclusion and Expulsion Processes in South Australian Government Schools: Final Report." *Brisbane: The Centre for Inclusive Education, Queensland University of Technology (QUT)*, 2020.

Greene R. *Lost at School: Why Our Kids with Behavioural Challenges Are Falling through the Cracks and How We Can Help Them*. New York: Harper Collins, 2008.

Greene R. *The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children*. New York: Harper Collins, 1998.

Hancock KJ, Shepherd CC, Lawrence D and Zubrick SR. 2013. Student attendance and educational outcomes: Every day counts. *Report for the Department of Education, Employment and Workplace Relations, Canberra*.

Hayden C, *Different Not Less: A Neurodivergent's Guide to Embracing your True Self and Finding your Happily Ever After*, Murdoch Books: Australia, 2022.

Higgins JM, Arnold SR, Weise J, Pellicano E and Trollor JN, 2021. Defining autistic burnout through experts by lived experience: Grounded Delphi method investigating# AutisticBurnout. *Autism*, 25(8), pp.2356-2369.

Hopkins S, Shanker S, Leslie R, "Self-Regulation, Self-Control, and the Practice of Shanker Self-Reg®." *Reframed: A Journal of Self-Reg* 1, no. 1 (2017): 58–75.

Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, Jones L and Dunne MP. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health*, *2*(8), (2017) pp.e356-e366.

Hupfeld KE, Abagis TR, Shah P. Living "in the zone": hyperfocus in adult ADHD. Atten Deficit Hyperactivity Disorder. Jun;11(2) (2019):191-208.

Jedrzejewska, A., Dewey, J. "Camouflaging in Autistic and Non-autistic Adolescents in the Modern Context of Social Media". J Autism Dev Disord 52, 630–646 (2021). https://doi.org/10.1007/s10803-021-04953-6

Kelley P, 2018. 'The biological reason why it's so hard for teenagers to wake up early for school' *The Conversation.*

Killian S, 2015 "The I do WE Do YOU Do Model Explained" accessed 5/2/2023 https://www.evidencebasedteaching.org.au/the-i-do-we-do-you-do-model-explained/

Kolk B. van der. *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma*. Penguin Books Limited, 2014.

Lai CLE, Lau Z, Lui SS, Lok E, Tam V, Chan Q, Cheng KM, Lam SM & Cheung EF. Meta-analysis of neuropsychological measures of executive functioning in children and adolescents with high-functioning autism spectrum disorder. *International Society for Autism Research*, 10(5), (2017) 911-939.

Lei. "What's The Problem With Whole Body Listening?" *Parenting Autistic Children with Love & Acceptance* (blog), 2015. https://autloveaccept.wordpress.com/2015/03/25/whats-the-problem-with-whole-body-listening.

Levine P. *Trauma and Memory: Brain and body in a search for the living past: a practical guide for understanding and working with Traumatic memory.* Berkeley: North Atlantic Books, 2015.

Macdonald L, Trembath D, Ashburner J, Costley D and Keen D. The use of visual schedules and work systems to increase the on-task behaviour of students on the autism spectrum in mainstream classrooms. *Journal of Research in Special Educational Needs*, 18(4), (2018) pp.254-266.

Milton DEM. "On the Ontological Status of Autism: The 'Double Empathy Problem.'" *Disability & Society* 27, no. 6 (2012): 883–87.

Morgan B, Nageye F, Masi G. and Cortese S. Sleep in adults with Autism Spectrum Disorder: a systematic review and meta-analysis of subjective and objective studies. *Sleep Medicine*, (2020) 65, pp.113-120.

Munkhaugen EK, Gjevik E, Pripp AH, Sponheim E and Diseth TH. "School Refusal Behaviour: Are Children and Adolescents with Autism Spectrum Disorder at a Higher Risk?." *Research in Autism Spectrum Disorders* 41 (2017): 31–38.

Murray D, Lesser M and Lawson W. Attention, monotropism and the diagnostic criteria for autism. *Autism*. (2005) May;9(2):139-56. doi: 10.1177/1362361305051398. PMID: 15857859.

NJ Autism Center of Excellence, 2022. *Are Kids Getting PTSD in School: Understanding the School Experience of Autistic Children*. https://www.youtube.com/watch?v=wxp3o04ZgoY.

Perry B. Trauma Informed Educators Network Podcast, Episode 7, 2020. Paradigm Shift Education. https://www.youtube.com/watch?v=Cv2sNQL-Blc.

Pirkis J, Currier D, Harris M, and Mihalopoulos C. "Evaluation of Better Access." Melbourne University, 2022. https://www.health.gov.au/resources/publications/executive-summary-evaluation-of-the-better-access-initiative?language=en.

Polanczyk, Guilherme V., Giovanni A. Salum, Luisa S. Sugaya, Arthur Caye, and Luis A. Rohde. "Annual Research Review: A Meta-analysis of the Worldwide Prevalence of Mental Disorders in Children and Adolescents." *Journal of Child Psychology and Psychiatry* 56, no. 3 (2015): 345–65.

Porges SW. "Orienting in a Defensive World: Mammalian Modifications of Our Evolutionary Heritage. A Polyvagal Theory'." *Psychophysiology*, no. 32 (1995): 301–18.

Porges SW. *Polyvagal Safety: Attachment, Communication, Self-Regulation*. WW Norton, 2021.

Porges SW. *The Polyvagal Theory: Neurophysiological Foundations Of Emotions Attachment Communication Self-Regulation*. WW Norton, 2011.

Psychotherapy Networker, 2020. *How Can Therapists Help Children with School Refusal*. . https://www.youtube.com/watch?v=GhzRLnaJMqk.

Psychology Today Australia, 2023, Executive Function. https://www.psychologytoday.com/au/basics/executive-function

Raymaker DM, Teo AR, Steckler NA, Lentz B, Scharer M, Delos Santos A, Kapp SK, Hunte, Joyce A. and Nicolaidis C. "Having all of your internal resources exhausted beyond measure and being left with no clean-up crew": Defining autistic burnout. *Autism in adulthood*, 2(2), (2020)pp.132-143.

Ross A, Grove, R and McAloon J. "The Relationship between Camouflaging and Mental Health in Autistic Children and Adolescents." *Autism Research* 16, no. 1 (2023): 190–99.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2021. "Public Hearing 7 - Barriers Experienced by Students with Disability in Accessing and Obtaining a Safe, Quality and Inclusive School Education and Consequent Life Course Impacts."

Shanker S. *Self-Reg: How to Help Your Child (and You) Break the Stress Cycle and Successfully Engage with Life*. Penguin Publishing Group, 2017.

Shanker S. "*What You Need to Know. Self-Regulation: 5 Domains of Self-Reg*." The MEHRIT Centre, 2017.

Shanker S. (2021) What you need to Know. Self-Regulation: 5 Domains of Self-Reg, The MEHRIT Centre. https://self-reg.ca/wp-content/uploads/2021/05/infosheet_5-Domains-of-Self-Reg.pdf Accessed 1/2/2023

Silberman S, and Sacks O. *NeuroTribes: The Legacy of Autism and the Future of Neurodiversity*. Penguin Publishing Group, 2015.

Slater EV, Burton K, and McKillop D. "Reasons for Home Educating in Australia: Who and Why?" *Educational Review* 74, no. 2 (2022): 263–80.

The Impact of Stress on the Body. Roots of Empathy, 2015. https://www.youtube.com/watch?v=TIUdALXnPlQ.

Tobias A. "A Grounded Theory Study of Family Coach Intervention with Persistent School Non-Attenders." *Educational Psychology in Practice* 35, no. 1 (2019): 17–33.

Tomchek S, and Dunn W. "Sensory Processing in Children with and without Autism: A Comparative Study Using the Short Sensory Profile." *The American Journal of Occupational Therapy* 61, no. 2 (2007): 190–200.

Trauma Informed Educators Network (2020), 'Episode #7 Dr. Bruce Perry-Trauma Informed Educators Network Podcast', Trauma Informed Educators Network YouTube channel, accessed 22 January 2023, https://www.youtube.com/watch?v=Cv2sNQL-Blc&t=2s

Tso M. and Strnadová I, 2017. Students with autism transitioning from primary to secondary schools: Parents' perspectives and experiences.

International Journal of Inclusive Education, *21*(4), pp.389-403.

UN. Convention on the Rights of Persons with Disabilities (2008).

Van Steensel, Francisca JA, Bögels SB, and Perrin S. "Anxiety Disorders in Children and Adolescents with Autistic Spectrum Disorders: A Meta-Analysis." *Clinical Child and Family Psychology Review* 14 (2011): 302–17.

Walker, RJ (2021) "Polyvagal Theory Chart of Trauma Response", version 10, rubyjowalker.com accessed 21/11/2022

Young A. Autistic Children Excel in Mainstream Classes: Amaze CEO, *Sky News* 2018. https://www.skynews.com.au/australia-news/autistic-children-excel-in-mainstream-classes-amaze-ceo/video/e736f73f0c63a568eabb9ee74a3dc434

18. Glossary of Acronyms

Table 26. Glossary of Acronyms

Term	Definition
AAC	Augmentative and Alternative Communication
ACES	Adverse Childhood Experiences
ADHD	Attention Deficit Disorder
AITSL	Australian Institute for Teaching and School Leadership
ANS	Autonomic Nervous System
ASD	Autism Spectrum Disorder
CASA	Centre Against Sexual Assault
COVID	Corona Virus Disease
CPS	Collaborative and Proactive Solutions
CYMHS	Child and Youth Mental Health Service
DCD	Dyspraxia
DLD	Developmental Language Disorder
DOE	Department of Education
GAD	Generalised Anxiety Disorder
NCCD	Nationally Consistent Collection of Data on School Students with Disability
NDIS	National Disability Insurance Scheme
NOS	Not Otherwise Specified
ODD	Oppositional Defiance Disorder
PBS	Positive Behaviour Support
PDA	Pathological Demand Disorder (aka Pervasive Demand Disorder) a subtype of autism
PDD	Pervasive Developmental Disorder
PTSD	Post Traumatic Stress Disorder
RTI	Response to Intervention Framework
SLD	Specific Learning Disability
SPSR	School Phobia, School Refusal
UDL	Universal Design for Learning
UNICEF	United Nations Children's Fund

19. Appendices:

19.1 The Autonomic Nervous System:

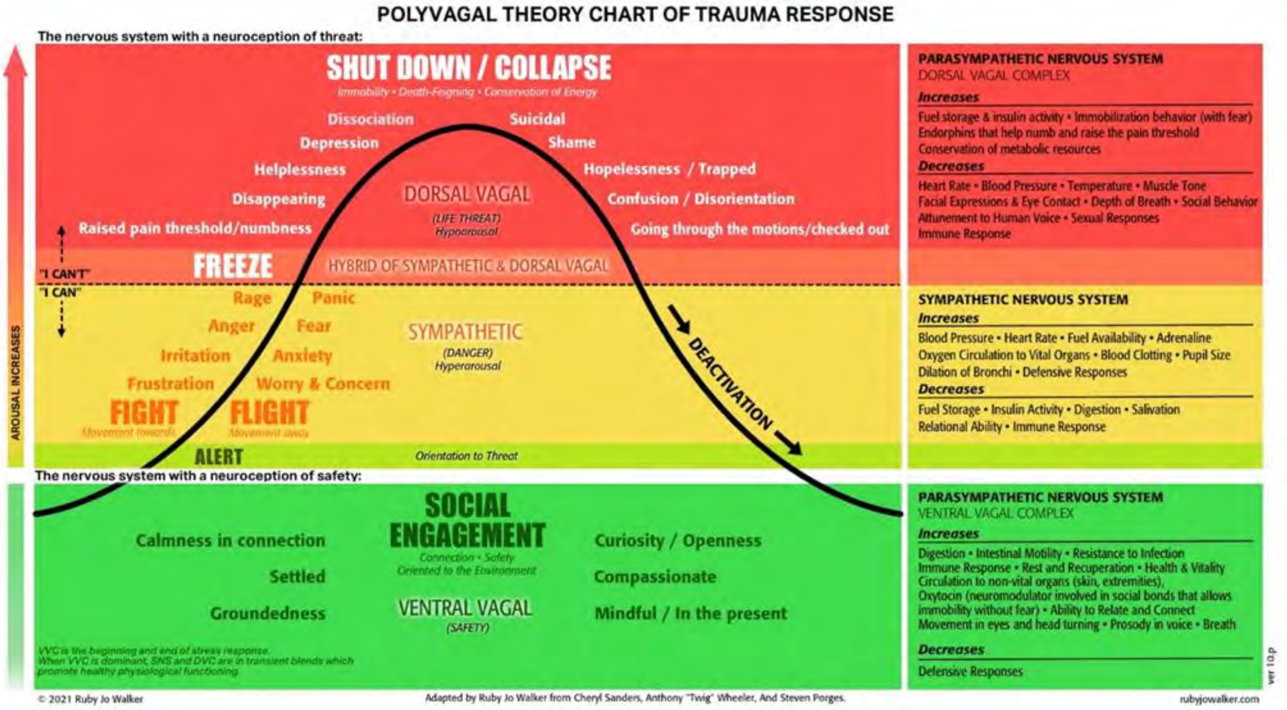


Figure 18. Polyvagal Theory Chart of Trauma Response (Walker 2021)

