LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON EDUCATION, EMPLOYMENT AND YOUTH AFFAIRS

(Reference: Inquiry into youth mental health in the ACT)

Members:

MR M PETTERSSON (Chair)
MRS E KIKKERT (Deputy Chair)
MS E LEE

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 2 JUNE 2020

Secretary to the committee:
Ms S McFadden (Ph: 620 70524)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

Privilege statement

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Amended 20 May 2013

The committee met at 9.32 am.

RATTENBURY, MR SHANE, Minister for Climate Change and Sustainability, Minister for Corrections and Justice Health, Minister for Justice, Consumer Affairs and Road Safety, Minister for Mental Health
GRACE, MS KAREN, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services, Canberra Health Services
PFEFFER, MR DAVE, Deputy Chief Executive, Canberra Health Services
MOORE, DR ELIZABETH, Coordinator-General Mental Health, Office for Mental Health and Wellbeing, ACT Health Directorate
RIORDAN, DR DENISE, Chief Psychiatrist, Health Systems, Policy and Research, ACT Health Directorate
ORD, MR JON, Acting Executive Branch Manager, Mental Health Policy Unit, Policy, Partnerships and Programs, ACT Health Directorate

THE CHAIR: Good morning, and welcome to the second public hearing of the inquiry into youth mental health in the ACT. On behalf of the committee, I would like to thank you, minister, and your officials for attending today. It is good of you to make time to be with us. I understand that all of you have been forwarded a copy of the privilege statement. Could you each please confirm, for the record, that you understand the privilege implications of that statement?

Mr Rattenbury: There are universal nods in this room, Michael.

THE CHAIR: For the record, can we get people saying yes, please?

Mr Rattenbury: Okay, sure.

Mr Ord: Good morning, chair. Good morning, committee members. My name is Jon Ord. I am the Acting Executive Branch Manager for the Mental Health Policy Unit and I acknowledge the privilege statement.

Dr Moore: Hello, I am Elizabeth Moore. I am the Coordinator-General, Office for Mental Health and Wellbeing. I acknowledge the privilege statement.

Ms Grace: I am Karen Grace, Executive Director, Mental Health, Justice Health, Alcohol and Drug Services, Canberra Health Services. I acknowledge the privilege statement.

Mr Pfeffer: I am Dave Pfeffer, Deputy Chief Executive, Canberra Health Services, and I acknowledge the statement.

Dr Riordan: I am Denise Riordan, Chief Psychiatrist, ACT Health Directorate. I acknowledge the privilege statement.

THE CHAIR: I think that is everyone. Minister, do you have a short opening statement you would like to give or would you like to jump straight into questions?

Mr Rattenbury: No, we are happy to jump straight into it. There is plenty of ground to cover. Obviously, there is an extensive ACT government submission, which was

coordinated by the Office for Mental Health and Wellbeing, through Dr Moore, and you have the other directorates coming through this morning. So we are happy just to start as you wish and work from that as the basis of our contribution.

THE CHAIR: Excellent. I will lead off with questions and we will make our way through the committee. One of the recurring themes that I have seen in the submissions and heard from the witnesses is that people struggle to navigate the mental health services that exist. What do you think the government is doing, and maybe could do better, to help improve how people navigate through mental health services?

Mr Rattenbury: Yes, thank you. That is feedback that we receive at times, and it is definitely a key area of focus. You have possibly seen the review of children and young people in the ACT done by the Office for Mental Health and Wellbeing, which was completed in December last year. That was an extensive piece of work which had more than 800 participants. The research work was done in partnership with Mental Illness Education ACT. That was very positive because it gave us a non-government partner, but it also gave them access to a lot of the young people who participated, and that really opened that process up. One of its key findings was that issue of navigation. So the government is, in response to that, preparing an online youth navigation portal. That work is currently underway. Dr Moore can speak in more detail about that if you wish.

THE CHAIR: That would be good.

Dr Moore: It was one of the recommendations that came through also from the Youth Assembly. We were lucky enough to obtain some funding from the Commonwealth government to look at what is available currently, in terms of navigation portals, and what would be of most use to children and young people and also to their families. We are partnering with the ANU. There are a couple of navigation portals around. They are not specifically ACT or youth based. The first of our focus groups will be this Thursday evening, via videoconference, and we expect that work, at least the scoping work, to be completed by the end of July.

THE CHAIR: Okay. So just for comparison, if in the future we are going to be directing people to this portal, what are the pathways that people are expected to try and go through currently to navigate the system?

Dr Moore: That is one of the reasons we are having the navigation portal. What we found from the children and young persons review was that there is a plethora of services out there. If you have a look at the review, you can see that most of them actually start later in adolescence, and are therefore at the more acute end of the services. We want to have more in the promotion/prevention end, teaching kids, young people, how to become more resilient, and also having options for parents to assist their young people.

It has always been a little bit of an issue in terms of how to get into specialist services. We recognise that there is a gap between primary care and specialist tertiary care, and that was another recommendation that came out of the children and young persons review. We are currently partnering with Capital Health Network, obviously with our

primary care partners and also with CAMHS, to see if there is a smoother pathway, and to prevent people going into tertiary care.

MS LEE: I have a question before I go to my supplementary question. I apologise, I have a bit of a frog in my throat. Dr Moore, you mentioned starting off with the focus groups on Thursday. Can you give us a little bit more information about those focus groups—the demographic of people in them and a little more background about those focus groups?

Dr Moore: Yes. We do have a lot of information already. The focus groups are there to hone what we know. I cannot tell you the number of people in that first group; I apologise. What we were hoping for was young people, parents and service providers. We have a reference group that is made up mostly of service providers across the spectrum, and we are really keen to get the voice of parents. We already have that from our children and young persons review, but we wanted information around specific questions about the navigation portal. What would they find most useful? How would they find it most inviting? What are the questions that they particularly want answered?

When we did focus groups last year, we did not get so many young people. That is not unexpected; they do not want to come with mum and dad. But the ones that did come were very vocal, very good value. So there are a number of ways of getting the information.

MS LEE: Thank you. Is it just a one-off or do you have more planned?

Dr Moore: No, we have three planned, and at various times of the day, to capture different demographics.

MS LEE: Minister, obviously when dealing with youth mental health, there is a huge overlap with what is happening in our schools. Are you able to give us a bit of background on your relationship with the Education Directorate? How have you worked together to ensure that mental health services are being offered and being supported in our schools?

Mr Rattenbury: It is a critical area. As Dr Moore has just touched on, working with young people in those formative years to help them build resilience skills and insights into their mental wellbeing is really important. One of the reasons we created the portfolio of mental health in the first place was to try and bring a more whole-of-government approach to mental health. Traditionally in the ACT government, it has been very much in the health department and clinically focused. We know that we need to deliver a broader spectrum of mental health and wellbeing responses.

The portfolio is the first step. Creating the Office for Mental Health and Wellbeing has been the second step. Dr Moore, in her capacity as the coordinator-general, when cabinet approved the creation of the office, was very clear in saying that it is a whole-of-government remit, that the office can work across the agencies to identify gaps, pool opportunities together and ensure better coordination. That is the big picture governance thinking behind how we get that right.

Let me give you a case study. Coming out of the summer holidays, with the bushfires, we knew that there was a real potential that many young people might come back to school having experienced a summer that they were not expecting. Some young people would have been at the South Coast, for example, and seen fires. The office worked very closely with the Education Directorate to make sure that when students returned to school this year, we had the right set of mental health responses in place: giving extra information to teachers and having follow-up networks where teachers identify a young person showing signs of having had a traumatic experience. That is a good case study of how those networks work.

MS LEE: One of the things that we have been hearing about, and Dr Moore also mentioned it, is wanting to focus on ensuring that there is some work and development in the early stages of the early age group. Can you give us a bit of insight into the work that your office, perhaps in conjunction with the Education Directorate, is doing to develop some of the support that will be available to a younger cohort?

Mr Rattenbury: Yes, certainly. As I am sure the Education Directorate will speak about in more detail, one of the things we have done this term is to increase the number of school psychologists. That has increased access for students. I am mindful that the Education Directorate are coming soon, and I do not want to speak too much in their space but, obviously, across schools it is not just about psychologists; there are a range of staff and roles, from school counsellors to various other people who provide support in the emotional wellbeing space. There are a range of programs. I will let Education speak to that a bit more.

The office has particularly brought to the space the YAM program, the youth aware of mental health program, which is specifically targeted at year 9. That program is one that has overseas evidence attached to it which shows very high rates of success. I will ask Dr Moore to add a bit of detail on that in a second.

