COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# HOUSE OF REPRESENTATIVES

## STANDING COMMITTEE ON EMPLOYMENT, EDUCATION AND WORKPLACE RELATIONS

**Reference: Education of boys**

THURSDAY, 7 JUNE 2001

CANBERRA

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

**INTERNET**

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to: **http://search.aph.gov.au**

**HOUSE OF REPRESENTATIVES**

**STANDING COMMITTEE ON EMPLOYMENT, EDUCATION AND WORKPLACE RELATIONS**

**Thursday, 7 June 2001**

**Members:** Mrs Elson *(Chair)*, Mr Barresi, Mr Bartlett, Mr Cadman, Mr Emerson, Ms Gambaro, Ms Gillard, Mrs May, Mr Sawford and Mr Wilkie

**Members in attendance:** Mr Bartlett, Mr Cadman, Mrs Elson, Mr Emerson, Ms Gillard, Mrs May and Mr Sawford

**Terms of reference for the inquiry:**

To inquire into and report on:

- the social, cultural and educational factors affecting the education of boys in Australian schools, particularly in relation to their literacy needs and socialisation skills in the early and middle years of schooling; and
- the strategies which schools have adopted to help address these factors, those strategies which have been successful and scope for their broader implementation or increased effectiveness.

## WITNESSES


**HORDERN, Ms Sarah, National Policy Officer, Australian Association of Social Workers...............1073**

**MOLETA, Ms Elizabeth Ann, Member, Australian Association of Social Workers ...........................1073**

**WILSON, Ms Rachel Louise, Member, Australian Association of Social Workers .............................1073**

**WYLES, Mr Paul, Member, Australian Association of Social Workers ...............................................1073**

**Committee met at 9.09 a.m.**

**HORDERN, Ms Sarah, National Policy Officer, Australian Association of Social Workers**

**MOLETA, Ms Elizabeth Ann, Member, Australian Association of Social Workers**

**WILSON, Ms Rachel Louise, Member, Australian Association of Social Workers**

**WYLES, Mr Paul, Member, Australian Association of Social Workers**

**CHAIR**—I declare open this public hearing of the inquiry into the education of boys. I thank you for your attendance. I am obliged to remind you that proceedings here are legal proceedings of the parliament and warrant the same respect as proceedings in the House. The deliberate misleading of the committee may be regarded as contempt of the parliament. The committee prefers that all evidence be given in public, but if at any stage you wish to give evidence in private please ask to do so and the committee will consider your request. We thank you for coming back. We know you have been before the inquiry before, but we had many disruptions with divisions going on. We appreciate the fact that you have come back so that we can look further into your submission. I now invite you to make some introductory remarks before we proceed to questions and discussions.

**Ms Hordern**—We do not have Peter Camilleri with us here this time—he came the previous time—but we invited Rachel to join us this time because of the things that had been mentioned in the letter inviting us back. You said that you were interested in hearing more about the program that Liz and Paul developed and also about ADHD and ADD. Rachel did her honours thesis in social work on ADD, so we thought she might be able to answer some questions. She is also involved in a local ACT government project called Schools as Communities. I remember that last time, Rod, you were expressing concern about how schools would be able to take on even greater responsibilities. I think this project is very interesting in that way.

**Mr SAWFORD**—It is interesting that the good schools that we visit have deliberately reduced their responsibilities, even against the orthodoxies of education departments. So it subscribes even more strongly to what I was saying before.

**Mrs MAY**—I was particularly interested in the school's role—you were talking about the expansion of the school's role—within the community and bringing on professionals, such as counsellors and maybe the Juvenile Aid Bureau, and really expanding their roles and making them part of the community. Often when you go into schools now, you talk to the principals and the teachers and they are just stretched to the limit—their budgets are stretched, their teachers are stretched and their resources are stretched. I was particularly interested in those sorts of comments that you made in your submission. I wondered if you might like to expand on that and on how you see the education department working hand in hand with other government departments. Can you expand on how you see those extra roles within the school and how that could help?

**Ms Wilson**—As a worker in the Schools as Communities Program, which is a similar model to what was proposed in the submission earlier, I am a social worker who is placed in two schools in Canberra. I work with families in two roles—a family support role and a community

development role. The community development role takes on more of a structural approach and looks at the bigger issues that are occurring in the schools. Say that there are a number of children with anger management issues, there are a number of parents who present with drug and alcohol issues at school or mental illness is an issue in the community, that community development role allows me to establish programs and links that bring professionals into the schools to deal with those issues with those parents. The family support role allows me to work with families in a supportive role. The school counsellors work with children around individual issues based on education, whereas in my role—a family support role—I get to work more with the families of those children and refer them to services, advocate for them and bring out what the issues might be.

