1 ESTABLISHMENT OF THE INQUIRY

Introduction

11 On 21 September 1990 the Presiding Member of the Standing Committee on Social Policy advised the Legislative Assembly that the Committee had agreed to conduct an inquiry into behavioural disturbance among young people.

12 During its inquiry into Public Behaviour which was conducted in 1989/ 1990 the Committee became aware of the need to address the issue of behavioural disturbance among young people. Members' experiences, approaches from teachers and community members and further inquiries by Committee members indicated the need for an investigation into the problem and as a result this inquiry was initiated.

13 Three major issues emerged during these early discussions . These issues were:

– non compliant or socially aggressive behaviour among school students;

– truancy; and

– problems with accessing services for young people with behavioural disturbance.

14 Over the last two decades there has been a diversification in what is seen as acceptable behaviour in our society. Society has had to grapple with ways of dealing and coping with behaviour that once may have been seen as unacceptable. The initial reaction is to blame the education system. Certainly the situation in schools is becoming more difficult. However any consideration of the problem of behavioural disturbance among young people must be examined in the context of complex and intertwining broad social issues. The following have been documented as contributing to socially inappropriate behaviour:

– the rate of change in society generally;

– changing economic conditions especially in relation to families;

– the level of unemployment;

– the bewildering array of values and beliefs;

– negative expectations about the fate of the world;

– the increasing inability of the range of changing family types to meet the needs of its members; and

– the rate at which marriages or relationships are changing.

Terms of reference

15 The terms of reference for the inquiry are:

In the context of developing a strategy over at least five years, investigate the extent of any problems of behaviourally disturbed young people, recommend measures to reduce the extent of such problems, and assist the integration or reintegration of behaviourally disturbed young people into the community, taking account of the particular responsibilities of family, society and the state towards such people.

In the course of this inquiry to assess the causes, impact and management of behavioural disturbance among the young including inquiry into the following:

1. measures to reduce or prevent behavioural disturbance;
2. the extent and appropriateness of existing family accommodation, education and employment support; and whether more effective options could be introduced;
3. the need for early intervention and remedial assistance;
4. the needs of behaviourally disturbed young people from any special needs groups identified by the Committee;
5. the needs of carers (such as parents, teachers and other professionals);
6. the needs of others (such as siblings, school peers or house sharers);
7. such other relevant matters that are drawn to the Committee's attention.

1 METHOD OF INQUIRY

1.1. The Committee advertised the inquiry in the press in late October and early November 1990. The advertisement called for submissions to be received by 13 December 1990. Due to the high level of interest in the inquiry as it progressed submissions were accepted throughout the inquiry.

1.2. Appendix 1 lists all those who made submissions to the inquiry. The Committee received submissions from 87 individuals and organisations.

1.3 The Committee held seven public hearings and received briefings from relevant government departments.

1.4 Appendix 2 lists people who gave evidence at public hearings and Appendix 3 lists officers who provided briefings to the Committee.

1.5 The Committee visited several programs for young people with behavioural disturbance in the ACT and New South Wales and held discussions with officials from the Departments of Police, Education and Health in South Australia. A list of visits made by the Committee is at Appendix 4.

1.6 The Committee thanks all those who made submissions, gave evidence and assisted the Committee both in the ACT and interstate with visits and informal discussions.

2 DEFINING "BEHAVIOURAL DISTURBANCE AMONG YOUNG PEOPLE"

Definition

2.1 In developing a definition two complicated, multifaceted elements must be considered, namely – behavioural disturbance and young people.

2.2 Definition of behavioural disturbance is a subjective matter. There is no standard definition that is acceptable to all those working with or associated with young people. Labelling behaviour as disturbed is directly linked with whatever the culture determines as intolerable and the conceptual model applied.

2.3 Many ACT organisations and individuals who contributed to the inquiry pointed out the difficulties of definition. Some applied a general definition while for others it was more appropriate to narrow the definition to specific problems.

2.4 Some of the general definitions of behavioural disturbance which emerged from the evidence included:

> an inability to respond to, or benefit from, services provided for young people, particularly educational provision;
>
> actions or behaviour that disturbs the public;
>
> a pathway of behaviour which is not normally associated with the person concerned or with community mores;
>
> behaviour that is temporarily or permanently outside the range of behaviour considered acceptable by society;

2.5 More specific definitions included:

> behaviour that persistently threatens the person's ability to reside in/or maintain stable housing, or live with the family of origin;
>
> behaviour problems related to intellectual disability or malfunction of the brain.

2.6 To further complicate the problems of definition sometimes a distinction is made between behavioural disturbance and disorder. The National Mental Health Strategy Statement (May 1990) differentiates between "mental health problem" and "mental disorder". A mental health problem is defined as a disruption in the interaction between the individual, the group and the environment producing a diminished state of mental health. A mental disorder may be defined as a recognised, medically diagnosable illness that results in the significant impairment of an individual's cognitive, effective or relational abilities. Based on this interpretation behaviour disorder is more akin to mental illness while behaviour disturbance is a more general problem.

2.7 The ACT Board of Health pointed out that in practice it is often very difficult to make this distinction, especially in young people. Developing a full blown mental disorder under the age of 17 is relatively rare, whereas behavioural disturbance is more common and may or may not lead to or be symptomatic of a serious disorder. It is often not possible to separate behaviour disturbance from behaviour disorder when referring to children and adolescents.

2.8 In psychiatry the term behavioural disorder is often interchanged with other terms such as conduct disorder, emotional disturbance and antisocial personality disorder.

2.9 The term "challenging behaviours" is also sometimes used to describe behaviour disturbance/disorder. Challenging behaviour as defined by Michael Steer and noted in **Time for Action** refers to:

> behaviours which place the physical safety of the person, or others, at risk or behaviours which seriously limit the person's access to ordinary and valued community experiences, services and facilities.[1]

2.10 In her report to the South Australian Government of the **Review of Services for Behaviourally Disordered Persons** Dame Roma Mitchell defined behaviour disorder as:

> Persistent or repeated behaviour of an antisocial or deviant nature which falls outside community norms and which is of such severity that at most times the person with the disorder is unable to look after himself or herself, or his or her affairs, or is incapable of living in a community without resorting to unlawful or dangerous conduct.[2]

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1 Patterson, Jan, **Time for Action,** South Australian Health Commission, Adelaide, 1989, p 24.

2 Mitchell, The Honourable Dame Roma, **Report of the Review of Services for Behaviourally Disordered Persons,** Department of Health, South Australia, May 1985, p 25.

2.11 This definition describes the relationship between the disturbed person and his or her community and addresses the issue of severity but does not identify the specific behaviours that are perceived as indicative of behavioural disturbance.

2.12 Kaufmann[3] provides a commonly used definition in the United States of America developed by Eli M Bower in 1981, which specifies persistent characteristics of behavioural disturbance in children as having to do with

> school learning problems
> unsatisfactory interpersonal relationships
> inappropriate behaviour and feelings
> pervasive unhappiness or depression
> physical symptoms or fears associated with school or personal problems.

2.13 Defining behavioural disturbance becomes even more complicated and confused by the interplay of associated difficulties such as intellectual disability, psychiatric illness and drug and alcohol problems. As Barbara Pamphilon states:

> even if an agreement on a definition of problem behaviour could be reached many young people present with multifaceted problems. The interplay of behavioural issues and factors such as drug and alcohol abuse, homelessness, sexual abuse, family relationships and criminality precludes a simplistic approach to the problem.[4]

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3 Kaufmann, James, **Characteristics of Children's Behavior Disorders**, Charles E Merrill Publishing Company, Columbus Ohio, 1985, p 33.

4 Pamphilon, B, **Out to Lunch – A Survey of Mental Health Services for Young People in the ACT**, ACT Council of Social Service, Canberra, 1988, p 2.

2.14 In its submission to the inquiry the Youth Affairs Network of the ACT drew attention to the need to distinguish between behaviour that is a part of growing up and behaviour that is disturbed.

> In any discussion of behavioural disturbance it is important to remember that this is not a single, easily identifiable abnormal behaviour. The behaviours range from those that are diagnosable as psychiatrically related (such as schizophrenia) through psychosocial disturbance (such as extreme aggression) to what may well be normal adolescent behaviour, but is classified as a disturbance by other (frequently older) people. For example, it is not abnormal for a young person to experiment with alcohol or sex; it is in fact a necessary part of growing up according to some researchers. However, many people are concerned about the levels of adolescent drinking and/or the amount of sexual experimentation being undertaken. This is not behavioural disturbance unless the behaviour is so extreme as to prevent the young person from participating in society. In addition, it is most likely that a behaviourally disturbed young person will consistently display a number of inappropriate behaviours, rather than just one which may be seen as inappropriate.[5]

The Committee's definition

2.15 Notwithstanding the problems of reaching an acceptable definition it was important for the Committee to define what it meant by the term in order to develop measures to reduce the problem in the ACT.

2.16 *Behavioural disturbance* in this report is defined as behaviour that is, or may lead to, behaviour that is seriously disruptive and/or dangerous either to the young person and/or others in the community.

2.17 The term *young people* also presented problems of definition. Some wished to define it generally while others were more specific. Since behavioural disturbance may be more evident as a child approaches the teenage years, because its cause may have been present from birth it is important to consider children from birth. The Committee recognises that "young people" covers a wide age range and did not wish to limit in its considerations to an arbitrary cut off age for example the legislated age for children. In this report *young people* refers to those generally aged from birth up to 18 years.

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5 Submission 34, p 2.

3 INDICATORS AND POSSIBLE CAUSES OF BEHAVIOURAL DISTURBANCE

Indicators of behavioural disturbance

3.1 During the course of the inquiry the Committee's attention was drawn to the wide range of behavioural problems evident among young people in the ACT. While definition of behavioural disturbance posed difficulties those contributing to the inquiry shared an understanding of behaviours that they saw as indicative of behavioural disturbance. Research suggests that there are two types of behaviour disturbance – externalised (eg anger, defiance) and internalised (eg apathy, withdrawal). The following lists a number of the behaviours identified:

violence against family members, peers, and those seen as authority figures;
depression;
inability to maintain friendships;
lack of concentration;
lack of social skills;
petty crime;
emotional disturbance;
truancy;
antisocial behaviour;
alcohol abuse;
drug abuse;
uncontrollable acting out;
defiance of authority;
extreme withdrawal.

3.2 Most of the behaviours identified above are of the externalised type. These behaviours cause significantly more disruption and on the surface are much more difficult to deal with than the internalised type. The Committee's attention was drawn to the fact that the majority of those exhibiting behavioural disturbance of the internalised type are girls and that their needs are largely overlooked.

Possible causes of behavioural disturbance

3.3 The majority of evidence received by the Committee was very cautious in attributing causes.

3.4 It was repeatedly stated that behavioural disturbance among young people has multiple causes, some of which are unknown, and must be considered in a broad context.

Any single case must be carefully studied to try to determine the set of interacting influences that may have contributed to the unacceptable behaviour.

3.5 National and international research indicates that there are biological, psychological, family and cultural influences which are related or may contribute to behavioural disturbance.

Biological influences

3.6 There is research that suggests that in some instances certain biological factors contribute to behavioural disturbance.

3.7 It is suspected that some specific behaviour disorders such as hyperactivity, distractability and childhood psychosis have a biological base.

3.8 Brain damage or dysfunction can and often does cause or contribute to behavioural disturbance. The damage may be existent from birth or may be caused by an accident or disease at a later stage. The degree, locus and extent of the damage varies as does its effect on behaviour.

3.9 Intellectual disability is often related to behavioural disturbance. There is general acceptance that behaviour disorder is significantly more prevalent among the mild/borderline retarded population than in the normal and moderately retarded populations.

3.10 There is a relationship between gender and behavioural disturbance. MacCoby Jacklin (1980)[6] reported that both aggression and conduct disorders are predominantly male conditions. Boys show more physical aggression than girls from 2 or 3 years onwards.

3.11 In the ACT boys under 12 years are four times more likely than girls to be referred to the Child and Adolescent Unit, which is part of the Mental Health Services Branch of the ACT Department of Health.[7]

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6 MacCoby, E. Jacklin, C. "Sex Differences in Aggression: A Rejoinder and Reprise", **Child Development**, 1980, 51:964–980.

7 Submission 37(a), p 5.

Psychological influences

3.12 Zagar (1989)[8] found that school age delinquents have higher frequencies of mental retardation and attention deficit disorder (with or without hyperactivity) when compared with rates of non–delinquent school age children.

3.13 Zagar (1989)[9] also demonstrated a correlation between learning difficulties and behaviour disturbance.

3.14 Matthys (1989)[10] concluded that personality characteristics are different in children with conduct disorders than others.

3.15 Lahey (1988)[11] noted that antisocial personality disorders are frequently found in the parents of conduct disordered children.

3.16 Behavioural disturbance can also result from a single traumatic incident such as unreported sexual assault.

3.17 Much of the anecdotal evidence received stressed the relationship between low self esteem and behavioural disturbance.

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8 Zagar, R. et al, "Developmental and Disruptive Behaviour Disorders among Delinquents", **Journal of the American Academy of Child and Adolescent Psychiatry**, 1989, 28:431–436.

9 ibid

10 Matthys, W. et al, "Person Perception in Children with Conduct Disorders", **Journal of Child Psychology and Psychiatry**, 1989, 30:439–448.

11 Lahey, B. et al, "Psychopathology in the Parents of Children with Conduct Disorder and Hyperactivity", **Journal of the American Academy of Child and Adolescent Psychiatry**, 1988, 27:163–170.

Family and cultural influences

3.18 A recent Canberra study, Shaw and Scott (1991)[12], found a relationship between parental disciplinary style and adolescent delinquent behaviour. Reports of delinquency increased when "punitive" parenting had been experienced. On the other hand "inductive" parenting, a style of parenting that emphasises explaining to a child the causes, effects and consequences for others of the child's behaviour, was associated with a decrease in the incidence of delinquent activity. The authors of this study concluded that an "inductive" parental discipline style can have a positive effect on teenagers' behaviour by enhancing their sense of personal control over events in their lives or their own behaviour. Conversely, "punitive" parenting and the withdrawal of love as a disciplinary technique appeared to have negative consequences, diminishing any sense of personal control for the teenagers and increasing the likelihood of delinquent behaviour.

3.19 Several studies, for example Johnson and O'Leary (1987)[13] have ascertained that there is a relationship between behaviour disorder, particularly among girls, and parental modelling.

3.20 Eckersley (1988)[14] cites many studies that show that the quality of care given to children is the most important influence on child development. The need for warmth and caring, good personal relationships, quality contact with both parents (or stable substitutes for parents) are important factors.

3.21 Edgar (1991)[15] cites a British study **The Family Way: a New Approach to Policy Making** which examines the evidence for blaming a range of social problems on the "breakdown of the family". He reports that divorce and separation affect children where there is a continuing poor quality relationship with each parent. Lone parenthood does not cause delinquency or underachievement, however the associated poverty probably does.

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12 Shaw, J. and Scott, W. "Influences of Parent Discipline Style on Delinquent Behaviour", **Australian Journal of Psychology**, Vol. 43, No.2, 1991, pp 61–67.

13 Johnson, J. and O' Leary, K. "Parental Behaviour Patterns and Conduct Disorders in Girls", **Journal of Abnormal Child Psychology**, 1987, 15:573–581.

14 Eckersley, R. **Casualities of Change: The Predicament of Youth in Australia**, Commission for the Future, 1988.

15 Edgar, D. "Valuing Children and Parents: The Key to an Australian Family Policy", **Family Matters**, 1991, 29:33.

3.22 Counsellors and welfare workers have emphasised how poverty can be a prime cause of family stress which adversely affects the behaviour of children. Unemployment has resulted in a dramatic increase in the number of families living in poverty. Single parent families can be particularly susceptible to poverty. Maas (1987)[16] reported that 55 per cent of single parent families are in poverty and they also have the lowest disposable incomes of any family type.

3.23 Ochiltree (1990)[17] reports several studies which indicate that ongoing excessive, unresolved and maladaptive conflict in families contributes to behavioural problems.

3.24 Kauffman (1985)[18] describes several studies which identify maladaptive interaction patterns in families with disturbed children.

3.25 Carsen (1990)[19] has recently reported a correlation between suicidal behaviour, family mental health problems and family disruptions.

3.26 Evidence was received from a range of professionals working with young people with behavioural disturbance who claimed that there is a strong relationship between behavioural disturbance and child abuse, particularly the more easily identifiable forms of abuse namely physical and sexual abuse. The literature provides strong support for these claims.

3.27 Lewis et al (1989)[20] demonstrated associations between symptoms of neuro–psychiatric and cognitive impairment, upbringing in abusive violent families and aggressive behaviours in children and adolescents.

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16 Maas, F. "Families and Poverty in the 1990's", **Australian Institute of Family Studies Newsletter**, 1987, 18, pp 6–7.

17 Ochiltree, G. **Children in Step Families**, Prentice Hall of Australia, Melbourne, 1990, p 121.

18 Kauffman, James, **Characteristics of Children's Behavior Disturbance, op cit.**

19 Carsen, G. "Suicidal Behaviour and Psychopathology in Children and Adolescents", **Current Opinion in Psychiatry**, 1990, 3:449–452.

20 Lewis, D. et al, "Towards a Theory of the Genesis of Violence: A Follow–up Study of Delinquents", **Journal of the American Academy of Child and Adolescent Psychiatry**, 1989, 28:3, 431–436.

3.28 Briere and Runtz (1987), Bagley and Ramsey (1985) and Peters (1984) are some of the many studies reported by Finkelhor and Browne (1988)[21] which found child sexual abuse to be related to depression. Other studies have demonstrated a relationship between sexual abuse, suicide attempts and self mutilating behaviour for example Bagley and Ramsey (1985) and Briere and Runtz (1988).

3.29 In an address given as long ago as 1985 Professor Emeritus Brandt F Steele drew attention to this relationship. He stated:

> Those who work with older children are quite familiar with the fact that formerly abused children are very commonly in trouble at school, both with learning difficulties and with general conduct difficulties. They tend to be either isolated and alone, socially inept, or on the other hand quite aggressive and trouble making. In more severe forms, this drifts over into what we call juvenile delinquency.[22]

3.30 In an address to the Australian Achievements in Special Education conference entitled "Issues for the Nineties" Professor Jeff Bailey also emphasised the problems related to family breakdown. He cited a study by Patterson (1982) which asserts that the amount of family coercive behaviour (hitting, threatening, whining etc) is a good indicator of later anti–social problems in children and adolescents. The outcomes for the child of excessive coercive management in families are reported in a later study (Patterson et al 1989) and can include delinquency, poor academic achievement, a failure to develop social skills and a deficiency in social–cognitive skills.[23]

3.31 Doctors, teachers, counsellors and community workers referred constantly to the strong relationship between the lack of effective parenting skills and behavioural disturbance in children and young people.

3.32 Professor Brent Waters drew the Committee's attention to single teenage mothers as a group who are at high risk to be less than competent parents and for whom advice and support on parenting can be very effective.[24]

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21 Finkelhor, D. and Browne, A. **Assessing the Long Term Impact of Child Sexual Abuse: A Review and Conceptualization**, in Hotaling, G, et al, **Family Abuse and its Consequences**, Newbury Park, CA, Sage Publications, 1988.

22 Steele, Brandt, F. "Notes on the Lasting Effects of Child Abuse throughout the Life Cycle", **Child Abuse and Neglect**, 1986, 10:288.

23 Bailey, J. **Issues for the Nineties**, Australian Achievements in Special Education Conference, October 1990, pp 11–14.

24 Transcripts, 7 June 1991, pp 333–334.

Conclusion

3.33 It is very tempting to try to pinpoint the causes of behavioural disturbance to biological, psychological or family and cultural factors. The extent to which these factors interact is unknown and is the basis for much scientific discussion.

3.34 Human behaviour is extremely complex and caution must always be exercised in attributing cause to a specific factor. This in itself is no reason for total despair since much of the research that has attempted to identify the causes of disordered behaviour has shed light on the design of therapeutic intervention.

3.35 Despite the fact that there are no clear causes, there are two areas where significant preventive measures should be taken, namely in the areas of child abuse and family dysfunction.

3.36 Evidence received by the Committee indicates a strong relationship between behavioural disturbance and child abuse and the need to change parental attitudes and behaviour in relation to physical punishment and coercive behaviour.

3.37 In its report **Violence: Directions for Australia** (1990) the National Committee on Violence made recommendations on strategies for the prevention of child abuse. These recommendations included conducting a national campaign on the prevention of child abuse and the establishment of a national research centre on child abuse. The Federal Government has recently announced the establishment of a National Child Protection Council which will promote and conduct research on child abuse prevention, including on community attitudes and the effectiveness of community education. The Council will comprise representation from each State and Territory, report to the Minister assisting the Prime Minister on the Status of Women and have its first meeting in late 1991.

3.38 The proposed terms of reference are:

- To promote and conduct research on the prevention of child abuse, including on community attitudes and the effectiveness of community education programs.

- To report to the Minister as soon as possible on the potential value of a national community education program, and if supported examine the feasibility of conducting such a program, in conjunction with States and Territories.

3.39 The Committee welcomes the involvement of the Federal Government in the prevention of child abuse and urges the ACT Government to give its full support to the National Child Protection Council.

3.40 In recent years the level and availability of family support services provided by the Department of Health and the Housing and Community Services Bureau has gradually been eroded to the extent that there is now very little easily accessible family counselling available and those working in the field cannot possibly meet the demand.