We have also undertaken specific initiatives. For example, this term, Menslink approached us saying that they have identified that young men from 10 to 12 were an area where they were getting a lot more attention. Their previous model was that you had to be 12 or older to be involved in Menslink. We funded a program to start work with some of those younger students. We are looking to identify particular areas and put some of those support programs in place.

I will ask Dr Moore to add more on YAM.

Dr Moore: The youth aware of mental health program is an evidence-based project through the Black Dog Institute. We started it in term 1 and we had 230 students complete it in term 1. We have 140 going ahead in term 2. In term 3 there will be 782 students expected to complete it. That means that by the end of the year we will have had over 1,150 students complete it. It is around resilience building. The other thing we heard was that kids like to have the skills to not only support themselves but also support their friends. They get a lot out of their friendship group. The five modules in YAM address some of those areas.

The other thing that might be useful for this committee to know is that we are currently scoping a project to look at youth mental health promotion in the eight-year-old to 12-year-old age group. So we are going to the lower levels.

The Education Department has always been part of our interdirectorate committee and has always worked very collaboratively.

MS LEE: With that program that you are talking about, aimed at eight-year-olds to 10-year-olds, can you give us a bit of a time line in terms of what the rollout of that will look like?

Ms Grace: The project is to look at what is occurring currently. We have MIEACT in that space and there are a number of other programs. It is to provide guidance to the Education Directorate as to what would be the best program, or the principles for the best program, and spread it across non-government schools as well. We are scoping that currently and we hope to have some advice out by the end of the year.

MRS KIKKERT: I want to talk a little bit about the complex care of our youth. Researchers have shown that there is no integration or coordination of care for young people with complex care—drug and alcohol abuse, those from migrant backgrounds, those in need of justice, those who are in the justice system, and Aboriginal and Torres Strait Islander youth. Can you talk to us a little bit about what the ACT government is currently doing to make sure that there is sufficient integration and sufficient coordination between the agencies to support these vulnerable youth with complex care?

Ms Grace: As you are aware, these are very complex issues. One of the reasons why my portfolio includes the areas that it does is to facilitate better service provision in these difficult cohorts within our community.

In terms of the interface with alcohol and drug services, our CAMHS team work closely with the alcohol and drug services to ensure that there is input into the care of the young people that are part of the CAMHS, as required. We are doing a body of work around how we can strengthen the integration between mental health and alcohol and drug services more broadly, including within the youth space. At the moment, however, there is a relationship between drug and alcohol services and CAMHS. That is a consultation-liaison relationship. Any young person accessing services through CAMHS is able to access consultation with alcohol and drug services in order to help support their management plan.

In the justice space, we provide services into Bimberi. That includes both forensic mental health services and alcohol and drug services. We offer a fairly holistic program to the Bimberi youth centre. Again, we are looking at strengthening that, in terms of the alcohol and drug component. The mental health component is fairly well established.

In terms of Aboriginal and Torres Strait Islander youth, this year we gained funding for a specific worker to work within our service and with Gugan Gulwan Aboriginal youth services to support mental health and alcohol and drug support with Indigenous youth within the territory. That is in the process, at the moment, of being established.

Whilst we can probably always do better in this space, and young people with complex needs require a very strong, multidisciplinary approach, which we offer through our CAMHS model, there is always room for improvement and we are always searching to strengthen that. However, I do feel that we have identified the areas where we can make the most improvements, and that work is in train.

MRS KIKKERT: In terms of residential care, I do not believe you touched on that. Could you talk a little bit about it?

Ms Grace: In terms of out of home care?

MRS KIKKERT: Yes.

Ms Grace: We work closely with the Community Services Directorate on the care of young people in out of home care. These are a small cohort but, as you would appreciate, they are the most complex young people that we work with. We do have strong relationships with CSD. We facilitate and participate regularly in interdirectorate multidisciplinary case conferences for each of these young people. There are complex care plans in place that sit across the different service areas and the different directorates.

With some of these young people, we have plans in place that are triggered in the community when an issue arises or when a young person presents to the emergency department. We have processes in place that enable us to trigger that management plan and ensure that everybody that needs to be advised and involved in ongoing management is advised early.

MRS KIKKERT: Does every young person in residential care have a complex care plan?

Ms Grace: I could not say that everybody in out of home care does; only those that have reason to have contact with our services, from a mental health point of view. If there is a health need that determines that this young person requires a complex care plan, we would work with CSD on ensuring that was in place. Not everybody requires our level of service provision.

MRS KIKKERT: In terms of having a mental health care plan for those young people, do the youth that look after them on a daily basis have access to these care plans?

Ms Grace: Yes, they would.

MRS KIKKERT: In regard to the ongoing support that mental health agencies provide to these youth, how frequently do you provide this support to them, especially the ones in residential care and also in Bimberi?

Ms Grace: It would be on a case-by-case basis. We would do an assessment and we would provide the level of care that was provided at any given point in time. If there was a reason to increase the intensity of our input into a case, that would happen as

needed. In terms of the complex care provided through CAMHS, the clinical partnership, we work under what we call a CAPA model, which is a partnership model with the young person. It is a clinical management approach, and the clinical manager would coordinate that care and would have regular contact with both the young person and the agencies that they were involved with, and respond accordingly, depending on need.

MRS KIKKERT: In terms of the alcohol and drug services working in partnership with CAMHS, what sort of support do they provide to families who have young people who are in need of this service? What sort of outreach program do you have for those families?

Ms Grace: In terms of alcohol and drug services, the counselling services we provide are primarily for the young people, rather than the families. There are supports from community organisations that can provide support to families. Primarily, we work with the individual within our services.

MRS KIKKERT: I understand that, but there is no education workshop for parents who have a young person who is going through drug or alcohol addiction, to help—

Ms Grace: Those services are provided but not directly by us.

Mr Rattenbury: Just in that vein, Mrs Kikkert, from a mental health point of view, certainly there is a very clear recognition across our service provision that interacting with the families can be quite an important part of assisting the young person. For example, a couple of years ago we launched AMOS, the adolescent mobile outreach service, which seeks to bring the services into the family environment. There is a recognition that we cannot just take the young person, treat them, give them back to the family and assume everything will be okay. Often, working in the family environment can be part of identifying, perhaps, some of the triggers and some of the behavioural issues. So there is a clear understanding in the service of seeking to reach into the home where it is appropriate.

MRS KIKKERT: I have been speaking to many families where there is that lack of support. They do want to know more; they do want to help the young person but they just do not know how. Minister, was that an app that you mentioned?

Mr Rattenbury: No, it is a service. It is the adolescent mobile outreach service or AMOS for short. It is a specific program within Canberra Health Services.

MRS KIKKERT: How are families made aware of this?

Ms Grace: AMOS is part of CAMHS. The way Child and Adolescent Mental Health Services operate is that, at the point of referral, every young person will be afforded what we call a choice appointment. That is a multidisciplinary, face-to-face appointment with a psychiatrist and usually two clinicians. That appointment is with the young person and the family, and that will take anywhere from an hour to an hour and a half. As an outcome of that initial appointment, a decision will be made around the service provision that will be afforded to that young person, depending on their need and in discussion with them and their family.

The outcome of that may be that they are referred to the partnership component of the CAPA model, which will give them clinical management, ongoing. From there they can be referred to the AMOS team. It is really dependent on the level of intensity in terms of support that is required. We work under an integrated service model that enables us to provide the level of intensive support required at any point in time. That can be introduced and pulled back as needed, depending on the needs of the individual at the time. The AMOS team may go in and provide intensive support to the family for a period of time; then they will be able to pull back and the clinical management can take over, as the young person's needs reduce at a point in time. If there is a need to increase that intensity again, that can happen through a referral from their clinical manager, back through to the AMOS team.

MRS KIKKERT: To access that service, is it free for families?

Ms Grace: Yes.

MRS KIKKERT: There is no limit to how many families this service can be provided to?

Ms Grace: Yes, it is limited. As I say, it is a fairly high-end service. It is the most intensive component of our outreach service. It is on a referral from a clinical management basis. At any point in time we will have maybe 35 families involved with that service. Since it was established, 74 families have been supported through the AMOS service, since February 2019.

MRS KIKKERT: Do you know how many families have been on the waiting list?

Ms Grace: No. I could take that on notice, though.

MRS KIKKERT: That would be great.

THE CHAIR: As a supplementary, in a similar vein, I was wondering if you could tell us what services are available when a young person is experiencing an exacerbation of their mental illness or potentially a crisis in a home setting. Who is the family meant to call and who will be responding?

