MENTAL HEALTH SELECT COMMITTEE

Members present:
Mr JP Kelly MP—Chair
Ms AJ Camm MP
Mr RI Katter MP (virtual)
Ms AB King MP
Mrs MF McMahon MP
Mr R Molhoek MP
Mr BL O'Rourke MP
Dr CAC Rowan MP

Staff present:
Dr A Beem—Acting Committee Secretary
Ms M Westcott—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE OPPORTUNITIES TO IMPROVE MENTAL HEALTH OUTCOMES FOR QUEENSLANDERS

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 11 FEBRUARY 2022

Brisbane

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The committee met at 10.08 am.

BROOKS, Mr Phillip, Deputy Director-General, Youth Justice, Department of Children, Youth Justice and Multicultural Affairs

CRAWFORD, Dr Meegan, Chief Practitioner, Department of Children, Youth Justice and Multicultural Affairs

MAURER, Ms Rebecca, Practice Leader, Mental Health, Department of Children, Youth Justice and Multicultural Affairs

McINALLY, Dr Beth, Director, Student Wellbeing, State Schools Operations, Department of Education

MISSEN, Ms Helen, Acting Executive Director, Strategic Policy and Legislation, Department of Children, Youth Justice and Multicultural Affairs

STEVENSON, Mrs Hayley, Acting Assistant Director-General, State Schools Operations, Department of Education

CHAIR: I welcome representatives from the Department of Education and the Department of Children, Youth Justice and Multicultural Affairs. I ask each department to make a very brief opening statement and then we will move to questions.

Mrs Stevenson: Before I start, I would like to respectfully acknowledge the traditional owners of the land upon which this hearing is being held and pay my respects to elders past and present. I thank the committee for the opportunity to provide an opening statement. As the Department of Education, we deliver education and support to over 580,000 students across 1,258 state schools. This includes 924 primary schools, 194 secondary schools, 94 combined primary and secondary schools, and 46 special schools.

For our department and all our state schools, our strategy and our moral imperative is 'Every student succeeding'. This means we focus on the needs of students to ensure the success of every child, both in terms of their learning and in terms of their mental health and wellbeing. Guided by our Student Learning and Wellbeing Framework, schools take a whole-school approach to supporting all students' mental health and wellbeing across the continuum of care. This includes whole-school approaches to providing universal prevention and promotion through to, at the school, providing support for students with mild to moderate mental health concerns and assisting students and their families to access specialised intensive support in the community when it is required. Developing and sustaining positive relationships, having mental health literacy and being able to ask for help when it is needed are the key components of good mental health. To support children and young people to develop these personal and social capabilities, we deliver social and emotional learning through the curriculum.

The department also has a really well established and highly respected guidance workforce. Our guidance officers are specialist teachers with training in mental health as well. They provide targeted support for students with mental health concerns. Last year we had approximately 804 full-time equivalent guidance officers across the state, and they were supported by 78 full-time equivalent senior guidance officers as well.

Anecdotally, we are aware that student mental health support is increasing in schools. We are also highly cognisant that the pandemic has had an impact on the mental health and wellbeing of young people. Queensland Health reports that an increased need for mental health support has been particularly evident in young people and that referrals to mental health community treatment services have increased around 20 per cent from the 2019-20 financial year to the 2020-21 financial year.

In response to rising demand, significant work and investment from the Department of Education has occurred to ensure that we strengthen our approach to supporting the mental health and wellbeing needs of students. Most notably, the department is implementing a $100 million student wellbeing package. The package will see state primary and secondary school students across the entire state with increased access to a psychologist or other similar wellbeing professional. Over three years, we will be employing up to 464 full-time-equivalent wellbeing professionals. In term 1 of this year we already have 62 new wellbeing professionals in our schools, and this includes 49 psychologists amongst that 62.

Data provided by the Queensland Mental Health Commission indicates that, in Queensland's population of over 5.18 million people, 730,000 people will experience mild to moderate mental health concerns. This is the focus of our wellbeing workforce—that is, supporting students with mild to moderate mental health concerns—because we know that early intervention in this space can dramatically improve the trajectory of illness and the life outcomes for those young people.

