THE CONTRIBUTION OF RESEARCH TO IMPROVEMENT IN HEALTH AND WELLBEING OF CHILDREN

Dr Victor Nossar
Director of Community Paediatrics,
South Western Sydney Area Health Service

Without good research into the health and development of children, our capacity to deliver services that achieve the best possible outcomes for all children would be severely compromised.

That said, the nature of the contribution that research (and researchers) can make to achieving improved child outcomes needs to be analysed more carefully.

It is worth recalling that famous physicist, Richard Feynman, who said that science was just like sex, there may be a practical outcome but that's not why we do it!

In a similar vein, it is clear that in Australia most research (and most research funding) connected with children's health, development or wellbeing is concentrated onto the basic sciences and clinical interventions, with a little on epidemiological descriptions. Remarkably little research seeks to establish the most effective interventions capable of improving the overall health and wellbeing of Australia's children.

If the presumption is that it is a lack of sufficient information or evidence, which prevents the attainment of improved health outcomes, how valid is this?

For more than a decade, the health goals and targets for Australian children and young people have defined the principal causes of mortality and morbidity of children. Countless academic papers define factors associated with (and sometimes even the causes of) many of these major child health issues. Overwhelming evidence continues to point to a powerful association between the socioeconomic standing of a family and the health of their children, as well as the likelihood of benefit from most common interventions. There is even some evidence indicating the efficacy of a few interventions, including those less likely to work, as well as those likely to make health inequalities worse.

Yet even in the face of this body of knowledge, there persists the belief that improved child health outcomes in Australia are somehow dependent on yet more information (and even more research.)

While not discounting that more research will help us understand children's health and developmental problems (and perhaps even the solutions to these problems) even better than we currently do, there is no escaping the fact that the critical issue has become the application of what is already known.

Most clinicians (and clinical researchers) working with health and development of children in Australia understand many of the rare and uncommon problems and diseases that can confront children. Many fewer, however, are aware of the health goals and targets for Australian children, of the central role of the social and economic contexts, or of the interventions able to improve children's outcomes at the population level. Indeed, over the last ten years, some prominent journals have felt compelled to advise authors that they will no longer publish simply descriptive articles about well known child health issues (unless compelling reasons to do so are presented), requesting that researchers instead focus on evaluations of the efficacy (or otherwise) of interventions for common child health problems.

It needs to be acknowledged that:

- many people still believe that improving child health outcomes depends on more research (in spite of the existing evidence to the contrary);
- many research dollars in Australia for child health (and many researchers) continue to focus on health issues other than those which are the principal determinants of morbidity and mortality of children in Australia;
- the principal foci of research into the health and development of children are still better treatments for affected individuals, basic science or more epidemiological descriptions; and
- comparatively little money (and research effort) is expended on trialing (and evaluating the efficacy of) population-level interventions.

Most children's health and development research springs from clinical contexts, and so aims to find better treatments for children's problems and better ways to improve their quality of care. It would seem that the underlying assumption has been that if we effectively respond to an individual child's problem, and then apply that intervention to all children who have that problem, we will have improved population-level child health and development. Very little evidence indicates that such strategies can improve the health and wellbeing of children at the population-level. Indeed, there is much more evidence that such approaches, even when effective with individuals, may exacerbate existing health inequities.

It is becoming clear that strategies which are capable of improving the health and developmental outcomes of individuals (with their focus on treatments and quality of care) are very different from strategies which improve the health and developmental outcomes of whole populations (with their focus on policies, social contexts and programs). This dilemma has been explored by a range of authors, with the realisation that research "inappropriately focussing on individual level determinants of health while ignoring more important macrolevel determinants, is tantamount to obtaining the right answer to the wrong question." (Smith, Ebrahim & Frankel, BMJ 2001; Schwartz & Carpenter, Am J Public Health 1999.)

In this context, it must be remembered how few child health & development clinicians (and, indeed, how few child health and development researchers) have any significant experience or expertise in developing, managing or evaluating population-level child health or development programs, (particularly programs with a focus on improving population-level outcomes in child health and development).

