The Prevention of Mental Disorders in Children

2018 Winston Rickards Oration

presented by

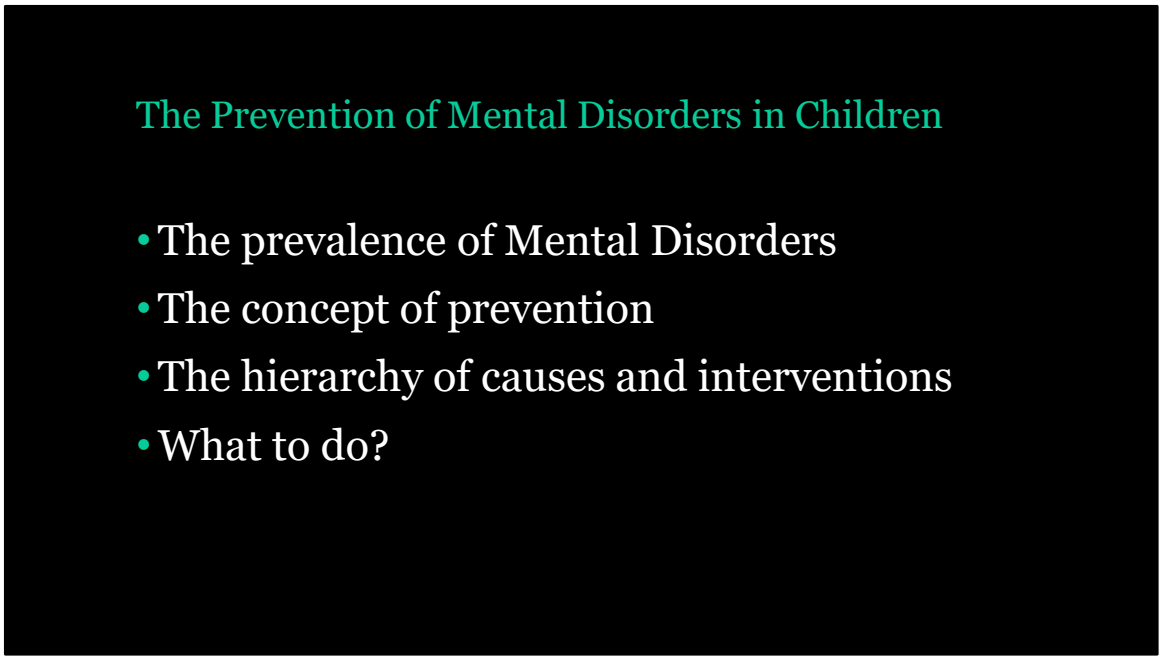
Dr Allan Mawdsley

Dr Winston S Rickards

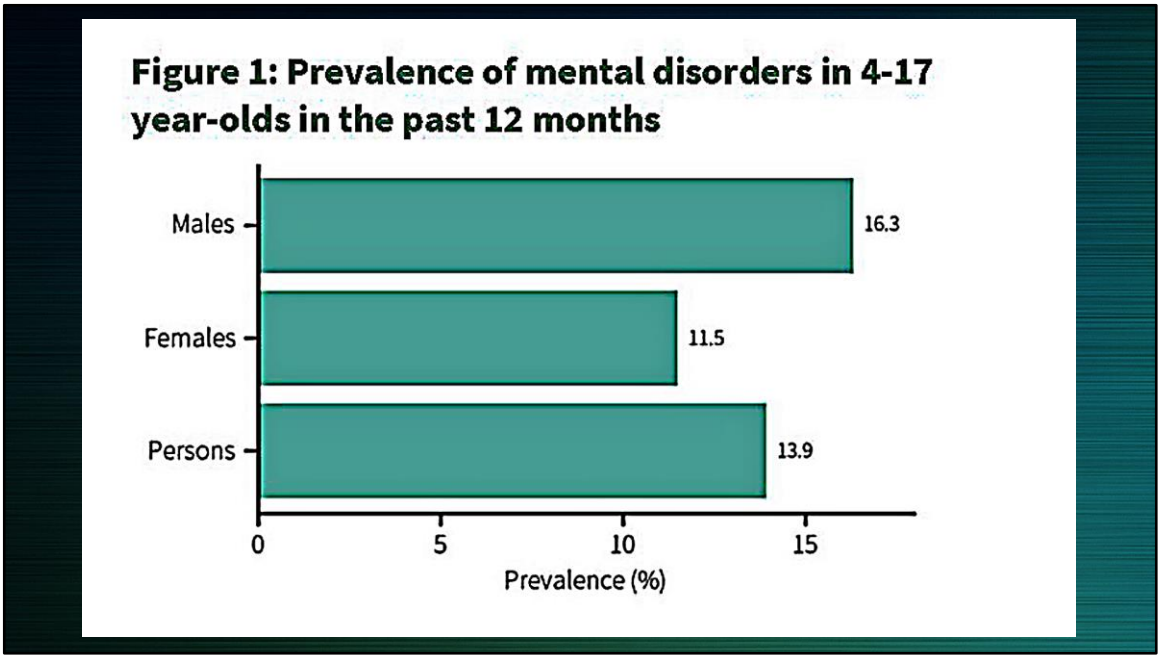
It is a great honour to have been asked to deliver the Winston Rickards Memorial Oration. My first contact with Winston was as a postgraduate psychiatry trainee when he led the first of 25 Friday afternoon sessions at the Royal Children's Hospital introducing us to the complexities of child and adolescent psychiatry. I must admit that that session was rather daunting because he had a table piled high with hundreds of books that he lovingly leafed through, telling our group of the wisdom enshrined in each one, and recommending that we read them. With less than a year to go before our specialty examinations, a twenty-year reading program for a subspecialty area did not have great appeal. What we wanted were quick and dirty answers to how to pass the exams.

However, aside from this enlightenment that there is no easy path for the getting of wisdom, Winston also revealed a wide-ranging spirit of enquiry, a strong commitment to multi-disciplinary work and a deep involvement in training. In time I came to share those qualities, I believe for the better. Winston was active in the College of Psychiatrist's Committee for Training, and

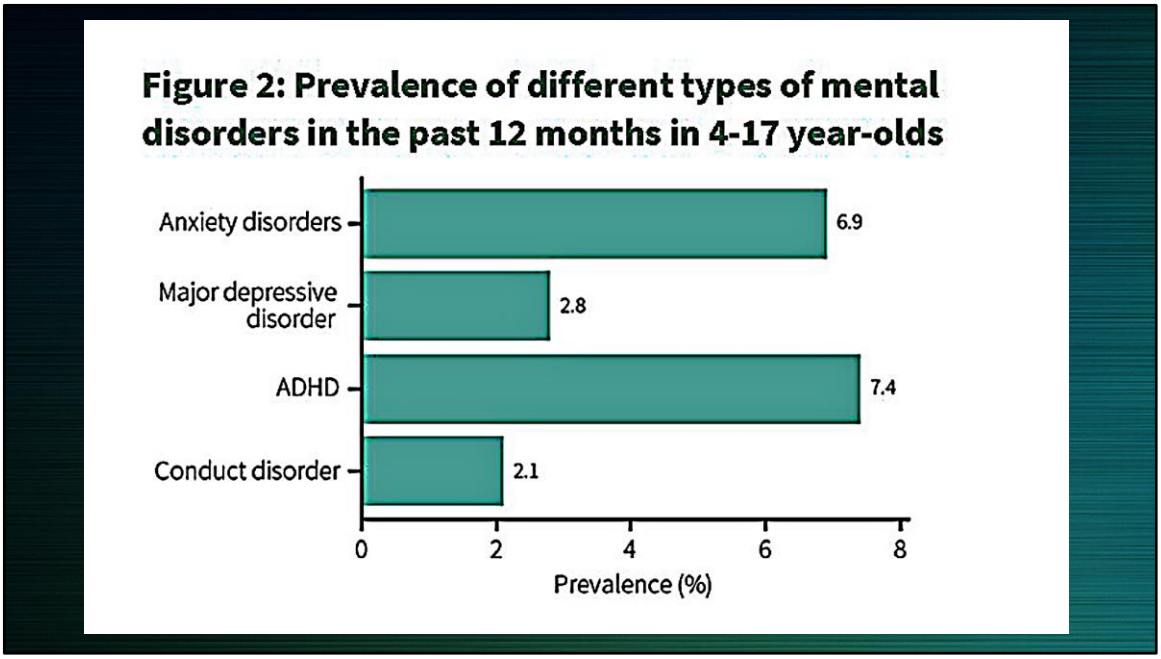
I was to follow those footsteps a decade or so later.
Another of Winston's interests was participation in the International Association for Child & Adolescent Psychiatry and Allied Professions. He was the prime-mover for Australia hosting the IACAPAP Congress in Melbourne in 1976. As a junior member of the Organizing Committee I felt impelled to make a modest original contribution. So, in collaboration with the late Gwen Graves of the Mental Health Research Institute, I undertook a research project on Grade Five students in a number of schools in the Dandenong region, where I was working at the time, using Michael Rutter's parent and teacher questionnaires developed for his Isle of Wight study. Our findings were that just under 15% of children scored above the threshold of emotional disturbance, and that only about one in twenty of these were actually referred for mental health services. The prevalence was higher in the urban schools than in the rural schools of the sample, particularly the poorer socioeconomic areas.
So began my lifelong consideration of the issues around the natural history of mental disorders in children. It was my first publication, apart from a report in the Medical Journal of Australia about a fatal overdose of antidepressant medication, and was published in "The Child in his Family" series, Volume 6, of proceedings of the 1976 IACAPAP Congress. One way or another, Winston set a lot of things in train, for which we gratefully remember him through this Oration.



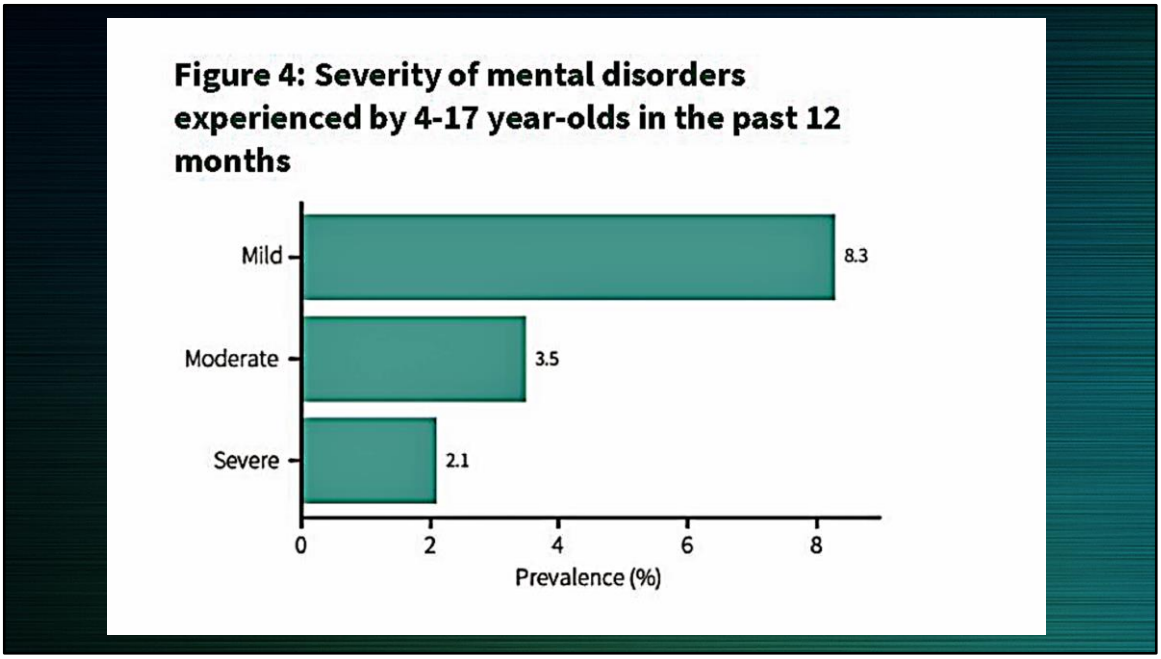
The old adage, “An ounce of prevention is worth a pound of cure” is well-established in folklore but difficult to prove. It is backed up by various parables such as the building of fences at the top of a cliff rather than having an ambulance at the bottom. In some instances, where the science is strong enough, the Government support of preventive campaigns has had major benefits. A good example is the Public Health campaign for prevention of cardiac disease advocating more exercise, weight reduction, control of hypertension, cessation of smoking, and reduced salt, sugar and fat in the diet. The approach to prevention in mental health has been much lower key.
I plan to talk about:
The prevalence of mental health disorders in children
The concept of prevention
The hierarchy of causal factors and interventions
My views on what we should do.