We are also conducting a pilot where we are placing GPs in 50 state secondary schools. This will allow secondary students with access to a GP on school grounds one day a week. This will overcome some of the barriers young people often experience in accessing health care within the community. We know that providing access to GPs will also play a pivotal role in the early intervention for mental health concerns. Our colleagues in Queensland Health attest that access to GPs and generalist health services as part of a stepped model of mental health care is critical in preventing conditions from worsening.

There is always more that can be done. We know that there is nothing more important than supporting the mental health of young people so that they can fully participate in education and enhance their outcomes in the future.

Ms Missen: Thank you for the opportunity to appear before the committee today. I begin by acknowledging the traditional custodians of the land on which we meet, the Jagera and the Turrbal people, and I pay my respects to elders past, present and emerging and I pay my respects to all of the Aboriginal and Torres Strait Islander children involved in our system, their families and our Aboriginal and Torres Strait Islander staff.

The department has portfolio responsibility across a broad range of topics. We have responsibility for children and families through the provision of family support and tertiary child protection services, through the provision of youth justice services, multicultural affairs and also a whole-of-government responsibility for the redress scheme established under the Royal Commission into Institutional Responses to Child Sexual Abuse. The department recognises the significant risk of poor mental health outcomes for Queensland children, young people, families and communities that we provide services to every day and the critical role of all levels of government and the non-government sector to address the causes of poor mental health outcomes and create the environment for good mental health and wellbeing for all children and families.

For Aboriginal and Torres Strait Islander peoples and communities, the separation and isolation of children, families and communities was and remains a traumatic experience that correlates with an increased likelihood of adverse cultural, health and socio-economic outcomes. Children and young people leaving statutory care or transitioning out of the youth justice system face significant risk of a variety of poor outcomes, particularly those who have traumatic family experiences and may have limited family support networks and connection to their communities and culture.

People from culturally and linguistically diverse backgrounds in Queensland, including the elderly, refugees and people seeking asylum, are particularly vulnerable to poor mental health outcomes. These experiences can be compounded by other disadvantages associated with language and cultural barriers and barriers to social and economic participation, including housing stress, unemployment and insecure employment. The department funds the Asylum Seeker and Refugee Assistance program to deliver financial and material aid, case management and coordination support to vulnerable culturally and linguistically diverse communities. This includes people seeking asylum and people with temporary protection visas residing in Queensland.

Through a partnership process with the World Wellness Group, support is provided for mental health through health advocacy, securing pro-bono health services, coordination of treatments, payments for medication and referrals to specialists. The Asylum Seeker and Refugee Assistance program provides services to clients through outreach hubs in Logan, Indooroopilly and Gatton and includes mental health support provided by the Queensland Program of Assistance to Survivors of Torture and Trauma.

Through the redress scheme, people who experienced institutional responses to child sexual abuse can access up to 20 hours of counselling and psychological care along with a financial payment and a direct personal response from the responsible institution. People who experienced child sexual abuse need access to a trauma informed, individualised approach across all spectrums of health care, not just access to counselling and psychological care as provided under the scheme. Positive experiences are reported by people who are supported by a trauma informed team of providers who operate together to meet the person's physical and psychological care needs.

Chair, I would leave it to Dr Crawford and Mr Brooks to speak to the specific needs of the families and children involved in the child protection system and the youth justice system and I offer that the department is well placed to connect the committee to leaders and service providers who can assist the committee with further information on this matter if required.

CHAIR: Did you want to make another brief opening statement? If so, we will give you two minutes.

Dr Crawford: Good morning. I, too, thank you for the opportunity to appear before you. I would like to acknowledge the traditional owners and pay my respects to elders past, present and emerging. I am going to cut right to it, Chair.

CHAIR: Please do.

Dr Crawford: Demand for child safety services is high. As at 30 June 2021, 14,123 children were receiving ongoing intervention from the department. Some 12,512 of these children were subject to child protection orders or assessment orders. First Nations children are significantly over-represented in the system and, as referenced by my colleague, face a range of significant intergenerational impacts as a result of colonisation. Throughout the department's contact with children, the mental health of both parents and children may be raised as an issue of concern. There are matters when a parent may be experiencing mental illness which impacts on their ability to safely parent. The department's data regarding the outcomes of our investigation and assessment processes reveals that in households where harm has occurred for children—so that is for around 6,408 individual children—mental health is recorded as a parent risk factor in 55 per cent of those households. Other parent risk factors include alcohol and other drug use, domestic and family violence and criminal history, and in almost three-quarters of those households more than one of these risk factors is also present.