3.41 The non–government sector has developed a wide range of parenting and family support programs, however they are not always well patronised and the organisations reported difficulties in targeting those who would benefit most. There is a need to review the availability, relevance and accessibility of community based parenting programs and for improved access to and availability of counselling services particularly in marriage guidance and family support. The Committee believes that the provision of easily accessible family support services at the basic level would go a long way to preventing some behavioural disturbance.

3.42 Strategies to address these issues will be discussed later in the report

4 THE EXTENT OF BEHAVIOURAL DISTURBANCE IN THE ACT

4.1 It is widely accepted that behavioural disturbance is a very complex issue with many complex causes.

4.2 In attempting to quantify the extent of behavioural disturbance among young people in the ACT it is necessary to draw a distinction between the types of data collected. There are two basic forms in which data on such issues as behavioural disturbance is recorded namely prevalence data and incidence data.

4.3 Prevalence data refers to the total number of active cases in the population during a specified period. Incidence data refers to the occurrence of new cases during a period. Prevalence rates do not directly reflect incidence rates since prevalence is dependant on rates of recovery and mortality as well as on the occurrence of new cases.

Prevalence Data

4.4 Prevalence rates have been widely used to assess the extent of psychiatric disorder among Australian children and adolescents. In the absence of any ACT studies the Committee has gone to national and international research. Various studies have reported that psychiatric disorder affects 15 per cent to 18 per cent of children and adolescents. For example Connell et al (1982) assessed the levels of psychiatric disorder among Australian children as ranging from 10 per cent in rural communities, 15.1 per cent in urban communities and 18.4 per cent in metropolitan areas. Connell defined psychiatric disorder as

> An abnormality of behaviour, emotions or relationships ... sufficiently marked and sufficiently prolonged to cause handicap to the child and/or distress or disturbance to the family or community... and is not synonymous with "maladjustment" or "illness" and does not necessarily carry connotations for a need of treatment.[25]

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[25] Connell, H. Irvine, L. and Rodney, J. "Psychiatric Disorder in Queensland Primary Schoolchildren", **Australian Paediatric Journal**, 1982, 18:177–180.

4.5 Since this definition is similar to the definition of behavioural disturbance adopted for this inquiry it is reasonable to apply Connell's estimate of prevalence to the ACT population.

4.6 Based on 1990 population forecasts the prevalence of ACT children under 18 years of age with psychiatric problems as defined above would range from 12,850 at a rate of 15 per cent to 15,420 at a rate of 18 per cent.

4.7 While this prevalence rate seems alarmingly high it must be remembered that the severity varies significantly and intervention is not required in all cases. Nevertheless there is cause for deep concern.

4.8 In 1988 the South Australian Government undertook a study of social and behavioural problems in school children. The findings of this study are contained in **Interagency Responses to School Children with Social and Behavioural Problems**[26]. The report concluded that probably fewer than one per cent of the school population exhibits behaviour which is extremely difficult to manage in a school setting. If this measurement were applied to the ACT government school system it would represent approximately 430 students.

Incidence Data

4.9 Incidence data records the number of clients coming into a service within a particular time period.

4.10 Because services dealing with behaviourally disturbed children inevitably use different definitions it is useful to consider incidence rates within three broad, but not mutually exclusive frameworks, namely:

- diagnostic category;
- problem oriented approach; and
- management capability.

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[26] Stratmann, P. **Interagency Responses to School Children with Social and Behavioural Problems**, 1988, Department of Premier and Cabinet, South Australia.

4.11 These frameworks are based on the work of Epstein and Cullinan and of Bruggen and were suggested by the ACT Board of Health.[27]

(1) Diagnostic category

4.12 This is an individual focus. A diagnosis such as schizophrenia or depression, when it can be made, is useful because it determines the treatment approach or approaches selected and anticipates ongoing and future difficulties.

4.13 In its submission to the Inquiry the ACT Board of Health provided the following information on admissions to psychiatric wards in Canberra.

Ward 12B Woden Valley Hospital

In 1988 there were 35 individuals less than age 20 admitted to Ward 12B of whom 21 were male and 14 female. Five of these cases were admitted on more than one occasion during that year. Between 15 and 19 years the age distribution was relatively even except for males between 18 and 20 where there was an increase. According to the ISD9 classification the majority were admitted for diagnostic psychiatric disorders including organic, affective, alcoholic psychotic conditions and neurotic disorders. In the remainder of cases it was not clear whether the problem was readily classifiable or if the behavioural symptoms, eg being out of control and therefore beyond the capacity of family and community to cope were the predominant reasons for the admission.

Calvary Hospital Psychiatric Ward 2S

Between July and December 1988 there were 19 individuals under 21 years admitted to this ward in a six month period comprising 12 males and 7 females. The age distribution was slightly weighted towards the older age groups. According to the ISD9 classification, the admitted group were mainly of diagnostic psychiatric conditions including psychotic and neurotic disorders with a minority of problems associated with drug overdose.

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[27] Submission 37(a), p 6.

4.14 Included in evidence from the ACT Youth Accommodation Group was the report **Stop the Madness**[28] which also provides incidence data on admissions to Ward 2S at Calvary Hospital. From 14 August to 31 September 1989 10 people aged from 14 to 20 years were admitted to the ward. This group comprised 8 males and 2 females. Again a greater proportion was in the older age bracket with five of the ten being aged 19 or 20.

4.15 Woden Valley Hospital indicated that in 1990 nine young people (4 females and 5 males) under the age of 18 were admitted to Ward 12B. Three of these young people were admitted on two occasions and one was admitted three times. The diagnoses included personality disorder, self mutilation and intellectual handicap. The length of stay on each occasion ranged from one day to 100 days the latter being a young woman with a diagnosis of intellectual handicap. Total occupied bed days in 1990 was 188.

4.16 Calvary Hospital reported that 11 young people under the age of 18 were admitted to Ward 2S in 1990.

4.17 The Autism Association of the ACT estimates that there are currently 60 autistic children and young adults in the ACT. At present about 5 new diagnoses are made annually, usually at the age of 3 years.

(2) Problem oriented approach

4.18 The focus of this approach is as much on the system which is maintaining the problem as on the referred child. For example the multiple causes of the problem behaviour and their interrelationships are examined in the context of the systems that impinge on the young person.

4.19 The Child and Adolescent Unit reported that in the three month period from June to August 1989 it received 37 referrals from schools for children (mainly boys) under 12 years of age with serious behaviour problems in school necessitating in some cases expulsion. As a result of changes in practice in the ACT Department of Education and the Arts there has been a significant reduction in this category of referral.

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[28] Duncan, C. **Stop the Madness**, ACT Youth Accomodation Group Inc, Canberra, 1990.

4.20 In 1990, 229 school students participated in the ACT Department of Education and the Arts' Behaviour Management Support Program, which comprises a primary and secondary withdrawal unit and an outreach program.

4.21 In 1990, 21 behaviourally disturbed preschool children enrolled in southside preschools were referred to the Play Therapy Program.

4.22 Examples of incidence rates that fit this framework are not as readily available as they are for the other two frameworks.

(3) Management capability

4.23 This framework involves a practical judgement as to what can be managed in existing settings and can easily accommodate different definitions or interpretations of behavioural disturbance.

4.24 The Act Board of Health provided the following information.

- In 1989 an Intellectual Disability Service survey identified 19 young people with low intellectual ability (but not intellectually disabled) who were severely behaviourally disordered.
- In August 1990 a community group "Care for Kids in Crisis" identified 12 adolescents with severe behavioural difficulties. The majority of these young people were intellectually disabled.

4.25 Callaghan (1990)[29] identified 36 young people who at the time of the study could not be placed in foster care because of severe behaviour problems.

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[29] Callaghan, B. **"Illusions and Realities", Responsibility for Children's Protection and Care in the Australian Capital Territory**, Bruce Callaghan and Associates, Balmain, NSW, 1990, p 92.

4.26 The following incidence data is taken from the Youth Accommodation Group's report **Stop the Madness**[30].

- Between July 1989 and July 1990, 43 of the 193 young people under 19 years of age accommodated in Canberra youth refuges were considered to be suffering from psychiatric disorders or severe behavioural disorders.

- In the same period at the Southside Refuge 40 of the 138 young people under 18 years of age who were accommodated were considered to be suffering from psychiatric or severe behavioural disorders.

- Of the 16 young people who went through the Galilee Family Placement scheme in that period nine were considered to have severe behavioural disorders and another three were described as having chronic psychiatric problems.

- In the six month period from March to August 1990, 48 young people under 18 years of age were placed at Scullin House, a Community Welfare facility which provides emergency shelter for children in need of care. Many of these young people have remained at Scullin House for extended periods because their disturbed behaviour precludes other placements.

4.27 The ACT Youth Affairs Network reported that the Civic Youth Centre deals with 15 behaviourally disturbed young people daily.[31]

4.28 A precise determination of the extent of the problem of behavioural disturbance among young people in the ACT is difficult to ascertain. Since there has been no prevalence study in the ACT we can only apply results from interstate or overseas studies to the ACT situation. Incidence data records the number of cases dealt with by a service over a certain time and is therefore not a true reflection of the extent of the problem. Combining these two types of data gives some indication of the extent of the problem. There is an urgent need for a prevalence study of the extent of behavioural disturbance among young people in the ACT to provide more accurate data and to facilitate better planning and service delivery for this client group.

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30 Duncan, C. 1990, **op cit.**

31 Transcripts p 108.

4.29 **The Committee recommends that:**

- **The ACT Government approach one of the ACT based universities to conduct a study into the prevalence of behavioural disturbance among young people in the ACT.**

5 BEHAVIOURAL DISTURBANCE IN THE EARLY CHILDHOOD YEARS

5.1 Behavioural disturbance is often evident from a very young age. Kashani et al (1987) in a study of conduct disordered adolescents found that they had significantly more behaviour problems during the preschool years as compared with a control group with no diagnosis of conduct disorder. The study emphasises the continuity of conduct disorder in some children but also points out that not all preschool children identified with behaviour problems will go on to develop conduct disorders as adolescents.[32]

5.2 In the ACT there are a number of services available to assist families in dealing with young children with behaviour problems. These include the Child and Adolescent Unit of the ACT Board of Health, special playgroups for children with behaviour problems and parents (usually the mother), and the Child Health Service. The evidence received indicates that these services cannot meet the current demand.

5.3 Many families do not seek help as they have no idea of how to access the appropriate service or because they do not see the child's behaviour as a problem. Often the latter is not because the child's behaviour is not perceived as very difficult to manage but that parents believe the behaviour is part of growing up and this view is reinforced by friends and even some professionals.

5.4 Many submissions expressed the view that the reintroduction of universal developmental screening for three year olds would result in the earlier identification and remediation of behaviour problems in young children. This service was discontinued because it was not seen as cost effective. The service is available on request, however this is not well known by parents, teachers, community workers and even some health professionals. The Committee believes that it is extremely important for parents, teachers, childcare workers and health professionals to be aware of the service and for parents with any concerns about their child's development to be encouraged to use the service.

5.5 The Committee is not advocating the reintroduction of universal developmental screening of three year olds, however it believes that measures need to be introduced to effectively publicise the availability of the service on request.

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32 Kashani, J. et al, "Conduct Disordered Adolescents from a Community Sample", **Canadian Journal of Psychiatry**, Vol 32, 1987.

5.6 The Committee has received extensive evidence on the long term value of early intervention[33] and believes that developmental screening is an important early intervention service. To ensure that the service continues to be effective it is important that community nurses receive ongoing training in the administration of the three year old developmental tests so that they continue to have the necessary skills.

5.7 **The Committee recommends that:**

. **The ACT Department of Health**

- **ensure that the availability of developmental screening for three year olds is adequately publicised;**
- **ensure that community nurses receive ongoing training in the administration of three year old developmental tests.**

5.8 Evidence from those working in the field reported that there are increasing numbers of children with behavioural disturbance using preschool and childcare services.

5.9 According to the July 1991 Census compiled by the ACT Department of Education and the Arts there are 4042 children enrolled in ACT government preschools. Of these 184 are special needs children who have been granted early entry. The majority of the children enrolled are aged four.

5.10 In a letter to the Committee dated 16 July 1991, the ACT Housing and Community Services Bureau advised that there are no figures available to give information about the actual numbers of children under compulsory school age who are in childcare. There is a total of 3613 licensed childcare places for children under compulsory school age. This comprises 2109 long day care places, 376 independent preschool places, 684 occasional care places and 444 adjunct care places. The number of licensed places does not however reflect the number of children who are cared for in these programs. The total number could be double this number because of the nature of some care situations where children attend on a part time basis and one place could be shared by one or more children.

5.11 Preschools and childcare centres have extremely limited access to support services to assist them in dealing with children with behavioural disturbance.

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[33] Refer to Chapter 11.

5.12 Preschools have one resource teacher, currently working in the Belconnen region, who among a myriad of other duties assists classroom teachers in managing children with behavioural disturbance. There is no formal allocation of school counsellor time to preschools, however this year each region has made some informal arrangements to provide a limited service to preschools. The Committee notes the view expressed by the Deputy Secretary that there seems to be little hope that the Department of Education and the Arts will be able to provide additional counsellor resources to preschools. In response to a question asking if the Department was planning to increase counsellor resources to preschools he stated in evidence to the Committee that:

> it (preschool) is a difficult area to provide more resources to ... it is not regarded – it is not part of the main stream schooling – education.[34]

5.13 The Committee finds this view most regrettable particularly in the light of the evidence supporting early intervention which is discussed later in the report.

5.14 In 1989 senior preschool teachers of the ACT Department of Education and the Arts became so concerned about the lack of support for young children with behaviour problems that they applied for and were successful in receiving a Commonwealth funded Early Special Education grant to establish a play therapy program. A play therapist is employed on a part time basis.

5.15 In 1990, 21 preschool children with behavioural disturbance (generally 4 year olds) enrolled in southside preschools were referred to the Play Therapy program. Resources available enabled 13 children to take part in the program. Children referred display some or many of the following behaviours.

> They are destructive, unpredictable, defiant, hard to restrain, have no apparent fear, run away, have flashes of uncontrollable behaviour, use foul language to intimidate others, show lack of tolerance to failure, want total success, aggressive to peers, unhappy, show negative attitude to others, are lonely, indicate low self esteem, are withdrawn and silent, inattentive, uncooperative ...[35]

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34 Transcript, 24 July 1991, p 367.

35 Submission 7, p 1.

5.16 The play therapy program is reported to have resulted in positive outcomes.

> Significant change has occurred with those children where parents and teachers were open to change and honest about factors that were contributing to the emotional disturbance... The change can be measured objectively by comparison of the Burks Behaviour Rating Scale before and after play therapy intervention. The change can also be measured subjectively by comments from adults involved....Even where change was not dramatic (4 children), the position of play therapist enabled a facilitative way to provide emotional support to those involved, enabling them to get through the difficult times.[36]

5.17 The program has been extended to cover all Canberra preschools in 1991. The continuation of the program is however dependent on the outcome of an annual grant application.

5.18 The Committee acknowledges the importance of this program and would hope that it will continue to receive support and priority for funding.

5.19 Support services for the management of children with behavioural disturbance in child care are also minimal. Childcare centres address the problem by providing extra staff if they are able to afford the extra costs. The Commonwealth Department of Health, Housing and Community Services provides grants to community based organisations to employ Supplementary (Sups) Workers and Children's Services Workers who support staff in childcare to integrate children with disabilities, children from non English speaking backgrounds and aboriginal children into childcare facilities. The integration of children with physical and intellectual disabilities is the primary concern of these workers and behavioural disturbance is only dealt with if resources allow.

5.20 The Children's Day Care section of the ACT Housing and Community Services Bureau has this year taken some initiative in providing support to childcare services in the management of children with behavioural disturbance by employing a special needs worker to work specifically in this area. The Committee strongly supports this initiative.

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[36] Submission 7, p 2.

5.21 In assessing the needs of childcare centres for support in managing children with behavioural disturbance, the ACT Housing and Community Services Bureau stated the following in a letter to the Committee dated 16 July 1991.

> At the moment the primary need is for workers to assist in a hands on fashion with children and in the training of staff. The counselling of parents is also a priority which is not being addressed adequately at the moment. ... The situation at the moment is one where limited resources are allocated and as a result the areas of coordination, assessment and review are questionable. Field workers must coordinate services to their clients. They are therefore often distracted from their primary task of support to personnel and children in the field.
>
> In summary, the current basic needs in catering for behaviourally disturbed young people in childcare settings are:
>
> i) effective coordination of services in the behavioural area;
>
> ii) adequate support for workers in the field;
>
> iii) adequate support for families; and
>
> iv) assessment of training needs.

5.22 There is an obvious need for more assistance and support to be provided to families, preschools and childcare centres in the management of young children with behavioural disturbance. Consideration of preventive measures, early intervention and remediation are contained in Chapter 11.

5.23 There is also a need for the agencies involved in the delivery of services to young children with behavioural disturbance to work together to provide better integrated and coordinated services. This issue is examined in detail in Chapter 12.

6 BEHAVIOURAL DISTURBANCE IN SCHOOLS

6.1 Dealing with students with behavioural disturbance has been a constant challenge for schools. This chapter concentrates on the problem of behavioural disturbance among students of compulsory school age in ACT government schools. The Committee invited some schools in the non–government sector to present a submission and received some general information.

6.2 Students with behavioural disturbance are found at all levels in the school system. In an article in *The Canberra Times* on 14 September 1991 the ACT Department of Education and the Arts is reported to acknowledge that student behaviour is a problem in its schools.[37] The Committee was told that the number of behaviour problems in schools is growing, particularly in government primary schools.[38] The problem of dealing with student behaviour in high schools has become much more difficult in the last few years.

6.3 Management of student behaviour in government schools is guided by the Department of Education and the Arts' **Policy and Procedures for the Management of Student Behaviour in ACT Public Schools.** Schools are required to develop their own individual policy on the management of student behaviour which is to be conveyed to the school community.

Mainstream students

6.4 There are two categories of behaviourally disturbed students in mainstream schools, the disruptive student and the extremely emotionally disturbed.[39] It was estimated that in each school 3 to 5 per cent of students would fit the disruptive category. This represents 1230 to 2050 students across the ACT government school system. In a school of 400 students the number would range from 12 to 20. One primary school reported that 9.5 per cent of its students had been identified as behaviourally disturbed.[40] The number of extremely emotionally disturbed students in a school is much lower, about one or two per school.[41]

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37 **The Canberra Times,** Saturday 14 September 1991, p C1.

38 Transcript, 16 May 1991, p 304.

39 Transcript, 16 May 1991, p 290.

40 Submission 44, p 2.

41 Transcript, 16 May 1991, pp 290–91.

6.5 In its submission to the inquiry the Education Division of the ACT Department of Education and the Arts identified three broad groupings of disruptive behaviour that are causing particular concern.

> **Males aged 12–15 across all years.** Some characteristics include aggression, low academic function despite being of average ability, being persistently disruptive in class, and defying any authority figures in school. These students are frequently difficult to manage at home and can be physically and verbally intimidating to staff. Often their attendance at school is erratic and some have been involved in criminal activities.
>
> **Females, typically in years 8, 9 and 10 of high school** who are resentful of authority and difficult to control in school and at home. These students often engage in "at risk" behaviours including drinking, drug taking and sexual activities. School performance and attendance is erratic and motivation for improvement is poor. These students are sometimes passive and withdrawn.
>
> Another group causing concern in schools is the **group of chronic non–attenders.** While precise numbers in ACT high schools are unknown they are sufficiently high for Principals and teachers to feel considerable concern.[42]

6.6 The Committee's attention was also drawn to some other groups of students who are at risk of developing behaviour problems for example the quiet withdrawn student, the gifted and talented and those who are unmotivated for some reason.

School based approaches to dealing with students with behavioural disturbance

Approaches used in ACT schools

6.7 The development of effective student management programs is of prime concern to most schools in the ACT. All government schools are required to develop a policy on student management. Many schools base their policy on the principles of Glasser which is based on reality therapy. Students are encouraged to take control of their own actions. The responsibility for an action is thrown back on to the individual. In dealing with unacceptable behaviour the emphasis is on starting with the problem behaviour and ways to change it rather than delving into the past in great detail. Other schools adopt an eclectic approach by combining for example elements of Adler, Dreikers, Glasser, Olsen and White. More recently some schools have been examining the programs developed by two Australian researchers and practitioners Bill Rogers in Victoria and Lindy Peterson in South Australia.

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[42] Submission 26, p 2.

The "Stop, Think, Do" Program

6.8 During its visit to South Australia the Committee met with Lindy Peterson and discussed the program she has developed with Ann Gannoni called "Stop, Think, Do". This program is based on behavioural and cognitive–problem solving methods. Children are taught how to think about, evaluate and choose solutions to their social problems before initiating behaviour. It places great emphasis on the development of social and relationship skills. It can be used in schools and in the home and as both a preventive or treatment program.

Training

6.9 The success of a school's student management policy is dependent on the commitment to a cooperative approach by all members of the school community including school staff and parents. It is also dependent on training. Many submissions from schools expressed concern about inadequate opportunities for both pre and inservice training in student management.

6.10 Teachers need to be trained at the preservice level in classroom management, the identification of potential behaviour problems and the development of remediation strategies. The Committee believes that much greater emphasis needs to be placed on this area in teacher training programs.

6.11 Teachers also need ongoing training in these areas. Schools reported that they experience considerable difficulties in attempts to provide professional development and training programs in school wide approaches to student management. These difficulties centre on the unavailability of high quality professional development packages on student management and competing priorities for time.