19.1.1 Autonomic Nervous System Dysregulation

Our Autonomic nervous system helps us to defend ourselves. It comprises two systems of nerves that facilitate communication between the brain and the body in order to help us to meet threats and challenge. When our brain perceives a threat, our Sympathetic Nervous System automatically acts to release an adrenaline rush to increase the heart rate and respiration, increase tension in the muscles and provides a charge of energy so that we are prepared to take action. The blood flow in the body is changed and the frontal lobes and digestion are shutdown to speed up our ability to fight or flee from the threat. If it is not safe to fight or after the fight is finished then freeze, submit responses are triggered by our Parasympathetic Nervous System via the automatic release of other neurochemicals that slow down the heart rate and respiration leading to physical collapse, exhaustion, weakness, increased gastro-intestinal activity. This process allows the nervous system to transition back to a "safe" state.

This is a biological response it does not require thoughts or intentional action and after the trauma, threat or stress is over the person's Nervous System would normally return to its usual level of functioning and thought processes. However, when a person is exposed to the ongoing stress of repeated threat and subsequent emotional dysregulation a trauma response occurs. The nervous system stays alert and is always prepared for danger. The down regulation to a 'no threat' position is no longer achieved. This threat position becomes the "new normal". If this goes on for too long the Autonomic Nervous system which controls the involuntary bodily functions is damaged and this interferes with the messages sent between the brain and the other areas of the nervous system and the organs of the body: the heart, the stomach, the bowel, and the bladder can all be affected. Common symptoms include: dizziness, fainting, urinary tract problems, sexual problems, digestive problems including diarrhoea, constipation, weight loss, heartburn, bloating, nausea, vomiting and difficulties swallowing, heart palpitations, blood pressure problems, sweating abnormalities, eye problems, sleep disorders, headaches, constant exhaustion and fatigue as well as severe impairments of memory and concentration. These symptoms are common for people who have suffered childhood abuse and neglect.

When the "new normal" is in control of the brain it is constantly assessing threat. It is reacting not thinking. The individual is not following intentional thought-out plans, they cannot weigh up the pros and cons of available actions instead their nervous system becomes an action force in the brain. It reacts and there is no relaxation. Relaxation feels like a risky situation and staying busy, and alert feels safer. Over the long-term the "new normal" can put a person's health at risk resulting in heart disease, heart attack, and high blood, gastrointestinal problems, cancer and autoimmune diseases such as Rheumatoid Arthritis. Medical practitioners often identify many of these symptoms and run lots of tests but cannot find definitive causes for them that can be treated. Currently, there are no medical treatments that can address the complex underlying cause of the Autonomic Nervous System Dysregulation.   (The above information provided by Dr Liz Westphal, Clinical Psychologist).

19.2 School Can't Survey 2022:

Purpose of Survey

We would like to invite you to be a part of survey that will be used to create a submission (based on lived experience) to the 2022 Senate Inquiry into School Can't. In order to participate in this survey you must be a:

1. resident of Australia
2. member of School Can't (School Phobia School Refusal) Australia's online parent peer support group
3. parent / legal guardian of a child of compulsory schooling age
4. parent / legal guardian of a child or children who is currently experiencing or has recently (in the past 5 years) experienced school can't.

Informed Consent Statement

This survey is anonymous and will cover your demographics, your school can't journey and its impacts on you, your child and your family, along with what supports you have accessed and how the school/s involved have responded.

The findings from this survey will be used by admin of School Can't (SPSR) Australia to inform a public submission to the 2022 Senate Inquiry into School Refusal / School Can't on behalf of the parent peer support group. The results of the survey may also be used by the School Can't administration team to apply for grants, and to educate others about school can't. This includes using quotes from open ended questions or comments made as part of the survey.

The survey should take around 45 minutes to complete.

By completing this survey you indicate your willingness to participate.

Sometimes thinking about the impact of school can't on you or your child's life can be distressing. Should you feel distressed at any time we encourage you to consider whether it is beneficial for you to complete the survey. If you experience significant distress please stop and speak to someone. You can speak with a partner, friend, or family member or alternatively please use one of the following help lines:

- Lifeline Crisis Support – 13 11 14
- Beyond Blue Support Service - 1300 224 636
- Family and Child Connect - 13 32 64
- Kids Helpline - 1800 55 1800 (for children aged 5-25)

1. *Please confirm you have read this information*
   - I confirm I have read this information
   - I have not read this information

Definitions

For the purposes of this survey School Can't refers to a child's inability to attend or participate in formal full-time education. Children in our School-Can't cohort may spend time in different educational settings, as parents search for an environment where their child experiences belonging, engagement and feels well supported. These settings may include mainstream, specialist, distance education, remote learning, and even home school environments. School Can't can occur in the context of any of these settings.

School Can't has many different names and shows many different presentations of varying impact. Some of the names you might be familiar with include:

- School Refusal
- School Phobia
- Emotionally Based School Avoidance
- School Attendance Difficulties
- Truancy

Often a distinction is made between School Refusal and Truancy. School Refusal is when parents are aware that their child or young person is not attending school. Truancy is when a child is missing school without their parent's knowledge, such as when a child wags.

School Can't (SPSR) Australia would argue that this distinction requires further investigation as the key difference identified above may not be related to the factors contributing to truancy behaviour but may instead be related to the degree to which a student feels they are likely to be met with adults who judge their behaviour as a sign of failure rather than as a sign that something is not going well for them at school, or where the student has decided that the problems at school have no solutions.

Signs of school attendance difficulties range from reluctance to attend, physical signs of anxiety such as stomach upsets and headaches, sleep disturbance, not wanting to go to bed or get out of bed or get dressed or eat, or to get in the car, or to get ready, anger, crying, begging, upset, late to school, missing school, missing particular classes, avoiding or refusing work or homework, hiding when at school rather than going to class or out for lunch or recess, unable to move physically or to talk, flight, fight, freeze, shutdown, absent from school for single days at a time over many weeks, absent from school for many days at a time, or extended absence from school.

We consider any of these presentations as manifestations of School Can't. For the purposes of this survey we would like to collect information in relation to any of the above listed presentations including what might be considered truancy.

Demographics

Firstly, we'd like to know more about you and your family.

2. Are you a member of School Can't (SPSR) Australia?
   - Yes
   - Waiting to join
   - No
3. Are you a parent or primary carer of a child / children who was of compulsory schooling age in 2022?
   - Yes
   - No
4. Has your child experienced school can't, as defined on the previous page, in the past 5 years?
   - Yes
   - No
5. And what is your relationship to the child/children who is or has experienced school can't?
   - Parent
   - Kinship carer
   - Foster carer
   - Step parent
   - Other legal guardian (please specify)
   - None of the above
6. Are you an Australian resident?
   - Yes
   - No
7. Do you live in?
   - NSW
   - VIC
   - SA
   - QLD
   - WA
   - NT
   - ACT
   - TAS

- Other Australian Territory

8. And is the area you live in?
    - Metro
    - Regional
    - Rural
    - Remote

9. Where were you born?
    - Australia
    - Other (please specify)

10. What is the primary language spoken at home?
    - English
    - Other (please specify)

11. Do you identify as a First Nations person?
    - Yes
    - No
    - Prefer not to answer

12. How old are you?
    - 19-29
    - 30-39
    - 40-49
    - 50-59
    - 60-69
    - 70+
    - Prefer not to answer

13. What sex were you assigned at birth?
    - Female
    - Male
    - Another term, please specify
    - Prefer not to answer

14. How do you describe your gender?

(Where gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents)

- Man or male
- Woman or female
- Non-binary
- I use a different term (please specify)
- Prefer not to answer

15. What is your current marital status?
    - Married
    - Living with a partner
    - Separated
    - Divorced
    - Single
    - Widowed
    - Prefer not to answer

16. What is your highest education qualification?
    - Postgraduate degree (e.g. PhD, Masters)
    - Graduate diploma or certificate
    - Bachelor degree
    - Advanced diploma or diploma
    - Certificate
    - Year 12
    - Year 10
    - Primary education
    - Other education
    - No education

17. What is your total annual household income?
    - Under $20,000
    - Between $20,000 and $39,999
    - Between $40,000 and $59,999
    - Between $60,000 and $79,999
    - Between $80,000 and $99,999
    - Between $100,000 and $149,999
    - Between $150,000 and $200,000
    - Over $200,000
    - Prefer not to answer

18. How long have you been a member of School Can't (SPSR) Australia?

(Not asked of non-members)

- Less than a year
- 1 year
- 2 years
- 3 years
- 4 years
- 5 to 6 years
- 7 to 8 years

Your School Can't Child

19. How many children do you have that were of compulsory schooling age in 2022?
    - 1
    - 2
    - 3
    - 4
    - 5
    - Other (please specify)

20. How many of these children have experienced school can't in the past 5 years?
    - 1
    - 2
    - 3
    - 4
    - 5
    - Other (please specify)

If you have more than one school can't child of compulsory schooling age in 2022, please choose one and answer the rest of the questions about your about this child.

21. How old is the school can't child you have chosen?

22. What grade or grade equivalent were they in, in 2022?

23. What sex was this child assigned at birth?
    - Female
    - Male
    - Another term (please specify)
    - Prefer not to answer

24. How does this child describe their gender?

(Where gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents)

- Man or male
- Woman or female
- Non-binary
- They use a different term (please specify)
- Prefer not to answer

25. Where was this child born?
    - Australia
    - Other (please specify)

26. What type of schooling was your school can't child enrolled in…

(primary or secondary)

For each of the following years:

- 2019 (pre covid)
- 2022 (most recent year)

Select the type of schooling for that year (please select all that apply):

- Mainstream government school
- Mainstream independent school
- Mainstream catholic school
- Learning unit at government school
- Learning unit at independent school
- Learning unit at catholic school
- Disability specific school
- Distance Education (Department of Education)
- Distance Education (private provider)
- Flex / FLO school
- TAFE
- Home-school
- Dual enrolment home school and mainstream government
- Dual enrolment home school and mainstream independent
- Dual enrolment home school and mainstream catholic
- Other (please specify)

27. Has your school can't child been diagnosed with any of the following?

Please select one of the following responses for each diagnosis below:

- Before school can't started
- After school can't
- Seeking diagnosis / suspected
- Not applicable

Diagnoses:

- ADHD
- Auditory Processing Disorder
- Autism (including Aspergers or PDD NOS)
- Autism with PDA profile
- Communication Disorder
- Developmental Language Disorder (DLD)
- Dyspraxia (DCD)
- Fetal Alcohol Spectrum Disorder
- Gifted academically
- Intellectual Disability
- Motor Disorder
- Physical disability - impacting mobility
- Physical disability - impacting hearing
- Physical disability - impacting vision
- Sensory Processing Disorder
- Specific Learning Difficulty (eg: Dysgraphia, Dyslexia, Dyscalculia)
- Tourette's syndrome

Other (please specify condition and whether before or after onset of school can't, seeking diagnosis or suspected)

28. Which of the following mental health conditions has your school can't child been diagnosed with?

Please select one of the following responses for each diagnosis below:

- Before school can't
- After school can't started
- Seeking diagnosis / suspected
- Not applicable

Diagnoses:

- Chronic Fatigue Syndrome
- Depression
- Major Depressive Disorder
- Emotional Regulation Disorder
- Feeding / Eating Disorder
- Gender Dysphoria
- Generalised Anxiety Disorder
- Oppositional Defiance Disorder
- Post Traumatic Stress Disorder

Other (please specify condition and whether before or after onset of school can't, seeking diagnosis or suspected)

School Can't Details

PLEASE READ THE FOLLOWING BEFORE PROCEEDING:

For the purposes of this survey School Can't refers to a child's inability to engage with formal full time education including attending or participating in:

- mainstream
- specialist
- distance education
- remote learning
- home school environments

School Can't is experienced on a spectrum from mild to severe. Please use the following descriptors to rate the severity of school can't for your child for each year that they have experienced school can't.