We are very aware that children who have experienced neglect and abuse are more vulnerable to mental health concerns and that trauma can impact the emotional wellbeing of these children. Research tells us that increased adverse childhood events lead to increased health and social problems across the life span. We know that for many children subject to child protection orders they have experienced a high number of adverse childhood events which further increases their vulnerability and risk of developing adverse mental health outcomes. Mental health expertise is often required to assist children and young people who are known to our system. We see young people with symptoms of conditions like post-traumatic stress disorder, depression, anxiety, reactive attachment disorders and self-harm and suicide risk.

Such is the need for mental health support for this cohort of children that the department has funded the Evolve Therapeutic Services through Children's Health Queensland Hospital and Health Service to provide specialist trauma informed mental health services for children aged zero to 18 years. These children experience severe or complex psychological and behavioural support needs. As at July 2021, 532 children and young people, mostly over the age of eight years, were receiving Evolve services. While these services can be very effective, we are currently working with Queensland Health to build a program that will better meet the needs of high-risk young people. These young people are typically aged over 15 years and their mental health, psychological and behavioural issues can create challenges in securing and maintaining safe accommodation and accessing therapeutic supports. What that means is that they often disengage from education or training, they lose their positive peer and family relationships and they can engage in very significant high-risk and self-harming behaviour.

I will skip forward. We do have a number of initiatives in addition to Evolve to support young people in this cohort. We have some health liaison officers, we have a Navigate Your Health program, we have a Strengthening Health Assessment Pathway and within my office of the chief practitioner we employ a number of specialist clinicians to meet those complex needs. We have an appointed mental health practice leader, who is with us today, but before I end I would just like to mention the child safety workforce. Child safety practitioners are often faced with very distressing, very complex and very frightening situations and they see firsthand abuse and neglect and the impacts of that harm to children. We know that such work impacts mental health and wellbeing and I would just ask the committee to consider the needs of essential workers like child safety practitioners. Thank you.

CHAIR: Thank you. Before we start questions, I would like to just declare a conflict of interest potentially to the committee. I am a volunteer registered nurse with the World Wellness Group which was referred to by Ms Missen. I do not believe it creates any conflict, but I did want to declare that.

Mr O'ROURKE: Thank you for being here today for your briefing. My question is directed to Mrs Stevenson or Dr McInally. Are students, particularly in the prep years, assessed for any adverse childhood events? If so, what steps are actually taken after that assessment? Is there any reassessment of a child who might experience a parent's death in the family or divorce or things like that?

Mrs Stevenson: We do not have any routine screening that would occur around adverse childhood events in the prep year, but what we do have is our guidance workforce, who are really skilled. They will often do assessments of that nature if there are concerns raised. If a teacher sees behaviours from a student that they are concerned about, they will talk to the guidance officer and there might be assessments made there. Our schools have a really effective response to trauma that they know their families have been through, so we have a systematic response to that. We would see that with the guidance officer or other support staff in the school, and in the regions too. If there is a death or a traumatic incident, we have our senior guidance officers who will go out and provide that bolstered support for a school or a family that might need it.

Dr ROWAN: I might direct this question to either Dr Crawford or Helen Missen from the Department of Children, Youth Justice and Multicultural Affairs. Based on what you have said this morning, should the Queensland government consider implementing a specific whole-of-government adverse childhood experience and/or complex trauma strategy, given that many of these matters cross departments? If so, should the responsibility for oversighting such a strategy sit with the Department of the Premier and Cabinet?

Ms Missen: The department operates under a number of whole-of-government strategies that impact on the provision of services to children and families experiencing risk. Supporting Families Changing Futures is the lead strategy driven by the department where the department has portfolio responsibility, and that is about that holistic approach to meeting family need and creating a service system that responds to the needs of children and families. The department then makes commitments under other whole-of-government strategies led by the Queensland Mental Health Commission and strategies led by the Department of Education that all point to a collective approach to responding to the needs of children and families. Through processes of reporting to government, the impact of the implementation of those strategies is assessed and government has the opportunity to consider whether or not there is any further need.

