LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH

(Reference: health of school-aged children)

Members:

MS K TUCKER (The Chair)
MR B SMYTH
MS K MacDONALD

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 15 AUGUST 2002

Secretary to the committee:
Ms S Leyne (Ph: 62050490)

By authority of the Legislative Assembly for the Australian Capital Territory

The committee met at 9.31 am.

RUTH CHRISTIE and

TIMOTHY BAVINTON

were called.

THE CHAIR: I declare this hearing of the Standing Committee on Health in session. I will read you a formal statement about committee hearings such as this.

You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections, but also certain responsibilities. It means that you're protected from certain legal actions, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Please state your names and the capacity in which you appear before you begin your address.

Ms Christie: My name is Ruth Cerise Christie, and I am a child worker from the Canberra Rape Crisis Centre.

Mr Bavinton: I am Timothy Paul Bavinton, the coordinator of SAMSSA, the Service Assisting Male Survivors of Sexual Assault.

THE CHAIR: Thank you. Would you like to address the committee?

Ms Christie: I will begin by talking about children's health in relation to sexual assault. What I am going to say this morning relies on the results of many published studies. The four main publications that I have taken material from today are *Sexual Abuse of Young Children* by Kee MacFarlane; *Assessing Allegations of Sexual Abuse in Preschool Children* by Sandra Hewitt; *Dissociative Children* by Lynda Shirar; and information from the national clearing house on family violence. I will also rely on my experience, and that of others working with children at the Rape Crisis Centre, which fits with the other study findings.

These studies clearly show that the consequences of sexual assault on children's health and their sense of wellbeing are huge. For the purpose of the presentation this morning I want to talk about the effects of abuse on children. I have put them into about nine different categories—the usual ones—but I cannot go through all those, so I will concentrate mostly on the psychological, physical, behavioural and academic categories. The other categories are sexual, interpersonal, self-perceptual, spiritual and subsequent violence.

Abuse may permanently alter the psychological wellbeing of children. The abused child is known to display a range of the following symptoms: extreme and repetitive nightmares and other sleep disturbances; anxiety; panic attack; depression; depressive

symptoms; prolonged bouts of sadness; social withdrawal; unusually high levels of anger and aggression; feelings of guilt and shame; dissociative disorders including DID, ADD and ADHD; phobias; general fearfulness and specific fears; psychosomatic complaints including headaches and stomach aches; bedwetting; excessive blinking; faecal soiling; negative body concepts; obsessive-compulsive disorders and disorders in cognition; and shattered assumptions about the world.

One of the studies says that post-traumatic syndrome does appear to exist in infants and children exposed to traumatic events, and repeated stress and trauma has an effect on the body even in young children. Cortisol is one of several hormones that are secreted by the adrenal gland to help the body respond to a stressful situation. It shuts down other responses that are operating during non-stressful times, and one of these responses is the immune system. Certainly, my work with children and the findings of studies show that sexually abused children have some disruption of their immune systems. Cortisol is also toxic to the brain tissue.

Abuse may also cause sleep disturbance. Children who are subjected to extreme stress may fall into a very deep sleep, which is different to normal sleep. It is much deeper and the child is less easily aroused. It is certainly something I find: they either wake frequently, have nightmares and don't want to stay in their own beds, or they will do the opposite and go into a very deep sleep, from which it is very hard to arouse them in the mornings.

Other physical consequences found by studies—and we've also found many of these ourselves—are gonorrhoea; genital warts, the frequency of which is quite high in my experience; chlamydia and genital herpes. Some of these untreated infections can cause damage and infertility, gastrointestinal problems, migraines, breathing difficulty, hypertension, aches and pains, rashes, allergy and poor hygiene resulting in poor overall heath, including infected gums and mouth. That is often related to the child's wanting to be as awful as they can so that a person will not abuse them, particularly when they're being told they're beautiful or lovely.

In my experience and in the studies' findings, anal fissures are quite a frequent occurrence, as is constipation, particularly in boys, and appendicitis. Those three seem to go with anal rape, and that includes anal rape of girls. Haemorrhoids are also related to that. Abrasions and lacerations of the hymen occurs in prepubescent females where there's been vaginal penetration, as does vaginal discharge. Injuries requiring surgical intervention sometimes occur. They are not as frequent, but I've certainly had that experience in my work and the studies show that.

Irritable bowel syndrome is very common. Anorexia, bulimia and urinary tract infections all occur, and these all occur in school-aged children and even primary school-aged children. My experience is that many of them will have eating disorders, and I will talk about that further.

Behavioural difficulties also occur. Sexual abuse adds stress and disrupts the psychological equilibrium of normal development. It disrupts self-control, the ability to self-regulate, so that many children have great difficulty in self-regulating. They are very distressed and over the top, and can easily become upset about minor things. Two-thirds of sexually abused children have behavioural adjustment problems. Some are anxious

and fearful and some are aggressive and angry. They have problems with eating, self-harm, risk-taking behaviour and accidental harm. They are accident-prone—there's a very strong relationship between accident-prone children and sexual abuse.

Substance abuse, particularly of tobacco, occurs even in young children and primary school-aged children. I find that some of them as young as five and six have talked about smoking cigarettes, and abusive parents actually give them the cigarettes. Extreme shyness or overt friendliness occurs—one or the other—as do regressive behaviour, suicidal thoughts and attempts, early use of drugs, alcohol and other substances, eating disorders, obesity, school-aged pregnancy, and self-mutilation, which also includes burning and other self-destructive behaviour. That occurs in primary school-aged children as well.

I think that it is a very hidden thing in primary-aged children, but they do talk about it, particularly if I ask about things they do to harm themselves. Delinquency and prostitution occurs in older children, and some down to the age of about 11. They might be doing that for money, for people in the neighbourhood. Many of these consequences manifest at adolescence, but are quite evident in younger children as well.

Studies show that sexual abuse and other forms of child abuse have a detrimental effect on the child's school performance. Over and over, research indicates that abused children demonstrate reduced intellectual functioning, and poor school performance that can have long-term consequences. Sexually abused children may display lower overall school performances, lower test scores, frequent grade repetitions—I find that very frequently—frequent disciplinary referrals and a high number of suspensions, and they work and learn at lower average levels than other children.

They have a weak orientation to vocational and educational goals. Lack of concentration is a major contributor to all of that: they tend to dissociate a lot in class and miss what's going on.

Alternatively, I also find that a portion of children dissociate in the other sense: they have extreme focusing, so they'll focus on tasks in extreme ways to block out everything else around them. This produces high achievers, so we have that either-end effect again. In my experience, the most prolonged or sadistic abuse will produce high-achiever children, who are focused on tasks. That is what I have to say about the children.

Mr Bavinton: I was just going to speak briefly about some of the longer term impacts in adolescence and adult life of child sexual abuse. Obviously, my work is primarily with men. SAMSSA operates under the auspices of the Rape Crisis Centre, so we work very closely together on a lot of issues.

I wanted to say that the impacts are largely the same for women and for men, and that they may manifest differently according to gender expectations and norms of behaviour in our society. I also wanted to acknowledge that the poor long-term social and health outcomes of the abused actually result from the failure to provide appropriate support at the time, in childhood or close to the age at which the person was abused. I want to acknowledge that survivors have enormous courage and creativity in the way that they deal with experiences that are sexually abusive, and that we shouldn't get into what I call the litany of destruction. In fact, people are very active in maintaining their integrity.

There is a polarisation of effects and impacts for survivors of sexual abuse. There is not one standard pattern of behaviour, but a move to extreme patterns of behaviour.

Probably the quickest way I can summarise my information is to talk quickly about some of the impacts. In the area of drugs and alcohol, we know that there's a very strong relationship between prior sexual abuse or sexual victimisation and problematic drug and alcohol use. Anywhere between 20 and 84 per cent of people in drug rehabilitation, detoxification and support services have a history of sexual assault.

There are very strong links between poor mental health and wellbeing and a prior history of sexual assault. I am referring to a book written by Mendel in 1997 called *The Male Survivor*, which is an excellent meta-analysis of other research conducted into sexual abuse. Studies indicate that a broad range of emotional and psychological difficulties arose in abused men and women, who report a greater degree of psychiatric symptomatology, including dissociation, anxiety, depression and sleep disturbance, than a comparison sample of non-abused men and women.

That's a continuation of the effect that you see immediately in children who are being abused, which tends not to go away after the abuse ends.

Ms Christie: Could I just add something there? The results of the 20 years of research and clinical work done by Dr Judith Herman in the United States, and studies done in hospitals, show that, if they are carefully questioned, 50 to 60 per cent of psychiatric inpatients, and 40 to 60 per cent of outpatients, report childhood histories of physical or sexual abuse.

Mr Bavinton: Yes, so if we were dealing more appropriately with trauma we may not actually have to—

THE CHAIR: As children?

Ms Christie: These are adults who present.

THE CHAIR: Yes, but they experienced the abuse as children?

Ms Christie: Yes.

Mr Bavinton: The primary difference between men's and women's experience of sexual assault is that, for men, an almost universal confusion about sexual identity arises from the sexual abuse. The needs assessment survey that my organisation conducted in 1998 found that the top issue listed by abused men was confusion about gender and sexuality: 84 per cent of respondents said that that was the primary impact.

Ms Christie: I'd like to say that, in my experience, male children, even very young male children, generally have sexual identity problems in drawing self-portraits. They'll often draw themselves with female and male genitals and have a strong confusion about that.

Mr Bavinton: Mental health workers in psychiatric and other mental health institutions find a high correlation between sexual abuse, mental illness and also alcohol abuse. This is connected to that dual diagnosis issue that we're constantly trying to grapple with in our health system.

THE CHAIR: Mental health workers?

Mr Bavinton: Yes, they find high correlations.

THE CHAIR: They find high correlations.

Mr Bavinton: Yes, not in the workers themselves, sorry. I should say that they find these correlations in their patients. A study by Glaser in 1997 found that 84 to 92 per cent of survivors of sexual abuse will develop post-traumatic stress disorder, which is one of the clearer links between a traumatic experience and developing post-traumatic stress disorder.

Other psychiatric disorders that may develop include clinical depression, anorexia nervosa, substance abuse, dissociative disorders and personality disorders. It's very common for adult women survivors to be diagnosed as having a borderline personality disorder. However, our experience is also that, if they are compliant patients, they'll be diagnosed with post-traumatic stress, but if they're non-compliant patients, they'll be given a label of borderline personality disorder.

Dissociative identity disorder, suicide attempts, general sexual difficulties and relationship problems are all experienced by survivors. In a study by Mullen, however, only 5 per cent of women in mental health institutions attributed their mental health problems to a history of child abuse, even though they were actually able to name that.

We see high levels of relational and interpersonal problems in adult survivors. Many report difficulty in maintaining employment, relationships with colleagues are difficult, they have difficulty in maintaining close intimate relationships with sexual partners or close friends, and they have a fear of men, or of women, depending usually on the gender of the abuser. There can be some level of correlation with criminal involvement, in fact a large percentage of people in prisons—of women particularly, but also men—are survivors of childhood physical or sexual trauma.

Ms Christie: Could I just add there that, in a study from a long time ago, in 1985 in New South Wales, on inmates in prisons in the New South Wales system, 85 per cent had histories of childhood sexual or physical abuse. That didn't come necessarily from the inmates themselves, but from children's court histories or earlier histories from DOCS. Also, 90 per cent of sex workers in New South Wales in 1985 gave histories of sexual abuse.

Mr Bavinton: We're also aware that an experience of sexual abuse can create a generalised sense of being different to other people and feeling isolated, even when the individuals concerned recognise how prevalent sexual abuse is. Sorry, I neglected to mention at the start that the prevalence studies indicate that about one in four girls and one in six boys will have had a sexually abusive experience by the time they turn 18.

We know that that generalised feeling of isolation or being different to others—not feeling socially connected to other people—can contribute to attempted suicides.

We're aware that many survivors of child sexual abuse report life-long poor health and pain. This may result from physical injury caused during the abuse that wasn't appropriately treated. Intrusive feelings and memories of pain can be experienced later in life. They can experience poor health because basic nutritional needs were not met if, in addition to the sexual abuse, there were also other types of neglect. They can experience a fear of being, or an unwillingness to be, physically examined by medical professionals, including dentists, particularly. Such examinations can be reminders of traumatic child sexual abuse, and this fear can actually prevent early detection and prevention of later illnesses.

Their physical health is also affected by self-harming behaviour, the compulsive or addictive use of drugs and alcohol, workaholism, sex addiction, homelessness, and other factors that influence the social determinants of health that are defined in public health policy.

Ms Christie: Some findings are that the largest commonalities among survivors of childhood sexual assault in women are dissociative disorders, eating disorders and postnatal depression. I have been part of a group in Sydney and I asked the group if they wanted to list those problems on a questionnaire. Of a group of 22 women who responded to the questionnaire, every single one of them with postnatal depression had been sexually abused as a child.

Sexual orientation and preference, other sexual problems, addictions to drugs, alcohol, gambling and sex, endometriosis, irritable bowel syndrome, gynaecological problems, urinary tract infections, herpes, anal fissures, allergies, skin disorders, chronic fatigue syndrome and obsessive compulsive disorders are some of the main effects we found in women.

Mr Bavinton: They're seen in children who are being abused, and also later in life. I won't repeat those general behavioural and social health and wellbeing issues, as we've touched on them already. In addition to the psychiatric diagnoses—many who experience difficulties such as personality disorders acknowledge a traumatic experience as an underlying cause—some survivors of child sexual abuse will find that their identity or sense of self is actually bound up in the sexual abuse, and that trying to separate themselves from the abusive experience can be quite difficult.

This can appear as generalised feelings of worthlessness or dirtiness, or it may lead to choices that are actually more detrimental to the abused person's health and wellbeing. Again, I want to acknowledge that that is not a universal experience, but that it is found particularly where abuse has continued over long periods of time or where multiple offenders were involved. People think that there's something wrong about them because many people have abused them in these different ways. This may also actually lead to the selection of adult partners in later life who operate in abusive ways.

Finally, on that issue of impact on the sense of self, pseudomaturity is a very important thing to recognise in children and adolescents. They're actually asked to behave as adults in particular spheres of their life, which can actually hinder normal development in other

areas of their life. We have to throw away normal developmental scales when working with children who've been sexually abused, because to try to link them to these standardised assumptions that don't factor in traumatic experiences will again lead them into situations where they are labelled as problematic, abnormal or different.

You can also see children who might be very good at interacting with adults—and adolescence is where this appears particularly—because that's been part of the grooming process for them, to make them available and able to interact with adults at a sexual level. Yet they may have other basic developmental needs. Their gross motor skills might be very reduced because they've had to focus significant attention on other areas of their life that they shouldn't have had to at that point in time.

In conclusion, what I wanted to say was that survivors of sexual abuse—men and women—are predominant users of mental health care facilities, drug and alcohol detox services, rehab and support services, adult correctional facilities and crisis accommodation services. We also know that sexual abuse is a significant factor in a range of social problems, including homelessness, drug and alcohol abuse, psychiatric illness, and self-harm, including eating disorders and suicide. I continues to be astounded by the reluctance of community and health service professionals to actually come to grips with those links, rather than bandaiding the symptoms that we see.

Ms Christie: Can I just have a moment to quote Judith Herman again and perhaps another couple of male psychologists? Judith Herman says her studies show that survivors of childhood sexual abuse, like other traumatised people, are frequently misdiagnosed and mistreated in the mental health system, and often accumulate different diagnoses before the underlying problem of a complex post-traumatic syndrome is recognised. They're likely to receive a diagnosis that carries strong negative connotations.

Three particularly troublesome diagnoses have often been applied to survivors of childhood abuse: somatisation disorder, borderline personality disorder—which we've mentioned—and multiple personality disorder. All three of these diagnoses were once subsumed under the one heading of hysteria. In the old days, they called it that. The common denominator of all these three disorders is their origin in a history of childhood trauma.

Psychologist Jeffery Bryer and his colleagues report studies that show that women with histories of physical or sexual abuse have significantly higher scores than other patients on standardised measures of somatisation, depression, general anxiety, phobic anxiety, interpersonal sensitivity, paranoia and dissociative symptoms.

Psychologist John Briere reports in his studies that survivors of childhood abuse display significantly more insomnia, sexual dysfunction, dissociation, anger, suicidality, self-mutilation, drug addiction and alcoholism than any other patients.

THE CHAIR: Okay. Thank you.

Ms Christie: Thank you.

THE CHAIR: I will ask a question first and then Karin might like to ask some questions. You've painted a very clear picture of the serious impact on young people of sexual and physical abuse. However, you said that it is particularly important for the abused person's long-term prospects to have a response which occurs at the critical time, sooner rather than later. Obviously, before that, prevention would be very good.

I have two questions. To help this committee make recommendations about this issue that are useful, would you tell us what the priorities for action should be, for prevention and service responses? And what is the role of schools?

Ms Christie: I see a high priority as being the education of parents about how to obtain some intervention for their children by talking to people about their children's behaviour, and checking what some of them mean. While it is not the role of schools to look after the emotional welfare of the children, I think there should be more attention given to children who are acting up at school, or perhaps more consultation with children's services. If that occurred, we might pick up a lot more of what's happening to children. We might be able to provide interventions.

THE CHAIR: I actually went to a conference where an ex-teacher gave a paper on ADD. He gave an example of a child who was diagnosed as having ADD and given medication, who had actually been sexually abused. That had ceased only a year before, and was subsequently found to have occurred. His point was that he thought this child's behaviour was a direct result of the sexual abuse, and that it was being medicated inappropriately.

I'd like your comment on the point he was making, which was that the responses to children who are said to be "acting out" are not sophisticated enough, and that behaviour—as he said—that is suddenly aberrant, if it's in a non-compliant patient, may be called a personality disorder.

Do you also think that the services or people in schools don't look at this potential cause of bad behaviour? You've said that we draw attention to the behaviour, but then is there another issue there?

Ms Christie: I think that, if attention is given to the behaviour, what then do you do with that? To me, there seems to be a gap in services for children who have those behaviours. They might be referred to mental health services, or they might be referred to behavioural psychologists and so forth. However, it seems that the education of those people about sexual assault is inadequate, so that they don't recognise that this behaviour could have a cause. They don't recognise that sexual abuse and physical abuse of children is often the core difficulty for those children.

As a worker in sexual assault for over 15 years, I have seen that there is a lack of acceptance that this is a possibility, that sexual assault could be implicated. At places such as the Canberra Rape Crisis Centre, we see children who have already disclosed some information about sexual abuse. However, children act out those behaviours. They communicate by other than verbal means. There seems to me to be a gap in understanding that this occurs.

Educating those services about sexual abuse in children seems to have been done. However, a mental health worker said to me recently, while discussing a 13 year old, that because the child was depressed as a result of a sexual assault—in my opinion depression was one of the outcomes of the assault—the worker was thinking of medicating the child because depression is the core business of mental health services. I was shocked to hear that. I know that mental health teams obviously look at this matter from a mental health angle, but "depression being the core business, so medicate" seemed to me to be—

Mr Bavinton: It does not even promote mental health.

MS MacDONALD: It is a short-term solution as opposed to a holistic solution.

Mr Bavinton: The medical model is going to have limitations consistently because it always looks to treat a sick person. Survivors of sexual assault, in our opinion, are not sick people requiring treatment. They are members of our community who have had an abusive or traumatic experience and who require support.

While we can't even talk with the mental health system to share an understanding of the client, I think we're going to face those difficulties. The medical response is always going to be to treat and to fix, but sometimes these issues can't be fixed and don't need fixing. There are people who need the support of their community to resolve the traumatic experiences, in whose recovery mental health services can play a role.

Then they can move on with their lives. We can't make it go away like we can fix a bone—we can't change that history. We need to include and support people with that history so that they can move on with their lives. We know that 95 per cent of people probably don't need ongoing counselling if they get appropriate support at the time that they disclose their abuse.

Regarding your question about priorities for action, I would think that there are two issues to consider. One is that stop-gap measures are being taken at the moment. I hope that most of what our services do at the moment will not need to be done in the future. Services are actually playing catch-up, because the appropriate response has not happened at the right time. My long-term view of my work is that there is probably always going to be a place for services that can resource our community to respond to sexual assault issues.

However, that support will be provided largely by the people who matter to survivors—their friends, family, the community around them, the significant people. When the response is coming from those people, the survivors don't need four years of psychotherapy to deal with their abuse. That's actually much more critical to recovery than any counselling response that we can provide. There'll always be some people who develop post-traumatic stress disorders who do need some kind of ongoing support.

THE CHAIR: Are you saying that it's a restorative justice approach, involving all the people close to the child?

Mr Bavinton: Those are the people from whom the child most needs support.

THE CHAIR: Yes. Is that what you do? Do you try to set up that kind of family response?

Ms Christie: Yes.

THE CHAIR: Would it be a circle of friends, or whatever?

Ms Christie: Yes. We include the significant others in our work with the child. Sometimes, where there's been a disclosure of sexual abuse, the Rape Crisis Centre does a concerns interview with the concerned carer or whoever is involved, and then may see the child with the carer for sometimes a couple of sessions. In these sessions the interviewer can see that the carer—and the members of the extended family—are responding positively to the matter, and that the child is actually receiving the support he or she needs.

Then there are other situations, of course, where the abuse occurs within a family situation, where the family takes sides. In that situation, children become isolated, and the mother may be isolated by the other family members. That is not such a happy, supportive environment at all. They tend to be the children and the carers that we need to work with over the longer term, to ensure that there is that initial response and support.

THE CHAIR: Would that circle include a teacher?

Ms Christie: Yes, it can include teachers. There are perhaps only two or three schools that will often consult with us about children. We will have meetings with them to talk about how best to support a child in the school. As Tim says, the situation where people have many supports in their everyday environment is far more the ideal than having them come into a room for an hour, once a week or once a fortnight.

The problem is that children generally don't disclose that they have been abused straight away. Often, a lot of the impact is already occurring before we get to see the children. I think there needs to be further education in the core training of, for instance, Family Services, about the impact of abuse on children.

I was in a case conference recently about a child I'm seeing who comes from a very abusive background. The person who was chairing the case conference said, before she invited me to speak about my work with this child, "I want to put out on the table that there's a whole body of evidence that indicates that counselling is not good for children who are sexually abused." She didn't provide any evidence, and a discussion ensued from that point about counselling being voyeuristic.

The principal of the school this child has attended, with whom I've had a very close association over the last months, spoke to me later about how appalled she was that a Family Services person could have thrown that out among people who are uneducated about sexual assault, to give them a totally different view of the matter. There's a lot to be done in educating such people, but there is a resistance in the community to receiving that education.

MS MacDONALD: I have a very quick question, because we are pressed for time.

Ms Christie: Yes.

MS MacDONALD: Following on from Kerrie's question, and from what you've been saying, do you think that the education of people working within schools—who are often the ones who will see children exhibiting behaviour that may indicate that they have been abused—is adequate to allow them to spot such behaviour? Do you think that mandatory disclosure is working?

Ms Christie: Regarding the first question, in the primary schools there are some principals who are very supportive of consulting. However, when you look at the number of schools in the ACT, those are a very small proportion. I think that teachers are probably very overloaded just trying to teach the children—they have said this to me—so that they do not want to take on any other roles with those children.

Where there is a problem with a child, sometimes a school will phone us and say, "Could you just come out and talk to the staff?" It doesn't happen often, or in the majority of schools, but occasionally it happens. However, in those cases I find that there's quite a resistance to hearing what we have to say. It's hard to hear. It's difficult for people to hear. This information has to be very slowly integrated into teachers' way of viewing the world, because it's not a nice thing to think that—

THE CHAIR: We don't have time to go into how you do that now. However, you are you saying that there needs to be more professional development in the area. Did you cover all your priorities for action? I know we sidetracked you.

Mr Bavinton: That's fine. I was just going to say that, as someone who does professional development training with teachers in secondary schools particularly, I find that resourcing for the catch-up service delivery, including professional development, should reflect the needs of abused people. My service was actually allocated an amount of money and asked, "What can you do for that?", rather than, "What is the extent of the need?" I realise that government really can't respond for the most part to the level of need in that way, but it would be nice to have an acknowledgement, at least, of the level of need, and to be able to say, "This is the resource that's available to go towards that."

THE CHAIR: Can you give the committee a sense of the unmet need? You could give it to us later.

Mr Bavinton: Well if it's one in four girls and one in six boys, that does not come into play anywhere in the allocation of funds. The decision is based on what financial resources we have to allocate to the issue. As I said, probably the service that's required is massive if we were to think that way. However, I think it's worth thinking that way so that we can at least recognise that there's a gap between what we can provide with our resources and what the need might actually be. We can also consider how else we can meet that need, other than just by expecting dollars to drop from buckets that the government doesn't have.

THE CHAIR: Is there anything else?

Mr Bavinton: No.

THE CHAIR: Thank you very much. If you have any ideas about the way you can raise consciousness on these sorts of issues, would you give that to the committee later? If you have seen models of professional development which have worked, in your view, perhaps you would let the committee know, because that gives us a concrete example to put to government. It would be helpful for them.

Mr Bavinton: Yes, thank you.