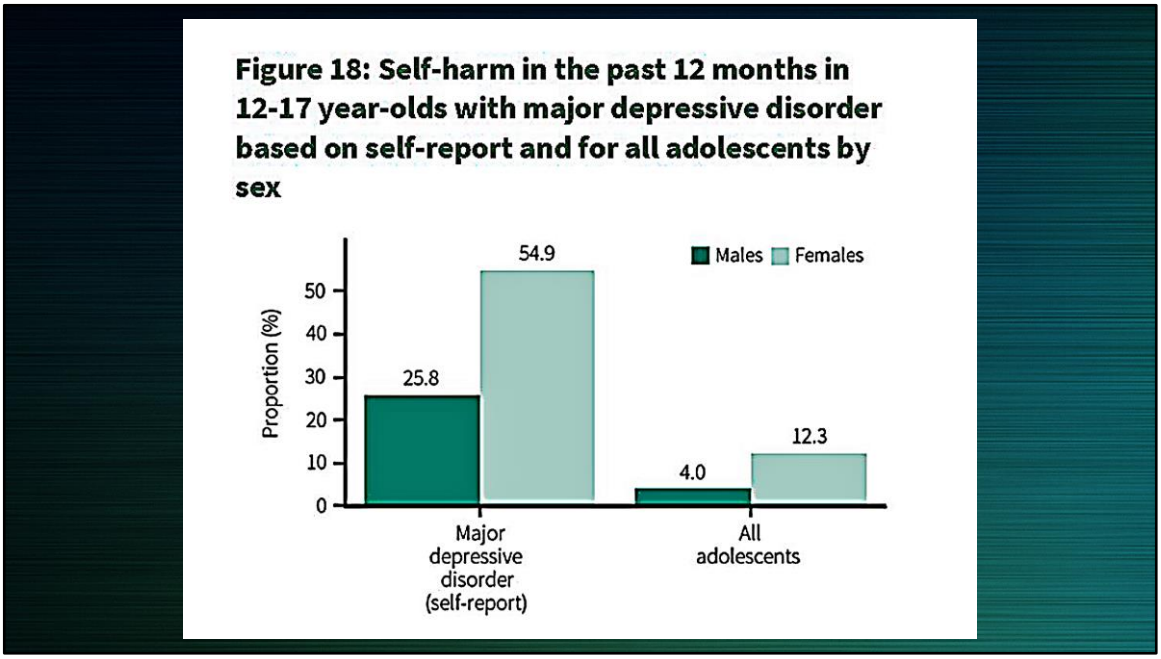
A more recent and much more sophisticated survey of child and adolescent mental health disorders than my modest effort of 50 years ago, was undertaken in 2015 by David Lawrence and colleagues for the Commonwealth Department of Health. It found just on 14% of young people had a mental health disorder in the previous twelve months, with boys slightly outnumbering girls.[1]



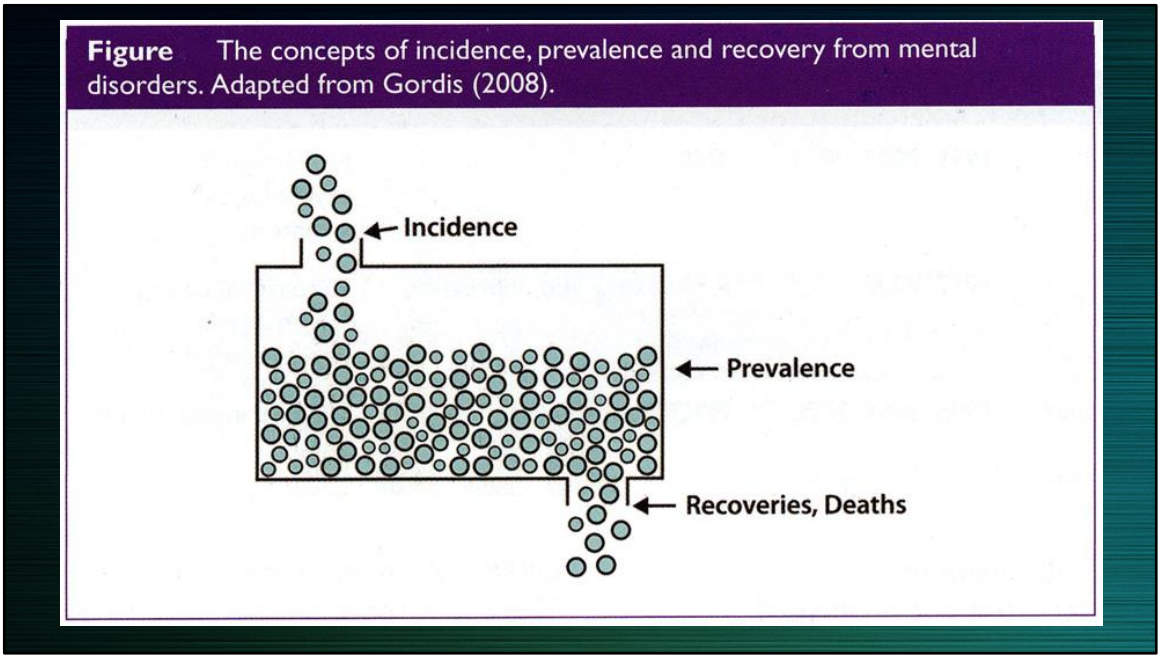
The main types of disorder were behavioural, depressive and anxiety disorders. Psychotic disorders are profoundly important although low prevalence. Their prevention is predominantly in the secondary and tertiary levels whereas my focus at the moment is on the primary prevention level.



The disturbances ranged in severity. Many of the mild cases resolve without formal treatment but some go on to become more severe, and are then less likely to spontaneously resolve. However, it is important not to dismiss mild cases as "worried well" because the annual number of suicides is similar in each group. Although the rate per hundred thousand is highest in the severe group and lowest in the mild group, the larger size of the mild group results in a similar number of suicides. We must take all cases seriously.



The frequency of self-harm in the severe group is quite high. Only a proportion of these complete suicide, but suicide is the commonest cause of death in this age group and merits every effort to prevent it.
A range of other studies over the years have all found fairly similar prevalence of mental health disorders in children. They have also found that only a small proportion has ever been referred for formal treatment services.



The relatively unchanging prevalence reflects the truth that whilst most treated cases get better and an even larger number of milder untreated cases get better through community-based influences and spontaneous remission, they are replaced by new cases. The untreated cases who do not get better, and the ones who do not respond to treatment, remain in the community prevalence pool. Whilst intuitively it would seem that increased availability of treatment services should reduce the prevalence, this is not what is observed, simply because of the sheer volume of cases in the community. If only one in twenty are being treated, and the availability of treatment services is doubled, then eighteen out of twenty would still remain untreated, so the prevalence would be virtually unchanged.

This is not an argument for not improving treatment services, but simply against unrealistic expectations of treatment reducing prevalence. Indeed, when a recent report was published on the achievements of the Headspace program, despite clear evidence of hugely improved accessibility to treatment programs for young people, particularly young people from poorly-serviced

rural areas, with response rates comparable to other service providers, some critics derided it as ineffectual because there was no evidence of reduced prevalence. Services would need to be increased about tenfold before one would expect to see a changed prevalence through treatment, and that is not going to happen.

The World Health Organisation statement on child and adolescent mental health states, “Worldwide 10-20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14, and three-quarters by mid-20s. These are the leading cause of disability in young people in all regions. If untreated, these conditions severely influence children’s development, their educational attainments and their potential to live fulfilling and productive lives. Children with mental disorders face major challenges with stigma, isolation and discrimination, as well as lack of access to health care and education facilities, in violation of their fundamental human rights.” [2]

There is some indication that the small proportion of disturbed children who are referred early for treatment are more from the severe end of the spectrum, and do have a high representation of cases that would otherwise have gone on to disorders in adulthood. There is evidence that the life trajectory of these can be improved by treatment, so improved early treatment services are quite significant.

Nevertheless, the greatest hope of reducing the prevalence of disturbance lies in reducing the incidence of new cases. Prevention is better than cure.

Prevention of Mental Disorders

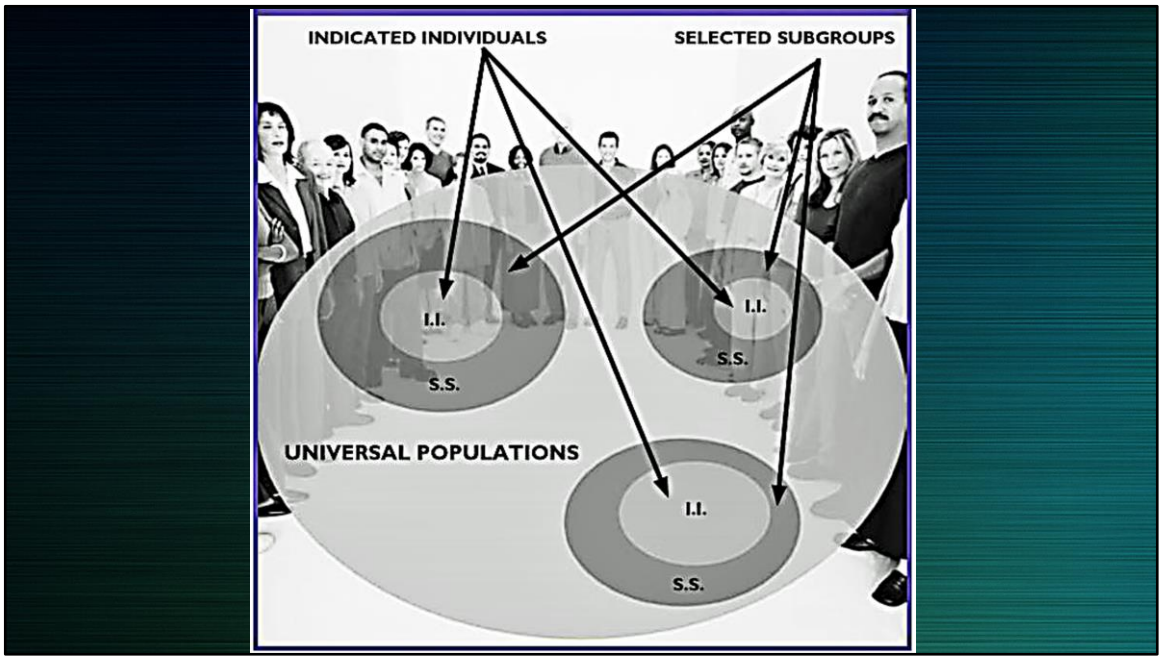
TYPES

- Primary prevents the disorder occurring
- Secondary prevents the disorder worsening
- Tertiary prevents disabling consequences

INTERVENTIONS

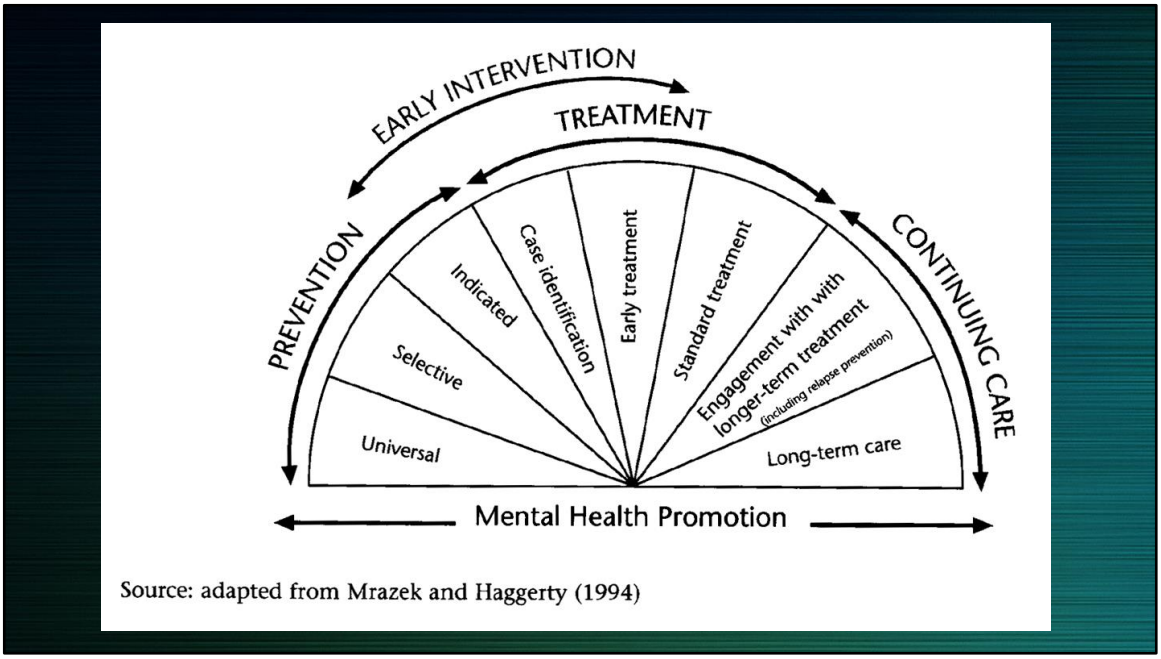
- Universal involves the whole population
- Selective intervenes with at-risk groups
- Targeted intervenes with persons impacted

The literature refers to:
Primary Prevention – the avoidance of a case occurring
Secondary Prevention – early detection and treatment to avoid a problem becoming established
Tertiary Prevention – the avoidance of consequences of disorder becoming a handicap
Although interventions attend to all three levels, this Oration will focus mainly on Primary Prevention. This is not to imply that the other levels are unimportant, but that as their methodology is better understood I prefer to focus on the less well understood.
Within Primary Prevention, the literature on interventions refers to:
Universal interventions – applicable to the entire population
Selective interventions – applicable to children in populations at risk
Targeted interventions – applicable to those in situations which will inevitably cause disorder.



The scientific evidence for targeted and selective interventions is much more clearly reported than evidence for universal interventions. This is because research is easier to undertake on smaller, defined sub-groups than on whole populations, and programs are less costly and easier to implement. Research methodology on cause and effect is generally simpler, with control groups of untreated cases. With whole population interventions it is hard to prove that you have prevented something when it hasn't happened!

Although I will refer to some selective and targeted interventions I will focus particularly on the universal interventions because I believe that they hold the greatest hope for meaningful reduction in prevalence of mental disorders in children. As represented in this diagram from the Center for Applied Research Solutions, [3] Universal interventions potentially reduce the incidence of new cases in a range of separate at-risk groups simultaneously, and therefore have a greater total impact, even if a targeted intervention for a specific subgroup is more effective for that subgroup. These interventions are not mutually exclusive and, indeed, multipronged approaches are desirable.



There are several things that underpin what I will be saying, that I may not necessarily emphasise again, but need you to understand that everything is viewed through these frameworks. The first is my understanding of mental functioning as an inextricable mix of biological, psychological and social or life experience factors. The second is the spectrum of mental health services summed up in the Mrazek & Haggerty model. [4] This ranges through the spectrum of Prevention, Early Intervention, Treatment and Mental Health Promotion, and underpins all that MHYFVic stands for.

