



LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON EDUCATION, EMPLOYMENT AND YOUTH AFFAIRS
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Submission Cover Sheet

Inquiry into Youth Mental Health in the ACT

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RE: INQUIRY INTO YOUTH MENTAL HEALTH IN THE ACT

In 2016, my husband and I welcomed a 1-year old Aboriginal foster daughter into our family. She had experienced severe heroin exposure in utero and because of this, she then experienced severe withdrawals in the months following her birth. Emergency orders were given by the court, due to the long history of child abuse from her birth family, and she was removed from her mother's care at 3 days old while still in hospital. She was placed in my mother's care, as my mother is very experienced in supporting foster babies through the drug withdrawal process, and she was prescribed morphine to manage the extreme pain she was enduring due to the withdrawals.

When she was 10 months old, my husband and I requested to become her forever family and were approved to be her carers. She transitioned to our care and we have since received Enduring Parental Responsibility (EPR) for her care.

When she was 3 years old, she attended the Koori preschool program, and this was where we first noted her challenges with functioning in a classroom environment. She had always been a very active toddler but as she grew, we were able to see she is hypervigilant and finds it very difficult to feel safe in places that are not her home. She ran away from the classroom repeatedly each day, she would visit the other preschool classes or hide in the playground and would hurt her classmates and teachers without provocation.

The school referred her to Child Development Services (CDS) for assessments and engaged with the Network Student Engagement Teams (NSET). She was assessed by a speech pathologist and occupational therapist at the CDS and noted as having a delay in expressive language and comprehension, play skills and fine motor skills. She was also diagnosed with obstructive sleep apnoea by an ENT after a referral was given when we noted she was snoring in her sleep. She then had an operation to remove her tonsils and adenoids, and to put grommets in her ears. It was hoped that this might reduce some of the challenging behaviours the preschool was managing, but this did not happen.

As the challenging behaviours also escalated at home, her GP referred us to the CDS Community Paediatrician. After a 12 month wait for the appointment, she was assessed by Dr Hilary Holmes in August of 2019 and then in September, was given the diagnosis of Unspecified Trauma-and Stressor-Related Disorder (DSM V 309.9) noting severe developmental trauma as a result of the drug exposure she endured through development and withdrawals after birth.

Her second year of preschool was in a mainstream class at the local school for our area. It was still challenging but she appeared to still be managing in a preschool classroom with some additional support from the teachers and close monitoring of her behaviour towards classmates. In term 3, I was called by the primary school psychologist and requested to attend a meeting to talk about her transition to kindergarten. The school psychologist advised that she had been identified as needing more support and that the school was going to be starting a new approach to supported learning and that she would be in this cohort. The psychologist explained that the group of children that

needed additional support would be in a smaller class that would integrate with the mainstream class where the children were able to manage in that setting, and then work alone for activities where they were not able to function in the larger class. We were very happy with this approach.

In the final term of preschool, the violent behaviours towards classmates increased and after she injured teachers and classmates, we were called to collect her early from school as her behaviours were no longer manageable. At this time, the after-school care program also contacted me and requested an urgent meeting as they were experiencing the same behaviours. We were advised that she could no longer attend the after-school program as her absconding and violent behaviours were too extreme. This came after an incident where she was initially hugging an educator, and then moved to start choking the woman with her hands. The organisation was happy to continue with before school care as this was a shorter period and she was able to manage better in the mornings than the afternoon.

In December, when her challenging behaviour was escalating at preschool and we were having to collect her early due to violence, I was also informed by the preschool teacher that the supported learning program we had been told about was not going ahead and that she would be placed in the general kindergarten class. I requested an urgent meeting with the school psychologist and principal team to clarify what was going to happen. At this point, the school requested me to complete an authority form so they could apply for the Inclusion Support Program (ISP) and I agreed. This was approved in the school holiday period and I was not able to contact the school to understand what supports would be provided. In December we were also approved for an NDIS package that would support early intervention therapies for her.