ANNE STANTON was called.

THE CHAIR: Thank you for coming and giving us your time. I need to read you a formal statement about responsibilities of a witness appearing before an Assembly committee.

You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. That means you are protected from certain legal actions such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Could you state your name and the capacity in which you appear, please.

Ms Stanton: My name is Anne Stanton. I'm a researcher with the National Toxics Network, and I'm on the executive committee of the National Toxics Network.

THE CHAIR: I'm aware of the group's work. Karin, would you like Anne to give you an overview?

MS MacDONALD: Yes, that would be good.

THE CHAIR: Maybe you could do that first.

Ms Stanton: Quickly, yes. This is hot off the press. This is our latest journal. I thought I'd leave some of these here. The National Toxics Network aims to increase awareness of the chemical load on the planet and supports the prevention and mitigation of pollution through appropriate environmentally sustainable technologies and policies. My particular interest is in children's health and toxics.

THE CHAIR: Would you like to address the committee?

Ms Stanton: Yes. About seven years ago I started researching this area, and I'm still finding new and shocking evidence that toxics harm children and the environment—unnecessarily, which is my point. This is all preventable harm.

Much of my information is sourced from the web. There's a handout with web resources on it to be followed up later if anyone is interested. I've also developed a number of websites to put this information together and publish it.

The most recent one is called the Tools for Healthy Schools website, which was done in association with the Total Environment Centre in Sydney and funded by Healthpact last year. A lot of the resource material in that website is from this book by Jo Immig of the Total Environment Centre, *The Toxic Playground: a guide to reducing the chemical load in schools and childcare centres*.

I'll describe the project in more detail later, but first I'd like to give an overview of the problem. Then I'll go into some detail on some of the major toxics in the environment and their impacts on health. With the project, the two areas I've been working on are indoor air quality and pest control. I'll elaborate on the current situation in the ACT in regard to pest control and indoor air quality in schools in more detail.

Why is this an important issue? The chemical revolution over the last five decades has involved the release of millions of tons of toxic chemicals into the environment—pest and weed control chemicals, plastics, cleaning agents, industrial solvents, fragrances and perfumes, and countless other petrochemical derivatives.

About 75,000 is the figure people are quoting these days for synthetic chemicals. Of those, there are carcinogens, neurotoxins and endocrine disrupters. Very little is known about even the basic toxicity of about the 3,000 most commonly used chemicals, and there's almost no data available on what effects they have when they interact either in the outdoor environment or in indoor air.

In the western diet there are thousands of chemicals in food alone.

How does this affect children in particular? They're about six times more vulnerable to toxic exposure than adults. Not only do they interact more readily with their environment by exploring it with their hands and mouths; they also breath faster than adults and they absorb more chemicals per unit of body weight. From the womb all the way to the school playground, their developing bodies are encountering increasing toxicity.

The central nervous system (the brain) and the endocrine system (immunity, growth, emotions) are struggling to develop according to the normal genetic blueprint in a world gone mad without meaningful adequate controls over toxic chemicals.

One report that has come out recently is called *In Harm's Way: Toxic Threats to Child Development*." It was put out by the Greater Boston Physicians for Social Responsibility. I'd like to read from that report:

> An epidemic of developmental, learning, and behavioural disabilities has become evident among children…
>
> These disabilities are clearly the result of complex interactions among genetic, environmental and social factors that impact children during vulnerable periods of development. Toxic exposures deserve special scrutiny because they are preventable causes of harm.

Most of the evidence I've got here is from the US or Europe, because there is so little public health or environmental monitoring in Australia. Our lifestyles and our consumer behaviours are comparable with, and our physiology surely the same as, those of Americans, yet when it comes to pesticides Australian babies are not immune to toxics, as I'll show with one of the few local studies I have found concerning pest control chemicals.

I'd like to talk quickly about neurotoxics and what they are. According to Dr Rob Apathy, who's a clinical neuropsychologist, child psychologist, in Canberra, the human brain goes on developing for 22 years. At any point in that time, but particularly in the earliest years, exposure to a toxic substance can cause permanent developmental damage.

He points out that most of the toxic substances that we're talking about have an affinity for fatty tissue—the brain, the lungs, the heart, the liver and the kidneys. So all these substances tend to accumulate in the vital organs.

He does chelation therapy with children who come to him with problems. He finds mostly lead, mercury, aluminium and often arsenic in people's blood. The chelation therapy crosses the blood/brain barrier and draws the toxin out of the tissue and into the bloodstream. He has showed me charts which show mostly heavy metals peaking in the blood and being expelled.

According to the report I mentioned earlier, *In Harm's Way*, vast quantities of neurotoxic chemicals are released into the US environment each year. Of the top 20 chemicals reported by the US Toxics Release Inventory as being released in the largest quantities during 1997, nearly three-quarters of were known or suspected neurotoxicants.

Lead is a good example of a neurotoxicant. Biomonitoring of lead in the blood of American children revealed that about 5 per cent of young children were seriously contaminated, leading to a national monitoring program for all children under 12 months old. This was on *Foreign Correspondent* this week. I don't know if you caught that.

In Australia the estimate is that 10 to 15 per cent of children are affected by lead, yet there are no federal plans to assess lead levels in children, despite prevalence of homes in Australia painted with lead-based paint.

THE CHAIR: Is that from cars? Where is the lead coming from?

Ms Stanton: From paint in houses painted before 1970—

THE CHAIR: That's still the major cause—lead paint?

Ms Stanton: Possibly schools as well.

THE CHAIR: And schools?

Ms Stanton: Yes. Last week, according to the paper, Minister Corbell rejected advice to reassess levels of lead paint in ACT schools, saying the education department has an inventory of buildings where lead is known to be and performs regular maintenance checks.

THE CHAIR: Are you not happy with that?

Ms Stanton: We're not happy with that at all. The global lead initiative is a worldwide initiative. A local person in Australia, Liz O'Brien of the lead support group, is the person who suggested to Minister Corbell that they should reassess.

THE CHAIR: But did he say that they already know where there is lead paint in schools?

Ms Stanton: Yes.

THE CHAIR: And they're monitoring what happens with it. What do you think they should be doing?

Ms Stanton: Because it's a children's environment, a school, there is extra vulnerability on the part of children, and you can't be so ad hoc about lead paint. Lead is sweet. Even lead-contaminated soil is sweet. *Foreign Correspondent* showed how toddlers tend to chew lead-based paint.

MS MacDONALD: But how do you know that it's an ad hoc approach that's being taken?

Ms Stanton: Perhaps that was a bit extreme, but I'm campaigning for guidelines for children's environment, so wherever children are spending a lot of time there should be extra assurance that there are no toxics in the environment that are going to affect their health.

MS MacDONALD: So if you were satisfied that the department did currently have an inventory of where the lead-based paints were present, then you'd consider that a program to eliminate lead paint in schools would be reasonable?

Ms Stanton: I think so, yes.

THE CHAIR: You want the paint removed?

Ms Stanton: I would say so, yes. It would be a good idea, but then removal of lead-based paint also releases a lot of lead dust, which can travel for kilometres, apparently. I'm not prescribing what action should be taken, but it should be taken more seriously.

THE CHAIR: You think it should be taken as a very serious issue?

Ms Stanton: Yes.

THE CHAIR: We can ask the government for more details about what they're doing. Please continue.

Ms Stanton: There are resources in the handout there on what other countries are doing about lead.

I turn to endocrine-disrupting chemicals. The Greater Boston Physicians for Social Responsibility, have put together another report, a follow-on report from the first one, presenting compelling evidence that human exposure to some toxic chemicals can have lifelong and even intergenerational effects on human reproduction and development.

The authors focus on classes of chemicals that people may be exposed to at work, at home and in their communities, including toxic metals, organic solvents and pesticides. In particular, I'm concerned about pthalates. Pthalates are the chemicals used to make plastics flexible. They are found in a huge range of things, from plastic wrap to flooring, cosmetics, various household products, soft toys. Pthalates are suspected endocrine-disrupting chemicals. I have another study here that says they're linked to asthma or the development of asthma in children by creating a hyperactive state in the lungs.

THE CHAIR: So the chemicals can't move from the soft toy through sucking or—

Ms Stanton: Yes. The chemical is absorbed through the skin—

THE CHAIR: Just through sucking or—

Ms Stanton: Or orally.

THE CHAIR: Through the skin as well?

Ms Stanton: Yes. The proof of that is that a recent national report on human exposure to environmental chemicals found pthalates and metabolites of pthalates in the blood of US citizens—this is in 1999—along with 13 other heavy metals and 28 pesticides.

THE CHAIR: And they have been shown to be an endocrine disrupter?

Ms Stanton: Pthalates have been, yes.

THE CHAIR: And they're in the blood of people? They've found that?

Ms Stanton: Yes. When we're talking about exposure, how do these toxics get into children in the first place. Indoor air quality is a big area. Not that they would get chronic strong exposures, but if children are in school every day, every week, they'll be getting low level but continuous exposure, which is a worry.

Good indoor air quality in schools and child-care centres means reducing or substituting with safer alternatives those products and services that contribute to the overall toxic load. Cleaning products, perfumes and fragrances, dry-cleaned clothes, carpets, furnishings, building materials, paint, art and craft supplies, glues and adhesives, classroom stationery, inks and dyes, plastics and plastic toys, soft plastic linings in food and drink packaging and food itself are all potential culprits.

A study in 1997 showed an excess risk of asthma from cleaners, but it's not clear which cleaning-related exposures induce or aggravate asthma.

There are a lot of things in cleaning products. I am concerned about solvents, in particular 2-butoxyethanol. It has a lot of other names such as ethylene glycol monobutyl ether. This solvent is approved for use in cleaning products in Australia. Approximately 1,000 tons are formulated into cleaning products in Australia each year. Workers using this solvent in cleaning products have reported respiratory irritant effects, nausea, headache and tiredness.

A number of gaps were identified in the knowledge base regarding the health effects of this chemical. I'll call it 2BE.

A precautionary approach would recommend withdrawal or regulation pending further investigation of a chemical that caused health effects like this. Instead, NICNAS has recommended that the National Occupational Health and Safety Commission use their assessment to prepare updated documentation for the occupational exposure standard and recommended that they consider whether the basis of the exposure standard should be haemolytic effects or other effects such as irritation, nausea and headache, because—and this is the final statement in the report—overseas regulatory agencies have adopted a lower regulatory standard based on these health effects than Australia currently has. Unfortunately, that's fairly typical of our regulatory authorities in Australia. They tend not to take the precautionary approach when dealing with chemicals.

A solvent comes under the category of a volatile organic compound. Most volatile organic compounds are neurotoxic, meaning that they poison the central nervous system. Things like air fresheners and pesticides used indoors will contribute to VOC, volatile organic compounds, in indoor air. Exposure to these can have several effects. They affect mood and behaviour. They can cause impairment of ability to learn, emotional instability, short-term memory loss, anxiety and insomnia.

Immediate health effects include headaches, nausea, dizziness, eye, nose and throat irritation, inability to concentrate, and disorientation, which aren't what you want in schoolchildren, obviously, if you've got them all in the one room. Long-term health effects can include cancer, anorexia, aplastic anaemia, birth and reproduction problems, and liver and kidney disease. All of this comes from *The Toxic Playground*, Jo Immig's book.

The ACT Department of Health and Community Care has a draft health action plan which includes a commitment to improving school and workplace environments in the ACT and to improving child health strategies, but there is no mention anywhere in that report of environmental toxics, which is a big oversight.

Other chemicals I've been asked to mention are the polybrominated diphenyl ethers, which are flame-retardant chemicals used in plastic casings. They've done some biomonitoring in north America on this chemical, and they've found that it appears to be doubling every two to five years in the blood of north Americans.

THE CHAIR: What sort of casings?

Ms Stanton: Plastic casings.

THE CHAIR: What does that mean?

Ms Stanton: It's used to decrease the flammability of various plastics. It is also used in polyurethane foam furniture padding. It's everywhere.

THE CHAIR: It's in foam and things like that?

Ms Stanton: Yes.

THE CHAIR: And it moves into the air and people inhale it?

Ms Stanton: Yes. I wonder about computer casings and even the internal workings of computers.

THE CHAIR: But that's doubling in people's blood?

Ms Stanton: Apparently that's growing. They did a study in 1998 in Sweden, looking at it in mother's milk, and discovered that the levels had increased fortyfold since 1972.

THE CHAIR: And what's the impact of that on the body?

Ms Stanton: This is an endocrine-disrupting chemical, I think. They're warning people against eating fatty animal foods such as meat, fish, poultry, eggs and dairy products. Presumably it's one of those that like fatty tissue. It concentrates in fatty tissue.

THE CHAIR: It's in the animals?

Ms Stanton: It's in the animals, it's in milk and it's in human milk. So it's not good news, I'd say.

THE CHAIR: We can't even eat fish. How does it get into fish? I wonder.

Ms Stanton: I think it's a persistent organic pollutant. It's so widespread they think it's in the atmosphere, as well as the water and so on.

I've done quite a lot of work on pest control in ACT schools in the last few years. One particular pest control chemical I'm concerned about is chlorpyrifos. It's an organophosphate pesticide. It's a neurotoxic chemical, so a single small dose on a critical day of development can permanently damage a child's brain, causing changes in neurotransmitter receptor levels, increasing DNA synthesis and resulting in deficits in cell numbers.

Other health effects include immune system damage. It's mutagenic in mice. It irritates mucous membranes and causes respiratory problems, tingling and numbness in extremities, inability to concentrate—it goes on. You can follow this up yourselves. Childhood cancers are also associated with chlorpyrifos.

A recent Australian study looked at the first bowel discharge of newborn babies in Townsville. It detected lindane in 78 per cent of the samples, PCP in 43 per cent chlorpyrifos in 59 per cent, malathion in 34 per cent, and chlordane, DDT, PCBs. So babies born in Australia are already carrying a toxic body load. We need many more studies like this. It's really ridiculous that there's only one.

You may have heard that just recently a review of pesticide use in Australia was put out by the Australian Academy of Technological Sciences and Engineering. They looked at sales figures that show that glyphosate, atrazine and simazine are the most widely used herbicides, and of the insecticides the most commonly used are chlorpyrifos, dimethoate, parathion methyl, profenfos and diazinon. then There are three fungicides that are commonly used.

Unfortunately, there's no detailed or publicly available data on usage of individual pesticides. We know how much is being sold, but we don't know where it's being used, by whom, in what quantities, how and whether it's being used safely.

In the ACT, it is my understanding—correct me if I'm wrong—that since 1995 we've changed the way we do things. Pest management has been reorganised into a purchaser/provider model. Providers of pest control services can be government business units or private companies that may also subcontract to private companies.

Prior to this there was a whole-of-government approach to pest control in the ACT and a manual. This was looked at by Dr Baker, the Environment Commissioner, in his report into the use of pest control chemicals, *Investigation into the ACT Government's Use of Chemicals for Pest Control*, in 1998. He said:

> … the absence of some co-ordinated arrangements for ensuring best pest management practice and minimal use of toxic synthetic chemicals in and around ACT schools is of considerable concern.

In the handout I've got a summary of the recommendations he made in that report.

MS MacDONALD: The NTN recommendations?

Ms Stanton: The NTN recommendations. We were asked to consult on guidelines for pest control in ACT schools and preschools, which we did. We're still not particularly happy with those guidelines, because they do allow everything bar schedule 7 poisons. Schedule 7 poisons are not allowed to be used in schools anymore as a result of these guidelines. But there are still five or six hazardous pest control chemicals still approved for use in schools. That's called attachment F on the schools intranet. Because the principals are responsible for choosing the pest control operator and service provider, they simply refer to their intranet and attachment F to work out what the contract arrangements are and so forth. A pest control operator now requires an environmental authorisation from Environment ACT. A couple of things have been done as a result of the commissioner's report.

Another very good thing is that the agvet chemical coordination network was set up within Environment ACT in 1998, its aim being to monitor use of pest control chemicals. I spoke to Gary Croston this week on the phone regarding how that

committee is working. Some government agencies are reporting pest control voluntarily; others are not. Unfortunately, the education department is one that is not. He says they are refusing to provide data because of independent school-based management. In other words, they're leaving it up to the principals of the schools.

MS MacDONALD: Is it that they're refusing or that they don't have the information?

Ms Stanton: They don't have the information, but they are refusing to collect the information. They're leaving it to the school principals.

THE CHAIR: Good point.

Ms Stanton: They have one auditor for the 120-odd schools in Canberra, and they're preparing an internal report annually on pest control. I have put a question in the handout. I don't know if this is appropriate or not, but I haven't been able to find this out. The environmental authorisations that they issue were recently reviewed for nine pest control providers in the ACT. In the *Canberra Times* there was a notice saying that the EPA had decided to take no action on these nine providers. I was just wondering what breaches were involved and why no action was taken on these things.

THE CHAIR: We can follow that up. The committee can ask those sorts of things.

MS MacDONALD: You're a researcher. What are your qualifications in the area?

Ms Stanton: I don't have formal qualifications in toxicology or science. I'm an arts graduate. I'm basically self-motivated.

MS MacDONALD: You're an arts graduate?

THE CHAIR: There are a lot of studies referred to here, so we can follow them up.

MS MacDONALD: That's fine. I was just curious.

THE CHAIR: I have a question on the webpage and the healthy schools toolkit. I'm interested to know whether we've got the capacity in the ACT to do these audits you're asking for. If the schools pick this up with commitment and assess chemical hazards, identify chemical hazards and follow all those steps, are there people who can do that in Canberra, and would it be a big cost to the schools or the government if they took this on?

Ms Stanton: It has cost Village Creek Primary School $200 for the day so far to have their OH&S officer go around with me and use the audit off the website, Tools for Healthy Schools—it has the audit, which is basically the same audit that's in this book—organised by areas in the school. I conducted that audit at Village Creek, and we got a low to medium hazard rating, based on the fact that I had inadequate information. This is my other point: the facilities section of the education department was asked to provide product, type and installation date for any renovations that had been done in the last five years in the school—carpeting, painting, pest control. They couldn't provide the information. They gave me a list with a year and type of renovation done but nothing more.

When I followed that up, I found Totalcare have a memorandum of understanding with the department of education to do renovations in schools, but there are no specifications or tender contract arrangements at all. When I asked Totalcare what they use in schools, whether they use anything particularly less toxic than they would elsewhere, I got the answer: "I can't remember what carpet was put in" and "We try to use water-based paints." My point is that there's no audit trail.

The OH&S committee of the education department is reviewing the use of cleaning products in schools, and they're looking at a policy document which I've put together for the website, but as it is they would like to say they're dealing on a case-by-case basis rather than doing a policy review.

THE CHAIR: So you'd obviously want to see an overarching policy that was audited, monitored, evaluated, et cetera, so we have a whole-of-government approach to chemicals in schools?

Ms Stanton: Yes.

THE CHAIR: We need to wrap up. Do you have any concluding statements?

Ms Stanton: It's no longer reasonable to assume that toxic pollution won't find its way into children and cause illness. Environment-related disease is on the rise, affecting our children's health, their development, their ability to learn and their general wellbeing.

For children who might be suffering daily toxic exposures at school or preschool, the lack of environmental guidelines is just untenable. It's a violation of our international obligations under the Convention on the Rights of the Child, so I take it very seriously. I think we should be doing something about it.

THE CHAIR: I appreciate it. Thank you very much for giving us your time today. We'll certainly look at the points you've raised, and we can ask the government about a response to some of them.

Ms Stanton: I'm happy to provide you with more. I've got things like CDs from Canada, and training manuals for your family GP on toxics. I have a lot of resources, so I am happy to provide more.

THE CHAIR: Maybe a whole body of work needs to be done, and there could be even another inquiry by another committee. I'm not pre-empting, of course. what this committee would say, but you can see there's a lot to do that we can't pick up in total. It is a really big subject. Thank you again for bringing it to our attention.

IAN MORGAN and

ROBYN CUMMINS were called.

THE CHAIR: Thank you for your submission. I need to formally advise you of your responsibilities as a witness for this committee. You should understand that these hearings are legal proceedings of the Assembly, protected by parliamentary privilege.

That gives you certain protections but also certain responsibilities. It means you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Could you both state your name and capacity in which you appear, please.

Dr Morgan: Ian Morgan, President of ACT Council of Parents and Citizens Associations.

Mrs Cummins: Robyn Cummins, Vice President, ACT Council of Parents and Citizens Associations.

THE CHAIR: Thank you for giving us your time, and your very comprehensive submission. Do you want to make a statement to the committee first?

Dr Morgan: It is probably worthwhile making just a couple of points. Obviously, the submission is based on the attitude of the P&C council, as determined through our consultative processes, so it is probably generally representative of parent opinion.

It has been informed by a certain amount of in-house expertise. Our secretary, Russell McGowan, has a particular interest in mental health problems in adolescents, so that has been a valuable contribution. I have a PhD in neuroscience and my paid work increasingly involves me in areas of public health and population health. So I have a certain amount of additional expertise in this area, but I have not inflicted, excessively, my views on the P&C council. If I do make a couple of specific points, I will make it very clear where I am drawing on my professional expertise.

The general thesis we put forward is the same thesis that we apply to investment in education—that is that early investment in preventing problems pays huge dividends in the long term. The best estimate I have seen is an estimate of about $7 for every dollar that is invested in early prevention of problems. I am pleased to say that that figure has received the imprimatur of the Prime Minister, who is now quoting that extensively.

To me, it does not seem to be a party political issue any more—early intervention is a good thing. I point out that, in the way we do our accounting, certainly these investments involve up-front costs, but, when we argue over sizes of budgets, we never look at the long-term costs of not investing, at this stage. Accrual accounting goes only so far in respect of future liabilities, and it certainly does not look at that.

As to the background for the report, we have drawn very heavily upon reports from the Australian Institute of Health and Welfare which outline very clearly the longitudinal or lifelong pattern of health risks and health outcomes. The AIHW has also released two reports with more specific data on the health situation of children, which are very valuable resources.

They are not beyond criticism, but I think there would be general acceptance of their validity. One of the very important things it has put an emphasis on—in fact, I think it has put it on the national health agenda, but it should also be on the national school health agenda—is the issue of mental health. Their figures show that, from the age of about five until you start to get the age-related cancers, cardiovascular disorders and neurodegenerative disorders coming through, overwhelmingly the most important health issue is mental health. This starts from about the age of five and continues on until the age of about 50. We put a lot of emphasis in our submission on the need to start addressing mental health issues within schools.

We would also put emphasis on the fact that, over the past 10 or 15 years, we have seen a progressive loss of school-based monitoring services for health. The dental programs have been seriously scaled back, testing for basic vision and hearing defects has virtually disappeared from the school system—and monitoring of fine and gross motor development and scoliosis has disappeared from the school system.

Whilst I think somebody needs to look at the evidence from a professional perspective, I know that there are preventive health committees in the United States, the United Kingdom and Canada, which make specific recommendations, on the basis of the most recent medical information, about what is worthwhile doing. They are doing a quite rigorous cost-benefit analysis. We would argue that the government needs to have a serious look at starting to put those services back into schools, where it makes good sense.

The other issue upon which we should comment briefly is the issue of fitness and obesity. There are numerous studies which indicate that fitness and obesity is an increasing problem in young Australians. We have been concerned about the tendency of previous attempts to address this problem to focus very much on competitive sport-related fitness, rather than general fitness and dealing with obesity.

We would also place a lot of emphasis on the need—and this applies across the board but specifically in this area—to go beyond simply identifying problems, and to provide the means of dealing with them. There is no doubt that, in some cases, issues around lack of activity and lack of fitness need to be addressed by helping to educate parents, and sometimes by helping parents more directly.

Issues of obesity are closely related to diet—perhaps to an excessive tendency to go for cheap junk food rather than to prepare healthier food. Many parents will need help to devise the most appropriate strategies. So we need to see, coming out of initiatives in this area, not just a monitoring program but a program which helps parents and families to deal with the underlying issues, when that is possible.

MS MacDONALD: Are you aware that a how-to-cook-type program has been developed, or a course is being run, for men who have recently become divorced, widowed or separated, because they do not know how to look after themselves?

I believe that there is a lessening of nutritional knowledge and how to prepare healthy, nutritional, meals occurring within society, which needs to be addressed. I think that needs to be addressed in a similar way—offering courses to men and to the general community. Do you have any thoughts on that? Clearly, it is a loaded statement on my part.

Dr Morgan: I believe there is a variety of programs of that kind. It may well be that males are particularly vulnerable to lack of culinary expertise and that they require additional help in that area. I think you would find, if you looked at data on approaches to food, nutrition and cooking, that there is a widespread need for that sort of information.

It needs to be directed generally at the community—we would agree with that—but schools also play a very important role. If you handle your health and physical education curriculum, and perhaps later on some of your optional activities, then you can start to address those sorts of issues. Children learn about food pyramids and things like that at school. A possible extension of those programs is certainly worth while looking at.

THE CHAIR: It is huge. You have covered many important points in your submission. There are a couple of specific points. I would like to understand what you think is a government's capacity to do this—and perhaps your points are not just about the role of government. For example—we will stay with nutrition—I had a meeting with student representatives of colleges and high schools and I also visited Kambah High. I want to give you some of the feedback we got from the young people.