That model does not put extra pressure on the teachers in the school; it actually relieves some of that pressure. Teachers at the moment are finding it very difficult to deal with a lot of the behavioural management issues and the family issues which are coming up in the classroom and preventing the children from learning. Children are turning up at school without having had breakfast or a good night's sleep and without adequate lunch, and they are not in a space to learn once they get to school. The teachers find that they have to deal with all those issues before they can actually get down and do the teaching. Putting social workers in the school means that teachers are able to refer the child to me. I can work with that child and their family and deal with those issues so that, when the child comes to school perhaps the following week or in the weeks after, they are in a better space to learn. That is the type of thing we mean by those programs.

For these children who are turning up and who are not in a place to learn, there may be other issues in the family—like mental illness, drug and alcohol abuse or youth justice issues with older siblings—and families often feel that they do not have access to those services. By bringing in other professionals, we can help link them up to those. It might be about dental care for the child, making it easier for parents to get that child to the dentist, or dealing with those issues which teachers do not always have the time to deal with.

**Mrs MAY**—Not all of those professionals would be on site. You are talking more about a counselling role on site that would then act as a referral or a link to those—

**Ms Wilson**—I am the only person on site. I link those families to those other services which are out in the community by driving them to those appointments, taking them to the first couple of appointments and establishing ways for the family to get there more easily for future appointments. There is also the possibility of bringing in other professionals. That is more in the community development role. Say there were 20 children in the school with severe dental problems—we could look at bringing a community dental person into the school on a regular basis to deal with the dental issues. If nutrition or mental health were an issue, we could bring those people into the school. They would not necessarily be located there full time, though.

**Mrs MAY**—You were saying that you are shared between two schools. Are those two schools funding you?

**Ms Wilson**—No, the ACT Department of Education and Community Services is funding me under the family services department.

**Mr Wyles**—The ACT is pretty unique in that the child protection service is actually within the department of education.

**Mrs MAY**—In Queensland, the schools all have their own budgets. If the budget for a school counsellor is not there, then there is no school counsellor.

**Ms Wilson**—It is the same in the ACT. The schools get allocated a certain number of points and they can use those points to purchase a school counsellor. Some schools might have a counsellor for four days a week. One of the schools that I am at is able to afford its counsellor for only one day a week. Their budget is tight within that. I come into the school under a separate program, so I am funded within the department.

**Mrs MAY**—Is that a new program being trialled just in the ACT?

**Ms Wilson**—Yes. It has funding for two years at this stage. It is being trialled in eight schools across the ACT. There are six workers, so some of the schools have us only part time. Some of the schools with greater need have us for four days.

**Mrs MAY**—Are you aware of that program running anywhere else in Australia?

**Ms Wilson**—In New South Wales. There is a program in Redfern—that is where ours originated. But I believe that their program has more of a community development type focus. I think they do a little bit of family support, whereas at this stage our program has a bit more of a focus on family support.

**Ms GILLARD**—How do you measure outputs for the program at the end of the two-year trial? What will the hallmarks of success or failure be?

**Ms Wilson**—At this stage we have gathered baseline data. We have done a survey within the community. We will do that again at the end of this 12-month period and then again at the end of the two years. We are also developing a survey that families can fill out when we work with them to see how they have felt the service has affected them and whether it has been a positive thing. We are looking at developing some research to work with the schools to find out what the staff are feeling and to find out about the wider community other than just the parents. There are also performance indicators that we have to meet. Every time we make contact with the family or we make a referral to other services, that sort of data is being collected as well.

**Ms Hordern**—Can I prompt you to talk about anecdotal reports from the teaching staff and about whether this is helpful or an added pressure?

**Ms Wilson**—Anecdotal evidence has suggested that lots of the staff feel that it is very much needed and that they are very thankful that the community outreach worker—which is our title—is able to work with the families. In particular, one of the staff mentioned this week that there is a worker who is going to be away for two days. She said, ‘What are we going to do without you for two days?’ even though we had been there for only two terms.