In January of this year, we were offered a scholarship placement at Dalwood Spilstead Service in Sydney to have a Neurosequential Model of Therapeutics (NMT) assessment for her. The Dalwood Spilstead Service provides multidisciplinary health, education and support services for vulnerable families, who are in stress or experiencing difficulties in the care and parenting of their children in the early years. The NMT assessment also includes an assessment of the child's cognitive functioning. An NMT trained clinician collects a complete developmental history and collates information from all current assessments of the client's current functioning. The clinician will use this information to complete the NMT report, including a "functional brain map" which is a visual representation of a child's strengths and needs. This report placed her ability to regulate lower brain functions, her behaviour, and emotions as age typical of a 2.42 year old, with no sign of intellectual disability.

I provided this report to the school at the commencement of kindergarten as she was not receiving any support in the classroom. Within a week, her behaviours started to become challenging for the teacher as she would frequently leave the classroom and refuse to return. At first, she was staying within the open plan pod (4 classes were within the same open plan building) but after a week or so, she started to leave the pod and run around the school grounds. By week 3, she was leaving the school grounds and had to have a learning support assistant (LSA) accompany her as she would refuse to return to the classroom or pod. Her violent behaviour increased, and she started to hurt the LSA's assigned to support her, other children in the school and displayed inappropriate social behaviours. We worked closely with the school and had her NMT therapist attend to try and provide the school with some strategies and response techniques.

In week 5, the school suspended her for a day as she had injured a number of people throughout a particularly difficult day. The school did not believe it would be appropriate or even possible to keep her in a room for an in-school suspension, so we were asked to keep her at home. That same week

the out of school care service requested an urgent meeting and informed us that before school care was no longer able to provide her care as even in that small window of time, her behaviours were too extreme to manage. At this stage, our family was in total crisis and were questioning how long we could continue like this as the violence at home was unrelenting. As a result of her intense meltdowns, we had a broken wall, a broken door and our son had been repeatedly attacked by her in completely unprovoked situations. We were terrified we would not be able to keep him or her safe and that I would need to leave my job, which would also mean we would have to sell our home as we couldn't afford a mortgage on one salary. At this stage, COVID-19 started in Australia and schools were closed.

We requested an urgent review appointment with her paediatrician, but this wasn't possible as the doctor was completely booked up. We had an appointment a fortnight later anyway, so we focused on self-care, keeping our son safe and managed for that fortnight with a huge amount of extended family support. The doctor received a report from the school, the out of school care service, her NMT therapist in Canberra and the NMT report from Dalwood Spilstead Services, all of which provided a very comprehensive understanding of what we were experiencing. Her doctor prescribed Risperdal (an anti-psychotic) and we started it that day.

Almost immediately we saw a change in her stress response, she could self-regulate emotions and be calm in the home. The violence stopped and we were able to enjoy her company and feel a sense of hope for the future in those three months we remained in isolation.

Since schooling recommenced, the school was much more proactive and had been able to engage NSET services. Our case was being managed by the NSET senior psychologist, OT team, school psychologist and principal team, as well as her classroom teachers. We commenced reintroducing her to school very slowly, increasing in 15-minute intervals for 3 weeks until she was attending full days. Within a week, her violent behaviours and absconding had started at school again. We are working with the ACT Education Directorate, NSET and the school to try and understand our next steps and options.

Although it is blatantly obvious that she is unable to cope in a standard classroom setting and that she meets the ACT Student Disability Criteria, it does not qualify her to be placed in a Learning Support Unit (LSU). The requirement is "Students must meet the ACT Student Disability Criteria for Intellectual Disability or Autism to be eligible for a placement in these programs." Children with mental health diagnosis are recognised by the ACT Education system as having a disability yet excluded from accessing the necessary supports because they are deemed to be 'behavioural issues'. Our five-year-old daughter has a diagnosed organic mental health disorder which causes her severe psychosocial disability, yet as she does not have a general intellectual disability, she isn't recognised as needing to be in a learning support unit. She is very resource heavy at her school, requiring 1:1 support for every single moment in a school day and still absconds and injures children and teachers. She is in desperate need of appropriate support in school in order to beat the statistical outcomes that children in her demographic - Aboriginal, in foster care, born heroin-dependent - so often succumb to, but this is not seen by our ACT education system as being worthy of the additional support. This is unacceptable, illogical, and frankly, negligent.