In spite of these, often unrecognised, limitations governments, policymakers and funding authorities continue to seek out these senior researchers in child health and development (or

senior clinicians working with child health and development) to advise about (and sometimes to direct programs responding to) population-level problems and issues that affect the health and wellbeing of children.

A few examples will illustrate these points a little more clearly.

Whooping cough is a devastating childhood infection, which in the past has caused the deaths of many infants and permanent lung damage to many more. The widespread use of a vaccine against pertussis has meant that this serious childhood illness can be very effectively controlled. Unfortunately because the organism causing whooping cough is so infectious, very high rates of coverage by the vaccine are required before epidemics cease to occur. Consequently, countries such as UK, which have maintained high coverage rates over more than a decade, have seen very few epidemics of whooping cough. In Australia epidemics of whooping cough continue to erupt and the immunisation systems struggle to get vaccine coverage rates for children above 90%. If it is recognised that the principal researchers addressing immunisation in Australia are either immunologists or clinical paediatricians, then it can be better understood why the bulk of research dealing with immunisation focuses on vaccines, on the use of antibiotic prophylaxis to protect individuals and on more descriptive epidemiological studies. Comparatively little research in Australia has focussed on determining the most effective policies and programs to achieve and maintain the highest possible vaccine coverage rates.

For many years sudden infant death syndrome (SIDS) has been the principal cause of infant death in the postneonatal period in developed countries. Most research around SIDS (until very recently) has focussed on factors in the children who die eg. genetic risk factors, cardiac risk factors, biochemical markers etc., with comparably less research effort on the influence of broader social correlates. It should not be too surprising then that when relatively simple behavioural interventions were identified, which subsequently were shown to significantly reduce the risk of SIDS, their uptake met some opposition from clinical establishments. Interestingly a number of studies now indicate that these behavioural modifications, which need to be parent initiated, have spread widely across our community, but because of differential uptakes have produced the least benefit for children with the highest levels of risk, in the most disadvantaged families.

Obesity in children is becoming a major concern for most developed communities because of the rapid rise of its incidence, because of its association with earlier presentation of “adult” diseases eg diabetes mellitus type II and because of its correlation with greater risk of adverse health in adulthood. The vast bulk of published research on obesity in childhood has focussed on genetic factors, on endocrinological factors and on treatment strategies for affected children. Despite the lack of evidence of efficacy of these approaches (in terms of reducing the prevalence of childhood obesity), in spite of the evidence for the significance of macrolevel determinants (e.g., in activity, television viewing, advertising to children and eating patterns) and in spite of the emerging evidence of efficacy for broader policy initiatives and population-level initiatives, there remains a fascination with the individual-level focus on obese children.

Recently a committee of the NSW Parliament began an inquiry into learning disability in children. While much attention has recently been focussed on issues connected with the diagnosis and treatment of specific causes of learning disability (such as ADHD), the fact that

the greatest cause of preventable learning disability in Australian children is once again poverty and socioeconomic disadvantage seems to have been overlooked.

Similar failures to improve population-level child health outcomes, while maintaining a research focus on individual-level determinants, can be seen in our current approaches to child protection, to child injury prevention (though this has been improving somewhat) and to Aboriginal infant mortality.

Given these considerations, we need to ask what steps can be taken to maximise the contribution of research into children's health and developmental to improving the health and wellbeing of all children, without the adverse consequences outlined. It is important to continue to acknowledge that good research into child health and developmental provides the basic building blocks for the improvement of health and wellbeing of children. Without good information, good evidence and good evaluations, little advancement towards this essential goal can be achieved. However, it is equally important to recognise that this information and this evidence remain simply "building blocks" until they are incorporated into effective child health policies and programs. Like brickmakers who produce the essential "building blocks" for building a house, researchers need the evidence they have gathered to be used appropriately, to achieve the outcomes everyone seeks. Few of us would hand over the construction of their "dream home"to a brickmaker. In the same way, governments and funding authorities need to seek out more skilled and experienced population-level child health specialists for policy development and macrolevel program design , if they wish to see more significant progress towards desired child health and development outcomes. Just as we would expect architects to draw on the most appropriate craftsmen and builders, these population child health specialists would be the ones to draw on the best possible evidence and information that researchers can provide.