Assistance in dealing with behaviour problems

6.12 Responding to and assisting behaviourally disturbed primary students was reported to be a major issue. Behaviour problems are widespread in some schools and one primary school stated that requests for assistance to allow teachers to fulfil normal teaching duties without disruptions from behaviourally maladjusted children are almost totally ignored.

6.13 Many primary schools argued that limited "in school" resources make it almost impossible to cater for children with special problems including behavioural problems. Key specially trained staff able to assist behaviourally disturbed students such as school counsellors and resource teachers are allocated to primary schools on a very limited basis. At present only 23 primary schools have a resource teacher and counsellor time is based on total school enrolments. For example a primary school with an enrolment of 400 students has a counsellor for one and a half days per week.

6.14 The Deputy Secretary of the Department of Education and the Arts told the Committee that the Department is hoping to increase the number of resource teachers in the coming year to one to every two primary schools.[43]

6.15 The Committee acknowledges the need for all primary schools to have access to a resource teacher and commends the Department's initiative in addressing this issue.

6.16 School counsellors are seen by schools to be a crucial resource in dealing with behaviourally disturbed students. Counsellor allocation is based on student enrolments and only a very small number of high schools and colleges have a counsellor full time.

6.17 As a result of a shortage of school counsellors a small number of schools have two counsellors sharing the school's part time allocation of counsellor time. This is seen as most unsatisfactory as it can often result in a student or family in crisis having to deal with one counsellor on one day and another on the next.

6.18 The issue of counsellors working with families in the home was raised in evidence time and time again. As a result of their award conditions school counsellors are not generally able to work in homes. This was perceived to be limiting in effectively dealing with behaviourally disturbed students.[44]

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43 Transcript, 24 July 1991, p 365.

44 Submission 60, p 4.

6.19 The Committee was also advised that the Department has difficulty recruiting trained counsellors due to their shortage. School Counsellors are highly trained. They are required to hold a four year tertiary award in Education which includes a major in psychology and a minimum of one year's specialised post graduate study in counselling. Many have completed a masters degree in counselling and are eligible for registration as psychologists. In the past the Department offered full time paid study leave to enable some suitably qualified teachers to undertake training as school counsellors. This scheme is now no longer available as a result of funding constraints, however teachers may apply for an award which gives them a maximum of 35 days paid leave in a year to assist them in undertaking counsellor training. The Deputy Secretary indicated that the Department is looking at retraining and redeveloping suitably qualified teachers in the system and moving them into the Guidance and Counselling area. It is also examining alternative approaches to the delivery of the counsellor services which would result in the better use of specialised skills.[45]

High Schools

6.20 Effective student management is seen as the most urgent and significant factor in creating quality schools. It is of particular concern to year 7 to 10 high schools at present. In 1990 a high school Student Management Action Team was formed. This team comprised several principals of government high schools who were particularly committed to improving student management in high schools. Its final report **High Schools of Excellence**[46] calls on the Ministry to review its policy on student management. Student management is not seen as synonymous with school discipline. The report stated:

> Effective Student Management requires the development of a positive school climate, relevant curriculum and intervention strategies in addition to the more traditional discipline procedures. ... pastoral care must be totally integrated into a school's ethos so that student management will focus on prevention rather than remediation.[47]

6.21 The report opposes the establishment of high schools with a student population greater than 800 and argues that large high schools will encounter increased problems in student management and staff and student stress.

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45 Transcript, 24 July 1991, p 365.

46 Submission 75, p 5.

47 Submission 75, p 3.

6.22 It recommended several changes to current provision and practice. These included:

the development of a resource guide to assist schools in the process of developing their own policy and procedures in a whole school approach to student management;

the provision of ongoing, top quality professional development programs to facilitate whole school approaches to student management in high schools;

the establishment of a position of Student Management Coordinator in each high school in addition to a requirement that the Deputy Principal shares some responsibility for student management;

the development of a variety of alternative "off line" facilities ranging from time out to day care to residential for alienated students;

the establishment of a home–school liaison team to deal with students at risk due to truancy; and

an increase in the level and better coordination of social services in association with ACT social service agencies.

6.23 The Committee also received evidence from parents, youth workers and community organisations expressing concern about student management practices and the need for high schools, especially, to develop a variety of curriculum options which would better meet the needs of some students including the gifted and talented as well as those with learning difficulties or behaviour problems.

6.24 Teenagers with depression comprise another group in high schools that need special help. In an address to the Australian Behaviour Modification Conference in July 1991 which was reported in *The Age*, Professor Peter Lewisohn urged schools to take an "outreach approach" to identify teenagers with depression.[48] These teenagers often go unnoticed in the school environment. They do not usually seek help and do not draw attention to themselves like the noisy troublemakers in a class. Yet they are at risk of developing long term mental health problems if they are not identified and helped to overcome their problems.

6.25 Some schools have taken serious steps to provide more relevant programs and curricula. Melba High for example has this year created a special class for year 7 students with poor classroom management skills or behaviour problems. This class is called the "On Task Class" (O T class) and has been established with the aim of intervening early in the student's high school life and assisting the student to develop appropriate classroom management skills and behaviour. The school reported that initial indications of the program's success have been very encouraging.

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48 Voumard, S." Watch Out for Quiet Ones, Psychologist Tells Schools", **The Age**, 10 July 1991, p 15.

6.26 In evidence to the Committee one parent was particularly critical of the student management policy of the schools where his son was enrolled. He stated that the difficulties being experienced by his son were reinforced instead of helped by the education system.[49] The parent advised the Committee that his son spent whole days at a time, and on the last occasion a week, in the time out room, where he was not allowed to talk or have any books. The parent claimed that his son got so far behind with his schoolwork that he became less and less inclined to do any work and the situation just got worse. The student "wagged" school frequently and an agreement was reached that he would leave school without going through the suspension and exclusion procedures. At that time he was 14.

6.27 This same parent strongly supported the idea of alternative programs which could better meet the needs of students who do not fit the system. He said:

> I really believe that there needs to be a mechanism in schools to recognise these kids. Not necessarily kids who are, say, a bit retarded who have another set of problems but these ordinary kids who are not fitting in. ... given the right circumstances, he could be at school still and instead I am stuck with the kid at home. No chance of him getting a job, no education.[50]

6.28 **The Committee recommends that:**

the ACT Department of Education and the Arts

- **give high priority to the development of effective student management policies and practices in all schools from preschool to college;**
- **support high schools in the development of more appropriate curriculum options and programs for unmotivated and disruptive students;**
- **increase the support available to classroom teachers in dealing with students with behavioural disturbance through training and the provision of more school counsellors and resource teachers;**
- **urge ACT teacher training institutions to include a greater emphasis on behaviour management and related issues in preservice teacher training courses; and**
- **develop incentives and options to encourage more teachers to undertake training as school counsellors or resource teachers.**

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49 Transcript, 16 May 1991, pp 247–254.

50 Transcript, 16 May 1991, p 258.

Behaviour Management Support Program

6.29 The Committee was advised that when schools have exhausted the school based options available in dealing with a student with behavioural disturbance that student is referred to the Behaviour Management Support Program. This program provides an outreach service using the skills of the 2.5 itinerant teachers for behaviour management and a withdrawal program.

6.30 There are two Behaviour Management Support Withdrawal Units – a primary unit located at Yarralumla and a secondary unit currently located at Holder. The Department stated that:

> The main aim of this program is to change inappropriate or self defeating behaviours and to teach the children more appropriate social skills so that they can develop a responsibility for their action and facilitate their return successfully to the normal school environment.[51]

6.31 Each Behaviour Management Support Withdrawal Unit caters for a maximum of 12 students and is staffed by three teachers who are assisted by two special teachers' assistants at the primary unit and one at the secondary unit. Students participate in a regular integration program during their time at the withdrawal unit, which assists their reintegration into mainstream schools on completion of the program.

6.32 The Behaviour Management Support Programs assisted 229 students in 1990. Of these students 158 received assistance in their own school from the itinerant service. The behaviour of the remaining 71 warranted enrolment in the withdrawal classes. The breakdown is as follows:

junior primary class (generally aged 5 to 8 years)	11
primary class (generally aged 9 to 12 years)	22
secondary class (generally aged 12 to 14 years)	38
Total	71

6.33 Evidence was received indicating strong support for the Behaviour Management Support Program particularly the primary unit. Some concerns were expressed about the punitive nature of the secondary program. The policy of suspending students from the unit when their behaviour became intolerable was severely criticised. Overall the program was seen to be meeting the needs of most of the behaviourally disturbed students in the government school system who were able to be placed.

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51 Submission 26, p 4.

6.34 Schools request placement of a student in the Behaviour Management Support Program when they are at a point of crisis having tried all in–school options. Many schools expressed concern about the high level of demand for places in the program and the long waiting time that often exists before a student can be placed. This places enormous stress on school resources at a time when the school has exhausted its options in dealing with the student and seriously affects the learning environment for others.

6.35 Several submissions pointed to the need for more Behaviour Management Support Units and strongly suggested that primary units especially should be planned on a regional basis. At present many students must travel long distances to reach the Unit, for example, a child from Charnwood enrolled in the Primary Unit is required to travel from home to Yarralumla. This can be quite a problem if the parent is unable to transport the child to the unit. The Committee supports this view and believes that efforts should be made to locate a program in each region.

6.36 A few schools reported that reintegration of students into their mainstream school sometimes poses problems. The most frequently reported difficulty was that the student was unable to cope unassisted in a normal sized class. The very small pool of behaviour management itinerant teachers cannot provide the support that some students require for successful reintegration.

Future plans for behaviour management

6.37 The Department of Education and the Arts is reviewing its services to students with behavioural disturbance. It recognises that there is no single answer to meeting the needs of these students and that a flexible approach is required.

6.38 Particular attention is being paid to the support and programs available for secondary students. The Ministry's discussion paper **Future Plans for the Provision of Services for Students with Behavioural Difficulties** (1991) identifies academic success and the perceived relevance of schooling as key factors in the explanation of bad behaviour. The discussion paper goes on to say:

> Failure in schoolwork increases the student's dislike of school and increases the chance of misconduct. A flexible, wide–ranging curriculum is a significant factor in preventing and controlling inappropriate behaviour. Schools should develop and review curriculum with the aim of meeting individual needs.
>
> A student's experience of the curriculum can be adverse if she or he:
>
> – finds it irrelevant
> – cannot relate to it
> – cannot meet the demands it makes
> – is left with a sense of failure.
>
> Where a student is having an adverse experience with particular curriculum, options need to be explored: modifying the requirements for that particular student or allowing the student increased involvement in areas that are proving more successful.
>
> Curriculum arrangements should be flexible in terms of timetabling and school structures. Options should be available within the classroom and within the school.

6.39 The establishment of "off line" programs which emphasise basic skills and the development of self esteem was seen by high school principals as a priority if funding was available.

6.40 The Government is planning to implement a range of programs for students who cannot be effectively managed in their mainstream school. These include:

- an Adolescent Day Care Unit;
- a Structured Day Program for moderately behaviourally disturbed adolescents; and
- a restructured secondary Behaviour Management Unit.

Adolescent Day Care Unit

6.41 An interagency, multidisciplinary adolescent day care unit is planned for severely emotionally and behaviourally disturbed students. The Committee was told that while this program has been under consideration for several years it is still not operational because of rigid policy and problems with the budget process.[52]

6.42 In a letter the Executive Director, Family Services Branch advised the Committee of the following:

> Funds have been allocated to allow the program to develop over a three year period. It is expected to operate partially in 1991/92 and reach full operation in the 1992/93 financial year.
>
> The Unit's overall aim is to assist the participating adolescents to learn self control and social skills. It will provide a time limited, therapeutic program which will rely on the services of appropriate agencies to assist towards the reintegration of the adolescent into the "mainstream". The Unit will call on the Child and Adolescent Unit, Mental Health Services, to provide diagnostic and consultancy services, where appropriate, and may call on other agencies to provide family therapy.
>
> The time to be spent in the Unit is to be specified in Individual Service Plans, which are to be reviewed at predetermined periods. The expected maximum stay in the Unit will be six months. The Unit is to be administered with a rigorous pursuit of outcomes, rather than merely as a day care centre for adolescents.
>
> Performance indicators are to be developed to measure success. This will be seen as achieving standards of tolerable behaviour, and continuing improved functioning on reintegration into school or work.
>
> The Unit is likely to operate on the basis of six adolescents at any one time.

6.43 The Committee is concerned by the time taken for programs such as the Adolescent Day Care Unit to become fully operational. Early in 1991 the Committee was informally told that the program would be operational in the second half of 1991. At the time of finalisation of this inquiry it was indicated that it will be February 1992 at the earliest before the program takes any students.

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52 Transcript, 3 April 1991, p 98.

6.44 The Committee is also concerned that the program may not be sufficiently flexible to ensure maximum utilisation and optimum reintegration of students back into mainstream schooling. In evidence some members of the community expressed the view that the program should be planned to take some students on a full time basis and others part time according to their specific needs.[53] If such an approach were adopted the program would be able to deal with more young people at any one time.

Structured Day Program

6.45 The ACT Housing and Community Services Bureau is also planning to develop a Structured Day Program for moderately behaviourally disturbed adolescents, a new policy initiative which was announced in the 1991–92 Budget. This program will provide a structured daily activity program focusing on the advancement and development of skills for a group of up to 16 moderately behaviourally disturbed adolescents. The target group will comprise adolescents aged 14 to 16 who are in care for example at Scullin House, unable to fit into the Department of Education and the Arts' Behaviour Management Program or referred by the Adolescent Day Care Unit.

6.46 It is envisaged that once these units are operating all students with severe behavioural disturbance who would have been placed in the Department of Education and the Arts' program will be placed in the Adolescent Day Care Unit. There will also be an alternative for some students with moderate behavioural disturbance especially those close to the school leaving age.

Restructured Secondary Behaviour Management Unit

6.47 The Department of Education and the Arts has announced that its secondary Behaviour Management Support Unit will be restructured and renamed.

6.48 To reflect its more flexible and varied approach to the management of student behaviour the program will be called the Adolescent Development Program. In September 1991 the Department released a more detailed outline of the proposed restructured secondary program in a paper entitled **Adolescent Development Program: A Brief Outline of the New Directions for Curriculum and Programs.**

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53 Transcript, 29 August 1991, p 450.

6.49 The Adolescent Development program will provide a developmental program to help students experiencing behavioural, emotional, educational and social problems. The program will cater for students aged 12 to 15 years and will include basic literacy and numeracy and a number of vocationally oriented and life education units.

6.50 It will aim for full integration of students back into the mainstream schooling wherever possible. Liaison with the home school will be facilitated through a teacher mentor who will take responsibility for the student while he/she is in the school and also act as a contact point between the home school and the program. Parental involvement will also be encouraged.

6.51 The development of high self esteem is seen as central to modifying problem behaviour and the principle of self esteem through mastery will underpin all aspects of the program. Some education authorities include wilderness training as part of the program for students with behavioural disturbance specifically to increase their self esteem and develop responsibility and commitment to a group. There are several wilderness training programs in other States which operate for varying lengths of time. For example the Committee visited the Tallong Wilderness Centre operated by the Sydney City Mission. The Deputy Secretary (Education) indicated to the Committee that the ACT Department of Education and the Arts was considering incorporating a wilderness training element in the revised secondary behaviour management support program. The Committee has been impressed with the reported outcomes of adventure/wilderness programs with which it has had contact. These programs were very carefully planned and employed highly trained, committed and skilled staff.

6.52 The Committee sees the development of a range of flexible approaches within the Adolescent Development Program as essential to its success. Students will have a variety of specific problems which may not be able to be assisted by a single approach.

6.53 A crucial issue related to the success of these planned programs will be effective coordination and integration, which is discussed in Chapter 12.

6.54 The Committee is not convinced that the Adolescent Day Care Unit will be able to meet the ongoing demand for placement for adolescents with severe emotional and behavioural disturbance since it is planned that the unit will only take six students at any one time. It may also be necessary for the Department of Education and the Arts to continue to offer an intensive remediation program for such students who will not be able to benefit from the restructured secondary unit until their behaviour is modified.

6.55 **The Committee recommends that:**

the ACT Department of Education and the Arts

- **review the primary Behaviour Management Support Program. Within this review particular attention should be paid to its location, transport and reintegration of students;**
- **pursue the development of a more diverse secondary behaviour management program which includes a range of program options such as the development of literacy and numeracy skills, outdoor pursuits and life skills; and**
- **review the appropriateness of the policy of suspending students from the Behaviour Management Support Program.**

Truancy

6.56 Both community and government organisations identified truancy, or absence from school without the parent's knowledge or without legitimate excuse, as a serious problem in the ACT, which is not being addressed satisfactorily.

6.57 It was reported that there are various degrees of truancy. Some children miss the odd day at school essentially for the fun of it while others are involved in a regular cycle of non attendance for long periods. Missing part of the day is a common form of truancy which is often not detected. Many of the children who try truancy once and get away with it try it again.[54]

6.58 The ACT Department of Education and the Arts' submission to the inquiry referred to chronic non attenders as a group of students causing particular concern in schools. The Department was unable to give precise numbers but indicated that the problem was of such a magnitude as to be of considerable concern to school principals. The Committee is most concerned that the Department does not have precise information on the extent of this serious problem.

6.59 A school counsellor estimated that daily at each high school in the ACT there would be at least five or six students who would be considered as truanting. Sometimes it is the same group of children and sometimes not.[55]

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54 "Truancy: Community Responsibility", **Behaviour Problems Network Newsletter**, ACER No 5, September 1990, pp 11–15.

55 Transcript, 5 April 1991, p 172.

6.60 The ACT Youth Affairs Network reported that the problem of non attendance at school is "huge" and that nothing is being done about it. Included in this group are many of the residents of Scullin House, an ACT Government shelter administered by the Family Services Branch (formerly Community Welfare Branch) of the ACT Housing and Community Services Bureau.[56]

6.61 The Committee's attention was drawn to another group of children under 14 years of age who because of their behaviour are not acceptable to any school. It was reported that by the end of every year there are at least 40 students under the age of 14 years who are in this category.[57]

6.62 There was a discrepancy between this information and the information received from the Directors of Schools of the ACT Department of Education and the Arts . The Directors of Schools were asked to provide statistics on the number of suspensions, exclusions and compulsory transfers in their respective region in 1990. No exclusions were reported. One region reported two suspensions of an indefinite period. A parent threw some light on this issue when he told the Committee that when he was faced with the problem of a truanting 14 year old son he suggested taking the student out of school and trying to get him a job. The Principal is reported to have responded:

> Yes. Well if you do that I won't put through the papers suspending him...[58]

6.63 Evidence received by the Committee indicated that there may be some informal arrangements operating or that a blind eye is sometimes turned in these situations.

The ACT Legislation

6.64 The ACT Government Law Office provided the following advice on the interpretation of relevant ACT legislation relating to truancy.

> There are essentially two pieces of ACT legislation which touch directly upon the issues of compulsory school attendance and truancy. These are:
>
> . the *Education Act 1937;* and
> . the *Children's Services Act 1986.*

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56 Transcript, 5 April 1991, p 113.

57 Transcript, 28 March 1991, p 85.

58 Transcript, 16 May 1991, p 253.

The Education Act

Part II of the Education Act (ss 8–19) deals with the issue of compulsory attendance at schools. **Section 8** requires a parent or guardian of a child who is between six and fifteen years of age to cause that child to be enrolled as a student at a school. Failure to cause such enrolment is punishable by a fine not exceeding $500.

Section 9 imposes the further requirement on a parent or guardian to cause the child to attend the school at which the child is enrolled "on every half–day on which the school is open" (dealt with further in **section 13**). Provision is also made for the imposition of a fine not exceeding $500 upon conviction for a failure to observe the requirement.

The balance of the Part deals mainly with the defences which are able to be advanced in the event of a prosecution under sections 8 and 9, and with certain evidential matters. The more significant of the defences which are available in respect of a prosecution under section 9 (contained generally in **section 11**) relate to the sickness of the child, and also to evidence of the satisfactory attendance of the child at the school during the three months prior to the time on which the offence is alleged to have occurred (ie. absences on not more than six half–days during that period). In addition, **Section 16** of the Act also provides that in certain limited circumstances, the Secretary to the Department of Education and the Arts (or a person authorised by him or her) may grant a certificate exempting a child from attendance at a school for a specified period.

The issue of truancy itself is specifically addressed in **section 18** of the Education Act. A 'truant' is defined in the Act (at **section 5**) to mean:

"a child who habitually disobeys the order of his parents or guardian to attend school".

Section 18 provides that if a prosecution is brought under section 9 against a parent or guardian for failing to cause a child to attend a school, and there is evidence of the service of a notice on the parent or guardian that it is intended to charge that the child is a truant, and the Court is satisfied that the child is a truant, then the Court may make certain orders in relation to the child. Those orders may be either the release of the child on probation for such time as the Court sees fit, or the sentencing of the child "to an institution selected by the Minister for the detention of truants". The balance of the section deals mainly with matters relating to the institutionalisation of the child.

The Children's Services Act

Part V of the Children's Services Act (ss 70–106) deals generally with child care proceedings. Section 71 of the Act deals with the issue of children who are in need of care and provides, at paragraph 71(1)(g), that for the purposes of Part V, a child is in need of care if:

"the child is required by law to attend school and is persistently failing to do so and the failure is, or is likely to be, harmful to the child".