Dr ROWAN: I have a question to Acting Assistant Director-General Hayley Stevenson in relation to the student wellbeing package—the $100 million. You spoke about the 50 GPs who are going to be in schools providing a day a week. That is going to be important working with the other professionals such as psychologists, nurses and other mental health professionals. Could I just ascertain from the Department of Education's perspective what infrastructure is going to be allocated to this—in other words, the spaces that will be provided for those people and whether there are additional buildings or dedicated spaces and the IT infrastructure or clinical software systems? I want to know about all of the detail, I guess, of how these people are going to be supported providing those services.

Mrs Stevenson: In the process of selecting the schools, schools submitted an expression of interest, and part of that was them identifying that they had a suitable space that could be set up as a clinic. Then the successful schools received an additional $20,000 for some of those infrastructure upgrades to ensure the clinic space was appropriate. There were some learnings from a school that already had a GP in place. One of those learnings was about the IT connectivity and the use of the medical records system. Learning from that, the requirement was that the GP brings their own laptop and with access to the internet so that we did not need to overcome any of those confidentiality issues or potentially have our staff having access to those medical records. We do have a very extensive operational guide to provide to schools so that they can ensure things like the waiting area is set up appropriately and they have a system for making bookings and that the GP brings along a clinic nurse to assist with supporting the young person who is seeing the GP and record keeping.

Dr ROWAN: Thank you.

Mrs McMAHON: This morning we heard from a range of youth advocates about their experiences and lived experiences with mental health. Most of them touched on their time at school. Notwithstanding the amount of pressure we put on our teachers and certainly the pressure that they have been under the last few years, many of them suggested further mental health training or experience with teachers. I was also interested that they spoke about the early years—that is, the

primary school teachers—where a primary school teacher has more face-to-face time with an individual student. Can you tell us: within the professional development space or within teacher registration, what mental health training is currently done or is sought to be done or do you believe should be implemented to make sure that our teachers are better prepared not only in working with children with mental health but also in potentially identifying in those early years where prevention can and may be possible with a better outcome?

Mrs Stevenson: I cannot speak to the teacher registration process and the training there, but I could certainly get some information about that. In relation to professional development provided to our teachers, it is a really busy space. We have done some work, particularly in partnership with headspace, around providing access to training for our teaching workforce. As we say, we have a workforce of around 70,000 people, so that is a lot of eyes on young people and who have the ability to detect if something is not quite right with a young person.

Beth may be able to speak to this in more detail. We have developed resources for teachers to be able to notice, the skills to then inquire and then plan the next steps to provide support for students. That would be a referral to a member of their support staff in the school. It is not mandatory training. It is training that is done as identified by the school or by the region. We have eight Principal Advisors Mental Health that work in our department—one in the central office and one in each region. They work with schools in a coaching role to assess the needs of their school workforce. They would then facilitate the training that they see as being required for the staff. That might be training in that notice, inquire and plan approach, or it could be training in implementing the social and emotional skills training within the curriculum. It is a differentiated approach, depending on the needs of the school and the complexity of the school community.

Dr McInally: To add to what Hayley said, the Principal Advisors Mental Health are really pivotal in that because they can provide some professional development sessions of their own to school staff when that is required around social and emotional development, but also they facilitate, like Hayley said, the headspace training which is called SAFEMinds, which is about early noticing, inquiring and knowing how to respond appropriately. We are only in the early stages of rolling that out, but at the moment there has been positive feedback. Also the Principal Advisors Mental Health can link the schools in with other professional development, so schools can make the local decisions about who may be best placed to provide that to meet the needs of their particular cohort as well.

Mrs McMAHON: Within the curriculum, what are we doing in terms of assisting our young people within school hours to recognise and identify and have pathways to look after their own mental health?