For those staff, it has meant that they now have greater links with the families. Previously, lots of these children were coming and going to the school. These parents are the sorts of

parents who probably do not feel comfortable coming to parent interview nights. They are not the parents who are highly involved at the school, and they do not feel that they can get onto the school committee and have a voice. But, since the program has come in, the community outreach worker has made a greater link between those parents and the teachers so that communication has been opened up and the teacher is able to say to the parent, 'Did you know that your child is having a lot of difficulty with reading? We need to get them extra services.' It has acted like a link.

**CHAIR**—In your submission you say that you have doubts about young people being wrongly diagnosed with ADD and ADHD. Have you undertaken research or have you run trials looking at these young people who are on medication for that, taken them off and then put them into another program and, if so, has that been successful?

**Mr Wyles**—A number of us have had experience in this area. I worked in a child and adolescent mental health service and, anecdotally, my experience was that, while undoubtedly some children came in, were assessed and were given the diagnosis of ADD or ADHD, we saw a number of families who presented with children after a period of some years on medication and the behaviour either had not changed or there continued to be some problems. I think it is interesting, looking at some of the literature, that increasingly in psychiatry they are questioning those diagnoses and the diagnoses are being reconceptualised a bit as a trauma experience. There is some evidence that children from homes with domestic violence have attention difficulties. They may not actually have attention deficit disorder, but they have problems concentrating or problems with hyperactivity. Anxiety and depression are often conditions that exist alongside that sort of hyperactivity, as well. I suppose that is anecdotal evidence, but increasingly there is a belief that it is overdiagnosed.

**CHAIR**—You do not have anything concrete? You have not tried any programs?

**Mr Wyles**—My experience was that sometimes people came to our service in the ACT to get a diagnosis, and if they did not get it there they went to Sydney and got one. So people can get one if they persist.

**Mr SAWFORD**—It is interesting to look at the prescription of drugs for ADD and ADHD, and compare the states and the electorates. I come from an area that has some very poor areas—and we will come onto poverty in a moment—and we have very low rates of ADD and ADHD. The highest rates are in Western Australia; they are in every seat. There are thousands and thousands of kids diagnosed in every seat in Western Australia and in New South Wales. When you come to a seat like mine, which is regarded as a much poorer area—and if you go through all the poorer areas in New South Wales, as well—you will find that they have very low rates. The orthodoxy says that poverty is a reason for all of this, and it is absolute nonsense. Some 20 years ago there was a standard practice in Australian schools of putting the best principals and the best teachers into the poorest areas. That has not happened in the last 15 years in any state in Australia. I do not accept the orthodoxy that because you come from a poor area you are more likely to have problems with boys.

If you look at the work of Faith Trent and Malcolm Slade, who interviewed 1,800 boys in South Australia in both private and public schools, then you will see that the boys said quite clearly that the problem is that they do not have good enough teachers in those areas, and the

teachers in those areas cannot cope. They may not cope for a whole range of other reasons—underfunding, et cetera—but it has nothing to do with poverty. All the empirical and quantifiable research in the English language in terms of poverty says that it is not a determinant of future failure or success. There is another reason, and that is poor schooling. I reject the poverty aspect. I reject the ADHD aspect. That is a middle-class disease, and you can see it by looking at all the electorates in Australia in terms of its diagnosis. In 25 years I have seen two kids, out of the thousands who have gone through my schools—all in poor areas—who it could even be argued had ADHD. But I can tell you about hundreds of kids who suffered from poor parenting.

**Ms Hordern**—I suppose that does hit on one of the central issues there: kids will be prescribed a medication and, in most cases, there will be very little other intervention. There is a hope that that is going to fix it all when there often can be parenting issues involved, but people do not seem to get the full—

**Mr SAWFORD**—In 99.9 per cent of the cases they are all parenting issues.

**Mr Wyles**—And I think that is the problem with diagnosis: that label describes a set of symptoms rather than actually looking to the causes.

**Mr SAWFORD**—Most boys who have problems come from single-parent families. There is no running away from this. That is quantifiable in the UK, Canada, New Zealand, the United States and here. We should not run away from the fact, and yet we do. We sort of feel as if we are blaming single mums because they are the head of the households, but I do not read it that way. What about the absent fathers? They both have a responsibility for all of this; they are both responsible. The real truth is that boys do not cope with their parents breaking up. They get very angry about it, and they do not know how to express that anger in many ways, and so they retain that anger. That is more likely to be the problem, rather than this defence that every time you say that the kids who are in trouble come from single-parent families, the defence is that this is victimising single mothers. Hang on a minute, theses kids have got fathers too: where the hell are these absent fathers and their responsibilities? That is the problem.