Thus good research is **an essential prerequisite** of achieving improvements in the health and wellbeing of children, but **of itself is insufficient**. To get the greatest possible benefit from the knowledge gained, it must be utilised effectively with clear focus on improving the health and wellbeing of all children in our community.

QUESTION SESSION

Ms CALVERT: We now have in our program an opportunity to address questions to all three of our speakers today. I might ask David, Victor and Sven to come down. Who would like to ask the first question or are you all questioned out, which we would be happy to accept?

QUESTION: *When I look at all the committees that people form, health, housing, education, crime prevention and those sorts of things, to me there is always this big gap in the first five years of who represents the people who provide care and education—not health intervention—for young children in the first five years which I would see as critical. I feel that service providers who actually care for children and develop strong relationships with families and probably would be the prime people who could work with families in changing behaviour are the people who are probably the least consulted perhaps because there is not one body that represents them. Early childhood educators have known for ever but now brain research is backing us up, I guess. So all these people get together but, to me, there is a gap in those first five years in the consultation process.*

Ms CALVERT: Do you want to comment?

Professor FERGUSSON: Yes. Interestingly, in New Zealand in the Early Start program the first time anyone ever recognised this, the Minister then actually drew his funding from health, education and social welfare, so actually all the funding for the Early Start program comes from three departments and their votes with three lots of stakeholders.

QUESTION: *But social welfare is still dealing with people who are dealing with individual families. The Department of Education is dealing with the education of children. The people provide services for children rather than families. That is what I am saying. There is still that big gap of service providers who actually work directly with children.*

Ms CALVERT: In New South Wales under the Families First Statewide Advisory Committee we were slow but we have now rectified it. June Wangman is on the statewide advisory committee, so we have at a statewide level child-care services as such represented. I do not know how far that has gone down to the regional group and whether the child-care services have formal representation on the regional group. You might want to talk about it.

Dr NOSSAR: It has varied according to who is active in the area. We have tried to have a lot of NGO groups involved.

QUESTION: *Well, I actually was involved initially in Families First, and I did bring it up as an issue, but, really, it was too hard. No-one quite knew how to do it, and yet I knew that there were people out there working with 70 families a week with very good relationships and seeing the children all the time, but they were not really part of the consultative process.*

Ms CALVERT: I think the other way with June being on the statewide committee is one way to go, but I also think that June has been able to use the learning from this and, in a sense,

feed it back into the child-care area. I am hopeful that over time there will be much closer co-operation. I do think some areas have got it more than others.

QUESTION: *It is probably because it is a fragmented role area, not one governing body like the Department of Education or the Department of Health.*

Ms CALVERT: Yes, tell me about it. The other thing that I think leads to the fragmentation in child-care services is that it also has the Commonwealth involved, so there are not only issues between departments but there are issues vertically as well between the Commonwealth Government and State governments, and I guess they are some of the interagency challenges that affect all four of us in this area, and probably everybody in this room has experienced trying to get something up on a population basis, so there are those tensions as well.

Professor FERGUSSON: Those sorts of tensions were actually the reason that Early Start started independently of government and local agencies and drew people together and drew itself up as an independent organisation which was fully aware that if they were to get mixed up with government departments and everything else there would be a huge superstructure and also a stakeholder and all that, so we are actually a provider organisation. I think there are difficulties with that model in the longer term. Somehow, this private organisation is going to have to be given back to someone at some level, but certainly for the pilot or for running things or setting up things you are much quicker on your feet if you only have a board of four or five people. You can make your decisions and, providing you get the money in the door with few strings attached—not no strings attached—you can do quite well.

Ms CALVERT: I will take you up on that. I think that is probably true when you are looking at programs and an individual program or one service. I do not think you can avoid government when you are looking at trying to change the system that sits around every child in New South Wales. You have to work with government. If you look at where the current investment is, overwhelmingly there is far more money in the existing system than we will ever get through additional funding, and even though Families First is something like $54 million over four years—it is not an insubstantial amount—compared to what is already in the system, it is not very much. So if you really want to change the system and have an effect on population outcomes, you have to deal with what is already there, and that means you have to deal with government. So we have to learn how to do it.