It should be noted that the provision may be qualified to some extent by subsection 71(2) of the Act which requires authorised persons, the Youth Advocate (now the Community Advocate), and the Court to have regard to the degree of failure to attend school and to disregard any failure which appears to be not sufficiently serious or substantial to justify action under Part V.

Paragraph 71(1)(g) of the Act has as its genesis the Australian Law Reform Commission's 1981 Report into child welfare in the ACT (see esp. pp 228–229).

Comparing the provisions of both the Education Act and the Children's Services Act, it seems that a greater degree of non–attendance at school is required to justify action under Part V of the Children's Services Act than action pursuant to sections 9 and 18 of the Education Act. This is largely because of the 'harmfulness' proviso in paragraph 71(1)(g) of the Children's Services Act and the qualification contained in subsection 71(2). In addition, the extra 'tests' contained in those provisions are more subjective in nature leading to a greater scope for argument as to whether in a particular case the basis for action has been established.

Dealing with non attendance

6.65 The Committee sought information on the action taken to deal with non attendance among children of compulsory school age in the ACT.

6.66 Schools keep daily attendance records and in a letter to the Committee the Department of Education and the Arts advised that:

> The Australian Capital Territory Education Ordinance (now an Act) of 1937 states that the parents/guardians of any child who is not less than six years of age and up to the age of fifteen years shall enrol and cause them to attend, a registered school on a regular basis.

Currently Principals of Schools, or a delegate, monitor this compulsory attendance and follow up where necessary with parental contact.

The assistance of the Regional Director of Schools, the Welfare Branch or the Police may be sought to assist with continuing offenders.

6.67 Family Services Branch (formerly Community Welfare Branch) advised that:

> As a general rule, the Branch does not become involved where truancy is the only issue. In such cases, the Education Department would take the necessary action through its school principals and school counsellors. In cases where truancy is one of a range of factors affecting the child, the Community Welfare (now Family Services) Branch may have a role if the case is referred to it by the Youth Advocate, or is notified directly.
>
> The Branch's two Youth Services Officers work with children who are homeless or who are at risk of becoming homeless as a result of family conflict. They also work closely with school counsellors and aim to keep the child in the education system wherever possible. In many of these cases, truancy is an issue or an indicator of other problems. The Youth Services Officer's role is non statutory in nature and focuses on intervention at a stage before serious incompatibility or family breakdown place the child at serious risk.
>
> In its statutory role under the *Children's Services Act 1986*, the Branch is required to take the question of degree into account. Therefore, in cases where there are other significant care issues involved – for example, serious incompatibility, self damaging behaviour, abuse or neglect – the case is conducted in accordance with statutory requirements for child protection.

6.68 Schools feel limited in the action that they can take. In instances where the parent does not cooperate with the school principal or counsellor, assistance may be requested from Family Services Branch but unless the child is considered to be in need of care no action is taken. In evidence to the Committee a School Counsellor said:

> The complications arise in a small number of settings. There are two in my particular school now where I will ring home and say "How is so and so?" And all I get is abuse saying "Look, she is sick, I will send her to school as soon as I can." And that is hard for us because we cannot really go to the home and demand to see the doctor's certificate, or verify that the child is sick. And yet day after day they just do not turn up. You ring Welfare and they say, "Are they at risk?" Well, there is no abuse, there is no obvious neglect, but they will not go around there because technically it is an Education problem.[59]

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59 Transcript, 5 April 1991, pp 173–174.

6.69 The problems associated with dealing with non attendance are largely attributable to the fact that the issue is covered by two separate pieces of legislation which are administered by two agencies. The Department of Education and the Arts administers the Education Act and the Family Services Branch has responsibility for administering the sections of the Children's Services Act relating to non attendance. While there is provision under the Education Act for a parent to be fined for failing to cause the child to attend school, the Committee is not aware of any recent prosecutions. The Committee is not convinced that the current legislation adequately addresses the issue.

6.70 The consequences of truancy are disastrous. Young people who do not complete their education to the year 10 level are severely limited in their employment and training options and the majority end up unemployed.

6.71 The Committee believes that much more could be done to ensure that high school aged students complete their education to the year 10 level. Several submissions suggested that the ACT should establish a home school liaison program along the lines of the very successful program operating in New South Wales. The problem has also been recognised by the Central Canberra school region where a pilot home school liaison program commenced in July 1991.

The New South Wales approach to non school attendance

6.72 The New South Wales Department of School Education was faced with the problem of dealing with non attendance in 1985 following the progressive withdrawal of involvement in school attendance matters by the Department of Youth and Community Services. By 1985 non attendance had become a serious problem with an estimated 22,000 children per day absent from school for reasons not allowed by law. Following a successful trial the home school liaison program was gradually expanded to cover the whole State by early 1987.

6.73 The Department attributes much of the program's success to the comprehensive training provided to all home school liaison officers and the authority granted by the legislation.

The New South Wales legislation

6.74 The legislation relating to school attendance in New South Wales was revised in 1987 resulting in the incorporation of measures allowing home school liaison officers to intervene in cases of non school attendance. For example officers in the Home School Liaison Program are authorised under Section 42 of the Education and Public Instruction Act 1987 to:

a) during school hours–

1) approach any child who is apparently of or above the age of 6 and below the age of 15 and is apparently not in attendance at school as required by this Act; and

2) request the child to furnish to the officer his/her name and home address, and the name of the school attended; and

b) accompany the child to his/her home, or school, to verify the information furnished to the officer by the child.[60]

6.75 The Home School Liaison Program was designed as a non coercive program based on the provision of support to students, parents and schools as a means of resolving problems and restoring satisfactory attendance. Schools retain the major responsibility for maintaining the regular attendance of all students.

6.76 A primary role of Home School Liaison Officers is to facilitate liaison between all parties capable of assisting in the resolution of the problem. Parents and teachers are central to this process and when appropriate referrals are made to other agencies for example Welfare.

6.77 Support provided by the Home School Liaison Officer includes:

a) conducting periodic checks on Class Rolls and other attendance and enrolment information;

b) providing advice to Principals and teachers on legislation, policy and procedures relating to attendance;

c) liaison with Principals and teachers on attendance problems and other matters that may require direct contact with the home;

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60 **School Attendance: Policy and Procedures**, NSW Department of Education, 1989, p 9.

d) working on cases of non–attendance referred by a school to the Senior Home School Liaison Officer;

e) liaison with students and parents on attendance matters;

f) making home visits where necessary;

g) providing assistance to schools in identification of school based factors contributing to non attendance;

h) assisting schools in the development of a school attendance policy;

i) working with Family and Community Services officers where family and welfare issues are present.[61]

6.78 Uniformed police in New South Wales are authorised to act as attendance officers in the context of the Home School Liaison Program. During school hours they may approach a child of compulsory school age, ask for information and accompany or direct the child to school.

6.79 If attempts by the school and Home School Liaison fail, under the legislation parents can be required to attend a conciliation conference. If all attempts fail the parents can be prosecuted.

6.80 The evidence received by the Committee indicates that truancy is a problem in the ACT and that the measures currently being used to deal with this problem are not working effectively. The Committee found it difficult to determine the extent of the problem because there appears to be no readily available data.

6.81 **The Committee recommends that:**

. **the ACT Government review the legislation relating to non school attendance;**

. **the ACT Department of Education and the Arts develop and implement a Home School Liaison program similar to the NSW program.**

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61 op cit, p 9.

Special School students

6.82 The Committee received submissions from several special schools. These schools cater for children with an intellectual disability. Many of the students enrolled are also emotionally disturbed and at times their behaviour is extremely violent and anti social. There are times particularly in the secondary schools when the behaviour of a student is so violent that it places other students and staff in serious danger. In such circumstances often the only option for the school is to suspend the student.

6.83 In the Woden/Weston region, a region with two of the five special schools in the ACT, 17 of the 51 students suspended in 1990 were from special schools and only one of these special school students was of primary school age. As pointed out by the Department of Education and the Arts in a letter to the Committee:

> the high incidence of suspension of children in special schools highlights the need to investigate effective alternatives for these young people with cognitive and social skill deficits and chronic conduct problems.

6.84 The principal of a Special School told the Committee that specific services to help these students with severe emotional problems are lacking.[62] There is no special facility for these young people in the ACT. Occasionally an ACT student is placed in a NSW residential educational and psychiatric facility. That program operates on week days only so that transport back to Canberra at weekends becomes a big issue for some families.

6.85 The needs of severely emotionally disturbed, intellectually disabled young people such as those attending a special school are addressed in a generalised sense by Intellectual Disability Services (IDS). IDS has established a Behaviour Intervention Support Team to provide intensive specialised services. Clients and their families or main caregivers will be offered intensive support. The service's primary focus is to work with the family or main caregiver, however obviously at times involvement with the school will also be necessary. The Committee welcomes this initiative which will fill a much needed gap in services.

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62 Transcript, 16 May 1991, p 292.

7 CHILDREN AND YOUNG PEOPLE WITH SPECIFIC NEEDS

7.1 This chapter examines the needs of several special groups in the ACT community namely the

- psychiatrically disturbed;
- adolescents requiring hospital services;
- intellectually disabled;
- brain injured; and the
- autistic

7.2 These young people have very special needs as their problems are often extremely complex.

7.3 The Committee recognises the need for clinical categorisation to assist in treatment and other professional interventions but its attention was repeatedly drawn to the problems that this categorisation creates in access to services.

Psychiatrically disturbed

7.4 The literature indicates that psychiatric disturbance or mental illness in children and adolescents is often not readily apparent. Psychotic symptoms in children usually develop slowly, becoming more apparent in adolescence. Psychiatric disturbance in these young people often manifests itself in non specific ways such as slow progress at school, fighting with peers or siblings, disciplinary problems and failure to achieve full developmental potential. There may also be physiological symptoms. The following symptoms are noted in studies and include high risk sexual behaviour, sexually transmitted diseases, delinquency, headaches, abdominal pain, vomiting, anorexia nervosa, mood swings, running away, withdrawal from peers, conflicts with family, suicidal thought and so on.[63,64]

7.5 Representatives from the Mental Health Services Branch of the ACT Department of Health stressed to the Committee the differences between adults and children in terms of assessment requirements and other needs. Working with children is not the same as working with adults. Children often present with a whole range of behaviours and emotional problems. Specific diagnosis is not possible because these conditions develop slowly and take time to form.

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63 Kosky, R. "Depressive Illness in Adolescence", **Australian Family Physician,** January 1978, 7(b), pp 673–81.

64 Dorin, A. "Adolescent sexuality/adolescent depression", **Paediatric Nursing,** 1978, 4:49–52.

7.6 This has serious implications in times when resources are severely constrained. Because psychiatric disturbance in children is difficult to diagnose and because early intervention can in many cases prevent later psychiatric dysfunction the provision of mental health services needs to be offered to a very wide range of presentations from moderate to severe.

7.7 Evidence received indicated that there is insufficient professional mental health support available for children and adolescents in the ACT. Submissions repeatedly stated that the provision of these services is sparse and access difficult. The Child and Adolescent Unit advised that because the Unit is located at Woden, children in outlying areas of the city must either travel to Woden or wait for the ambulatory (mobile) service to visit the region. Due to limited resources the Child and Adolescent Unit must restrict its services to children up to the age of 16 years.

7.8 Among the States and Territories only the Northern Territory has a greater proportion of persons under the age of 20 than the ACT. A comparison of spending on designated child and adolescent mental health services prepared by the ACT Department of Health reveals that the ACT now spends much less per capita than other parts of the country, for example New South Wales, Victoria and South Australia. Previously, significantly more funds were spent in this area. In the early 1980s the ACT had designated Child Guidance Clinics at Kingston, Phillip and Civic and a four bed inpatient child psychiatric unit on the paediatric ward of Royal Canberra Hospital.

7.9 Young people who require hospitalisation for psychiatric conditions in the ACT are usually admitted to one of the adult psychiatric wards either, Ward 12B (now 15B) at Woden Valley Hospital or Ward 2S at Calvary Hospital. Information provided by these hospitals indicates that in 1990 nine young people under the age of 18 were admitted to Ward 12B and 11 to Ward 2S. The youngest of these patients was 13 years of age. Diagnoses included borderline intellectual functioning with severe behavioural disturbance, schizophreniform illness, depression and parasuicide[65], anorexia nervosa, acute psychosis, intellectual handicap, autism, and self mutilation. One young person aged 16 at the time, diagnosed with intellectual handicap at one hospital and borderline intellectual functioning with behaviour disturbance at the other hospital spent a total of 212 days in 1990 in either Ward 12B or Ward 2S.

7.10 The Committee has very serious concerns about the suitability of these psychiatric wards for young people and is most concerned that there is no alternative facility.

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[65] Parasuicide refers to behaviour associated with suicide such as attempting, threatening or even talking about suicide.

Adolescents requiring hospital services

7.11 The Committee also has concerns about the hospital services generally that are available for adolescents. The Committee met with a group of adolescents at an ACT Secondary College who had all experienced serious medical or psychiatric problems including drug overdoses, depression and serious medical conditions.

7.12 These young people were distressed by the way in which they were treated in hospital. They felt that the overriding emphasis was on their medical condition and that no consideration was given to their psychological needs. The general tendency was for the medical staff to concentrate on the symptoms rather than the causes of a problem and the young people stated that giving a presciption was a frequent solution. They found it very difficult to cope with and relate to the other adults when placed in an adult ward. One of the young people reported that it was very distressing to be in a ward where a patient was constantly moaning about dying.

7.13 The number of young people in the ACT requiring hospitalisation for psychiatric conditions does not warrant the establishment of a dedicated psychiatric ward for adolescents. The senior specialist in Child and Adolescent Psychiatry for the ACT Department of Health suggested that the establishment of an Adolescent Ward with two or three dedicated psychiatric beds would enable more effective management of most psychotic adolescents and would be a significant improvement on the present situation. Only the most severe cases would then need to be admitted to an adult psychiatric ward. The establishment of an Adolescent Ward would also better meet the needs of adolescents with medical and surgical conditions.

7.14 The Committee visited the Adolescent Ward at Westmead Hospital in Sydney. This is a 30 bed ward with the age of the patients being the common factor. Patients had a range of conditions including medical, surgical, orthopaedic and psychiatric. A school operates in the ward from 9 am to 3.30 pm on week days.

7.15 Evidence received by the Committee indicated that a 20 bed ward would meet the ACT needs. No additional resources would be required as beds would be reallocated from existing wards. The benefits to the young people would be considerable as they would all be in a more supportive environment.

7.16 Such a ward would need to be staffed with professionals who are sympathetic to the special needs of adolescents, have a sound knowledge of adolescence and ideally who have specific training. The fact that in the ACT there are currently very few psychiatrists, psychologists, social workers and nurses who are specifically trained to work with adolescents is not a reason not to proceed with the establishment of an Adolescent Ward. The issue of training needs to be addressed concurrently. The shortage of social workers has been attributed to the fact that there is no course in social work in the ACT and all social workers must be trained interstate. This is clearly a significant gap.

7.17 The Committee is most disappointed that the provision of an Adolescent Ward is not being included as part of the ACT Hospitals Redevelopment Plan. In a letter to the Committee the Minister for Health advised:

> While support for the concept of an Adolescent Ward exists, the Paediatric Working Party agreed that the provision of an Adolescent Unit in association with the paediatric facilities was not physically possible or clinically desirable.

7.18 **The Committee recommends that:**

. **the ACT Government**

- **redirect resources to the provision of mental health services to children and adolescents;**
- **establish an adolescent ward with a minimum of two dedicated psychiatric beds at Woden Valley Hospital;**
- **negotiate with one of the ACT based universities for the provision of a training program in social work; and**
- **negotiate the inclusion of training in working with adolescents in existing ACT programs in nursing, clinical psychology and welfare work.**

Intellectually Disabled

7.19 For the purposes of this report the term intellectual disability refers to below normal or even sub normal general intellectual functioning. Young intellectually disabled people sometimes also exhibit disturbed behaviour.

7.20 Organisations representing the intellectually disabled saw accommodation as a major contributing factor to disturbed behaviour in young people with intellectual disability. Both The ACT Council on Intellectual Disability and FOCUS ACT expressed the view that intellectually disabled young people with a behaviour problem should be able to live in a supported environment in the community and not be incarcerated in institutions. The level of support available should be flexible, tailored to meet individual needs and develop self control and self confidence.

7.21 In its submission to the inquiry FOCUS ACT argued that:

> behaviour of people who have an intellectual disability which is viewed by society as aberrant or sometimes dangerous is almost always a symptom of personal anguish and distress (often to degrees which would provoke suicide in other people who have access to the means). This is most likely to be ameliorated by surrounding the person concerned with supportive people, eg family, friends and genuinely empathic (though not patronising) people.
>
> Most currently utilised practices such as segregation in special units, transfer interstate and surrounding "behaviour problems" almost exclusively with psychiatric nurses and psychologists is, in our opinion, more likely to exacerbate negative public and media opinion and the personal anguish of individuals.[66]

7.22 The ACT Housing and Community Services Bureau is moving away from placing these clients in large institutions. Some young people are successfully living in supported group houses in the community. There are still some young people residing at Bruce Hostel, which is a facility planned on a medical model. The Committee visited Bruce Hostel and noted the unsuitability of this facility for behaviourally disturbed young people. The Committee is pleased to note that the closure of Bruce Hostel as a residential facility for the intellectually disabled was announced in the 1991–92 Budget.

7.23 The limited availability of suitable day time activities for intellectually disabled young persons is an issue which was brought to the Committee's attention. Many activity programs for the disabled are subject to constant threats of funding cuts.

Brain injured

7.24 Young people who are brain injured are a small but very special group whose normal development has been interrupted by the injury. Acquired brain damage has many different causes including stroke, epilepsy, infection, drug and alcohol abuse and accidents such as road or sporting accidents. In some cases behavioural disturbance is one of the consequences of brain injury.

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[66] Submission 2, p 1.

7.25 Services for young people with acquired brain damage who are also severely behaviourally disturbed are extremely limited. Families of these young people often find themselves caught up in battles over categorisation when seeking accommodation and support. This is to some extent a result of budget cuts where agencies are working strictly within their statutory responsibilities and are unable to stretch their funds to take on clients who do not meet the agency's defined area of responsibility. While there is considerable goodwill between individuals within the agencies concerned this alone is not a satisfactory long term solution.

Autism

7.26 Autism is a behavioural syndrome caused by some organic brain dysfunction which can be present to a mild, moderate or severe degree. Most autistic children also have an intellectual disability. It is characterised by social, cognitive and communication disabilities which have a substantial impact on the young person's ability to function independently.

7.27 From early in life autistic people exhibit disruptive behaviour. These behaviours include tantrums, incessant screaming, pervasive eating and sleeping disorders, destructive, aggressive or self injurious behaviour. In adolescence as the young person gets bigger and stronger these behaviours become frightening and sometimes dangerous to others. At times the police are called to protect persons or property.[67]

7.28 The Autism Association of the ACT reported that the accommodation options for autistic young people are extremely restricted and generally the environment is not conducive to enabling an autistic adolescent to develop living or working skills, or to feel safe

[67] Submission 38, p 7.

1 Probably the most urgent of these is the one of categorisation and demarcation. As mentioned above services tend to be organised around specific categories of disability and clients (or more often their families) can have great difficulty in accessing a service because they do not fit the category for which the service is funded. The Committee acknowledges the efforts of individual officers in beginning to break down these barriers but believes that long term strategies must be developed to ensure that the services provided fit the client rather than the client being required to fit the service, as seems to be the case now.

2 **The Committee recommends that:**

. **the ACT Government review the organisation of Health, Welfare, Education and Intellectual Disability services and develop a more integrated model of service delivery.**

3 Accommodation is another major issue. In recent times a more flexible approach has been taken to meeting the accommodation needs of these groups. It is recognised that large institutions based on a medical model are not conducive to a reduction in inappropriate behaviour or the development of effective relationships. The practice today is tending much more towards setting up a family type environment by establishing supported small group houses. The Committee was advised that group houses are not only more beneficial to the clients but also more cost effective.

4 At the end of 1990 three agencies (Health, Welfare and Intellectual Disability Services) cooperated to develop a new accommodation initiative for two severely behaviourally disturbed young people. A small two bedroom cottage was provided and staffed on a one to one basis around the clock. Prior to their placement in this facility both of these young people had spent time in psychiatric wards and larger institutions where their behaviour was not able to be modified and in one case the young person's violence provoked industrial action. This program cost in the vicinity of $300,000 per year. By the completion of the inquiry it was no longer needed as a multi–agency house and was being used by Intellectual Disability Services as a group house. While the project was very expensive it met the needs of the young people at the time. The Committee is of the view that in such instances agencies must work together to develop suitable accommodation options for young people with severe behavioural disturbance. Ongoing monitoring of outcomes is however essential.

5 **The Committee recommends that:**

. **the ACT Government continue to develop flexible small group accommodation facilities for young people with severe behavioural disturbance.**

6 Some organisations also expressed concerns about the availability of respite care. The Autism Association argued that more extensive and preventative respite care needs to be available to reduce the likelihood of parental burnout. There is a particular need for greater planned respite during holidays. The Committee was told that the respite care services are generally adequate. The Committee however acknowledges that there would be times when suitable respite care may not be available.