I found it very interesting as to how many of the high school students at Kambah were asking questions such as, "How come, in our society, we are exposed to so many things that are bad for us? No-one tells us they are bad for us, and the advertisements tell us that we should eat them."

They also asked, "How come there are all these food additives that are bad for us?" I found it really interesting. In a way, it was a naïve question—yet a totally legitimate question from young people—to ask, "If it is so obvious that there are a great many people in Australia dying from diseases which are related to what they eat, how come it is always out there?

You have said here that there should be an attempt to reduce negative lifestyle choices being promoted by the media. This is clearly an issue, so how do you imagine that that can be addressed?

Dr Morgan: We do not have specific recommendations on that, but we have seen areas where this has been done. This has been an area of debate around the attitude towards smoking, so we have a lot of precedents as to how we might deal with it.

Over the years, we have seen attitudes to the advertising of smoking going from a stress on having, at the same time health warnings, to progressive banning, to the active promotion of anti-smoking messages. We are probably going to go through the same process—and we have already gone a little way down that track—in relation to alcohol.

THE CHAIR: What about fast foods?

Dr Morgan: That obviously is an issue that is promoted. Somebody needs to do the detailed economic analysis, first of all, to determine the real impact of fast foods. In general, they are high fat, high sugar, low fibre, processed cereals—all the things which it is generally accepted provide dangers. If the operations of an industry like that have long-term economic impacts on the community, you do have to think about pointing them in more healthy directions.

MS MacDONALD: Ian, I recall that there have been studies done in Australia, as well as overseas, on the number of preventable illnesses seen in our hospitals which are caused by what we put in our mouths—whether it be a cigarette stick, with tobacco, or a McDonald's hamburger, which is loaded with fat and contains a very limited amount of fibre or nutritional value. There are studies already out there which show that society would reduce the amount of illness seen in our hospitals if we were to take action to reduce—not cut out all together—the amount of soluble fat we consume.

Dr Morgan: I am sure there are lots of studies that address parts of this issue. This is not my own area of expertise, but what I suspect is not out there is a comprehensive study that looks at the overall impacts, and the source of those impacts.

For example, there is plenty of evidence to show that a combination of high fat and high sugar products is not desirable. I suspect there is less evidence on where the overall impact comes from—whether it does make sense. Anecdotally, people would accept that the fast food industry has a certain responsibility in this area.

I think we would need the solid data, before we moved on to some sort of positive regulation. The important thing in what you said is that whatever regulatory regime you go to, it should be one that is sustainable. In other words, it is not a matter of completely eliminating certain kinds of products, but making sure that we get more balance back into our diets.

MS MacDONALD: Reducing the reliance on fast foods and take-aways, as being part of life.

Dr Morgan: Issues of advertising are important there. It may well be that, as we started to introduce, for example, differential taxation regimes on high and low alcohol beverages, there needs to be some sort of cost premium put on some of the products that are regarded as less desirable. Speaking now as a shopper in a supermarket, if you go hunting for low-salt or low-fat products, you often find that they are the ones that carry the cost premium, rather than the other way around.

MS MacDONALD: I can say, having just come back from overseas and having been into supermarkets in the United States, that at least you can find them here in Australia. I am sorry to digress, but I was at a supermarket check-out in the United States and there were chocolate peppermint patties labelled as low fat.

Dr Morgan: I know the problem. We are definitely ahead. The range of healthy food we find in our supermarkets is exemplary, compared to that which you find in most countries in the world.

THE CHAIR: Yes, we have a lot of choices.

Dr Morgan: We are quite sophisticated in that. However, one of the issues is making that sophistication more general. One of the points I did not emphasise in our submission—but it is a very strong one—is that not only are there correlations between low socio-economic status and particular backgrounds and low educational outcomes, but there are those same correlations for health outcomes.

The issue with the indigenous community is the clearest, where they are facing an epidemic of diabetes. They are also facing an epidemic of low educational outcomes. In reality, those things are very closely related.

THE CHAIR: Moving on to the other comments you have made here about mental health and how important it is with the students we spoke to, especially with the student rep group that we saw, mental health came up as a major issue, as did sexually transmitted diseases and sex education. They were very concerned about fitness testing because of the impact on self-esteem. You have covered all those issues in your submission. I know you said in your submission that you are not doing detailed analyses of the programs, but telling us what we should be aiming to cover.

In light of the comments in the media in the past week about burnout for teachers, and pressures on teachers, this submission is requiring greater capacity from teachers, in some way, which I understand. What is your response to people who would say, "Hang on, they have already got too much—we know that"? Is this about more professional support or smaller class sizes? How do you think teachers can increase their capacity?

Dr Morgan: Anything that gives teachers more time to deal with fewer students is a step in the right direction. In general, we would argue that, given the sorts of outcome measures—both educational and health—and their correlations with a lot of background factors, we ought to be targeting some of these initiatives, rather than making them general, across the board. We would argue, for example, that reduction of class sizes probably needs to be targeted to specific schools, rather than be made general. We would get more out of our limited resources.

As to your specific question, clearly it is going to be a mix of things. One thing that we think is very important is professional development for teachers. Let us take the area of mental heath. It is really important that teachers receive professional development so they are more able to detect early signs of problems and are more prepared to attempt to deal with those.

Being more prepared to deal with them is, in the final analysis, going to mean more para-professional support and more services to refer children on to. It is very clear—and any teacher who is involved in a school will tell you this—that they often have quite good networks already within the schools for detecting problems, be they mental health problems or other sorts of social problems, but they have nowhere to go. Identifying the problem, at this stage, tends—unless it becomes really extreme—to put additional pressure on the teachers to try to cope, and try to do something.

So it would have to be a combination. Professional development is really important, so that teachers are more aware of mental health as an issue. But this is a general issue. Teachers also need to be more aware of the implications of asthma and allergic responses in students. I am just picking things out of the air. There is a whole range of things that teachers need to know more about, but they need to be backed up by appropriate professional services.

THE CHAIR: Appropriate and accessible, yes. There was very good feedback from the students about the Bay, for example. They really liked the fact that there was a resource there. There was also feedback from them which you have raised before, in different committees that you have contributed to, that the type of service has to be one that is confidential and non-threatening to the students.

Dr Morgan: Absolutely.

THE CHAIR: On the mental health issue, it was quite disturbing to hear how many of those student reps had experienced firsthand a peer who was considering, or who had considered, suicide. Some of them felt that they did not know how to handle it. Others said that they tried, but did not know where to go for extra help. We are inviting VINE to speak to this committee and give their response to that. It was quite concerning to realise that there is such a high prevalence of that.

Dr Morgan: There is a lot of data on the evidence on depression in young people, and depression is undoubtedly a major problem. The links of that and other forms of mental health problems, through to youth suicide, are almost intuitively obvious.

THE CHAIR: We then get to the social health question, to a degree, don't we? You mentioned social health and I am really interested—I know we do not have time now, although we can go a little over, because we have a morning tea break. This has come up with a question about values education and religious instruction in schools.

Do we need to be looking, as a committee or as a society, much more carefully at what the term 'social health' actually means? I wonder if there is a whole area here. It is starting to be discussed a little bit and there has been almost a fight, unfortunately, about whether or not we have religious instruction in schools. But I think there is something at the centre of that which is really important. I wonder if you have a comment on that.

Dr Morgan: Social health is a huge issue, because it covers everything. At one level, that would address all the problems that lead to what is a well-documented spiral out of the education system, the health system and the employment system for indigenous kids, for example.

In that broad sense, there is a whole set of important social health issues, and they do need to be addressed. They are spectacularly marked for the indigenous community, but they are very generally applicable—just sticking to the ACT for the moment—to kids from lower SES families. The same sorts of issues, on average, tend to arise, although perhaps not as starkly as with indigenous kids. Clearly, there are issues about creating self-esteem in communities, and in kids from particular kinds of backgrounds that need to be handled very sensitively in schools. Once again, we are looking at a really big picture now.

One of the things the P&C council is going to put on the agenda over the next two or three years is the importance of looking at these sorts of issues in relation to teacher education. They want to make sure, for example, that teachers who are, almost by definition, middle class—largely in background and in their current existence, get an education which tells them something about the inequalities and differences in Australian society, which makes them sensitive to those matters and sensitive to appropriate ways of addressing the issues which flow from them.

This is a very big issue. I will give you a specific educational example of this. Recent ACER data shows that, on average, in their year 12 results, kids from indigenous backgrounds score 15 points lower than the average, and that kids from Asian backgrounds score about 15 points higher. This means that family and community background in Australia can make a 30-point difference in your TER score. This swamps anything else that happens in the education system.

These sorts of factors are very important determinants—and what is true for educational outcomes is almost certainly true for health outcomes. We certainly know that, from the statistics on health outcomes for indigenous people, they are really—

THE CHAIR: What about mental health outcomes? Is that as closely correlated?

Dr Morgan: This is where you will have to get expertise. I am not aware of data on mental health outcomes in indigenous communities.

THE CHAIR: No. I meant, across society, the relationship between educational outcomes and mental health outcomes.

Dr Morgan: I do not know that anybody has done that in real detail, but those are issues which need to be addressed.

I want to make a comment on another aspect of that. You have mentioned the issue of sexually transmitted diseases as being one of the things that the students raised as an issue. I think there is a quite complicated debate which needs to be had around sex education in schools. I refer to the recent debate around religious education in schools—I will not even call it a debate.

THE CHAIR: Yes, unfortunately it was not, but we can have a debate on it. We can talk about it.

Dr Morgan: It has put that into stark relief. One of the things we need to do in the school system—I would explicitly say we need to do this not only in the government school system, but also in the non-government school sector—is to ensure that all schools in Australia provide appropriate public health education as part of their curriculum.

What they choose to teach when it comes to religious education, values and attitudes to that public health information, is another matter. However, there are certain public health messages—for example the public health message about safe sex, which was so important in ensuring that Australia did not have the epidemic of AIDS that other countries have seen.

It ought to be an obligation of all schools to convey that message to all kids. What they choose to do about it, in the light of their religious education and values, is a different matter.

THE CHAIR: Thank you, Dr Morgan.

ROD KATZ and

TONY SHIELDS

were called.

THE CHAIR: Welcome to representatives from Pedal Power. Thank you for giving us your time. I need to read you a statement regarding your responsibilities as witnesses at an Assembly inquiry.

You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Could you both state your name and the capacity in which you appear today.

Mr Katz: I'm Rod Katz. I'm a member of Pedal Power.

Mr Shields: I'm Tony Shields. I'm the advocacy team leader from Pedal Power.

THE CHAIR: Thanks for your submission. Would you like to talk to the submission, and we can have questions afterwards?

Mr Katz: I've got some notes which Siobhan is very kindly copying and will hand around, so you don't need to take notes.

Firstly, thank you for having us here today. It's certainly an issue that is vital to the future of society. I should say by way of introduction that Pedal Power is probably well known to the people here, but it is a community group with approximately 1,500 members. It seeks to promote cycling, because we see it as a great means of transport and recreation. It's fun, it's healthy, it's safe, it's sustainable and it's pro-social.

I should say something about us as well. Tony Shields is the past president of Pedal Power and also current advocacy team leader. I am a transport consultant professionally with a longstanding research interest in bicycle use and education. In fact, I did a PhD in demand for bicycle use in urban New South Wales 10 years ago. More recently, I've worked with the NRMA Road Safety Trust in developing a curriculum for years 7 to 9 students on transport issues. That has yet to be piloted, but I'm hopeful that that will be piloted in the near future.

Pedal Power obviously has an interest in school-age children for two reasons. Firstly, they are a significant group of the current cycling population and, secondly, the youth of today are the decision-makers, the road users and the cyclists of tomorrow.

What do we see as the major challenges to children's health? I'm sure many of the people who have presented to you previously would have cited the decline in the physical activity of school-age children. That's causing physical ill-health.

In addition to that, there is a decline in the independence of our children. Today I think a lot of commentators refer to the battery child syndrome. They're taken from box to box by their parents in a car, then to the school, a classroom and a carefully confined playground, and they're taken home in a car and put in front of the box. We see that contributing to emotional and social ill-health.

These declines can be at least partially attributed to a perception that outdoor settings are unsafe due to traffic and stranger danger. Those are the issues that we believe policy should be addressing—traffic and stranger danger.

For any good policy to be worked out for the issue of physical activity particularly and children's health generally, we believe we need a framework for setting policy. Many people may have presented to you the recent work in the public health promotion area, the activity promotion area in particular. Much of that work promotes a settings approach, which makes a lot of sense as a way to attack the issues.

In this presentation I'd like to talk about school settings and non-school settings. For school settings, one of the first issues is getting to school. That's a tremendous lost opportunity at the moment for increasing the physical activity of our children. Mum's taxi, or dad's taxi to a lesser extent, is probably the major form of transport to our schools. That carries with it all sorts of problems—many costs associated with traffic congestion, et cetera around schools, as well as the ill-health that it brings with it.

THE CHAIR: You said it probably is the most common form of transport.

Mr Katz: Yes.

THE CHAIR: Do you know that? Are there any studies to show that?

Mr Katz: I don't have figures for the ACT.

THE CHAIR: It's more anecdotal, is it? But you do have figures for elsewhere.

Mr Katz: Studies have been done.

Mr Shields: I've got some figures from the UK. This is all pretty rusty in my head. Something like 20 years ago, 70 per cent of kids used to make their own independent way to school, and now it's something like 8 per cent. I suppose a similar thing has happened in Australia. I suppose we can find those figures.

THE CHAIR: I don't know if we know that. It was just interesting. It's about schools and where they are located. It could be quite different in the UK. Please continue.

Mr Katz: You mention school location. Obviously that is a crucial thing, and that's something we need to look at in the overall policy settings. I think we need to encourage people to use schools that are close to where they live, and we need to

review things like school closures in the light of the impact that that will have on pupils' transport choices.

MS MacDONALD: I think you also need to keep in mind that the changing demographics mean that schools aren't being built where the children are. It's not just the school closures.

Mr Katz: Absolutely, not just the school closures. Yes, I think that's a very good point. That's one overall issue that needs to be addressed.

Initiatives we can look at include car exclusion zones, which have been tried in various places. A boundary of about 500 metres, or 300 metres in some cases, is put around a school and cars are forced to drop off pupils at that perimeter. I can imagine that there would be a number of problems with instituting that in the ACT, but that's not to say it's not something that could not be considered. At least in that way students would get the opportunity to do some walking during the day, and it would also reduce some of the congestion problems and safety problems around schools.

In order to encourage parents to believe that it's acceptable for students to access schools, we need to make sure that there are safe routes to those schools. A number of programs have been instituted in various parts of the world to promote safe routes to school. They have been looked at but not implemented, as far as I'm aware, in the ACT.

Obviously if we can incorporate good bicycle parking in schools, then that would be a big incentive for students to bring their bicycles to school and know that they're safely locked up and won't be stolen. It is possible to encourage children as young as three to pedal to school. You might be surprised by that but there are a number of innovative schemes in the UK. Tug-a-tots, which are one-wheeled bikes that clamp onto the back of the parent's bike, are rented out in a rental system. That sort of thing allows toddlers to get into the habit of riding a bike to school and not being in a box.

They're a number of physical measures. There are also various educational measures. I've split those up into primary, junior secondary and senior secondary. At the primary level we can do things like having a walking school bus, where one parent will go around and collect kids from various houses, so you'll have a row of kids walking to school. That's been trialled very successfully in a number of places. That takes the stress away from the parents who might think that they're a bad parent if they don't drive their kids to school as all the other parents do.

Bike Ed is a program that's been running in the ACT for primary-age children. It's not comprehensive and it's quite limited in its use. It's quite a good program. $300,000 of BP money went into redeveloping it a couple of years ago, and it does work in giving confidence to primary-age children and some awareness of road issues. It's not enough, though, to think that by them doing that they can be set free to roam the streets by themselves.

Other measures that are useful are bicycle rodeos, as they're called in the United States, and the Belconnen Traffic Centre, which is a great resource for encouraging children to learn road rules and use their bicycles.

The junior secondary level is where real commitment is required. It's at the ages of 12 to 14 that students desire independence. They want to get out by themselves for any number of reasons, not the least of which are romantic reasons. There is a great incentive for students to shake off the shackles of their parental guardians and they seek that independence.

This needs to be encouraged if we want to encourage that emotional and societal healthiness. How do we do that? We can't just say, "Go. I'm sick of you in the house. Leave." We need to provide them with the strategies to cope. That's where we can look to various aspects in the school curriculum. I've put down on this sheet the PE curriculum as an area where cycling can be encouraged and walking can be encouraged. PE doesn't have to be about competitive sport. Indeed, competitive sport may not be the best way to encourage physical activity in children. Many children are put off by the competitive element, and we need to look at alternatives for those children.

One of the great possibilities for encouraging independence and a sense of real achievement in children is to allow them to go on bicycle rides. These can be short ones to explore the local neighbourhood, day rides or, as has been done very successfully by some committed teachers in the ACT, a series of rides that build up to a trip to the coast. That provides a tremendous incentive to students, and they get such a feeling of achievement from doing that. The reports from those teachers are very positive.

I'd like to mention the SOSE curriculum, the study of society and the environment curriculum, which at the moment lacks any great discussion of transport issues and the effect that transport has on our environment and on our society. That is what the curriculum I have been looking at developing can promote. Considerable work has been done on it already. It can help to make students aware of the need for physical activity and the impact of car use on their physical health.

Recently a study has been done in the UK. Siobhan has very kindly done copies of a summary of that study, which showed tremendous potential for getting students to examine their transport behaviour and their levels of physical activity in that.

At the senior secondary level, in transport education in the ACT, we have the road ready program, which is focused very much on that great rite of passage, the achievement of the drivers licence. That is very good as far as it goes, but in no way does it attempt to put driving into context by saying that driving is probably not very good for you; that the alternatives to driving can be good for you and can be good for society. That is something that can be improved in the road ready program and the road ready curriculum so that there is some level of balance; it's not just all about senior secondary kids getting a drivers licence and driving around. Independence can be achieved differently.

THE CHAIR: What's the road ready program?

Mr Katz: The road ready program was introduced two years ago, and it's preparatory to getting L plates. It's run in schools. It's certainly a vast improvement on what there was before.

MS MacDONALD: Nothing.

Mr Katz: It allows students to get their L plates six months earlier than they would otherwise get them, but in return for that they have to do some work. They have to go through this course. I believe it's 10 hours.

THE CHAIR: You think there should be more in it about using other forms of transport?

Mr Katz: Absolutely.

THE CHAIR: Does it deal with being a bike rider next to a car, that sort of thing?

Mr Katz: Minimally. Not at all.

THE CHAIR: There's potential there too.

Mr Katz: It covers it to the extent that the existing traffic regulations mention cycling. It is not very much.

THE CHAIR: So there's potential to make that a more useful experience You could even do practical stuff, riding a bike on a road and find out what it's like.

Mr Katz: Yes.

THE CHAIR: It might make you more considerate as a driver of a car.

Mr Katz: Yes. Those are the school settings we've mentioned. There are many others, but we're conscious of the very short time.

In non-school settings, there are transport settings, obviously. We believe that traffic demand management, traffic calming measures, slow-ways and speed reduction programs can make the environment much more conducive to using active transport—walking and cycling—and public transport.

Initiatives can be introduced to make public transport a more attractive alternative to the car. Once people use public transport, they're also walking, which is a desirable thing.

From a cycling perspective, we believe that public transport could be enhanced by the bikes-on-buses initiative which we've been harping on about for many years now. But we hope that we'll get there eventually. And we need to look at other concessional bus travel issues for students and bus safety promotion.

Sports and recreation programs are another setting that we can look at to encourage physical activity. As I mentioned before, we shouldn't look just at competitive events in that setting. I think we need to look at non-competitive activities—cycling, walking.

Behavioural programs in the transport area and in other areas are another setting which we can look to—travel smart and travel blending are programs you may have come across. One has been trialled in the ACT, and we'd certainly strongly encourage that to be introduced, with an emphasis on how schoolchildren get around and the ways that they fill in their days.

One thing that I didn't mention on this list of settings is the medical setting. Obviously people turning up to their GPs can be encouraged to pursue healthy lifestyles in a number of ways. We'd strongly encourage GPs to be proactively saying, "Take a walk around the block," "Ride your bike to school," "Ride your bike to visit friends," et cetera. I think that is another policy setting that needs to be encouraged. It requires an education program for many of our doctors, speaking as one who's married to one.

I come to prioritisation. We believe that cycling promotion policies deserve to be at the top of the list of policies for improving children's health. It may not seem obvious that it cuts across a number of areas. We believe that cycling can be very beneficial for children's health, for three reasons—for their physical health; for their social health, being out of the box, mixing more with their community; and for the emotional reasons, the sense of independence and achievement that you get from going under your own steam from place to place. I don't think any of those things can be underestimated. We think that pro-cycling policies can be enormously beneficial.

Obviously cycling has benefits from a safety perspective. Cyclists, as they go through their youth, are less likely to run people over in fast cars and are more likely to develop road user skills.

Cycling is sustainable and non-polluting. People who start out cycling will hopefully continue to be cyclists. Promoting cycling, we believe, is cheap, compared to other measures. For those reasons, and the considerable community support that cycling has, we'd endorse the measures that we've set out here as a good way to go to promote the health of school-age children. Thank you very much for your attention.

THE CHAIR: Thank you very much for your submission. The submission from the P&C said that, excluding infant deaths, injuries account for almost 50 per cent of deaths in the one to 14-year-old group, with traffic accidents including bicycles, pedestrian accidents, poisoning and drownings being major factors. I don't know how many of those were cyclists. But I know that that can be a reason that parents are reluctant to let their children cycle.

Mr Katz: Absolutely.

THE CHAIR: You talk about having a safe route to a school. Could you go into more detail about how you would envisage that would work?

Mr Katz: Some of the programs that have been done have involved schoolchildren investigating safe routes themselves. They're given a project and told, "We want you to devise the safest route you possibly can from your house to the school, and we want you to mark the dangerous spots on that route. This provides incredibly useful information for schools to figure out what treatments can be suggested to the road authorities at those danger points along the routes.

THE CHAIR: Empowering for the students too.

Mr Katz: Absolutely. That's the sort of initiative that can be done.

THE CHAIR: And do you recommend that the students ride on footpaths or on roads?

Mr Katz: It depends on the student. For anybody under 10 you would not recommend many of the roads. But even for children under 10, if they are supervised by an adult in front and preferably an adult behind, then it's not a problem to ride on the roads. If they are by themselves, I think most parents would feel more comfortable with them riding on footpaths. It may not necessarily be safer. That is the only caveat.

THE CHAIR: Because of driveways?

Mr Katz: Exactly. So I'm always very keen to provide good education to students as to how to be vehicular cyclists, to ride as they would expect any other road user to behave so that they are predictable. Students, at an incredibly young age, are capable of absorbing the fundamentals of vehicular road use. That's the sort of program I would be encouraging through bike ed at the junior high school level.

THE CHAIR: Bike security is an issue for kids My son took to school a bike that he made that was worth nothing, just because he was so concerned about his bike that he valued being stolen. How do you see that working? I know one school had an enclosure where they locked the bikes up. I guess it's where you locate that enclosure, isn't it? But there were still incidents.

Mr Katz: There will always be incidents, unfortunately.

THE CHAIR: It's giving it a priority, though, isn't it, to have an enclosure at least? Do you know how many schools have enclosures?

Mr Katz: Quite a number do. It's quite interesting how many bikes you'll see in those enclosures. In the ACT, it is still quite a popular method of getting to school, I'm pleased to say. Unfortunately, I don't see it increasing. I see it going the other way at the moment unless we take steps to address—

THE CHAIR: Why do you think it's going the other way?

Mr Katz: Because of those parental perceptions that it's unsafe and—

THE CHAIR: So there's a role for schools here?

Mr Katz: Yes.

THE CHAIR: To set up these projects where students work out safe routes, et cetera, you think would be good, as well as the physical education taking into account cycling and getting behind it? How do you do that in providing equity to all kids? Do you think schools should own bikes that they can let kids that don't have bikes use?

Mr Katz: That's a difficult one. If the resources were there, that'd be fantastic. But I don't think the resources are there at the moment to equip schools with enormous numbers of bicycles. In New South Wales, they have a CARES product, which is basically a trailerload of bikes that goes around from school to school. That's a good way of providing practical input and practical bicycle lessons.

The Belconnen Traffic Centre has bicycles for the primary school-age children, so that's not bad, but we need to make sure that the use of that centre is maintained.

I think we can do an enormous amount without involving bicycles, quite frankly. That may sound funny coming from somebody from Pedal Power, but teachers are going to be very wary of getting their students outside on bikes. I think bikes are a major obstacle, because teachers consider them a nightmare, from a liability viewpoint and various other viewpoints.

I think we need to maximise the amount we do in the classroom with fabulous audiovisual media, website stuff, the use of safe routes to school, and then have extension programs running from that for the students who can see a role for the bicycle for themselves, who can see themselves on bicycles. In that way I think we'll target the students who are most likely to use them and hopefully encourage students who might not have otherwise thought of themselves as outdoorsy cyclist types to get out and use bikes. It's not threatening. It's not competitive—"Am I going to get beaten by little Johnny or Mavis down the road?"