**Ms Hordern**—I think there is another strong dimension in there which is to do with family violence. Those single-parent families have very often had a history of some form of domestic violence.

**Mr SAWFORD**—And they tend to repeat it with new partners.

**Ms Hordern**—Yes.

**Mr SAWFORD**—They go from one violent relationship to another violent relationship.

**Ms Hordern**—I am not sure about that, but I do know about it as a precursor.

**Mr SAWFORD**—There is plenty of evidence to suggest that that is what they do: they just repeat it. They finish up with the same sorts of deadbeat men, and repeat one after the other.

**Mr EMERSON**—I was a bit late, so what I am about to ask may already have been dealt with. We visited Eagleby State School, in Kay Elson's electorate, and they have a very highly

regarded literacy program which they start first thing in the morning and it goes for, I think, an hour or 1½ hours. They regard that as the most valuable time of the day in terms of concentration and so on. They were telling us something that you were talking about, which is that there are problems of poor nutrition. That is that many of the kids may not have had breakfast, and I think they were talking about getting a Gold Coast program applied to that school so that there was breakfast available for the kids and then they would be much better at learning. So that has happened there. It reminded me of the Headstart program in the United States which has been running since the 1960s in a whole lot of different forms in different states. Have you done any work on the Headstart program and these sorts of issues to be able to establish that you do get a good result from basic things like providing kids with nutrition early on to help their concentration?

**Ms Wilson**—At one of the schools I work at we have a breakfast club—it runs two days a week and is now being extended to run four days a week—whereby the children can come in and have breakfast. I have not been very involved in that. But obviously there are some positive effects of that because they are continuing and extending it. It is not just about giving those children breakfast as a starter but also teaching them about what is good for breakfast—that a packet of chips and a bottle of cordial is not going to put you on your best foot for the day—and just getting them into that routine.

**CHAIR**—Do you have many boys come to that breakfast club? It seems that at some of the schools the girls turn up but not the boys.

**Ms Wilson**—Yes. I do not know what the ratio is but there are definitely boys that attend.

**Ms GILLARD**—It seems that, in some of the schools that we have talked to, and I know this from schools in my electorate, there is a bit of a debate—and I would not want to put it too sharply, so a difference of view—about whether, in terms of behavioural questions which tend to be predominantly about boys, you are better off having some sort of alternate education setting for kids with behavioural problems. In my electorate there is an alternate education setting in the secondary school range but there is now discussion of that being available in the primary school range because the behaviour problems are so acute. There seems to be a school of thought that says that is a good idea, and another school of thought that says your kinds of interventions—trying to keep kids in a mainstream school environment and providing, through the school environment, family support and other kinds of linkages—is the better way to go. Do you have a view about that debate, about whether it is a mix of the two, and about what the best way forward is? For us there is a pressure there, where parents of kids in mainstream public education do not want their children's education disrupted by an element that is causing difficulties. That causes pressure for school management structures about how they are going to deal with those things.

**Ms Wilson**—I think that the two are not separate. I do not think that you can take a blanket approach to dealing with children. The majority of children probably respond better to mainstream education, but there are always going to be those few in each class who do not respond to the traditional teaching methods and you need to have alternative programs available for them. I do not necessarily think that that needs to be separate from the role that I am doing at the moment, the family support role. You could have some sort of program in the school whereby those children come in for certain classes but they might go off and do other

vocational, hands-on type subjects. There are a number of children who, later in the afternoon, are not able to concentrate. It is much harder for the teachers to manage them at those times of the day. So perhaps they could go off and do those sorts of programs then. You need to have the availability of diverse types of programs.

**Ms Moleta**—There is quite a lot of research that indicates that boys and girls learn quite differently but I do not think that that is always implemented at the school level. Sometimes there are creative ways of structuring the school day in a conventional school—for instance, adding some kind of physical activity into the school curriculum. I have seen that done very creatively as part of the curriculum where it is incorporated into maths and so forth. It works really well, identifying that boys and girls do learn differently. In primary school most of the teachers are women and they probably tend to teach in the style that is compatible with the way they learn. I do think all these other things, if they are implemented in schools, cut down the need for the special facilities. Sometimes children do benefit from that but I think that that would be and should be the minority.

