

Stronger Futures for all Young Victorians

Response to Discussion Paper on Youth Transitions 2010

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We respectfully submit this response to the "*Stronger Futures for all Young Victorians: discussion paper on youth transitions*". We commend the authors on presenting this very complex issue and highlighting current strengths and new initiatives aimed at supporting students to remain in school and go on to navigate a career pathway that can be tailored to the individual's strengths and interests.

We unreservedly support the intent of the paper to serve **all** young Victorians and wish to direct our comments to the 'at risk' student population. The scope of our work in the child and adolescent mental health system brings us into daily contact with 'at risk' young people who require a targeted approach to transition: the 'at risk' students we wish to highlight are those with mental health issues.

The key social and economic determinants for mental health can be themed as:
social inclusion;
freedom from violence and discrimination;
and access to economic resources [1]

The young person's engagement with work, friends and family, accessibility to housing and other social supports can influence their mental health and well being.

Early identification and interventions for mental health problems are empirical to reducing the risk of social isolation, social disintegration and poor economic participation. And in turn disintegration of determinants of mental health increases the risk of mental health problems.

In our response we aim to

- broaden the *scope of competencies* outlined in the paper that are critical to youth transitions and Managed Individual Pathways
- describe those with mental health issues who are clearly at risk, but who, with targeted support may go on to contribute socially and economically in their adult years
- consider the *place of parents* in developing *managed individual pathways* and *career plans*
- consider adaptations to the development of career plans for 'at risk' young people
- consider the *mental health* training needs of Careers staff, mentors and coaches so that an understanding of mental health, language and developmental issues can shape staff-student interactions and ultimately the young person's career pathways and plans.

We anticipate there may be benefits from this discussion that will extrapolate to the universal population.

Broadening the scope of competencies

A broad range of skills is necessary to participate in the social and academic curriculum. Literacy and numeracy are without doubt core and critical skills, so too are capacities to sustain attention, motivation, and concentration, manage the sensory / physical environment, process verbal information, express oneself, regulate one's behaviour and emotions, see and respond to others' perspectives, manage impulses, be flexible, plan and organize one's day and activities, think beyond the 'here and now', reflect, learn from one's mistakes, and make decisions by anticipating outcomes and consequences.

These areas are impacted where the young person has a mental illness, or mental health issues. They are further amplified when co-occurring with a developmental disorder.

Oral language competencies [speaking and listening] are critical to school and work life. Young people compromised in these areas will struggle in the workforce to manage, develop and sustain relationships with work colleagues and the public, struggle to participate in interviews, workplace orientation and training, find it difficult to problem solve when things go awry, and assert themselves in socially appropriate ways.

During their primary and secondary schooling, students are refining the oral language skills critical to life in the workforce: conversation, discussion, persuasion, negotiation, compromise, appropriate and timely help-seeking and managing conflict. In hand with this, they are refining their capacities to understand idioms, sarcasm and jokes, and to read social nuance and intent. These skills underpin their capacity to adapt what is said and how it said, along with when to speak up and when to keep one's thoughts to oneself. Learning to adapt communication to various context context, audience and society's notions of deference and tact are ongoing tasks over the age period targeted in the discussion paper.

Impairments in oral language competence can occur alongside mental health problems and are key features of developmental disorders such as Autism Spectrum Disorder, ADHD and Language Based Learning Disability.

Broadening of concept of 'at risk' groups

Child and Adolescent Mental Health Services [CAMHS] are moving towards providing services from zero up to 25 years of age. This extension of service delivery, beyond 18 years, recognises that young people with a mental illness and their families often experience an interruption of the normal adolescent milestones making them emotionally vulnerable when faced with negotiating the complex tasks of socialization, decision making, and career planning in the context of a separation from the more supportive environment of secondary school.

Many of the young people attending services such as CAMHS & Avenues Education have underlying developmental problems that impact on emotional regulation, seeing the big picture, reflective and critical thinking and forming satisfying social relationships with peers and teachers. These skills are critical to participating in the career planning process: that is *engaging* in dialogue, *clarifying* when not understanding or confused, *reflecting* on one's achievements and challenges, *describing* what one is interested in or struggling with, and *imagining* the future and themselves as an emerging independent and responsible young person. The formation of personality and identity, emotional separation and individuation are key developmental milestones that are empirical to youth transitions and may be impaired in the presence of mental health problems.

These areas are often compromised in young people who *develop* a mental illness in their adolescent years such as psychosis. Developmental issues may increase the risk of mental illness. And mental illness may also impair the achievement of developmental milestones. This is particularly devastating when mental health problems are identified and treated later in the illness process, after developmental milestones and youth transitions have already keeled off trajectory and resumption is a momentous task. Early identification and interventions for metal illness is imperative to reducing disability, and prompting the achievement of developmental milestones and health youth transitions.