MS MacDONALD: Do your kids cycle to school?

Mr Katz: She's only six, but she does on the back of a tandem, which is great. She loves it. She's one of the few children who do at that age. But she's also got the strongest legs of any kid in her class.

THE CHAIR: Thank you very much.

RICHARD WINDSOR and

BERYL GOVER

were called.

THE CHAIR: Thank you for giving us your time. Before we commence, I have to read you a statement regarding responsibilities of witnesses. You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means you're protected from certain legal actions such as being sued for defamation for what you say at this public hearing. It also means you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Could you both state your name and the capacity in which you appear, please.

Mr Windsor: My name is Richard Windsor. I'm the President of the Canberra and Queanbeyan Attention Deficit Hyperactivity Disorder Support Group.

Mrs Gover: I'm Beryl Gover. I'm the Vice President and lifetime member of the Canberra and Queanbeyan ADD Support Group.

THE CHAIR: Would you like to talk to us about the issue?

Mr Windsor: As a support group we experience perhaps the most negative of all ADHD experiences, so from that point of view we will have a perceived bias and probably a degree of emotional attachment which is very hard to remove, but we'll try.

As a group we believe attention deficit hyperactivity disorder, or ADHD, constitutes a significant health problem for children in the ACT. ADHD has been recognised in the literature since at least 1902 but has been described by very many terms, including minimal brain dysfunction, minimal brain damage, hyperkinesis, hyperactivity attention deficit disorder and attention deficit hyperactivity disorder.

The descriptions of ADHD are usually based around the American formal clinical description which is lodged within the diagnostic and statistical manual version 4R, the 4R standing for 4 revised. ADHD in this setting is described purely in behavioural terms. The stereotype of the hyperactive child has dominated the public perception and dominated the medical fraternity's perception of what constitutes ADHD.

However, modern research is showing that ADHD is far from being a behavioural disorder. It is in fact a complex neurological disorder involving failure of normal pathways in the brain to develop, of failure of normal metabolic processes in the brain to proceed.

There is at the moment a process being undertaken in the United States, headed by Professor Russell Barkley, to rewrite the diagnostic and statistical manual, which will now be version 5, to accommodate the changes in the understanding of the nature of ADHD, to take away the reliance on subjective, descriptive terms relating to behaviour and replace them with objective, measurable terms relating to neurology, neurochemistry, neurophysiology and anatomy, so that we then may have a picture of ADHD as a brain, physiology and anatomy problem which results in some sufferers in perverse and diverse behavioural abnormalities, together with a wide range of learning difficulties.

We believe that the learning difficulties aspect of ADHD has been grossly misrepresented and—I've lost the word—not accepted by the professions when it should be. So we have a skewed perception in diagnosis, a skewed perception in treatment and a very much skewed outcome in that we are not giving appropriate treatment to any of the people who are diagnosed with ADHD.

The federal government recently had an inquiry or a study, and they found that over 14 per cent of school-age children suffer from a mental disorder, of which 11.2 per cent suffer from ADHD in its behaviourally described character. We believe this is an under-representation of the true extent of the problem.

What is ADHD? It is in fact part of the normal spectrum of human development. It is not an either/or situation. ADHD is multifactorial. There are a number of aspects to ADHD. There are a number of aspects of the neurological disregulation. There are different neurological pathways which are disregulated. It is only when such disregulation causes harm or disadvantages a person or disadvantages other people around that person that ADHD is diagnosed and considered a problem. If you scratch any person, you will find some aspect of disregulation. So it is very hard to draw a cut-off as to where normality ends and ADHD begins. In fact, I would argue that ADHD is probably more normal in this day and age than most people would ever dare to guess.

ADHD is dimensional. You may have a lot or a little. Its dimensionality is reflected also in the expression according to place or setting. In one environment you may not express any disregulation. In another environment you may express a great deal of disregulation.

This is particularly relevant to schools, where the quality of teaching becomes an issue. We have an example where a child placed in a school with a teacher who, for want of better, employed a very rigorous style of teaching. The child was on the most phenomenal level of medication, 20 Ritalin a day, because he was so stressed. He changed schools, changed teachers, and he's back on to—

Mrs Gover: A lot less.

Mr Windsor: Something like what approximates a normal dose of Ritalin and his schooling is progressing at a rapid rate. This is just a change in setting that has changed—

Mrs Gover: He doesn't come home with anger and frustration.

Mr Windsor: So it really does spill over. ADHD is considered to have many beneficial characteristics as well. It is not a pathology, although it has some pathological overtones, but it is also highly associated with creativity. Writers, visual artists, actors, entrepreneurs, sportsmen, risk takers, people who are pushing the boundaries all have a component of ADHD which is very strong. You might reflect upon the fact that artists, writers and musicians are renowned for their abuse of drugs and alcohol. Many writers are renowned for their absolute financial incapacity, and many entrepreneurs likewise. You've only got to look at the current inquiry into HIH and the absolute brainlessness of Ray Williams, who is saying they cannot pay claims for creditors for insurance policy holders but goes and blows $30 million on fripperies.

THE CHAIR: I heard about the first class seat for the briefcase.

Mr Windsor: This is a characteristic of ADD/ADHD behaviour—failing to perceive the consequences of an action and failing to see an action in its social context. We penalise our kids at school very heavily for stupidities such as this. But people who are in a different setting, high fliers in the business world, seem to be able to do it with a great deal of impunity.

ADHD, in behavioural terms, is situation dependent. It is mediated by stress. Or put it this way: the adverse behavioural things are, to a certain extent, stress related. Change the level of stress for the better and behavioural symptoms may well disappear. I don't know whether Ray Williams will change his behaviour if he goes to jail when he has no stress on him, but that's another thing.

Things that can change ADHD behaviour include diet. This is a contentious issue, but a large number of placebo-controlled double blind studies have shown no influence of diet. But these studies are designed to minimise individual differences and to show broad trends.

Dietary interventions can be very idiosyncratic, very individual. I can attest to that from my own personal experience, because only a month ago I discovered that I am milk intolerant. As an ADHD sufferer, I have been able to eliminate my stimulant medication by the simple expedient of not drinking milk.

Mrs Gover: Do you want to mention Sue Dengate?

Mr Windsor: There is an ADHD support group based in Darwin chaired by a woman called Sue Dengate, who has written extensively on diet and ADHD and maintains a website for parents with ADHD children who are concerned about diet. The number of stories that come to her attention about particular food additives in diet is somewhat extraordinary.

But it goes to more than that. ADHD is not only a neurological dysfunction which moderates conscious behaviour. It also moderates immunology and it moderates all body processes. ADHD sufferers frequently have gastrointestinal malfunction. They are poor producers of digestive enzymes. They suffer from leaky gut syndrome and irritable bowel syndrome. These things lead to the development of quite profound

vitamin and mineral deficiencies. It's well recognised that ADHD people are zinc deficient and frequently B vitamin deficient. Frequently just those two additives to the diet can make a very significant difference, particularly zinc.

Mrs Gover: And calcium too.

Mr Windsor: And Calcium and magnesium.

Mrs Gover: Can calm them down.

Mr Windsor: ADHD sufferers also have poor dietary discrimination. They tend to be junk food eaters. They tend to be very heavily swayed by advertising and by peer group pressure. Their dietary discrimination frequently leads them down the path of a high-fat, high-sugar, no-nutrient density diet. They tend to have worse dietary outcomes.

Mrs Gover: They find it difficult to chew. They will always choose food that's easy to eat. If you give them a piece of steak, a chop or something that's difficult, they'd rather go for a sausage or mince or, as you said, the quick food.

Mr Windsor: They also suffer from food allergies and sensitivities. Of great importance is the problem of allergy to grains and dairy products. Two proteins—alphagliadin in grains and casein in milk—give rise to neurotoxic breakdown products which can cause neurological sequelae. As ADHD is a neurobiological problem, any additive load of excitotoxic substances or substances which are nerve toxins make the system so much worse.

They are also very sensitive to inhalants and the formaldehyde which comes out of new carpets and out of furniture. Furniture manufactured from particle board can be enough to hospitalise some children.

ADHD sufferers are affected by poor quality lighting. There are two aspects to this. One is a susceptibility to glare, or photosensitivity, and the other is a spectral sensitivity, sensitivity to an incomplete spectrum. One of the really interesting studies done was on the provision of full spectrum lighting for schools, which not only benefited ADHD students remarkably but in fact benefited all students.

THE CHAIR: What does it mean?

Mr Windsor: With full spectrum lighting, the light quality is as close as you can approximate natural sunlight in its content of red, green and blue.

Mrs Gover: Constable Steve Neuhaus runs groups out at Wee Jasper or Eagles Rest. He gets the kids—usually ADHD kids, undiagnosed—into the natural environment. He likes to have them there without medication. They go on camps and they learn to work together, and they're really great. He said as soon as he comes back and hits the lights of Yass they all change back into what they were before. It's just incredible.

The other thing I want to point out is that Sue Dengate's report is going into the *Paediatric Journal*.

THE CHAIR: We have a submission from her.

Mrs Gover: That's good. That's very interesting. One of the best outcomes of the double blind placebo trials was that everyone's learning improved. That's important for school tuckshops to take notice of.

Mr Windsor: There have been a significant number of studies showing that if you radically alter the diet offered at school tuckshops to eliminate a number of suspect items—particularly the aso dyes, including tartrazine yellow, food preservatives based around propionic acid particularly, and carageenan, which is—

THE CHAIR: What sorts of foods are they in?

Mr Windsor: You name it—chips, Twisties, anything with colour in it. Even flavoured milks have aso dyes in them, unnecessarily.

Mrs Gover: What we're finding is that as the American companies are taking over the Australian companies they're adding more and more colourings, preservatives, additives. Unfortunately, ANZFA does not recognise behavioural problems. Even though Sue and her group have all written letters, they are not taken any notice of, which is a shame.

Mr Windsor: Use of full spectrum lighting improves learning and improves behaviour. If it improves behaviour for ADHD kids, it improves learning for the whole class. It also improves learning in kids who are not ADHD. That in itself is a very significant factor.

MS MacDONALD: In how many schools has this lighting been implemented?

Mr Windsor: None in Australia.

MS MacDONALD: And overseas?

Mr Windsor: I'm not sure. There would be several hundred in the United States. It becomes an issue of cost and it becomes an issue of the motivation of the person pushing the program. Like all programs that are perceived to be on the fringe, when that person retires or dies the program is frequently abandoned.

MS MacDONALD: Is it possible to obtain the lights in Australia?

Mr Windsor: I buy them myself at Phillip Project Lighting. They cost double the price of ordinary fluoro tubes.

THE CHAIR: But they last longer, don't they?

Mr Windsor: Just as long or longer.

THE CHAIR: They last longer, don't they? You don't think they do? I thought they did.

Mr Windsor: The ones I buy are called 5,500-degree K colour-corrected lights. You can actually go a little further and buy a different set of lights, according to the work of Dr John Ott, who has done a great deal of research into this, and supplement more in the near ultraviolet, which is the thing that apparently we, in our modern society, are failing to get enough of.

Of course the incidence of subclinical vitamin D deficiency in 27 per cent of the population is suggestive that we must have far more exposure to full spectrum lighting than we are getting.

THE CHAIR: They're like the lights artists use?

Mr Windsor: Yes.

THE CHAIR: We've got them at our house, because I used to have time to be an artist.

Mr Windsor: They're used by people in the printing industry, where colour matching is particularly important, in the motor vehicle trade, in paint shops, where colour matching is done, and in drafting offices, where high definition and high visual acuity is required. They're available. They're not expensive.

The next subject is air quality. ADHD sufferers have high levels of asthma. This is related to atopy, or generalised heightened immune response, an allergy-type reaction. They also have higher levels of upper respiratory tract infections, particularly viral ones. This is related to immune dysfunction. For schools particular attention needs to be paid to air quality. I don't believe that it is. I don't think I've ever seen an air quality monitoring program in a school.

THE CHAIR: An interesting submission came this morning from the chemicals in schools group. You should get the transcript. Do you know their work?

Mr Windsor: Yes.

THE CHAIR: And Ms Stanton?

Mr Windsor: Yes.

THE CHAIR: She made that point.

Mrs Gover: A lot of our children used to have grommets put in their ears surgically because they were getting so many ear infections. I don't hear so much of that these days.

Mr Windsor: Because they've stopped doing it. They've realised that it doesn't do any good. If you want to change the nature of a child's ear infections, you have to improve its immunological status rather than treat a symptom.

Noise is next. ADHD sufferers have auditory processing problems. There can be heightened sensitivity to all noise or heightened sensitivity to certain frequencies or a decreased sensitivity to certain frequencies. One of the major problems is the differentiation of signal-to-noise ratio, picking out a conversation over a background noise. I cannot do it. I cannot operate in an environment where there's background noise. If I have to work, if I have to listen to a conversation and take it in, I have to be in relative quiet. I'm not as bad as a lot of people I know.

The problem can be very severe where classrooms are designed with noise abatement furthest from mind. This includes open plan classrooms, but not only open plan classrooms. Some classrooms are particularly acoustically bad. Their echo level is just so high. With hard floors, scraping furniture and the constant babble of voices, some kids just don't survive.

The level of overcrowding is probably the greatest contributor to noise. It does it in an exponential way, in that not only are there more voices but the more voices are louder in clamouring for attention and there is much more movement of chairs and tables and whatever, just from the sheer crowding and people having to move to allow passage for other people. I think that's an aspect that's been under-resourced, not looked at enough.

Visual processing problems are rife in ADD kids. They can go from light sensitivity, just a sensitivity to bright lights, to spectral sensitivity, also called scotopic sensitivity syndrome, which is the term used by the Irlen practitioners who use coloured lenses to correct and filter excessively sensitising wavelengths.

But the other problem that's probably more a problem and more negatively viewed or unobserved is the lack of three dimensional perception, the lazy eye syndrome. It goes unrecognised to a large extent. If children are using only one eye to see, then they're getting a very distorted view of the world. They have no depth perception. This influences their physical dexterity, and it influences a great deal of their social relationships in the classroom.

If you see with only one eye, one half of your visual field is ignored. That means half the classroom is outside your sphere of comprehension, and if the teacher happens to be in that half of the classroom you're sunk.

THE CHAIR: Are you saying that that can happen to all children?

Mr Windsor: It's one of the things. It can happen.

THE CHAIR: And it's not picked up.

Mr Windsor: It's not picked up. What I'm saying is that when it does occur it's rarely picked up. I've seen so many cases of it.

Mrs Gover: Some publications—and I'm not sure there's any within the school system—are printed on white glossy paper with light blue print. That's the most difficult to read, even for people in the general public. It may look nice, but it's very difficult to read, particularly for our children. They need to be on coloured paper.

Mr Windsor: They need to be on neutral-coloured paper with a complementary ink, whether the paper is buff coloured or off-white. Black on white or absolute contrast sometimes can be just as difficult to read as pale blue on grey paper or something like that.

THE CHAIR: Why?

Mr Windsor: It's because of the relative abundance of rods and cones in the eye and the relative effectiveness of the nerve transmission from the rods and cones. It's a physiological and neurological mechanism that disadvantages these kids.

Mrs Gover: Sometimes if they've got a whiteboard rather than a blackboard that can be very difficult for them in the classroom.

Mr Windsor: But it's one of these things where screening is unheard of.

MS MacDONALD: Do overhead projectors present difficulties?

Mr Windsor: Can do. Every visual presentation can present difficulties for one portion of the ADHD kids. We're talking about 25 per cent of kids that may have visual processing problems. Probably half—so you're talking about 12½ per cent, or an eighth of the kids in the room—can have visual processing problems of one kind or another which will limit their utilisation of visually presented materials.

MS MacDONALD: When you say visual processing, does that include dyslexia?

Mr Windsor: I do include dyslexia, yes.

Mrs Gover: With the auditory processing, the information comes through to the wrong side of the brain. Then it's got to travel back to the area for deciphering it, and sometimes the message can get mixed up. If the child's in the classroom and has been asked a question, it may take them a few minutes to work out what the question means. It's the same with vision, when they're looking at an exam paper or a question on paper. It'll take them a while to understand what it means.

MS MacDONALD: What are the methods of assisting with this—coloured glasses, different papers—

Mr Windsor: Irlen lenses are one very effective technique for a small proportion of kids.

Mrs Gover: But the child might outgrow them and need another colour, so they have to go back all the time for testing. It could be very expensive. Auditory processing is supposed to be helped by the tinitus method or sound therapy.

Mr Windsor: There are any number of therapeutic techniques for auditory processing difficulties. Visual processing difficulties at this stage are difficult to deal with, in that the Irlen system is proprietary and the ophthalmological associations wish to have

nothing to do with it. Therefore, they won't do the research. They cannot differentiate between those who will be helped and those who won't be helped.

But it is incumbent upon every parent, I believe, to have every child assessed for visual processing problems in the broadest sense rather than just concentrating on myopia, presbyopia and astigmatism, which are corrected by conventional lenses.

MS MacDONALD: Is the testing reasonably simple? Is it something parents can do themselves?

Mr Windsor: It's elegantly simple. It's just that the ophthalmologists won't do it.

Mrs Gover: Part of that is because they're not in the game to make profits out of the Irlen lenses. It's a closed shop. But a speech pathologist can diagnose and try to help.

MS MacDONALD: But with the visual processing, are parents able to do the testing themselves?

Mrs Gover: No.

Mr Windsor: They can do a crude test. I recommend to a great number of people to do a very crude test, which is just using coloured overlays over a printed page. Get very black print on a very white page and then use coloured overhead transparency sheets or cellophane. Throw it across the page and see if it makes reading any easier. If there is a perceived difference, then my recommendation is that they persevere and visit an Irlen practitioner.

Mrs Gover: They see rivers of white lines going down the page. They don't see the words. Or it looks like it has been in a typewriter or a printer a few times. It's slightly off. It's all blurred and it's very difficult for them.

MS MacDONALD: You can do impressions of it by blurring the overhead projector. That shows what it may look like for some people.

Mr Windsor: The other thing is to defocus your eyes and try to read. If you get two images superimposed, you get an idea.

MS MacDONALD: Or just have jetlag. That'll do it.

Mr Windsor: Yes. Recommended.

THE CHAIR: We're running out of time. There's one other important issue we should address, if you can do it reasonably briefly. What you have said has been really useful. I would like to try to summarise it to make sure I've understood what you've said, although obviously we can read the transcript. You were explaining that there are ways that you can work with children who have this condition. We've all got it a bit.

Mr Windsor: Yes.

THE CHAIR: You said at the beginning that you get negative feedback. I'm assuming that's the parenting problem. Is that what you were talking about?

Mr Windsor: Yes.

THE CHAIR: But there's also the question of medication and the overuse of it because the other things aren't done. I'd like a quick reaction to that as well as the fact that Ritalin is being quite broadly traded in the ACT. So there's a question about how you give kids who are old enough to start selling it—

Mr Windsor: Dead easy.

THE CHAIR: Can you deal with those issues?

Mr Windsor: The multimodal study just completed in the United States has found that the stimulant medications are more effective than any other intervention bar none. While they are effective in promoting social adaptation, they don't have a greatly significant effect on learning outcomes. But the multimodal study didn't look at learning outcomes to a great extent, so that's a whole new area still to be looked at.

They found that other interventions, while not as good as stimulant medication intervention, were complementary and additive. Counselling, biofeedback, dietary change, et cetera all had their part to play and all improved learning outcomes as well.

We know in Australia that something over 10 per cent of kids are ADD. We know that less than a tenth of them are being treated with Ritalin or dexamphetamine. That represents an under-treatment. We also know that there is an under-diagnosis. That magnifies the level of under-treatment.

The singular problem we face in Australia is that dexamphetamine is usable in only about 70 per cent of cases but is not the drug of choice for 70 per cent of cases. It's probably the drug of choice for about only 30 per cent of cases.

Mrs Gover: It's on the PBS too.

Mr Windsor: It's on the PBS. Ritalin is not on the PBS. It's probably the drug of choice for about 70 per cent of cases. There are 20 per cent of cases where neither Ritalin nor dexamphetamine is usable, and there are other drugs that can be used, particularly Catapress or clonidine, and there are new drugs in the pipeline. The fact that Ritalin is not on the PBS means that parents and their children are financially disadvantaged in having to deal with that. It's costing $60 to $70 a month for the average prescription for Ritalin.

Mrs Gover: You can get it through Pharmacy Direct for about $40. Some of the chemist here now, when Pharmacy Direct came in, lowered their prices, but you had to produce the catalogue, and they'd charge the postage that Pharmacy Direct does. You also have to have a New South Wales script.

Mr Windsor: But the reality is that Ritalin and amphetamine are the two most significant successful interventions. The problem of Ritalin being traded in school grounds, I think, is infinitesimally small. From our experience, the vast bulk of people who are using Ritalin do not admit at school that they are taking it.

Mrs Gover: Because other kids call them schizos and everything like that.

Mr Windsor: I say to you that I suspect that the concept of trading Ritalin is inconsequential. This can be solved in the fell stroke of a pen by the simple expedient of adding Ritalin and its slow release derivatives to the PBS list.

MS MacDONALD: The slow release derivatives would surely be less appealing to sell as well.

Mr Windsor: Exactly, but they're a one-a-day option. The parent supervises the child with its drug dose in the morning. That kid is set for the rest of the day. It doesn't have to take medication to school and take it.

The big problem is that ADD kids are renowned for either not wanting to take their medication or forgetting to take it. This is supposed to be a drug of addiction. How can you forget to take an addictive drug? It's crazy.

Schools are in loco parentis. They have an obligation under law to ensure that a child's medication is delivered on time and safely, as I understand it. This may be open to debate. I know the schools will deny it, but I understand that the concept of loco parentis means that that is one of their responsibilities.

It is the fault of the school system and perhaps of the parent that a child is allowed to take Ritalin to school that can be distributed for sale, if you will. But the other problem is the fault of the prescribing system, which allows you to fill your prescription only every so many days. You cannot then have a backlog or a surplus of tablets that you can deposit at the school and say, "Here is my child's Ritalin for the next fortnight. Please dole one out to him at 11 o'clock every morning." You've got to take a pill to school every morning. That's the only way the law will allow you to dispense Ritalin.

MS MacDONALD: Is the slow release form of Ritalin as effective as the other forms of Ritalin?

Mr Windsor: Much more effective.

Mrs Gover: There's one coming on the market called long acting. That's early next year, we hope. There's one in America that's called slow release. Apparently it does slow release, whereas this one will have the peak up here ready for them to start their school learning experience. It will slowly go down during the day, so it's much better. The other one took a while to kick in, and then of course there were problems at the school. I believe there was some talk about dexamphetamine coming out to Australia, but I believe that you still have to get it overseas. You have to apply through the TGA.

MS MacDONALD: It's really interesting talking but we are pressed for time.

THE CHAIR: Yes, we are. I just want to ask one other quick question, because it's important. I was at a conference recently where a speaker, a teacher, gave an example of misdiagnosis. I would like your comment on the issue of misdiagnosis.

Mr Windsor: Misdiagnosis is extraordinarily common. Misdiagnosis is so extraordinarily common that almost every paediatrician, psychiatrist or GP is guilty of it. But misdiagnosis is frequently, and I'd say predominantly, the failure to diagnose ADD when it exists rather than the diagnosis of ADD when it doesn't exist.

The diagnosis of ADD is couched in behavioural terms. It does not look at the underlying neurological deficits. The behavioural terms are grossly influenced by setting and by diet. If a person has the neurological deficits which allow the demonstration of ADD behaviours and you change your diet, you don't change the diagnosis of the neurological underpinnings of ADD. You only change your diagnosis of the behaviour. So when people say that their children have been misdiagnosed, I am not willing to buy into the argument, but the anecdotal reports of misdiagnosis are very common. The actuality is that the misdiagnosis is extremely common in failing to diagnose ADD people.

THE CHAIR: The example he gave was a child who had been sexually abused and was acting out. She was diagnosed as ADD, but in fact it was post-traumatic stress from the sexual abuse.

Mr Windsor: I will guarantee that a child who is sexually abused comes from an environment where ADD is the predominant guiding influence.

THE CHAIR: Why do you say that?

Mr Windsor: Because it is my experience that ADD, the failure to understand the consequences of actions, the impulsivity, the disregard for—

THE CHAIR: This is from the abuser?

Mr Windsor: From the abuser. So you're talking about an abuser who is ADD. If the child is a blood relative of the abuser, which in 80 per cent of cases they are, there is a very strong chance that that child will be ADD. This is not to say that ADD is the cause of that child's behavioural problems. It's just to say that the child may well have underlying ADD which predisposes her to much more severe problems from sexual abuse than would occur otherwise.

Mrs Gover: Children, even teenagers, have no perception of body language where they may be in danger. That's quite frightening. I know of a number of—

THE CHAIR: These are people suffering from ADD?

Mrs Gover: They found out later.

THE CHAIR: You're saying they're vulnerable?

Mrs Gover: Yes.