Dr NOSSAR: I caution against the belief that there are no advocates. That is the sole agenda of Families First.

QUESTION: *Not no advocates. For under-fives there certainly are advocates, but I think they come from the one-to-one clinical background that you were talking about rather than the service providers who work with large groups of children.*

Dr NOSSAR: I venture to say it is the other way round. Our biggest problem is the people who want to push individual clinical issues rather than population issues. It is a much bigger concern for us. It is people who have their particular centre or clinical issue that they want either funded or addressed. It is a much bigger concern in the bids than what are the population outcomes.

QUESTION: *Do you involve children and young adolescents in your projects but not as part of your research?*

Professor SILBURN: You mean—

QUESTION: *Sitting there and contributing, analysing, being part of the outcomes rather than your research groups that are there and you use for the substance of your data but sitting around discussing—*

Professor SILBURN: As active participants in the whole process?

QUESTION: *Yes.*

Professor SILBURN: I could answer that very briefly on two projects. The first one is the triple P project, which was an effectiveness study. We knew the program worked but what we needed to know was would it work with a high risk population. The research question was, could you actually get the most needy people into the program and to find out what would make them take up the program. The answer is simple. Child care is critical to the program being available. If you cannot provide the program with the child care you may as well pack up and go home. That is one example. The other example would be in the Aboriginal child health survey where Aboriginal people have said "These are the important issues for us." That means about 20 community consultations around the State saying what is helping you as a community in bringing up kids and what are the big problems for you in bringing up your kids, what do you see as the most important questions, rather than assuming that we know.

Professor FERGUSSON: We hear a lot about the participation of young people in research. A colleague and I have been working on youth suicide and there has been a lot of pressure on researchers to include young people as advisers on the etiology and causation. We did a project to see exactly what young people did know about youth suicides. It is a presumption of, because you are one you have expertise. We took a group of people who should have been well-educated, university students, and asked them what they knew about suicides. It turns out that the perceptions of young people about youth suicide are extremely distorted because they get their information about youth suicide from exactly the same place as many of us do, from the newspapers.

So they overestimate the prevalence of youth suicide by about tenfold. They did not know the risk factors. They knew nothing about it. There is a very good reason for this. Very few of them had ever been involved in this event. They were as much participants in the area of youth suicide as you and I or anyone else. So, if you are to involve young people in these things, you are going to have to involve the right kind of people who have the experience and they are going to be the most difficult to engage of young people.

I recall being on the Medical Research Council assessing someone who wanted to understand youth violence by doing a focus group. There were going to be about 40 people doing it. The focus groups of these young people were going to tell why people oung people they are and how are you going to bring them into your project and what kind of information you want to get. Just getting someone because they are under the age of 20 to say vague and general things

about youth wellbeing I do not think is helpful. I have seen it done far too often and I think it is a form of tokenism.

QUESTION: *I was just listening to the radio with Moira Green and what she has done in London involving them. It is difficult.*

Ms CALVERT: It is difficult involving adults also at times. We make the effort with adults so we will make the effort with kids.

QUESTION: *I want to comment on targeted programs versus university programs. One is more preventive and the other more therapeutic. Do they go hand in hand or how do you see that?*

Dr NOSSAR: In Families First we have both. There are four components in Families First, and there is a whole range. The first two are really population programs focusing on community-wide approaches. The third element is looking at families that have specific problems. It is much more targeted, and we try to provide a much more therapeutic environment. The fourth component is actually community interventions, which are targeted to children in need.

Professor SILBURN: I think there are, again, huge advantages to target a community and then make it universally available in that community. I would completely agree with what you said about going to target communities and waiting for the bulk to match up.