Mild school can't: A child with mild school can't might express a desire not to go to school but is still able to attend school most days. They might have several days a term where they cannot go to school. They may be persistently late to school because of their reluctance to go. They may report feeling unwell (tummy ache or headache). They may feel anxious on Sunday nights as the school week is about to start. They may be unable to complete school work either at home or at school.

Severe School Can't: A child with severe school can't might be unable to attend school at all. Duration is often for more than 6 months. They may not be able to leave their bedroom or the house. They show signs of severe distress and or shutdown. They may develop atypical sleep patterns often awake all night and asleep during the day. They may show signs of self-harm, clinical depression, or severe anxiety.

School Can't often escalates over time. It is frequently episodic in nature returning in subsequent years to varying degrees.

29. Thinking about the same school can't child, as for previous questions, how old was your child when they first experienced School Can't?

30. How would you describe the severity of their most recent or current episode?

- Mild 1
- 2
- 3
- 4
- Severe 5

31. Can you please tell us why you have given the above rating?

32. If your child is enrolled in distance education or mainstream school, how many weeks of schooling do you estimate that your child has missed in the past 12 months?

- Up to 2 weeks or up to 5%
- 2 to 4 weeks or 5% to 10%

- Over 4 weeks to 8 weeks or 11% to 20%
- Over 8 weeks to 12 weeks or 21% to 30%
- Over 12 weeks to 16 weeks or 31% to 40%
- Over 16 weeks to 20 weeks or 41% to 50%
- Over 20 weeks to 24 weeks or 51% to 60%
- Over 24 weeks to 28 weeks or 61% to 70%
- Over 28 weeks to 32 weeks or 71% to 80%
- Over 32 weeks to 36 weeks or 81% to 90%
- Over 36 weeks or over 90%
- Not enrolled in mainstream or distance education schooling
- Unsure

33. Still thinking about the same child and the past 2 years, with the exception of remote learning due to COVID, how many different schools or types of schooling have you tried in order to help your child engage with learning?

(include engagement programs, flex schools, home schooling, distance education etc)

34. And how many different schools or types of schooling have you tried since school can't first started for this child?

35. And thinking about the same child in the past 2 years, how helpful were the following clinicians or experts you have sought help from in relation to your School Can't child?

Please select one of the following responses for each clinician or expert below:

- o Not all helpful 1
- o 2
- o Neutral 3
- o 4
- o Very helpful 5
- o Not used

Clinician or expert:

- Counsellor
- General Practitioner
- Hospital Inpatient mental health service
- Hospital Outpatient mental health service
- Paediatrician
- Private Psychiatrist
- Private Psychologist
- Publicly funded Child and Adolescent Mental health service (eg Headspace or CYMHS)
- Occupational Therapist
- Speech Therapist
- Social Worker
- Other (Please specify below)

Please specify the other clinician or expert you sought help from.

36. And how helpful have you found other community-based services you have accessed in the past 2 years to support this School Can't child?

Please select one of the following responses for each community based service below:

- o Not at all helpful 1
- o 2
- o Neutral 3
- o 4
- o Very helpful 5
- o Not accessed

Community based services:

- Ambulance
- Beyond Blue
- Emergency Department
- Kids Helpline
- Lifeline
- Parent peer support group (eg School Can't or disability specific parent peer support)
- Police
- Support worker
- Tutor
- Youth worker
- Other (Please specify below)

37. And how helpful have you found school and Department of Education supports you have accessed in the past 2 years for this School Can't child?

Please select one of the following responses for each Department of Education service below:

- o Not at all helpful 1
- o 2
- o Neutral 3
- o 4
- o Very helpful 5
- o Not accessed

Department of Education services:

- Classroom teacher
- Year level co-ordinator
- Pastoral Care teacher
- School teacher with special education / inclusive education qualification
- School Wellbeing officer and/or school counsellor
- School psychologist
- Navigator program (Vic) or other outreach service
- Department of Education – Distance education service
- Department of Education – Regional Representative
- Department of Education – Other
- Other (Please specify below)

School Can't Statements

Trigger warning. The statements in the following question may cause you to have some strong feelings and are not necessarily indicative of the views held by School Can't (SPSR) Australia.

38. Please indicate how you personally feel about the following statements:

Please select one of the following responses for each statement below:

- o Strongly disagree
- o Disagree
- o Agree
- o Strongly agree
- o Not sure

List of statements:

- School Can't can be remedied by teaching a child how to manage their worries
- School Can't can be remedied by teaching a child self regulation strategies
- School Can't is a reflection of ineffective parenting
- School Can't can be remedied by setting and enforcing clear boundaries
- School Can't can be remedied by making home a less hospitable place than school
- School Can't means your child is being disobedient
- School Can't is a response to stress

- School Can't can be remedied by increasing a student's tolerance for distress
- School Can't means that your child will have a poor outlook in life
- School Can't means a child is probably experiencing a difficulty at school
- School Can't means a child's needs at school are not being met
- It's important to identify underlying issues and barriers at school
- School Can't parents need to push their children harder
- School Can't parents should use consequences to gain compliance
- School Can't children need home to be a safe space
- School Can't children need adults who are compassionate and not judgemental
- School Can't is a nervous system in flight mode or shutdown mode
- School Can't children are manipulating you to let them stay home
- Wellbeing matters more than attendance
- School can't parents should use rewards to gain compliance
- Parents of school can't children are too accommodating of their children
- School Can't children should face their fears and attend school anyway
- School Can't children need well regulated adults both at home and at school.
- School is a child's job. Parents have to work and children have to go to school.
- School Can't is evidence that a child needs to become more resilient
- Children should never be given a choice about whether they go to school or not
- Adults should be aware of and responsive to a child's capacity to attend school

Aspects linked to school can't

39. Are difficulties with any of the following linked to your child's school can't?

Please select one of the following responses for each item below:

- o Yes
- o No
- o Maybe
- o Not known

(Please note more detail can be provided at the end of this series of questions)

List of items:

Environment
- Learning spaces didn't meet student needs
- No access to quiet space
- Class or school size too big

Sensory
- Uniform sensory issues
- Difficulty with classroom acoustics (eg noise level in classroom)
- Difficulty with classroom climate (eg aircon, heating, drafts, ceiling fans)
- Difficulty with classroom lighting, glare etc
- Visual clutter in classrooms

Emotional
- Limited "safe" people and places at school
- Pressure for full attendance
- School was focused on behaviour management
- Difficulty meeting teacher/school expectations
- Unpredictability of daily school activities
- Difficulty meeting expectations of self
- Early experience of learning failure
- Student didn't feel safe to be themselves (needed to mask)

40. And how about difficulties with any of the following being linked to your child's school can't?

Please select one of the following responses for each item below:

- o Yes
- o No
- o Maybe
- o Not known

List of items:

Social / communication
- Poor access to communication tools and supports: between child & teacher (eg AAC)
- Difficulty communicating student distress to teacher
- School staff unable to identify signs of distress
- Poor access to communication between parent & teacher
- Lack of friends, couldn't find their tribe
- Student has difficulty with a specific teacher
- Student experienced social exclusion by peers
- Student experienced bullying
- Difficulty with group work
- Behaviour of other students impacted sense of safety

Cognitive
- Difficulty with remembering things
- Difficulty with executive functioning
- Student difficulty with attention or focus
- Difficulty with processing speed

41. And, how about difficulties with any of the following being linked to your child's school can't?

Please select one of the following responses for each item below:

- o Yes
- o No
- o Maybe
- o Not known

List of items:

Academic
- Work too hard
- Work too easy
- Work not of interest
- Difficulty with a specific subject or type of work
- Curriculum / teaching not culturally responsive
- Lack of explicit instruction
- Lack of clearly documented expectations

Disability Accommodation
- Difficulty accessing disability friendly textbooks, online content, and handouts
- Lack of individualised supports and planning
- School placing responsibility on student to change instead of providing support
- Lack of or poorly conceived reasonable adjustments
- Lack of staff informed about disability needs

42. And, lastly how about difficulties with any of the following being linked to your child's school can't?

Please select one of the following responses for each item below:

- o Yes
- o No
- o Maybe
- o Not known

List of items:

Structural

- Length of school day
- Early start times
- Number of transitions / periods each day
- Use of exclusionary discipline (eg suspension, expulsion, being sent home)
- Gatekeeping, segregation, or partial enrolment
- Exclusion from school activities
- School leadership did not value inclusion
- Lack of flexibility to accommodate student need
- Lack of trauma informed staff
- Focus on behaviourist practices
- Execution of the curriculum (eg lack of explicit instruction / interest based / self directed learning)

Physical

- Difficulty with chronic pain
- Difficulty with fatigue
- Inadequate movement breaks
- Difficulty eating at school

43. In the past 2 years, have the following COVID related stressors impacted your child's attendance at school...

Please select one of the following responses for each item below:

- o Yes
- o No
- o Maybe
- o N/A

List of items:

- Negative experience of remote learning
- Positive experience of remote learning
- High rate of teacher absence
- Difficulty due to missed learning
- Anxiety about catching COVID
- Masks made communication in the classroom difficult
- Lack of support from peers during remote learning
- Parents not allowed on school site to support transitions or attendance
- Teacher stress leading to reduced capacity to provide support
- Increased unpredictability
- Difficulty transitioning from remote learning back to face-toface learning
- Perception of self as learner impacted by experience of remote learning
- Difficulty meeting expectations to work independently
- COVID related illness in family resulted in interruption to learning
- Routines interrupted
- Remote learning removed sense of home being a refuge from school
- Masks and sanitiser caused sensory difficulties
- Lack/inadequate provision of disability related accommodations during remote learning
- Lack of contact with peers

Other (please specify)

44. What, if any, further details would you like to share about how the school- based factors / stressors in the previous questions contributed to school can't?

45. Have there been family and personal impacts outside of the school environment (excluding disability or child's mental health) that have impacted your child's school can't? (eg loss of a family member, parental illness, impacted by natural disaster)

- No
- Yes (please list these impacts below)

46. Has your child experienced any forms of exclusion or exclusionary practices subsequent to onset of school can't?

- Asked to leave school
- Denied enrolment
- Difficulty accessing enrolment due to history of school can't
- Difficulty accessing distance education
- Other (please specify)
- None of the above

Impact on parents/carers and families

We'd now like to ask you about the impacts on you and your family

47. Please select the option below that best describes your current work status...

- Working full-time
- Working part time
- Working casual
- Self employed
- Seeking employment
- Studying full time
- Studying part time
- Home duties
- Other (please specify)

48. How many hours per week do you usually work?

49. If school attendance difficulties were not an issue for you how many hours of paid employment per week would you like to do?

50. Thinking about the past 5 years, how has School Can't and associated caring responsibilities impacted on your ability to undertake paid employment?

Please select all that apply.