7 The other major issue that was raised mainly by parents is the availability of day programs. This is a problem for many young people with disabilites and extremely difficult for the behaviourally disturbed. The principle of community living applies to the disabled as well as the able. Currently those with disabilities are encouraged to participate as fully as possible in community life and the practice for those living at home, in hostels or group houses is to go out into the community to participate in activities. While the Committee supports this principle it shares the concerns expressed by some parents about the availability of suitable activities when a placement cannot be made. When it is impossible to place a young person in a suitable program the Committee believes that it is not satisfactory for that person to have no program at all. In such cases arrangements should be made to implement a program at the group house or hostel.

8 **The Committee recommends that:**

. **the ACT Government give priority to the ongoing provision of activity programs for young people with disabilities.**

1 SPECIFIC ISSUES RELATING TO ADOLESCENTS WITH BEHAVIOURAL DISTURBANCE

1.1 This chapter examines specific issues concerning adolescents with behavioural disturbance. It covers accommodation, the problem of poor literacy and numeracy skills and drug and alcohol abuse. The Committee acknowledges that the chapter does not address the whole range of problems. Some other problems, for example teenage pregnancy, are addressed in other chapters.

1.2 In considering behavioural disturbance among adolescents it is important to remember that this is not a single, easily identifiable behaviour. Behaviours range from diagnosable psychiatric disorders (which have been addressed in Chapter 8) to psychosocial disturbance (such as extreme aggression), to what may well be normal adolescent behaviour by some but is classified as disturbed by others.

1.3 The Youth Affairs Network of the ACT drew the Committee's attention to the fact that it is not necessarily abnormal for a young person to experiment with alcohol or sex. There are even some researchers who believe it to be a necessary part of growing up. These behaviours are indicative of behavioural disturbance when they become so extreme as to prevent the young person from participating in society. A behaviourally disturbed adolescent usually displays a number of inappropriate behaviours rather than just one which may be seen as inappropriate.[1]

1.4 The Committee was told that there are currently extremely limited services outside the education system specifically for adolescents with behavioural disturbance. The planned Adolescent Day Care Unit and the Structured Day Program referred to earlier in this report will to a certain extent fill an identified gap.

1.5 The Committee is of the view that the funds directed to the youth sector in the ACT are adequate. In making its recommendations about youth services the Committee's intention is not to support the provision of additional funds but rather to promote better utilisation of existing funding levels by the development of more coordinated and integrated services. The Committee believes that a review of the coordination of funding of youth services is timely.

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1 Submission 34, p 2.

Accommodation

1.6 Much of the evidence received by the Committee identified accommodation for homeless adolescents with behavioural disturbance as a major concern.

1.7 In the report **Stop the Madness** which is based on research conducted in September 1990 it is reported that the accommodation needs of adolescents 18 and under with behavioural disturbance are not properly provided for even though their needs are recognised by both government and non–government organisations.

1.8 The report goes on to say:

> The gap in accommodation and support services for young people with psychiatric or behaviour disorders is so wide and long standing that no one service could effectively address the need. There is a need for a continuum of accommodation options to address the varying needs and levels of independence.[2]

1.9 The research identified young homeless people with psychiatric or behaviour disorders as the most vulnerable. At the time that the study was undertaken it was estimated that there were at least 20 young people severely affected by psychiatric or behaviour disorders who required accommodation. Such young people generally have no family support, no appropriate or stable accommodation and little income. Youth refuges attempt to maintain the young person for as long as possible, however refuges are funded for short term crisis accommodation and do not have the specially trained staff required to deal with such clients. Workers in refuges reported that the emotional and mental wellbeing of a young person with psychiatric or behaviour disorder deteriorates as the young person moves through the refuge circuit as a result of lack of stability and specialised support.

1.10 According to refuge workers the accommodation situation for these young people has not improved since the completion of the research study. Some refuge workers felt that young people with psychiatric or behaviour disorders were frequently being inappropriately directed to Supported Accommodation Assistance Program (SAAP) services, which receive neither funds nor specialist support for such clients.

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2 Duncan, C. **Stop the Madness**, Youth Accommodation Group, Canberra, December 1990.

1.11 The view was expressed that Family Services Branch (formerly Community Welfare Branch) should take a greater responsibility for these young people and either place them in more appropriate accommodation where they could receive professional support, or fund outreach workers to support the young person in a refuge or other appropriate accommodation.

1.12 Family Services Branch is no longer referring young people under the age of 16 to youth refuges. Such young people requiring residential care are placed either in Scullin House, a Family Services Branch facility, at Marymead Children's Centre or in foster care such as the Barnardo's program – Residential Alternatives for Teenagers (RAFT). However young people with behavioural disturbance who are not Family Services clients may refer themselves to refuges.

1.13 Youth refuges provide crisis accommodation for young people aged 12 to 17. Most youth refuges are funded under the joint ACT/Commonwealth Government Supported Accommodation Assistance Program (SAAP). In 1990–91 $1.66m was granted under the SAAP program in the ACT. Eight refuges and two multi–faceted accommodation programs received funds. Three of the refuges provide only crisis accommodation while the remaining five offer medium to long term accommodation. SAAP funding to refuges is limited to accommodation and does not cover funding for counselling or family support.

1.14 Not all of the young people who seek accommodation at youth refuges have behavioural disturbance. However most are in crisis and need specialised support as well as accommodation.

1.15 The availability of counselling and family support for residents of youth refuges is severely limited. Young people referred to the Child and Adolescent Unit often have to wait several weeks for an appointment because that service is in heavy demand. Without counselling and family support the Committee believes that young people in youth refuges are at risk of perpetuating existing problems and developing more serious problems.

1.16 The Committee believes that because of the restrictions on the use of SAAP funding, youth refuges are not able to employ the range of professionally qualified staff such as counsellors, social workers or psychologists that are necessary to provide the support required by the residents.

1.17 The Committee felt that the expectations some refuge workers had of residents with regard to responsibilities and values was very low. More could be done to encourage the residents to take greater responsibility particularly for household tasks, and for the refuge to provide more meaningful programs and to develop life skills.

1.18 **The Committee recommends that:**

. **the Minister for Community Services request the Commonwealth Government to review SAAP funded services particularly in relation to including professional support services such as counselling as part of the service to youth refuges.**

1.19 During the course of the inquiry the Committee visited Scullin House, Marymead and Barnardos and held informal discussions with some of the staff and residents.

1.20 Scullin House is a shelter which provides emergency accommodation for young people aged 12 to 17 years who are either awaiting placement in foster care, for whom there is no other accommodation, or are deemed in need of care under the Children's Services Act. It can accommodate a maximum of ten residents at any time however on average has six residents. Most of the residents have suffered severe trauma and at times can be very difficult.

1.21 Staff at Scullin House include welfare workers and resident house parents. It costs approximately $270,000 per year to operate.

1.22 On its first visit to Scullin House the Committee was concerned by the location, and design of the building, the lack of planned day activities for the residents, some aspects of the residents' diet and the staff's knowledge of the wherabouts of some residents. Some changes had occurred by August when the Committee made another visit and it is hoped that this progress will continue. The planned Structured Day Program, a New Policy Proposal announced in the 1991–92 Budget will also go some way to addressing the urgent need for an activity program.

1.23 Marymead provides a shelter for children aged 0 to 17 years and a range of other short term residential programs. In its submission to the inquiry and in later discussions Marymead emphasised that its capacity to effectively assist young people with behavioural disturbance is a resource issue. A recently introduced funding agreement for young people in residential care limits the duration of their stay.

1.24 The length of stay for young people placed by Family Services Branch in Marymead's Family Restoration Program is targeted at eight weeks with a maximum of three months after which the young person usually returns to the family. Marymead also provides a Permanency Program which includes in its target group children who have behaviour difficulties which without therapeutic intervention are likely to cause future foster placement breakdown.

The length of stay stipulated for children in the Permanency Program is three months with a maximum of six months only after a full case review if the child remains in the program after the three month period. Following placement in the Permanency Program most clients are then placed in foster care.

1.25 These young people are often severely disturbed, have a background of serious abuse and have very complex problems which are often impossible to establish let alone begin to resolve in three months. The Committee is concerned that the policy of limiting the stay in residential care of some young people with behavioural disturbance to three months will place the recovery of the young person in serious jeopardy. It is unrealistic to expect all these young people to be ready for another accommodation arrangement in such a short time. The Committee believes that premature placement in foster care or other accommodation merely exacerbates the problems and often results in further instability. The Committee has serious concerns about the long term effects of this policy. While it may realise savings in the short term, unless these young people are given a realistic chance of recovery by allowing them adequate time in a therapeutic program these savings will quickly be eradicated as further more expensive intervention or even custodial care becomes necessary.

1.26 **The Committee recommends that:**

- **the Government adopt a more flexible funding policy which allows young people with behavioural disturbance to be maintained in residential care for a period of up to 12 months when that is required to stabilise the young person's behaviour and give him/her a realistic chance of rehabilitation; and**

- **during this period case reviews be conducted at least quarterly.**

1.27 As is the case with SAAP funded youth refuges existing funding for Marymead does not provide the additional resources urgently required for these young people such as specialised counselling. Marymead has a team of highly qualified staff and is able to provide some counselling from within its own resources.

1.28 Marymead argued that efforts should be made to creatively resource existing programs before any consideration was given to establishing new programs. The Committee strongly supports this position.

1.29 The Committee is of the view that there is inadequate suitable residential accommodation for adolescents with behavioural disturbance and that the policy on funding residential services does not take into account the special needs of these young people.

1.30 **The Committee recommends that:**

- **the Government ensure that existing residential accommodation programs to which young people with behavioural disturbance are referred by Family Services Branch be given flexibility within the funding guidelines to provide counselling and specialist support to the young people.**

1.31 The Barnardo's program RAFT offers adolescents aged 12 to 17 years foster care with paid professional carers. The RAFT program was threatened with closure in mid 1991 when the ACT Housing and Community Services Bureau reduced the level of payment to foster carers from $240 per week to $104 per week. Barnardo's has a strong commitment to this specialised foster care for adolescents and has agreed to contribute the necessary funds from its own resources to enable the professional carers to continue to be paid at the rate of $240 per week. It is regretful that this program can no longer be as fully supported by government funds. Barnardo's has once again demonstrated a strong commitment to local young people and their families by taking this action.

Working conditions of youth refuge staff

1.32 The Committee has some concerns about the working conditions and availability of emergency assistance for staff working in youth refuges particularly at night. At most times there is only one staff member on duty and always only one person on paid duty at night. If that staff member requires additional assistance to deal with a crisis such as an overdose, an outburst of violence or develops a sudden illness, the options are to call the emergency services or if it is less serious to call in another worker who will come in on a voluntary basis. The police and ambulance services respond very quickly. A Mental Health Services Branch after hours crisis service is also available. Many refuge workers were not aware of the existence of this service until several months after it was established. They reported that the service is not always able to assist refuges because of more urgent requests. The Committee accepts that the crisis service has a need to prioritise its limited service. This unfortunately can place refuge workers at risk, which is unacceptable. Some of these situations may be averted if as part of their staff refuges were able to employ professional counsellors, or counsellors were readily available on an outreach basis.

1.33 Refuge workers reported that instances such as violence and overdosing can be very unsettling for the other residents and after the initial crisis has been dealt with the worker on duty often needs the assistance of another (unpaid) worker to deal with the aftermath.

Low Literacy and Numeracy Skills

1.34 The level of literacy and numeracy among some adolescents was identified as a major concern by many individuals and groups who gave evidence to the inquiry. Research over many years has demonstrated that poor literacy and numeracy skills is related to low self esteem, which in turn can be related to behavioural disturbance. Youth workers told the Committee that the large majority of young people seen at the youth centres have a literacy problem. This is largely due to irregular attendance at school.

1.35 Young people with poor literacy and numeracy skills are typical of students who do not fit into the school system as it is currently structured and are likely to benefit from "off line" or other innovative programs.

1.36 A group of staff from high schools in Belconnen expressed to the Committee concerns about another group of students, namely those who are not motivated by school and who drop out as soon as they reach the school leaving age. These students typically have low self esteem, are not achieving and cannot cope with the structure of high schools.

Alternative programs

1.37 The Committee's attention was drawn to two specific programs which are successfully addressing the problem of low literacy and numeracy skills among adolescents. These are the Study Centre program operated by Burnside at Campbelltown, New South Wales and the post compulsory program operated by Oxley Secondary College in Queensland. The Committee believes that these programs could provide models which would be useful in addressing the issue in the ACT.

1.38 The Committee visited Burnside at Campbelltown to discuss its program of Study Centres. The Study Centre program was established in response to the need to provide young people with more equal access to educational opportunities and encourage them to complete their high school education. Macarthur area has one of the lowest school retention rates in New South Wales and a low number of students who go on to further study. The program is targeted at educationally disadvantaged high school students including those at risk of getting into trouble or dropping out of school.

1.39 Each Study Centre operates from 3 p.m. to 6 p.m. daily, is open to students from years 7 to 12 and is staffed with trained teachers, who work with 5 students each. A total of 250 students attend the program each week. Staff work closely with the schools in the area.

Students are enrolled on a term basis either for 2 or 3 sessions per week depending on the program. They are required to and do attend regularly. They are given an individualised program which as well as assisting them with their studies also takes into account other needs such as self esteem, self discipline and social skills. An interesting feature of the program is that many of those who attend have a record of truanting or suspension.

1.40 The Committee was told about a program operating in Queensland with some success for high school drop outs. Oxley Secondary College has a post compulsory program aimed at young people who for a range of reasons have not completed year 10. Most of the students enrolled are aged between 15 and 19 years, however it is open to anyone of post compulsory school age and include a number of young mothers. The program operates from 3 p.m. to 6 p.m. daily in ten week blocks. Three subjects are offered namely English, maths and science. Students study one subject in each 10 week period. The course is accredited at the junior level (year 10). On completion students are eligible for entry to TAFE courses or may proceed to year 11. Classes are limited to 14 and great care is taken with the selection of teachers. According to a High School Principal the establishment of such a program in an ACT High School would require few additional resources and could be done with one full time equivalent teacher.

1.41 The success of Burnside's Study Centres and the Oxley Secondary College program seems to be closely related to careful structuring, the employment of qualified teachers who have a proven record in dealing with difficult adolescents and clear expectations of the young people.

1.42 In the ACT there has recently been some recognition of the need to provide alternative programs which develop literacy and numeracy skills among adolescents. In mid 1991 the Civic Youth Centre received funds from the Commonwealth Government's Youth Activities Services program to establish a literacy project for disadvantaged youth. It is too early for an assessment of the success this project.

1.43 Marymead Children's Centre reported the need for remediation programs in literacy and numeracy is almost universal among the adolescents in its residential program. Many of these young people spend a significant period of time out of school because they have been suspended and are awaiting transfer to another school. This creates enormous problems for the young person, the community and the carer. Marymead has recently addressed this problem by employing a remedial teacher and setting up a part time school with funds provided by community organisations and business. At the time of completion of the inquiry Marymead indicated that the program was progressing well.

1.44 The Committee applauds this initiative of Marymead but questions the appropriateness of an ACT Department of Education and the Arts' policy that enables students to be suspended from regular school for long periods and provides no alternative within the education system.

1.45 The Committee strongly supports the idea of high quality alternative programs which are aimed at improving literacy and numeracy skills among young people and believes that schools and community organisations should be supported in the development of such programs.

1.46 The Committee recommends that:

- **the ACT Government support the funding and development of a range of alternative educational programs for young people who have not completed or are at risk of not completing high school.**

Young people with drug and alcohol problems

1.47 Drug and more particularly alcohol abuse is seen by those working with young people as a very serious problem which is often not recognised.

1.48 The effects of any drug depends on a number of factors including the drug used; the amount taken; the manner taken; the circumstances under which the drug was taken for example place and company; and individual factors such as age, sex, body weight and health. Depending on the drug behavioural disturbances may include hyperactivity, lethargy, impaired mental and physical abilities, impulsiveness and in some circumstances violence.

1.49 The Alcohol and Drug Service of the ACT Board of Health has recognised that in order to plan sound education programs and develop appropriate policy concerning drug and alcohol abuse among young people it needed to collect accurate student drug use information.

1.50 In May 1991 the Alcohol and Drug Service conducted an extensive survey of 2700 students in years 7 to 11. The survey was conducted in co–operation with the ACT Department of Education and the Arts, the Catholic Education Office and the Association of Independent Schools.

1.51 Preliminary findings from the survey, which were released by the Minister for Health on 20 November 1991 confirm that underage drinking and binge drinking are serious problems among ACT secondary students. In the ACT 26 per cent of boys and 22 per cent of girls were using alcohol at least weekly. The preliminary findings also showed that of those ACT students who drank in the four weeks immediately prior to the survey, 40 per cent of boys and 30 per cent of girls reported "binge" drinking, that is having five or more drinks in a row, at least once during the month.

1.52 In the ACT there is a limited range of services and programs both government and non–government for young people, particularly young women with drug and alcohol related problems. These programs provide counselling, information and referral and some treatment and rehabilitation.

1.53 There are however significant gaps in services. There are no primary prevention programs targeted at "at risk" youth such as children of alcohol and drug dependent parents or youth with specific identified behaviour disorders such as attention–deficit hyperactivity disorder or conduct disorder. Research has demonstrated a greater likelihood of the development of alcohol abuse or dependence among young people with either of these disorders.

1.54 There is also a need for early intervention and preventive programs. Most young people who present at specialist drug and alcohol treatment services have well advanced problems. Programs such as the Life Education Program play an important preventive role. The Alcohol and Drug Service has identified the training of generalist workers and an expansion of early intervention programs as a priority when funds are available. Teachers, the police, and general health and welfare workers can also play a very important role in prevention and early intervention. They need however to be trained in alcohol and drug related issues.

1.55 On 20 November 1991 the Government announced four initiatives aimed at reducing underage drinking. These initiatives include:

- the development of an integrated campaign incorporating media and supporting community projects directed at underage and binge drinking;
- the provision of an intervention kit specifically aimed at young people which will be available free of charge through the Alcohol and Drug 24–Hour Crisis and Information line;
- funding through the Alcohol and Drug Service Grants Program of a "School Development in Health Education Project" to schools in the Tuggeranong region; and
- the development of a pilot drug education program concerning binge drinking by the Department of Education and the Arts.

The Committee supports these initiatives.

1.56 The area of greatest concern to the Committee in relation to gaps in services is the fact that there is no specialist treatment program for adolescents. This became increasingly evident to the Committee as it visited youth refuges and met with workers dealing with adolescents. What also became evident was the need for any proposed therapeutic program to involve other members of the young person's family.

1.57 The Alcohol and Drug Service argued that a specialist treatment program for adolescents need not necessarily be an inpatient program as generally it is preferable for alcohol and drug affected people to remain in day to day contact with their normal environment while treatment is progressing. Environmental cues and interpersonal situations are closely related to drug and alcohol consumption and wherever possible treatment should take place in the context of the environment in which the problem developed. There are sometimes circumstances when it would not be either possible or advisable for a young person to remain in his/her normal environment. In these circumstances the young person needs decent accommodation as a prerequisite for change and suitable arrangements would need to be made.

1.58 **The Committee recommends that:**

- **the ACT Government establish a specialist treatment program incorporating family therapy for adolescents with drug and alcohol problems.**

2 YOUTH SUICIDE

2.1 The Committee received evidence from a number of groups and individuals who stated that youth suicide in the ACT is a serious problem. It appears that the rate of youth suicide in the ACT has increased.[3] There is very little ACT data on youth suicide. Where ACT data is not available, the Committee has used Australian or overseas data. The Committee was told that youth suicide is one of the most sensitive issues when considering the topic of behavioural disturbance in youth.[4]

Definition

2.2 Suicide is the intentional taking of one's own life.[5] The Committee accepts this definition.

2.3 Suicide is murder of oneself, and should not be presented as an option by our society or by the media. Problems in life must be confronted instead of avoided. Suicide creates a great tragedy for the people left behind.

Magnitude of the problem

2.4 Youth suicide in the ACT fluctuates in numbers from year to year. The Committee was told that the incidence of attempted suicide and suicide had increased.[6] Table 1 shows the number of suicides which have occurred among young people aged 10 to 24 in the ACT between 1985 and 1989.

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3 Submission 79, p 1.

4 Submission 32, p 14.

5 **The Macquarie Encyclopedic Dictionary,** The Macquarie Library Pty Ltd, Macquarie University, NSW, 1990, p 995.

6 Transcript, 29 August 1991, p 447.

Table 1

Number of suicides among young people in the Australian Capital Territory[7]

	10–14		15–19		20–24		Total	
Year	Males	Females	Males	Females	Males	Females	Males	Females
1985			2		10		12	
1986				2	12	6	12	8
1987			4	8	16	2	20	10
1988			8	4	8		16	4
1989					12	2	12	2

2.5 There are no further figures available from the Australian Bureau of Statistics after this date, however the ACT Coroner's Register indicates that in 1990, there were 5 youth suicides in the ACT.[8]

2.6 In percentage terms, the youth suicide rates have in fact remained fairly static in the ACT between 1985 and 1989. That is, expressed as a percentage of the 15–19 and 20–24 year old population of the ACT, the suicide rate for 15–19 and 20–24 year old youth has not changed between 1985 and 1989. There have, however, been times, such as in 1987, when the percentage has increased dramatically.

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7 Australian Bureau of Statistics, Special Tabulation.