Ms Grace: I think the answer to that question depends on what their current involvement is with our services. If they are already an existing client of CAMHS, their clinical manager can be their point of contact and can work through what the immediate needs are for that young person.

If they are not currently a client of our service, we have introduced, over the past few months, the PACER program. If there is a need for an emergency services response to an exacerbation of behaviour in the community, the mental health clinician will attend, along with police and ambulance, and they can do an initial assessment of that young person. The PACER clinician can also refer on to CAMHS in order to involve CAMHS in the care of that young person or, if needed, they can support transport to hospital for emergency assessment and then their management will be dependent on the outcome of that assessment in the emergency department.

Mr Rattenbury: I think, perhaps, the other part of the answer to your question is that initial contact will be either through calling an emergency service or the Access mental health line, which is the single point of entry into ACT mental health services, and they will triage someone—much like turning up to the emergency department—and will direct the person to the right part of the service system. There is no wrong door to come through. You just come through, particularly the Access mental health line, and they will take that responsibility. It goes back to some of your earlier questions about navigation. We do not need the community to understand all the different services teams within mental health; they just need to know that they can access that service and our end of the equation will identify the right team to respond.

THE CHAIR: You mentioned that the PACER program is a trial. When did that commence and when is it potentially going to be assessed?

Mr Rattenbury: PACER commenced in December 2019. Initially, it was a four day a week program. The team implemented it and began to see how it is performing. Recently, that has been increased to a seven day a week service. The initial data was very positive, in that around 83 per cent of people in the first batch of data did not need a hospital admission. The experience was that those that were being taken to hospital were, in fact, being admitted. This was the very early data.

We have not done the formal evaluation yet, but it is clear that the model is delivering on expectation. It has now been extended until the end of the year through the funding that was provided in the COVID mental health package response—for two reasons. One, it is going quite well and we want to continue the service. The second is that, because the budget has been deferred, we want to make sure that it continues and does not stop because of the absence of a budget to make a long-term decision on the program. That is the status of PACER at the moment.

THE CHAIR: You mentioned that it is now seven days a week. What hours does it operate?

Ms Grace: It is 10 hours a day, midday till 10 pm, I think—or two till midnight.

Mr Rattenbury: I was thinking two until midnight.

Ms Grace: We can confirm that for you.

THE CHAIR: That leads into the next question. What happens in those hours when the PACER program is not in action?

Ms Grace: The response outside those hours is as it was previously. It would either be an ambulance or a police response and then they would make a determination about whether that person needed to be escorted to hospital for assessment. The reason we chose the hours that we did was that that is when you see most people presenting in crisis and needing an assessment. We have picked the hours based on attempting to capture most people, but outside those hours the previous responses are available.

THE CHAIR: I have one last question on the PACER trial. Is there a clinical need for a different service between young people and adults? From what I have gathered here, it is the same services, the same individuals going out and assessing these people in crisis. Does it need to be someone different for an adult or a young person, or is one specialist suitable to cover both areas?

Ms Grace: The mental health clinicians that are involved in the PACER trial are very experienced clinicians that are able to make an assessment of a young person and an older person's mental state. They also have the ability to draw on the intensive elements of both services. If they need to pull in the intensive treatment teams from either the CAMHS perspective or the adult perspective, they are able to do that. Part of their role is the link between the person and the breadth of the services that are available.

Our sense at the moment is that PACER is able to meet the needs of the community across the life span, in terms of being able to do that initial assessment and then provide advice on the best pathways from there and bring in the specific subspecialties elements of the service as required.

Mr Rattenbury: Another thing I should add in that context is that the PACER program has been in touch with police, ambulance and clinicians; and that service recognition is that, often, there will be circumstances where somebody, while they are having a mental health crisis, may also either be violent or may be injured and have a physical injury.

Part of the package is that actually having the three services combined produces a holistic response to the situation. That is probably the unique part of PACER. And that is probably its focus, rather than necessarily the age group component.

THE CHAIR: I have a substantive question. At the end of 2018 the government released a position statement on eating disorders in the ACT, in response to a petition that was lodged initially in the Assembly. I was wondering if you could update the committee on what actions have emerged from that position statement.

Mr Rattenbury: I might ask Mr Ord to speak to that, as he was involved in both the preparation of policy and the follow-up.

Mr Ord: As you referred to, in the 2018-19 budget there was $2.2 million appropriated for eating disorders support services. This includes an expansion of the clinical team, as well as the establishment of a clinical hub. Those positions have been recruited to this year, I understand.

In addition, regarding eating disorders, there has also been significant development at a commonwealth level, which has really been the result of some significant advocacy from organisations like the Butterfly Foundation and organisations very similar to those. The MBS items have also been extended to enable people to receive significant support within general practice, which previously was not the case and was viewed historically as a barrier.

As part of the funding package which Dr Moore referred to in relation to the youth

navigation portal, we will receive $13.5 million for the establishment of a residential eating disorder centre in the ACT which is based on a model which is currently being finalised—and the construction is currently being completed—on the Sunshine Coast in Queensland.

THE CHAIR: Sorry, I am confused. The model for the in-patient service is based on a service that is being provided on the Sunshine Coast?

Mr Ord: Yes. As part of the residential eating disorders investment, which the commonwealth has made, there is a model of care for an eating disorders residential centre, as well as a physical build. The commonwealth is committed to investing in a residential eating disorder centre in every state and territory in Australia. The model of care for that particular operation of a residential eating disorder centre, as well as a physical build, is heavily influenced by a building which is currently being completed on the Sunshine Coast in Queensland.

The building that will eventually be built in the ACT, once the funding comes through from the commonwealth, will, of course, have to be absolutely specific to the ACT, but it is very clear that the commonwealth expects that the funding and the development on the Sunshine Coast will influence that.

THE CHAIR: That makes sense. The position statement was released at the end of 2018 and we are recruiting people for some of those commitments now in 2020. When can we expect to see the residential centre open its doors in the ACT?

Mr Ord: The commonwealth funding for that is $13.5 million and that will come over three years. I wouldn't wish to put an absolute date on that at the moment, but the funding actually only starts in 2021-22. Between now and the start of the 2021-22 financial year there will be significant planning work undertaken to ensure that we find a good location, in addition to ensuring that it also is a good fit and integrates into existing eating disorder services.

Mr Rattenbury: The way I see it is that, off the back of having to put together our position statement here in the ACT, the idea in that position statement, if I put it simply, was to build up capacity in the ACT and create somewhat of a stronger specialist team. The commonwealth money was announced after the release of that position statement. It really comes as a bonus for us because I think we will spend the next couple of years building up our capability and, as the commonwealth money comes across on top of that, we will continue to build our capability in the ACT.

THE CHAIR: I am still hopeful that someone has got a potential year that they think that this thing might be open. Are we thinking of commencing construction when the money starts to flow in or are we going to wait for all the commonwealth money to arrive in the ACT coffers before we start building?

Mr Rattenbury: Let us take that on notice. I just cannot think off the top of my head what the time line is for the release of the commonwealth payments; but no, it is not like we need to get all the money in the bank before we can start. As is the case for many of these projects, there will be a series of payments and we can start the works to match those payments.

MRS KIKKERT: With regard to youth with eating disorders, at the moment, where are they being sent to for that support? If there is no facility here in Canberra to support them, where do they go?

Mr Rattenbury: Dr Riordan might be our best person there.

Dr Riordan: At the moment, the main source of support for people accessing services here in Canberra would be to receive support through the eating disorders program, which is physically based in Woden. That is a community-based service and offers a multidisciplinary service that includes access to psychiatrists, dieticians, psychologists, nurses et cetera. In terms of young people, it works very closely with young people and their families. It also works very much in collaboration with the young person's GP. So that integration between primary care and the secondary service is very well established. There is obviously a focus on the young person's physical health and wellbeing, and making sure that that is appropriately monitored whilst therapeutic work to support re-feeding and helping a young person get back to more healthy eating continues.

In addition to that, there is the potential for young people, if they are medically compromised with an eating disorder, to be admitted to the Canberra Hospital. They get admitted to the paediatric adolescent ward. The paediatric adolescent ward is obviously staffed with paediatric nursing staff, and there is always access to child and adolescent psychiatrists, working very closely with that team. They follow a program of supporting a young person who has difficulties with eating, as I said, to the point where they have become medically compromised. That is a program that is based very much on the model that is used, for example, at the Children's Hospital at Westmead. It is very much an evidence-based approach.