- Unable to work at all
- Working casual work in place of permanent work
- Working in a less demanding role
- Working fewer hours than I would like
- Have had to take unpaid leave from my employment
- Have had to ask family or friends to care for my school can't child so I could work
- I have felt stressed about my ability to maintain my employment
- No impact on my ability to work

51. In relation to your employment situation has any of the following happened in the past 5 years?

Please select all that apply.

- Career progression has been impacted
- Lost a job because of caring responsibilities
- Became /are self-employed due to caring responsibilities
- Resigned from a job because of caring responsibilities
- Changed work roles due to caring responsibilities
- Changed working hours due to caring responsibilities eg working weekends or nights instead while partner / relative cares for child
- Working in less secure employment
- Other impact on your employment or career (please specify)
- No impact on my employment or career

52. Do you receive any additional financial supports?

Please select all that apply.

- Carers payment
- Carers allowance
- Disability support pension
- Job Seeker
- Parenting payments
- Assistance for Isolated Children payment
- NDIS for yourself or your partner
- NDIS for your school can't child
- Rental assistance
- Other (please specify)
- None of the above

53. Which of the following best describes how having a child with School Can't has impacted on your family's financial situation?

- No impact
- Minimal impact
- Coping but impacting longer term financial security
- Coping but living frugally
- Limiting ability to participate in usual family activities such as holidays
- Impacting on ability to afford essentials eg. food, housing, transport, health and basic needs
- Other (please specify)

54. Has having a School Can't child impacted on your relationship with your partner?

- Yes, in a positive way
- Yes, in a negative way
- No impact
- Not applicable

55. How has having a school can't child impacted on your relationships with your wider family, friends and informal support networks?

(Please select all that apply)

- I've had to reduce contact with some family and friends
- I've had to cease contact with some family and friends
- I've learned that I can't discuss my child's school attendance with some people
- I've lost contact with the social connections I had at my child's school
- I've found new friends who are understanding and supportive
- There is no one in my social network that I can talk to about school can't
- There are very few people in my social network that I can talk to about school can't
- School Can't has led me to have a closer relationship with some family and friends.
- I don't feel that my social relationships have been impacted much
- Other (please specify)

56. In the past 12 months, to what extent has having a School Can't child impacted on...

Please select one of the following responses for each item below:

o Positive impact 1
o 2
o 3
o Neutral 4
o 5
o 6
o Negative impact 7
o N/A

List of items:

- Your physical health
- Your mental health
- Your perception of yourself as a parent

57. Is there anything you would like to share about the impact on your physical health, mental health, and/or perception of yourself as a parent?

58. What support for yourself have you accessed in the past 12 months?

Please select one of the following responses for each item below:

o Have access
o Wanted to but unable to access
o Not needed and/or wanted

List of items:

- Visit the GP for own health needs
- Consult with Psychologist for carer support
- Consult with Social worker for carer support
- Consult with Counsellor for carer support
- Respite / child care while you have a break
- Support with house cleaning
- Able to attend a carer support group meeting
- In home support from a support worker
- Engage in regular exercise
- Engage in activities you enjoy for pleasure

59. What kinds of supports not listed above would you like to be able to access?

60. What barriers to accessing carer support have you experienced?

- Single parent with sole custody (no down time)
- Unable to afford supports or activities
- Waiting lists to access support
- Unable to leave my chid unattended to access support
- Unpredictability of school attendance
- Caring for other children or family members
- Don't know who to ask for help
- Overwhelmed and just surviving
- Lack of free time
- Other (please specify)
- None of the above

Being a Member of School Can't

We would now like to ask you about your experience of being a member of School Can't (School Phobia School Refusal) Australia Parent Peer Support group.

(Not asked of non-members)

61. Please tell us how much you agree or disagree with the following statements about how the School Can't (School Phobia School Refusal) Australia Parent Peer Support group has helped you...

Please select one of the following responses for each item below:

- o Strongly disagree 1
- o 2
- o Neutral 3
- o 4
- o Strongly agree 5

List of items:

- Understand that my child is doing the best they can
- Focus on identifying the problems underlying school can't
- Identify potential solutions to the problems impacting my child
- Feel less alone and isolated
- Feel less anxious about my child's future
- Support my child better
- To identify appropriate supports
- To be able to connect with my child better
- To learn skills I need to support my child
- To feel less stressed
- To identify alternatives to mainstream education
- To see education differently
- To focus on my child's mental health and well being
- To reduce conflict with my school can't child
- To know what support I can expect from my child's school
- To be a better advocate for my child
- To see school refusal differently
- To feel better about myself as a parent
- To have hope
- To learn more about mental health and wellbeing
- Save my child's life
- Engage my child's school in finding ways to support my child

Access to Supports

62. In the past 12 months, what barriers have you faced in accessing supports (medical, education and community based) for your School Can't child?

Please select all that apply.

- Not knowing who to contact
- Gaps between education, disability and family support services (eg NDIS doesn't help with education or mental health)
- School refusing access to external supports
- Lengthy wait lists preventing timely access to assessments
- Lengthy wait lists preventing timely access to medical or psychological care
- Lengthy wait lists to access external to school re-engagement programs
- Cost of accessing privately funded supports
- Cost of time off work to access supports
- Parental overwhelm
- Parental mental or physical health issues impacting help seeking capacity
- Insufficient time to access supports for a whole family
- Unpredictability of "school can't" – seems OK and then suddenly not OK.
- School denies there is a problem and won't provide access to school based supports
- Child / young person is too anxious to engage with supports
- Unable to access suitable re-engagement programs near us
- Child too traumatised / shutdown
- School not following recommendations from experts
- Not sure about other education options
- Difficulty finding supportive people within the school
- Waiting on a diagnosis to access supports
- Difficulty finding clinicians who are trauma aware
- Difficulty finding clinicians who understand school can't
- Difficulty engaging the school in exploring underlying issues
- School difficult to communicate with
- Feel uncomfortable attending meetings at school
- I've been given poor advice in the past and am reluctant to seek help
- I've been told by clinicians/school that my child is misbehaving
- I've been told by clinicians/school that it is my fault my child stays home
- I've been told that I just have to make life unpleasant at home and they will go to school
- Other (please specify)
- None of the above

School Can't Recovery / Response

63. Have you ever felt that your child's mainstream school pushed them out?

- Yes
- No
- Not applicable

64. Has your School Can't child's mainstream school ever obstructed your request to enrol in an alternative learning environment?

- Yes
- No
- Not applicable

65. In the past 2 years have you been threatened with or had any of the following happen due to your child's School Can't?

Please select one of the following responses for each event below:

- o Yes threatened
- o Yes it happened
- o No

List of events:

- Referral to child protection in your state
- Court proceedings
- Issued with a fine
- Police attending your home to escort your child to school
- Principal / school employee coming to your home to escort your child to school
- Received a letter warning you of consequences if you don't send your child to school
- Told your enrolment would be terminated or you would have to leave the school
- Your child excluded from significant school events such as: graduation, end of year celebrations, camp, school formal due to reduced attendance

- Told your child's future prospects in life will be impacted due to their
- attendance
- Your school can't child's attendance will exclude them from applying for leadership positions
- Other (please specify)

Your thoughts on School Can't

Following are a number of questions for you to tell us what you think about these aspects of School Can't.

Learning and Education system

66. What things have made a difference to help your child re-engage with learning?

67. In relation to the Education system what could be done to prevent school can't?

68. In relation to the Education system what would help support your child when they are experiencing school can't?

Health system

69. In relation to the Health system (including NDIS) what could be done to help prevent school can't?

70. In relation to the Health system (including NDIS) what would help support your child when they are experiencing school can't?

Learning environment

71. In relation to the learning environment/school what changes might help prevent school can't?

72. In relation to the learning environment / school what would help support your child when they are experiencing school can't?

73. Thinking about your child and your family, what supports (not already mentioned in your responses to the questions above) would help prevent school can't or support your child when they are experiencing school can't?

74. Finally, is there anything else you would like to tell us about your experience of School Can't that we haven't already covered?

75. I confirm I am a current member of School Can't (School Phobia School Refusal) Australia's online parent peer support group.
    - Yes
    - No

19.3 Testimonies of School Can't Parents/Carers:

The following testimonies were provided by parents of School Can't (SPSR) Australia in 2022 when we asked for their feedback about how the group had supported them with their child's school can't journey.

Response 1

When a child can't go to school you lose all your support and networks, often work becomes very difficult or impossible, your child needs understanding, their needs need to be investigated, they need strong support personally and advocacy, school administrators become demanding. Life becomes stressful but yet suddenly it becomes impossible to share parent to parent support, at the school gate, for a quick coffee and you often don't know what to say and how to protect your child's privacy but stay connected to school communities. In short, you and your child become isolated at the time you most need community support and understanding. This is what this group provides- as well as practical support, more than anything it's the understanding and support of others walking the same path. It helps us just about keep our heads above water.'

Mum of ASD GAD 9 year old

Response 2

After many years of school can't my son's transition into yr 7 tipped him into a mental health crisis and burnout. This affected the whole family and we were spiralling into a dark place.

I had never felt so isolated and alone, I had no idea what was happening or how to fix it. Neither did any professionals or school staff. I hadn't found anyone who understood and I had been searching for years. I found this group and I feel like it literally saved our lives. I'm so grateful to everyone here.

Single parent to school can't autistic 15yr old boy

Response 3

With the support of this group I have been able to seek the right professional help and advocate for my sons disability. Prior to finding this group we were heading on a path which I now have learned was further damaging my school can't child and adding to the trauma he experienced at school from unmet needs.

I am so grateful for this support which has helped me to find answers leading him on the right path and the road of recovery.

Having a school can't child is deeply isolating, has huge financial and other major impacts to families. We continue to struggle. This group was honestly our saviour.

Mum to school can't autistic (and pathological demand avoidant) and ADHD 10 year old

Response 4

I felt so alone, isolated and such a failure as a parent with regards to my school can't daughter. She is the youngest of eight children and prior to her I had never experienced any issues with my other children attending school. This really floored (*sic*) me. I constantly received pressure and unhelpful advice from my extended family, particularly my aging parents who felt it was a discipline issue. But then I stumbled upon this wonderful site and was relieved in the fact that I was not alone in this journey. I have learn't so much through other people's stories on this site and eventually sort assessment and diagnosis for my daughter. If it wasn't for this site I'm not sure we would have got so far as we have in providing the assistance and approach that my daughter desperately needed. She is now attending 100% at an "alternative" school, is far less stressed and a lot happier with life.

Response 5

As a result of this group, when I enter difficult meetings with school, I no longer feel alone. Instead I feel informed, knowledgeable and supported. I am able to use all I have learnt from this group along with their strength to better advocate for my child and to improve their outcomes. The leaders of this group should be considered for citizens awards for what they have done to support so many families and to shed light on this debilitating and stressful issue affecting thousands of Australian children. Without them we would not have come as far as we have in advocating for the health of happiness of these young Australians who are experiencing debilitating distress just trying to attend school like every other child.

Mum to 8 year old with GAD

Response 6

I found this group early in our journey, when I was struggling to get Ms 9 to school, but still insisting she go unless demonstrably ill. This was the rule when I was a kid, after all. Reading the stories and approaches here, I realised my error, and changed the way I parent. We now work together to understand and overcome the barriers, and if that's not possible, well, sometimes a doona day is good for both of us.

Our relationship was suffering from my fixed idea of what was 'acceptable', but a few months later, she is relaxing and opening up to me again. She is far less anxious about school and more open to learning, too***. We are also both now being assessed for ASD and ADHD***, partly thanks to information I learned in this group!

Without this kind of peer support, I may have permanently damaged my kid's relationship with both me and with school and learning. Thank you for existing.

Response 7

Until I found this group I felt like I was doing something wrong as a parent. The trauma-informed advice here helped me repair my relationship with my children.

Mum of 2 school can't teens, diagnosed late with ADHD, anxiety, autism

Response 8

As a result of this group I realised I wasn't alone. I was able to advocate for my child and explain to others why I was using a particular approach. It has also given my more information to help others in my career, and I know can support people in my role at work as I have a deeper understanding of what they are going through.