Professor FERGUSSON: I am not sure I agree with that. There was an unfortunate experiment conducted in New Zealand called Parents as First Teachers, which used exactly that form of targeting. It targeted communities rather than individuals, and actually it ended up having predominantly an uptake of the affluent and well educated. There is no such thing as disadvantaged communities. There are communities with higher or lower proportions. The targeting was very ineffective. I have never seen a randomised trial produce means as flat as those in the evaluation of parents as first teachers. The control group was exactly the same. I think there is a lesson there, and I think it is a vast one.

If you want to deal with cardiac disease services you would not say that you need a cardiac ward or an advertising campaign about smoking; you would say you need both, that you need to decide when those investments are appropriate. I think for the kinds of families I am talking about that we have in Early Start that we are at an individual level, a therapeutic level, trying to change life directions, but no-one would propose that we should abolish all pre-school education, which is universal, so I think there are components that should be targeted at different levels for different purposes. The critical thing in the end of all of this is not the rhetoric about targeted or not targeted but what works and what does not, and why we have these debates is that we have a lot of theories, we have got a lot of ideas and very few good evaluations.

There is what I will describe as the law of inverse knowledge. The law of inverse knowledge says this: the less you know about a topic the more you can be dogmatic about it. If you want to see the ultimate topic where people get dogmatic, it is the origin of the universe. We do not know which is the best balance. What all this dialogue is about everywhere is finding that mix and moving ahead, and I think ultimately we will do that. One of the things that really gives

me a lot of heart is the history of what happened with cardiac disease from the 1960s. Cardiac disease has been tracking down steadily since the 1960s within populations. No-one knows why this is so, but there was a massive input of information about diet, weight, smoking. All of the randomised trials have actually failed to show any benefit of any of these interventions, but somehow historically the accumulation of knowledge we have had has actually shifted the population. One can argue in the area of social wellbeing that these things are happening and there will be secular trends and changes. All of our data are really trying to find the more or less right recipe. I do not think there is a right one, but there is a more or less right recipe of population level services, welfare services, benefits, individual level therapists.

Dr NOSSAR: The best buy changes from week to week amongst the mothers as the economy changes.

Professor FERGUSSON: As your knowledge state changes.

QUESTION: *There has been an indication today to involve politicians in programming, and I just wondered if you had any clues or any advice about how to do that very effectively both at a local level and at a global State level.*

Ms CALVERT: I can answer, but I am actually mediating the discussion.

Professor FERGUSSON: The New Zealand experience, and we certainly have a lot of success with this, is that you need to find a good person. In this case it was a good guy.

QUESTION: *A mentor?*

Professor FERGUSSON: Yes. You need to get a politician who has the sense to listen to you and is prepared to spend the time and to get them on side. A lot of politicians I do not think have those abilities, so you need to find the odd one or two exceptional individuals who really want to make a difference. There are people, I get the impression, and really I may be doing them a disservice, who really want to maintain their job, and there are those who have really got there because they want to make a difference. If you can find one of those and convince them and sell them the product, you are half-way there. The risk, of course, is that you lose them at the next election. That is what happened to us. We are now without a benefactor. I am in the market to search for a political benefactor.

Dr NOSSAR: I think you also need to focus your message on what politicians are interested in. I never cease to be amazed by health professionals who know what the issue is and are miffed because no-one is listening to them. I think there is a message in that, that perhaps they are on the wrong track, or certainly not a track that the public is going to buy.

Professor SILBURN: One of the things that the people who were most interested in research that we had was the Department of Treasury because it demonstrated what the costs to the community were. If the current trends continue, what we are looking at is incredible costs to the community down the track. People in Treasury are not unused to thinking in terms of 20-year forecasts. The way our Government started looking at this was that what we are looking at here is an investment, not an expenditure. Just as the northwest shelf project is the largest resource project Australia has ever had, it has taken 25 years before it has produced profits and now it is a huge earner for the country. We need the same kind of vision that can

go well beyond the span of government to say for the state of the good of the nation we need to make these economic forecasts and invest a fraction of the money that they spend monitoring progress as they do monitoring the economy.