The plan is to work very closely with young people and their families in hospitals for the period of time that they need to be there but then to transition their care back to the eating disorder program. Often, the clinicians from the eating disorder program will continue to have contact with the young people and their families, even if they are an inpatient.

MRS KIKKERT: That is good to hear. With regard to the psychiatrists working with these young people, how many psychiatrists are on hand to support them?

Dr Riordan: At the actual eating disorder program, we have just been able to commence one psychiatrist who is child and adolescent trained, who is working there one day a week. That has been an increase on what has happened previously; for a period of time, there was just half a day a week of actual psychiatry time.

In addition, at the adolescent ward, we have a consultant child and adolescent psychiatrist who is based on the ward each day. Generally, because of the way the ward works, what happens is that there are two psychiatrists who share the week between them, if you like, and that provides that continuity of care.

MRS KIKKERT: With regard to just one day a week for the psychiatrist to be present at the community service centre, do you think that that is enough time for the

psychiatrist to be there? I have heard many reports where families do not have access to a psychiatrist here in the ACT, so they are required to travel interstate to receive that support.

Dr Riordan: I think it would be fair to say that the ACT, like many jurisdictions across Australia, and indeed internationally, has difficulties for periods of time with the recruitment of psychiatrists. I think it is fair to say that things here in the ACT have improved quite significantly compared to what they were a number of years ago. Within the last two months, we have recruited 2.6 full-time equivalent child and adolescent psychiatrists to work here in Canberra. Two of those people were, if you like, home-grown; they were our registrars, who then completed all their training and became fellows of the college and were appointable as consultants. We also appointed a colleague who moved interstate from New South Wales to work here in the ACT.

I hear what you say, that one day a week of a psychiatrist is bad enough, and of course we would always like there to be more, but in terms of using the resources that we have available, given that we are making sure that there is also a lot more availability of psychiatric care for young people who are more severely affected, by having people at the hospital, that equates to more than one person per day in that regard.

The other thing to say is that some of our child psychiatrists in other teams may also be providing services to young people with eating disorders. For example, if you have a young person who presents who maybe is at risk of developing an eating disorder but has not got the level of symptomatology that would warrant a full diagnosis, the psychiatrists in those teams would also work with the young people and their families to try and change the trajectory of that eating disorder.

So it is broader than just that one day per week in terms of input; and, of course, within the service there are very experienced nursing and allied health staff who have a lot of expertise in delivering the evidence-based therapies to support young people with eating disorders.

MRS KIKKERT: Finally, on access to these services, is it free for families and for young people to see a psychiatrist and to have that outreach service provided to their families and, also, in-house?

Dr Riordan: Access to a psychiatrist through the eating disorders program, as with any of our public mental health services in the ACT, is free at point of contact, for sure. And access to all the other range of services is free. It is all part of the public service.

MS LEE: Minister, the review conducted by the office for mental health identified that two of the reasons for factors that were identified as being barriers for young people seeking support or assistance were access and, also, affordability. I note that recommendation 1 of the report is to make access to services easier and affordable and to increase capacity of current providers.

In relation to the online portal, you have already spoken about the project that is underway, but when I read the part in this review that says what the government will do, it seems like the response from government is that there is a lack of matching of

people to services, as opposed to addressing the crux of affordability and whether there is sufficient expertise. Are you able to address that?

Mr Rattenbury: Certainly, Ms Lee. Let me come about it in a couple of different ways. I think the first part is the navigation issue, which we have spoken about earlier and I will not repeat that. Part of what people struggle with is that they feel like they spend a lot of time trying to find the right place. So improving that initial access is important for people's sense of participation in the system.

In terms of capacity, Dr Riordan has just spoken about the workforce issues that we face. For example, those families in Canberra that want to go to a private psychiatrist report the fact that they cannot get an appointment because there are simply not enough. This is an issue we need to take up nationally, to talk as a whole nation about how we increase the number of people being trained in psychiatry, how do we make it more attractive and those sorts of issues. There is no point for the ACT to enter into a bidding war to get all the psychiatrists to come here because that is not a sustainable position. So that is an issue.

The commonwealth government has announced that there will be a second headspace funded in Canberra. That is currently out to tender. I believe the tender results are due any time now. That is being conducted by the Capital Health Network. That is due to be open by the end of this calendar year. There may well be some delay to that because of COVID. So work is being done to improve capacity.

The other part of it that I want to speak to briefly is the necessity of taking a long-term perspective and investing in the resilience-building and preventative programs which we spoke about earlier as well—things like the youth aware of mental health program. That also helps us give young people the skills that should avoid many of them escalating into the system in a way where it takes a lot of resources to support them.

MS LEE: And the affordability issue?

Mr Rattenbury: Yes. The commonwealth government has increased the number of Medicare-available services.

Dr Moore: It also had had a trial at telehealth. Telehealth has increased accessibility. Certainly, the College of Psychiatrists would encourage the commonwealth to think of telehealth in the long run, in terms of psychological support.

But one of the things we found in all of the people that we talked to is that they were not aware of the number of different online self-help support areas. Beyond Blue is one of those that has a number of cognitive behavioural-type therapies available. Beyond Blue also receive support from the commonwealth government to have a helpline. This level of access may be what people need. Obviously, if people then need to see an ongoing professional for increased psychological support, we need to continue to promote that, but there are a range of needs and we must not always go to just the acute end.

We heard a lot from people who said, "Well, if I'd known that Mind Gym was available, I may not have needed to see a psychiatrist or psychologist." So it is that

promotion of the lower levels and what you can do to help yourself.

MS LEE: Acknowledging all those services that are available and also what you said, minister, about obviously not wanting to get into a bidding war—I am not sure whether you tuned into the evidence from last week—we heard from some people who, because of a lack of services in Canberra, were forced to travel with their child on a regular basis to places like Bowral and Yass. We heard from people who seemed to be quite surprised at this severe lack of services in the nation's capital when they were able to get them from places that were much smaller and, theoretically, less funded.

Given that your response from the review did not really touch on these issues, I want to ensure that the community is aware that work is being done on the accessibility, the capacity and also the affordability of services.

Mr Rattenbury: Yes.

MRS KIKKERT: Minister, in your submission you said that, in addition, services are provided to people in the ACT through one private psychiatric in-patient facility and highly specialised mental health facilities interstate. Could you tell us a little bit more about that? Where is this facility and how many are there? How much is the ACT government currently giving to this facility to support ACT residents?

Mr Rattenbury: Mrs Kikkert, can you remind me of which page you are referencing, just so that I am providing you with the right bit of information?

MRS KIKKERT: Yes; it is on page 12.

Mr Rattenbury: Thank you. We think the reference is to Hyson Green, which is the private mental health facility at Calvary Hospital. I think that is what your question is about.

MRS KIKKERT: It actually refers to mental health facilities interstate.

Mr Rattenbury: Let us take that question on notice.

MRS KIKKERT: I am a little bit confused. Who wrote the submission and what did they have to offer to write that in?

Mr Rattenbury: Yes, we are just trying to get to the bottom of that.

Dr Moore: The Office for Mental Health and Wellbeing collated the submission from various sources. My understanding is that it is related to Hyson Green within the ACT. We have access to private psychiatric institutions interstate but, obviously, that is at a person's own cost.

MRS KIKKERT: So you are basically referring a patient to a psychiatrist interstate?

Mr Rattenbury: I have read the paragraph now and I think that the point being made is that there are some cases where somebody's circumstances are so specialised that

we see very few cases in the ACT and so referrals will be made to interstate facilities. That is the point being observed in the latter part of that paragraph. Dr Riordan can probably add to that.

Dr Riordan: In relation to children and young people, there are occasions throughout the year when young people may be referred not necessarily to private children and adolescent mental health units but to the specialised adolescent inpatient services interstate. Predominantly we are talking about services in New South Wales and the Shoalhaven and Orange, as well as the units in Sydney—one at Westmead Children's Hospital and one at Campbelltown. They would be the ones that we would be most likely to use. So that is for young people accessing specialised mental health inpatient services, and those are public services.

There have been occasions, which I am aware of anecdotally, where families have got access to private health cover and may seek to go to a private health facility in Sydney. Obviously, if a family we are working with, for example, in child and adolescent mental health services—usually those services are for 16 to17-year-olds—seeks a referral to such a place, we would support that referral in order for them to be able to access those services. That would be a very small number of people. So there may be a number of people who go to the interstate public services, but the number of people who go to interstate private services would be infinitely smaller than that.