Mrs Stevenson: Within the Australian Curriculum, in the general capability, there is a range of social and emotional skills that are built on from prep all the way through the years of schooling. That is already within the curriculum. Part of our role and the role of the principal advisers is to support teachers to be able to deliver that. It is built within there. In a recent look at the curriculum, particularly around the sexual consent and reporting aspect, we have identified a number of junctures where particularly help-seeking behaviours are incorporated and called out within the curriculum. We think that is a really important element that we need to address and further strengthen. We know that young people need to know not only how to ask for help and how to help their peers but also how to access health care. We think part of having GPs in schools is upskilling our young people in making an appointment, having that first conversation about what their issue is and then accessing and getting the extra support they need.

Ms CAMM: My first question relates to education—you may have answered it—with regard to the rollout of GPs and psychologists which has been very much welcomed, particularly in my electorate. In rural and remote schooling, is there flexibility within the department, particularly where there may not be the services, and do you foresee any challenges around the recruitment of those services, like psychologists and GPs, where it is predominantly—you might have a township or community with only one GP now, so do you foresee any challenges or have you built in a strategy to be able to provide services alternatively to those schools?

Mrs Stevenson: Yes, both: we see challenges and we have built in strategies. In relation to the GPs within schools, it was part of the expression of interest. A school already had to have a GP who had agreed that they would provide the service to the school. They had already established that relationship with the GP who was willing to then provide one day a week out of their practice to go to the school. For some of the GPs or the clinics, they are rotating it so that there might be two GPs who will alternate and take turns at the school. I know that in the Murgon hub, for three of the days of the month it is a female GP and then for one day it is a male. Schools are doing that flexibly and in response to what capacity there is in the community.

In relation to the psychologists, we do know that there are challenges in the mental health workforce, and that is nationally. We have a range of strategies in place and a lot of contingencies. With respect to the rural and remote, in Queensland Education we have four centres for learning and wellbeing. There is Roma, Mount Isa, Atherton and one more. Part of the process is that if our schools cannot recruit people in small fractions then we will have the professionals based at these centres for learning and wellbeing, and they will then provide that outreach support to the smaller schools. We have also built in the flexibility that if schools at any certain time cannot employ directly, there is that opportunity to partner—it might be an Aboriginal mental health service—to broker in that support. We have also had discussions with other agencies, like the Royal Flying Doctor Service. We have a range of plans. Ideally, we want to build our own workforce, and that is the goal—to have psychologists that we have employed who are in schools—but we want to make sure that students have the access to support.

Ms CAMM: Dr Crawford, in relation to the workforce across Child Safety and Youth Justice, do you feel the department has adequate support for its own workforce who are dealing with significant and more complex trauma and issues that they are facing? This is a recognition by me, and I am sure many, as I travel the state and meet with departmental staff. We know that there are turnover rates and that retention is really important—and I have commended the government strategy for recruitment—but what kinds of supports are in place currently for the workforce? Do you see the workforce taking up those supports, or do you think there is a greater need for resourcing for that support for the workforce across your departments?

Dr Crawford: I think it is worth mentioning that the prerequisite for our staff to join as child safety officers is that they have an undergraduate degree in social work, human services or psychology. We do allow some other pathways, but mostly they are coming with a human services qualification, which does give them a platform to do this very complex work. We know that support is always required. As you have said, the work is complex. We have in place formal supervision processes. We talk often about peer relationships and peer supports that should be available to staff. We have training, we have mentoring programs, and we have access to debriefing and therapy if and when required through Benestar. Those supports are in place. We take the wellbeing and safety of our staff very seriously, and we do look to proactively provide that support to them.

Mr Brooks: Can I please also acknowledge the traditional owners on the lands on which we meet, elders past, present and emerging and, of course, any Aboriginal and Torres Strait Islander people watching today. I am a Bidjara man but grew up in North Queensland. I would like to pay respects to my family and also my wife’s family from Cloncurry-Mount Isa way. I acknowledge the impact that this committee can have on the lives of young people in Queensland and the also the Aboriginal and Torres Strait Islander young people in Queensland.

Only by exception, as the member would understand, we are part of the same department, including around the professional services. One of the things we did identify in relation to Aboriginal and Torres Strait Islander mental health supports was going out and ensuring that we have access for our staff to Aboriginal and Torres Strait Islander clinicians and counsellors, and we have done that now.