As a framework for my exploration I have chosen two main sources. The first is the World Health Organization Report "Prevention of Mental Disorders: Effective interventions and policy options" 2004, Geneva. [5] The second is the "US Surgeon General report on mental health: culture, race and ethnicity" Public Health Rep. (2001), 116(4): 376. PMC1497348. [6]

WHO Report

- Prevention is a public health priority
- Multiple determinants – needs multipronged effort
- Effective prevention can reduce risk
- Implementation should be evidence-based
- Programs should be widely available
- Need for more knowledge of effectiveness
- Need to be sensitive to culture and resources
- Needs human and financial investments
- Needs inter-sectoral linkages
- Protecting human rights is a major strategy

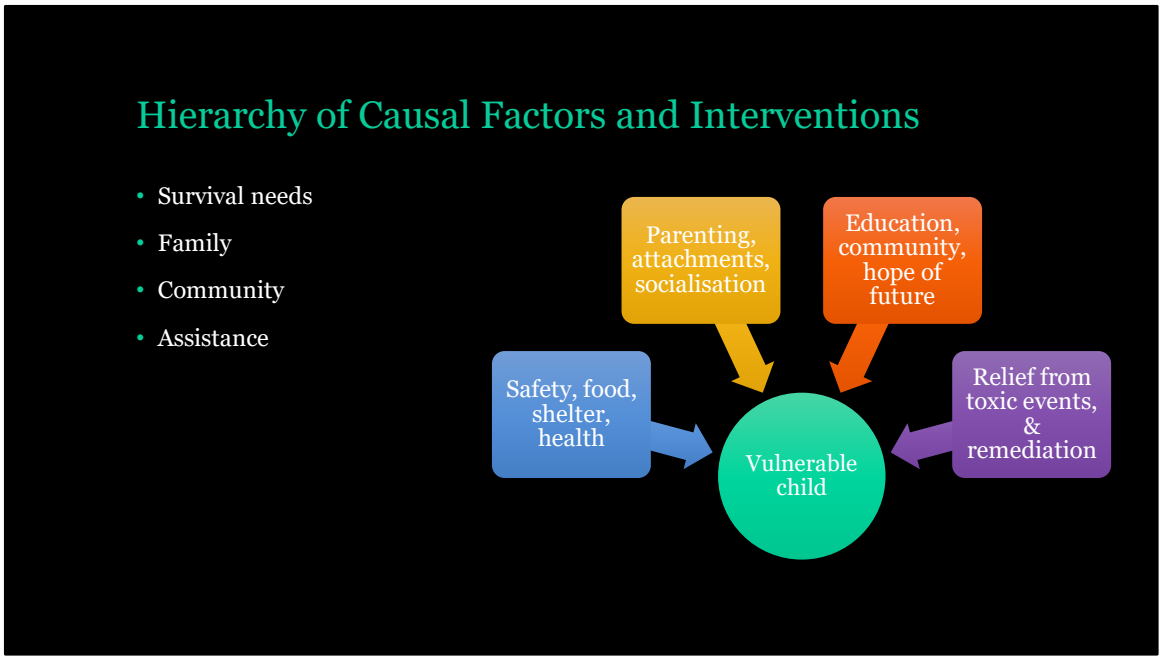
The World Health Organisation has published considerable literature on prevention. The Australian Government's National Mental Health Plan expresses support for the concept, but in practice there has been minimal funding devoted to preventive programs notwithstanding authoritative support by the medical profession. A paper by Jorm, A.F. and Reavley, N.J. "Preventing mental disorders: the time is right" [7] and an Editorial in the Medical Journal of Australia in October 2013 emphasise that not enough is being done.

The WHO Report gives the following ten-point summation:

1. Prevention of mental disorders is a public health priority
2. Mental disorders have multiple determinants; prevention needs to be a multipronged effort
3. Effective prevention can reduce the risk of mental disorders
4. Implementation should be guided by available evidence
5. Successful programmes and policies should be made widely available
6. Knowledge on evidence for effectiveness needs further expansion

7. Prevention needs to be sensitive to culture and to resources available across countries
8. Population-based outcomes require human and financial investments
9. Effective prevention requires intersectoral linkages
10. Protecting human rights is a major strategy to prevent mental disorders

The implementation of these principles highlights the public health paradox. Universal interventions are notionally the most effective for the population but are the costliest and have the weakest evidence base. Selective interventions are moderately costly although the evidence shows them to be reasonably effective. Targeted interventions have the strongest evidence base and are the least costly but have limited community-wide effectiveness because, by definition, they are focused on a small, significantly disadvantaged group. MHYFVic advocates support for preventive mental health measures at all three levels but particularly at the universal level because of its potentially greater public health benefit.



Universal interventions for children and families means programs that:
Ensure adequate safety, housing, food and general health, welfare and educational services. Although these could be termed 'Survival needs' they are actually much more.
Promote social stability, family functioning and adequate parenting skills. These can be termed 'Family functions'.
Enhance social cohesiveness and pro-social participation. These are partly family but largely community functions.
Encourage every child's educational progress to reach his/her potential. These, too, are partly family and partly community functions.
Provide processes to identify and deal with toxic events. Only when the foregoing factors are stable is it efficient to engage in psychotherapeutic interventions.
These aspects of prevention form a kind of hierarchy of significance, somewhat similar to Maslow's *Hierarchy of Needs*. If you are in a war zone, unsafe, with no reliable food and water, no shelter and no support services, there is a high

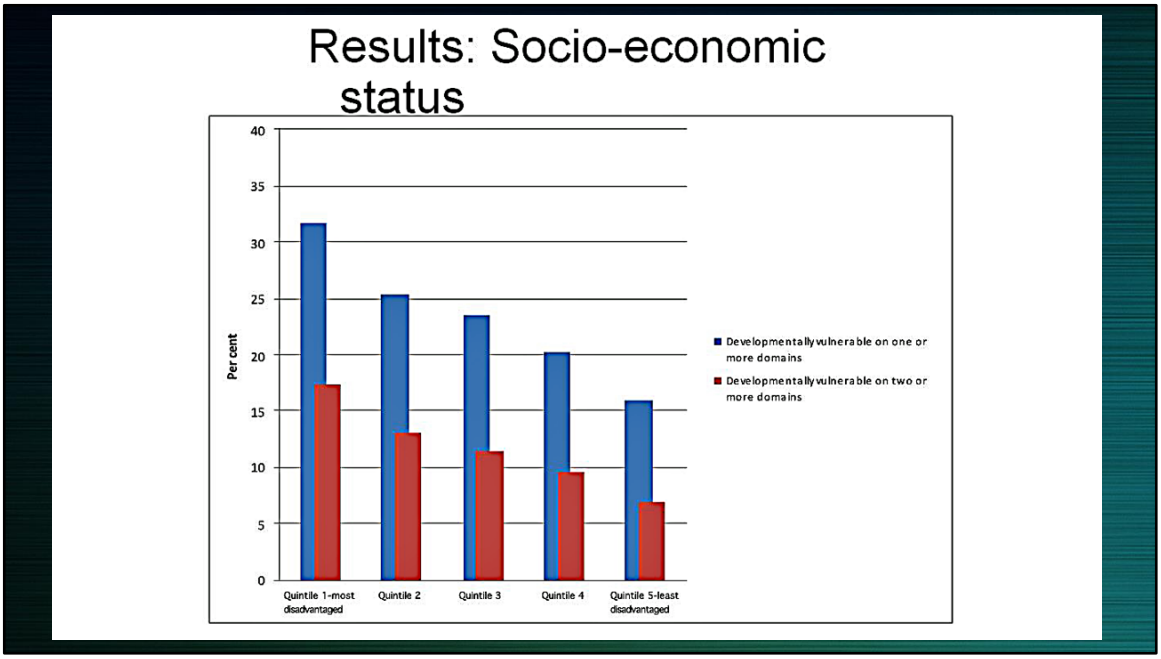
level of stress and not much else matters. Once those basic needs are met there is time to look at family functioning and parenting. Enhancement of attachment and pro-social behaviours then become feasible, paving the way for processes to reach one's potential and to respond to individual therapeutic interventions. Self-actualisation is the top of the pyramid, not the starting point.

As resolution is needed for each aspect if later steps are to be successful, I will talk about each aspect in sequence notwithstanding that many processes are occurring simultaneously. This is why the WHO Report says that "prevention needs to be a multi-pronged effort".

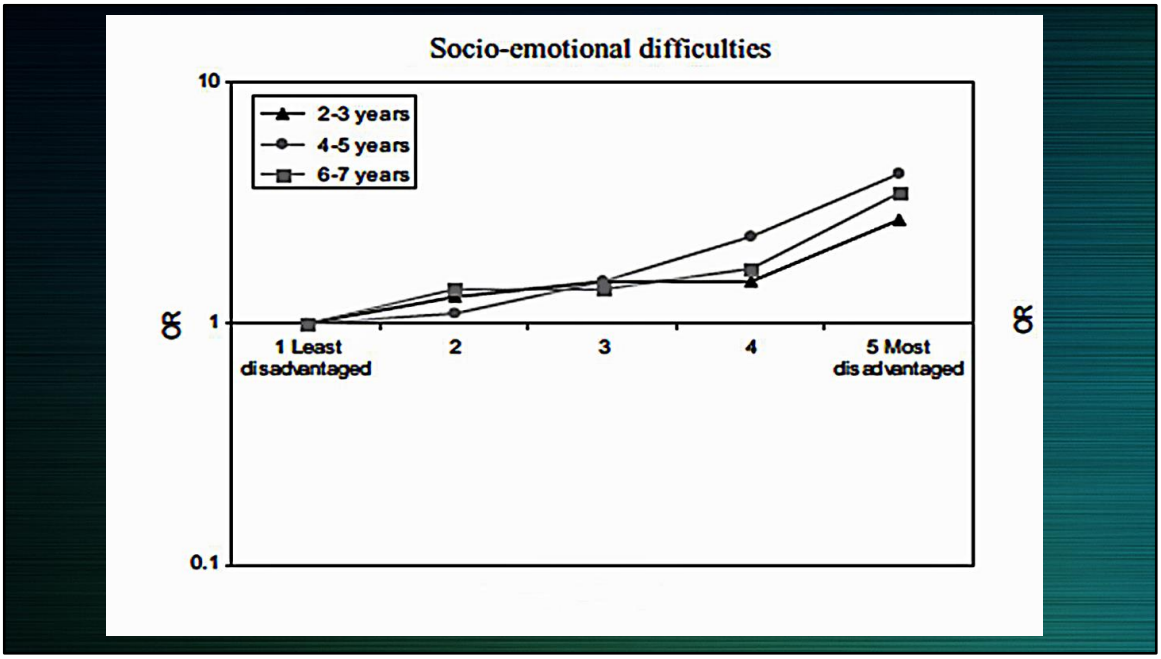
Safety, General Health and Welfare

- Safety and personal security
- Housing
- Food
- Health care
- Employment / unemployment support
- Education and training

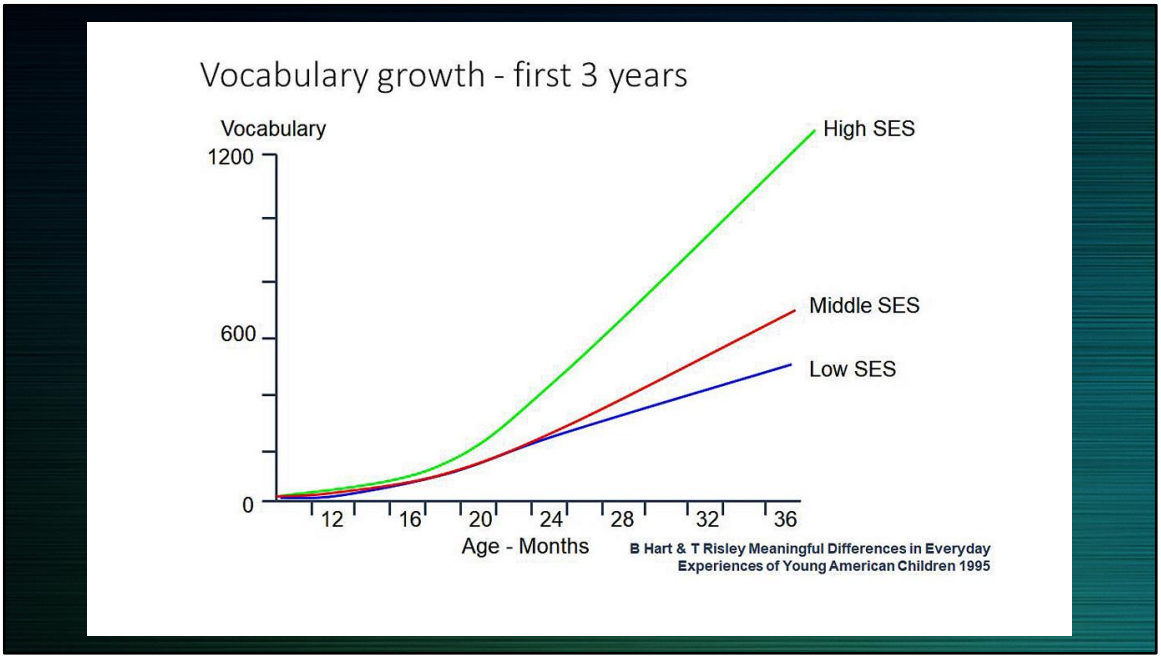
How do we ensure adequate safety, housing, food and general health, welfare and educational services? We have Government Departments and non-government agencies that deal with all of these issues, but are they enough? What are the appropriate benchmarks of adequacy?



Research has shown that socioeconomic factors have a profound influence on achievement outcomes.
32% of children from socio-economically disadvantaged families have developmental vulnerabilities, which is double the rate of advantaged children in the pre-school years.



Children from socio-economically disadvantaged families have Odds Ratios of five to seven times the rate of emotional difficulties as advantaged children throughout the early childhood years.



Children from more advantaged backgrounds not only have lower vulnerability rates but as a whole they make better progress, as illustrated for example by this graph of vocabulary rates.

In fact, the gap between the haves and have-nots widens as time goes by. Studies of developmental progress of children of high, medium and lower initial achievement levels find that children from more privileged socioeconomic backgrounds make better progress at all levels than comparable children from deprived backgrounds. Within the socio-economically advantaged group the higher-functioning children make much better than average progress, the average children make good progress and even the developmentally challenged children make progress towards the average range. By contrast, disadvantaged children with early signs of potential struggle to maintain that promise; the developmentally challenged fall way behind.

It is not just money, but how families are able to use their money to best effect. Advantaged families generally have better-educated adults with better

employment and higher aspirations. They value education, read more, converse more, and have high expectations of what their children should do. They generally spend more time on their children's activities and if there are vulnerabilities are more likely to recognize these and arrange support.

The socially disadvantaged, on the other hand, are struggling to make ends meet. They may well be working several menial jobs at odd hours that leave them little time to spare for their children. Although they hope for their children to have a better life, it is difficult for them to do much to make it better, especially if they have not had a good education themselves. They are often unable to meet the special needs of vulnerable children.

This socioeconomic disadvantage translates into a biological slipway. The poor have shorter life spans, higher rates of heart disease, obesity, type two diabetes, smoking and substance use. Recent evidence also indicates impaired brain function. Neuroscientists used Magnetic Resonance Imaging to study the brains of healthy children from various socioeconomic strata. They report, "We confirm behaviourally that language is one of the cognitive domains most affected by Socio-economic Status. Furthermore, we observe widespread modifications in children's brain structure. A lower SES is associated with smaller volumes of gray matter in bilateral hippocampi, middle temporal gyri, left fusiform and right inferior occipito-temporal gyri, according to both volume- and surface-based morphometry. Moreover, we identify local gyrification effects in anterior frontal regions, supportive of a potential developmental lag in lower SES children." [8]

Although I am not a neuropsychologist, I think this means reduced brain capacity in areas to do with expressive language, verbal reasoning and executive functioning such as planning and foreseeing the possible consequences of one's actions. The scientists did not discuss cause but I speculate that it might be partly impoverished cognitive stimulation failing to enhance development, combined with an inhibition of development due to higher cortisol levels from stress. Those hypotheses are clearly open to further investigation. However, they emphasise that income support must be provided in a way that enhances education and personal development.