Response 9

Before finding this group I had no idea how many people were in the same situation. You feel so alone and alienated by school can't. You lose networks that would be available to you in other circumstances like the other parents at school, or sports clubs etc. Places that used to be warm and welcoming become hostile and judgemental.

Mum of 2 school can't (9 with ASD and anxiety, 14 with ASD, ADHD,ODD and anxiety)

Response 10

I was so fortunate to be informed about this group by a family friend. In the 5+ years that my daughter has been experiencing a range of mental and physical health challenges and has been diagnosed (late) as autistic (PDA profile) and ADHD, it has been a key source of excellent information and sharing for people going through similar, yet unique challenges. The reality is that currently school staff and health professionals usually don't have the knowledge and skills to adequately support students with very complex needs and this group has developed a wealth of expertise through lived experience and drawing on the work of worldwide leaders in the field. It can be very isolating for parents who lose their networks when their child isn't able to attend school (and sometimes other activities), and having this group is so beneficial. I would love to see further advocacy, education and resources available to all, not just to the lucky ones who happen to know someone who is in this group.

Parent of autistic School Can't child, age 17y

Response 11

Even as a teacher with 20+ years' experience, I was still blind-sided by School Can't. After initially feeling like a failure, I realised how the system is failing so many students, & how much of it is teachers being unaware. This group has been a lifeline of support, encouragement & resources to help shift us from feeling like failures to realising we are not alone & there are many ways through the education maze.

Mum of 2 School Can'ts, aged 16 & 14.

Response 12

I have learnt so much in this group. Most importantly we are not alone in this journey and each child just has their own path. It has empowered me with informative information so to fight for my son and I'm so grateful for that.

Mother to an ASD and ADHD son aged 13.

Response 13

With finding this group I found support. We were no longer alone. I was able to learn and change my mindset, understanding and thinking. I became a better advocate and support to my child and was able to rebuild our connection after many years of old hat unhelpful "make her go" advice. Understanding that it's "can't go not won't go" changed our lives and I truly believes saved our child. Our son now benefits from the ongoing support of this group and hopefully his journey will be one without school based and academic trauma.

Mother of four children, two of whom are autistic with ADHD and experience school can't ages 9 and 17

Response 14

Individually we can feel our backs to the wall and isolated, on a burn out loop. Facing ongoing meetings and gatekeepers, possible gaslighting conversations ongoing from multiple directions; public, private and professional settings. The group creates a community that is empowering, honest and helps us in turn empower our kids to share their words and needs going forward.

Mum to 4 neurodiverse individuals 8 to 14

Response 15

I've only just discovered this group. The connection to other parents going through the same thing, to feel understood, and the realisation that I'm not alone in this journey has had a positive impact on my own mental health. The advice on how to help my child on a practical level and how to navigate some of the bureaucracy around his inability to attend school has been invaluable. The online forum is perfect - because sometimes my child's anxiety level means we can't get out of the house. My child and I are not alone in this now.

Mum of an 11 year old with severe anxiety disorder

Response 16

When my School Can't child started to have panic attacks and constant anxiety, I thought it was a medication issue. We tried a few different meds with no change. It as getting worse, and school attendance was less than 50%. We tried learning plans, counselling and changing schools to no avail, and attendance dropped to around 5%. Since joining this group, I have learnt that I am not alone, and I am not a failure as a parent. What I had was a failure of information. I didn't know about alternatives to mainstream schooling or different diagnosis that may be contributing to their difficulties. This group gave me the courage to pull my child out of school to help them recover. It also led us to an Autism diagnosis, and helped us find an alternative school much more suited to my child's interests and ability to learn. We now have a much more positive outlook for next year.

Mother of an Autistic ADHD Anxious School Can't 16yo

Response 17

I watched my child's mental health decline. All the while school was telling me I had to force myself to take my child to school, and make home traumatic so school was more appealing. The icing on this cake was legal threats from the education department for my refusal/inability to force my child. Their mental health is still affected with PTSD from the cruel punishments and treatment from both primary and secondary schools.

Exclusion from school camp, exclusion due to disability and staff physically dragging my child from the classroom will linger as trauma for many years.

Mum to 19 year old diagnosed with ADHD PDA Autism PTSD Anxiety Depression GAD

Response 18

This group has provided me with emotional support and so many a-ha moments. In a new town with no family or friends, I actually don't know what I would have done without it. When School Can't hits it can be an incredibly lonely place. I've been educated by its members and pointed in the direction of so many resources, so I could then advocate for my son with school and the medical system. It's also helped me talk to my husband and children and help them understand what's going on. I can't thank this community enough.

Mum to anxious, School Can't 8yr old son

Response 19

School had no ideas other than 'you just have to encourage them to go'. They made vague efforts to implement 'supportive' strategies without understanding the basic problem - if the child can't trust that their needs will be met at school, because they have experienced many many occasions when their needs were not met, how can they possibly feel safe? How can they possibly learn? This group has been so validating to show me that I wasn't crazy - my child really was being traumatised by school, and so are many others all over the country. Thanks for giving me the courage to acknowledge it wasn't working, and try something else. Now I'm connected with other parents going through the same thing, I feel hopeful that we can advocate for better options for our kids.

Mum of one perfectly happy school attender, and one autistic school can't

Response 20

This group has provided a space to share and learn from others in a similar situation in a safe, non judgemental way. I so enjoy the trauma informed support that is in opposition to the current behavioural paradigm in schools. It has been immensely helpful in my not feeling so alone, isolated and rejected which is how it feels when you are having to constantly advocate for your child in the current system. The impact of this difficulty on families can not be understated. I am saddened that my only real choice has been to home educate.

Parent of an autistic 7yo school can't

Response 21

The help from this group meant that my child was able to complete Years 9 and 10 through Distance Education. I learned strategies to cope with the local public school and the Education Department. This Facebook group literally changed my and my child's life for the better. It has also meant that I don't feel so isolated and alone.

Response 22

The lack of support and understanding I've felt for my 10yo ASD daughter in her school can't journey since prep - at all level from parents to teachers to school admin staff - made me feel isolated and judged. I could see the trauma school created for my daughter over five years and had to climb mountains to get others to understand this wasn't just me being soft/letting her have her own way. I judged myself enough let alone the judgement I felt from others. This Facebook group has been my saviour. Literally. It helped me further feel my daughter and I were not alone, that her school trauma and inability to cope with the school environment was very real, and has helped empower me to empower my daughter. So much that I overcame the fear of what might happen because of her extremely low attendance and take her out of school to try something new next year through Virtual Schools Victoria. I have support in this community, people who listen, give advice when I need and help me set more realistic expectations of the future. I couldn't cope without the support of this incredible Facebook community - all parents with an incredibly stressful misunderstood experience of having a school can't child. All grappling with a system that doesn't cater to their child's needs at all. We fight a real fight daily for our children and this group helps me to stand strong.

Response 23

Day 2 of year 7 my daughter started her school can't journey. She had been a bright, sporty, popular year 6 school captain. It hit us like a sledgehammer. After 6 months of virtually no attendance and me coercing and cajoling which I now regret, she slowly made her way back. Then struggled again, followed by attending again. And so began the 6 year roller coaster of high school.

Year 10 she had an ADHD diagnosis. She is now in year 12 completing her HSC after a choppy 2 years through COVID. She was determined to stay to the end despite our acceptance of other alternatives including unschooling. She has cut it down to 3 subjects which is more doable but some days she is still completely unable to engage.

Such is the TRAUMA of school can't.

If it wasn't for this group I don't know where we'd be. The conversations here made me realise we were not alone and allowed me to breathe through the hardest times. Through calming my nervous system slightly my daughter was able to coregulate through me. I realised the most important thing was her mental health and self-worth. She is an impressive adult now about to leave the school system and continue her life education however she wants to.

The compassion and understanding exchanged in this group is actually life saving and I'll be forever grateful.

Member School Can't (SPSR) Australia's Facebook group, Testimonial sent to admin via Facebook Messenger , Used with permission.

19.4 Table of results: School Based Stressors – Factors Contributing to School Can't:

Table 27 shows the results of difficulties / stressors nominated by parents/carers as contributing to their child's experience of school can't in SC Survey-22 in response to Questions 39 through to 42.

Table 27: Non-COVID School Based Stressors - Factors Contributing to School Can't

Non Covid School Based Stressors	% Yes	% Maybe	% No	% Y+Maybe
Limited safe people	71%	13%	7%	83%
Staff unable to identify signs of distress	69%	13%	7%	82%
Communicating Student Distress to teacher	68%	15%	7%	84%
Masking	67%	14%	7%	81%
Teacher / school expectations	64%	11%	13%	75%
Work not of interest	64%	16%	10%	80%
Placing responsibility of student to change instead of providing support	64%	10%	15%	74%
Expectations of self	64%	15%	9%	79%
Lack of trauma informed staff	62%	9%	12%	72%
Length of school day	61%	16%	13%	78%
Difficulty attention or focus	61%	12%	17%	73%
Sensory Acoustics	60%	16%	11%	76%
Lack of or poorly conceived reasonable adjustments	59%	11%	17%	70%
Lack of individualised supports and planning	58%	13%	18%	71%
Pressure for full attendance	58%	11%	19%	69%
Difficulty with executive functioning	57%	14%	18%	71%
Lack of flexibility to accommodate student need	56%	14%	19%	70%
Lack of staff informed about disability needs	55%	11%	18%	66%
Diff with Specific Subject or type of work	54%	15%	19%	70%
Execution of the curriculum	54%	18%	13%	72%
Learning Spaces didn't meet Student Need	52%	22%	12%	74%
Number of transitions / periods each day	51%	16%	18%	67%
Class or school size too big	51%	22%	15%	73%
Focus on behaviourist practices	50%	13%	15%	63%
Student behaviour impacting sense of safety	49%	19%	20%	68%
Fatigue	49%	15%	26%	64%
Processing speed difficulty	49%	13%	25%	62%
Unpredictability	49%	17%	20%	66%
Behaviour Management	47%	12%	23%	58%
No access to quiet space	46%	21%	18%	67%
Early start times	46%	11%	33%	57%
Difficulty with group work	45%	21%	19%	67%
Sensory Uniform	44%	15%	29%	59%
Difficulty Eating at School	44%	11%	35%	55%
Poor access to communication between teacher and parent	42%	17%	31%	59%
Difficulty remembering things	42%	18%	30%	60%
Difficulty with specific teacher	40%	15%	32%	56%
Lack of friends	40%	17%	33%	58%

Non Covid School Based Stressors	% Yes	% Maybe	% No	% Y+Maybe
Inadequate movement breaks	36%	19%	29%	54%
Student bullying	35%	16%	37%	51%
Social exclusion - peers	35%	18%	36%	53%
Lack of explicit instruction	34%	24%	24%	57%
Early Exp of learning failure	32%	17%	35%	49%
Social / Communication	31%	23%	26%	54%
Lack of clearly documented instructions	30%	24%	30%	53%
School leadership did not value inclusion	29%	10%	40%	40%
Sensory Climate	27%	20%	31%	47%
Sensory Lighting	26%	21%	30%	47%
Work too hard	26%	19%	43%	45%
Exclusionary discipline Practices	26%	5%	54%	31%
Visual Clutter in classroom	23%	22%	27%	45%
Difficulty accessing disability friendly textbooks, online content and handouts	21%	12%	42%	33%
Gatekeeping, segregation, or partial enrolment	19%	5%	52%	24%
Work too easy	17%	19%	49%	36%
Exclusion from school activities	16%	8%	60%	24%
Chronic Pain	10%	7%	69%	17%
Curriculum not culturally responsive	10%	9%	54%	19%

19.5 Parent/Carer Perspectives on Prevention, Support and Reengagement

Table 28: Thematic Analyses of parent/carer suggestions for Prevention, Support and Re-engagement