Mr Windsor: Yes, very vulnerable.

Mrs Gover: They found out later, after all the trauma and everything, that that was part of their problem.

THE CHAIR: Interesting.

Mrs Gover: You were going to touch on genetics.

THE CHAIR: I saw that report last weekend.

Mr Windsor: ADD is genetic to a large extent. But it's part of what are called autistic spectrum disorders. Another autistic spectrum disorder which has had a high profile in the last couple of days, because of the Press Club session, is Aspergers syndrome.

You will find that many aspects of Aspergers syndrome are present in many ADD children. ADD is rarely by itself. Fifty per cent of ADD sufferers have another co-morbid psychiatric manifestation. So if you look at ADD, you should always look at what else is with it. Aspergers syndrome is the lack of ability to have social awareness as much as anything else. I know a great number of adult ADD sufferers who exhibit classic Asperger syndrome social skills.

When you look at the anecdotal evidence, sexual abuse is rife in this group of people who have disregulation disorders. You might ask why. Is it because they do not have the social skills to recognise the difference between an overtly sexual approach, or do they mistake a non-sexual approach for a sexual one because of their lack of social skills? I don't know. But it struck me in reading a whole lot of information how many of these people with disregulation problems—

THE CHAIR: It's a literal interpretation they're making, yes. They don't see the subtleties. I think we have to finish. It's been very interesting. Thank you.

Mrs Gover: We've got a lot more.

THE CHAIR: Are you leaving us that?

Mrs Gover: That's a draft and Richard still has to add the bibliography.

Mr Windsor: I'll put a bibliography into that. ADD is the most researched disorder in the world, yet it is still contentious. You might ask why.

Mrs Gover: We went to a big conference last Friday. That came out loud and clear. It was interesting.

MS MacDONALD: We look forward to reading your written report.

Luncheon adjournment

PETA COX was called.

THE CHAIR: Thank you for giving your time to the committee. I will read to you some formal requirements. You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing, but it also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Could you state your name and the capacity in which you are appearing.

Ms Cox: I am Peta Cox and I am here as an individual.

THE CHAIR: Not with an organisation. Thank you. Would you like to address us?

Ms Cox: My name is Peta. I identify as lesbian and I am a year 12 student at Narrabundah College. I realised my sexual orientation in between year 5 and year 6 and I did not speak to anyone about that until the end of year 9. I was in what I would consider a fairly homophobic school at that point in time and didn't feel safe. I then went to the Stepping Out course run by collective women and also by the AIDS Action Council, which was my first step into the gay/lesbian community in the ACT. That was in the middle of year 10.

I am now fairly involved in the Canberra gay and lesbian community. I am part of the gay and lesbian choir and I also do quite a lot of work in a volunteer capacity for Family Planning ACT. I speak to classroom panels. I also was one of the founding members of Gilbert's Friends, which is a support group for young gay and lesbian or transgender bisexual youth; also with Family Planning; and I have spoken on Radio National, 666 and 2XXX here.

There are a couple of things that I would like to address. The main one is homophobia. So we are talking about homophobic violence and the homophobic environment. It is also about heterosexism, about how coming out is a particular process that is exclusive to gay, lesbian, bisexual, transgender youth, and also about safe sex access issues for young people.

Homophobic violence affects predominantly those who fit a certain stereotype, so if people don't think that you are gay then you are not going to be vilified for that. And it doesn't really matter whether you are or not at this point in time, it is whether you are perceived as that. Youth are more aware of male stereotypes and they are also far more willing to act physically or verbally violently towards men, and it is for that reason that men are far more likely to be the victims of homophobic violence.

However, homophobic environments affect everyone. They are basically the use of homophobic language and, I guess, not taking down homophobic graffiti—just an environment that is not friendly towards gay or lesbian youth. That language and that environment is basically a constant affirmation, especially if it is a school environment, that a gay person is not worth anything, that their sexual orientation effectively devalues

them as human beings. There is a constant reminder of it, especially in the school environment. That child is in there for six hours a day minimum. It is there constantly. It is in the language, it is in the culture.

Heterosexism, as in the assumption that all people are straight, again reinforces that sense of being isolated, and that this is not acceptable. It isn't nearly as strong as homophobia, it isn't actually a fear, but it is just the assumption that you don't exist, which again is quite detrimental to your sense of self.

It is important to note that homophobia affects more than just gay, lesbian, bisexual and transgender youth. It affects everyone. It affects how people dress, how they think it is appropriate to behave; it affects anyone who has a gay friend, brother, sister, parent. If you are talking about 10 per cent of the population, then basically everyone is going to have someone that they know and therefore is basically directly affected by it.

Gay youth have a huge sense of isolation, especially when they are just beginning to realise their identity—that no-one is like me and therefore I am alone in this, and that this must be so horrible because no-one else is here with me. One of the reasons why Gilbert's Friends was developed was to hopefully address that need for a sense of community, especially for young people who are just starting to realise what is going on.

It is because of that that gay youth have a much higher rate of suicide. It is about four to six times higher than general youth—I have that on one of the pieces of paper here. Also, there is a much greater level of drug-taking. I have a quote from Healthpact in respect of funding for Two in Every Classroom. It reads:

> This creates conditions for much higher than average levels of suicide, homelessness, drug and alcohol abuse, early school leaving and conflict with parents and peers.

So it is a pretty severe problem. Coming out, as in telling people about your sexuality, is definitely stressful. It is particularly stressful when a person is yet to fully feel comfortable within their own identity, and so they are looking for reaffirmation by other people to be able to say, "Well this person said it's okay, so then maybe it is." The effect of negative responses can be huge—that people no longer feel that who they are is okay, just because one person had an issue with it. It is also very confusing when you are trying to work out your own sexuality but you are also trying to express that to other people.

I was reading through my diary of year 10 and there was a quote in respect of telling people. It was, "I want to yell it from the rooftops, I just don't want anyone to hear it." I think that captures effectively what it is like, that you want everyone to know yet you don't want anyone to know. It is all rather traumatic at the time.

Coming out to parents is quite a different matter, particularly for youth who are still reliant on their parents for housing, funding, food, clothes et cetera. It is quite legitimately scary in that I do know people who have been kicked out of home; I do know people who have had the locks changed in their house; I do know people whose parents don't speak to them anymore. I think it is very important to work out strategies for looking after youth in that way to safeguard them when they attempt that process.

As I said, I realised my sexual identity between year 5 and year 6. To suggest that we do not talk about homosexuality until someone is in year 9 or year 10 to me seems ridiculous, because by doing that you are effectively saying that homosexuality is something that you would prefer people not be, so if we don't talk about it then maybe they won't change that way. It is buying into a culture of, basically, "We would prefer to be straight and back into heterosexism." Perhaps if we didn't silence it like that then we would reduce the rates of suicide and self-harm, because then people will not feel ashamed and will be more likely to speak up about it.

I would also like to talk about safe sex information, especially for lesbians. In the Canberra community heterosexual youth information is quite readily available. Gay men aren't too bad, unfortunately because of the AIDS epidemic, and the AIDS Action Council do cater basically specifically to getting that information out. However, in Canberra there are—and I have asked Family Planning—only three publications that I know of on lesbian safe sex. There is one booklet called *The Informer*, which is 62 pages long; there is an R-rated video in the AIDS Action Council; and there is a booklet on PAP smears, that lesbians should have PAP smears, and that is it basically.

It is also quite disturbing that schools only take a prevention of pregnancy approach to sex acts, which is not particularly relevant to gay youth for some unknown reason. I read recently, from FBA Health, which is the New South Wales version of Family Planning, a nice quote, which was basically "Sexual activities are not limited to sexual identities". It is important, I think, that safe sex information includes practice, like all practices essentially, because they are not just limited to gay youth or lesbians. It is an all encompassing thing and I think the society is doing a disservice to all people by not discussing it. That is about it.

THE CHAIR: Thank you. That was very important evidence. This came up in a previous inquiry into services for children at risk of not completing school, with which I was involved, and also in a mental health inquiry. So I am sorry that you have to still be here speaking about this subject. But that is still the reality of our community at this point in time. I would like to ask one question and then I will ask other members of the committee whether they would like to ask further questions.

Do you have a sense of what is happening in schools in Canberra in terms of best practice that you might see? You might be able to say to us that there is a school that is actually managing this well.

Ms Cox: I think that Narrabundah is quite an amazing school for its policies and its environment. I feel very lucky to be there because of that.

THE CHAIR: Can you tell the committee what it is that is happening there that is good?

Ms Cox: I think part of it is to do with the culture in the school. It is well known that it has a large gay community and so therefore it is not a large issue.

THE CHAIR: Does the school itself do anything to facilitate acceptance or is this just a peer group there?

Ms Cox: There's a lot of information in the school. There are posters on homophobia. There is information on—

THE CHAIR: Throughout the whole school there are posters?

Ms Cox: Yes. Also, when you have health days there are a lot of gay oriented, I guess you would describe them, health organisations there. It is something that is not seen as a major issue and so it is part of that normalising process.

MS MacDONALD: You stolen one of my questions. I suppose it is a slightly different slant. In an ideal world what could be done to actually give more support for youth who are coming out, realising that they are?

Ms Cox: I think that Gilbert's Friends is a good start in giving that support group that is away from the school. I think it is important again for the safe sex information to be available, for people to not assume that your family is necessarily heterosexual and that you have to be open to the fact that there is sexual diversity.

I think probably the education of teachers in what the students may be going through is very important. Probably also important is talking to students directly about it and discussing issues not in so much a "Well, now we're going to talk about homosexuality" way because that just buys again into the culture of this is different, this is something that we have to talk about because it's scary. I think processes that help to normalise that are most important.

MR SMYTH: You ran off a list of things—higher suicide level, higher drug taking, higher drop-out rate. Was there a fourth one that I missed?

Ms Cox: Suicide, homelessness, drug and alcohol abuse, early school leaving, conflict with parents and peers.

MR SMYTH: Where did that information come from?

Ms Cox: That came from the Hillier report, *Writing Themselves In*, a national report on the sexuality, health and wellbeing of same-sex attracted young people.

MR SMYTH: Thank you.

THE CHAIR: We had a meeting here with student reps from colleges and high schools, and it was quite interesting what they were saying. I was particularly interested in the comment—and I don't know if you would agree—that it is actually becoming much more acceptable to be bi if you are a girl. So, if you are a girl and you are bi, that has sort of become almost okay in some schools, probably not all of them. But it is still very difficult for boys. Do you agree with that?

Ms Cox: Yes. I think it is much more difficult for men. Our culture is far more violent towards men generally and the expectations of masculinity are far greater. I think, because of feminism and so forth, in part the stereotypes for women have been reduced. I think generally people are a lot more threatened by gay men.

THE CHAIR: It is interesting that you should say it is important to not assume that parents are heterosexual, because that doesn't often come up in this discussion—what it means for the children who come from families, lesbian couples or whatever; that language of mum and dad is always making those children feel different.

Ms Cox: Yes. I remember when I was doing one of the panels that there was a mother and child, and the child was probably in year 6. She was explaining how there would be people who wouldn't let their child go over and that kind of thing. I think that sense of direct isolation, even if it is not just cultural, would have a huge effect on a child.

THE CHAIR: The child wasn't allowed to visit the home of the child who had lesbian parents or whatever.

Ms Cox: Yes.

THE CHAIR: I have heard that too. Also, when the publicity was occurring around access to IVF I was told by one woman that her children were vilified because she was in a lesbian relationship. They were being harassed and asked did they come out of a test tube or whatever. So a really quite unpleasant situation developed in the school and her concern was that in the school environment the school wasn't prepared to deal with that, that it was incapable of dealing with it.

This takes me to the question of: do you think it necessary for there to be—the poor teachers—more professional development? I don't know where this ends, but the profile of teachers is, I think, over 40 or 45.

MR SMYTH: I think it is somewhere between 49 and 53 in the ACT.

THE CHAIR: Is it? Okay. This doesn't have to mean anything—I am in that age bracket and I am not homophobic. But there is a suggestion that because of that some teachers may have a real difficulty with knowing how to manage and deal with this; they find it confronting and don't see it as okay basically. So, what do you think should be done to address that issue? Have you got ideas?

Ms Cox: Family Planning is doing quite a bit in that they will go into schools and they will talk to teachers. I think it is rather scary, though, that although they had offered to all the schools in Canberra, two schools have taken that up and Quamby have also taken up the offer. I have been to one of them at Canberra College and they had probably eight teachers there, when all the staff had been directly asked.

THE CHAIR: That is interesting because you would think that the people who need it most would be the ones that wouldn't go.

Ms Cox: Yes. You are talking to the converted.

THE CHAIR: Yes.

MR SMYTH: If Narrabundah College is relaxed and impressive, how was high school?

Ms Cox: High school was pretty ordinary. I didn't have any things put directly to me—there was no vilification—but predominantly it was the language used within the school and the use of words such as "you poofter" as an insult. There is an equation that I like to describe, which is effectively that if you say, "That thing over there is gay and I'm gay," what you are basically saying is that I am awful because you are saying that thing is awful by the use of that language. I know people who have not been able to take that on, but I did and it wasn't very nice.

MR SMYTH: What support did you get from the high school?

Ms Cox: I didn't really talk very much at my high school. I didn't feel safe in doing so. I had talked to some of my friends and most of them were supportive. It was actually quite interesting that it was generally those people who were secure in their own identity who would respond more favourably. Those people who weren't secure felt very threatened by me.

MR SMYTH: I assume we still deliver basic sex education to the fifth grade, sixth grade?

Ms Cox: Yes.

MR SMYTH: Where did that leave you when you were in primary school?

Ms Cox: What do I remember of primary school? I think primary school seemed more about reproduction—it didn't actually talk about what sex was per se. But I remember particularly that in high school it was starting to become quite full on sex education instead of "where do you come from", which was in year 7. And then we had another bout of it in year 10 and essentially it was condom use. And that was it. That is not the whole range of sex act practices.

MR SMYTH: No.

MS MacDONALD: I'm sure the words "dental dam" didn't actually come up.

Ms Cox: No, definitely not.

THE CHAIR: It was primary school children I was talking about. So the knowledge and the whole issue are there in primary school.

Ms Cox: Even the homophobic language is in primary school. We know of year 2 students who are using those insults—not actually understanding what they are saying but they are still buying into that culture, and they are brought up without thinking about it.

THE CHAIR: Was Family Planning looking at doing something about lesbians not having access to information on safe sex?

Ms Cox: At this point I don't know what they are planning to do. I think they are aware of the need for it. But it is definitely an issue because there just isn't anything there. It is kind of like, "Well, no, they don't have sex," or this is a culture that fully denies that.

MS MacDONALD: You said that you became aware when you were in years 5 or 6. Do you think, considering that Narrabundah College has a fairly high amount of non-heterosexual students, that that is a common experience or do you think that you actually realised earlier than others?

Ms Cox: I think people become probably aware of their feelings. But I think feelings, especially for females, are more easily attributed to "Oh, that's my friend" or "Oh, I just really want to be close to her" or whatever. I think it very much depends on whether the person is prepared to admit that to themselves and, depending on how their family is affected, on their perception of that possibility.

THE CHAIR: I have noticed on television recently that it is more normalised. There are a couple of shows. There is obviously that *Queer as Folk* show. I don't know anything about that, but it obviously is important on one level—I won't go into the quality of it but we could have that discussion. It is a really important thing in terms of it being at that time of the week and it being prime TV time et cetera. I have noticed in other programs, too, that same-sex relationships are now in the plot. That seems to me, not that I watch a lot of telly, to be becoming—and in film too—more common. And I guess that is an encouraging sign in terms of the impact of media, mass media, on the community.

Ms Cox: Yes, definitely. I think, though, there seems to be still quite a bit of tokenism in it.

THE CHAIR: Yes. Sure.

MS MacDONALD: It is the token gay male in the show and the token lesbian female in the show.

Ms Cox: Yes, for two episodes or something and you get all very excited and then they disappear again.

THE CHAIR: But it is not stereotyping like it used to be so much, is it?

Ms Cox: I'm not really aware. Again, I'm not a person who watches a lot of television.

THE CHAIR: It would be interesting to see if anyone was watching that.

MR SMYTH: Not that I watch much TV, but *Secret Life of Us*, which is run at prime time on Monday nights, or it was until it finished, explored some of these issues.

Ms Cox: Yes. Definitely.

THE CHAIR: I don't know what the situation is for students in religious school. We will have some people from this area giving evidence this afternoon.

Ms Cox: I know of one person who is in a Catholic school and she was commenting on the fact that two of her friends were going out and people would make up stuff about them kissing in the corridor or something, which of course they wouldn't do—they weren't prepared to risk that. So basically they were suspended for that kind of thing.

THE CHAIR: They were suspended by the school?

Ms Cox: Yes.

THE CHAIR: Okay. I don't have any more questions. Thank you very much.

Ms Cox: Great. Thank you.

MR SMYTH: Thank you, Peta.

MICHAEL GAFFNEY and

DOMINIQUE MARSH

were called.

THE CHAIR: Thank you for giving us your time. I appreciate it. As a formality, I need to make you aware of the responsibilities of witnesses appearing before a committee inquiry. You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Could both state your name and the capacity in which you appear.

Dr Gaffney: Mike Gaffney. I am Head of Education Services at the Catholic Education Office of the Archdiocese of Canberra and Goulburn.

Ms Marsh: Dominique Marsh. I have the role of Parent Participation Officer in the Catholic Education Office of the Archdiocese of Canberra and Goulburn.

THE CHAIR: Thank you and thank you for your submission. Would you like to address the committee.

Dr Gaffney: What I would like to do is open the batting and talk about the way we have approached the terms of reference. Perhaps we could take your questions from there. So this is really just a framework for discussion.

At the outset I would like to really push the point and reinforce the point of our desire to work collaboratively with the ACT government and in particular with the government school sector in ensuring that the children in the ACT have every best chance to develop in all of those different ways—physically, socially, emotionally, spiritually and intellectually. And so that sense of the Catholic school sector wanting to work in partnership is very strong. I think that can be realised by a continuation and an extension of the sorts of collaborative projects that have happened across the student health area broadly over the last several years.

We have looked at the range of issues that may be of interest and tried to divide them into what we would see as the areas of student need and what we are doing organisationally as a Catholic education system and in partnership with the government system to address it. Those areas in terms of student need range from issues of student fitness and health in the physical sense through to their own social and emotional wellbeing, and their sense of belonging and also their own personal development, which brings in a whole range of different forms of support and objectives and which extends to the spiritual as well.

Our organisational response to that in relation to the student fitness area extends from the more traditional forms of physical education and sport and inter-school sport through areas in relation to school and community links and the involvement of Catholic schools in the healthy school communities projects over the years and our partnership with government schools in that. Thirdly, in relation to the personal development, the significance that we place on health and in relation to the core values of Catholic education, how that is reflected through the religious education program in the curriculum.

So we see a range of student needs on the one hand and some organisational responses in terms of program, policy areas and initiatives that are sometimes run individually by schools, sometimes run across schools, sometimes run systemically and sometimes run cross-sectorally in all of those areas.

What we see, though, I think is, in terms of bringing that together, a range of issues and priorities that are based on the fact that we are as open as we can possibly be to all children in the ACT and that is reflected in changes to enrolment policies that are taking place this year. We wish to use the resources that are at our disposal most effectively as possible and efficiently as possible, but we are limited in the capacity to promote student health compared with other schools and other sectors. That is frustrating in a way because we see the Catholic school sector as being one that, while based in terms of Catholic ethos, is providing a public service and it does have very much a dimension and a commitment to the public good and to the community good. That is not being helped at the moment by the inequity in government funding between Catholic schools, Catholic systemic schools, and independent schools and government schools.

So there are implications in terms of our capacity to engage in productive sorts of collaborative activities based on those resources. But that is not to diminish the absolute commitment that we have to the well-being of Canberra students, whether they be in our schools or whether they be in other schools.

Where would you like to go from here? There are ranges of different policy areas that we could talk about.

THE CHAIR: Maybe I could give you some of the feedback that we have got from some students that we have talked to. We had a meeting with student reps and they included students from independent and public schools. There were a few main issues that came up from them. There was mental health, suicide, substance abuse, safe sex education—like not getting pregnant-type education—and sexuality issues. I also noticed that you talked in your submission about fitness testing.

I would be interested in how you are managing that because the students whom we talked to—it was just one group, of course—were pretty unanimous in saying they were most upset at the fitness testing notion because it was very humiliating and not useful for one's self-esteem. They were much more keen on seeing a range of physical activities offered to students. That has come up in other evidence too, so it is not just competitive or ball sports—it is dancing, it is gym, it is riding bikes as a group; it is a lot of different opportunities for using your body. If you are worried about obesity in kids or lack of physical fitness, they are the sorts of opportunities you need.

It has also come up today that children these days are less likely to be walking or riding to school—I won't go into the reasons for this because I am sure you know what they are. So I guess I would be quite interested in a response from you to those issues that were highlighted by the students. For instance, how do you deal with the mental health issue in schools?

Dr Gaffney: Mental health: it depends. Just in terms of the evidence that has been given, I think there will always be pockets where the policy doesn't follow the practice and the capacity to be able to generalise from anecdotes. What we are looking at in each of these areas are policy developments that hopefully will be set in place or have been set in place to correct the issues, and to be able to develop forward. In relation to mental health, students have access to counselling services through Centacare and other bodies.

In relation to areas of sex education, morality, the sorts of curriculum developments that are taking place: on the one hand, through, for example, the Talking Sexual Health initiative, the teaching and learning resource for secondary schools which has recently come to light, there is the willingness of the Catholic sector to involve with the government sector in looking at the resources that are available and then taking them and saying, "Okay, where are the gaps here, where does further explanation need to take place?" and that includes in relation to how the resources link with Catholic teaching.

So in terms of those sexual morality areas, there is the taking on board of the secular curricula and supplementing it with specifically devoted resources, and we can forward copies of those to you. One of them that is particularly popular not only here in the local Canberra and Goulburn archdiocese but throughout New South Wales and increasingly on a national level, is the Contemporary Issues resource, which gives the Catholic teaching perspective in relation to those areas.

In relation to PE in the curriculum and students' general fitness and health, it is very, very difficult to be able to effect change in that area. The previous minister, Bill Stefaniak, I think in his initiatives early in his period as minister, was looking at and implemented a certain number of minutes per day for physical exercise. I think in many ways that was a symbolic act by the minister which focused attention on the need for kids to be fit and to be well. The difficulty for that to be productive is that we need well-trained and appropriately sensitive teachers, whether they be in Catholic schools or government schools, and that can be difficult for a number of reasons, one of which is the crowded nature of the curriculum; finding space to do that.

Secondly, there is the capacity of the teachers to be able to do that. Some are more able to engage in PE with students than others, particularly considering the median age of teachers, and some of the older teachers feel quite threatened in engaging in those sorts of activities. I am talking generally here across the school sectors; I don't think it is particularly more evident in one sector than the other.

Then I think there are the areas for linking between what is happening in school sport and PE with local sporting clubs. What we are seeing at the moment is an incredible pressure and a growing fear on the part of school organisations and local communities to be able to engage in any type of activities which involve, for example, the transport of students from A to B in terms of insurance in negligence and other associated security checks and so on. So the broader school community links in part are being frustrated by

the increasing incidence of litigation and the risks involved in that. So I don't think that is really helping.

THE CHAIR: No. That is a big issue. I will hand over to other members of the committee for questions, but just on that: you said that you are working with broader community responses and you have your spiritual and Catholic way as well. So you have got the two kinds of impulses, if you like, working together. I would like your comment on what was said by the previous witness. What would you say was happening if people in a Catholic school felt that they were same-sex attracted; what would be a Catholic school response to that?

Dr Gaffney: How do you mean?

THE CHAIR: The young woman was explaining that there is—

MS MacDONALD: Would there be a formal response or would it be from school to school?

THE CHAIR: There is a mental health issue for young people who, in working out their sexuality, decide that they are same-sex attracted. They are feeling isolated, excluded, harassed. "Homophobic language in the school" and "don't feel safe to speak" were her words. And there is a relationship between becoming attracted to same-sex and suicide; a higher percentage of young people who have different sexuality will be likely to commit suicide et cetera. So, I am interested to know what would be, in a Catholic school, the pastoral response to a student who had those issues. For instance, do you think it is okay for schools to normalise same-sex relationships? Would you have posters normalising same-sex relationships? I know there are different views within the church so I am interested to understand whether, with a Catholic education system, you have a view, a policy; is it left up to individual schools; how does it work? I am just curious to understand it.

Dr Gaffney: I think at one level, and probably the most basic and foundational level, you would hope that it would be a caring response that respects the individual dignity of each person. That is core to Catholic teaching, and you take it from there.

Ms Marsh: That would be the system response, that the dignity of the individual is always upheld, and then how local school communities would respond to that would be up to them. Each of our schools would have a pastoral care policy acknowledging the dignity of each student. In reality there would not be a public statement to say that it was okay; or posters put up in schools normalising same-sex relationships, as there would not be posters put up in schools about heterosexual relationships. It would all be dealt with within pastoral care about the dignity of the individual and that relationships need to uphold that, and it would be dealt with in general. I wouldn't see any schools—

MS MacDONALD: Is there—

THE CHAIR: Some schools do—that is what she was saying. And it is about the language. It is about do you say it is always mum and dad—what the witness called heterosexism; where everything is always framed in terms of that being the way people are and that is what causes the isolation for the people who are not like that, obviously.