Council of Australian Governments

- National Mental Health Plans
- Australian Institute of Health & Welfare
  - Indicators
  - Goals
  - Outcomes
  - Results informing remediation

- Political emphasis on Social Welfare payments
- Secondary emphasis on child protection laws

As one of the world's more developed countries, Australia has relatively satisfactory universal services although we should do better. Our policing and criminal justice systems assure a reasonable level of safety and personal security. Our education system assures reasonable levels of literacy and numeracy. Our public housing system struggles to meet the needs of our poorest citizens and needs considerable propping up by non-Government agencies. Our Health system is probably one of the world's best, although in the area of mental disorder prevention is still in early stages.
In recent years the Council of Australian Governments (COAG) has endorsed a series of National Health and National Mental Health Plans, and has set up the government-sponsored but administratively independent organisation, "The Australian Institute of Health and Welfare", to monitor the performance outcomes of various health initiatives. By agreeing on indicators, setting goals, measuring outcomes and reporting the results to inform further remediation, huge steps have been made in our general health status. [9] The reports show, however, that there has not been a comparable focus on mental disorder

prevention.
In the area of Welfare, there has not been a coordinated management by objectives approach. Instead, the system has been very much more fragmented. The two main themes have been on Social Security payments and Child Protection services. Interestingly, an internet search of welfare monitoring revealed a surveillance system for animals which, if applied to humans would hugely improve our public welfare policy.

The animal welfare measurement is based on the list of 'five freedoms'.
Freedom from pain, injury, disease
Freedom from discomfort
Freedom from fear and distress
Freedom from thirst and hunger
Freedom to show normal behaviour

RSPCA Australia is responsible for:

- Setting standards
- Assessment
  - Review of non-compliance with standards
  - Decide on required actions and timeframes
  - Incorporate expertise and advice as needed
- Procedures and findings

- Compliance is voluntary except for law-breaking

The RSPCA sets standards, undertakes assessments, offers expert consultancy on resolving non-compliance with standards, and publishes the outcome studies. Compliance is voluntary except where there has been law-breaking, but the spotlight of public scrutiny is generally enough to encourage compliance. We have seen some examples of this in live animal exports. [10]
I believe we should advocate an approach of this general format by the Australian Institute of Health and Welfare. The success comes from defining and measuring standards which are then achieved through targeted programs; they have done this for health but do not do it for welfare. At present we have no agreed standards for income and housing, and therefore the outcomes cannot be systematically achieved. It is an example of the old sports trainer adage, “What we measure we can improve”.

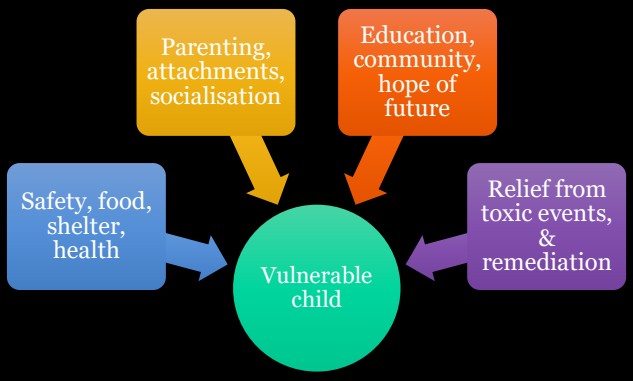
Social Policy Research Centre of NSW reports:

- Single adult requires $600 pw
- Couple with no children requires $830 pw
- Couple with one 6yo child requires $970 pw
- Couple with two children (6 & 10) requires $1170 pw

- Social Security benefits fall short by $100+ pw
- Minimum wage barely copes

Data from the Social Policy Research Centre at the University of NSW, published last year, calculated the minimum amount required for families to lead a healthy life. A single adult would need to spend $600 a week. A couple with no children would need $830. Add a child of six and that rises to $970. Add a second child, of 10, and it's up to $1170. Of that, one third would go on rent and the remainder to cover all other costs. Current Social Security benefits fall short of this minimum need by at least $100 per week. Minimum wage employment barely scrapes home, leaving almost no time for nurturing children. [11]

Hierarchy of Causal Factors and Interventions



How do we promote social stability, family functioning and adequate parenting skills? Removing the destabilising influences in general welfare is a necessary step but not sufficient; we also need processes to develop self-sufficiency in employment and recreation, social networks and skills.

Social Stability and Parenting

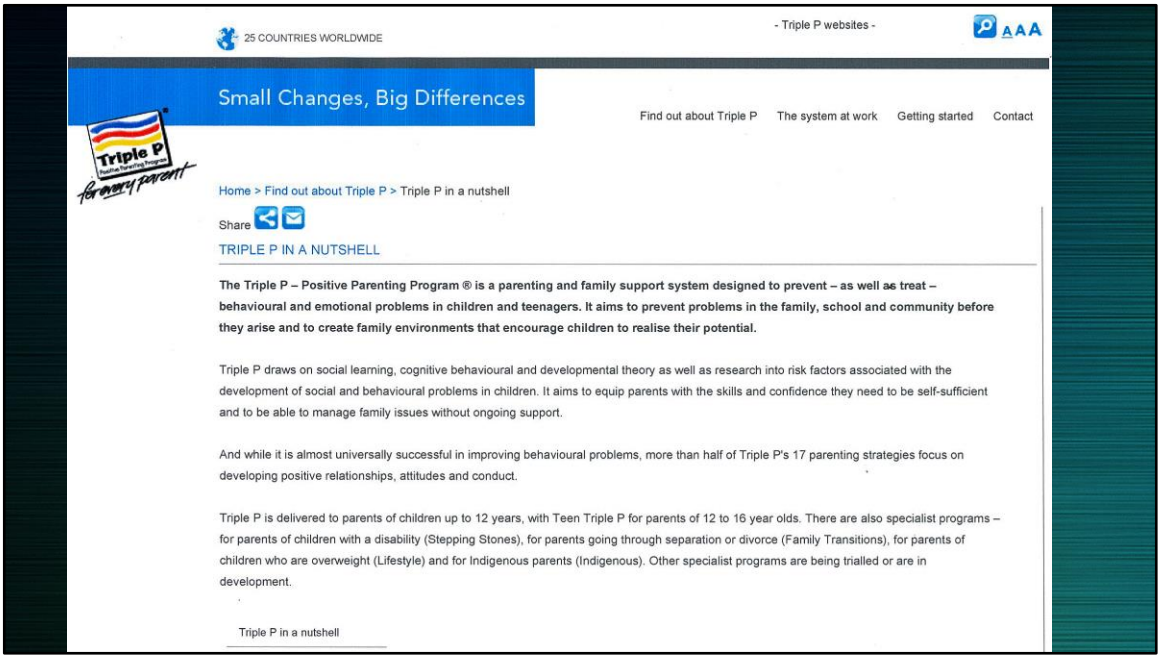
- Social stability
  - Maintaining status quo
  - Resolving instability
  - Developing self-sufficiency
- Family functioning
- Parenting

Social stability in the political context means maintenance of the *status quo*, but in the context of mental health has more to do with removing instability that undermines family functioning. Kristi Openshaw has shown clear evidence that family resilience is a predictor of quality of life and that parent-child relationships, social support, family conflict, and family type are variables that impact quality of life. [12]

A Commonwealth Department of Family and Community Services report in 2000 said, "(The use of…) indicators of social and family functioning… identifies opportunities to modify risks which have been associated with increases and decreases in the prevalence of problems of developmental health and wellbeing. This allows the development of prevention strategies and better intervention". [13] The report went on to recommend the use of some measures, one of which was the "psychological capital" of the family.

The concept of psychological capital arose primarily in the industrial psychology field where factors increasing productivity were being researched. Four factors were identified as relevant to individual productivity and, when

clustered under the concept of psychological capital, do provide a measure which is as applicable to families as for work groups. The factors are:
Hope
Self-efficacy
Optimism
Resilience
An analysis of the international social capital literature reports, “There is considerable evidence that social capital can have a positive impact on future outcomes for children.” Families with high social capital are likely to produce children who fare positively in areas of general wellbeing, including mental and physical health, educational attainment, and formal labour market participation. Social capital, after poverty, is the best predictor of social welfare. Poverty is a negative indicator for criminality, school dropout, teenage pregnancy and infant mortality, whereas social capital is a positive indicator.[14] An important goal, therefore, would be to implement programs to enhance the psychological capital of families. [15]



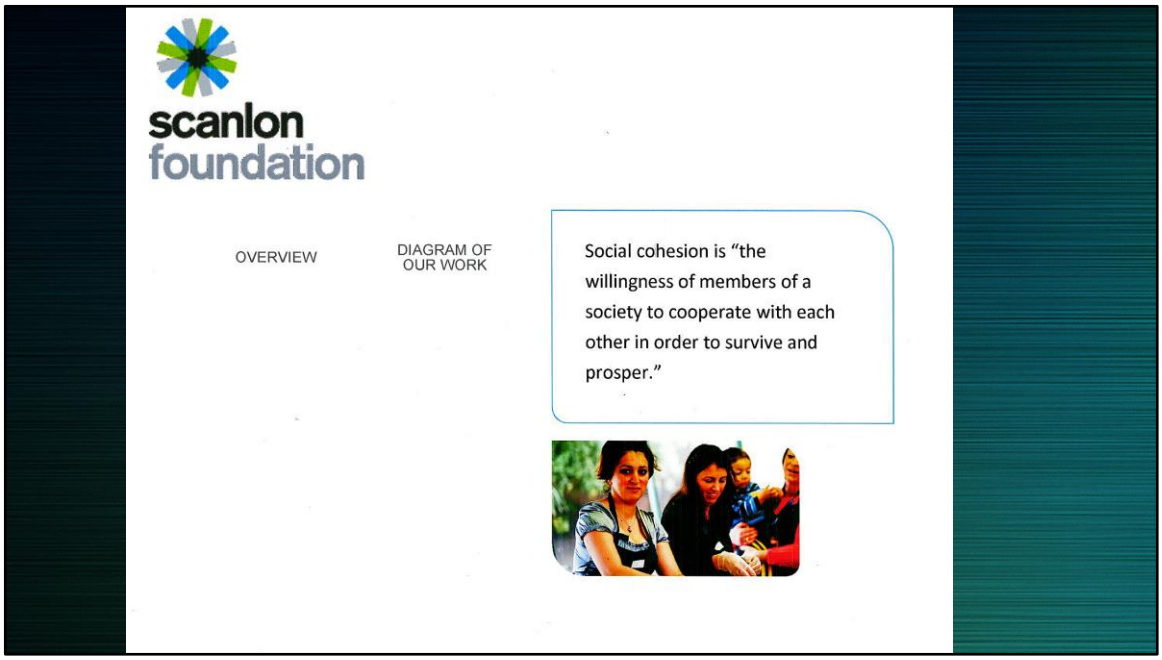
Important for family functioning, also, are the practicalities of parenting. Parenting skills may be assisted by interventions such as the Triple P program used as a Public Health measure available to whole populations. These can be provided in group sessions at Community Health Centres and non-Government agencies. [16] This has been undertaken in Western Australia with published reported success. Where actual problems of parenting are identified, the program can also assist with resolving these, or lead to referral for specific therapeutic interventions.

Pro-social participation

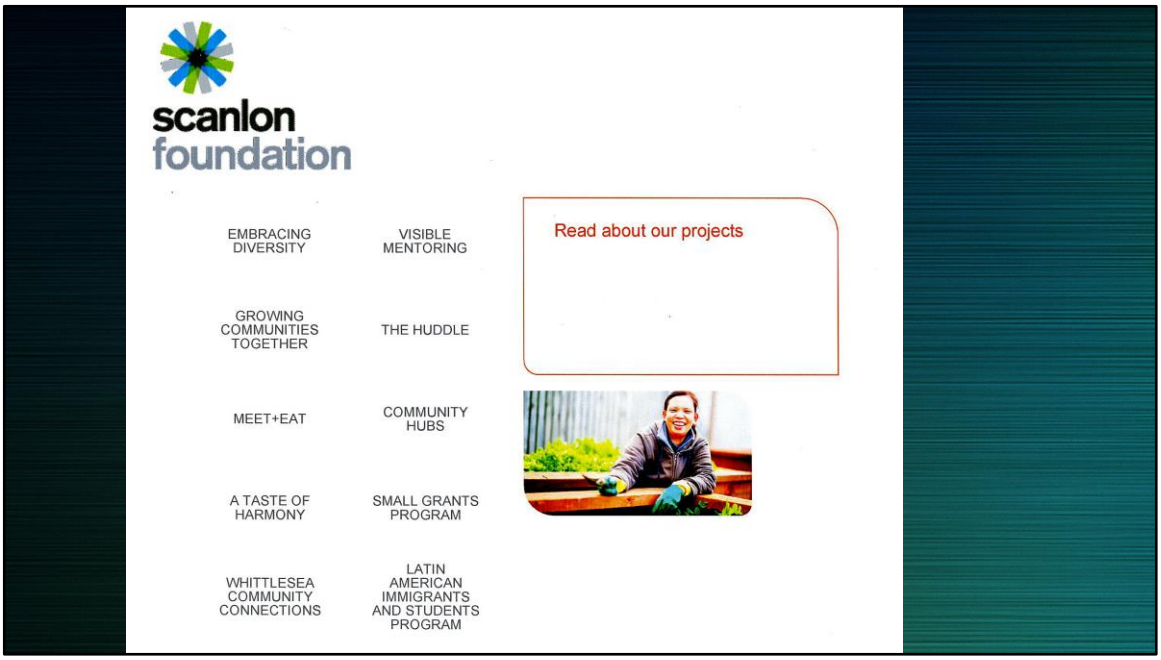
- Diversity and Social Cohesion Program
- Multicultural support
- English language assistance
- Religious tolerance
- Community hubs
- Volunteering