8 Letter from ACT Minister for Housing and Community Services, 3 October 1991.

2.7 It is obvious from Table 1 that more males than females commit suicide. This is generally the case for the ACT and for the whole of Australia.[9] One possible explanation of the fact that males complete suicide more frequently than females is that males choose more violent methods that are more likely to succeed.[10] In addition, members of the ACT Prevention and Management of Youth Suicide Working Group (ACT Working Group) noted that young women find it easier to talk about their problems than young men. However the Committee was also told that girls in the ACT now complete suicide more often because they too are using more violent methods.[11]

2.8 The Committee was told that suicide among young people affects all socio–economic levels.[12]

2.9 In 1988 Richard Eckersley reported that Australians aged 15–24 are now taking their own lives at the rate of one a day.[13] Reporting in the September 1991 issue of **Modern Medicine of Australia**, Psychiatrists Dr Michael Dudley and Professor Brent Waters of the Department of Child and Adolescent Psychiatry, Prince of Wales Hospital in Sydney stated that after traffic accidents, suicide is now the greatest killer of young Australians.[14]

2.10 Hassan (1990)[15] notes that suicide among young Australians has been gradually increasing over the past 30 years. One in six deaths of males and one in nine deaths of females aged 15 to 19 years in 1988 was caused by suicide. In 1966 the corresponding figure was only one in twenty for males and females.

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9 Mason, G. **Youth Suicide in Australia: Prevention Strategies**, Department of Employment Education and Training (Youth Bureau), Canberra, 1990, p 16.

10 Transcript, 29 August 1991, pp 423–4.

11 Transcript, 29 August 1991, p 424.

12 Transcript, 29 August 1991, p 423.

13 Eckersley, R. **Casualties of Change: The Predicament of Youth in Australia. An analysis of the social and psychological problems faced by young people in Australia**, AGPS, Canberra, 1988, p 1.

14 Dudley, M. & Waters, B. "Adolescent suicide and suicidal behaviour", **Modern Medicine of Australia**, September 1991, p 90.

15 Hassan, R. 'Unlived lives: Trends in Youth Suicide', in **Preventing Youth Suicide: Conference Papers**, Australian Institute of Criminology, Canberra, 1990, p 1.

2.11 Dudley and Waters (1991) state that:

> the rising trend in completed suicide is almost entirely due to deaths of males aged between 15 and 19. Among them, the rate per 100,000 has increased from 7.3 in 1968 to 21 in 1988. Over the same period, the suicide rate among teenage girls increased from 2.4 to 4.7 per 100,000.[16]

2.12 Hassan (1990) comments that the higher numbers for youth suicide are partly due to more detailed data collection. In addition, there is now more likelihood that the coroner will find the cause of death has been suicide than in the past.[17] However Hassan still considers there has been an increase in Australia in the number of youth suicides.[18] Hassan also notes that youth suicide is now a global problem of increasing magnitude.[19]

2.13 Attempted suicide is also a serious problem in the ACT and is discussed more fully in a later section.

Causes

2.14 Differing views were put to the Committee as to causes of youth suicide. One view is that only people with psychiatric problems commit suicide. Another view is that it is part of a continuum of at–risk and self–destructive behaviour. The latter view is preferred by Mason (1990) in her work on Youth Suicide in Australia.[20] The ACT Working Group told the Committee that there is an enormous range and combination of factors which cause a young person to commit suicide. The following factors were described as possible causes of youth suicide by those working in the area, in submissions and in research.

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16 Dudley & Waters, op cit, p 90.

17 Hassan, op cit, p 3.

18 ibid, p 5.

19 ibid, p 1.

20 Mason, op cit, p 15.

Loss and grief

2.15 The Committee was told that a primary cause of youth suicide is a serious loss in the life of the young person. The ACT Working Group advised that early losses, such as losing a parent or parents divorcing in early life, are significant. Any serious loss somewhere along the line in the child's life, not necessarily just before the suicide, can be significant. The effect of loss and grief was also discussed in evidence at a public hearing when the Committee was told that:

> the main risk factors in youth suicide are an accumulation of experiences of loss and change in the previous 12 months. And adolescents experience a lot of loss in a lot of different ways ... loss of friends, loss of esteem, loss of job opportunities ... loss of expectations ... family break up.[21]

2.16 The ACT Working Group stated that the break of close peer relationships, such as the loss of a girlfriend or boyfriend, can be the final contributing factor for some. This is also mentioned by Mason (1990) as a triggering factor in suicide.[22]

Substance abuse

2.17 Research has linked the use of legal and illegal drugs to youth suicide.[23] The ACT Working Group confirmed this link. Legal drugs include alcohol and prescription and non–prescription medication. Substance abuse by young people has also been considered in Chapter 9 of the Report.

2.18 It has been reported[24] that there is an increase in alcohol use by young people, and in the nature of alcohol use. The Committee was told that alcohol is an enormous problem with adolescents, as well as with adults. Mason (1990) states that:

> alcohol is present in the blood of a large proportion of those who complete suicide.[25]

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21 Transcript, 29 August 1991, p 424.

22 Mason, op cit, p 37.

23 ibid, p 42.

24 ACT Health Authority, **ACT Health Survey Bulletin 1: Survey of Year 6–Year 12 Students**, Canberra, 1984, pp 13 and 23, cited in Submission 32, p 9.

25 Mason, op cit, p 42.

2.19 Stankevicius[26] cites Mason (1990)[27], who reported that a large number of those participating in research she conducted (hospitals in particular) expressed the view that alcohol and drug abuse is one of the main reasons young people attempt and commit suicide. It has been suggested, Mason reports, that alcohol and drug dependence contribute to a general sense of alienation and despair among young people. Drugs, both prescription and illegal substances, are said to be too accessible. Virtually no person who participated in her research believed however that alcohol and drugs are really the cause of youth suicide, but rather that they act as a triggering factor: their abuse is, like suicide, a symptom of more serious problems. This view was supported by the ACT Working Group.

Unemployment

2.20 A number of studies in Australia and overseas have confirmed the association between suicide and unemployment (Martina 1985; Hassan and Tan 1989).[28] Hassan (1990) comments that over the whole of Australia:

> the period of increasing youth suicide strongly corresponds to the high youth unemployment rate.[29]

2.21 Unemployment for young people aged 15–19 in the ACT has been on average over 20 per cent during 1991.[30]

2.22 Hassan (1990) comments that unemployment in general and prolonged unemployment in particular is associated with low self esteem and with emotional, economic and psychological insecurity. Those who cannot cope with unemployment become more susceptible to self destructive behaviour.

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26 Submission 32, p 13.

27 Mason, op cit, p 42.

28 Martina, A. **Suicide and Unemployment Amongst Young Australian Males, 1966 to 1982**, Working Paper No 56, Department of Economic History, The Australian National University, Canberra, 1985; Hassan, R. & Tan, G. 'Suicide trends in Australia 1901–1985: an analysis of sex differentials', **Suicide and Life–Threatening Behaviour**, 1989, 19:4. Both articles are referred to in Hassan, 1990, op cit, p 6.

29 Hassan, op cit, pp 5–9.

30 Australian Bureau of Statistics, **Labour Force Survey**, unpublished data.

2.23 Mason (1990) sounds the warning, however, that it is too simplistic to suggest that providing full employment will reduce the problem of youth suicide. She said that in many cases much more is required. Furthermore, she says it has been suggested that in today's economic climate, full employment may not be realistic.[31] In addition, many youth are currently at school, and so are unaffected by unemployment.

Family relationships

2.24 The ACT Working Group reported that if people have a long history of poor relationships and poor peer relationships they are at risk of suicide. They also commented that there can be an intact family, but poor relationships within the family. Both the families and youth need support. If children have experienced violence or various forms of abuse in the home, they feel they have no support. The relationship between family dysfunction and behavioural disturbance is discussed briefly in Chapter 4.

2.25 Hassan (1990) comments on the changing family structure in Australia. The fastest growing family type over the past 20 years is the single parent family.[32] Hassan comments also on divorce as a potential factor in suicidal behaviour.

2.26 Hassan points to the increasing educational attainment of parents, and comments that children who find it difficult to reach the academic expectations of their parents may experience a sense of failure and depression which under certain circumstances may have serious implications for their well–being.[33]

2.27 With increasing unhappiness in families, absent parents and unwanted children[34], better parenting skills are essential for many people.[35]

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31 Mason, op cit, p 41.

32 Hugo, G. **Australia's Changing Population**, Oxford University Press, Melbourne, 1986, quoted in Hassan, op cit, p 10.

33 Hassan, op cit, p 11.

34 ibid, quoting Hendin, H. 'Youth suicide: a psychosocial perspective', **Suicide and Life–Threatening Behaviour**, 1987, 17:2.

35 Mason, op cit, p 70.

Mental Health

2.28 Mental health problems are a major contributing factor to youth suicide (Hassan 1990).[36] In statistics which Hassan gathered in South Australia, it was revealed that the majority of people who committed suicide had a history of depression, anxiety, or serious disturbance in interpersonal life at the time of suicide. At the time of suicide, very few of them were receiving psychiatric assistance. Hassan concludes that this points to a need for improving access to psychiatric services among young people.[37] The Committee has identified a gap in services in this area in the ACT, which is referred to in Chapter 8.

2.29 The ACT Working Group stated that clinical depression, for a series of reasons, was one of the causes of youth suicide.

2.30 Stankevicius[38], however, wanted to dispel a commonly held belief that all young people who kill themselves are suffering from a psychiatric illness. He reported that Mason (1990) estimated that less than 50 per cent of young people who commit suicide have a psychiatric problem.[39] In such cases, it may not be the illness that leads them to suicide, it could be family pressure, drug and alcohol problems or a general feeling of hopelessness. This view is supported by Vleeskens (1990), of the Macarthur Suicide Prevention Task Force, who states that:

> We believe that the majority of suicidal individuals are not psychiatrically ill and do not have a diagnosable psychiatric condition.[40]

2.31 Hart (1990) observed that a family history of psychiatric illness, especially with suicidal behaviour, puts the offspring at greater risk of suicide.[41]

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36 Hassan, op cit, p 14.

37 ibid.

38 Submission 32, p 16.

39 Mason, op cit, pp 30–31.

40 Vleeskens, op cit, p 9.

41 Hart, B. 'An approach to the issue of youth suicide and attempted suicide in Western Australia', in **Preventing Youth Suicide: Conference Papers**, Australian Institute of Criminology, Canberra 1990, p 9.

Concern for the future

2.32 The Committee was told that research on adolescence and suicide has shown that despondence about issues can cause them to suicide. Issues mentioned were nuclear war, which was an issue several years ago, and now the environment.[42]

2.33 Eckersley (1988) comments that:

> many studies, both in Australia and overseas, suggest that a large proportion of young people regard the future of the world with fear and trepidation. They see a world devastated by nuclear war and ravaged by pollution and environmental degradation, a dehumanised society in which technology is out of control (or even in control) and unemployment rampant.[43]

He goes on to say, however, that:

> other research and expert opinion suggest that these concerns do not weigh heavily on the minds of young people; the things that distress them are personal, such as problems with friends, family, school or work.[44]

Homelessness

2.34 Eckersley (1988) draws attention to the fact that youth homelessness, virtually unknown 20 years ago, is increasing at an alarming rate.[45] Differing views about the extent of youth homelessness in the ACT were presented to the Committee. The Committee was not in a position to assess these claims.

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42 Transcript, 29 August 1991, p 440.

43 Eckersley, op cit, p 33.

44 ibid, p 39.

45 ibid, p 2.

2.35 A submission[46] pointed to the Inquiry into Homeless Children.[47] In preparing part of the report for that inquiry, Dr Ian O'Connor interviewed 100 young people, 25 each from the Gold Coast, Sydney, Brisbane and Canberra. O'Connor states that homeless young people have a high risk of depression and suicide.[48]

Copy cat or cluster suicides

2.36 A cluster suicide has been defined as:

> a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community.[49]

American research indicates that teenage clusters have become more common in recent years.[50]

2.37 Mason (1990)[51] notes that the copy–cat effect occurs where one suicide is followed by another committed in a similar manner, place or by a person with similar characteristics. There may be only one copy–cat suicide, or there may be several. They can feasibly develop into a cluster.

2.38 The Committee was told that copy–cat suicides have occurred in the ACT.[52]

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46 Submission 32, p 7.

47 Human Rights and Equal Opportunity Commission, **Our Homeless Children: Report of the National Inquiry into Homeless Children**, AGPS, Canberra, 1989.

48 Quoted in Submission 32, p 7.

49 Mason, op cit, p 133, quoting the Center for Environmental Health and Injury Control in Atlanta, Georgia.

50 Mason, op cit, p 133.

51 ibid.

52 Transcript, 29 August 1991, p 422.

Media influence

2.39 Mason (1990)[53] reports a study suggesting that the increase in youth suicide is connected with the expansion of the mass media and their increasing tolerance of attractive models of destructive and auto–destructive behaviour. Mason continues that:

> there is now evidence strongly indicating that media coverage of suicide can have an influential effect on the suicide rate, in particular by provoking 'copy–cat' and cluster suicides.[54]

2.40 It has also been argued that reporting of suicides may create a situation whereby suicide is seen as a normal and available means of solving life problems.[55]

2.41 The Committee notes that there have been some successful discussions with the media in the ACT aimed at increasing media sensitivity in reporting suicide and reducing sensationalism. The Committee supports these moves and hopes that the media continues to take a responsible attitude when reporting youth suicide. In particular, the media should be wary of depicting scenes and details of suicide. There is evidence that such depictions have led to copy–cat suicides.[56]

Schools

2.42 The ACT Working Group commented that an important factor in youth suicide is how schools are run, the pressures schools put on students, and the alienation felt at school. In evidence it was reported that bigger schools tend to have a higher proportion of students with behavioural disturbance than smaller schools. Larger institutions make students feel much more alienated.[57]

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53 Mason, op cit, p 43.

54 ibid.

55 Gostelow, C. "Youth suicide prevention: a school personnel training approach", in **Preventing Youth Suicide: Conference Papers**, Australian Institute of Criminology, Canberra, 1990, p 5.

56 Mason, op cit, pp 139–44.

57 Transcript, 29 August 1991, p 447.

2.43 The Deputy Secretary of the ACT Department of Education and the Arts stated:

> I acknowledge the capacity of small schools to look after individual student needs... However ... because schools are large, I do not believe it necessarily follows that they cannot do their job well.
>
> It is a question of structures... You have to have appropriate welfare structures, ... appropriate people chosen to be year masters or whatever the structure is ...[58]

Attempted suicide

2.44 The study **Out to Lunch** indicated that the problem of attempted suicide by youth in the ACT is quite serious. In 1988 the Juvenile Aid Bureau estimated one attempted suicide per fortnight as an average, noting that some young people repeatedly attempt suicide.[59] Evidence given to the Committee at a public hearing indicates that the incidence of attempted suicide, as well as suicide, has increased.[60] The Committee was told that there have been several suicide attempts this year, and a number of hospitalisations.[61]

2.45 It is impossible to determine the exact number of suicide attempts by young people. Dudley and Waters (1991) state that:

> ... Overseas authors suggest that most attempts go undetected by adults, and the great majority never come to medical attention.[62]

Furthermore, not all suicide attempts are recorded as suicide attempts. Some, for example, are recorded as accidents. It is estimated that about 20,000 people under the age of 23 attempted suicide in Australia in 1988.[63]

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58 Transcript, 24 July 1991, pp 370–1.

59 ACT Council of Social Service, **Out to Lunch: A Survey of Mental Health Services for Young People in the ACT**, Canberra, 1988, p 10.

60 Transcript, 29 August 1991, p 447.

61 Transcript, 29 August 1991, p 446.

62 Dudley & Waters, op cit, p 90. Footnote reference: Brent, D.A. "Suicide and suicidal behaviour in children and adolescents", **Paediatrics in Review**, 1989, vol 10, pp 269–75.

63 Bureau of Statistics, quoted by Macarthur Task Force at a Conference on Prevention of Adolescent Suicide, held in Canberra, May 1991.

2.46 A social work crisis service operated at Royal Canberra Hospital until March 1991 when it closed as a result of budgetary constraints. The service dealt with such cases as sudden deaths, serious motor vehicle accidents, assessment of overdoses and patients with self destructive behaviour. The Committee sees this service as crucial in dealing with suicide attempts. At a time when the hospital system is undergoing reorganisation, it is essential that as a part of this process a crisis service is re–established.

2.47 **The Committee recommends that:**

. **the Government re–establish the twenty four hour social work crisis service.**

2.48 The Royal Canberra Hospital provided figures on the number of people admitted to that hospital who have attempted suicide. Table 2 shows the number of people admitted to Royal Canberra Hospital between 1985 and 1991 aged between 0 and 24 who had attempted suicide.

Table 2

The number of attempted suicides which have been noted by Royal Canberra Hospital

	0–14		15–19		20–24		Total	
Year	Males	Females	Males	Females	Males	Females	Males	Females
June/May								
1985/6	4	1	4	7	6	9	14	17
1986/7	2	2	4	6	3	19	9	27
1987/8	1	4	10	28	8	16	19	48
1988/9	3	1	6	15	10	11	19	27
1989/90	3	4	6	17	5	16	14	37
1990/91	0	1	6	15	5	11	11	27

2.49 Evidence was given to the Committee that young women attempt suicide more often than young men.[64] Dudley and Waters (1991) state that Australian female teenagers are admitted for suicide attempts about three times more often than Australian male teenagers.[65]

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64 Submission 32, p 15.

65 Dudley & Waters, op cit, p 91. Footnote reference: Kosky, R. "Is suicidal behaviour increasing among

2.50 This common view about attempted suicide, that it is predominantly a behaviour of females, has however recently been questioned. Psychiatrists Dr Anthony Davis, Senior Consultant in Psychiatry, Royal Adelaide Hospital and Professor Robert Kosky, Professor of Child Psychiatry at the University of Adelaide and Chair of the Child and Adolescent Mental Health Service, South Australia, have studied the rates of attempted suicide in Perth and Adelaide.[66]

2.51 The recent changes in attempted suicide rates reported by Davis and Kosky indicate that there may not be such a clear sex–linked pattern and that males attempt suicide almost as frequently as females.[67] In Perth, according to their research, there was a striking increase in the rates of attempted suicide among males in the 15–19 age group between 1971–2 and 1986–7.[68]

2.52 This is supported by other research[69] and was confirmed in evidence given to the Committee. The Committee was told that males make about the same number of attempts as females, but quite often they are more clouded attempts, such as excessive use of alcohol.[70]

2.53 A concern was expressed to the Committee about hospital admission procedures after a suicide attempt.[71] In a joint submission Owner and Pearse stated that adolescents may be admitted to psychiatric wards, where they are assessed prior to discharge by a psychiatrist. The submission notes that the adolescent patient often appears to be confused about the roles of the professionals they have seen, whether psychiatrist or social worker. Further the view was expressed that it may not be appropriate to admit adolescents who have attempted suicide to a psychiatric ward.

> This event has an effect of confirming in the mind of the young admittee that they are indeed different by being mentally sick ... Adolescents who have been admitted to psychiatric wards are often discharged without a case management plan, or at least one that involves the school environment, where there is the real opportunity to follow up and intervene by qualified and experienced school counsellors.[72]

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[65] Cont. Australian youth?", **Medical Journal of Australia**, 1987, vol 147, pp 164–6.

[66] Davis, A. & Kosky, R. "Attempted suicide in Adelaide and Perth: changing rates for males and females, 1971–1987", **The Medical Journal of Australia**, May 1991, vol 154, p 667.

[67] ibid, p 668.

[68] ibid, p 667.

[69] McGrath, J. "A survey of deliberate self–poisoning", **The Medical Journal of Australia**, 1989, vol 150, pp 317–24.

[70] Transcript, 29 August 1991, p 431.

[71] Submission 79, p 4.

2.54 Furthermore, concern was expressed that following hospital admissions there appears to be little support for the family of the adolescent patient.

2.55 The Committee held discussions with a group of adolescents from a Canberra college in September 1991. During these discussions the Committee was told that some adolescents claimed they were inappropriately treated when they were admitted to hospital following a suicide attempt. Some were given negative comments by medical staff. Some of these adolescents felt they were not treated as a person in hospital but as a medical case. They felt they were dismissed by the medical staff without regard for the depth of their problem. They also claimed that they were given medication when this was inappropriate.

2.56 Dudley and Waters (1991) state that when adolescents are admitted to hospital following a suicide attempt, they are often caught in a 'rejection cycle':

> The patient who is seen as irresponsible, ungrateful, or weak, encounters punitive treatment, reflex referral to 'the shrink', or the use of medication in the place of sensitive interviewing.[73]

They go on to say:

> Suicidal patients search for someone to help them bear the unbearable.[74]

The suicidal patient should be listened to and taken seriously. The Committee was told that if a suicide attempt is a cry for help, it ought to be a cry that is recognised.[75] Appropriate help should always be sought.

2.57 In addition, the establishment of an adolescent ward, described in chapter 8, will provide specialist support to young people who attempt suicide.

Prevention

2.58 Just as the causes of youth suicide are not straightforward, neither is the prevention of youth suicide .

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72 Submission 79, p 4.

73 Dudley & Waters, op cit, p 95.

74 ibid.

75 Transcript, 29 August 1991, p 421.

Parenting

2.59 Research by Mason (1990) found that:

> family conflict, discord and dysfunction ... is a major contributory factor or cause of self–destructive behaviour, including suicide, among young people.[76]

Therefore the great weight of prevention should focus on the family.