When you look at the percentage of people in our community who are same-sex attracted, you have got a significant group. You must have in your school two in every classroom—that is what the report was, wasn't it? So in every Catholic school the percentages would say there are two in every classroom, and they are experiencing isolation and anxiety if the environment doesn't prevent this. We have already had a discussion about children whose parents are in same-sex relationships.

Ms Marsh: There is, within our system, the assist program, which is the suicide prevention education program. Our system has people trained to present that and quite a number of our teachers have been trained in that. As part of that program that whole issue of same-sex relationships and its correlation to suicide is raised and teachers are alerted to that. The same applies in terms of the mental health issues in schools. Teachers are made aware in their training of mind matters, resilience and those sorts of things.

MS MacDONALD: I understand that it wouldn't be acceptable necessarily to have the posters up et cetera. You have talked about taking the caring approach and the individualistic approach to each child or person within the care of the school. I am thinking about somebody I know within Canberra who is a Catholic and whose sister is a lesbian. When she found out that her sister was a lesbian she actually sought spiritual guidance from a priest outside of the school system and the priest's response was: "Well, your sister is going to go to hell," which didn't help her very much; she didn't actually have a very good response to that at all.

I want to know if a child in a Catholic school, or somebody in a Catholic school, went up and said, "I'm homosexual, lesbian, or I know such and such. I've just found out that such and such within my family is," are they going to find that they will actually get support from the person that they go and speak to, or would that be the response that was being encouraged?

Dr Gaffney: I would hope they would be cared for and listened to and respected. It is about them being good people.

THE CHAIR: What about the expelling—the suspension—of the students that the last witness talked about? Would you think that was acceptable?

MR SMYTH: I suspect any students that get caught kissing in the corridors of a Catholic school may be suspended.

Ms Marsh: I would be very surprised if that was—

MS MacDONALD: Sexual relationships as well, yes.

MR SMYTH: In most cases it is just not tolerated.

Dr Gaffney: It is quite bizarre.

Ms Marsh: I would argue that. I don't think that would be a response. I think most of the schools are—

Dr Gaffney: Or a responsible action by the school.

Ms Marsh: Yes.

THE CHAIR: So if this young woman has a friend that this happened to, do they go to the Catholic Education Office to raise that? What is the process for complaints in the Catholic education system? If that did happen—and you are saying, "Well, it shouldn't have"—can they make a complaint to you?

Ms Marsh: Yes. In a circumstance like that the decision for suspension of students is made at the local school level. Parents then, if they are unhappy with that and are unhappy with the response that the school gives to their concern, have an avenue to come to the Catholic Education Office to discuss it.

MS MacDONALD: But that is the parents, it is not the students.

Ms Marsh: Well, so too do the students.

Dr Gaffney: Yes.

MS MacDONALD: The students there?

Ms Marsh: Yes. But in most cases parents act as advocates for students because students do feel daunted by approaching the system. But it is open to both students and parents to go through that process.

MR SMYTH: But public displays of affection, whether it be heterosexual or homosexual, are certainly not encouraged, I take it?

Ms Marsh: Well, no more than they would be in a government school.

MR SMYTH: So the system is not different at all, is it?

THE CHAIR: In government schools, if teenagers kiss they are not expelled.

Ms Marsh: Nor are Catholic school students.

Dr Gaffney: Be careful you are not trying to generalise from an anecdote.

THE CHAIR: I thought you were just saying anyone would get into trouble.

MR SMYTH: No. You heard "expelled" but they were suspended, which is curious, and it would be interesting to find out about the specific example. But the Catholic system in this doesn't vary from the state system.

Ms Marsh: I would be very interested to find out the circumstances of that and whether that is myth or reality.

Dr Gaffney: Or whether it was because of the homosexuality or for other reasons.

MS MacDONALD: Especially as she didn't know the people it had supposedly happened to and the theory was that it was all based on hearsay anyway.

MR SMYTH: There is a wonderful program called MIEACT, which is where people go into the schools and talk about mental health. Does that come to the Catholic system? It was an initiative funded previously by our government and continued by this government.

Ms Marsh: I'm not sure. I do know that some of our high schools have invited agencies in to talk to students about mental health. Quite a number of our schools are picking up on the MindMatters program and running with that, which is about mental health. Our schools have actively been pursuing issues of mental health, I would say sexuality as well, drug use and abuse, all under the banner of resilience and trying to build up resilience of students in order to cope with all those other things that are happening.

MR SMYTH: So give them the tools that they need to make the right decisions and, if they get into trouble, how to withdraw or how to overcome.

Ms Marsh: Yes.

MR SMYTH: I think somebody at a previous hearing described it as a moral toolbox, where they can make decisions that lead to good outcomes.

Ms Marsh: Yes.

Dr Gaffney: At least know what the teaching is or where to go for help—those sorts of resources so that they are able to make informed decisions.

THE CHAIR: So you do educate on sexually transmitted diseases?

Dr Gaffney: Yes.

Ms Marsh: Yes. Talking Sexual Health is a cross-sectoral initiative. There was a day recently where teachers from both sectors were trained in it, and then a week or 10 days later the Catholic Education Office ran another day for teachers in order to show how to implement that program in Catholic schools. What the Catholic Education Office acknowledged was that there are a lot of teachers who are unsure as to how they can implement that within the context of the Catholic ethos. There was a whole day on it about how teachers might talk to students. The people who ran it came away saying that it was a conversation that needed to continue, and they spoke about the emphasis they needed to make to the teachers being about the dignity of the child, and that is foremost in everything.

THE CHAIR: Did the sexually transmitted diseases include practices between same-sex relationships, because that was the other point made by the previous witness?

Ms Marsh: Look, I can't speak definitively on that. I know that the education officer responsible for student health and safety, who couldn't be here today, actually spoke about that whole issue—that that was one of the things that they needed to raise because a lot of the teachers are parents. She was talking about talking to some young people.

They hadn't even thought of that—that there were issues of sexually transmitted diseases in same-sex relationships.

THE CHAIR: So are you saying that that is being discussed at the moment, too?

Ms Marsh: At what level? I can't say definitively whether it was raised on that day, but I certainly know that they are aware of it as an issue.

MS MacDONALD: In all fairness, it wasn't an issue that was discussed in sex education in government schools, I would have thought.

Ms Marsh: We're not aware of it.

MR SMYTH: On the issue of physical fitness of the students, are kids these days in the Catholic system fitter or less fit than they were previously? Has there been any monitoring of fitness levels of students over the years?

Dr Gaffney: No definitive work, and I think that is probably an area that is in need—to get a fix on the levels of health of kids. It really is just anecdotal stuff in terms of participation of kids in cross-country runs at lunchtime and that sort of thing.

MR SMYTH: So what is the anecdotal opinion—yes it works better?

Dr Gaffney: That kids aren't as fit as they were; that, as Kerrie was saying, they are not doing as much exercise after school as they used to and that type of thing. But my point was whether you actually legislate it into an already crowded curriculum and say "You've got to do 30 minutes of push-ups every day" is not probably the issue. It is more about, I suppose, building linkages between school and community support.

THE CHAIR: And asking the kids what they want to do. Just listening to that bunch of kids who were here, I can tell you it was very different from what the so-called experts were telling us in terms of—

MR SMYTH: This was the other day?

THE CHAIR: Yes. It was after you left, unfortunately. I was really sorry about that because I know you are interested.

Ms Marsh: I was a little surprised that they were testing fitness levels, which they found very uncomfortable and then having programs run according to that. Again speaking from a parent's point of view, I know that the high school that one of my children is at has a formal PE class within their fortnightly schedule or weekly schedule, but also once a fortnight—it is a Wednesday afternoon—they have activities which are health-related. But there is a whole range of things where the kids can choose to go bike riding or do lawn bowls. There is a huge range of activities they can do.

MS MacDONALD: What activity is there in lawn bowls? I am sorry, there is no activity in lawn bowls.

MR SMYTH: Hang on, I was a member of the West Canberra Lawn Bowls Association at age 18.

Ms Marsh: Giving options like that is actually acknowledging that there are different levels of fitness, and that the idea of students being active is more important than running them through a program.

THE CHAIR: What were you surprised about? I didn't quite understand what you were saying. What surprised you?

Ms Marsh: I was surprised at you saying that the students said that they were actually having fitness testing and then having to do things addressed at their level of fitness, and that they were finding that uncomfortable.

THE CHAIR: I didn't say that. I am sorry, I might have been unclear. They didn't like the fitness testing because they thought it was humiliating. They made comments about girls not necessarily wanting to do sport with boys; they made comments about, "Well, I don't want to kick a ball and I don't want to compete but I'm happy to dance." In terms of fitness testing, I think they were saying, "They're asking for things that we would like to do with our bodies but they're not being provided by the schools". Particularly the girls, and maybe one of the boys, said that that is the last thing that girls need—body weight, body mass, body fat, running in front of other people; generally that measuring thing.

If you want people to become physical you give them stuff they like to do with their body, and you take it out of that context of, once again, success or failure. It is fine for some kids who are competitive and they love it and they thrive on it, although that can have issues too, according to some of the reading I have done. But they just had a lot of ideas about how they would like to get fit and it wasn't kicking a ball around.

MS MacDONALD: It never appealed to me either.

Dr Gaffney: It is the same with kids with intellectual disabilities sitting literacy and numeracy tests. It is the same issue. Different ways in which kids learn and want to use their brain is an analogous sort of argument too, Kerrie. I suppose it is about the capacity of schools to be able to deliver that and to provide that sort of choice.

THE CHAIR: Yes, it is about a philosophy too, and an ideology of an education system.

Dr Gaffney: And how that is played out in resourcing.

THE CHAIR: Yes, true. We will need to finish. You talk about drug education and the drug education project and I have got information from Mr Corbell so we can understand again what that is. Have you done any assessment or evaluation of how different schools are actually working within that framework? I am interested once again to see if anyone has got a handle on how individual schools are interpreting and implementing these sorts of frameworks. I just wondered if you had done that work?

Dr Gaffney: In a couple of ways: one is that each of the schools that is involved in that has a liaison officer and the curriculum development is working there, being developed at a local level and shared across schools. The results of the project: it is in its second phase, as I understand it, so it has been effective. But in terms of the specifics, I haven't got the details with me but I can pass on those reports.

THE CHAIR: You know it has been effective, did you say?

Dr Gaffney: I understand it has been very effective, yes.

THE CHAIR: How did you evaluate that?

Dr Gaffney: Through responses from the people who were involved at the local level.

THE CHAIR: From the students or from the people who ran it?

Dr Gaffney: Not from the students but from the staff that are involved in the delivery of the program.

Ms Marsh: I know that one of our schools, through that project, ran a smoking cessation program. We ran a drug summit on Monday for our schools in the ACT region and one of the students who participated in that program came and spoke to the group and another student who was part of the project attended but didn't get up and speak. She spoke about the success of that approach. Although not all students who attended the program stopped smoking, the student said that most of them reduced smoking. A number of them did give up smoking, and she was one of them, but she said most of them actually cut down the number of cigarettes that they were smoking.

THE CHAIR: Did you ask her what it was that influenced her that much? Was it a "shock, horror, this is a picture of your lungs" kind of thing?

Ms Marsh: No. She said that was part of it. She said that what doesn't work with young people is those ads on television where you see that—all the tar being tipped over you and all that.

MS MacDONALD: It works with me and I don't smoke.

Ms Marsh: She was very specific about that. She said that doesn't work. But what she believed worked—and a number of people asked her several questions—was the fact that the information that was given was sound. They got the opportunity to speak to people who were smokers, or had been smokers, and who were suffering the effects of smoking. They spoke to people who had developed cancer of the mouth and throat.

THE CHAIR: So it was personal—seeing it.

Ms Marsh: Yes. She said that had greater impact on them than any of the other hype that they see on television. She actually later when I was speaking to her made the comment that most kids question what is put forward on TV in terms of advertising.

THE CHAIR: So they don't believe it.

Ms Marsh: I think they see it as propaganda.

THE CHAIR: Interesting.

MR SMYTH: There was a nice program in Florida where they actually got kids to tell kids not to smoke, and that proved to be even more effective.

Ms Marsh: She also said the thing that influenced them was the fact that there was a group of them doing it together and that there was strength in that—that she and another friend of hers did it together and they sort of kept each other working at it.

THE CHAIR: Stopped smoking together?

Ms Marsh: Yes.

MS MacDONALD: So it is providing the support to each other.

THE CHAIR: Okay. If there are no other questions, thank you for appearing before us.

MR SMYTH: Thank you very much.

MS MacDONALD: Thank you.

DANIEL STUBBS and

SANDRA LILBURN

were called.

THE CHAIR: Thank you for giving us your time. I will read a statement regarding the responsibilities of witnesses.

You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections, but also certain responsibilities. It means you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Please state your names and the capacities in which you appear.

Mr Stubbs: I am Daniel Stubbs, Director of the ACT Council of Social Service.

Dr Lilburn: I am Sandra Lilburn, the Health Policy Project Officer for the ACT Council of Social Service.

THE CHAIR: Thank you. Please proceed.

Mr Stubbs: As you have just heard—and I am sure there have been other examples of this—many ACTCOSS member organisations, and other organisations in the community sector, can give a range of examples about the specific issues related to the health of school-aged children.

The council therefore comes to this committee wanting to make some statements that are somewhat more general, and are with respect to our role as the peak body of the ACT community sector and our role as advocates of the interests of people living in disadvantage in the ACT.

The areas in the terms of reference which we will talk to are, in particular, the relationship between social and physical health, the socioeconomic factors affecting health, and the role of the ACT community sector in this issue. I want to say that probably our key proposition with respect to health and the work of this committee is that health to us is a holistic concept. This is in line with the World Health Organisation's view of health—that health is not just about not having illness in your life. It is more than that. We recognise, as a lot of other research recognises, that socioeconomic factors influence quite heavily the short and long-term factors related to health.

The World Health Organisation produced a report called *The solid facts*, and that report indicated that the relationship between health and socioeconomic factors is quite complex. It found that some of the factors influencing health include stress; early life experience, which we will, of course, be concentrating on today; social exclusion; work;

unemployment; social support; addiction; transport and food. The report makes the conclusion—and other reports say this as well, as does some of our own research—that, if people have access to all the things they need, then they will lead a long, healthy life.

We would suggest that a systematic approach is required, rather than the ad hoc and short-term approaches sometimes used in this sector, in this territory. Often we hear the issues of promotion, prevention and early intervention used as a bit of a catchcry in this area. I would tender that early intervention is being talked about quite seriously as important in children's health. However, we also need to recognise that children's health is not just all about early intervention, but about actually providing the services that people need at the right time. At the moment we do not do that, so when we do it we call it early intervention. I think that is very important and very powerful.

The need to be systematic and organised in the way we approach this, and the way we provide the right level of service, has been referred to in some literature as joint ways of working. In this process, we draw on the collective resources, wisdom and capacity of government and the community sector to actually provide for the needs of people in different circumstances. The fact that children have mental illness does not mean they are clients only of mental illness services. It may mean that they also have problems to do with their schooling, to do with their housing, or to do with other areas of their health.

To deal with this, we need to have those joint ways of working across government and the community sector, and between those two sectors. Some of ACTCOSS' other research, and other work we have done in this area, has also shown that there are a lot of factors regarding children's health that are connected with socioeconomic factors. We consider that the relationship between socioeconomic status and health is a key issue for this committee to take up.

We believe strongly that socioeconomic status determines health status, and this is commonly referred to, and is referred to in some of our recent work, as social determinants of health. Obviously, the poverty task group reports go into this in significant detail. An example of that is that 38 per cent of people in the ACT, in 2000 at least, were children.

Dr Lilburn: That is, 38 per cent of those living in poverty.

Mr Stubbs: Sorry, 38 per cent of people living in poverty in the ACT in 2000 were children. Children are most likely to access advocacy, health services and other support services, and often that access is related to abuse. In the poverty task group, we found that there are probably three groups who are most disadvantaged in the ACT. Those groups are indigenous people, single parent families, and people with a disability or people living with someone with a disability. Obviously, children are often a part of those three groups, and I think that is very important to remember. You are much more likely, if you are in one of those groups, to be living in poverty in the ACT.

THE CHAIR: Was that 38 per cent?

Mr Stubbs: 38 per cent of people living in poverty are children.

We also did a submission last year to an Assembly committee inquiry into the health of Aboriginal and Torres Strait Islander people, and that inquiry reported last year. We would urge this committee to go to that report.

THE CHAIR: The work that was done there?

Mr Stubbs: Yes. The important fact is that indigenous people are some of the most disadvantaged people in our community as, therefore, are their children. For a long time we have promoted the need to implement that report, and we want this committee to pick up anything from it that particularly relates to children.

The council recently completed a needs analysis of homelessness for the government. We found that children in supported accommodation services, refuges, are more likely to have behavioural problems and low self-esteem, and to be falling behind with respect to skills development and education and other areas of development, than the rest of their peer group. Although, in many ways, homelessness is not considered an issue that concerns children, there are often children who are found homeless, often with a single parent, in the ACT. Those children really do suffer. Those are school-aged children who end up being homeless and living in refuges, usually in the refuges that are targeted at women.

There is also our submission on the rights and entitlements of children and young people, which is a more recent submission. That inquiry has not actually reported, but we would urge this committee to also consider what is happening in that committee, and the submissions going to that committee. I am not sure if anyone here is on that committee or not.

With respect to some recommendations we would like to make, I go back to the point that I made before about early intervention: it is not about intervening early, it is about having adequate support for children or families living in the ACT. It is not about saying we are intervening early, but that we are intervening on time, giving the right amount of service at the right time. We would also like to recommend that this committee recognises that targeting need when the need has already arisen is resource intensive and resource wasteful, and it is often too late once the cycle of poverty has begun.

Finally, I want to urge this committee to support any work going on in the ACT with respect to health promotion. In the past, a lot of health promotion work was targeted at the middle classes. However, there has to be a greater take-up and a greater consideration of the needs of people living in disadvantage with respect to health promotion.

Health promotion is often different for people who are living with disadvantage than for much of the rest of the population. For some parts of the population health promotion might be about eating well, or not working for too long, and for other parts of the population health promotion might be about not sharing needles, or obtaining stable housing or accommodation. We must recognise that there is not one single health promotion message. It is quite different for some groups living in disadvantage. We recognise that Healthpact, and health promotion sections in the government, are starting to take up this idea with some vigour, but it needs to be supported.

THE CHAIR: Can you give us some examples?

Mr Stubbs: Where it has been taken up?

THE CHAIR: Yes. Where you think good things are happening.

Mr Stubbs: One has been around for a while—the breakfast program for kids in schools.

THE CHAIR: Yes.

Mr Stubbs: That is very important. The other extreme, of which there is a little less now, is paying a lot of money to the Canberra Cannons to teach kids how to play basketball. That is well known. Those are the two extremes, I suppose.

THE CHAIR: Do you think both are good?

Mr Stubbs: No.

THE CHAIR: You do not think the basketball one is good?

Mr Stubbs: I think there needs to be more of the former.

THE CHAIR: Yes.

Mr Stubbs: I think there has been an imbalance with respect to how we do health promotion in the ACT. The hard work is at the lower socioeconomic end and therefore that is where we need to target some of our resources: indigenous communities, people with a range of complex needs and so on.

MR SMYTH: Daniel, it is Brendan. Sorry, I am back. Is the kind of thing you are more in favour of the five fingers program at Narrabundah Primary School and Gowrie flats, and the promotion of contests under healthy schools, to get schools to think about how they will help themselves and get the kids working on that sort of thing?

Mr Stubbs: Yes, that kind of thing.

MR SMYTH: Okay.

Mr Stubbs: That is the end of our presentation. We have a little more detail in a short paper. We did not actually provide you with a submission, so I am glad to be able to come to make a presentation. However, we are happy to send over our notes, which draw together some of our previous work on this issue. It would not be a formal submission, but it might be worth the committee having that during its deliberations.

MR SMYTH: Yes.

Mr Stubbs: Would that be appropriate?

THE CHAIR: Yes, that would be good. Thank you for that. One of the things I am interested in pursuing what the last government used to call social capital. It is the relationship between social cohesion and social health. It seems to me that some of the

reading I have been doing lately keeps coming back to that. There are some fundamental questions there.

If you look at the political debate as it occurs, it is very often a contest between one political group that sees the role of the market as being greater than the other, and another group that sees the role of the state as being greater. It is all about that. That is what the political debate is about. However, when you actually look at it under either system, where either the state or the market is getting a lot more focus or priority, or has more power, the social problems are still there. What we seem to see is, over the last 30 years, a disintegration of this thing called whatever you want to call it—social good, social capital or whatever.

Some people talk about this as being the result of a lack of institutions in our society which were once there, and which brought to our lives a kind of moral framework or context, and a sense of community belonging. I don't know if you have thoughts on this, or if you know of work on the subject, as I think it would be interesting for the committee.

We can talk about obesity and the physical issues too, but if you look at this matter in a social and cultural context, the socioeconomic status of people is very significant, as you have pointed out. However, if you talk to the kids from right across the spectrum, they mention substance abuse, mental health problems, suicide, depression and so on. I wonder what this is really about, and whether is it the social context that is creating this. In one of the books I read, teachers were asked what the main problems were—in I think it was the seventies or the sixties—that they encountered in schools. They were chewing gum, pushing out of line and not wearing uniforms or something. Now it's what I just said.

Mr Stubbs: Outrageous.

THE CHAIR: Yes. This is something you hear reflected in the community debate, isn't it? Some people say it is because we do not hit them any more, or whatever. Do you have any thoughts on this that we could consider?

Mr Stubbs: We refer to the issue of isolation, which is one extreme of the matter you have raised—people being isolated in different ways. A term that I sometimes use which is sometimes more meaningful for people is "community connectedness", which refers to whether people actually feel linked to the community, or their community, whatever that might be. The flip side of that, of course, is the lack of community connectedness of some groups.

That can be related to kids' mental health, which can be influenced by their physical health, whether obesity is involved or whatever. That feeling of isolation is incredibly important, and it has been found to have a big impact on people's health.

We have done a bit of research in this area and we are looking at doing a lot more applied research in the ACT on the social determinants of health and how they play out in the ACT. That community connectedness is just as much an issue as levels of income or access to money. However, another big factor to which I alluded is the idea of what's referred to in some of the literature as joint ways of working—working across

government, but also across community. It involves government and community working together. We tend to promote that sense of isolation in the way we work.

Before, I referred to the idea that young people might have a mental illness or a mental health problem, and so they are put into that pigeonhole, but in fact their health problems may be related as much to their lack of housing, their problem in getting to school, their food or a whole range of other things. All of the services responsible for these factors aren't talking to each other about this issue.

It has been shown, particularly in some UK research that we've been drawing on, that just getting those areas to work together a bit is quite significant. They then recognise that they are working with a person who has all these challenges, rather than saying that housing will provide them a house, the school will provide them an education, and youth centre might provide them some counselling. However, everyone is seeing those elements quite separately, or seeing access to one of those services and not seeing the rest of the need.

I think that goes to some of what you were saying. However, I also think there are implications of social capital or community connectedness, or whatever we want to call it. People need to be part of a community and to be linked to the community in different ways, because that helps them get on in education. It helps people get a job. It helps them get on and be successful. All those things—community connectedness and gaining education and employment—are big determinants of people's health. Some of our work has been about this, and we are looking at doing some more work, particularly about applying that in the ACT.

THE CHAIR: You should keep us in touch with that work.

Dr Lilburn: Okay.

Mr Stubbs: We will. Yes.

MR SMYTH: What are your member groups telling you are the big issues for school-aged people in the ACT?

Mr Stubbs: Just before you came in, I said that we recognised that a lot of our member groups and other organisations will be making more detailed submissions to this inquiry, or I hope they will be, and that we would be making a higher level submission. The issues are often about isolation. Sometimes they are sexuality related issues, and I mean in the broadest context: whether they are about identifying with a particular sexuality, or even just about that changing time when teenagers are developing, and trying to understand that time.

Substance abuse comes up as an issue with young people, particularly related to health, for some of our member organisations. Also, a range of factors seem to create some sort of isolation for young people. Public space is a great example. Increasing private space, say, though indoor malls and that kind of thing, tends to push young people away from the centre of the city and away from being part of an urban environment. That isolates young people from the city, rather than making them part of it. That has also come up as an issue across the sector.

THE CHAIR: Are move-on powers an issue?

Mr Stubbs: Yes, that is one extreme.

MR SMYTH: All the people are inside the Canberra Centre, but the young people with their skateboards are outside playing on the *Canberra Times* fountain, so you have a divide.

Mr Stubbs: Yes. If you have a strip shopping centre or an open shopping centre, and you replace that with an indoor mall such as the Canberra Centre, there are not a lot of places just to sit and be inside. It becomes private space. Whether we say it is private space or not, it becomes more private.