Why do we need to enhance social cohesiveness and pro-social participation? Research tells us that even when homelessness and poverty have been alleviated there are still differences in rates of childhood development difficulties between economically similar communities differing in social cohesion. Children from poor neighbourhoods with strong social cohesion do better than equally capable children from socially fragmented neighbourhoods. This has been confirmed in research by Sharon Goldfeld and others at the Department of Community Child Health here at the Murdoch Institute. [17, 18, 19] Conversely, when the social cohesion of a community is diminished there is an increase in mental health problems. Yang and associates undertook a thirty-year follow-up of a large cohort of Jino people in China. Up to the 1970s the Jino people had been an ethnic minority group living an isolated traditional agricultural existence in remote rural China, but large-scale government planning programs and market forces produced a transition to a more urban lifestyle. Although social and economic development helped minimise poverty, there was a major increase in alcohol abuse, family conflicts, divorce, criminal

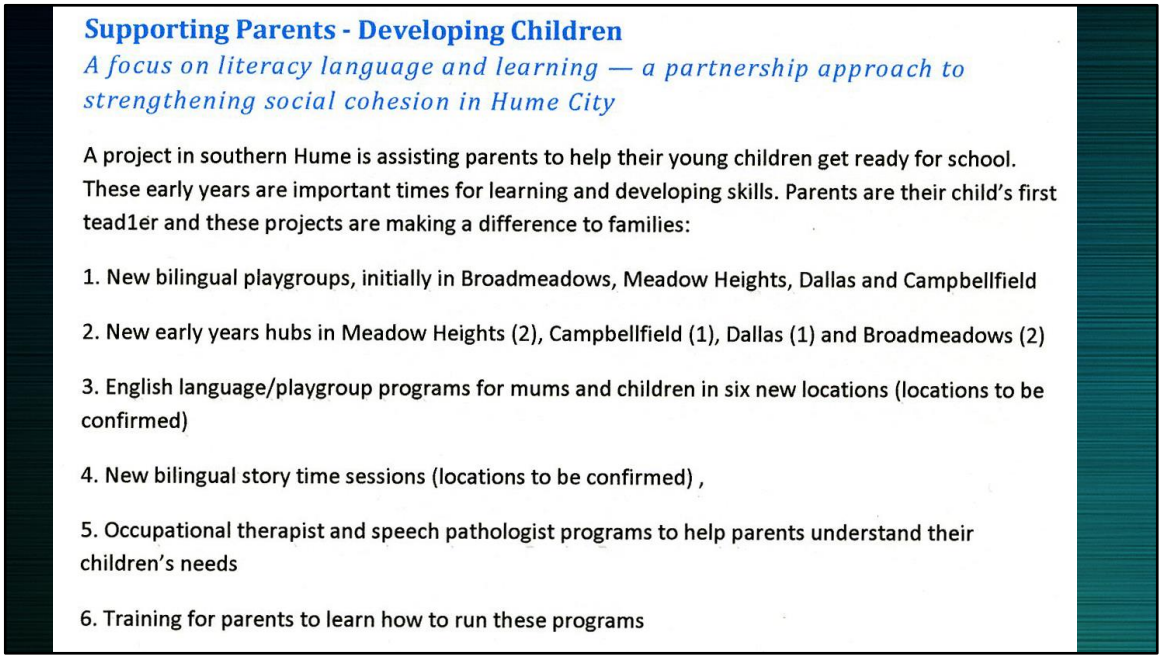
activity and gambling. At the same time, the annual suicide incidence had increased at least three times in 2009 compared to that of 1989. [20] Recognizing the importance of social cohesion in the integration of diverse multicultural groups into Australian society, the Commonwealth Government Department of Social Security has developed a 'Diversity and Social Cohesion Program' which gives grants for multicultural festivals and projects. [18] However, this is not just an issue for a selected population, it is a universal issue. As a means of enhancing social cohesiveness and pro-social participation we need to encourage participation in community groups and volunteer activities.



A private philanthropic organisation, the Scanlon Foundation, has picked up this theme and developed a whole raft of social cohesion programs. It defines social cohesion as "the willingness of members of society to cooperate with each other in order to survive and prosper".

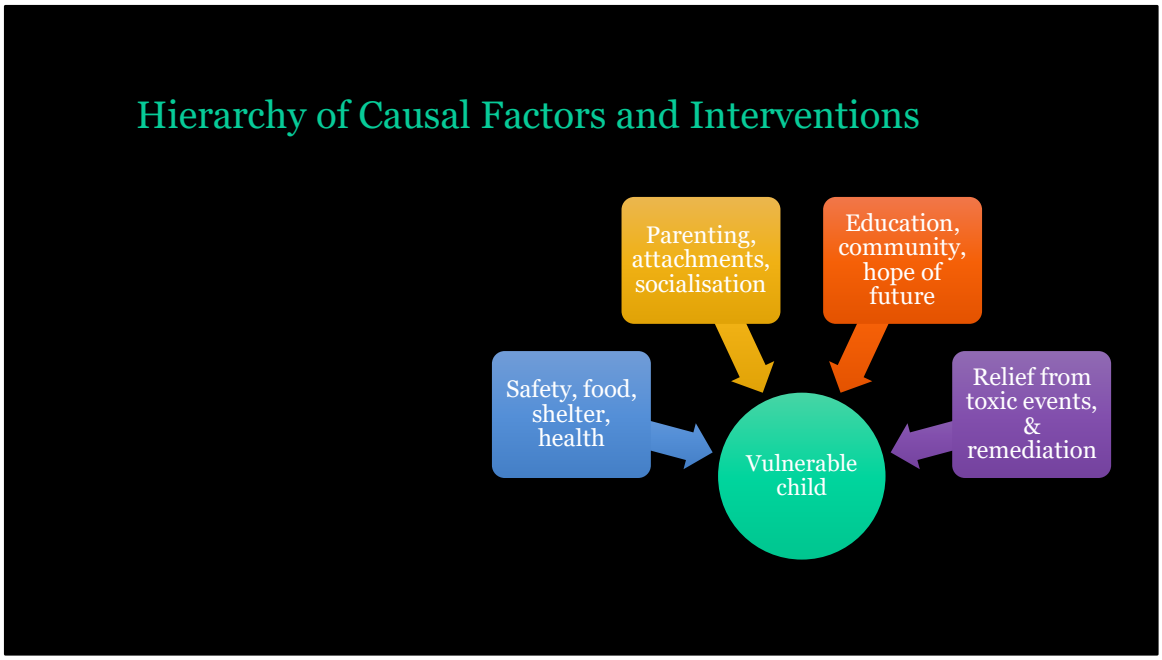


Scanlon Foundation initiatives in collaboration with local government authorities include several pilot programs for new Australians at community hubs which offer "practical assistance to establish links to wider community services and support in a safe and familiar environment, so they can build better lives and move towards full participation in Australian society." Although the concept is aimed at supporting immigrant families it is equally valid for all families. [21]



As an example of one such local government area in Melbourne, the City of Hume advertises on its website its program "Supporting Parents – Developing Children". This is a scattering of 'one-stop-shops' that give a diversity of professional supports to multilingual self-help activities. It would be highly desirable for research to measure the cost-effectiveness of such programs to aid advocacy for wider implementation. [22]

Such research is being undertaken for youth health care. A paper by Sarah Hetrick, Patrick McGorry and others in the MJA last year, titled "Integrated (one-stop shop) youth health care: best available evidence and future directions" report that many young people who may not otherwise have sought help are accessing these mental health services, and there are promising outcomes for most in terms of symptomatic and functional recovery. It is desirable for such 'Headspace" services in every Local Government area. [23]



In advanced societies the importance of education is so obvious that asking the question, “Why do we need to encourage children to reach their educational potential?” seems almost fatuous. Similarly, its corollary, “How do we encourage children to reach their potential?” seems equally self-evident. In simplistic economic terms, better education equates to better jobs and a higher standard of living. Ipso facto, education is important.

Education and Personal Development (1)

- Education to reach potential
  - Life trajectory is enhanced
  - Schooling is to children what employment is to adults
  - School environment is crucial

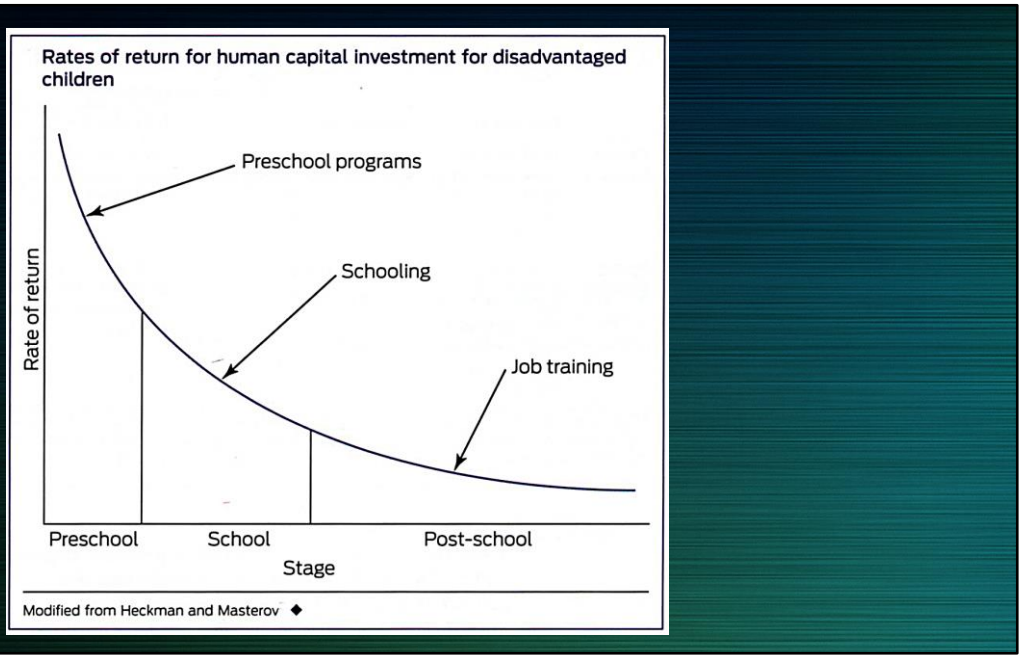
    Findings of 'Lyndale Project' + contemporary methods

    eg Mind Matters Program

However, education is not just about jobs, it is about the development of the whole person. This includes the person's mental health. The seminal Perry Preschool research program showed that quality pre-school education changes the whole life trajectory of the child. Not only is there an economic benefit over the life span from better jobs and less reliance on welfare support, more importantly there is benefit from greater family stability. This means lower rates of family breakdown and lower rates of involvement in the criminal justice system. Such benefits extend to the next generation. In all, it was estimated that the benefits were about sixteen times the costs of providing that quality early education. Isn't it amazing that our society begrudges spending more on quality education but finds more and more money to spend on putting people in prison. [24]

The psychological benefits are at many levels. At a basic level, schooling is to children what employment is to adults. Successful employment is at the core of personal identity. It is central to self-esteem. The mental health of unemployed people is significantly at risk. So it is with children. If they are not succeeding

at school, their mental health is at risk.
At the highest level, education enhances self-actualisation, participation in the arts and sciences, and personal well-being. The earlier we start, the greater the impact.



The beneficial effects of education are greatest in the early years, as illustrated by this graph of the impact on developmental progress of input at various stages. [25] The graph indicates we should be investing not only in pre-school programs but probably even more in early child care centres. This would not only provide developmental enrichment for the infants and toddlers but also an opportunity for parenting support, including the opportunity for employment. Education enables greater access to information, improving prospects of maximising available benefits within society and minimising avoidable problems. We have known this for a long time. It continues to be relevant through to the secondary school level. The Lyndale Project highlighted some of these issues 45 years ago, when the solutions had to be developed within the school. Nowadays there are many programs available for implementation, such as the 'Mind Matters' series.

Education and Personal Development (2)

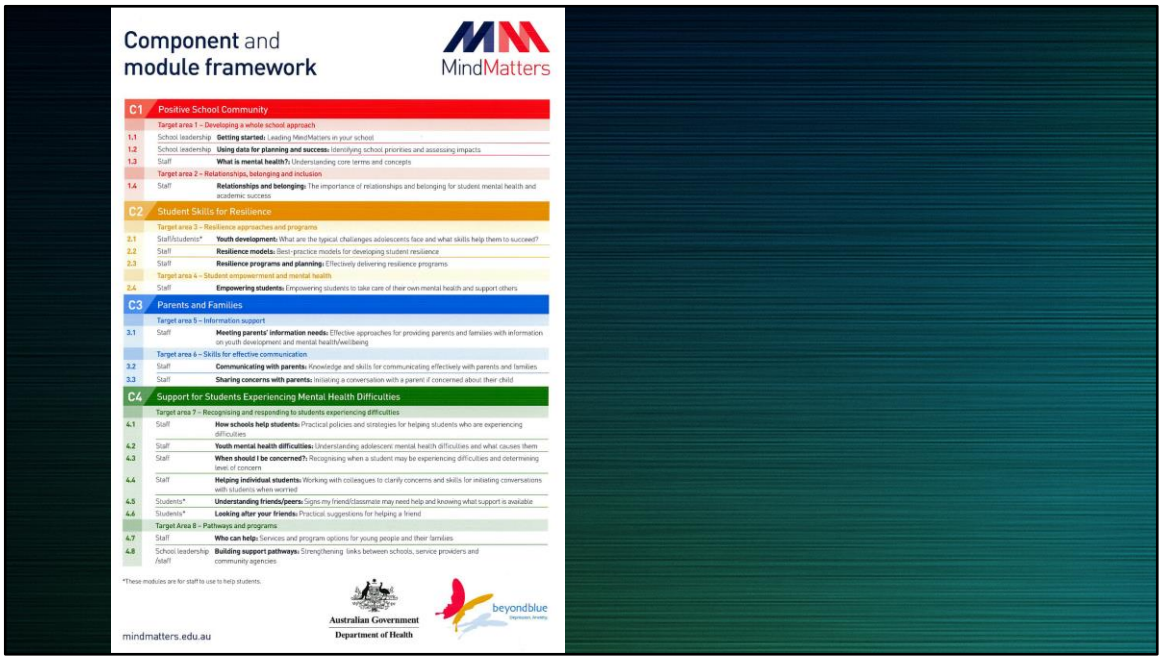
- 'Lyndale Project'
  - Literacy and numeracy needs
  - Social development needs
    - Form co-ordinators & Counsellors
    - Student participation and responsibility

Forty-five years ago, when I was working in the Dandenong region, the Lyndale High School experienced the most troublesome year nine student group that the staff had ever encountered. As an alternative to accepting an avalanche of individual referrals, the School Support Service and the staff of the school undertook a collaborative project of investigation and program development. They undertook literacy and numeracy assessments, sociograms of friendship groupings, and individual interviews of students and staff to understand the needs. These were followed by workshops to arrive at solutions. [26]

<u>The findings were:</u>

There was a high prevalence of reading difficulties, with a high proportion of students unable to cope with the advanced language level of their textbooks. Rather than admit to not understanding, many students engaged in disruptive behaviour. This interfered with the progress of those capable of understanding, to the point where many lessons became unrewarding. Some of the capable students joined in the disruptive behaviour to stay on-side with the

ringleaders.
Comprehension of mathematics was even worse.
Students had many different teachers, with numerous staff changes making classes unsettled. Teachers had many different classes with little opportunity to know their students well.
Sociograms indicated clusters of friendship groupings that spread across multiple classes and across year levels. Some charismatic disruptive students were able to engender "competitions" as to who could be most disruptive. More capable students attempted to keep a low profile to avoid being scapegoated.
Families tended to distance themselves from the school as most communication centred around unsatisfactory behavioural incidents.
The solutions implemented were:
Subject classes were streamed, with textbooks chosen to match the reading levels of the students in each stream. Remedial reading programs were implemented. A similar approach was taken with mathematics.
Form Teachers were appointed, whose task it was to carefully monitor the progress of each student in that Form, and also to have regular communication with the student's family to report progress and encourage pro-social participation. The Form Teacher of Year Seven this year would become the Form Teacher of Year Eight next year and Year Nine the year after, to maintain the continuity of involvement.
An effort was made to disperse the disruptive clusters. A Student Representative Council was instituted, and an effort was made to address issues reported by students.
The following year saw a dramatic improvement in the previously reported problems. However, the task then became 'how to maintain the enthusiasm of the teachers for the additional roles' now that the crisis had passed. Positive reinforcement for good work applies just as much to teachers as it does to students.
These days, NAPLAN tests inform teachers of the literacy and numeracy challenges, and 'Mind Matters' provide many of the helpful approaches to problems that underpinned those at Lyndale so many years ago.