Ms CALVERT: In my view politicians are extremely interested in children and they are interested in children because they are generally elected by the community and there is a lot of interest in the community about the wellbeing of children. I think the community does have a capacity to have a long-term view. I think there are a number of ways in which we have successfully interested politicians. I do not think it is a mistake that in

New South Wales we are having a seminar like this in Parliament House jointly hosted by the Commission for Children and Young People and 11 politician members of the Joint Parliamentary Committee on Children and Young People. That is a fantastic opportunity for getting your message across to Parliament and to parliamentarians about children. I think really it is up to us to try to find the language and the ways of explaining or putting our case forward to politicians that will give us the results that we want.

Dr NOSSAR: You have to be prepared for hard questions. It is quite fair for them to ask questions such as what is the probability that your program will work, firstly, and the probability that in five year's time you will not come along and ask for 50 times more therapists, because if that is the case, who is going to pay the additional taxes. I think they are legitimate questions.

Professor FERGUSSON: I went to a meeting at the New Zealand Parliament very much like this following the introduction of the Labor Government. The Labor Government came to office very much on a Maori vote. What that meeting on children showed me was the way in which the political agenda can colour the debate. We spent two days in a room like this and no-one talked about children. Everyone talked about ethnic differences the whole day long. There was not a discussion about children. It is quite remarkable to come here and very refreshing to hear a dialogue in which the whole day has not been dominated by one theme. I am not here to negate any issue about ethnic differences, but it is only one aspect of a much more complex problem. Certainly in the New Zealand context when the Parliament called together a group of experts, we ended up talking the whole day only about ethnic differences. That does show that the agendas of the Government will colour these things if those agendas become strong needs for the Government to actually survive.

QUESTION: *I am involved in the beginning stages of a committee to set up a Good Beginnings program in our local area. Given some of the things that both David and Victor have said about the merits of doing it on a population level and putting a lot of money into this, two areas concern me. One is the use of untrained volunteers to do the home visiting and the other one is not targeting the most at risk families in that area. I was wondering if you could comment on the merits of setting up something like that?*

Professor FERGUSSON: Certainly we have used as part of our program untrained volunteers and we have not been happy with them. There are issues of boundaries and all sorts of problems. I would suggest if you are starting out, to start with professionally trained workers who have boundaries. You may wish as you move on to add in your volunteers, but I think I would start with someone with tertiary level education in child development. Not only that, people with street experience also. Those people do exist. The targeting? I think it is

really a matter of deciding who you want to provide the service to and working out the sort of windows of opportunity of obtaining those people. What I would suggest you avoid doing is using a referral system where people just get referred to you, because those systems can become extremely biased so you get only a certain kind of client and others are excluded. You do want to try to get a sample right across your population and say, "Our clients are all those who . . . " You should have some mechanism for enlisting all of those people. If you just get people referred, you will get a very uneven treatment.

Dr NOSSAR: The comment I would make would be that if you are setting up something in New South Wales, odds on you would have a Families First program about to be set up in the area or in the area around you.

QUESTION: *Not in the lower North Shore area.*

Dr NOSSAR: You will.

QUESTION: *If the money holds up.*

Dr NOSSAR: In a sense, I would be trying to form a coalition because you know the sea is going to change around you in terms of the interest of other departments, so I would try to enrol their interest sooner rather than later. It may be that you may act as a nidus for some thinking around that in your area because most area health services I know in the State are interested in this kind of program development anyway. The other thing that you need to do on this issue of targeting what I want to talk a bit about firstly—the volunteers. We actually did run a case control group in Campbelltown. We were surprised that we could recruit people; second, that they stayed; third, that they actually made a difference on our microstudy. We had such a small group that it was not worth publishing, but it was the same sort of thing that David Olds was doing. We saw changes out there in the families who suddenly appeared who were prepared to attend clinics or get their kids immunised, so we felt much more confident in having a go at trying to provide a spectrum of volunteers, but supervised, monitored, trained, debriefed, all that.

QUESTION: *But they had training, didn't they?*

Dr NOSSAR: Yes, it was supervised. They had debriefing. They had in-services, all that.

Professor FERGUSSON: We found that when we did that we did have to increase our supervisory load quite a bit. You probably have to double the amount of time you spend. So although you are getting some advantages, you do actually pay for the supervisory role.