THE CHAIR: And you get moved on if you are not a certain sort of person.

Mr Stubbs: That is right. You have to be able to spend money.

THE CHAIR: If you don't look like a shopper.

MR SMYTH: Whereas, in the refurb of the Curtin shops, there are lots of seats and outdoor spaces. There is that central, almost courtyard effect.

THE CHAIR: Community space.

MR SMYTH: Yes. Where you can actually be part of the community.

Mr Stubbs: The development of Ainslie Avenue is a bit of a hybrid of those things, and my sense is that that seems to be creating a bit more private space than public space as well. We are yet to see how that is going.

MR SMYTH: I hope it is not. They wanted to build a fort and we said no, it has to open onto a street where people can be, so I hope it is not.

Mr Stubbs: That is yet to be seen.

MR SMYTH: Yes, it is yet to be seen.

School-aged health covers a whole range of issues. Are issues of nutrition and access to food coming up in the work that you are doing and, therefore, the effect on educational outcomes? Or does it appear in any of the work that you have access to?

Mr Stubbs: We haven't yet got to that in our research. I am not saying it is not an issue yet, but we are trying to cover a range of issues. One of the issues that does come up a bit for us is that need to link what is going on in the school with what is going on in the community and the community sector. For example, counselling is available in schools, but there is a need to link those aspects of what is going on in schools with what is going on in community services, youth centres and so on.

That is happening a bit with work such as the schools as communities program, and I think it needs to be promoted. We understand that it is difficult for some young people to get access to counsellors in schools, and it doesn't always feel appropriate.

MR SMYTH: Was the schools as communities program worthwhile?

Mr Stubbs: Yes, that is our understanding. I think there are opportunities for more joint work between the education department and the community services areas, and probably the health area as well. I do not think there are any bureaucrats in the gallery.

THE CHAIR: No.

MR SMYTH: There is no gallery.

Mr Stubbs: No, I am making an observation.

MR SMYTH: They will get to read the transcript.

Mr Stubbs: I am making an observation about the fact that no-one considers this their responsibility. There is no-one from education here, because they think it's health's responsibility, and there is no-one from health here because they think it's education's. I think this provides an opportunity for this committee because, at the same time, no-one is going to say it is not their area. It is not as if it is not on someone's agenda. There is a lack of an agenda in this area.

THE CHAIR: One person suggested we have a youth policy, and that we need to have a framework which can bring about some accountability, with implementation strategies and so on. What do you think about that?

Mr Stubbs: Well, my understanding is that there is a youth framework and there is a youth policy.

THE CHAIR: A children's policy?

Mr Stubbs: No.

THE CHAIR: Okay, this suggestion was for a health policy for children. That is basically what we are looking at, because it has such long-term consequences for society.

Mr Stubbs: As I said before, children's health is a huge determinant of people's ongoing health. Your early health affects whether you have chronic illnesses and a healthy life in a whole lot of other areas.

Dr Lilburn: One of the things I find really interesting is that substance abuse, mental health, suicide, depression, and other things that obviously come up for this inquiry, are precursors of more substantial things, such as particular incidences of cancer, and difficulties with the more physical manifestations of health in later life. You see the beginnings of such problems in childhood health and some of the patterns of behaviours that are set up then, so it is an enormously important moment.

MR SMYTH: Just listening to what you have said there prompts me to wonder whether it is actually a flaw in the cabinet system that we have a minister for health, who is responsible for your physical or mental wellbeing, and a minister for education, who looks after whether you can add up and whether you are literate, numerate and whatever. Now we have a minister for disabilities, housing and whatever the third one is that Bill is responsible for. There is another segmentation.

The Victorian model is now that of superministries, where you virtually have a minister for human beings, who has under him or her health, education and all these things. Is it a flaw of the public service structure that we hive those areas off and say, "I do not have money to do that. You have to talk to X"? Do we actually make it too hard for people? We are asking people to meet the government and the bureaucracy where they are, rather than the bureaucracy and the government saying, "We will meet you and your needs where you are."

Mr Stubbs: We have views about appropriate structures of portfolios in departments but, taking a step back, we would also contend that, no matter which way you cut it, you are going to cut it. You might have a human services portfolio, but that is going to be separate from education. What is really needed here is pressure on government ministers, cabinet, and probably particularly the bureaucracy, to ensure that those linkages are made between, in this case, education and health. No matter which way you divide up the responsibilities, you are going to have to create divisions, which, in an ideal world, you would not want to make.

THE CHAIR: We need some coordinating. Another proposal that has come up over the years is a children's commissioner, and obviously that position has been created in some places. I do not know if it would work in a small jurisdiction like this. Do you have a view on that?

Mr Stubbs: Yes, we have suggested there should be a children and youth commissioner for the ACT.

THE CHAIR: You do support that.

Mr Stubbs: I am pretty sure we talked about that in our submission to the inquiry on the rights and entitlements of young people, to ensure that an independent eye is kept on this area.

THE CHAIR: Yes, that position could have the function of coordinating all the different areas. One other quick question I have is, if 38 per cent of people in poverty are children, and remembering the discussion we just had about feeling isolated, the impact of poverty and the increase in the user-pays system in schools, how are these children actually experiencing school? Do they feel disadvantaged in their capacity to join in? That would be an interesting study.

Mr Stubbs: The poverty task group made recommendations about that issue: about access to education, the copayments that go on with respect to schools, and how we provide equal access to activities for which people end up having to pay in a way that does not embarrass, judge or identify people.

THE CHAIR: It is just basic. It is subject levies. It is not even, "Let's go for an excursion." That is way out of the range of potential activities. It was for me as a parent.

MR SMYTH: Then you get to wanting to participate in a sport. The fees there are going up.

THE CHAIR: Some subject levies cost heaps.

MR SMYTH: There is the cost of boots and gear.

THE CHAIR: That is right. Sport is another example of that, yes. That is interesting. Do we have any more questions?

MR SMYTH: Can I just ask about the links? Throughout your speech you talked about community connectedness, the links and all that sort of thing. What is breaking down that we are not linked any more, that we are not connected? Is there a root cause of this, or is it is just a consequence of modern society?

Mr Stubbs: A comment was made by your learned chair about the breakdown in social institutions, or a decrease in the numbers of social institutions that had certain moral associations, whether it be churches or other institutions. My understanding is that there is no clear understanding of why this has happened, but that is certainly one of the hypotheses put forward. As a society we have left behind a lot of those social institutions, and as a society we have not built any new ones.

MS MacDONALD: We are becoming more isolationist within our own little group.

Mr Stubbs: Yes.

THE CHAIR: Mrs Thatcher said there is no such thing as society, just individuals. Can you seriously believe that any leader could say that? That is just totally invalidating the whole—

MR SMYTH: Monty Python said it before her: "You're all individuals"; "No, I'm not."

THE CHAIR: It was Monty Python. When you reflect on that, it is such an incredible statement. It just invalidates what we all know, as people, is the most important thing to our experience of life. In a way, our society now is saying that. It is saying that life is about individual success. We have choices. We all make our own choices as individuals for our own individual expression, and we have these rights, in some way, to promote ourselves. All that is very nice and it is couched in terms of liberty, but I just think there is something missing.

MS MacDONALD: Who organises social dances and church dances these days?

Mr Stubbs: No-one can afford the insurance.

MR SMYTH: Nobody can afford the public liability insurance. I have one final question. I think it was Richard Eckersley from the ANU who said, when I asked him, "If you had one thing you could fix for youth, what would you do?", that he would give

them the tools to develop their own moral toolbox. Such a toolbox would, I assume, carry on from the old church, school and society structures that have disappeared. How important is that? Do young people have the tools to make good moral decisions?

Mr Stubbs: They do, absolutely. It comes back to the power of self-determination, I suppose, the power to own what you develop. Some of our members have worked at trying to convene groups of people as part of an ongoing network. Giving them the power to facilitate their own groups has been quite effective, whether they be indigenous groups or other groups that I know of that come together. They can be given some resources to facilitate themselves, and move forward to develop their own framework and their own code.

THE CHAIR: As a group?

Mr Stubbs: Yes.

THE CHAIR: That is quite different from an individual toolbox for an individual moral framework. That is about a responsibility for someone other than the self, isn't it? That is what you are saying.

MR SMYTH: Perhaps that is the structure or the framework within which people feel comfortable to then make their own decisions and to be themselves, yes.

Mr Stubbs: That is right. You are with a group of people who find themselves in the same situation.

MR SMYTH: It is a community model versus an individual development model.

THE CHAIR: Yes. I think it is a really important discussion and distinction, in a way.

Mr Stubbs: We, as a society, are not necessarily coming together to facilitate our own way forward. Young people are arguably less inclined to be joiners than anyone else and so, if we expect them to join each other, we have a bit of an obligation to resource, support and promote that. We should do whatever we have to do to move that forward, to create those kinds of opportunities for young people, so that they can be part of something, though not necessarily what we want them to be part of. That self-determination aspect is important.

Dr Lilburn: I think it is very true that the whole notion of empowerment is really crucial. However, the other thing I always like to think about is the notion of belonging: how you see yourself belonging to things, and how you see yourself being empowered in the contexts you encounter. If children and younger people these days are empowered by having a mobile phone, that is something that they seek and desire, but they are very individual achievements and successes, aren't they? Until you can give them a context in which belonging and being empowered in a community context is meaningful, they are the sorts of things that—

MR SMYTH: The flip side of that coin then is acceptance. If the entry price is that you have to be part of the group that has a mobile phone, you cannot be accepted unless you have the key.

Dr Lilburn: Exactly. That is right.

MR SMYTH: Sometimes what might seem frivolous symbols or keys to parents are actually really crucial to your ability to be a 14-year-old girl or a 16-year-old boy, and you cannot fully participate if you do not have the key. I think you are right, because probably for my generation and before, children should be seen and not heard. We were taught history. Now we are taught to understand history.

Mr Stubbs: And question it.

THE CHAIR: And question it.

MR SMYTH: Yes, and question other people's interpretations. Maybe AJP Taylor got his concise history of the second world war wrong. How dare you say that? My teachers would have died if I had said that.

What we have done is empower kids. We have given them the tools for self-determination, but I still think there is a segment of society that thinks that means that they should be respectful, quiet and still believe everything that mum and dad says. However, just the school groups we talked to have opinions, they have ideas, they want to go places, they want to do things, but society does not accept that they have the right to do it.

THE CHAIR: There is also the question of them—and I know this is going to sound weird—

MR SMYTH: Kerrie, would you say something that sounds weird?

THE CHAIR: This issue is not just about individual rights: it is also about responsibilities. I am sounding like my mum, but it is the common good thing.

MR SMYTH: God, Kerrie Tucker has turned into her mother.

THE CHAIR: It is about the difference between believing that we are all individuals, and that we are part of something bigger.

MR SMYTH: I am not.

THE CHAIR: We have to be supporting the thing that is bigger for our own individual fulfilment as well. We are not all little islands.

MR SMYTH: But not at the cost of individual loss.

THE CHAIR: No, but there can be both.

MR SMYTH: We should not have to surrender individuality.

THE CHAIR: No. Well, that is what we are discussing: do you treat everyone with respect? It is as basic as that. Are we civil, are we polite, are we welcoming to people? That is basically about having a shared value system which says yes. We do have that to a degree in our society, but sometimes—well, I don't know. It is a philosophical discussion. We should stop. This is not really evidence.

MR SMYTH: If you can solve that you are doing very well.

Mr Stubbs: I wonder whether we have to recognise that, before we expect some groups in society to live up to certain responsibilities, we also have to live up to our own responsibilities. It is not only for these young people to do that.

THE CHAIR: Totally. I do not mean to sound like John Howard here. Do not get me wrong.

MR SMYTH: Kerrie, you were sounding wonderful there for a moment.

Short adjournment

DEBRA RICKWOOD was called.

THE CHAIR: Thank you for giving us your time.

Dr Rickwood: Thank you for asking me.

THE CHAIR: I need to read a statement regarding your responsibilities as a witness. You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Could you state your name and capacity in which you appear, please.

Dr Rickwood: My name is Debra Rickwood. I'm the Head of the Centre for Applied Psychology at the University of Canberra.

THE CHAIR: We have a copy of your report on help-seeking behaviours, *Program evaluation for mental illness education*. Maybe you can address the committee.

Dr Rickwood: I wasn't aware that I would be specifically talking to that report.

THE CHAIR: No, you're not.

Dr Rickwood: I've put together something more broadly on help-seeking behaviour. Specifically, I've given you a handout that has some data. Last year I did a big survey in four public high schools that was supported by Healthpact. That looked at help-seeking behaviour. Nearly 1,200 young people were surveyed. The data here are from that survey. I can also talk to the report, but I've been researching primarily in the schools and around mental health for nearly 20 years. For most of that time I've been focused on help-seeking and mental health, particularly in adolescents. So I've brought a bit of all of that into this.

THE CHAIR: That's excellent.

Dr Rickwood: I'll briefly go through the main points and then I guess you'd like to ask me questions.

THE CHAIR: Sure.

Dr Rickwood: I've started off by defining what help-seeking is. We use lots of terminology, but people aren't always sure what we're talking about. I see help-seeking as a particular form of coping with problems, in issues or adversity in your life. We generally define coping in a number of ways. There's what we call approach types of coping, which are usually the most successful ways of coping. You seek out information or help that enables you to resolve a problem. Obviously there are some problems you can't resolve. If a young person's parents divorce, you can't fix that. You need to cope in

a way to manage your emotions and make sure you stay well. We see help-seeking as a form of approach coping and assume that it is an effective way of coping with some sort of mental health problem.

The literature says that a less effective way of coping is avoidant coping, which is using drugs or alcohol. Even excessive work or excessive exercise are ways of avoiding dealing with a problem.

There's also emotion-focused coping by people who get caught up in their emotions and focus on how they feel. They think, "I can't cope." They work themselves into a dramatic state.

In the research there are very contradictory results on what are the best ways to cope under what circumstances, particularly in seeking help from other people. It's not clear that seeking help is necessarily a good thing. My PhD work demonstrated that people seeking help didn't necessarily improve their symptoms. For girls seeking help from their friends, it can almost have the opposite effect. Girls tend to amplify each other's distress. If people are not trained in how to deal with a mental health problem, they can talk up their distress and become drama queens. This may have some other positive outcomes, but I think it contributes to girls' elevated psychological distress.

We assume help-seeking is a good thing, but it's more complicated than that. We need to realise that. You need to teach young people what type of help is appropriate in what sorts of circumstances. It might even mean teaching girls that talking to your girlfriends about problems may not be the best way of dealing with problems. There needs to be a match between the problem and the type of help you need. That's a type of learning that young people probably don't get.

I then went on to look at some of the patterns of help-seeking—who young people seek help from. I've given some graphs in the handout. These are from data collected last year, supported by Healthpact, from nearly 1,200 young people from years 7 to 10. This supports information and trends we've seen for a long time.

We know that young people tend to prefer seeking informal help. In this case we specifically asked them about who they intended to talk to and who they did talk to about symptoms related to depression. It was specifically around depressive symptoms.

We found that both boys and girls preferred to talk, not surprisingly, to friends and family. In this case it was primarily parents. They were very loath to go to formal services. We included a whole lot of services they might go to: youth workers, clergy, their GP, school counsellor and such like.

In a number of studies we've done we have found the same pattern. There's not a strong correlation between who they say they would choose to seek help from and who they actually do seek help from. There are only very weak correlations between what they intend to do and what they actually do. So clearly there are a lot of things happening apart from their own rational decisions.

In year 7 the boys seems to have the highest level of help-seeking. They particularly seek help from their family and more so from formal services. Over the high school years, from years 7 till 10, boys drop off dramatically in their help-seeking, and in all types of help-seeking. On page 4, in figure 4, I've looked at the students who on our measure were depressed and sought help. In year 10 none of the boys who were depressed sought help from any formal services. So something is happening with boys over the high school years. They learn that it is not right to talk about their mental health problems and to seek help.

A different pattern occurs for girls. The incidence of girls seeking help from their family declines over the high school years, but they seem to substitute seeking help from friends. The incidence of this rises quite dramatically,. and their formal help-seeking increases a little.

My background is in developmental psychology. I would see that as probably a healthy developmental pattern. These are the years when young people are establishing their autonomy and independence from their family, so it is appropriate for them to turn to their peers and your friends for more support but also to pick up formal help-seeking services. They don't stop talking to their family by any means. There's still a lot of talking to their family, but there is a decline. I would say that that's probably a healthy pattern. It's what you'd expect young people to do.

The incidence of boys talking to their family declines, but they don't pick up talking to anybody else. So over time they start to talk to nobody, which is what we know boys do. They don't share their problems. The ultimate outcome of that is that it manifests as a suicide that nobody expects. Boys suicides sometimes seem to come out of the blue, because nobody knew they were upset. When you start looking back a bit, you'll find there was a series of events. They might have broken up with their girlfriend, failed an exam or not made the football team, but nobody thought anything of it at the time because the boy wasn't displaying any signs of distress so they was not given any support. Then it gets too much and the next thing you know you have a suicide.

I think it's clear that something happens in high school for boys around help-seeking. Probably year 7 is when you need to do something to intervene, to stop. The decline, from my data, seems to happen between years 7 and 8. Once they get to high school, they learn very quickly that it's not right to be talking about how they feel psychologically and about any problems they have. They've got to stop it.

In the survey, we asked them whether they talked to mental health professionals—school counsellors, psychologists and psychiatrists. Unfortunately, the school stuff is with the other mental health professionals. We also asked them whether they talked to any school staff, except for the counsellor, such as the classroom teacher, their principal, support staff. In figure 5, I have the patterns for what they do in seeking help from the school. Again you see the same pattern of the boys dropping off but the girls increasing somewhat, particularly in talking to teachers. Even so, less than 10 per cent of young people in high school are saying that they will seek help for mental health problems and other life issues from the supports provided at the school.

In the study we did, we asked them specifically what their barriers to help-seeking were. Some of those barriers came out in the mental illness evaluation, but we gave some open-ended questions. Overwhelmingly, the major barrier is that young people are scared and shy. They don't like to talk to strangers. They do not want to open up about their personal feelings to people they don't know. They said they were embarrassed. They were shy. They were scared. They wouldn't know what to say. They like to talk to people they already have a relationship with, people they felt they could trust and they knew how to interact with.

We know that depression and suicidal thoughts cause help negation. Those problems make people apathetic and hopeless. That becomes a real barrier. They have no oomph to get up and help themselves, so there's a vicious circle of hopelessness and apathy that becomes a barrier specifically for depression and suicide.

It was also clear that the kids, especially the boys, lack what we call emotional competence. They don't have a language for talking about their emotions. They're not comfortable talking about both their social and their emotional environment. They haven't been provided with a language. With girls that's much less the case. Most of girls' relationships are built on sharing intimacy, so girls have quite a good vocabulary for sharing their internal world. But boys do not have such a vocabulary.

Many of them have had experiences of seeking help. They weren't helped. Their problems weren't taken seriously. Although I'm a bit reluctant about going on record saying this, I pulled out data for those who saw the school counsellor who said they had previously seen the school counsellor. We asked them whether they found the visit helpful or not. You can see from the graph in figure 6 that most of them were neutral or found it unhelpful. With some notable exceptions, there are some excellent school counsellors, but usually if you talk to kids you don't get a positive response about the school counsellor. The school counsellor is somebody they will not choose to go and see. They say they don't trust them to keep their confidentiality.

THE CHAIR: We've heard that before.

Dr Rickwood: They see them just as another teacher, but a teacher with a bigger stick. You get sent to the school counsellor when you're in trouble. They're not there as a support for you. Occasionally you hear stories of the girls going to the school counsellor because there's something happening in the social group and they're concerned about somebody else and they get a bee in their bonnet. But that seems to be one of the few times when they will actively seek out the school counsellor to intervene.

THE CHAIR: Did you ask if they were more prepared to ask youth workers and people like that?

Dr Rickwood: We didn't specifically ask them that, no.

THE CHAIR: Some of the schools have access to youth workers, who are sometimes preferred by students. We've been told this in another inquiry.

Dr Rickwood: I wouldn't be surprised. I've had some thoughts about the role of counselling in the schools. The youth worker model, I think, would be appropriate.

They also have generally negative attitudes towards seeking help. especially boys. They just say, "I just wouldn't do it. It's not something I'd do." They have quite a high fear of stigma, not surprisingly. They don't want their friends to know they're crazy, weird or such like.

On the other side of the coin, the facilitators of help-seeking are the opposite of those things, but I think young people will seek help when they've got a secure and trusted relationship with somebody. That can be any number of people, but they often form a particular attachment with an adult they're likely to seek help from. That can be a teacher. Very often it might be an aunt. Sometimes they need someone a bit removed from whatever conflicts they have with their parents. PE teachers and people who are involved with the kids directly in activities are the ones they're more likely to open up to.

They obviously need to understand and have a vocabulary to describe their social and emotional state, which some of them don't have. They need to know what services are around and what to expect from them. You can't say to them to go to the counsellor or to go to a psychologist. They would say, "What would happen to me if I went to a psychologist? When I walk in the door, what will they do to me?" Knowing exactly what might happen to them behind the doors might encourage help-seeking.

As in building up most behaviours, you need to have mastery experiences. Start young with graded experiences, find out that it worked and build up a mastery of help-seeking or ways of getting support for your mental health issues.

We know that adolescence is an essential time for mental health and that young people spend a lot of times in school, so that schools are an ideal point to put mental health interventions in place.

There is a plethora of school programs coming out now. The question for schools is: what do they choose? What are they going to go with? For many of them there isn't an evidence base, but the evidence base is building for some of the school programs. With those I've had something to do with or know a bit of, I've pointed out specifically what the evidence in relation to help-seeking is.

We found that the mental illness education evaluation clearly had an effect in reducing stigma, but stigma specifically towards other people with mental illness. So it improved young people's attitudes towards other people in the community with mental illness, which is one of its major aims.

It did improve mental health literacy to some extent, particularly understanding the symptoms of depression and the symptoms of schizophrenia. But there's more it could do in looking at issues that are especially important to young people. It could be a bit broader than it is.

What the mental illness education program lacks—and we pointed it out in the evaluation—is that it is not having an impact on help-seeking. The program doesn't increase young people's help-seeking behaviour. It doesn't increase their awareness of the resources in their community.

It would probably be better to get young people to do their own research. Some facilitated way whereby they go out and find out what the resources are might be a better way of learning than just telling them and them totally forgetting. But the program doesn't impact on help-seeking, which is something they're going to think about.

The program seemed to work equally well for boys and girls, but boys were starting at a much lower point. So a lot more needs to be done for boys. We made some suggestions about trying to have more male presenters. Mental health is a female thing largely, and that will be a barrier for boys. They don't want to get into female-dominated areas. They need to see it as being a legitimate concern for males.

MindMatters is a program with a growing evidence base. It has some components on help-seeking, but I don't think they've been systematically evaluated. Because MindMatters is a whole-school thing, it takes some resources and some real commitment by the school to fully implement it. It's quite a big ask of the schools to implement MindMatters.

THE CHAIR: Is it helpful?

Dr Rickwood: Yes, I think so. Elements of it have been evaluated and shown to be helpful. I don't know specifically whether it helps with help-seeking, but it's theoretically based, and the evaluations I'm aware of are showing that it is helpful. It tries to get the whole school to be mental health promoting, which is good and essential.

Yellow Ribbon is not coming out well in evaluations. It doesn't encourage help-seeking at all. So it doesn't seem to be an effective way of getting young people to take their mental health seriously. I've noted a few other programs. Programs seem to impact on kids' knowledge and their attitudes, but there don't seem to be any yet that get them to seek help. That's because I think a lot of the barriers to help-seeking are not necessarily just attitudinal or knowledge. There's more to it than that.

MR SMYTH: So there's no program that you're aware of that encourages help-seeking.

Dr Rickwood: None that has been evaluated to be effective at increasing help-seeking that I know of.

MS MacDONALD: You say it's not just attitudinal. I'm making an assumption here. Feel free to shoot me down. Certainly society's attitudes towards seeking help would play a large part in that as well.

Dr Rickwood: No, I don't deny that attitudes impact. We find often that the link between attitudes and behaviour is not very strong. Improving people's attitudes doesn't translate necessarily into changing behaviour. There are a lot of other things with young people that are largely environmental. Very often you change the behaviour and the attitudes change afterwards, and then they'll sustain a behaviour.

A good example of changing health behaviour is the approach we took to seatbelts in Australia. We started off with a legislative approach and some big sticks to wearing seatbelts, and it did change behaviour. The attitudes changed afterwards, and now people think it's a sensible thing to wear your seatbelt. So the change in behaviour has produced

a change in attitudes and social norms that then supports the behaviour. Getting a behavioural change to start with, somehow triggering that change, is more effective. You can change attitudes all you like, and people think it is the right thing to do that, but they still don't do it. It's a problem with lots of health behaviours. The attitude behaviour link is problematic.