This is an image of the module framework of the Mind Matters Program sponsored by the Commonwealth Government Department of Health, with resource materials available for any school that wishes to implement any of the components. [27] Although the detail is too much to take in from the slide, the eight Target Areas indicate the scope of the programs.
Developing a whole school approach
Relationships, belonging and inclusion
Student empowerment and mental health
Information support
Skills for effective communication
Recognising and responding to students experiencing difficulties
Pathways and programs.
Better communication, logic, and better understanding of other viewpoints can also improve prospects of problem-solving, maintaining relationships and avoiding disruptions. Interestingly, these principles are at the heart of two other MHYFVic Projects.

Education and Personal Development (3)

- Language development program in Juvenile Justice
  - Executive functioning impairment
  - Can language development improve executive function?
- Stigma is rejection of the feared 'outsider'
  - Bullying is a common result
  - Can stigma and bullying be reduced concurrently?

Laura Caire's project on language development programs for young people in the Juvenile Justice system highlights that many delinquents have significant developmental language impairments that are highly correlated with cognitive executive functioning impairments. This means that not only do they lack the skills to compete in the everyday world, they also have impaired foresight, judgment, impulse control, and capacity to understand the consequences of their actions. When they have offended they also lack the capacity to explain their actions and negotiate acceptable outcomes. Laura is assessing evidence that improving their language functioning may also improve their cognitive executive functioning and reduce recidivism. If such educational programs can work for impaired adolescents, how much better would they work for young children without developmental impairments? [28]

My own project on stigma also highlights a central role for education. Within all cultures children are taught normative values and characteristics from an early age. They are also taught to reject others who do not fit these characteristics. Belonging to the "in-group" and being sheltered from a feared

“out-group” is comforting. “Stranger danger” seems to have survival value. Stigma is a process of labelling a feared “out-group” and rejecting it. It is all-pervasive around characteristics of race, colour, language, religion, social class, political beliefs, illnesses, physical deformity and mental disorders. The severity of the rejection ranges from non-inclusion through to ethnic cleansing, with bullying somewhere along the spectrum.

The primary issue in stigma is the boundary of the socially-acceptable “in-group” from a-rejected “out-group”. The out-group is labelled with feared characteristics that justify vilification and exclusion. Dealing with stigma requires reappraisal of the actuality of the fears. A non-feared person can then become part of the “in-group”. Prevention of stigma, however, is even more difficult because it needs a whole societal change in the attribution of feared characteristics (religious, racial, political and cultural) towards tolerance and empathy. [29] I will have more to say about bullying later in this presentation.

Education and Personal Development (4)

- Pre-school education improves the whole life trajectory
- Child Care programs may begin this process earlier
    - The primary goal is enhanced child development
    - The secondary goal is support of parental employment
    - Importance of the early years must be the motivation
    - Qualified professionals are essential to quality care

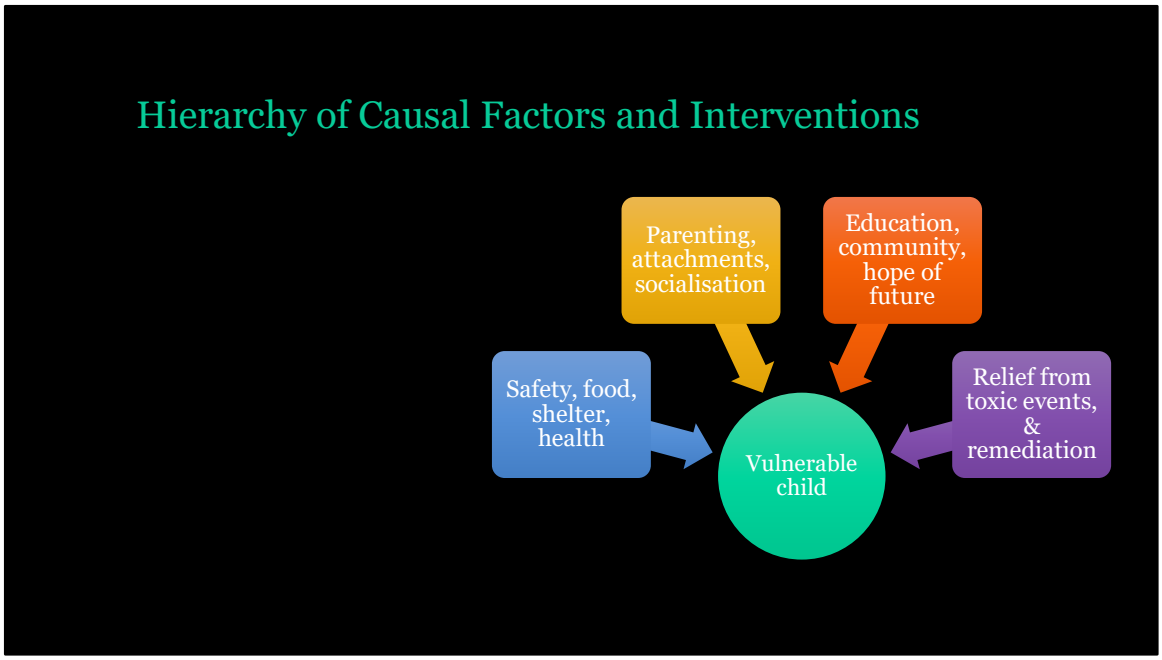
Assuming that we accept the central importance of education not only in economic terms but also in development and mental health, we need to consider the next question. How do we encourage every child's educational progress to reach his/her potential?

Making arrangements for education of children has traditionally been the responsibility of the family, although the state has provided free, secular and comprehensive schools for the public. The previously-mentioned research, showing that the whole life trajectory is elevated by quality early education, means that the human capital of the nation is influenced by this balance between family and public contributions. Also, the earlier this begins the better.

There are two policy issues: (1) measures to improve availability, particularly in quality pre-school programs (2) measures to improve the cultural valuing of education.

The availability of quality education and the opportunity to participate is *sine qua non*. Considerable gains have been made over the last few years in public

acknowledgment of the importance of quality pre-school education, and in government provision of this service. The time is now right for the further extension of this service to include quality day care for infants and toddlers. Although many parents would prefer to provide this early care within the family, there are also many families that are unable to do so. The option of quality early child care is not only about assisting parental participation in the workforce but also about maximising early developmental opportunities. Encouragement by the family remains an essential additional factor. The high representation of Asian and Jewish children at universities compared to their numbers in the population is tribute to the importance placed on education within these cultures. The human capital of the nation would be greatly increased if similar cultural valuing of education was shared by the whole community. The growing acknowledgment of the importance of kindergarten shows that the public is open to this awareness and is likely to support the universal availability of quality child care. Widespread public support for this service is needed before it becomes politically imperative. While this is happening, it is important to insist that qualified professionals are essential to quality care.



The final section of this consideration of the hierarchy of causal factors and interventions will look at the identification and dealing with toxic events impacting on the mental health of children. The earlier sections were predominantly about universal interventions based upon the World Health Organization literature on prevention of mental health disorders. [5] This final section is more about risk factors and selective or targeted prevention. It uses the approach described in the 2001 report of the USA Surgeon General on mental health. This referred to many biological factors, psychological factors and the interaction between these that we would refer to as social factors. [6]

Surgeon-General's listing of risk factors

- Biological factors
  - Genetic and chromosomal disorders
  - Brain injuries eg trauma, infections, prematurity, poor nutrition
  - Pre-natal toxicity eg poisonings, foetal alcohol, other drugs
- Psychological and social factors
  - Dysfunctional family life eg out-of-home care
  - Stressful life events eg bullying

The biological factors included not only the genetic and chromosomal disorders but exogenous causes such as very low birth weight, poor nutrition, lead and similar poisonings, brain injuries from trauma and infections like measles, rubella, syphilis and HIV, and pre-natal toxicity such as foetal alcohol syndrome and effects of other drugs including cigarette smoke. Many of these are avoidable and preventive measures are included in what I said earlier about general health and welfare.
The psychological and social factors were in two broad groups – dysfunctional family life with its attendant attachment difficulties, and stressful life events.
The dysfunctional family factors included discord, parenting deficiencies and antisocial conduct. Particular note was made of maternal depressive disorders and parental substance abuse. Preventive measures about these are included in what I said earlier about promoting family functioning and pro-social behaviour. Two particular interventions should be mentioned.
The first is the early detection and treatment of post-natal depression. Phillip

Boyce and others noted that “the Maternal Mental Health Alliance in the United Kingdom has been advocating for establishing specialist perinatal service, including mother and baby units, arguing that an investment in perinatal mental health will reap great health benefits for the next generation as well as reducing costs in the long run.” [30]

The second is for children of parents with a mental illness. The COPMI website says that the risk of development of mental disorders in children of parents with mental illness ranges from 41 to 77% and that family interventions have the potential to reduce this risk by about a half. [31]

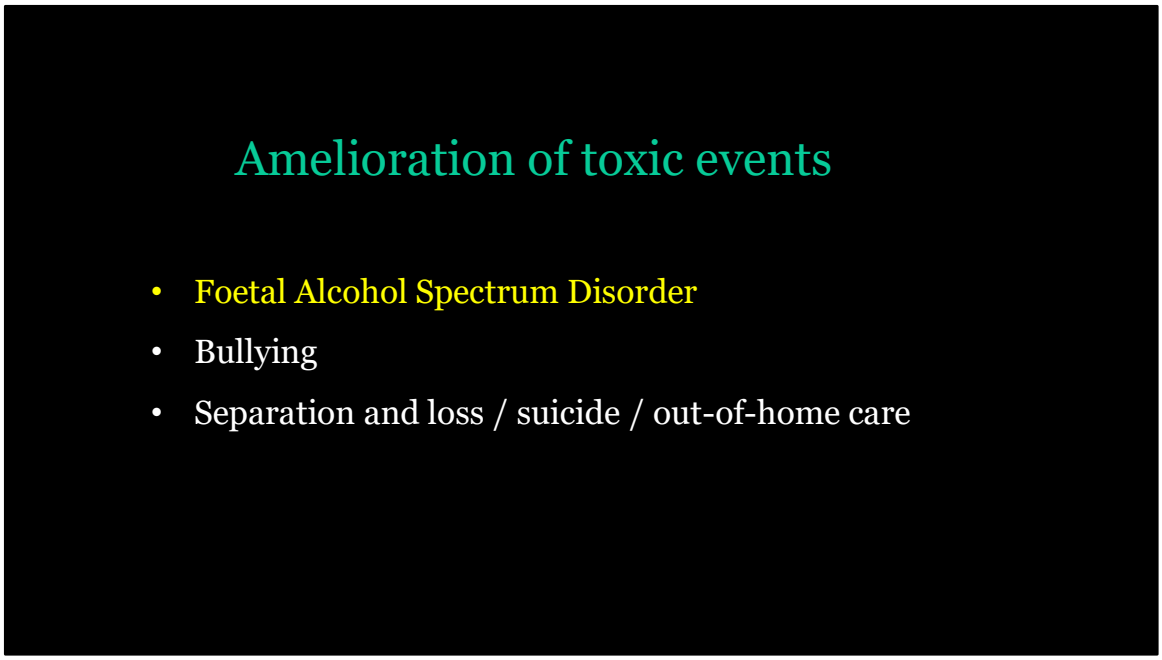
Stressful life events included bereavements and separation losses, and maltreatment including physical, psychological and sexual abuse and peer pressures such as stigma and bullying. In the Australian context we could also add refugee detention. The 2007 Australian national survey of health and wellbeing found that suicidal behaviours are two and a half times more frequent in people who have been subjected to sexual violence than in the general public. [32]

It is clear from this list that if I were to review the literature on each of these factors we would be here for a very long time. I am not going to do that. As most of these issues have been broadly covered already, I propose to comment on only three of them as representative examples of their group, because of their major impact and potential for improvement:

Foetal Alcohol Spectrum Disorder.

Bullying.

Separation and loss, including child protection and out-of-home care.



FASD is a complex neurodevelopmental disorder caused by prenatal alcohol exposure, resulting in lifelong learning and attentional difficulties. Because diagnostic criteria have only recently been agreed, there is no general population data available but impressions are that it is more widespread than previously recognized. Professor Elizabeth Elliott gave the Howard Williams Oration at the recent Royal Australasian College of Physicians congress, and reported on a survey she had undertaken in the aboriginal population of the Fitzroy River district in far north-western Australia. [33]

45% of the women did not drink during pregnancy, but many of the 55% who did drink, drank at high risk levels. One in five of the children had FASD. The survey led to investigations of the psychosocial reasons for high alcohol use, as well as public health interventions for prevention and for special programs for affected children.