Thematic analysis highlights the following key themes	Example Responses
Question 66 of SC Survey-22: "What things have made a difference to help your child re-engage with learning?"	
An **acceptance of where the student was at**; lowering expectations; giving time and space; time to heal; focus on wellbeing; no pressure (13.5% of respondents). Note that this might include this type of acceptance from the school as well as the parent describing the home environment. There were also parents who particularly described their own reduction of expectations; reduced demands at home; focusing on parent-child relationship; making home a safe space (8.6% of respondents). Nearly one-fifth of respondents (19%) made a comment in one or both these ways.	*"Dropping all academic expectations. Focusing on wellbeing over academics."* *"The school finally taking all the pressure off and being fine with our boy attending if and when he could. This took pressure off us which we had really struggled with."* *"Focusing on the child's wellbeing first and foremost, not attendance and academic requirements. Providing hope and understanding. Reduced all pressure to attend. Allowing time for the child to heal and be a part of the process to re-engage."* *"Understanding and compassion that she was doing her best but that if you pushed her the pressure to attend made it almost impossible"*
Reduced hours, subjects and accommodations in the classroom were mentioned by 17.4% of respondents (i.e. They mentioned 1 or more of these things as helping their child re-engage in learning). Breaking that down further: • Reduced attendance; reduced hours; slow return to school, were mentioned by 7.4% of respondents. • Reduced subject load was specifically mentioned by 2.7% of respondents. • Accommodations in the classroom; no homework; no assessments; alternative assessments; and supports to regain confidence were mentioned by 11.1% of respondents.	*"Flexibility in classroom activities, eg access to personal "passion project", option to sit out of certain activities he finds stressful."* *"Having his interests recognised. Knowing he is not dumb, he just needs more time and help. "* *"The only things that were working was reduced hours days at school. So he would attend anywhere from 2-4hrs instead of 6. This got my son happier about going to school, a lot of his physical symptoms abated and for the first time this year he felt a sense of achievement. However pressure from the school due to their concerns about his education got to me and we slowly worked up to full hours so reversed any positive progress we had made"* *"Deep learning, strength based with less deficit based but slow development of these skills. Being heard and taking more ownership. Developing compensatory strategies. Less time pressure and less assessment "*
Homeschooling, un-schooling, de-schooling and distance education totalled together were cited by 16% of respondents. Within those responses was discussion about: • the flexibility of learning when they wanted and at their pace, • being in a safe space,	*"Home-schooling: safe environment with trusted teacher. Backing right off for a while. Doing tiny bits within my child's limited tolerance window. Making those bits a pleasant experience and emphasising my child's competence. Acknowledging that their capacity is dynamic and today they might not be able to do what they did yesterday. "* *"We are now home schooling. Having a period of unschooling made a huge difference. Being able to gradually build skills and increase learning opportunities as he is able."*

Thematic analysis highlights the following key themes	Example Responses
• taking the pressure off, • learning in their own way. Some of these themes are picked up elsewhere.	
Supportive teachers; teachers relationship building; teachers who were trauma-informed; teachers who were showing additional care and concern, were cited by almost 15% of respondents.	*"Connections with teachers who care about her. Teachers who are willing to take her 'where she is at' and focus on progress from that point. Encouragement and positivity towards her has also helped."* *"Time off from any demands of learning or life in general. Teachers taking time to build a relationship with child that centres around child's interests. Supporting child to develop new friendships."* *"A warm caring adult who 'takes them under their wing'. Acceptance of where they are at. Working with them collaboratively to create solutions and following through on those. Implementing recommendations fro psychologist. Providing a lot of extra support eg aide) for a short time to restore confidence in the environment."*
External supports e.g. medical, allied health, advisors and tutors; including obtaining a diagnosis, were mentioned by just over 10% of respondents.	*"The school actually listening to myself, psychologist and Speech pathologist about the important of relationship. Making the school a safe place. Dropping academic expectations."*
Child agency or voice e.g. giving child ability to say when they need to come home, or how long they will stay, or whether they can go; collaborative problem solving, was cited by 9.5% of respondents	*"Slowly increasing exposure at school. Knowing she can take a break from school when she needs it has made a huge difference. She takes about 1 day each week."* *"Choice. The knowledge that if he is in an environment that isn't accommodating to his needs, that he can leave. "*
Following child's interests was cited by 8.6% of respondents.	*"Removing school attendance and assessment pressure; following interests vs curriculum; reducing anxiety and stress."* *"Following her interests, taking the pressure off, making learning fun"*
8.8% of respondents said that nothing yet has helped their child re-engage in learning.	
Other responses that came up a bit less frequently: • Alternative school settings; re-engagement programs • Having a friend at school; a friend in their class; peer connections • Increased safety at school; safe spaces they can go to • Medication • Changing school • Wellbeing team; school-home partnership; working well together • Allowing parent supports e.g parent in or near classroom; parent walking to classroom • Meeting sensory needs; reduced sensory impact; quiet spaces	*"Having a good case manager through Navigator (which in itself took a lot of advocacy to get the right person, and a very long wait) Having a school where they actually listen and are focussed on finding ways to support a child to re-engage (VSV), having a dedicated learning advisor who learns about your child's needs and helps with navigating the school system. "* *"Changing to alternative setting, Flexi school, where the focus is on wellbeing, connections and communication rather than conformity and academics."*

Thematic analysis highlights the following key themes	Example Responses
• Feeling valued and successful, e.g. leadership roles; encouragement vs criticism • Mental health improvement	
Question 67 of SC Survey-22: "In relation to the Education system what could be done to prevent school can't?"	
One third of respondents to "what the education system could do to prevent school can't", made comments related to **teacher understanding and education** around disability, inclusion, mental health and school can't, and particularly understanding masking and connection. Teachers were also seen to need more support, and to need more time for planning.	_"Much better training and support of teachers to better understand school can't and the concept of "children do well when they can" and that they aren't "misbehaving"."_ _"Smaller class sizes, teachers who are resourced to accommodate different learning styles, teachers trained to identify a child who is masking, school staff believing parents when they say their child isn't coping, safe spaces for kids to go, tailored learning."_
The need for **trauma informed** and less behaviourist responses was identified by almost a quarter of respondents. This included improved teacher and principal education; relational safety; CPS; less "controlling" and fewer behaviourist attitudes; prioritising engagement over attendance; being compassionate and showing empathy; and not penalising or threatening children who can't attend.	_"A whole new paradigm - trauma aware, change school's attitude and understanding of disability, reduce stress for teachers, reduce competition so there is less incentive for students and teachers to bully."_ _"Flexible, gentle approaches. Listening to the distressed child."_ _"Working with the child to identify what they can do what makes them feel safe to engage. Not put rigid rules and practices around the child and family. Stop the mentality that is we do it for you we have to do it for everyone. Better understanding of neurodiversity and how the brain works. Forcing them through things creates trauma not resilience."_ _"Having schools trained in collaborative proactive solutions and teachers who are curious about students and are not hell bent on making a student conform to their understanding of the problem or the solution to a problem."_ _"All staff, teaching and non-teaching and *especially* in leadership positions need to do trauma-informed training with Blue Knot. Currently so many children and family members are being further or re-traumatised by staff (many of whom are well-meaning but ill-informed) who lack compassion or understanding, and assume that if there is a struggle then that person is not trying hard enough. Compassion and genuine en-courage-ment make all the difference in the world."_ _"Less of a "police state" in secondary schools."_
Working with, and listening to, parents and experts, was suggested by 15% of respondents. This included not dismissing parent concerns; not blaming parents; liaising with therapists; working as a parent-school team; providing more support for parents; and providing parent education related to school can't.	_"Educate the parents - truly educate - don't do things that follow the schools agenda of shirking responsibility under the guise of "educating parents" - point them in directions of facebook groups, articles, websites (e.g. Pathological demand avoidance, Aspergers experts, Ross Greene you tube videos) instead of the parent having to stumble on these things themselves. Educate all staff in these areas too."_ _"Follow doctors and psychologist recommendations. Stop raising the bar. Eg if a child is permitted partial attendance and they manage, don't tell them that tomorrow they can do more."_ _"Listen to parents instead of blaming them. Actually follow the guidelines around disability support instead of pretending a child doesn't have an invisible disability."_

Thematic analysis highlights the following key themes	Example Responses
The importance of a **proactive approach** to school can't, disability identification and support, and bullying was identified by 15% of respondents. There were some suggestions of early screening programs for disabilities. A number of respondents also mentioned in-school mental health and disability practitioners and programs that could assist, for example mental health youth workers, OT's, psychologists, and wellbeing programs.	*"Acting before school cant is established. I could see where we were heading when my child started school. The school and private psychologist didn't/ wouldn't act until things became dire. I was told so many times " we have to wait for things to become really bad before we can do/apply for/ implement that. Then things got really bad and no one knows what to do and now I'm told "you have to apply for the unit class we can't accommodate and it's only going to get worse. That's the only option left"."* *"Early identification of kids experiencing anxiety in the classroom, and engagement with support staff - before anxiety becomes trauma."* *"Having more awareness in mental health, health checks as in psychology staff. If a teacher suspects there is something they feel is effecting the child's ability to handle the work. First contact the parent, have the meeting and instead of the parent having to go on wait lists for assessment it can be done there at the school."*
Different teaching and learning modes were suggested by almost a fifth of respondents (19%). This included a need for more interest-led learning; providing extension and individualised projects; more flexibility in how the curriculum is taught and assessed; individualised learning; and taking a strengths-based approach with less focus on mistakes.	*"School is not a one size fits all. Different kids learn in different ways"* *"More interest led and activity based learning rather than separated subjects which are artificial and not conducive to Neurodivergent children"*
The link between school can't and disability saw **appropriate accommodations in the classroom** as an important theme (15%). This included fewer assessments, executive functioning, support for learning disabilities, social supports, proper consultation on ILPs; communication between teachers; and meeting sensory needs. Related to this, comments about **smaller classes,** more teacher aides and classroom supports were made by 11%, and some respondents highlighted the need for additional supports at key transition points – starting school and move to high school.	*"Having schools with teachers who are trained in how to support all students to experience success. What ever that looks like for each student. Personalised learning plans that don't resemble behaviour management plans. Every time I asked for a learning plan I was presented with a behaviour plan that had everything the student was going to do differently and nothing about what the teacher was going to do to help them get there."* *"a teacher assistant in every classroom so the classroom teacher can actually teach and support the children's needs. There is a lot of behavioural needs in the classrooms today. Teachers cannot and are not coping with all of the needs. And before you know it-students can't get to school. Not enough support."*
Flexibility in attendance and load was a significant theme (14%) - modifying timetables, reducing hours, reducing subjects, allowing dual enrolment, online options, and providing home learning when school is missed.	*"Providing schools or encouraging schools to do half days or reduce timetable instead of expecting full enrolment. More schools that cater for students who struggle with school but do want to learn but have challenges but don't fit in at mainstream or can't attend special development school."* *"Get rid of school uniforms that are uncomfortable and gender identifying Make attendance time more flexible and have some option to attend part time"*
Many respondents (12%) commented on the importance of school being **safe, supportive and with a sense of belonging**. This particularly included addressing bullying and social exclusion,	*"Having a connection with a trusted adult at the school who they can turn to if they started to feel overwhelmed by school."* *"Better enforcement of bullying policies A policy is only good if it is enforced."*