As a therapist for seven years, I have been working for 80 per cent of the time with children and I have seen a lot of violent behaviour in boys. It is something that is really easy to get rid of if you are able to implement the parenting work and you are able to work with the child, either through the anger management group that we run or individually. These boys—I think you mentioned it before, Mr Sawford—need an opportunity to talk about some of their issues. That is why they are hitting out. When they have that opportunity to express and communicate they learn that pretty easily. They are the ones that are crying out. The ones who internalise and go into the bedroom and take drugs are a much harder group to deal with. I think there are many things that can be done to remedy those behaviour issues.

**Ms GILLARD**—In your experience is there any evidence to suggest that those behavioural problems are manifesting at earlier ages than they used to?

**Ms Moleta**—It is hard to say because our understanding of behavioural issues is so much greater now. There are a lot more people working in our type of profession now and we understand the nature of children and what is going on with them. I do not think as a community we blame children anymore for being naughty. We try and get behind what is causing the issue. There is always a reason for it. I think we understand it better, but I would not say that you see it earlier. I work with children from an early age. I think people go to services earlier now. They cry out for help earlier.

**Mr Wyles**—Drug use and abuse has had an impact on parenting and therefore we are seeing behavioural problems in younger children as they enter school. It has implications for how we intervene early with those children. In the literature there has been quite a rebirth of attachment theory which indicates that the first three years of life is really the crucial time for children's learning and development. Things like the way children attach to parents can actually impact on their brain development and their social development. It is commonsense but we are going back to what we knew, really. Some of the children entering school come with that package: they come from families in which there has been horrendous drug abuse and lack of attachment and domestic violence. There is a need for very early intervention.

**Ms Moleta**—Getting back to your point, these are the children that present a lot of the time with ADD problems. I have worked 80 per cent of my time for seven years with children and I have never once referred them for an ADD assessment. Yet I have been successful in helping families and children manage these behaviour issues and reconcile these problems within themselves, so that now they are functioning without the issues that they started with and without any medication.

**CHAIR**—Can you give us any more details about your anger management program and what makes it so successful?

**Ms Moleta**—Would you like a brief outline? It is a six-week program. Paul and I wrote it. It has to be run by a man and a woman. Underpinning the whole purpose of that is that these boys see a man and a woman relating equally to each other. There are completely different segments each week. It is quite cognitive in its approach, but we do allow anger and frustration to emerge within the group and then we deal with that, but we have a process we go through every week. The first three weeks are about understanding anger. Most of the boys that we have seen would say they get angry, they hit someone, and there is no in-between time. So we help them understand that this is a process and there are things that are happening to their body and to themselves that they can trigger into, and they develop an understanding of that. The last three weeks are about looking at different options.

The purpose of having it in a small group context—we like to do this with 12- to 13-year-old boys, or around that age group—is that the peer group is the strongest influence. So when your mate says, ‘I’ve just laughed at him and I’ve never had a problem with him,’ it is very powerful. If two people who look like your parents say that, it loses its impact and it does not work at all. There is all of that, and also we are able to receive their behaviour and receive their explanations. As in all small group practices, if they say, ‘The teachers are picking on us and our parents hate us and no-one understands us,’ we accept this; we do not necessarily collude or agree, but we never disagree or say, ‘What did you do about that?’ So there is a value base around that that helps the children. They want to come and they want to change their behaviour.

They are almost exclusively motivated by not getting into trouble. There is no empathy with the person that they are hurting. They are very hurt people themselves and they are dumping it all on other people. They are often from domestic violence or child abuse backgrounds. You could say that perhaps not 100 per cent but 80 to 90 per cent of all boys in our groups come from that. Or, periodically, you get other issues like unresolved grief. In one group that I ran it turned out—just through the course of the group and no-one knew this before the referral—that four out of the six boys had a parent who had died. Those sorts of things occur, but by and large it is through violent behaviour at home.

So the six-week program is run like that. I simply ran it with Paul because there was a need in the school I worked in. It was very successful and it was run continually while I worked in that school. I evaluated it after two years. All the boys were initially referred in the first six months of year 7, and then followed up when they had new pastoral care workers in the first six months of year 9. Not one of the boys exhibited any violent behaviour after two years. Their family situations had not changed and I had not intervened with one family. It is a very powerful tool to be able to work with an adolescent because they are automatically moving away from their

family. All adolescents are looking for options and alternatives, so these ones are very ready for some kind of change.