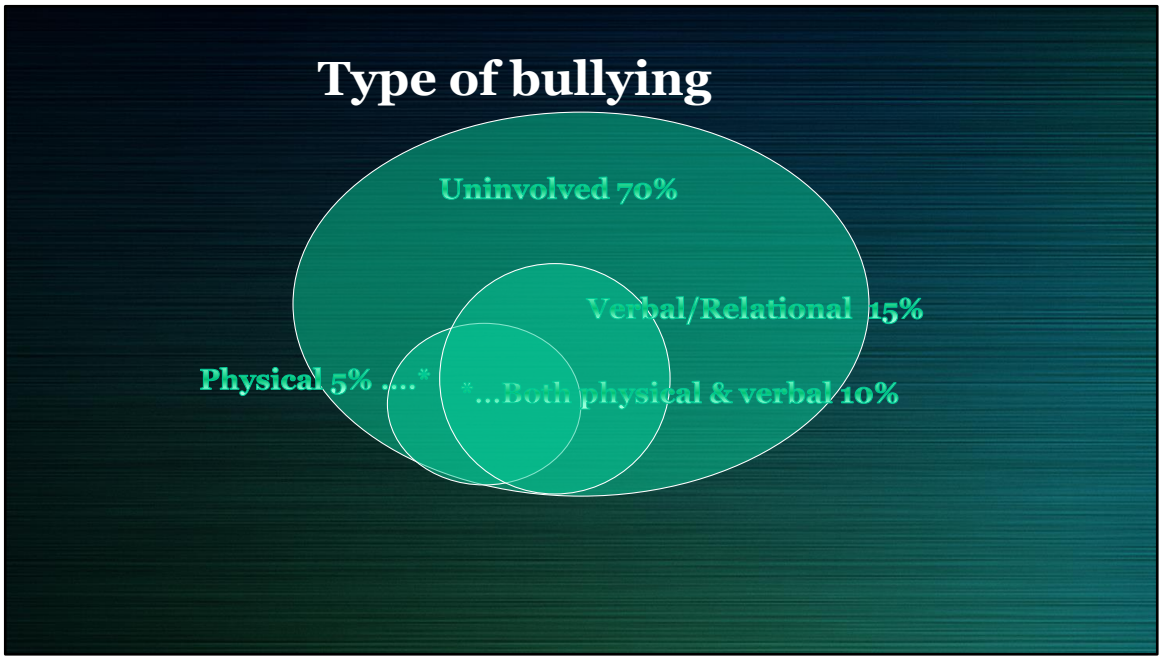
The reason why I chose this example is that it highlights how research can lead to effective public health initiatives, once a problem has been identified and measured. Professor Elliott set up the Australian Paediatric Surveillance Unit

(APSU) in 1993. It facilitates active surveillance of rare childhood diseases, complications of common diseases or adverse effects of treatment. It is through scientific study like this that preventive measures can be found.

Amelioration of toxic events

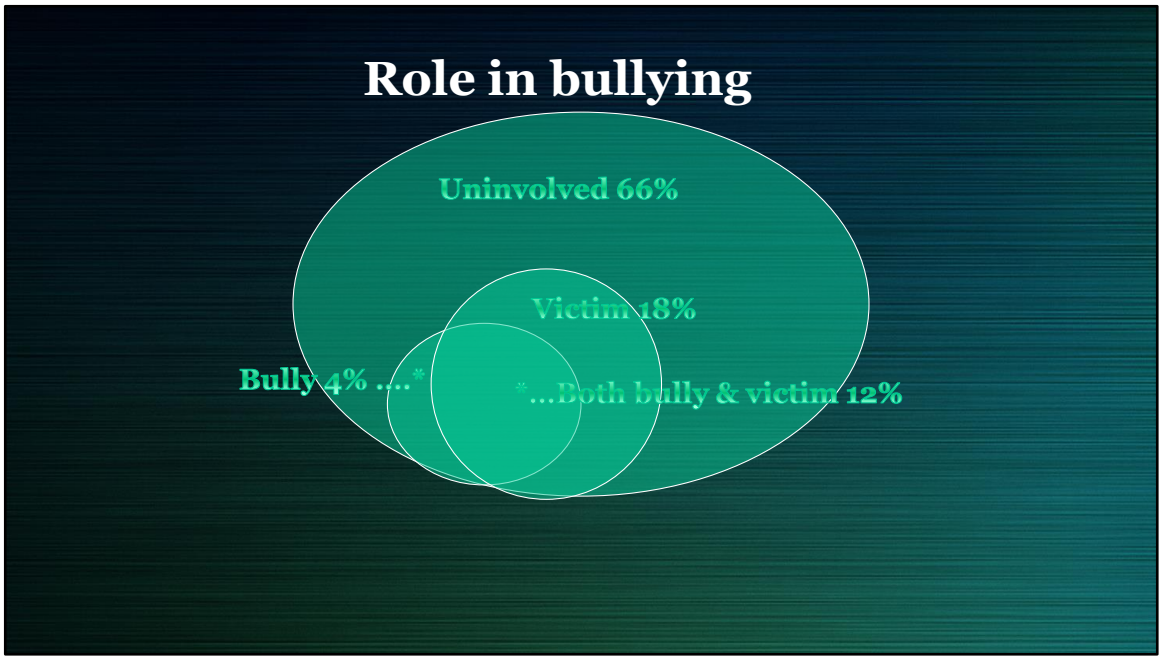
- Foetal Alcohol Spectrum Disorder
- Bullying
- Separation and loss / suicide / out-of-home care

Bullying may be one of the most harmful components associated with stigma. It is a toxic influence on mental health regardless of who is the victim. An excellent summary has been published by Essays, UK. (November 2013). Treatment Interventions for the Victim of Bullying Psychology Essay. [34]
An ANZ Journal of Psychiatry editorial in 2017 by Professor Jorm summed up papers by Scott et al., Ford et al., and Thomas et al., in that issue, by saying, "Bullying in schools is arguably the most important etiological factor for mental illness that could systematically targeted at population level. Taken together, these studies show that bullying is common in Australian adolescents and that it has a medium to large association with a range of mental health problems and suicide attempts."

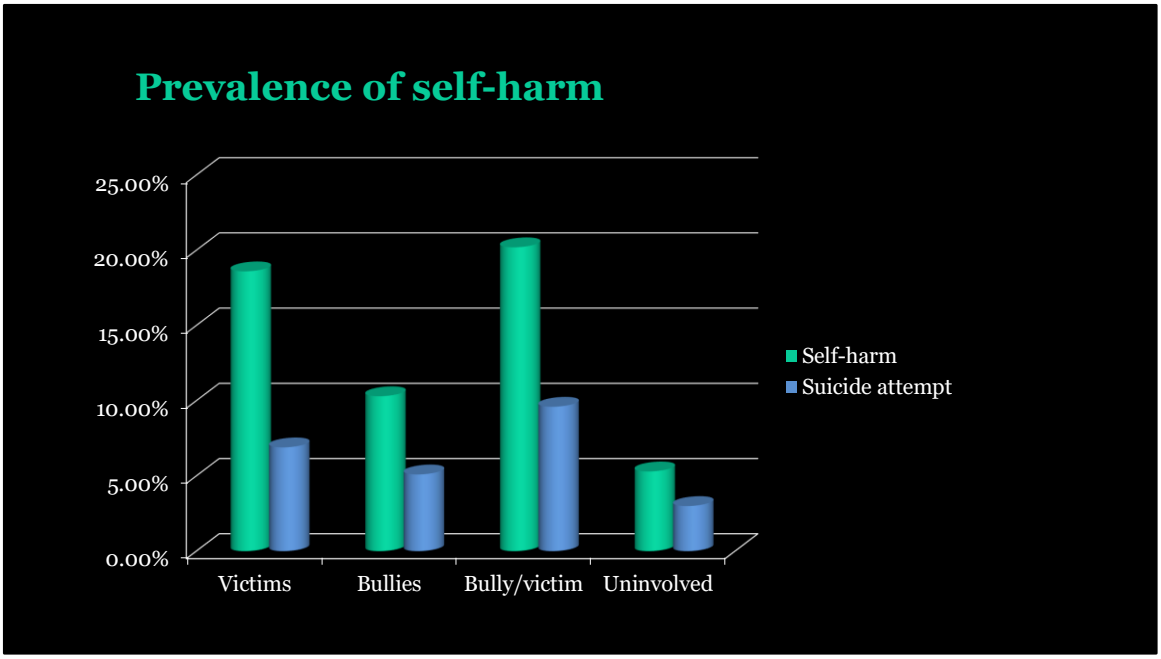


Ford's paper reported a nationally representative longitudinal study of Australian children in a cohort that began at kindergarten in 2004 and were aged 14-15 at this interview a decade later. One third had been bullied in the previous month, and one quarter experienced bullying frequently. This quarter revealed poor mental health, low self-regard, depression and anxiety, and violent behaviour.

The types of bullying were reported as physical, relational (such as exclusion from friendship groups and spreading rumours), and verbal abuse, including through social media. About half the bullying was verbal/relational and the other half was physical or a combination.



The simplistic view is that there are bullies and victims, and that the bullies should be punished for their misdeeds. The truth is much more complex. The roles reported in bullying are victim, bully, or both victim and bully. There are nearly as many bullies as victims, and in the bullying group there are twice as many who are victims as well as bullying. This group has the worst outcome. They are significantly disturbed, and simply punishing them will make this worse.



Adolescents involved in all bullying roles scored higher on the anxiety and depressive scales of the Strengths and Difficulties questionnaire than non-involved adolescents. Percentages for boys and girls are fairly similar. Victims scored poorly but those who are both victim and bully scored worst. This is in keeping with the concept that some acting-out bullying is an emotional response to being a victim. Nearly half this group have attempted suicide. Further punishment for their bullying is likely to worsen their emotional state. The rates of self-harm and suicide attempts are highly correlated with bullying. Furthermore, post-hoc analysis of the sample showed that those in the lowest income category were likely to report higher levels of suicidal behaviour. One can only agree with Professor Jorm that this is one of the important public health issues of our time.

Amelioration of toxic events

- Foetal Alcohol Spectrum Disorder
- Bullying
- Separation and loss / suicide / out-of-home care

The deleterious effects of separation and loss on children's development are nicely summed up by Susan Hols on the Prevention of Child Abuse Vermont website. [35] The essence is that the risk to mental health should be recognized and appropriate counselling provided. In Victoria the issue is addressed by the Australian Association for Loss and Grief. Local General Medical Practitioners and Community Health Centres should collaborate in the recognition and provision of appropriate counselling services.

The suicide of loved ones is a special case of separation and loss combining not only the grief of the loss but also the potential guilt relating to fantasies of failure to prevent the death and stigma relating to the mental disorder. It is even more critical that appropriate counselling services be provided in these cases.

The health care system has for many decades recognized the need to adapt services to minimise separation and loss. Children's hospitals no longer exclude parents from visiting on the misperception that it avoids distress, but on the contrary, will encourage parental access and support, including

rooming in for some cases. The early discharge from hospital and treatment in the home is not only cheaper but generally better for the child's progress.
The Child Protection system, on the other hand, has lagged badly behind in dealing with this issue. True, the old institutional congregate care model has shifted to a foster care model, based on it being more family-like. But it is not the child's own family and there is inevitable loss and grief with the disruption of parent-child attachments. When this is repeated through several cycles of failed re-unifications and further fostering in different families, permanent damage is done to the developing child's emotional state. The Cummins Report recognized this and made recommendations aimed at reducing the time taken before a child is in ongoing care in a family that provides healthy attachments and developmental nurturance. [36]
Recent amendments to the Children's, Youth and Families Act introduced mandatory time-limits on the duration of out-of-home care before a permanent placement decision is made. The authority of the Children's Court to determine what is in the best interests of the child has been severely curtailed. Whilst MHYFVic supports the concept of early decision-making about the long-term placement of children, the process is fundamentally flawed and needs further amendment.
Most children in out-of-home care are there not because it is the best option but because Child Protection Workers do not have the expertise to do a family functioning assessment and appropriate remediation. If they did have that expertise, most of the children could remain in their families without the need for out-of-home care, let alone permanent placement away from their families. The families incapable of ever meeting the developmental needs of their children would be identified much earlier than in the current trial and error method. It is unconscionable for children to be placed permanently away from their families without a thorough attempt to remediate family dysfunction. The current amendments are facilitating a whole new "stolen generation" and must be further amended to ensure adequate treatment.

What should we do?

- Universal welfare including income, housing, and employment
- Universal health care including mental health & selective programs
- Universal education including child care & selective programs
- Community hubs and social inclusion programs
- Remediation in Child Protection & Justice systems

In this era of high tech medical procedures, like heart transplantation, it is easy to forget that the reason we have the highest life expectancy in recorded history is because of fundamental public health measures. Clean water, safe sewerage, good food, immunisations, proper obstetric care, health and safety regulations, and proper child care and nursing the sick. High tech interventions are the icing on the cake.

By the same token, universal mental health measures are fundamental, before individual psychiatric interventions have their best chance of success. So, what are my key recommendations?

Universal Welfare system, including selective programs
Universal health care including selective programs
Universal education including child care and selective programs
Community hubs and social inclusion programs
Remediation in Child Protection and Justice systems

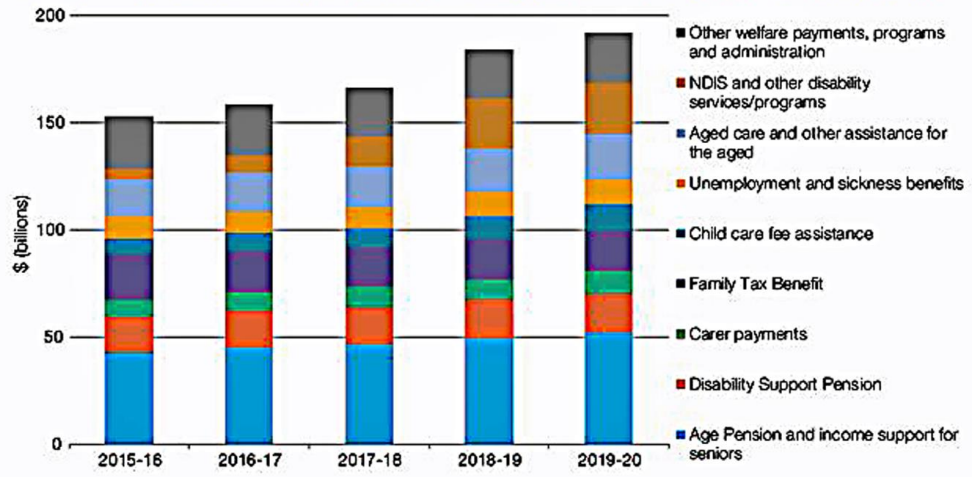
You may say that we already have these. Superficially that may be true, the systems fall far short of what they could be.