MRS KIKKERT: Is that why we do not have the services or the programs or the facilities here in Canberra—because just a small number of people require them and so the answer to that is to refer them interstate?

Dr Riordan: Some young people present with a level of mental ill health that requires a hospital admission, and we feel confident that we can meet their needs for that sort of acute stabilisation and getting into position appropriate community supports within the ACT. That would be the case for most young people who present to the Canberra Hospital; but there would be occasions when we have somebody who has, as Mr Rattenbury described, very high specialised needs and who would need to go interstate.

Ms Grace: Mrs Kikkert, I can add to that. I have some numbers here. Since April 2019 there have been three referrals to New South Wales hospitals. Two of those were referred by community teams and one was from the hospital liaison team.

Mr Rattenbury: Chair, I am mindful of the time. We have the answers to a couple of questions taken on notice earlier which we could cover now if you wish?

THE CHAIR: Sure.

Ms Grace: In response to the number of people on the AMOS waitlist, there has been a maximum of five at any point in time. All five of those young people were clinically managed by either the north or south community team at the time, so they were receiving support while they were waiting.

I can also confirm that PACER operates from 2 pm to midnight, seven days a week.

MRS KIKKERT: Chair, I have further questions to the minister and the directors. Can I put them on notice?

THE CHAIR: Of course. We are out of time. Thank you, everyone, for your attendance and for the effort you went to to get those answers to us in time. That is much appreciated. You will be sent a copy of the transcript. Make sure that you double-check it because this is an online hearing, so things are a bit different.

BERRY, MS YVETTE, Deputy Chief Minister, Minister for Education and Early Childhood Development, Minister for Housing and Suburban Development, Minister for the Prevention of Domestic and Family Violence, Minister for Sport and Recreation, Minister for Women
HAIRE, MS KATY, Director-General, Education Directorate
MATTHEWS, MR DAVID, Acting Deputy Director-General, Education Directorate
HAWKINS, MR ROSS, Executive Group Manager, Service Design and Delivery, Education Directorate

THE CHAIR: Minister Berry and officials, thank you for making time to speak with us today. I understand that you have been forwarded a copy of the privilege statement. Can you please each confirm, for the record, that you understand the privilege implications of the statement?

Ms Berry: Yes.

Ms Haire: Yes, I can confirm.

Mr Matthews: I can confirm too.

Mr Hawkins: And me too.

THE CHAIR: Excellent. Do you have a brief opening statement or shall we jump straight into questions?

Ms Berry: No, we are happy to take questions.

THE CHAIR: I was wondering if someone could explain to me how many school psychologists there are in the ACT and how the determination is made as to how they are allocated across schools in the ACT.

Ms Berry: Yes, we do have that information; we have quite a bit of detail about the numbers. We can also talk about other supports in schools that are provided as part of the multidisciplinary approach to supporting young people and children.

David, do you want to provide that detail?

Mr Matthews: I will just make a couple of introductory remarks and then ask my colleague Mr Hawkins to provide more details about FTEs.

As the minister said, we do have a multidisciplinary team approach, both based out of our education support office and, also, with our school-based teams. When we talk about our FTE today, we will be talking about what we have in office-based staff. Those staff, though, do work directly with schools; their key role is to interface with schools and to provide direct services to schools.

Within each of our schools there are, of course, our teaching staff and our administrative support staff, but there are a full range of other allied health professionals that work directly to support children and young people with the range of needs that they have on every individual day. That is basically how our staffing

structure is formed. I will ask Mr Hawkins to talk about the FTE of school psychologists.

Mr Hawkins: As Mr Matthews said, the way our construct works is that each school has access to a psychologist. We have about 81.5 FTEs tied up in our school psychology service. They are out supporting schools. Above them sit some senior psychologists. In terms of broader help and support, and the mentoring and coaching that you would expect, that would take place. Then we also have some psychologists, within a very small team, essentially to help support our assessments for supporting kids with disability and for any interventions that we need to do.

Our service is organised but is school-based, and then structurally it provides advisory support for those psychologists. Then there is a small component that sits centrally that can be used to manage out as schools need. The total number is 81.6, not 81.5.

THE CHAIR: I was curious about how school psychologists are allocated across schools. Is it the case that every school gets the same number of FTEs or is it dependent on the individual school's circumstance?

Mr Hawkins: That is exactly right. It is a bit based on the needs base of the schools and on enrolment numbers. Every other year we have taken a process to look through what we see in terms of enrolment numbers and growth within our schools. Then we work through that on a proportional basis, allocating school psychologists based on the kind of need assessment and enrolment numbers.

MS LEE: In terms of school psychologists within primary schools, are there more school psychologists in high schools? How does that split work?

Mr Hawkins: Not necessarily. What we find in our primary schools is that there is a lot of work done in terms of assessments, especially as to disability or any kind of learning needs. When you start to get into colleges and high schools, it is more about mental health-based support that exists. We take all of those elements into account with those enrolment numbers as we go through and look at the number of days that a school is allocated a psychologist.

MS LEE: Minister, on page 24 of the ACT government submission, the final paragraph says:

> ACT public schools use evidence based practice to build school environments …

Can you please advise what evidence that is? Where is that evidence from? It is in the second half of the final paragraph on page 24 of your submission.

Ms Berry: Evidence-based practice is used. That is one of the reasons why the positive behaviours for learning framework has been implemented across all our schools. The evidence across other states and territories, and across the world in fact, is that having an embedded culture within schools works much more efficiently than just having a program delivered over a short period of time and then moving onto the next issue.

That is one example of where evidence has been used to build environments around making sure that students are feeling safe and connected, and that support staff and teachers are all provided with expert advice and coaching about how they can support students better.

Mr Hawkins, I am not sure where there is a list of all the different expert evidence-based practices. I think we provided it to the SEAC.

Ms Haire: Page 28 of the government's submission sets out the triangular framework which underpins our approach. There is an approach for all students, and they are selected and targeted. Then we have a range of policies and approaches that are aimed at that universal service offering, based on the best evidence.

As the minister said, the behaviour for learning framework is one of those which has been internationally tested, with the whole school approach, through having a student wellbeing team and the safe and supportive schools policy, which requires every school to have a whole school approach. Then, through the Australian curriculum, there is the explicit teaching of social and emotional learning through the social and personal capabilities strand of the Australian curriculum. There is a whole set of interlocking pieces which form the universal program offering, all of which are based on evidence, both Australian and international.

On the next tier of the triangle, we have a range of further offerings based on the needs of the students, which we could go into further, including the flexible education offerings; the school psychologists, which we have already discussed; and other supports for students in need.

Finally, at the targeted end, we have the approach at places like Muliyan for students who are unable to attend school. And we have individual approaches, such as individual learning plans and behaviour plans. Again, the school psychologist supports students all the way through that triangle. That is the basis of the approach that we have employed across our schools.

Ms Berry: Ms Lee, the literature review that was provided as part of the education advisory committee work on violence and bullying in schools is probably a good starting point for you on evidence that the Education Directorate has used. If there are particular areas that you are interested in getting advice on, like what expertise led us to the decision-making around implementing particular programs or supports in schools, I am sure we can take that on notice as well.

MS LEE: No; thank you. Whilst you are talking about SEAC, now there have been a few months under your belt since having the report and the recommendations from that, where is education, and where are you at with that?

Ms Berry: Mr Hawkins may be able to provide an update on where things are up to. Of course, there has been a bit of a gap with COVID.

MS LEE: For the sake of *Hansard* and anyone who is livestreaming, I was referring to the advisory council that the minister set up, the bullying inquiry. I would just like to confirm.

Ms Berry: Just before you start, Ross, let me say that the implementation of some of those recommendations has a gap because of time out of school in responding to COVID. But a number of approaches have been funded by the government around the recruitment of staff to support the positive behaviours for learning framework; the strengthening of communications within the community around the development of a promotion of targeted resources in schools and families in relation to safe and supportive schools; supporting the directorate's data analysis, which was an important issue that was raised through the inquiry as well as through the committee; enhancing cyber safety for students; and enhancing flexible education, which the committee has seen through the Muliyan program, which has capacity for 10 to 20 students. The delivery of those commitments has commenced, with the eight-week and 10-week caveat of COVID-19 in the middle of it.

With some of it around the flexible learning approaches, we have learnt a lot more through the development of the remote education programs and also how that can be used to provide more flexible learning for students where the school classroom or the school environment does not quite work.

Mr Hawkins, do you have anything more to build on that?

Mr Hawkins: I was going to go exactly where the minister went, but just to add to what the minister said, there are elements that we implemented at the back end of last year; things like the reporting time scale for staff and our commitment to PBL were all published as per what the committee asked us to do back in November.