**Mr SAWFORD**—Are the kids in those groups the ones that are expressing anger?

**Ms Moleta**—Yes.

**Mr SAWFORD**—You mentioned before about the kids who internalise the anger. Do you deal with those kids as well?

**Ms Moleta**—The ones who do best in the group are, by and large, the ones who are really out there bashing, hitting kids against walls and creating an absolute ruckus. We do do the ones who are internalising things more. They are a much harder group to work with no matter what you do, but we work with them. We also work with the victim-aggressors, the ones who get picked on and then pick back. We work with them all and we do have victim-aggressors in the same groups as aggressive people, even though a lot of research has said that that is not such a good idea.

**Mr SAWFORD**—What are the characteristics and attributes of the children who internalise their behaviour?

**Ms Moleta**—That is a good question. I do not know that I could answer that off the top of my head; I think I would really have to think about that in a lot more detail. My initial response would be to say that they have a much more fearful approach to expressing anger—perhaps there is something around things at home or there is a fearfulness within themselves about expressing anger and so they bottle it up in terms of wanting to hit somebody. I do not really know why they do that, I just know that it happens. I am not quite sure what the characteristics that distinguish that would be.

**CHAIR**—Just to extend the question I asked before: with the angry boys, do they have a high incidence of literacy and numeracy problems and, two years down the track, has that improved because they have been able to control their anger?

**Ms Moleta**—The school I used to work in had a special education unit and about 70 per cent of the boys from that unit would attend either my social skills or my anger management class. The frustration around learning and not being able to express yourself often comes out in anger. But it crosses all sides—you get the very bright children right through to the not so bright. Often, because of their violent, angry behaviour, they are not achieving, they are unable to concentrate, there is a lot of anxiety in them and there is a lot of distress and depression around living this violent family life. So they may not be working at their optimal level, but they can often be quite bright.

**Mr BARTLETT**—On the issue of ADD and ADHD—and this question may have been asked earlier—what percentage of children diagnosed with ADD are boys?

**Mr Wyles**—I thought of this question yesterday and I was going to check it but I did not.

**Ms Wilson**—It is three to one. It presents in both but there is a much greater tendency for boys to be diagnosed with it. Girls are less likely to show hyperactive behaviours so boys are more likely to stand out.

**Mr BARTLETT**—What is your thinking about why that is the case?

**Ms Wilson**—Why it is that boys are more likely to be diagnosed? I guess boys showing the behaviour of hyperactivity are much more likely to stand out whereas the girls are more likely to have ADD, which is just attention deficit disorder, so they are more likely to be the child that sits in class and fades off or cannot focus on things, so they are not going to stand out as much. That is one part behind it.

**Ms Moleta**—Boys are more physical though. It is well known that boys express themselves in a more physical manner. As I said before, I think a lot of this can be managed by simply addressing the fact that boys relate and learn differently.

**Mr BARTLETT**—What is your view then of the opinion that is sometimes expressed that really ADHD comes down to poor parenting or lack of direction or discipline with children?

**Ms Wilson**—I guess my approach is that there are two ways of thinking. There is either the medical approach, which says that it is a neurological cause, or there is the psychosocial approach, which says that it is not just one cause—there is not one single reason that you can put it down to. There might be medical reasons, biological reasons or environmental reasons. It might be that these children are coming from disorganised homes where there is family dysfunction. And you cannot take a single approach. You cannot say that giving this child a tablet is going to solve all the problems for that child if it is coming from all those systems. I guess children that come from families where there is a lack of boundaries, there is family dysfunction, and there might be absent fathers, absent mothers, inconsistent male role models or domestic violence, are probably more likely to come to our attention. If they have a predisposition to ADHD, they are less likely to function in that sort of environment. I do not think you can put it down to bad parenting alone. I think there are a number of causes.

**Mr Wyles**—There are parents who, despite getting a diagnosis, choose not to medicate and try a range of other options such as physical activity to try and broaden out the options for the child.

**Mr BARTLETT**—How successful are those programs?

**Mr Wyles**—I think that tends to be a personal choice. I have certainly seen parents in the past who have chosen not to medicate because some people have a concern about the long-term effects of the medication.