2.60 Mason was told in her research that:

> Greater parenting skills are essential for many people.[77]

2.61 Birleson considers that:

> Potentially, parents are the best preventative resource. Those who talk with their children and help them develop ways of understanding the world and managing its complexities do much to leave the youngster feeling supported, raise their self esteem and diminish possibilities of their becoming depressed or being likely to contemplate suicide.[78]

2.62 Balson (1991) also believes that the key to suicide prevention among adolescents lies in better parent education.[79]

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76 Submission 32, p 16, citing Mason, op cit, p 35. See also section on family relationships above.

77 Mason, op cit, p 70, quoting a questionnaire respondent or interviewee. The interviewees and questionnaire respondents for Mason's report included people from hospital and community–based psychiatric services, counselling services and youth refuges. Those interviewed work specifically in the field of youth suicide. Among them were Dr Chris Cantor, Dr Bret Hart, Dr Riaz Hassan, and Dr Robert Kosky.

78 Birleson, P. "Depression and Suicide in Adolescence", **Australian Family Physician**, 1988, 17:5, pp 331–5.

79 Balson, M. **Becoming Better Parents**, Australian Council for Educational Research, Hawthorn, Victoria, 1991, p 135.

2.63 The Committee considers that the development of parenting skills is of utmost importance. Further discussion and recommendations concerning parent education are contained in Chapter 11. In addition, Dudley and Waters (1991) state that:

> "The family should be involved wherever possible in the [medical/psychiatric] assessment [of the suicidal behaviour], or at least informed about it.[80]

2.64 In a submission to the Committee, Stankevicius stated that:

> not everyone has a loving family to go to and not all families have the emotional and physical resources some youths may require. As a caring society it is up to us through our government offices and taxation monies to pick up the slack.[81]

2.65 The Committee recognises that a suicide can occur in the most loving family. Therefore the Committee notes that the spending of money by the Government will not necessarily solve the problem of youth suicide. The Committee is also concerned about pressures on parents. These pressures, economic and otherwise, are further expanded in other parts of the report.

Organisations

2.66 There are several organisations and people in the ACT involved in the area of youth suicide. One group specifically focuses on youth suicide, while other people and groups touch on this area as part of their operations. These groups are relatively new and at the time of the inquiry were working in isolation.

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80 Dudley & Waters, op cit, p 94.

81 Submission 32, p 3.

2.67 In early 1991 a seminar on the prevention of adolescent suicide was held in Canberra. Representatives from the Macarthur Suicide Prevention Task Force spoke at the seminar. The Macarthur Task Force is based in the Western suburbs of Sydney, and formed of people working in health and welfare in that area. The Task Force has put out a series of brochures, addressed to youth and to parents. It has also trained other professionals to work in the area of suicide prevention, and prepared a training package for a range of health, welfare and legal professionals, among other activities.[82] Another important part of the role of the Task Force is to encourage networking and the development of other Task Forces in other areas.[83]

2.68 The Prevention and Management of Youth Suicide Working Group, Mental Health Branch, of the ACT Board of Health, was formed in 1990. The Working Group aims to bring together those involved in the area of youth suicide, to arrange training for those involved in working with depressed and suicidal youth and to provide a focus for issues involved in youth suicide.

2.69 There is a group of school counsellors in the Belconnen area who have frequent contact with school–aged youth, and in particular with youth that is disturbed and occasionally suicidal. A school counsellor stated in evidence that:

> It is very important that we do put a lot of effort into the preventative area because it is preventable. ... Any school counsellor in a college or a high school would be working at some time or other with a student who is feeling suicidal. And the bulk of these students, in my experience 100 per cent of the students that I have worked with, have not gone on to make an attempt ... There are a lot of supports around and the counselling really does work in preventing suicide.[84]

Another school counsellor echoed this when he said:

> The counselling process, to me, is the preventative tool.[85]

2.70 Gostelow (1990), quoting Pfeffer (1986) states:

> ... Persons working in the school may constitute the most important referral source for suicidal children for psychiatric evaluation and treatment.[86]

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82 Vleeskens, op cit, pp 4–8.

83 ibid, p 8.

84 Transcript, 29 August 1991, p 425.

85 Transcript, 29 August 1991, p 425.

86 Gostelow, op cit, p 2, quoting Pfeffer, C.R. **The Suicidal Child**, The Guildford Press, New York, 1986, p 264.

2.71 The Committee was told that there is a need for more counsellors, social workers, psychiatrists and psychologists in the adolescent area. The ACT Working Group noted the inadequacy of child and adolescent psychiatric services. Mason (1990) notes that the need for specialised psychiatric services for young people in all States is critical.[87]

2.72 This was confirmed in evidence by a school counsellor who spoke of:

> the great shortage of professional psychiatrists in the public sector ... the great shortage of professional psychiatrists who are skilled and able to work with adolescents.[88]

2.73 The Macarthur Task Force comments that there are more options that just maintaining and relying upon our psychiatric hospitals, psychiatrists and psychiatric workers as being the only help for the majority of suicide attempters. The Macarthur Task Force believes that:

> in providing a community based prevention service, with a broad range of workers such as psychologists and social workers, we are reducing the burden in our already overtaxed psychiatric hospitals and community mental health services.[89]

2.74 The proposal for an adolescent ward referred to earlier in the report was supported by those working in suicide prevention.

Training

2.75 A major issue in the prevention of youth suicide is the training of those working in the area. Two school counsellors have developed a package for schools and are offering some information sessions to teachers. This package is based on information provided by the Macarthur Suicide Prevention Task Force.[90] In late 1991 the ACT Working Group will sponsor a workshop aimed at training people involved with youth at risk of suicide.

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87 Mason, op cit, p 84.

88 Transcript, 29 August 1991, p 428.

89 Vleeskens, op cit, p 9.

90 Transcript, 29 August 1991, pp 442, 445–6.

Co–ordination

2.76 The co–ordination of groups and people working in the area of youth suicide is an issue requiring attention and is discussed in Chapter 12.

2.77 The need for co–ordination was confirmed in evidence.[91] A school counsellor emphasised the need for co–ordination, communication and encouragement of people involved in the area. It was also mentioned that there is a problem with lack of time, as the case load of school counsellors is very high.

2.78 The Committee commends the work being done by the ACT Prevention and Management of Youth Suicide Working Group and by a group of school counsellors. The Committee commends the efforts which have already been made by the ACT Working Group to co–ordinate groups in this area, and supports further co–ordination between groups involved in youth suicide in the ACT.

2.79 **The Committee recommends that:**

- **the ACT Government continue and extend its support of the work of the ACT Prevention and Management of Youth Suicide Working Group in the development of strategies to assist in the prevention of youth suicide in the ACT.**

Consultation

2.80 Dudley and Waters also emphasise that it is important for doctors faced with suicidal patients to seek assistance from more expert doctors or to consult with other doctors:

> Consultation with colleagues or expert help may be vital in exploring options, and keeping the young person alive.[92]

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91 Transcript, 29 August 1991, pp 423, 430, 437, 438 and 446.

92 Dudley & Waters, op cit, p 95.

Telephone counselling services

2.81 In the ACT Lifeline and Youthline exist to counsel people over the telephone. Youthline operates from 4 p.m. to midnight. Most of its calls relate to problems with families or peer group relationships. Approximately two per cent of calls received by Youthline are related to suicide or suicide attempts and it is impossible to quantify the effect of this service in preventing youth suicide. Even the saving of one young life is of enormous value.

2.82 The mobile service operated by Lifeline is a valuable service which can be deployed if the telephone service client reveals his/her identity.

Mental Health Crisis Service

2.83 There now exists in the ACT a 24 hour Mental Health Crisis Service. The service came into operation in December 1990. It was set up to deal with people with a mental illness, or people with high psychological distress.

2.84 It was suggested to the Committee that because this service covers all age ranges, the needs of young people may not be adequately catered for.[93]

Firearms

2.85 Recent research evidence has shown that a substantial proportion of suicides, especially among young males, are carried out with firearms.[94] A recent study[95] has found that 76 per cent of deaths by firearms recorded in Queensland between 1980–1989 were suicides. This proportion is confirmed by other Australian and US studies.[96] Rural youths have been found to use firearms for suicide more frequently than their urban counterparts.[97]

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93 Submission 32, p 3.

94 Mason, op cit, p 128; Cantor, C.H., Brodie, J. & McMillen J. "Firearm victims – who were they?", The Medical Journal of Australia, October 1991, vol 155, pp 442–6; Cantor, C.H. & Lewin, T. "Firearms and suicide in Australia", **Australian and New Zealand Journal of Psychiatry**, 1990, vol 24, pp500–509.

95 Cantor et al, "Firearm victims", op cit.

96 Mukherjee, S.K., & Dagger, D. **The Size of the Crime Problem in Australia**, 2nd ed, Australian Institute of Criminology, Canberra, 1990; Wintemute, G.J. "Firearms as a cause of death in the United States 1920–1982", **Journal of Trauma**, 1987, vol 27, pp 532–6.

97 Dudley, M., Waters, B., Kelk, N. & Howard, J. "Youth Suicide in NSW: urban–rural trends 1964–

2.86 There is a shortage of ACT and Australian research on the relationship between suicide and access to firearms. Therefore Cantor et al (1991) refer to studies which show that the prevalence of gun ownership in the United States is proportional to the rate of suicide by firearm.[98]

2.87 However studies on the connection between suicide and tighter gun control do not conclusively show that tightening gun ownership laws leads to lower suicide rates.[99] One possible explanation for this is that, as Mason (1990) states, it is a mistake to focus on access to the means of suicide, as a cause of suicide. While access to firearms may be a factor in the mind of a person contemplating suicide, the fact that the means of suicide exists does not explain in any way how and why people reach the stage where they want to kill themselves.[100]

2.88 Mason asserts, however, that availability of method is relevant to prevention.[101] The Committee notes that the ACT Legislative Assembly has recently introduced more restrictive guns laws into the Territory and commends this move.

Research

2.89 It has been suggested that there is a need for more research into the area of youth suicide.[102] A longitudinal study of youth suicide in the ACT is being undertaken by several members of the ACT Working Group. The ACT Government should take note of this study when it has been completed.

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97 Cont. 1988", **Preventing Youth Suicide**, Australian Institute of Criminology Conference, Adelaide, 1990.

98 Markush, R.E. & Bartolucci, A.A. "Firearms and suicide in the United States", **American Journal of Public Health**, 1984, vol 74, pp 123–7; Lester, D. "Effects of changes in handgun control laws on suicide rates", **Psychological Reports**, 1988, vol 62, p 298; Boyd, J.H. & Moscicki, E.K. "Firearms and youth suicide", **American Journal of Public Health**, 1986, vol 76, pp 1240–2.

99 Cantor et al, "Firearm victims", op cit, p 444; Mason, op cit, p 128.

100 Mason, op cit, p 44.

101 ibid.

102 Mason, op cit, p 55.

Postvention

2.90 Postvention involves providing counselling and support to those close to the suicide victim in an attempt to minimise the trauma. Postvention is aimed at family survivors, schools, including staff and students, friends or local communities.

2.91 The tragedy of suicide has an enormous effect on all the people who were associated with the victim. The period of grieving after a suicide lasts longer than it does when death is by other circumstances and the complications of not being able to understand why, or feelings of guilt, have a lasting effect on many people.[103]

2.92 Offering constructive support to such people reduces the likelihood that they will attempt suicide themselves or that clusters will develop.[104] Activities involved could include individual counselling, group discussions, talking with families and friends.

2.93 Within the government school system school counsellors have established a network of support which can be called upon when a school community experiences a suicide.[105]

2.94 It is crucial that those working with young people at risk of suicide are aware of preventive measures and receive training in recognising risk factors and in dealing with a suicide. They also need to be aware of all groups working on the issue in the community.

2.95 **The Committee recommends that:**

- **the Government ensure**
  - **the co–ordination of government and non–government groups working in the youth suicide area; and**
  - **the provision of training in preventive measures and the recognition of risk factors related to suicide for those working with adolescents.**

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103 Transcript, 29 August 1991, p 432.

104 Mason, op cit, p 134; also Taylor, B. & Silva, P.A. **In a Time of Crisis: Some Management Recommendations for Schools and Other Institutions in the Event of a Death or Other Serious Crisis**, Ministry of Youth Affairs, New Zealand, 1990, p 11.

105 Transcript, 29 August 1991, p 433.

3 EARLY INTERVENTION AND PREVENTIVE MEASURES

3.1 This chapter discusses the concept of early intervention, some research on the efficacy of early intervention and the current provision of and future needs for early intervention programs for young people with behavioural disturbance in the ACT.

The concept of early intervention

3.2 "Early intervention" is a term that is usually used in relation to the early childhood years. In discussing it Moore (1990)[106] points out that early intervention is not a particular type of specialist help but rather refers to a wide range of services which are provided for young children and their families. These services are specifically for children whose development is already significantly delayed or at risk. Children whose development is at risk include those from deprived or disturbed backgrounds and are not always easy to identify.

3.3 One of the central aims of early intervention is to prevent the development of secondary problems. Secondary problems arise either because of failure to deal with the primary problem or as a result of distortions that develop in the relationship between the child and the family, for example the acceptance by the family of inappropriate behaviour. By providing appropriate home and community based programs from the time of diagnosis or referral early intervention may be able to minimise the handicapping effects of a child's disability or prevent later problems.

3.4 The development of behavioural disturbance can occur at different times depending on the influences and factors that shape the young person's life. For example family breakdown or brain injury can result in the development of behavioural disturbance at a later stage than the early childhood years. For this reason the Committee will not confine its consideration of early intervention to these early years.

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[106] Moore, T. "Helping Young Children with Developmental Problems: An Overview of Current Early Intervention Aims and Practices", **Australian Journal of Early Childhood**, 15:3, 1990, pp 3–5.

Research evidence

3.5 The Committee heard from many people that behavioural disturbance is often evident from a very young age. This view is also supported by research evidence. For example a study by Kashani et al (1987) reported that adolescents diagnosed with conduct disorder had significantly more behaviour problems in the preschool years than a control group.[107]

3.6 Landy and Peters (1991) cite several studies which have found the incidence of behaviour problems in preschoolers and toddlers to be very similar to the incidence of psychiatric disorders in school aged children. They also report several studies which demonstrate that even when identified early, children with conduct problems typically prove to be the most difficult to treat among children referred to mental health services.[108] However research is now emerging on the efficacy of treating identified toddlers.

3.7 This recent research indicates a poor record for the successful treatment of conduct disorders in older children. Landy and Peters report that most of this research indicates that immediate post treatment gains do not persist and success occurs only with the least disturbed families. There is now a strong call among researchers and practitioners to examine the reasons why this is occurring. One of the major reasons suggested is the emphasis on external symptoms alone to the exclusion of parental internal dynamics and the child's developmental failures.[109]

3.8 Professor Brent Waters also made these points. He said:

> Once kids get past the age of about eight or nine with behavioural problems, it is almost too late. I think it is important that you have realistic goals about behavioural problems. If you catch it early, there is some chance you might be able to help things. If you catch it late there is almost none.[110]

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107 Kashani, J. et al, "Conduct Disordered Adolescents from a Community Sample", **Canadian Journal of Psychiatry**, 32, December 1987, pp 756–759.

108 Landy, S. and Peters, R. "Understanding and Treating the Hyperaggressive Toddler", **Zero to Three**, XI:3, February 1991, pp 22–31.

109 Landy and Peters, op cit.

110 Transcript, 7 June 1991, p 336.

3.9 In commenting on the research evidence which points to the critical time for intervention in behavioural problems as being before eight years of age the Deputy Secretary (Education) of the ACT Department of Education and the Arts said:

> I do not doubt that. ... I think what it requires, though, is a kind of quantum leap, in terms of attitudes towards resources. I mean what we are talking about here is large investments at the bottom end to prevent social investments later on. ... But that is very risky of course, is it not? ... Certainly, the experts that we have had over the last few years are saying the same sort of thing now. Our understanding of the brain and its development is such that we know there are certain windows of opportunity and if you miss those, you have lost it. So yes, I just think that we have got to continue to try and press for ways to increase the resourcing at that lower end of schooling.[111]

3.10 Unfortunately the development of early intervention programs is severely hampered by current Government attitudes towards resources. Until governments are prepared to give a high priority and commitment to early intervention programs the provision will be piecemeal and unsatisfactory.

3.11 Early education programs have been shown to be effective in reducing problems in adolescents. The Perry Preschool Project examined the long term benefits of preschool programs for disadvantaged children. The findings of this study demonstrated that these benefits included decreases in delinquency, crime levels, use of welfare services and adolescent pregnancy rates.[112]

3.12 There is also a large body of research that demonstrates the importance of early intervention for children with special education needs. For example in a major study in the USA Lazar and Darlington (1982) found that early education programs significantly reduce the number of children assigned to special education programs.[113]

3.13 The efficacy of early intervention for children with behavioural disturbance is clearly established. The question is how to provide effective early intervention programs in the context of resource restraint.

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111 Transcript, 24 July 1991, p 367.

112 Weikart, D., Epstein, A. S., Schweinhart, L. and Bond, J. T. **The Ypsilanti Preschool Curriculm Demonstration Project: Preschool Years and Longitudinal Results,** High/Scope Educational Research Foundation, 1978.

113 Lazar, I. and Darlington, R. **Lasting Effects of Early Education: A Report from the Consortium for Longitudinal Studies,** Monographs of the Society for Research in Child Development, 1982, 47:2.

3.14 **The Committee recommends that:**

. **the ACT Government recognise the value of and give high priority to the development and implementation of early intervention programs for children and young people with behavioural disturbance;**

Early intervention programs

3.15 The research shows that there are common elements of effective programs for children with special needs namely –

early identification, assessment and intervention;
suitably structured programs;
multidisciplinary input; and
parental involvement.

3.16 In its submission the Belconnen Regional Support Centre of the ACT Department of Education and the Arts pointed out that the emphasis is now moving from the critical period concept of intervention to focus on the continuity of provision. Zigler and Berman (1983) are cited as suggesting that the most successful intervention should comprise a series of dovetailed programs, independently available as the need arises, with each appropriate for a particular stage of development.[114]

3.17 The evidence presented to the Committee supported this concept. There is a need to provide preventive and early intervention programs for both parents and children at different stages of development.

3.18 The Committee heard over and over again that ineffective parenting is a major cause of problem behaviour among children and young people. Professor Maurice Balson in his book **Becoming Better Parents** observes that unlike former generations, today's parents are unsure of their ability to raise responsible children. He attributes this change to parents being deskilled as the autocratic social system collapsed and was replaced by a democratic social system. This has had a profound effect on relationships between parents and children and left many parents with a reduced ability to influence children.[115]

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114 Submission 67.

115 Balson, M. **Becoming Better Parents**, Australian Council for Educational Research, Hawthorn, 1991, p 1.

3.19 In discussing problem behaviour among adolescents Balson states:

> Delinquency is now a major problem in most countries. Its origins, however, like most other difficult behaviours, are found in the mistakes which parents make during the formative years. ... The answer to delinquency, drugs, alcohol and the like is prevention. As Manaster and Corsini (1982) correctly observe:
>
> Every delinquent starts in the home: children only attack others if they have been trained to attack. Parents who are either brutal or neglectful or spoiling are equally liable to generate delinquents through their misguided methods of dealing with their young ones ... Better parenting is the major solution we recommend to counteract delinquency.[116]

3.20 The Committee considers that the development of skills that will equip young people to become effective parents should begin early in life. To this end the development of interpersonal relationship skills such as conflict resolution and negotiation should become an integral part of the school curriculum. Emphasis should also be placed in the school curriculum on the development of an understanding of child growth and development.

3.21 In evidence to the Committee Professor Waters discussed the need to identify the beginnings of chains of events that end up with bad outcomes and to develop intervention strategies that will stop the cycle.[117] Others have also talked about the notion of "stopping the cycle".

3.22 Unsupported teenage mothers have been identified as a group who generally make poor parents and whose children very often have serious behaviour problems. Professor Waters believes that there is an urgent need to do something about breaking that cycle. He stated:

> One chain is the teenage mother, and you have got to do something about that. ... They make poor parents and their children, whichever way you measure the outcome – if it is in terms of mental health measures ... or if you measure it in terms of whether they turn out to be good parents – they come out badly. The children of teenage parents become teenage parents themselves, in a word, and it is very important that one puts resources into interrupting that cycle.[118]

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116 Balson, M. op cit, p 117.

117 Transcript, 7 June 1991, p 333.

118 Transcript, 7 June 1991, p 333.

3.23 Prevention of teenage pregnancy through birth control and family planning measures is one of the answers to this problem. However in reality such measures will not solve the problem. There will always be teenage pregnancies and support will be needed for them. The ACT has little in the way of specific services to assist single teenage mothers. During its visit to Westmead Hospital, which is in the Sydney metropolitan area, the Committee met with medical staff who had established a clinic for teenage mothers. The clinic is held weekly and provides ante natal care, information on child care and post natal care. A special post natal ward has been established for them and they spend seven days in hospital after the birth during which time they are taught basic baby care skills and helped to develop an understanding of the task they have ahead.

3.24 **The Committee recommends that:**

- **the ACT Department of Health establish a pre and post natal program for unsupported teenage mothers.**

3.25 Immediately after the birth of a baby is a time when effective intervention can occur. Maternity hospitals and maternity after care services provide professionals with the opportunity to identify parents who may be at risk of being less than competent parents. These parents need support and some practical advice about parenting. Professor Waters stated research demonstrates that advice and support can be very effective early on in parenting. This approach does not work with everybody but is an effective intervention for some.