MENTAL HEALTH – A SNAPSHOT

Mental illnesses have been described as the chronic diseases of young people, with 75% of mental illness emerging for the first time before the age of 25 years **[2]**. In 2000 the Australian national survey of mental health and wellbeing found that the prevalence of depressive, conduct and attention deficit hyperactivity disorders among 14 - 17 years old in Australia was 14% **[3]**. Mental illness places a significant burden on the quality of life for a significant number of children and adolescents in Australia and impacts on young people across the socio-economic, cultural, and educational spectrum.

Substance abuse is also common for adolescents. As many as 25% having reported to have used cannabis, associated with an increased risk of depression, hallucinations, conduct problems and other health related problems **[4,5]**

Developmental disorders are also both highly prevalent and equally have a significant impact on the lifelong quality of life for children and families, in part because of the significant co-morbidity of autistic spectrum disorders, attention deficit behaviours and affective disorders. One in 160 children between 6 12 years have an Autism Spectrum Disorder.

The prevalence of language-learning disability (LLD) in children and adolescents is estimated to be between 10 and 15% **[8]** and is considered a lifespan issue. **[9]** School-aged children and adolescents with LLD are at risk for significant academic, social, emotional and behavioural problems. They are also likely to exit school early, often with minimal marketable work skills and little prospect of successful engagement in further education. **[10]**

Psychological difficulties experienced by children with speech and language problems include relationship issues **[11]** and reduced self-esteem. **[12]**

Behavioural disorders may indicate undiagnosed communication, learning, literacy and/or attention/concentration problems.

Children with severe behavioural problems are likely to continue demonstrating these problems into the school years **[13]** compromising both academic achievement and the formation of pro-social bonds with other children.

Longitudinal studies indicate that language impairment in childhood in boys is a significant risk factor for antisocial behaviour in adolescence. **[6, 7, 14]**

Attention deficits may limit a child's ability to "tune in" sufficiently to learn the rules of communicative discourse.

The impact of psychological trauma on language development in children is now recognized with disorders of multiple delays, communication and social-relatedness identified in children who have been traumatized. **[15]**

In particular, emotional neglect has been found to be correlated with poor auditory comprehension and expressive language ability. **[16, 17]** Factors impacting on academic performance include reduced cognitive ability, sleep disturbance causing poor concentration and delayed receptive and expressive language development. The impact on social relationships may evolve from a need for control, attachment difficulties, immature social skills and unstable living situations reducing learning and engagement at school. **[18]**

Maltreatment and compromised language and mental health outcomes have been recently identified. **[19]**

Refugee immigrants who have experienced trauma are a new group being referred to mental health services. A complexity of communication and psychological issues may present, such as the need to learn English as a second language, trauma associated with horrific experiences in the refugee's country of origin, detention, the immigration process, and adaptation to the new country. The risk and protective factors for mental health in refugee children suggests that child and adolescent refugees have a high incidence of depression, anxiety and post-traumatic stress disorder. **[20]**

The beginnings of disengagement from school often appear in the primary years. School refusal occurs in 1-5% of all school children, peaking at ages 5-7 years, then 11 years and 14 years. It occurs across all socio-economic groups, and equally among boys and girls. [21] School refusal is often associated with depression, oppositional behaviour, overt anxiety symptoms stemming from fears of separation, of tests or teachers, or of transition. Often these children say they want to go to school but can't. Somatic symptoms are common and include headache, abdominal pain, nausea, shakiness or dizziness. Symptoms present in the morning and may disappear if the child remains at home. [22] Family dysfunction may contribute if the following factors exist: high dependency; isolation, conflict and rigid roles. [23] School refusal impacts on accessing the curriculum and transition education, and transition experiences such as work experience or vocational training.

Mental health issues can have an enormous impact on young people in being able to *effectively participate* and *sustain involvement* in educational or vocational systems, their community and be socially connected. Mental health issues may be experienced either directly by the young person or as a consequence of living with a family member, such as a parent or sibling, with mental illness.

Considering the levels of mental illness in Australian young people, a significant proportion receives little or no formal help. The associated burden of mental illness includes significant disruption to attendance at school and ability to participate in the social and learning opportunities available.

These young people are vulnerable to being missed at critical times of transition planning from primary to secondary school and from secondary school to tertiary training or workforce planning. Symptoms associated with mental illness can directly impair concentration, ability to organise, plan and process information.

The place of parents in youth transitions

The changing expectations of school systems as the *typical* student matures reflects a path towards increased personal responsibility, independent decision making and autonomy with gradually less involvement of parents as the student approaches the upper end of high school. Mental health issues often impact on this trajectory. This can require schools to *adapt* and *actively* work towards closer involvement of parents in supporting the young person's participation in everyday schooling activities and broader decision-making, such as tailoring a career plan to take account of the student's broader circumstances, strengths and vulnerabilities.