**Mr BARTLETT**—Has any work been done on the relative degree of success of that approach?

**Ms Hordern**—There is a whole lot of conflicting evidence, I think, because you do have these fairly strong camps of people: those who believe in the medical nature of it and those who see it more as a psychosocial thing. Believers in the medical model say that Dexamphetamine

has been used since the 1920s. Consistently, their studies show no negative side effects. It intrigues me that during the early nineties, when there was a lot of discussion about ADD—that was when it really took off as a diagnosis—the doctors were saying that this was really a childhood illness that people grew out of during adolescence and that it was okay to prescribe this stimulant medication because kids metabolise things differently. I have no problem with that. But, over the last decade, we have been seeing increasing numbers of adults being diagnosed and being prescribed Dexamphetamine and Ritalin. I have not seen any writing about why it has changed and why adults are able to take these medications, which are very popular recreationally as well—Ritalin is not, but Dexamphetamine is a highly sellable drug in school playgrounds.

**Mr Wyles**—There was a report in the *Sydney Morning Herald* some months ago about a growing view in the United States that the American Psychiatric Association is too cosy with medical companies and that there is huge explosion of prescriptions for ADHD there, increasingly for adults.

**Ms Wilson**—Certainly medication represents the majority of treatment. That is researched, and it is also my experience of working in the schools. A lot of the kids are only on medication, and other things—such as behavioural management, working with parents around parenting strategies, working with the class teacher around classroom strategies and making sure that those classroom strategies are consistent with the home behavioural management strategies—do not happen. It is medication alone. So, if the problem exists and it is something at home like domestic violence or the child's diet, those things are not being addressed. Only the medication is being used.

**Mr SAWFORD**—Paul's comments are very valid in the sense of where and in what areas around Australia the propensity of the drug is being prescribed. It is just appalling.

**Ms Wilson**—That is right.

**Ms Hordern**—I would be interested to know what the difference is between prescriptions of Ritalin and Dexamphetamine. Dexamphetamine is on the pharmaceutical subsidy scheme and so that is much cheaper, whereas I think that, for the average rate of prescription, Ritalin is around $90 a month.

**Mr BARTLETT**—What is the oldest age of children that you deal with?

**Ms Moleta**—I work with children aged right up to 18.

**Mr BARTLETT**—For children of that age who have been presented with ADD or ADHD in their early years, is there any difference in the outcome—the behaviour, attitudes and success at school—for those who have been prescribed with Ritalin or Dexamphetamine compared with those with whom a medical approach has not been taken and with whom you have worked, helping with parenting and so on?

**Ms Wilson**—I know that some children that have ADD at a younger age are then diagnosed with oppositional defiance disorder or other disorders along that line when they get to 14, 15 or 16.

**Ms Hordern**—I am not aware of any clinical studies that have been done using proper controls.

**Mr BARTLETT**—It would be difficult because there are so many variables.

**Ms GILLARD**—What is oppositional defiance disorder? I have not heard that term before.

**Mr Wyles**—There is a South Australian therapist who says that ADD is the new name for childhood and oppositional defiance disorder is the new name for adolescence. They are medical terms which encompass a range of behaviours.

**Ms Hordern**—ADD is there in the diagnostic and statistical manual of the American Psychiatric Association that all these diagnoses come from.

**CHAIR**—So is ADD controlled with the same drug as ODD?

**Ms Hordern**—I am not sure whether doctors would be prescribing for that.

**Mr SAWFORD**—I would like to move on to teacher education. In your submission you raised a whole number of matters about teacher education. Would you like to expand on those for the benefit of the record?

**Ms Hordern**—Unfortunately, that is Peter Camilleri's area of expertise. I cannot comment.

**Mr SAWFORD**—I did not mean to put you on the spot.

**Ms Hordern**—I will ask him if he would like to write something for you about that.

**Mr SAWFORD**—That is fine.

**CHAIR**—Thank you very much for appearing before us again and giving us more evidence. It has been a great help and we appreciate it. When the inquiry is complete we will make sure that you get a copy of the report and its recommendations.

**Ms Hordern**—What is the time frame on that?

**CHAIR**—We do not think it is going to be completed by the end of this parliament. Because it is a big issue and we have received many hundreds of submissions, we will keep the inquiry going until we make sure we have received all the evidence. So I would say that it will go over into the next parliament.

Resolved (on motion by **Mr Sawford**):

That this committee authorises publication, including publication on the parliamentary database, of the proof transcript of the evidence given before it at public hearing this day.

**Committee adjourned at 9.51 a.m.**