3.26 Families often find the toddler period is a time when they first have feelings of not being able to cope and when parenting becomes very difficult. Dealing with a hyperaggressive toddler can leave parents feeling frustrated, frantic and angry. Landy and Peters describe the pattern of behaviour which often develops in these circumstances as a circle of rejection. The child acts out, the parent/caregiver punishes, the child feels further rejected and acts out again. The child sees himself and the world as bad and these perceptions are reconfirmed by experiences outside the home and with other children.[119]

3.27 The Committee is of the view that children and their families must be helped when these problem behaviours first emerge and often this is at the toddler stage. In the past the emphasis has been on treating the child's symptoms often to the exclusion of examining the underlying factors, the family dynamics and the quality of the family relationships. In the ACT families who are experiencing problems with toddlers often do not have these problems acknowledged and their cries for help go unnoticed. There is a need for existing parenting programs which focus on toddlers to be more adequately publicised.

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[119] Landy and Peters, "Understanding and Treating the Hyperaggressive Toddler", **Zero to Three**, XI:3, p 25.

3.28 **The Committee recommends that:**

- **the ACT Government acknowledge a need for professionally staffed parenting programs for families with toddlers and ensure that existing programs are adequately publicised.**

3.29 As outlined in Chapter 6 childcare and preschool centres are very concerned about the numbers of children with behavioural disturbance enrolled in these programs and about the lack of support available to assist them in dealing with the problem.

3.30 Schools and the abovementioned services are often the most significant, or even the only, community resources outside the immediate family experienced by some children and their families. Preschools and childcare services are in a good position to offer parents support in casual discussion, modelling of good child/adult interaction and stimulation. They are also in a good position to identify emerging behavioural problems and to develop and implement remediation programs.

3.31 The appointment by the Children's Day Care Section of the ACT Housing and Community Services Bureau of a special needs worker to work with children with behavioural disturbance in child care centres demonstrates some recognition by the ACT Government of the need for specialist support and early intervention. This service is minimal and offered to ACT government funded and non funded services. On the other hand the Commonwealth Government which funds Supplementary (Sups) Workers as part of its policy of integration of special needs children, does not recognise behavioural disturbance as a specific need and consequently sups workers can only provide very limited support to centres with children identified as having behaviour problems.

3.32 Another ACT Government initiative is the establishment of a Behaviour Intervention Team by Intellectual Disability Services to provide intensive specialised services to behaviourally disturbed clients with an intellectual disability residing in the community. This service will be available to childcare centres.

3.33 While these ACT Government initiatives are a beginning they cannot possibly meet the demand. They can only provide crisis intervention and cannot possibly address adequately the early intervention aspect of prevention.

3.34 **The Committee recommends that:**

- **the ACT Housing and Community Services Bureau redirect funding to expand its program of support to children with behavioural disturbance in child care.**

- **the ACT Government seek Commonwealth recognition of the expansion of the role of Supplementary (Sups) and Children's Services Workers to cover children with behavioural disturbance in child care.**

3.35 Preschools also have very little specialist support for children with behavioural disturbance. The continuation of the Play Therapy program operating this year is not guaranteed as it is dependent on the outcome of an annual grant application. Apart from this program there is no other specific early intervention program.

3.36 There are no staffing points allocated to preschools for school counsellors and only one resource teacher position for the whole preschool sector.

3.37 Some early childhood educators suggested the extension of the Department of Education and the Arts' Behaviour Management Support program to provide an early childhood unit for four to six year olds. It is argued that an extension of this program would not only give preschools access to the program but would also be a more suitable educational environment for five and six year olds requiring such intervention.

3.38 As reported in Chapter 7 primary schools are facing great difficulties in dealing with the increasing number of students with behavioural disturbance and are forced by lack of resources to focus on crisis intervention rather than early intervention.

3.39 Children with learning disabilities are also at risk of developing serious behaviour disorders. Some educators have concluded that the majority of behavioural problems that occur in the classroom and playground are caused by underlying and unremediated or undiagnosed learning problems. Early intervention is crucial for these children. The ACT Department of Education and the Arts' Junior Assessment classes and Learning Centres offer specially designed educational programs for this group. Many of these children have complex problems and it is apparent that there is also a need for early intervention and remediation of a multidisciplinary nature for some students particularly those with specific learning disabilities.

3.40 The Committee was unable to locate any evaluation studies of ACT early intervention programs dealing with children and young people with behavioural disturbance. A behaviour modification program for preschool children with behavioural disturbance operated at the University of Canberra in the early 1980s, however unfortunately there was no long term follow up study of its effectiveness. The Committee believes that it is imperative that long term evaluation studies are conducted on ACT early intervention programs.

3.41 In 1989 a comprehensive review of NSW schools was undertaken by a committee chaired by Sir John Carrick. The issue of early intervention was extensively reviewed and a recommendation of the report stated:

> Because early detection and remediation have the greatest potential for an optimum outcome, the main thrust of available resources in future should be phased in to early childhood, pre–school and primary school. In the longer run, the cost efficiency of early intervention is far greater than remediation attempts in secondary schools.[120]

3.42 The Committee considers that if the Department of Education and the Arts is serious about addressing the problem of students with behavioural disturbance in the long term, it must make a stronger commitment to early intervention while at the same time providing support and remediation programs for high schools until the results of early intervention programs have had time to take effect.

3.43 **The Committee recommends that:**

- **the ACT Department of Education and the Arts redirect adequate resources to early intervention programs for children with behavioural disturbance at the preschool level.**
- **the ACT Department of Education and the Arts in cooperation with the ACT Department of Health ensure priority is given to the identification and assessment of children with learning disabilities and the development of multidisciplinary early intervention programs.**
- **the ACT Government ensure that research is conducted on the effects of ACT early intervention programs.**

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[120] Carrick, J. **Report of the Committee of Review of New South Wales Schools**, New South Wales Government, 1989, p 237.

4 ORGANISATION AND COORDINATION OF SERVICES

4.1 The issue of the organisation and coordination of services for young people with behavioural disturbance was raised in the majority of written submissions, by most people who gave evidence at public hearings and by staff in programs visited by the Committee.

The current position

4.2 Agencies currently involved in providing services to young people with behavioural disturbance include both government and non-government organisations. The government agencies include the Department of Education, the Board of Health, the Family Services Branch (formerly Community Welfare Branch) and the Community Programs Branch of the ACT Housing and Community Services Bureau and the Youth Affairs Section of the Chief Minister's Department. Non-government organisations include among others the Youth Affairs Network of the ACT, youth refuges, youth centres, Barnardos, Marymead, St Vincent de Paul, the Salvation Army, the Open Family Foundation, Richmond Fellowship, Centacare, Focus and Careforce.

4.3 Much of the evidence detailed the fragmented nature of service provision. Careforce[121] reported that service provision is generally arranged for the solution of a single problem at a time because of government bureaucratic needs for division of functions and the single issue nature of most non-government organisations. Many others claimed that there is little organisational recognition that most problems have more than one significant dimension. As a result young people with behavioural disturbance or their families or carers go from place to place to have their needs met.

4.4 Case management was also reported as a major concern. Individual cases tend to be dealt with as isolated referrals and coordination and feedback are not included as a feature of case management. When an interdisciplinary approach is adopted it was reported that there are unclear guidelines for roles and responsibilities of each agency and as a result the approach falls down. Where case management occurs it is not as a matter of policy but rather coincidental to referral. Informal networks often substitute for case management policies.

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121 Submission 80, p 1.

4.5 Some young people are receiving support from several regional and Territory wide agencies. Examples were quoted of an excessive number of case workers intervening in a case without proper coordination and clarification of goals and responsibilities. This was seen as seriously inhibiting successful intervention. Duplication of services is involved, and sometimes contradictory information is given to the client. In many cases there is ignorance of the involvement of others. This is of particular concern where such knowledge would be beneficial and may increase the chances of a positive outcome. The lack of adequate case management sometimes results in young people slipping through the system.

4.6 The lack of a system of case management encourages the referral of clients from one service to another. Several factors were identified as contributing to this practice and included:

- frequent staff changes in Health and Welfare;
- changes in diagnosis as other workers become involved;
- change in diagnosis as the behaviour either escalates or appears to be maintained in spite of referrals; and
- self initiated referral or termination of referral by the young person usually because of perceived lack of progress or perceived inappropriateness of the referral.

4.7 The Drug and Alcohol Service of the ACT Department of Health reflected the views of many organisations and individuals when they stated in their submission:

> Given the variety of professionals and non professionals encountering behaviourally disturbed youth there is a need for greater coordination of efforts between agencies and even workers within agencies. Behaviourally disturbed youth may be identified by one agency and yet not referred on for appropriate specialist treatment. Co–ordination in this area should occur at the policy, strategic and, where appropriate, individual case level.[122]

[122] Submission 37(d), p 13.

4.8 During the course of the inquiry the Committee became increasingly aware of the fact that many young people and their families or carers are largely unaware of the services available to them. Even worse the Committee found that those working with young people with behavioural disturbance often were unaware themselves of available services. For example youth refuge workers were surprised to learn in a public forum of the availability of an after hours Mental Health Crisis Service more than three months after its establishment. School counsellors working on the prevention of youth suicide in Belconnen schools were unaware of the existence and work of the Working Group on the Prevention and Management of Youth Suicide which is coordinated by Mental Health Services Branch and has a representative from the ACT Department of Education and the Arts.

4.9 Frequent turnover in staff, different regional boundaries between Health, Education and Family Services Branch, confidentiality issues and interdisciplinary misunderstandings were identified as constraints to the development of effective communication between agencies involved in service delivery to young people with behavioural disturbance.

An interagency approach

4.10 The processes of addressing behavioural disturbances require an interagency approach involving community services, health, education, parents and other relevant individuals and organisations. There is considerable goodwill among agencies about the need to work more closely to achieve the best possible outcomes for young people. However, current practice has not been successful in achieving the level of coordination, cooperation and clarification of responsibilities which would ensure optimal use and delivery of existing services.

4.11 For several years the concept of the establishment of a single referral point or "one stop shop" referral centre for health, welfare and education services has been discussed in the community. The concept has not been developed further largely because of difficulties associated with the crossing of agency barriers and the associated funding policies and issues of confidentiality. Agencies particularly in times of severe budgetary constraints understandably are very reluctant to become involved in cases which they see as the responsibility of another program. This can result in strict demarcation of services which is often not in the best interest of the young person. Young people with behavioural disturbance often have complex needs which cannot be adequately addressed by one service. Because a problem is identified and most evident at school does not mean that intervention and support is the total responsibility of school system. In order to achieve the best outcomes for the young person a holistic approach needs to be adopted and the health, welfare and education needs of the young person addressed.

The South Australian approach

4.12 Following an inquiry in 1988 into interagency responses to the social and behavioural problems of school children in the State, the South Australian Government developed an interagency approach to the referral, assessment and case management of students with social and behavioural difficulties. The Committee was fortunate to have the opportunity to meet with some of the people involved in the development and implementation of the interagency referral process.

4.13 A State Interagency Committee (Student Behaviour Management) was established to oversee the implementation of the recommendations of the **Interagency Responses to School Children with Social and Behavioural Problems.** In September 1990 the interagency referral process was piloted in one region and extended to all regions in 1991. Interagency Implementation Committees have been established in each of the five areas and are managed by an Interagency Referral Manager. A case manager is appointed for each case and there is an inbuilt review to ensure that no student falls through the system. In most areas the service is open to school students aged 5 to 15 years and adolescents aged 15 to 18 who wish to return to school. In one district the Interagency Committee has already developed into an expanded planning group and is not limited to school behaviour problems but encompasses all services.

4.14 The interagency referral and management process is incorporated in a preventive whole school approach to student behaviour management. A student is referred when:

- there are multiple needs, requiring the school to seek additional aid and support, or requiring coordinated servicing;
- existing interventions are not changing the behaviour which is of concern or are not meeting the needs of the student;
- local services appropriate to the needs of the student are not available;
- the school is experiencing a crisis in managing the behaviour of the student and requires immediate support and additional expertise.[123]

[123] South Australian Government, **The Interagency Referral Process: A Mechanism for Integrating Health, Education and Welfare Services for School-aged Children and Adolescents with Social and Behavioural Difficulties**, 1991, case study for the *Children and Youth at Risk* project coordinated by the OECD Centre for Educational Research and Innovation.

Adoption of an interagency referral process in the ACT

4.15 The Committee was very impressed with the interagency referral process in South Australia and believes such a model is appropriate for the ACT. There is recognition among those working with young people with behavioural disturbance of the need for greater coordination and particularly for case management. An added advantage is that geographically the Territory is compact without the problems of long distances and isolated areas.

4.16 In most agencies the development and implementation of an interagency referral process will not require additional resources. The notable exception is in the area of mental health services to children and adolescents which have been identified earlier in the report as inadequate.

4.17 The success of the development and implementation of an interagency referral process in the ACT will be dependent on a strong commitment to the concept from Departmental heads and senior staff and extensive input and representation from those working in direct contact with young people and their families.

4.18 **The Committee recommends that:**

- **the Government establish an interdepartmental Committee to develop and implement an interagency referral process for young people with behavioural disturbance;**
- **the interagency referral process be developed and implemented first for school aged students and in the second stage be extended to include all children and young people with behavioural disturbance.**

5 FIVE YEAR STRATEGY

5.1 The Committee was asked to investigate the problem of behavioural disturbance among young people and to make recommendations to deal with this problem in the context of developing a strategy over at least five years.

5.2 The ACT is in a unique position in relation to the organisation, coordination and delivery of services to young people with behavioural disturbance. The Territory is geographically compact and has a dedicated and skilled workforce both in the government and non–government sectors. The ACT ought to be able to develop a system of service provision and delivery that leads the nation.

5.3 The next five years will be critical for the ACT in terms of funding and resource allocation. The Commonwealth Grants Commission's Fourth Report on Financing the Australian Capital Territory released in 1991 confirms that the ACT has been funded by the Commonwealth at a more generous level than the States and that adjustments to the level of Commonwealth funding will be necessary in future years. There has been and will continue to be a decline in Commonwealth financial assistance to the ACT. The capacity of the ACT Government to raise additional funds itself through taxation is limited to the level the electorate will tolerate and is strongly influenced by political forces. Past experience has demonstrated that the electorate will not tolerate an increase in taxes and charges above a certain level and that most increases are very unpopular. The ACT is faced with severe funding problems and the Government will need to be innovative in overcoming these problems. In considering its recommendations the Committee has been mindful of the need to ensure that implementation can occur within existing funding levels.

5.4 The Committee became aware of two major issues which in its view each warrant a separate inquiry, namely the provision of youth services and drug and alcohol abuse. The Committee's terms of reference and time constraints restricted it to an examination of these two issues in the context of behavioural disturbance.

5.5 It became increasingly evident as the inquiry progressed that the integration and coordination of services for young people with behavioural disturbance in the ACT requires urgent attention. The Committee sees the implementation of its recommendations on integration and coordination as fundamental to the development of a five year strategy. Of particular importance will be the adoption of the recommendations relating to the development and implementation of an interagency referral process. The Committee has recommended a staged approach and would expect the interagency referral process to be fully implemented by the end of 1995.

5.6 The Committee cannot emphasise too strongly the critical importance of early intervention in dealing with behavioural disturbance.

5.7 It is a reflection of the breadth and seriousness of the terms of reference and the issue that the Committee has made more than 30 recommendations. These recommendations form the basis of the five year strategy which is underpinned by the following principles:

– integration and coordination;

– early intervention;

– social justice;

– fiscal constraint;

– ongoing involvement of both the government and non–government sectors;

– ongoing evaluation and review; and

– appropriate intervention and care.

5.8 As a general principle resources should be directed to service delivery rather than administration particularly in the areas of health, education and welfare. Overall the Committee believes that existing funding with annual adjustments for inflation is adequate to enable the implementation of the five year strategy. What will be required however is some changing of priorities and redirection of resources.

5.9 The recommendations that form the five strategy have been grouped around several common themes.

5.10 **Integration and Coordination**

The Committee recommends that:

- **the Government establish an interdepartmental Committee to develop and implement an interagency referral process for young people with behavioural disturbance;** (para 12.18)

- **the interagency referral process be developed and implemented first for school aged students and in the second stage be extended to include all children and young people with behavioural disturbance;** (para 12.18)

- **the ACT Government review the organisation of Health, Welfare, Education and Intellectual Disability services and develop a more integrated model of service delivery;** (para 8.31)

- **the Government ensure the co–ordination of government and non–government groups working in the youth suicide area.** (para 10.95)

5.11 Early intervention

The Committee recommends that:

- **the ACT Government recognise the value of and give high priority to the development and implementation of early intervention programs for children and young people with behavioural disturbance;** (para 11.14)

- **the ACT Department of Health establish a pre and post natal program for unsupported teenage mothers;** (para 11.24)

- **the ACT Government acknowledge a need for professionally staffed parenting programs for families with toddlers and ensure that existing programs are adequately publicised;** (para 11.28)

- **the ACT Housing and Community Services Bureau redirect funding to expand its program of support to children with behavioural disturbance in child care;** (para 11.34)

- **the ACT Government seek Commonwealth recognition of the expansion of the role of Supplementary (Sups) and Children's Services Workers to include children with behavioural disturbance in child care;** (para 11.34)

- **the ACT Department of Education and the Arts redirect adequate resources to early intervention programs for children with behavioural disturbance at the preschool level;** (para 11.43)

- **the ACT Department of Education and the Arts in cooperation with the ACT Department of Health ensure priority is given to the identification and assessment of children with learning disabilities and the development of multi disciplinary early intervention programs.** (para 11.43)

5.12 Programs

The Committee recommends that:

- **the ACT Department of Education and the Arts**

  - **give high priority to the development of effective student management policies and practices in all schools from preschool to college;** (para 7.28)

  - **support high schools in the development of more appropriate curriculum options and programs for unmotivated and disruptive students;** (para 7.28)

  - **increase the support available to classroom teachers in dealing with students with behavioural disturbance through training and the provision of more school counsellors and resource teachers;** (para 7.28)

- **review the primary Behaviour Management Support Program. Within this review particular attention should be paid to its location, transport and reintegration of students;** (para 7.55)

- **pursue the development of a more diverse secondary Behaviour Management Support Program which includes a range of program options such as the development of literacy and numeracy skills, outdoor pursuits and life skills;** (para 7.55)

- **review the appropriateness of the policy of suspending students from the behaviour management program;** (para 7.55)

- **develop and implement a Home School Liaison Program similar to the NSW program.** (para 7.81)

. **the ACT Government**

- **redirect resources to the provision of mental health services to children and adolescents;** (para 8.18)

- **establish an adolescent ward with a minimum of 2 dedicated psychiatric beds at Woden Valley Hospital;** (para 8.18)

- **give priority to the ongoing provision of activity programs for young people with disabilities;** (para 8.37)

- **support the funding and development of a range of alternative educational programs for young people who have not completed or are at risk of not completing high school;** (para 9.46)

- **establish a specialist treatment program incorporating family therapy for adolescents with drug and alcohol problems;** (para 9.58)

- **re-establish the twenty four hour social work crisis service;** (para 10.47)

- **continue and extend its support of the work of the ACT Prevention and Management of Youth Suicide Working Group in the development of strategies to assist in the prevention of youth suicide in the ACT.** (para 10.79)

5.13 Legislation

The Committee recommends that:

. **the ACT Government review the legislation relating to non school attendance.** (para 7.81)

5.14 Accommodation

The Committee recommends that:

- **the ACT Government**

  - **continue to develop flexible small group accommodation facilities for young people with severe behavioural disturbance;** (para 8.34)

  - **adopt a more flexible funding policy which allows young people with behavioural disturbance to be maintained in residential care for a period of up to 12 months when that is required to stabilise the young person's behaviour and give him/her a realistic chance of rehabilitation; and during this period case reviews be conducted at least quarterly;** (para 9.26)

  - **ensure that existing residential accommodation programs to which young people with behavioural disturbance are referred by Family Services Branch be given flexibility within the funding guidelines to provide counselling and specialist support to the young people;** (para 9.30)

- **the Minister for Community Services request the Commonwealth Government to review SAAP funded services particularly in relation to including professional support services such as counselling as part of the service to youth refuges.** (para 9.18)

5.15 Training

The Committee recommends that:

- **the ACT Government negotiate with one of the ACT based universities for the provision of a training program in social work;** (para 8.18)

- **the ACT Department of Health negotiate the inclusion of training in working with adolescents in existing ACT programs in nursing, clinical psychology and welfare work;** (para 8.18)

- **the ACT Department of Education and the Arts urge ACT teacher training institutions to include a greater emphasis on behaviour management and related issues in preservice teacher training courses;** (para 7.28)

- **the ACT Department of Education and the Arts develop incentives and options to encourage more teachers to undertake training as school counsellors or resource teachers;** (para 7.28)

- **the ACT Government ensure the provision of training in preventive measures and the recognition of risk factors related to suicide for those working with adolescents;** (para 10.95)

- **the ACT Department of Health ensure that community nurses receive ongoing training in the administration of three year old developmental tests.** (para 6.7)

5.16 Research

The Committee recommends that:

- **the ACT Government**

  - **approach one of the ACT based universities to conduct a study into the prevalence of behavioural disturbance among young people in the ACT;** (para 5.29)

  - **ensure that research is conducted on the effects of ACT early intervention programs.** (para 11.43)

5.17 Publicity

The Committee recommends that:

- **the ACT Department of Health ensure that the availability of developmental screening for three year olds is adequately publicised.** (para 6.7)

Carmel Maher
Presiding Member
4 December 1991