Universal Welfare System

- National Welfare Plan monitored by Aust Institute H&W
- Basic income
- Housing Support

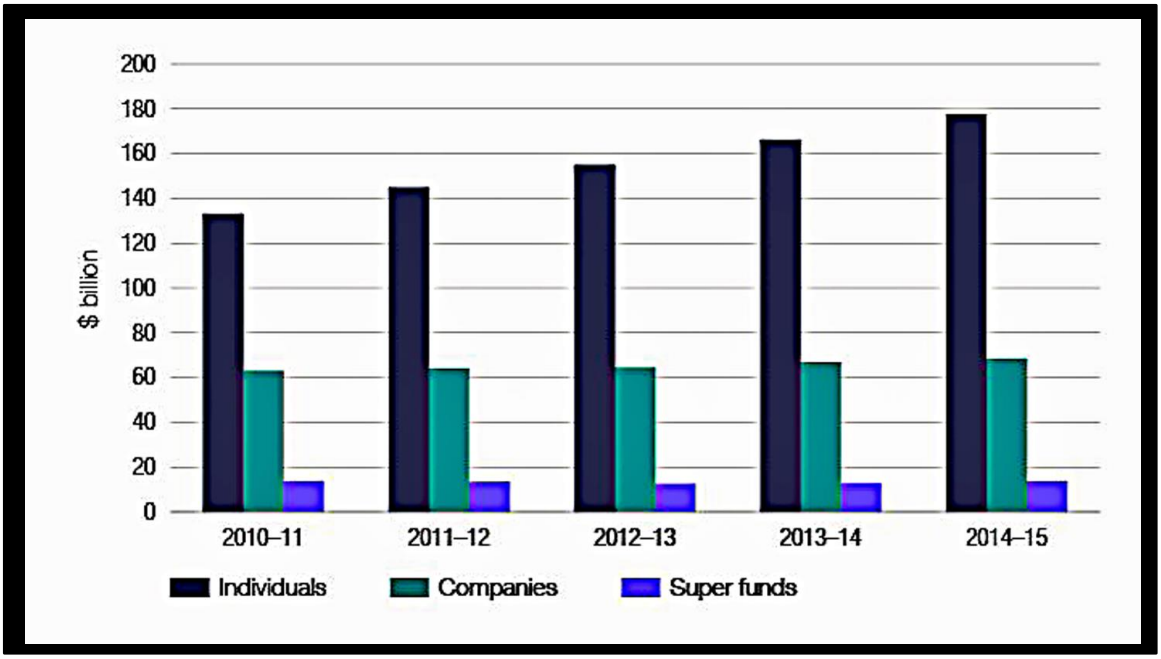
Universal Welfare system, including selective programs:
National Welfare Plan monitored by the Australian Institute of Health & Welfare, to set goals, monitor progress and make necessary adjustments.
Basic income provided to every person on a scale calculated annually by a process highlighted by the University of New South Wales report mentioned earlier. It needs to be to every person because the high-income taxpayers who will bear the burden must be given the same amount in order to dispel the myth that they are getting nothing for their contribution.
Housing support to ensure that the cost did not exceed one third of the basic income.
This would cost a lot. For a population of 23 million, of whom just over half are working aged adults, 7 million young people and nearly 4 million aged persons, I estimate that the annual cost for basic income would be around 400 billion dollars. The current expenditure on social security and welfare is about 200 billion dollars, constituting about 35% of Australian Government expenditure.

Figure 1: Estimated Australian Government expenses on social security and welfare



Source: Australian Government, *Budget strategy and outlook: budget paper no. 1: 2016–17*, pp. 5-25-5-29.

Although my proposal notionally doubles the cost of welfare, examination of the various components suggests that reduced costs of administration and removal of some revenue concessions might make this gap less confronting. Most of the current social security and welfare payments would be subsumed by the basic income payment. Some, such as aged care support and aged pensions, could be ameliorated by a compulsory National Superannuation Scheme. This major change in national income and expenditure would need to be accompanied by major taxation reform. The current Australian Government taxation income is illustrated in the following graph.



The current income tax receipts are in the vicinity of 260 billion dollars out of a total Government revenue of about 570 billion dollars. Assuming that the basic income level would be the tax-free threshold, any further income would be taxable. The injection of 400 billion dollars into household incomes would result in a very large increase in taxable incomes in the community. This would enable a significantly increased taxation revenue. This should be done by a levy on taxable income. The levy would have to be an annually calculated, realistic figure that would actually cover the cost of the disbursements.

This is not new money, but redistributed money. It transiently arrests the trend of the rich getting richer and the poor getting poorer, by levelling out the gradient so that poor do not get poorer. It would not stop the rich getting richer, but would slow it down. A levy would ensure that it was a progressive tax. It would also largely remove it from the political sphere because collectively you pay for what you get, and you get what you pay for, and it is not the politicians' choice.

There is no free lunch. It has to be paid for. However, it will be worth it. Last

week's United Nations World Happiness Report 2018 showed Finland to be the No.1 country in the world, followed by Norway, Denmark, Iceland, Switzerland, Netherlands, Canada, New Zealand and Sweden. 156 countries were ranked on six variables – income, life expectancy, freedom, social support, trust and generosity. Australia came in tenth. These leading Nordic countries are characterised by lower wealth inequality, high taxes, good access to health care, long life expectancy, low corruption, and support for those who need help from their communities. [37]

The hurdles are the political will to do it, and the argument that a basic income would remove the incentive to work.

The political will to do it is similar to the political will to have a universal health insurance. The American attitude of "every man for himself" precludes a universal health insurance scheme in that country, but the Australian experience shows that the overwhelming majority think it is a good thing. I predict that the same will apply to welfare. Once we have a system, we wouldn't want to be be without it.

The fear that it would remove the incentive to work is not in keeping with the evidence that most people see employment as part of their identity and wellbeing. The ones who don't seek employment are those who have given up hope. The way this system is administered could emphasise the mutual obligation between the individual and society for give as well as take.

For those who are not otherwise occupied by child or disability caring duties, employment for at least 15 hours per week could guaranteed by Local Government programs in return for the income support. Employment for additional hours would be paid at the industrial award rates. Employment by commercial employers of more than 30 hours per week could be subsidised by a reduction in payment equal to the basic income.

Universal Health System

- Area Health Board
- Illness system – Emergency, Inpatient, Outpatient
- General Practice – acute & chronic disorders + health plans
- Community Health Centres – allied health services + counselling
  - + University Department General Practice
  - + Community Mental Health – Adult, Headspace, Kid's Life Centres
  - + Safe Injecting service
  - + Substance Abuse programs

Australia has one of the best health insurance schemes in the world. However, it is heavily oriented towards hospitals, doctors and procedures, and might better be called an "Illness system" than a "Health system". The Illness system revolves around relatively autonomous hospitals with their Emergency Departments, Outpatient Clinics, Inpatient Wards, and cluster of affiliated specialists fed by a network of local general medical practices.
Separately, there is a network of Community Health Centres that provide a range of counselling and allied health services that have rather limited connection with the Illness system or with General Practitioners. The General Practitioners have the major role in monitoring individual health issues such as obesity, diabetes, hypertension, exercise, musculoskeletal problems, smoking, alcohol and substance abuse problems, together with many of the anxiety and depressive disorders and family relationship problems that emerge in the population.
The Illness system and the Health system need to be much better integrated. I believe this could be achieved by Area Health Boards with oversight

responsibility for all of the facilities in the designated area. Each area should have a University-affiliated, super-specialty teaching hospital together with a network of secondary public and private providing general medical and surgical services, plus a network of Community Health Centres decentralised throughout the region. Community Health Centres should house General Practice Clinics as well as allied health practitioner services, and would host the outpatient clinics of the hospitals network.

The hospitals and Community Health Centres would collaborate with each other not only in the provision of allied health and outpatient services but, most importantly, with the General Medical Practitioners of the area. University Departments of General Practice would use the Community Health Centres as locations for supervised training of post-graduate Registrars in General Practice. GPs of the area would have affiliation with hospitals and Community Health Centres, including the option of paid sessional practice. This would enable access for their patients to the allied health and counselling services of the Community Health Centres.

Every patient, whether inpatient, outpatient or GP service, should have their own GP automatically involved in their care. Every patient should have a Health Maintenance Plan devised in collaboration with their GP.

A crucial element of this network would be the incorporation of Community Mental Health Services within the Community Health Centres. This would enable treatment and follow-up of major mental illnesses in parallel with treatment of more common psychiatric disorders that do not generally reach the threshold of enrolment for public specialist mental health services. Consultancy by mental health professionals would be available to generalist staff of the Community Health Centres, and the intake interviews for specialist treatment could be undertaken at the Community Health Centre. Cases deemed not sufficiently severe as to warrant specialist mental health services would be treated by Community Health Centre staff.

Multiple waiting areas could be provided for child/family clients and general adult or special patients such as Safe Injecting Room clientele so that different needs could be catered for.

An important opportunity would be available for every Community Health Centre to have the capacity for safe injection and monitoring of addictive drugs. This would make such services more widely and locally available, more likely to be safely used, and less concentrated on stigmatised sites. If people are foolish enough to take opiates, cocaine, amphetamines and other mind-altering drugs, that is their choice and they should not be unnecessarily criminalised for their foolishness, except insofar as it causes harm to other people.

An even more challenging possibility is the controlled supply of illicit substances to registered users. The reality is that if substances are not available

legally they will be obtained illegally by unsafe criminal methods. Controlled supply at less than street prices would significantly undermine the illegal dealers. Penalties would apply to unregistered users and all levels of illegal dealing. The proceeds of sales would be used to fund treatment programs available through the Community Health Centre. The supply of these undesirable substances would be accompanied by packaging and information highlighting the risks to health and wellbeing, and recommending cessation. If the remarkable change in community attitudes and frequency of smoking could be replicated for illicit drug use, this would be a huge improvement in community mental health. This is not about condoning drug use, any more than we condone tobacco use, but is about engaging the public in changing attitudes towards chemical mind-altering. Can life be more rewarding without having to use a substance?

Universal Education System

- Free, secular, compulsory primary and secondary schools
- Kindergartens
- Child Care Centres
- Specialist programs eg Learning Difficulties, Bullying

Universal free, compulsory, secular education was introduced in all Australian States from the early 1870s for children from six to thirteen years of age. Enrolment was later extended upwards on a voluntary basis to Year Twelve Matriculation, and downwards to a Preparatory year for five-year-olds. Kindergartens for four-year-olds were introduced initially in the early twentieth century as a philanthropic exercise through the Free Kindergarten Union. This was endorsed by the Federal Government Health Department in 1939 by the funding of Lady Gowrie Centres in each Capital City as model child development initiatives. The State governments have gradually improved the availability of kindergarten services as the evidence for the importance of quality pre-school education has become overwhelming.
Recent discussion about child care has focused on its importance in enabling women to return to the workforce, and the problem of affordability. The growing evidence about the crucial importance of pre-school child development has been largely obscured. The availability of affordable, high quality child care is essential for overcoming the generational transmission of

social disadvantage.
The time is now right for child care and kindergarten services to be available in every State primary school as part of the universal education system. Privately run child care centres can co-exist with government centres in the same way that private schools co-exist.
Schools have a central role in the character development of children in their care, second only to the family. Whole of school approaches are desirable for promoting mutual respect, tolerance and reciprocity. General support can be obtained through the 'Mind Matters' programs. Specific assistance is also required through programs for learning difficulties and to deal with bullying.

Community Hubs & Social Inclusion Programs

- Municipal Supports – home care, play groups, social work
- Social cohesion programs
- Legal, financial, parenting
- Agency consultants

Local Government programs have considerable potential for promoting collaboration between diverse government and non-government agencies. By providing community hubs of the kind mentioned earlier in this Oration, where Municipal support services are co-located with consultants from other service providing agencies, much of the confusion and difficulty in problem-solving can be avoided. Financial and legal advice can co-exist with various social cohesion activities such as children's' play groups, parenting programs and the like. Ideally, such hubs would be close to Community Health Centres where the more specialised treatment programs would be provided. Similarly, Municipal swimming pools and local gymnasiums should be included in the network of facilities used by allied health professionals for the treatment of their patients of the Community Health Centres.
Traditional Departmental management and budgetary systems work against outreach and cross-agency program resourcing but 'Whole of Government' policy could require certain proportions of Departmental budgets to be spent collaboratively with other agencies for provision of such shared services. This

would then ensure acknowledgment in Key Performance Indicators.

Criminal Justice Programs

- Streaming of offenders
- Employment training, psychotherapy and rehabilitation

Columnist, John Silvester, wrote an article in 'The Age" describing changes to the criminal justice system in Texas. He said criminals were in three streams. One was of first offenders who could learn from their mistake and would be unlikely to offend again. They required minimal special attention. Another group was of hardened criminals who would continue to offend, regardless of consequences, and who required high security incarceration. The third group was of offenders who might go either way. This group required intensive training for useful employment and treatment for substance abuse and relationship or other mental health issues they may have. By doing this, the rate of recidivism was greatly reduced and the savings to the community through reduced crime and reduced need for prisons greatly outweighed the cost of the treatment. This is what we should be doing for our prisoners, especially the young who potentially have many productive years ahead of them.

Child Protection System

- Child & Family assessment + Protection assessment
- Expectation of remediation rather than removal
- Permanent out-placement only if not remediable
- Children's Court must remain the final arbiter

Similarly, we need fundamental changes to our child protection system. The current system assesses risk of harm and removes children at risk into substitute care without assessing the dynamics of the family and providing remedial intervention. Removal of children largely negates the opportunity for therapeutic change, and itself inflicts significant harm. Recent legislative amendments will make that harm permanent, even when there has been no attempt at remediation. This is unconscionable.

Instead of a preoccupation with removing maltreated children to substitute care we should have a system of remedial intervention to improve family functioning whereby most children remain within their kin. This requires Child Protection Workers to have mental health assessment and treatment capabilities, concurrently with their risk assessment capabilities. Permanent out-placement would only occur if the family dysfunction is not remediable. Conclusions about potential for remediation will be reached much more quickly than with the present trial and error method of referral out to other agencies.

The training systems are already available and the long-term savings will far outweigh the costs. Research into functional outcomes of such an approach would be relatively easy to do.

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Although this Oration has canvassed a large number of potential changes, many of them could be undertaken incrementally within existing resources. A few would require larger-scale policy and legislative changes. My vision for what should happen is offered, for what it is worth, in the hope that lobbyists will find it useful. With luck, my grandchildren will grow up in a better world.