I've been talking with Bill Thompson, who is involved in the department of education in the training and recruitment of school counsellors. In my role as head of the Centre for Applied Psych, this has been brought home to me recently. A trickle of teachers come to us in Psych wanting to become school counsellors. It's not simple. The training for school counsellors is a bit of a mess. There's a lot of debate at the moment with Education, Psych and school counsellors about what sort of training a school counsellor should have and what their role should be.

One of the problems is that to be a school counsellor at the moment you're supposed to have taught in a school for three years, so you have to have your Dip Ed. Then they want you to have a major in psych and to have done a subject in psychological assessment or school assessment.

Teachers don't usually have a major in psych. There's no point doing a major in psych, because there are very few jobs as a psych teacher, so it doesn't fit to do that. So they come to me. Here they are professionals, and I tell them they have to do psychology 101 and 102 and go through doing a whole major in psych.

We don't teach, and most universities don't teach, psychological assessment until fourth year. To get into fourth year you have to have a double major in psych. So they can't get in to do the psychological assessment subjects. At the University of Canberra, we don't teach the types of tests that they need as a school counsellor. We do a broader thing, so they still wouldn't come out adequately trained to be a full school counsellor.

We're putting some things in place for that. At the moment they need school counsellors. They're trying to quickly train some people to get them into the system, but it's not simple to do, because the universities aren't set up to do that. Apparently there used to be a graduate program run in the education faculty. Because it wasn't funded and there aren't that many who want to do these programs, they let it drop. The demand wasn't enough to make it sustainable. This is a bit of a problem for the universities if you need only five to come through a year. The universities are cutting courses that have that many people in them. It's not always possible to repackage other things when you're trying to meet a specific need.

We're going to start a double degree in education and psych, which will mean you could become a teacher but have an extra string to your bow and go down the psych path later on. Bill agrees with me. He thinks we should have in the schools two levels of mental health and specific mental health help. We have basically educational psychologists. I don't think they need to be teachers. These are people who are trained in assessment and in referral. They would be specialists in diagnosis and assessment. They wouldn't be attached to a school, because you couldn't afford to have one for every school, but they'd be a resource that the schools would use.

But then I think you need a youth worker model. I think you'd train up teachers who showed a particular affinity with the kids, give them some extra training and make them youth workers—I think I called them health promotion workers—within the school. They would put in place health promotion and prevention and maybe do some counselling, but then they wouldn't be assessing for ADHD or things like that. They would notice kids at risk and refer them on. You need to have those two levels. Somebody who is really doing mental health promotion work needs to be part of the school community. They need to be out there with the kids, interacting with them.

But you're not going to have somebody who has spent six years at university and has all these specialist skills and is quite expensive. You can't afford one per school. They're going to be spending their time in their office. They're not going to be able to be out there developing relationships with the kids. I think that would be better coming from a teacher—PE teacher, whoever.

I'll finish off by talking a bit about mental health promoting schools. The MindMatters program tries to turn the whole school into a mental health promoting school. There's a lot schools could do. I have a particular bugbear about school assemblies. I don't know if you've been to a school assembly recently, but they're not mental health promoting.

THE CHAIR: They are a kind of general oppressive old structure. Yes, I know. There's a lot of that in schools. We had an interesting submission from a person from ANU on restorative justice. Does MindMatters include those sorts of principles? That is a fundamental cultural issue which is challenging that more oppressive structure. I think it is bad for anyone's mental health to be in a structure that is so hierarchical.

Dr Rickwood: MindMatters won't put it in that sort of language, but it's the same type of principle.

MR SMYTH: How good are the websites Reach Out, Head Room and Blue Pages?

Dr Rickwood: They're good as starters. Reach Out has some general info. Head Room is specifically around help-seeking behaviour. Reach Out is more general. They have stories by kids and try to be pretty whiz-bang. You go into Blue Pages and there is a sort of a do-it-yourself cognitive behavioural therapy called MoodGym for the kids, which is the most effective technique for depressive symptoms. Those three sites are good. They're just beginning to develop these sorts of sites.

At the University of Canberra we are developing an Internet counselling platform where kids can seek help from a counsellor over the Internet, so do it in an anonymous way.

THE CHAIR: Has anyone evaluated how useful that is?

Dr Rickwood: We're still developing the platform at the moment. We've just done some research this year with our own students. We didn't fully implement the counselling, but we had them have a play with it and tell us what their concerns would be, what they would like and what they wouldn't like. We're in the process of analysing those data at the moment. What we'd like to do next is find somewhere we could put it into action and evaluate whether it was effective. We think particularly boys might seek counselling more over the Net.

MR SMYTH: You said there's no program that encourages help-seeking. Is that because we can't develop one, or is it we haven't tried, or is it yet to come?

Dr Rickwood: Other programs have elements of it. They're not specifically focused on help-seeking. They're focused a bit more broadly. I think help-seeking falls off the edge a bit, and that's where they don't seem to be having an impact. It may be how we're measuring it. Maybe they'll have an impact further on, but they don't seem to be having an impact at the moment. Probably the closest one that's specifically focused on help-seeking is the DIT kit, which is very new. It was an offshoot of a National Health and Medical Research Council grant that Wollongong University has done. They've done a very minimal evaluation. It was a very small sample. It is fundamentally focused on help-seeking. You have to put a whole lot of processes into place. There's no point encouraging kids to seek help if there's nowhere they want to go to seek help. You're not going to get them to do it. You've got to work from both sides—develop some services they will use and then teach them how to use them.

MR SMYTH: Going to see the school counsellor is not going to work.

Dr Rickwood: No, I don't think they will.

THE CHAIR: I didn't get a chance to read it this morning, but there's an article in today's paper by Tom Stirling. He came to see me. He was a social health visitor in the 1970s and quotes Hennessey quite a lot. I don't know if Hennessey said this, but he said that if you give ordinary people ordinary help with ordinary crises they probably won't have a mental health problem. You said that help-seeking isn't necessarily good. You talked about the potential for beating up the drama between girls. I'm interested to know whether that's what you meant when you said that it's not always necessarily going to be useful. If it isn't, what is the research saying? You said that mental health educators go to schools and give definitions of depression, schizophrenia and so on. There's a danger that you move into the medicalisation of normal behaviour because there's a spectrum of behaviour, blah.

I remember that a number of friends of my daughter were using the word "depressed", whereas at that age I wouldn't have articulated it at all. It was a totally different environment. I would've just suffered in silence probably. Maybe that was okay; maybe it wasn't. But I was concerned because there was a tendency for them to use that language and then say they needed medication, or they needed to see a doctor, and getting it sometimes. I knew these girls well. I'm not an expert, so I couldn't tell how serious it was. But I was wondering why five of six girls would require medication. Maybe it was warranted. But I wondered whether there was a danger. It's not the ordinary health in ordinary crises stuff that's happening. This language is developing around it. I'm not saying that it's not incredibly important to help people who are seriously mentally ill. Do you have a comment on those concerns?

Dr Rickwood: I have a lot of time for the promotion, prevention and early intervention approach, but there are some issues around that. I read the article also. I thought it was excellent and something we need to take more on board.

One of the issues young people have—it's an issue we all have—is what's normal and what's not. How do I know if my feelings are within the normal range or they're not? What sort of help do I need in what types of situations? I think that's something we need to learn and that we are not good at learning. You'll see in the data I have here that there is a huge amount of depression in teenage girls. So there is a real problem.

Best practice for young people is not in the first instance to give them anti-depressants. You would try cognitive behaviour therapy to start with. I've changed my tune a bit. I used to be very anti-drugs, but I think drugs are improving so much. They're not a panacea . But early drug treatment in some cases can stave off a more serious problem.

Pat McGorry's work in EPPIC on early psychosis is finding that if with early signs of psychosis they put people on low-dose anti-psychotics they can prevent full-blown psychosis. So I think we need to be careful of having a completely anti-medicalisation approach. Notwithstanding, that shouldn't be the first port of call. We need to know what works when. I think all young people need cognitive behaviour therapy, to be able to recognise irrational thoughts, to think positively. MindMatters is a resilience building thing. These are positive things for all of us. It is especially effective for reducing depression. With other things like panic attacks, anxiety and ADHD there's a stronger biological base to the disorders, so it's less a matter of mind control. But then again we need to recognise those disorders early. I think they need a better language. We say the word "depressed". It can mean any number of things. There's depression, depression and depression. But I guess if they know more about being depressed because something awful happened today and you'll be all right tomorrow—

THE CHAIR: So it's really connected with that skill building?

Dr Rickwood: I think so.

THE CHAIR: That's an important and interesting point.

MR SMYTH: Which site had the cognitive program on it?

Dr Rickwood: Blue Pages. The Centre for Mental Health Research at ANU have put that together specifically for young people. It's CBT stuff. Once you learn the skills, you can teach yourself.

MR SMYTH: Page 3 says that 18.4 per cent young ladies show signs of clinically significant depressive symptoms. What does CESD stand for?

Dr Rickwood: That was the measure we used—the Centre for Epidemiological Studies depression scale.

MR SMYTH: So that's something developed here in Australia?

Dr Rickwood: No, I think it's an American instrument.

MR SMYTH: So it's a standard?

Dr Rickwood: Yes. There are a number of instruments. This is just the one we used in this case. Specifically, we chose this one because it doesn't have a suicide item in it, and these days you can't get into schools and use the "suicide" word.

THE CHAIR: That's interesting, because when we had a group of student reps here, we had a conversation and we asked, "What's the main issues for you?" They said suicide. It was really quite concerning how many of that group from high schools and colleges said that was an issue, that they had been told by a friend that they had been considering it and they didn't know how to handle it.

One person said that it had been said—I can't remember whether it was to her or to someone else—and the response was, "Well, I've got my own. It's too much of a downer. Don't talk to me about that." There was story after story after story. I don't know why schools aren't letting you say that word, because the kids are sure saying it.

MS MacDONALD: Is that Australia-wide or is it ACT?

Dr Rickwood: There has been a bit of a move Australia-wide. Some people in education and in some of the mental health services have a problem with a focus on suicide. They're well intentioned. You don't prevent suicide by doing suicide prevention. Very often if you give drug and alcohol education you increase drug behaviour. There's a similar problem with suicide. They prefer to build resilience, so they work on basic skills However, I think they're taking it too far, in that you're not allowed to use the word. There's evidence now to show if you ask people about suicide it does not increase suicidal behaviour.

MR SMYTH: You say 18 per cent of year 10 girls show significant depressive symptoms. How close is that to suicide?

Dr Rickwood: Depression is one of the most highly correlated factors with suicide. Even though we know boys are more likely to complete suicide, girls are still more likely to attempt it, which I don't think we should minimise. We seem to say, "Don't worry about that, because they don't complete it." But it's only because they use less lethal methods. There's always the potential.

MR SMYTH: You might accidentally do it?

Dr Rickwood: Yes, they do.

MS MacDONALD: They're using drugs as opposed to throwing themselves off a bridge.

Dr Rickwood: Yes. Girls attempt suicide more than boys but boys, because they shoot themselves or hang themselves, are more likely to die as a result of it.

MR SMYTH: Or in a fast car?

Dr Rickwood: Yes.

MR SMYTH: The 1200-odd kids you saw in four schools is a good sample, isn't it?

Dr Rickwood: Yes.

MR SMYTH: Did it vary from high school to high school? Are there geographic factors?

Dr Rickwood: Not a lot. That was something I had set out to look at. I got money from Healthpact because I wanted to look at social capital. I picked two inner city established schools and two outer schools. I was anticipating some differences. There were hardly any differences at all on any of the measures amongst the schools. One thing we were looking at was their awareness of Yellow Ribbon. There were differences in that, but deliberately we picked two schools that had implemented Yellow Ribbon and two schools that hadn't.

MR SMYTH: That might be good if it's a bad program.

Dr Rickwood: But then it was a bit strange. One school had very high awareness of Yellow Ribbon. The other three schools were equivalent. Two of them hadn't implemented it and one of them supposedly had, but I think they had only partially implemented it.

MR SMYTH: Do you know if MIEACT had been to the four schools?

Dr Rickwood: Back then? I don't think so. I know they hadn't been to Melrose for a while. I think they might have gone to Belconnen and Gold Creek later in the year. I don't think they'd been to any of those schools recently, but I'm not entirely sure.

THE CHAIR: I think we will have to finish. We've gone way over time.

MR SMYTH: What was the fourth school? I wasn't going to ask but you mentioned three. What was the last one?

Dr Rickwood: They were Lanyon, Gold Creek, Belconnen and Melrose.

MR SMYTH: It was a good spread.

THE CHAIR: It's really interesting. Thank you for talking to us. We might even have some more questions. Can we write them to you? I want to think about what you said.

MR SMYTH: Can I just ask one final question? When did the 18.4 per cent figure become available and what has been done, if anything?

Dr Rickwood: I'm in the process of feeding the information back to the schools.

THE CHAIR: It's recent?

Dr Rickwood: Yes. I'm writing a report for them at the moment. That's the trouble. Being in a teaching institution, I spend a lot of time teaching. I'm about to go the Institute of Criminology, so I can spend more time doing research. I'm going to focus on

mental health and crime, but I'm hoping I can still keep up some of this, because this is where my heart is, I suppose.

THE CHAIR: It's really important work.

MR SMYTH: Thank you. That's really informative.

KYLIE EASTON was called.

THE CHAIR: You should understand that these hearings are legal proceedings of the Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means you are protected from certain legal actions such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Do you know what that means?

Ms Easton: Yes.

THE CHAIR: Can you state your name and capacity in which you appear.

Ms Easton: I am Kylie Easton. I'm a year 10 student at Canberra High School. My concern is in regard to compulsory physical education in ACT high schools. It should be compulsory in earlier high school years, but towards the end of high school it is unnecessary.

I've had seven enforced physical education units over my high school career, and it has quite seriously affected me in many different ways. I'm a lot worse than average on the sports field. As a result I find it quite hard to fit in during the lessons.

When teams are chosen, I'm normally picked towards the end. Thus I'm rarely given a chance to demonstrate skills in the sports I do perform well in. It has led to ostracisation from my classmates. I'm definitely not the only one in my year level or the ones below me who feels this way. Lots of students in my year I talked to about this were very upset about how they were being treated by their classmates because of the way they performed in PE. Some of them have even cut themselves off from their peers altogether.

Low self-esteem was a direct result from it. With depression rates rising steadily, we should be looking for a cause, but here's one that's staring us in the face and everyone seems to just ignore it. PE is a compulsory subject.

Popularity I see as a menial problem compared to the damage that the subject does academically. For me personally, it has put a scar through my record. My sports teachers all refuse to mark on participation, and examine purely on physical ability, which doesn't give anyone like me a chance.

Our school offers many extension programs in a whole range of subjects. My maths, science, English and history teachers requested that I make full use of this opportunity and join the extension program in their subjects, so I omitted one class from my timetable. After a few days I was informed that I couldn't presume to miss sport for academic subjects, because sport was compulsory. Unfortunately, I couldn't miss any of my other courses, so I had to drop out of the extension class altogether. Thus instead of bettering my abilities in maths and science I am forced to play sport.

I intend to go on to university and complete a science degree. None of my ambitions involve sport. I already know how to keep myself healthy, from information I have received at home and at school. Instead of being beneficial to me as it was intended, PE has held me back without being pertinent to my future.

I gather the aim of introducing compulsory sport into high schools was to ensure that our population, which is rapidly becoming obese and unhealthy, were aware how to eat and that our youth received regular exercise. Unfortunately, we learn little in physical education classes in the way of keeping ourselves healthy after we graduate. Not enough information is given, and we tend to just spend time playing team sports on the field, and half of the students don't even participate. I find this quite redundant. Thus I believe we need to offer at least one theoretical physical education class at every high school, and it should be compulsory, to year 7 students.

As I said in my submission, the background health needs to come from home and a trusted source as opposed to coming from a PE teacher. An awareness campaign through the media or something similar would benefit us more than PE at school. It's important for youth to gain a rough idea about health while they're at school. However, the focus should be on the theoretical side rather than how well you perform. If it's taught well earlier on in years 7 and 8, it's unnecessary in years 9 and 10.

Having completed the required units of physical education, making this course an elective as opposed to a compulsory subject wouldn't affect me. However, I know that most of the students in my year don't want sport to be compulsory because it has led them to low self-esteem and problems in their academic areas. Thus I think physical education should not be compulsory in years 9 and 10.

THE CHAIR: Thank you. Do you want to make a comment on fitness testing?

Ms Easton: Fitness is the area I do worst in. I think a fifth of our grade is completely devoted to how well we perform in fitness. I think we run 1½ kilometres and we have to do it in a certain time, otherwise we automatically fail. You're not even given a chance to improve. It's an automatic failure if you're over a certain time. Other than that, the grades are very defined. Even if you make a two-minute improvement, it doesn't affect your grade. It can still be an E. You can still fail even though you've improved lots.

We also have a fitness test called the beep test. You run laps of the hall or the gym to a tape that's played, and you have to make it to the other end before the beep or you have to stop. Again, they don't take into consideration improvement. It's just how well you do by level. Again that's unfair.

THE CHAIR: And do you do that in front of other students?

Ms Easton: Yes, always.

THE CHAIR: Is that an issue?

Ms Easton: It's normally the whole class. Sometimes we do it according to sex, but I don't find that helps a lot. I find the criticism comes more from the same sex than the opposite sex. The boys tend to pick on other boys and the girls pick on other girls. It's always in front of the other students, which again leads to low self-esteem and depression.

MS MacDONALD: In PE what sports and activities are offered, apart from the fitness testing?

Ms Easton: In years 7 and 8 it's set. You don't have a choice. In years 7 and 8 they cover dance, soccer, AFL, sometimes a little bit of tennis, netball and basketball. Then in years 9 and year 10 you have a choice of outdoor education, which I don't think has a fitness component. You are not judged on fitness in that.

MS MacDONALD: What's outdoor education?

Ms Easton: You go abseiling, rock climbing, caving. There are lots of camps and things like that that are compulsory.

MS MacDONALD: Basically throwing yourself off a cliff, by the sounds of it.

Ms Easton: Pretty much. But there's not a fitness component in that subject.

THE CHAIR: What's your comment on those sorts of activities? You don't like them either? Are all those things you raised graded?

Ms Easton: You are graded on how well you perform. If you were graded on improvement, it would be better, because at least you would be showing that you're trying and you're putting in the effort, but they don't even consider it. They just grade you according to a—

MS MacDONALD: You talked about the subjects which were offered in years 7 and 8. If you like any of those subjects, are you able to take them further in years 9 and 10?

Ms Easton: No. They don't let you specifically take a certain subject in years 9 and 10. At my high school, Canberra High School, you can take outdoor education, normal PE or female PE. They run a separate female PE class. They also run a coaching class where you can learn how to be a coach and you get some level O coaching certificates, which is the one I took last semester, but in that you're still judged on your fitness, even though that's not pertinent to how well you coach. You're still judged on your fitness level and how well you perform on the field. You seem to spend under half the time in the classroom anyway. You spend it all on the field not learning anything.

MS MacDONALD: There seems to be a large emphasis on team sports. There's no offer of individual sports like swimming, walking or things that would generally promote health.

Ms Easton: They tend to avoid all of those. It's all team sports. Our school doesn't have the resources to coach students individually in things like swimming. I think there is a swimming component to the outdoor education course, but it's only a brief one. It only lasts two weeks in a 20-week term.

THE CHAIR: Do you have to pay?

Ms Easton: Some of them have levies. The outdoor education class has various camps throughout the year, and they're quite expensive.

MS MacDONALD: We're speaking about your high school. I don't know if Kerrie or Brendan knows how widespread this is across other high schools. Do you know how widespread it is across other high schools?

Ms Easton: Talking to people from Belconnen High, I think they have a pretty similar structure to what we have, but other than that I don't really know.

MS MacDONALD: You've talked about it being compulsory in the lower years but not in the higher years. A number of people coming before our committee talk about the general level of fitness dropping off not just among school students, which we're focused on, but across society generally. We're looking at the health of school-aged children, obviously.

While you may be able to learn about health and nutrition in your family environment, there are a lot of students who may not. How amenable do you think other people in your school and other schools would be to the idea of a general health and nutritional element as opposed to a focus purely on physical education?

Ms Easton: Speaking to other students my own age, I think a theoretical subject on health and nutrition would be much more beneficial and should be compulsory in year 7, just to give you the background, and then you should be able to take PE as an elective the whole way through high school. I don't think it should be compulsory, because in years 9 and 10 all we seem to do is spend every lesson on the field playing a team sport. That's not teaching us how to have the right diet and exercise regularly. It's only making kids depressed and—

MS MacDONALD: Especially if you don't like the sport.

Ms Easton: Yes.

MR SMYTH: You said earlier that you weren't allowed to participate in the ones that you were either good at or interested in. What would you rather do?

Ms Easton: One way to combat that would be to have smaller class sizes or even to level PE—have students who aren't very good at PE in a lower level with other students of the same ability. Another way to combat that would be to avoid kids selecting the team, to just have teams set by the teacher and also to play more individual sport where you have the opportunity to demonstrate your skill without having to avoid other students who are trying to do better—

THE CHAIR: Kids choose the team?

Ms Easton: Yes, lots of the time.

MS MacDONALD: But didn't they do that in your time? They did that in my time.

MR SMYTH: That's standard practice.

THE CHAIR: I think I opted out of sport at a very young age, for obvious reasons.

MR SMYTH: What are you interested in? If you had a choice and the teacher said "What sports are we doing this week, Kylie?" what would you say?

Ms Easton: I would choose swimming. I love swimming. I swim most days after school. But that's not offered to us as a course. I also love tennis, but our school doesn't have the resources for it. There's are not enough racquets for every student to have a tennis racquet. They get broken too easily. I tend to go more towards the individual sports.

MS MacDONALD: A lot of evidence seems to indicate that health and nutrition are going downhill around the Western world. What about the idea of PE credits. You've said that you like swimming and you do it almost every afternoon. What if you were able to trade in that time at swimming and say, "I've done this particular physical activity and therefore I shouldn't need to do this"?

Ms Easton: I would say that would be much better. Our school offers a similar idea called the program of excellence. If you participate in a sports subject or a musical program outside of school, then you can take off your PE line and instead spend it in the library studying or whatever. But when you do that, you don't receive a grade for that line, so you're then missing a grade on your year 10 certificate and it's impossible to get any of the academic awards, best all rounder awards or anything like that.

MS MacDONALD: I'm chair of the Education Standing Committee. I might see if I can contact you at some point and have a chat about other things. I am always looking at ways of helping improve the education system. Your ideas would be appreciated.

MR SMYTH: Lovely presentation. Thank you. Well done.

MS MacDONALD: Have you had any conversations with your parents about your frustrations?

Ms Easton: I would say my parents are a little biased, both coming from academic backgrounds. Both of my parents are academics, so both of them strongly believe that sports is redundant.

MS MacDONALD: It's good to see that you've got a little bit more of a balanced view than that.

Ms Easton: They agree with me. They can see that I'm being ostracised from a lot of my classmates. The group at school I spend most of my time with is pretty much set by how we perform in PE, which is rather unfortunate. Most of the kids in my group hate PE and don't perform well in it. There are a few who do well but those who do not tend to stick together. If you're a team in PE, then you tend to be a friendship group.

THE CHAIR: I'm interested in why you think this uncomfortable situation you find yourself in wouldn't also be uncomfortable for a younger student. I understand your argument. It's very reasonable. Why are all the concerns you've raised not a problem for a year 7 or 8 student?

Ms Easton: From what I remember of years 7 and 8, the teachers tended to always choose the teams for us.

THE CHAIR: So it was handled differently?

Ms Easton: They knew that this would happen, but in years 9 and 10 this seemed to be forgotten or—

THE CHAIR: It's just the law of the jungle, Lord of the Flies.

MS MacDONALD: Part of the development experience.

MR SMYTH: Do kids who do not do as well or who are less interested in academic studies feel the same?

Ms Easton: I have several friends who do well in PE, not in my particular group, but one girl in my group in a program of excellence does well in PE. She does quite well in her academic subjects but doesn't particularly enjoy them. She intends to be a triathlete when she grows up. She also says that sport shouldn't be compulsory. I think she can see that other students are being ostracised and are getting depressed. It shouldn't happen just because of one subject. Students should be able to get a well-rounded education without worrying about one particular aspect of their curriculum.

THE CHAIR: Brendan's point was that this can happen to kids who are struggling in the academic area. The attitude of scoring, making winners and losers and having competition and grades in schools is always going to make it difficult for the ones who are failing. Is that your point?

Ms Easton: In our compulsory subjects—maths, science and English—we're levelled, so students who are of lesser abilities are kept separately. I don't think that makes them feel outcast, I would say that that's probably an improvement rather than just putting everyone together. It allows for specific development for students, for instance, in level 3 maths who only have very basic ideas of maths. They can get the individual attention they need, whereas in PE they don't even consider that. They never level and students are just put in together.

THE CHAIR: Quite inconsistent, isn't it?

Ms Easton: Our school is a feeder school for the AIS. A lot of the AIS students come to our school. Some of them are in our normal PE classes, and that just makes it impossible to compete. They star in PE.

MS MacDONALD: Which makes it particularly unfortunate.

THE CHAIR: We appreciate your time. Thank you.

The committee adjourned at 5.14 pm.