Thematic analysis highlights the following key themes	Example Responses
having quiet areas, helping foster friendships, and including friends in classes. This is also related to an **inclusive culture** that was mentioned by about 10% of respondents.	*"Somehow supporting my child to develop relationships with other students, including real support in how to manage relationships at school when they are complex."* *"Help them build a sense of belonging, support those isolated to connect with other friends, intervene early when struggling with being there rather than waiting till can't be there."*
Bigger picture comments about structural improvements to schools, funding, curriculum, student voice, school size, and the role of assessment and ranking were made by 16% of respondents. Some noted that the voices of lived experience of both disability and school can't should be included in this.	*"Systematically reducing the cognitive load of school, especially in the curriculum demands (too much time spent having to do too much work across too many topics). This is why so many children now are experiencing toxic stress in relation to school. For some it presents as school refusal, for others it manifests in other ways in terms of their mental health and wellbeing."* *"A radical change to the education system so it is more accessible for ALL students. A high number of school can't students are also neurodiverse because the education system not only doesn't support neurodiverse students, it often actively harms them due to outdated ideas and systems."* *"We need to have a genuine reform of education so that it encourages a love of learning, it is so prescriptive that the more a child loves learning as an all-encompassing approach the more likely they are to be completely shut down. People (adults and children) are naturally primed to learn, we don't need to be forced!"* *"Less emphasis on awards and scoring points."* *"Fewer learning areas. Interest-based learning. Engaging teachers who have time to teach rather than hacing to rush through a crammed curriculum. Less focus on assessment and reporting. More play in the early years."*
Related to the bigger picture comments, a number of respondents specifically suggested having more **alternative school choices**, recognising that not all students learn the same way and that there should be more acceptance of alternative paths. These schools were often described as smaller, and specifically meeting the needs of autistic students.	*"We need more SMALL, alternative schools, which offer a less overwhelming environment for kids with these issues. There are so FEW options that these kids have no choice but massive schools. To attend the few alternative schools they have to be on a wait list and I have to give up working to drive them across town to get them there. And - then they feel they are in a "weird" school and feel excluded from normal life because these schools are so rare they're not seen as "normal" to a teen. We need many more alternative schools run by the state govt so that kids everywhere have other options."* *"More community schools or non traditional schools. The mainstream schools are designed for neuro typical kids. More schools for kids who don't fit the mold."* *"Access to school environment suited to students with Autism (and PDA profile), including for students who have high intelligence and are suited to, or wish to pursue an academic pathway (eg VCE, not VCAL or TAFE), either distance ed or on campus school, or both."*
Question 68, SC Survey-22: "In relation to the Education system what would help support your child when they are experiencing school can't?"	
The most significant education-related supports once a child is experiencing school can't were related to reducing pressure, being flexible, and being understanding and compassionate. It was difficult to separate out the **reduced pressure and flexibility**, with	*"Patience. Stop focusing on the number of days a child is there and focus on whether they feel safe."* *"No pressure Listen to parents and children and what they can do. Don't threaten or tell them it's full time or no time. Get rid of 10 week plans"*

Thematic analysis highlights the following key themes	Example Responses
almost 40% of respondents commenting on one or both of these themes. From an attendance perspective, reduced pressure included no pressure around attendance, not calling daily to check on attendance, giving them space, allowing time away from school, and not having attendance reward systems.	
Reduced pressure overlapped with many flexibility themes – including having the flexibility of reduced hours, reduced subjects, later starting times, early finishing times, attendance without pressure to do any work, no assessments, providing appropriate accommodations, allowing students to just do subjects they enjoyed, and allowing movement breaks.	*"Once it's got this point it's very very difficult to alter that trajectory. We need to be reducing the cognitive load of school for all children as the best means of prevention. Once they are experiencing school can't, then it needs to be understood as a form of burnt out in children due to the excessive cognitive stress/cognitive load of school. It's completely predictable."* *"Allowing part-time attendance for an unlimited time. Allowing participation in those classes that the child enjoys to build relationships with the teachers."* *"Teacher making more differentiated learning projects, more choice, less rigid expectations, less punitive responses to children in the classroom, less trying to overcome issues with 'building resilience' and 'growth mindset' when children need validation of their significant difficulties and accommodations."* *"More flexible options regarding what is priority work, and what subjects/assignments could be modified or dropped when a child is struggling."*
Flexibility was also described in relation to uniform expectations.	*"Encouraging and supporting them, not punishing them for things that don't really matter. Understand that the uniform is a problem for some kids - and don't implement stupid rules like "if you are not wearing the correct uniform you have to wait at the canteen until everyone else has been served". In 10 years time, it won't matter whether they wore the correct uniform, but it will matter that they were punished and made an example of in this way."*
There were many respondents that described flexible approaches to school delivery – being able to do work from home, having online learning options, having distance education options (without having to leave the school), and being able to do assessments from home.	*"Online access to timetables and current schoolwork for all school students so they can keep up to date with what's going on in the classroom when they are unable to attend."* *"Flexible learning models. Shorter days. Able to finish school work at home. Not sending learning home increases anxiety as they know when they go back they've missed things that makes learning harder. Current policy for my daughters school is not to send work home, as it's seen to be encouraging the child to stay at home."*
Supporting students through **understanding, compassion and kindness**; taking a trauma informed approach; not judging, shaming or blaming; not using behaviouralist approaches; collaborating with students; and putting the child's wellbeing first, was identified by 30% of respondents.	*"Less judgment and less talk about resilience and growth mindset. This places the blame back on the child and leads to a cycle of shame. The child would if they could."* *"Acceptance, patience, emotional support in the form of a person or animal . Not focusing on how to increase hours and education at school, but how to increase emotional stability whilst at school, and accepting and understanding that this may not involve learning content at all. Focusing only on how to make the school feel like a safe and happy place so that learning will be a natural consequence."* *"Understanding the meaning of defence mode - constantly being in fright/flight/fight mode because you are trying to protect yourself from the overwhelming stress around you. Understanding that these kids are not attending not because "they don't feel like it" or the "parents can't be*

Thematic analysis highlights the following key themes	Example Responses
	bothered bringing them"...so threatening with court or involving a truancy officer is not helpful and only benefit is putting more stress on the family and child and taking it off the school. The parent wants their child to go to school - many parents have been through the university system and want the same for their children. These "options" only serve to take the responsibility off the education system and put it on the shoulders of the child or the parent. The parent thinks there is something wrong with their parenting - that they are failing their child. We are being treated by the education system like we are deadbeat parents. What happens when the child can't do distance education or home-schooling- because they are still in flight/ fright/ fight mode? what helpful support is there for the family then? No one has told the parent about trauma or depression - its not on the parents radar. It's not until the parent educates themselves in what is really going on. It's the parent that has to find this information. Then, they try to advocate for their child....but they are fighting against an education system culture of deflecting responsibility. The options offered to parents are distance education or home-schooling - again, taking the responsibility from the school and putting it on the parent. They need to support the parent in offering lots of decompression time to the child at home - taking the pressure off. Not having to email school every day and say xxxxx will not be attending today. Allowing the parents to rebuild that trust between them and the child and being supportive of that (and even pointing parents in the direction of Facebook groups or articles that show them how to do that), and then allowing the parent to communicate with the child. Being supportive of the parent and the child - truly supportive - not what is currently happening now, where the primary aim is for the school to deflect responsibility and accountability." *"To not be singled out more or have more attention focused on them. They just want to blend in like all the other students."*
Teacher relationships with students; maintaining a relationship without pressure; being caring; and improved teacher education and awareness of disability and anxiety, was described as supportive by almost 14%. **School-related supports** were mentioned by 13% and included access to teacher aides; school-based psychologists and mental health workers; wellbeing programs; providing teachers/tutors for home-based support; support for teachers so they could do more individualised learning and assessment planning; and more in-class help, including 1:1 supports. 10% of respondents described the importance of **working with parents**. This included comments about not threatening them, not blaming them, listening to them, and supporting them	*"Being given other options to mainstream schooling. Being referred to support groups with other school can't families (eg this School Can't group) so child (and parents) might feel less alone and freakish. Take away the stress of continually being told by every single person in the education and medical system that child MUST get back to school. That this should be their only goal. But not being offered any alternative when this doesn't work."*

Thematic analysis highlights the following key themes	Example Responses
by linking with other school can't families.	
Other recurring themes included: Having access to **less overwhelming spaces**, access to quiet spaces to regulate, smaller classes, and supervised quiet spaces. Making school feel **safe** with safe persons, safe places, and emotional support. A few people mentioned support animals. **Different approaches to learning,** including interest-based, special interest projects, different types of schools, gap year options, and focusing on life skills or more relevant curriculum. **Being proactive, and acting quickly** with early signs of school can't. **Continuing contact at home**. Some respondents described having teachers (or support team) stay in touch through email and home visits. Note that this type of contact was not about pressuring return to school or forcing a child to attend. Engaging with **external supports**, e.g. referring to external advisors, getting assessments done, allowing NDIS supports, accepting medical advice, and allowing allied health professionals to visit school. **Contact with friends**, having a sense of belonging, developing peer relationships. **Changing school** or moving to homeschooling. **Structural issues** to do with lack of awareness of the issue, Dept of Education policies and guidelines limiting ability of schools to respond, funding, structure of year 12 assessments, need for external review / support mechanisms.	*"In high school some classes are intimidating or difficult to attend so it could be good to have a casual workroom where students who can't attend a class or classes can go to do their work in a non threatening environment."* *"A safe space to go to regroup. And when a safe space is found, not forcing them out."* *"Regular, non-judgemental checking in, continuing to remind my child that she is still a part of the school community"*
Question 71, SC Survey-22: "In relation to the learning environment/school what changes might help prevent school can't?"	
There were three clear themes – quieter, smaller and more flexible. A quarter of survey respondents commented on the need for **quiet spaces that were less sensory**	*"the noise level/brights lights can be difficult for some kids to handle and lead to dread of being in that environment."* *"Quiet spaces that are accessible all the time. Movement breaks that are not dependant on staff availability to supervise. Perhaps a dedicated sensory space that is always staffed."*

Thematic analysis highlights the following key themes	Example Responses
overwhelming. Suggestions related to noise, lighting, visual overwhelm, having less transitions, quiet spaces for breaks, calmer classrooms, and access to fidgets and emotional regulation tools. These often included comments about giving students open access to these spaces (so they weren't restricted by time or someone else sending them there).	*"Easier access to time out/breakout rooms without scrutiny"*
Smaller classes and smaller schools was a consistent theme through responses (nearly 19%).	*"Smaller classes, no class changes every year; kind teachers who understand the issues and don't apply pressure."* *"much smaller, quieter classrooms with access to nature and movement."*
More flexibility was also seen as helping prevent school can't (17%). This was often a generic comment about flexibility. More specific examples included flexibility of location (allowing for some remote learning); shorter days; reduced subjects; flexibility of teaching styles; and many comments about flexibility of uniform rules.	*"More flexibility in learning options, stop packing the curriculum so full that teachers have no time for anything else and if one day is missed by a child they have no time to help them make that up"*
Other common themes included:	
Accommodations - for example, appropriate accommodations; independent learning plans; alternative ways of demonstrating learning; not having to go to assembly; supported group work, or no group work; and careful class placement.	*"Working collaboratively with parents to make adjustments to remove any barriers that can be removed eg wearing shoes, coming into class after the line up, not attending assemblies, structured play activities at lunch, lots of support in group tasks"*
Disability awareness and training of staff, with particular references to understanding different presentations of neurodiversity and anxiety, sensory overwhelm and school can't. Related to this was having a **fast response** to students needing more support with disability, anxiety and learning difficulties. This included suggestions around screening programs.	*"Having good support staff in all schools - especially primary schools - who can identify potential mental health issues early and put supports in place before things get bad. Education for our teachers on mental health and neurodiversity and trauma and implementing that into every part of the curriculum - schools implementing these 'fluffy' 'feel good' social/emotional learning programs where everyone 'just needs to be more resilient' does way more harm than good and leaves out so much basic information that teachers need to support kids."* *"Understanding invisible disabilities; true inclusionary practices in school management as well as school community; addressing bullying and recognising the autistic experience of bullying; listening to parents; not normalising or ignoring distress behaviours; flexibility and accommodations properly applied; changing classes / teachers when there is a problem (listening to students)"*
Trauma informed responses, including training around this; showing compassion; not shaming or judging; not forcing attendance; understanding the child; not behaviouralist practices; and using CPS approach.	*"Regulatory Supports NOT behaviour supports. Collaborative and Proactive Solutions (Dr. Ross Greene). Stop shaming practises in schools such as writing children's name of the whiteboard when they are struggling."*
Trusted teacher relationships. This was about teachers understanding relationship building; having time with	*"The school can't came from a big list of little problems. Each on their own isn't much. If someone at school checked in regularly with my child one on one. Perhaps a lot of them could have been removed before the child was*