This year has been slightly tricky, given COVID. However, I always say that some of the lessons that we learnt through the conversations last year have really helped us through this period. Take, for example, e-safety. We have brought on board a dedicated e-safety officer who has been completely embedded within our team to help establish our remote learning. That means that the conversations we have had around the provision of remote learning, providing information to parents around what that looks like and how to stay safe online, have all been one of the fundamental premises as we provided our remote learning packages and remote learning information to parents.

Whilst we have had that disruption in learning, effectively, from what we intended to do for the start of this year, there are key elements that have continued and really supported us through this period.

The other element the minister mentioned was around flexible education. We are still seeing students attending Muliyan; we have also seen some students that have wanted to connect in with that program and some of the supports that it provides, where either they have not necessarily felt safe at home because they are vulnerable or there have been other factors going on in their lives. We are seeing more students reaching out and looking for supports more along the lines of those flexible education offerings than we were seeing at the back end of last year.

MS LEE: In terms of the move to online learning—I do not know; it could be a bit early to tell—did you see a change in trend? Obviously, there would have been no

data to speak of in terms of physical bullying in the playground, for example, but did you see an increase in cyberbullying? Is that something that you are able to see at the moment?

Ms Berry: I have not seen any data on that at this stage. I have not even had any feedback from schools yet. Mr Hawkins, have we had anything around that yet?

MS LEE: Yes, it might be a bit early.

Mr Hawkins: No, nothing with us. We keep an eye on what we see from our incident reporting, through SAS. We anticipated that there might be an uptick in cyberbullying, but it is not something that we saw. As we turned on different parts of Google, some students were trying to use that in different ways, but we managed to track down what was going on there to make sure that we managed any technical loopholes within the system. But in terms of broader cyberbullying, no; we certainly did not see an uptick during this period.

MS LEE: Okay. On the back of the devastating bushfires that we had over the summer holidays, students coming back and then COVID, have we seen an increase of students exhibiting anxiety and stress? If so, how has that been in—

Ms Berry: I do not think that we have heard of an increase in anxiety and stress in schools. In fact, the feedback that I have been getting so far is that students are incredibly resilient and returning to school. We have had over 90 per cent attendance in the last couple of weeks in each of the different year cohorts. So that is a really positive sign.

Teachers are saying that students are returning in a really positive frame of mind, so that is great news; but they have been ready and prepared because, as you know, anxiety and stress can come after the immediate impact has passed. So they are ready to support students, should that occur. Did you have anything else to add to that, Mr Hawkins?

Mr Hawkins: Only to say, minister, that coming out of the bushfires at the back end of last year and getting ready for term in February, we did a lot of training with our schools and with our psychologists to help manage trauma and how that might appear. So we did a lot of preparatory training with our educators and our psychologists. A lot of that is helpful now, coming into COVID, in terms of how to have some of those structured conversations in schools and how to help prepare the kids that are going to come back in very different states. Some would have been absolutely fine during this period and a lot of the time; others would have found it quite distressing.

So our teachers are finding various different behaviours as they exhibit. They may not all exhibit straight away; it may take some time to come through. We have done a lot of professional development with our educators and our psychologists to support them through this type of approach.

MS LEE: Thank you. This is my final question, minister. There was a review into children and young people that was released in December last year, and there were quite a few issues that arose out of matters surrounding school life—like bullying and

anxiety about school. How is the Education Directorate going to be dealing with some of the recommendations that have come out of the review? What is your remit of what you take on from here on?

Ms Berry: Yes. It is—

MS LEE: The director-general is pointing to that review. Yes; that is the one I am talking about.

Ms Berry: Yes. It is really within the Minister for Mental Health's remit, but of course the ACT government and the Education Directorate work closely with mental health services and with the minister around supports for young people and children in our schools and how we work together across agencies. The Education Directorate has been engaged around this report and what we need to do to continue to support young people in our schools and build on the supports that we have already got in place. We know that whilst you can put in place holistic programs to support every child, everybody is different. So, humans being humans, some students will need different kinds of supports. And we are always ready to learn about what changes might need to be made to support young people even better.

MS LEE: Thank you.

Mr Matthews: The only thing that I would add to that briefly, if I can, is that the report is very informative. It really helps us get further and fresh information, including the voices of youth, around some of the mental health issues that are being faced in the community. I think it is fair to say that the report has strongly endorsed our current understandings and given us some fresh insights into how we can continue on our journey to support young people's mental health.

The focus on anxiety, study problems and pressures, and experiences of being bullied are driving our current approaches to supporting children and young people in schools. The emphasis on destigmatising mental health within our school environments, and the community more generally, is a very important feature of what we have been doing with our primary programs like PBL and our general school supports. So we are very much encouraged by the report and very happy to work with our colleagues across government who continue to emphasise progress in this area because it is a very key message coming from children and young people that they are looking for this to be a focus of our activities.

MS LEE: Thank you, Mr Matthews.

MRS KIKKERT: Mr Hawkins, you mentioned earlier that the psychologists in primary schools tend to do the assessment and then the psychologists in high schools do the overall counselling. We have heard many reports that students from as young as eight years old are in need of counselling, are in need of support. So do the primary psychologists also do counselling and support for primary aged kids, as well as doing the assessment?

Mr Hawkins: Yes, absolutely. Sorry, Mrs Kikkert, I was just talking more generically. Assessments are done in high schools as well; it is just that the majority of

assessments are done in primary schools. Our school psychologist will provide supports to her students and, where they need it, support families; and if that is around any apparent mental health issues, they will provide those supports in schools.

MRS KIKKERT: Okay. With regard to ongoing support for a student as young as 10 years old, they are too old to access child and family centres and too young to access youth mental health service providers. Can the school actually wrap their arms around 10-year-olds—kids who are in that age gap—and support them mentally, as well as their families?

Mr Hawkins: Yes, that is correct; they can. They also could look for other third-party supports if it is appropriate to connect them with headspace or another provider, but, depending on the nature of the issue, certainly, schools and those broader wellbeing teams that we support—teams that we have talked about before in terms of social workers and other supports—can be there to support students and families.

MRS KIKKERT: Thank you.

THE CHAIR: We still have time for one more question. Minister, I was wondering if you could tell us what safe schools does to support mental health and wellbeing in our schools?

Ms Berry: The safe and inclusive schools program for LGBTIQ+?

THE CHAIR: Yes.

Ms Berry: Yes. It is a really important program to support young people in their life situations. Imagine what it would be like if you were a young person and you had been told your whole life that you were either a boy or a girl and you must be attracted to the opposite sex, and that that was the way the world worked, if you found, in your mind, that that was a whole completely different perspective from what you had in your heart. You would have to come to terms with that as a young person—maybe even as young as 10, eight or five.

Having the safe and inclusive schools program, with support from the SHFPACT organisation, offers support to all students in schools to be inclusive of young people regardless of where they are. It is also providing confidence for young people in that space, who might be coming to terms with their own sexuality and understanding, "You are different to what the world says that you should be," even though that is not the case. It is really important to make sure that those young people are supported and that other people in schools can support those young people.

That is what that whole program is about. It is about providing supports to teachers and students to ensure that young people who are going through that decision-making in their lives can be supported and included in our schools. We know that children and young people who are identifying as LGBTIQ+ in our schools are more likely to be bullied and are more likely to have thoughts around suicide than any other child. So these programs are absolutely important to ensuring that those young people are supported.

THE CHAIR: Thank you. We have got a new question from Ms Lee.

MS LEE: Thank you, chair.

THE CHAIR: Just quickly.

MS LEE: Yes, it is a quick one. Minister, we heard evidence from MIEACT last week about some of the programs that they are rolling out in schools at the moment, including one that is taking place in primary schools, supporting people as young as years 5 and 6, but that at the moment the take-up is quite low. Is it the intention of the ACT Education Directorate to roll that out further, given the current need for making sure that there is support for the younger cohort? Is that something you are looking at?

Ms Berry: I reckon that is probably a program that is being pursued by individual schools, based on their own school communities. I was re-reading the transcript from that and I saw that that was a program across some of our schools; but our school communities have different needs and so, sometimes, individual schools will make decisions based on the needs of their existing communities to engage other non-government organisations to support school students through a particular period.

Whilst the Education Directorate has a holistic approach to supporting schools, when they are going through different situations where families might have very ill students at the school, and the student needs to cope and get through that trauma period, then the Education Directorate can support them through that. But a school might decide on its own that it wants something in addition to what the directorate does.