Mr KATTER: The member for Whitsunday went straight to the point of where I see my primary interests lie, which is the remote areas, and Mr Brooks answered in part another one of my questions. We have enormous trouble even trying to get in to see a GP in Mount Isa at the moment. You responded with regard to the doctors engaging with the RFDS and working with the CLAWs, who, I might add, are a terrific service that the government has provided. We have a CLAW officer here in Mount Isa. I think that will be an enormous challenge trying to get that. It is a good initiative, but I think that will be an enormous challenge when we are trying to get doctors and nurses in these areas, trying to insert that in there, but it is very well intentioned.

Say with a school like Sunset School in Mount Isa, where you probably catch a lot more socially disadvantaged kids, the question which sits in my head as a layperson is: a lot of those kids may be classed as just misbehaving, playing-up kids who are a bit lost, so where do they fit into the mental health space? Where is the threshold on that? I imagine you are going to start capturing a fair bit. Then do you have strategies to pre-empt where you will have the bulges of cases at, say, Doomadgee or maybe Sunset where we could really use that help?

Mrs Stevenson: I agree. I have been out to the Mount Isa CLAW on a number of occasions and it is a fantastic service. They have a head of wellbeing out there as well. In relation to providing that early intervention, I do think that our psychologists and wellbeing professionals are really well placed to be able to support students. It does not require a diagnosis of a mental health issue. It could be that some of the behaviours they are exhibiting are concerning. You could have a wellbeing

professional or the range of different support personnel available to schools to be able to do an assessment and to provide some of that wraparound support. We also have, in all of our regions, somebody leading this work who will be touching base with the schools to be able to pick up those emerging patterns of high need. Where we cannot recruit to a particular area, we will be able to provide support, either somebody visiting face to face or linking in. We are trying to make the service really accessible. We will have our schools cluster the amount of wellbeing professional service that they have available so that we can then employ a full-time person, and that full-time person will need to travel and do a bit of a circuit or be based at the CLAW or, as we said, we can broker in services from already established organisations.

Mr Brooks: I acknowledge all the Aboriginal and Torres Strait Islander persons present. One of the things I want to raise is that the 1997 *Bringing them home* report spoke about child-rearing practices being removed by previous government policies. Why is that important? The lack of child-rearing practices or permissive parenting can actually lead to childhood trauma. We do know that childhood trauma ultimately leads to, unfortunately, mental health issues, antisocial behaviours which we have seen and the traumatic experiences which are otherwise seen within the courts and/or police activity and then ultimately our youth justice system.

I do want to say very quickly, because I am not sure I will have another chance, that of all the Aboriginal and Torres Strait Islander young people in Queensland aged 10 to 17 inclusive in 2020, 94.9 per cent did not touch the youth justice system. There is strength in our Aboriginal and Torres Strait Islander families. There is strength in our communities. Aboriginal and Torres Strait Islander families do see things differently and, again, there will be some clinicians you will talk to later. Ultimately, we would like to see more Aboriginal and Torres Strait Islander clinicians fill the space.

On behalf of my colleagues in health, I say this is not a unique problem to mental health. All services across Queensland would like to see more Aboriginal and Torres Strait Islander clinicians and/or people with decision-making powers to assist families.

CHAIR: That is an incredibly important point. My question is for Dr McInally and Mrs Stevenson. In your opening contribution you talked about the focus of EQ services being around that mild to moderate end of people with mental health issues. Is that because there is not much beyond the school gates for people who are in that category in terms of seeking early intervention and treatment?

Mrs Stevenson: I believe that is the case. We hear from school communities and families that it is sometimes difficult to access support before it gets to crisis point. In mapping the availability of services, we wanted to make sure we covered the continuum. Our colleagues in Queensland Health have that tertiary system and that intensive support covered. Certainly the goal was to provide that early intervention when something is not quite right so that hopefully we have a more positive outcome on the trajectory of illness. The feedback particularly in regional areas—and also in rural and remote areas—is that it is very difficult for families to get that early intervention support, before it becomes a crisis.

CHAIR: You talked about wellbeing professionals, which I think was the term you used. Are you anticipating more than just psychologists, or are you talking about peer support workers, counsellors and maybe nurses and social workers?

Mrs Stevenson: At the moment our first preference is to employ psychologists, but across our regions we have also employed some social workers—so social workers, guidance officers with a particular counselling focus and youth workers. That is the workforce mix at the moment that we are targeting for the wellbeing professionals.