Thematic analysis highlights the following key themes	Example Responses
students; not yelling; having consistency of teachers and less swapping; and showing genuine interest in the student.	*overwhelmed"* *"one or two staff they have a solid relationship with not rotating staff and support staff,"*
Interest-led learning and other related approaches were mentioned by 10% of respondents. These included child-led learning; project-based learning; hands-on learning; more outside learning time; more creative opportunities; and alternative school options. Related to this were comments around **encouragement** – finding angles for success; celebrating unique interests and skills; and more enjoyment at school.	*"Options for small group learning that are capable of academic extension and socialising with like minded peers."*
More in-school supports were suggested. This ranged from more teachers and teacher aides to learning support; wellbeing and allied health supports; and more supports for teachers.	*"Lack of support (large classrooms where the teacher cannot provide 1-on-1 assistance) can also lead to a vicious cycle. If the student doesn't absorb the full benefit of the lesson (didn't understand, have questions, need help to get started, etc), this turns into failing to keep up with their peers and performing badly on tests/assignments, which discourages them and makes them feel worse about their abilities and less likely to try next time."* *"An advocate, wellbeing support worker who can provide 1:1 support during periods of anxiety. Greater communication between teacher/student/parent as child is unable to self-advocate"* *"More integration aides to help with the kids who fall through the cracks because they are too good to receive the help they require but not bad enough to receive help with limited resources."* *"Smaller classes, better trained and supported teachers. Teachers are drowning under admin and overwork and even those with good intentions don't have the time or skills to help."*
Reduced pressure, including fewer assessments; no homework; different grading systems; less competitive pressure; slowing down; and having more break times.	*"We need to dramatically declutter the curriculum and not apply such pressure on children to be doing academic tasks that children 20 years ago did not have to attempt."* *"Less assessment. Less time pressure. More choice. Time for creative and deep learning."*
Feeling safe at school – safe places, addressing bullying, safe ways to ask for help, and access to safe people. Related to this was a theme of **inclusion**, an inclusive culture and building friendships. Some suggestions included lunch time programs and buddy benches.	*"There needs to be clear communication with students of a safe place to go if feeling overwhelmed- without judgement. Make students feel safe expressing their discomfort instead of being dismissed"* *"genuine inclusion so that those who can't manage a 'one size fits all approach' are not made to feel wrong/weak/failed/othered."*
Other recurring themes (but less frequently mentioned) included: **Student autonomy, trust and respect** and validating student experiences. **Focus on mental health and wellbeing**. Often this was linked with statements about less academic pressure. Some suggestions were related to wellbeing programs, helping students learn about themselves (eg coping strategies and	*"Emphasis on social emotional development rather than academics"*

Thematic analysis highlights the following key themes	Example Responses
learning styles), and pastoral care programs. **Listening to parents** and working with parents. **School "rethink"** which were bigger picture comments e.g. about the need to modernise education or the curriculum; reduced pressure at the start of school and start of high school; having less tech in schools; and shorter learning blocks.	
Question 74: **SC Survey-22:** ***"Finally, is there anything else you would like to tell us about your experience of School Can't that we haven't already covered?"***	
Judgement was by far the most common theme, highlighted in 19% of the responses to this question. Many said that school can't was isolating.	*"I often felt lost, alone and powerless when our son was experiencing school can't."* *"(We) were treated by our son's school as if we were stupid, terrible, weak parents who really didn't understand the importance of education and what we were 'doing to' our son by letting him miss school."*
The emphasis by schools on **behaviour** and the way schools push the use of **force** to get children to attend was underlined.	*"School has highlighted that my son's stress response can easily be misinterpreted by many as a child being disobedient and rather than a child that is truly struggling."* *"The system as it stands is literally punishing them for being different, for being unable to do things that they simple cannot do, due to disability &/ or trauma."*
Declining mental and physical health were common effects of school can't on children. Common effects of school attendance difficulties on parents were **trauma**, declining **mental health**, **overwhelm**, **exhaustion**, and **isolation**.	*"The impact on my ability to work, my own life as a person who has choices and my mental health is significant."* *"We have experienced trauma. Possibly we have PTSD now as a result of school can't and how we have been treated or neglected by schools, education dept, health professionals. It has changed everything about my life and the life of my child. I feel like we have been in a war. It has changed me irrevocably."* *"My daughter's School Can't is more stressful than my cancer diagnosis."*
Financial distress and **impact on career** were frequently cited along with **impact on relationship with partner**.	
Several respondents outlined how school can't **affects the whole family**. This included the emotional impact, and a negative effect on siblings' schooling.	*"School can't is an extremely stressful time for the whole family. I cry every single day. My whole life has been impacted to the point where I feel like I want to break up with my husband so I can have a break from my son. It feels like it's never going to get better and the only people who understand are ppl in the same situation."*
Of those who responded to this question 13% cited a **lack of support**. Common themes were the **lack of resource**s and need for e**ducation of teachers** in school can't.	*"Schools can listen and understand but there is not a clear path of strategies and they don't know what to do."*
The need for **accommodations** and **flexibility**, and conversely accommodations not being provided and lack of flexibility were frequently	

Thematic analysis highlights the following key themes	Example Responses
mentioned. **Gatekeeping** was also highlighted by several people.	
Many respondents said that there are not enough **alternative education** settings. Others have already moved their child to an alternative setting. Some have turned to **home education**.	
Many took the time to say how valuable the peer support Facebook group is. Several said that they appreciated having a voice in the Senate Inquiry through the survey.	

PISA 2022: Estonia consistently among the world's best

The PISA 2022 educational survey published on December 5th 2023, shows that the knowledge and skills of Estonian 15-year-olds are at the absolute top in Europe and in the top eight in the world, with the top countries in Asia. This time, the study focused on mathematics but also assessed students' skills in science and reading. Among European countries, Estonia ranks 1st-2nd in mathematics together with Switzerland, 1st in science and 1st-2nd in reading with Ireland.

The Minister of Education and Research, **Kristina Kallas**, said that Estonia's results compared to other countries are characterized by the fact that a significant number of Estonian children achieve baseline level of proficiency in mathematics. "This means that our teachers pay a lot of attention to all children equally in the class, and we achieve the top results in the world not only thanks to the most capable children, but with the above-average result of all children. The professional skills of Estonian teachers are a key here," said the minister.

Estonia's continued success

PISA 2022 results were released globally at the same time today. A total of 690,000 students from 81 countries or economic regions took the test in the spring of 2022. In Estonia, 6,392 students from 196 schools took the test. The PISA test consisted of tasks in mathematics, functional reading, science and creative thinking, and this time the emphasis was on mathematics. Students and school heads also completed questionnaires, which have been used to analyse and interpret the test results.

The study showed that in addition to having very good knowledge and skills, Estonian students are mostly satisfied with their lives. The assessment of their life satisfaction (average 6.91 points on a 10-point scale) is higher than the OECD average (6.75), similar to Sweden(6.91) and slightly lower than in Finland (7.41). Boys are more satisfied with their life than girls. Students with a better socioeconomic background are more satisfied.

Students believe in self improvement and growth mindset

Estonian children also believe that their results are in their own hands. Similarly to the PISA 2018, we rank first in the comparison of countries in terms of growth mindset. This means students believe that they are capable of improving their intelligence and willing to put effort into their development to secure a better future.

In addition, children in Estonia feel safe at school. Students' sense of security is higher than on average in OECD countries, especially because of the safer way to school. The feeling of safety in the classroom and in other areas of the school is similar to the OECD average. Estonian basic education system supports students to become self-directed learners. Estonia is among the countries where seven out of ten students feel that they are ready for self-directed learning.

Estonia excels in educational autonomy

PISA shows that the headmasters and teachers have a great deal of autonomy. Estonia is in first place in the comparison of countries in terms of teachers' freedom in setting up the school curriculum and participating in school management decisions.

The biggest challenge in Estonian education, which we are actively dealing with in the coming years, based on the results of the survey, is the lack of qualified teachers, which has increased compared to the previous survey. In addition, the influence of students' socioeconomic background on receiving quality education has increased, we are approaching the OECD average (Estonia 13.4%; OECD 15.5%). The results of students with the Estonian language of instruction are better than results of students with Russian language of instruction. The results of students in schools in smaller cities have fallen, but the results are still strong, being 34 points above the OECD average.

All over the world, students' results have fallen compared to the results of PISA 2018, but the results in Estonia fell less compared to others, which shows that we managed to organize education quite well during the COVID-19 pandemic.

For more information about the results of PISA 2022, please visit the Estonian Ministry of Education and Research's website.

See also:

OECD. PISA 2022 results

Estonia. OECD nountry note, PISA 2022

Related

- Estonian education system (https://www.educationestonia.org/about-education-system/)
- Estonian and international reports on Estonian education (http://educationestonia.org/reports/)
- Insights from 5 leading education systems, including Estonia (https://www.educationestonia.org/leading-education-systems-including-estonia/)

5 December 2023

Share

Print

Queensland Government
QUEENSLAND TREASURY
Queensland Government Statistician's Office

Schools Queensland, 2022

Source: ABS, *Schools*, released 15 February 2023, 10.30 am (AEST)

Key data

Full-time students (annual change):

Queensland	↑ 0.4%
Australia	↑ 0.3%

Teaching staff (full-time equivalent annual change):

Queensland	↑ 1.2%
Australia	↑ 1.2%

Student to teaching staff ratio (full-time equivalent):

	Primary	Secondary
Queensland	14.7	12.1
Australia	14.4	11.9

Main findings

- In August 2022, there were 1,791 schools in Queensland, of which 69.7% (1,248) were government schools and 30.3% (543) were non-government schools.
- Of the 1,791 schools in Queensland in 2022, 1,141 (63.7%) were primary schools, 276 (15.4%) were secondary schools, 279 (15.6%) were combined primary/secondary schools and 95 (5.3%) were special schools.
- Queensland had 868,380 full-time students attending schools in 2022, 21.5% of the Australian total. Of these, 65.6% attended government schools and 34.4% attended non-government schools. The proportion of full-time students attending non-government schools has increased by 1.0 percentage points since 2012.
- The number of full-time students in Queensland increased 0.4% over the past year, compared with 0.3% for Australia. Queensland's full-time equivalent teaching staff increased 1.2% over the past year, compared with an increase of 1.2% for Australia.
- In 2022, there were 77,638 Indigenous full-time students in Queensland, 30.5% of the total number of Indigenous students in Australia.
- In 2022, the full-time equivalent student to teaching staff ratio for Queensland schools was 13.4, this was higher than the Australian ratio of 13.1 (Figure 1). For Queensland primary schools the student to teaching staff ratio was 14.7 and for Queensland secondary schools the full-time equivalent student to teaching staff ratio was 12.1.
- Queensland schools employed 65,045 full-time equivalent teaching staff in 2022. Of this total, 32,426 were employed in primary schools and 32,619 in secondary schools.
- Of the full-time equivalent primary school teaching staff in Queensland, the female to male ratio has increased from 4.1 in 2012 to 4.9 in 2022. Similarly, for full-time equivalent secondary school teaching staff, the female to male ratio has increased from 1.5 in 2012 to 1.6 in 2022 (Figure 2).

Figure 1 Student to teaching staff ratio (full-time equivalent), 2022

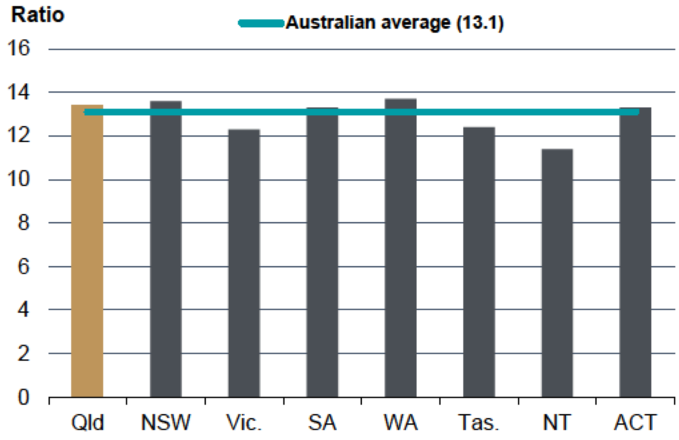


Figure 2 Full-time equivalent school teaching staff, female to male ratio, Queensland