MS LEE: Thank you.

THE CHAIR: Thank you. We are out of time. Thank you, minister, and your officials, for your attendance today. It has been particularly informative. You will be sent a copy of the *Hansard* transcript. Please double-check it because this is a web public hearing—a bit new for everyone.

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Children, Youth and Families, Minister for Health
WOOD, MS JO, Director-General, Community Services Directorate
SABELLICO, MS ANNE-MAREE, Deputy Director-General, Community Services Directorate
PAPPAS, MS HELEN, Executive Group Manager, Children, Youth and Families, Community Services Directorate
ROBINSON, MS JODIE, Executive Senior Branch Manager, Child and Youth Protection Services, Community Services Directorate
DUNNE, MS ELLEN, Executive Branch Manager, Office for Disability, Inclusion and Participation, Community Services Directorate

THE CHAIR: Good morning, and welcome back to this public hearing of the Standing Committee on Education, Employment and Youth Affairs as we inquire into youth mental health in the ACT. I thank Minister Rachel Stephen-Smith for being here with her officials. I understand that you have been forwarded a copy of the privilege statement. Could you please confirm, for the record, that you understand the privilege implications of the statement. Minister, if you acknowledge it now and anyone else who speaks can acknowledge it then.

Ms Stephen-Smith: I acknowledge the privilege statement. For the information of the committee, I have in the room with me my chief of staff as well.

THE CHAIR: Minister, do you have a short opening statement or should we jump into questions?

Ms Stephen-Smith: No, thank you, chair; I do not have an opening statement.

THE CHAIR: Minister, can you tell me some of the common concerns you hear from young people when it comes to accessing youth mental health services?

Ms Stephen-Smith: We often hear from young people that mental health is an increasing concern. I think that is a twofold thing—I think there is both the willingness to speak about mental health issues and the acceptance that this is something that we should be talking about. The impression that we get from young people is certainly that, particularly around issues like anxiety, there seems to be an increase in prevalence as well. It is not entirely clear why that is the case.

Certainly, from the Youth Assembly last year and the Youth Advisory Council more broadly, it is an issue that is consistently raised at a range of levels from the belief that we need, as a community, to ensure that issues are addressed early and that people are supported to recognise if they are struggling. We need to address that early, right through to the acute end of mental health support for young people.

I would not say that there is necessarily one specific area; it is an issue and a topic, though, that young people are increasingly raising and are aware of. I think that their awareness is a good thing; it is then how we work with young people to ensure that we continue to improve services in a way that meets their needs and is accessible to them.

MS LEE: One of the things we have been hearing about is the growing prevalence of mental health issues among our very young people, from about eight years old, and the lack of services for those very young people. Do you have any views on that and what your directorate is doing to ensure that those young people are looked after?

Ms Stephen-Smith: Over the last couple of years we supported Families ACT to do a project on middle years—eight to 12 years of age, roughly, although "middle years" has a number of different definitions. That was one of the issues that came up. We certainly heard that from Menslink as well, as one example of where they have been funded to go down to 10 years old with their services, and they are seeing an increased demand for that. I will hand over to someone from the directorate to provide a more detailed response.

Ms Sabellico: I acknowledge the privilege statement. I will give a general overview and then I might hand over to my colleagues from CYF to talk a bit more about the work they are also doing, or identifying, with working with younger children and families.

The minister is right—there are a couple of projects we are doing with the sector more broadly in terms of focusing on the needs of younger children, eight to 15, who are not necessarily supported through other parts of the service system. We identified that there was a bit of a gap in terms of expertise, specialisation and everything to work with this younger cohort, particularly those experiencing either mental health or high risk-taking behaviours that then would lead to greater mental health issues as they get older.

The middle years project supports work with the sector more broadly around building that expertise and looking at how we provide better connection and integration across the services they are getting. We are looking at trying to bring more organisations together to work the issue, rather than thinking that we can all do it separately and in isolation to others.

Another project specifically to have a look at this age group, mainly 10 to 16, is the safe and connected youth project. That looks at how to work with children and young people in the context of their families to help support sustaining children and young people at home and accessing the services and supports they need, like family reconnection or mental health, where that is required. We are getting a lot of learnings from that project in terms of some of the gaps in services and how best to look to start to integrate and connect the service system in a way that will address this, going forward.

They are a couple of the projects we are looking at broadly to try and get some information and some learnings for those children and young people who are not coming to the attention of child, youth and family services. I will hand over now to Helen and Jodie to talk about what they are doing for those children and young people who come into contact with their system.

Ms Pappas: I acknowledge the privilege statement. The child protection system sees a cohort of children and young people who are particularly vulnerable and

disadvantaged in our community. Mental health is presented in a number of ways and, usually for the kids in our system, it relates more directly to trauma. It is difficult to untangle the difference between trauma and the behaviour you would experience out of trauma and mental health. So the response is about trying to engage with the behaviour and the concerns and the issues of the young person in their entirety rather than looking at this mental health issue over here—because trauma has an impact across everybody's life and you have to address those issues as they present themselves.

We see it in the context of children who have, as the minister was saying, high levels of anxiety, low impulse control and difficulties in terms of learning and processing issues—this is the trauma response and mental health is wrapped into this—low levels of functioning, and poor social connection and emotion. In response to that, and in recognition that we need to do better in terms of the kids in our care, we established, in 2015, Melaleuca Place. It is our trauma recovery centre and the staff are highly professional and experts in their field. They provide direct clinical service to children up to the age of 12, in recognition of the impact of trauma and the lifelong consequences on mental health.

There are small numbers of kids in that service, but it is very intense and it is very sustained. We can have children there for up to about 18 months, for those who have quite extreme behaviours. The team do a whole lot of clinical interventions. They do a lot of brain mapping to understand the impact of trauma on the brain and then develop clinical responses to try and reconnect those bits of the brain that are not working properly. The team work with parents, carers, schools and children directly to respond and to support those kids to recover from trauma. We hope that that has a positive impact on their mental health as they become adolescents.

I will throw over to Jodie, but there is also a response to young people who are in Bimberi Youth Justice Centre in terms of mental health.

Ms Robinson: I acknowledge the privilege statement. Before I go into the support provided specifically at Bimberi Youth Justice Centre, adding to what Helen was saying in relation to Melaleuca Place, for all children and young people that enter care we also undertake a therapeutic assessment. That was introduced under A step up for our kids. We are progressively working through and ensuring that all young people in care have a therapeutic assessment. We are on track for completion of that in early July. That looks at the context of a child's early experiences in terms of abuse and neglect. It looks at the impact of trauma and then develops a therapeutic response.

It takes into account their social, emotional, developmental and psychological functioning and then determines—within the context of their care environment, their school environment, their biological family, their culture and identity—how best to respond to that child and young person's needs. They are undertaken by a specialist team within CYPS. At times, we also seek support from private providers. That then provides the process for recovery from trauma when young people enter into care.

In relation to Bimberi Youth Justice Centre, we work very closely with forensic mental health services and forensic health services. They provide the service to young people in Bimberi. Within 24 hours of a young person entering detention, whether

they are on remand or sentenced, they all have a health and mental health assessment. That assessment immediately informs the type of response that we provide to young people in Bimberi.

Often, it might be the first time that a young person's mental health has been assessed because they are often challenging to engage with services in a community. Mental health services undertake that assessment and then seek to provide them with a mental health response both within Bimberi—at times they might have quite an acute presentation both when they first come into Bimberi, particularly regarding anxiety, depression, self-harm type behaviours—and to look to provide them with ongoing supports upon their release into the services offered in the community, such as child and adolescence mental health services or the AMOS service, which is specifically for young people, such as those in Bimberi or residential care, who are more difficult to engage with and require an outreach response.

Some young people who come into Bimberi already had existing mental health providers in the community and, where that is the case, their mental health providers will continue to come and see them for the period in which they are in Bimberi and then back into the community.

MRS KIKKERT: You mentioned the therapeutic assessment care plan, and that all kids who enter residential care have a plan. There are also reports suggesting that the kids in residential care receive the lowest rates of access to mental health care. After they receive the care plan, how often are these children given mental health support throughout their stay in the residential care system?

Ms Pappas: A correction: all children in out of home care receive therapeutic assessments, not just children in residential care. They are very individualised responses, so the individual needs of the young person will determine the type of response and how often they receive that response.

The ACT Together consortium have the Australian Childhood Foundation as one of their partners. The Australian Childhood Foundation is focused on working with staff in residential care to understand what triggers young people, to understand what their needs are and to respond in line with their therapeutic plan.