CHAIR: This is for Dr Crawford, Mr Brooks and perhaps Ms Maurer. In terms of young people who are in care or custody, could you outline what assessments and mental health services are currently available?

Ms Maurer: I would like to begin by acknowledging the traditional custodians of the land we are meeting on here today and pay my respects to elders past, present and emerging. Essentially, within Child Safety I do want to acknowledge that we are not trained mental health clinicians, but there are things in place around training and our procedures that assist with child safety practitioners to be identifying some of those signs and to be accessing referral pathways including to our Evolve Therapeutic Services and to our Child and Youth Mental Health Service colleagues. Within the department, though, we do have other resources available and supports to be accessed. Some of those are our specialist services clinicians who are throughout the regions. They might be engaged if there is perhaps something that is not quite as straightforward as being able to just easily access the referral to be providing some more assessments, or people from the regions may be reaching out to me for some consultation, support or advice.

Mr MOLHOEK: Dr Crawford, what assessments, supports and considerations are made around children in foster care, particularly around issues like multiple placement? I am not sure whether they call that multiple placement syndrome, but I know that it has been a huge issue within the system. How is the department dealing with that and trying to improve the mental and emotional health of young people who go through that process?

Dr Crawford: Stability or permanency, as we often refer to it, is very important for us. We do have a number of strategies in place to ensure that we are increasing stability for children and young people. We always preference the placement of children or care arrangements for children with their own family members. That is an attempt to bring additional security.

In terms of assessment, as my colleague referenced, we do rely very much on our Child and Youth Mental Health Service colleagues and our Evolve colleagues. I have—and I mentioned it previously—specialist services clinicians within the Office of the Chief Practitioner and interfaced back with the NDIS. In recognition of the number of adverse childhood events that many of our children coming into the system have faced, we have suggested that we refer all zero- to seven-year-olds to the NDIS pathway, the early childhood pathway, so that they can be assessed and the development can be assessed and so we can get early intervention for them. We know the benefits of early intervention. That is a strategy we are employing at the moment.

Mr MOLHOEK: We know how many children are under orders in care, but do we track the number of placements? Do we have any data on that or any sort of key findings or information that has flowed out of that data?

Dr Crawford: Yes, we certainly do collate data on the number of placements. I do not have that at hand today. Our focus is very much on increased stability, so reducing the number of placements and care arrangements that children have. As I say, our primary goal is to have care arrangements with children's own families. We are very conscious of the impacts. It is not just change of care arrangements; it can often mean for children a change in school or a change in friends or a change in access to their family members. Our priority is to try to maintain them in a stable arrangement.

CHAIR: Could I ask you to take on notice that you provide that data to the committee?

Mr MOLHOEK: Following on from that, are there any recent or current programs that the department has undertaken around trying to keep children with their families? We ran some pilots back in 2014 called Fostering Families, which had some interesting outcomes. However, we never got to see it through. That was related to wrapping services around the family so the kids could actually stay with their families. What is the approach now? What programs are there around providing that support?

Dr Crawford: I should mention that our very top priority in terms of permanency is to keep children safely at home with their families. Our main focus is to increase safety for children at home. We have a number of programs and initiatives and funding available to provide some in-home supports for that to occur. If children cannot remain safely with their parents then, as I say, our main aim is to ensure that care arrangement with their own family members.

We implemented what we call a permanency strategy in 2020. We are looking at a range of options to better support kin arrangements. We are working in partnership with our First Nations peak, QATSICPP, to look at what there could be to wrap additional support around kin carers. The research is very clear: the outcomes for children are much better when they remain with their family or are placed with their extended family members.

Mr MOLHOEK: I seem to recall Create providing data years ago—I have not looked at any recent data—that suggested that, as dysfunctional as their families were, when they had a choice to return most kids always wanted to be back with their family. There was some argument at the time that the outcomes may actually be better to support them in place rather than put them through a number of foster care or other arrangements.

Dr Crawford: Yes.