Parents and carers have an enormous role in supporting their adolescents as they go through the increasing complexity of learning requirements and decision-making about subjects and future. They can bring a longitudinal knowledge in addition to cross-sectional information about their child's functioning across a range of contexts.

We know parents and carers are a positive resource to schools in encouraging young people to cope with adversity and building resilience however, it must be noted that parents or carers who have a young person with a mental illness will be highly stressed and concerned about their young person and may need additional support from school. Flexibility and "thinking outside of the box" can assist these families and the young person to remain in school. Indeed school can be a very positive environment for young people with mental health issues as it keeps them in the primary mainstream activity of adolescence which is education.

Young people who have parents living with a chronic physical illness, mental illness, disability or drug and alcohol substance abuse may be more vulnerable to disengaging from education and vocational opportunities. The young person may carry responsibility in caring for the parent. The parent may have a limited capacity to support the young person. These young people and their parents require additional support in order to assist the young person to focus on the tasks of learning and stay connected to social support networks.

It is important to note that some young people will have their schooling interrupted if they require a psychiatric admission to hospital. It is vital that links with school can be forged and maintained between hospital and school so reintegration can be as positive as possible. Parents and school are included in treatment planning during the admission including discharge planning and follow up by public or private mental health services post discharge.

Adaptations to Career Plans approach

CAMHS tends to understand children's, adolescents' and young adults' mental health difficulties from a developmental perspective focussing on all aspects of the young person's life, both from a past history and current functioning perspective.

Cognitively it is more unusual for a young person to have a sense of themselves in the future when they enter secondary school as they are still struggling with the normal adolescent tasks of identity formation, and their place in relation to family, school, peers and the wider world.

At a time when young people are facing huge changes in the transition from the more protective environment of primary school to the busy, more independent learning environment of secondary school they are also often negotiating forming new friendships and adjusting to higher learning expectations.

Identifying students who are transitioning from primary to secondary school with significant emotional, behavioural, learning or developmental disorders is vital as part of wrapping around the individual a shared understanding and response plan that builds on the primary school experience and perhaps allows greater opportunity for consistency and containment at a time that is experienced by many students as stressful and anxiety provoking.

In addition to identifying how the student is progressing with numeracy and literacy, it is important to map their competencies with

- Academic and literate language use, ability to work independently, social skills, speaking and listening skills, range and flexibility of vocabulary, language expression and 'text' level use of language, planning and organization, planning and organization
- Planning and organization in the domains of: academic and literate language use, behaviour, ability to work independently, social skills, speaking and listening skills, range and flexibility of vocabulary, language expression and 'text' level use of language
- Functional areas in the domains of: leisure, self-care, communication, functioning in the community, home living skills, health and safety, leisure, self-direction, social and work

The following tools might be helpful in establishing a broad profile of the student's capabilities and identify life skills that require extra support and learning in order to ensure the student is *work ready* for year 10 work experience and further down the track *vocational or employment ready* as they transition out of school.

- *Vineland Adaptive Behaviour Scales, Second Edition* - Teacher rating form
- *Adaptive Behaviour Assessment System [ABAS]*, typically completed by parents, [P. Harrison & T. Oakland. 2003. The Psychological Corporation)
- *Language for Learning: A checklist for language difficulties; Secondary level. 2001* completed by teaching staff (Oz Child: Children Australia)

Ideally, the career transition planner is able to have a role within the pastoral care team. This would allow for joining together to work with teachers around the development of appropriate curriculum that meets the needs of the individual whilst also contributing towards successful engagement in the planning about educational and vocational options. This model facilitates a strength based and scaffolding-up of learning, that gradually develops student's notions around matching personal interest with learning achievements, dovetailing into a curiosity and identification with vocational opportunities that present themselves in year 10 work experience and again in VCE or VET. Such a model allows for greater opportunity to identify the individual student's barriers to stepping into the workforce due to reduced functioning because of mental illness or developmental disorder.

Careers Mentoring

Given the significant impact mental illness can place upon a young person's functioning we encourage consideration be given to the professional development training needs of career transition workers. Development of partnerships with area mental health services may be an arrangement that would foster collaboration and allow for opportunities to address training needs about mental illness, the mental health system and treatments that workers in Connections and other settings might have. Speech Pathologists as one part of the CAMHS workforce could assist in understanding accommodations necessary where oral language competencies as described in this discussion paper are compromised.

We support the notion of an individualised and differentiated approach to vulnerable students across their school experience and particularity as part of the process of career pathways planning.

In responding to submissions such as this one, we believe the Victorian government will be creating an environment in which young people with mental health issues, *not only survive* but can *thrive*.

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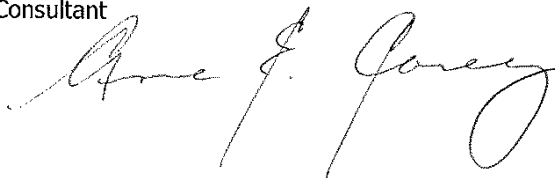


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