Not all of the services are met within ACT Together. There are other services that come into residential care to support young kids, and young people go and receive their services from others as well. Some of them have private practitioners and clinicians that they see, that their parents have organised and continue to provide access to. Other young people go to Child and Adolescent Mental Health Services. Other young people see headspace. It really depends on the individual's circumstances, what their needs are and then what the response is to that. So it is very individualised; I cannot tell you that it is three times a week or that it is five times a week.

There are also young people who access services within school settings. There are youth workers and psychologists within school settings who also provide support to these young people, not only with regard to accessing school but also in response to their mental health issues.

You might know that we use a care team process within our work to make sure that all of those people who are involved with young people know what each of the others is doing and understand their roles and responsibilities, and to make sure that the practitioners in the lives of these young people speak regularly to understand what is happening for that young person and to be able to respond accordingly. It is very fluid.

MRS KIKKERT: I understand. There are many people, many different agencies who support the youth. Is there open information-sharing between the agencies and CYPS, as well as the young person having the option to choose whether someone else can have access to their private records?

Ms Pappas: When you declare a care team under the legislation, that allows for open information sharing for those people who are part of that care team. As I have mentioned before, that is usually health providers, education, the child, their family, their carers, CYPS and others who are involved. Once you have declared a care team, you are able to access information, and information should flow freely through that process.

MRS KIKKERT: Does that also include the staff for youth in residential care? They have access to kids' therapeutic assessment plans?

Ms Pappas: Yes, they certainly do. It depends on who the organisation sends to the care team meetings. Sometimes their therapeutic specialist comes; other times it is the people in the homes. It depends on what the arrangements are for those young people. But the care team allows for information to flow freely through for those people who are part of that care team.

MRS KIKKERT: So they have free access to it. From my understanding, a lot of the staff who work with children in residential care do not actually know or do not have access to the youth therapeutic care plan. So it pretty much stops the staff from supporting the youth as they want to, because they do not have access to the therapeutic care plan as they want to.

Ms Pappas: When the therapeutic assessment team develop the plan, they call a care team meeting. Everybody who is involved with the young people comes to that care team meeting, and the therapeutic assessor talks through their assessment and then talks through the plan. That is about trying to close those loops that you are talking about, those information-sharing loops. Then copies are distributed to the people in the care team arrangement.

So I cannot tell you that 100 per cent of the people who are involved with all of those kids have that information, but it is available and it is available within the organisations. They could ask the question of their own organisations about access to that information or they can come directly to CYPS and we can provide them with another copy of it if that is not happening.

The sharing of information is not the issue. How you distribute that through individual organisations across health and education and through our community providers is the challenge that you are describing there.

MRS KIKKERT: Because it is a challenge, how are you monitoring this sort of information sharing to make sure that the youth are actually getting the best support that they currently are in need of? If youth are falling through the cracks because there is a lack of information sharing, how is CYPS making sure that that does not happen?

Ms Pappas: Annual reviews occur through therapeutic assessment, so it is not a static document. As circumstances change, and every 12 months after the initial assessment, there is a review of the assessment to make sure that it remains contemporary. We try to do that every 12 months for kids. It could happen more regularly for those kids who are particularly vulnerable or whose life circumstances are more challenging. With the process of case conferencing and care team meetings, the way we do that is to make sure we have the right people in the room when we are having those conversations. We can take individual circumstances, so if the information is not flowing then we can deal with that on a one-to-one basis.

We have only one residential care provider here in the ACT and we are in daily communication with them. So if that circumstance is happening, it is easy for the agencies to come back and say, "We don't have it," or for us to provide that information to them. The Australian Childhood Foundation is very active in this space. They are the people who go in and support residential care for Barnardos and for ACT Together, and there is daily communication. So I would hope that, through those mechanisms that are established, what are you describing is the exception rather than the rule.

MRS KIKKERT: With regard to youth homelessness and their mental health, we know that there is no facility that caters for youth under 16 years old. Can you please share with us what the government is doing with regard to providing a facility for youth who are under 16 years old? What sort of mental health support is offered to these youth?

Ms Stephen-Smith: Anne-Maree Sabellico would be the best person to take this question. You would be aware that last year we funded the safe and connected youth pilot program, which does include respite for young people under the age of 16 who need a break from their families, as well as case management support. Anne-Maree will talk about that. We have already provided some additional funding as part of our COVID response to extend that program.

MRS KIKKERT: Before you answer that, can I ask another question? With regard to respite, does the youth need a signature to be provided by the parents to go into respite?

Ms Sabellico: I think I can answer that question, but I might need to get you more details in terms of what the arrangements are for different respite services. I might start there and also talk about the program. As part of the safe and connected youth program, we have some brokerage money that is attached to that in order to provide support for young people who may need some form of respite or crisis alternative accommodation, which is used as a bit of a circuit-breaker between them and their families, to be able to separate the conflict in order to get back in and work on whatever the underpinning issues are.

We made it brokerage because we also understood that, for each and every young person, there might be a different solution. So far there have been a couple of different ways in which the respite has been provided. One of them, in the main, has been through Marymead. They have done quite a bit of the respite service. I believe they have an arrangement with the Youth Coalition and the partner agencies around the provision of that brokerage, which would not necessarily require individual signing of any forms in order to access the service. But there would need to be agreement between the family and the young person in order to access that respite because the family are still responsible for the young person. The whole program is about how we sustain the young person back at home, as the primary option. We do not want them to drift in the system, which means that they will be pushed up the pathway to the crisis service.

This particular service was set up to have a look at how we make sure that we can divert young people from child protection, from homelessness, from youth justice and those sorts of things. It is important to include the family in the decision-making, and that respite is something that will be positive and will be put in place in order to support that family in terms of the issues that they are experiencing. My understanding is that no formal signing is required, but there is that conversation which would be required because you are trying to work with both the family and the young person.

With the service itself, every young person and their family has an allocated youth worker. That is through a number of the services that have youth workers funded to deliver this service. They work to identify what the needs are for that family, primarily around what the family needs in order to have reconnection of the family unit. Also, it is about what that young person needs. What is the underpinning issue that means that conflict has arisen within the family and they look to access the services?

From my reading of the many case scenarios that we get from the project to understand what the issues are, because we are also trying to do a bit of a research project around what the gaps in the system are, and we are using some of the live cases to undertake that research, they are accessing mental health services where that is required. They are accessing extra family support or other youth support programs in order to build a package of support around that young person and their family.

Sometimes there is extra advocacy required to access the services in a timely way, to be able to address the issue. That is where the Youth Coalition takes the lead in terms of being able to provide support for that advocacy to occur across the service system.

MRS KIKKERT: How many rooms does respite offer?

Ms Sabellico: So far they have been able to meet all of the respite needs that have come through. I think there were two young people there at one time, for a couple of nights. They were able to cater for that. I am sure they would be able to cater for more, if required. With the nature of the casework and the different options that are available there, if that one is not available for any young person, there are other options that can also be looked at.

MRS KIKKERT: Do you know what is the maximum number of beds or rooms for young persons at a given time?

Ms Sabellico: At Marymead? No, I would have to ask specifically.

MRS KIKKERT: With regard to making sure that there is an agreement between the youth and their carer, or parents, if there is a circumstance where there is no contact with the parent, what happens?

Ms Sabellico: There would be work undertaken with that young person and any identified significant others, in order to work with them around what the options are for the young person. They might also make contact with the family to see if there is any possibility for a level of reconnection that would help support that young person, no matter where they end up.

MRS KIKKERT: I came across a youth; they said that their parents were interstate and they had no relatives here in Canberra. In those circumstances, what happens when there are no relatives in Canberra and no contact? I am sure you would still take them into respite; is that right?

Ms Sabellico: Again, they would have to be accepted as part of the program in order to get access to that. If they were to meet the criteria to gain access to the service, they would meet the criteria for access to brokerage.

MRS KIKKERT: We are out of time. I will put some more questions on notice.

THE CHAIR: As Mrs Kikkert said, we are, indeed, out of time.

MS LEE: Anne-Maree gave an answer about having to double-check the capacity of respite. Did you take that on notice and will you get back to us? Thank you.

THE CHAIR: Okay, that was a head nod. Thank you, minister, for being with us today and thank you to your officials. It was particularly informative, and we appreciate it. You will be sent a copy of the *Hansard* transcript. Make sure that you double-check it. This is an online public hearing; it is new to everyone. The hearing is adjourned.

The committee adjourned at 11.33 am.