Ms KING: Thank you for your part in caring for and supporting children across Queensland. Mrs Stevenson, we have talked about what schools are currently providing—and have provided over a period of time—particularly around guidance counsellors. We have talked about the rollout of the GPs in schools and mental health supports in schools. It certainly appears to me that the Department of Education has stepped into the space of providing a lot of primary care for children. What other services could we be providing in schools and what would their focus be? We might be talking about prevention, early detection or treatment and referral. If the sky was the limit, what would be the low-hanging fruit there?

Mrs Stevenson: I actually think it is about—I guess it is a medical term—the dosage. I think we have the strategies in place that are appropriate for a school setting. I think it is about overcoming some of the workforce issues that we are experiencing. If we were able to fully recruit and ensure that we did not have vacancies and that we had our positions filled, I think we would have that continuum of care so that we could support students who need that just-in-time support but also free up teachers in the classroom to provide that everyday support needed by those students. That teacher-student connection is so strong. We cannot underestimate how important that is as well. I think it is about supporting our teachers and ensuring they have somebody to support them when they have a concern about a child.

Ms KING: Is there any opportunity for young people in the school settings that will be receiving this support to contribute to the design and the way the programs will be delivered?

Mrs Stevenson: Many of our schools do that already through mechanisms and through their student councils. We are in the process of providing to schools the range of materials about how they might develop their student support program. Much of that would be informed by the students themselves and asking what types of support they want. I have seen it in practice in Merrimac State High School on the Gold Coast; they have their students very much involved in the design and they have a range of supports from non-government organisations coming in to provide lifestyle support through to the psychologist and they will also get a GP. I think getting the young people's views on what makes a service accessible within a school is really important.

Dr ROWAN: This is a further question to our Department of Education representatives, Mrs Stevenson or Dr McInally. In relation to mental health literacy—and I guess this in part adds to what the member for Pumicestone was talking about. Within the Department of Education, could you outline the process of collaboration, coordination and engagement that occurs with other agencies, whether it be the Mental Health Commission, Health and Wellbeing Queensland or external third parties, whether it be the Alcohol and Drug Foundation or Lifeline? All of these external agencies and departments are trying to do what they can. In terms of getting that collaboration and coordination of improving mental health literacy within our schools and an understanding of that, what has been happening to date and are there any recommendations for what could be done to improve that into the future, given that the select committee is looking at opportunities for improvement moving forward?

Mrs Stevenson: I guess it happens in layers. There is a lot of collaboration even across this table centrally. There is a lot of joint work that we are doing together. We then go out to our seven education regions. Dr McInally already mentioned our principal advisers in mental health. They also work really closely with Queensland Health's Ed-LinQ coordinators. Part of that role together is to ensure that services within a region connect up. It might be through the public health network or other service providers. That is something that we work really hard at at the region.

We also see more and more that our principals, deputy principals and other staff are needing to link with the local agencies at a school level. I do think that is the changing face of education in that our principals are doing much more of that interagency work than they ever needed to do in the past. That is something where we can build that capability and make it easier to cut through some of the barriers that might exist at a local level.

CHAIR: In terms of how your departments carve up the map of Queensland, do your regions overlap one another, do they mirror one another or are they different? Does that create confusion and difficulty in terms of communicating about specific situations?

Mrs Stevenson: In short, they are different. Our regions are different but we meet at regular intervals and then at a regional level. Even though they might cross over in education, our regional directors certainly know who the relevant regional lead is across all of the other agencies and they work closely but they do not map exactly.

CHAIR: I have a final question for Youth Justice. Previously, I was chair of an organisation called SPELD, and I know from data I have seen there that a significant number of young people in custody and care have undiagnosed learning differences and that contributes obviously to mental health issues. Is the department working towards diagnosing learning differences and putting strategies in place to work with kids in the way that they learn?

Dr Crawford: As I mentioned before, we have a strategy now to refer all of our zero- to seven-year-olds for that developmental assessment and assessment of any learning difficulties. We then would rely on our colleagues in Education around those assessments of any learning difficulties and seek out the expertise that we need from our partner agencies to progress the supports that children need.

CHAIR: Thank you for your time this morning. It has been greatly appreciated. There has been one question taken on notice. We would request that a response to that be received by 18 February. Please note that members of the committee may forward additional questions through for answers as well. Thank you for your time this morning and thank you for all of the work that you do.

The committee adjourned at 11.03 am.