QUESTION: *The issue of agendas brings me to something that has not actually been part of what has been talked about today but was alluded to before, which was the brain research and the way in which there has been a passage of the brain research through a number of different sectors of the society. That it is being picked up by politicians and picked up by government as something that we need to respond to instead of what was also said, which was that people in early childhood services have known for a long time that you have to deal with the whole child, and other political philosophers have known for a long time that poverty causes some of these things, so I wonder if any of you would like to respond to the brain stuff and where you see it fitting in with some of the other broader questions?*

Dr NOSSAR: I think your question leads to somebody's earlier question about the political aspect of this. If that is what politicians are listening to, so long as there is significant research, I am prepared to work with them and help them understand it and help them implement what it says. If that is what it takes for them to get children on the agenda, so be it.

Professor SILBURN: I think it has probably been a little overstated and I think that is setting things up to potentially backfire, but I think it has been very useful in providing an insight into some of the mechanisms that may be important, that where these windows of opportunity do open up, it is really telling us something very important about why programs that are targeted to that developmental point are much more efficacious. So, from that point of view, it provides validating information, but I think probably there is still a lot more that we are still learning.

QUESTION: *Is there not a danger of the effort being directed towards learning more about the functioning of the brain and focusing on those moments in time when things might happen rather than about doing something about poverty?*

Professor SILBURN: And there are two sides to it. One model says there are these windows of opportunity that open and shut and the other is the accumulating exposure, and there is evidence for both models.

Dr NOSSAR: I work with other governments on developing their child development services around other countries in the world. You are right, many people have known that poverty is a major player for a long time but nobody has done anything about it. I am now working with groups from the World Bank who are suddenly prepared to fund child development initiatives as part of their country development initiative to reduce poverty in that country. Ten years ago there was not even an opening. Now they are prepared to give money to countries under development aid to help them develop child developmental issues that are not going to be delivered through doctors, but through educationalists to make that happen, which has not happened in the past.

Professor FERGUSSON: I have two comments. I suppose neither of them will necessarily please you. Firstly, I think that the brain research has been quite misleading because it has dealt with children subject to very extreme abusive conditions. One of the risks that always happens of generalising extreme pathological conditions to the normal population exist here. I suspect that the brain changes that have been shown only apply to a minority of pathological conditions and not across the spectrum. It may very well be that it is just a simple, ordinary, straightforward social learning theory that most people use is as good. Secondly, there is also the mystique of the brain. It is all magically going on in there and there are these things being laid down, but it is no more different to any other kind of learning in some ways, but we do not see it.

The second point is about poverty. Poverty has always been given a big airing as a causative factor. In the Christchurch Health and Development Study, income and poverty have only been weak predictors of child outcomes. If you want to see how a kid turns out, watch how his parents behave. Do not count how much they earn. People have forgotten the honest poor. One can go back through the English language, talking

about the north of England, people talking about the black poor and the white poor, where people were poor but they were decent. Those distinctions are being recognised in folk literature. I do not believe that how much a family earns plays a major role in how well they function or how well their children behave. I suspect it may very well be the other way round. How they behave may have a bearing on their income levels.

Putting an aetiological role to poverty may be putting the cart before the horse. I have said this in many forums. Let me give you a counter of how this might be, because people have said to me, "This is all wrong." As part of the Early Start project or indeed the Christchurch Health and Development Study, you get this family and the father is an alcoholic and the mother is an alcoholic. They are really in trouble. They are spending all their money on booze. The world is falling apart around them. Someone rushes up and says, "You have got to help them. They are in poverty. Let us give them $100 a week more." You have done them a really good deal, haven't you! This is something that happened in New Zealand in another context as a result of the sexual abuse scenario, where it was discovered that everyone got entitled if they were sexually abused to payments from the ACC, which provides compensation,. Heroin addicts, many of whom were sexually abused, rapidly learned of this and they queued up for their $15,000 ACC payment for being sexually abused. What is about the worst thing to get a heroin addict out of the habit? I would suggest giving them $15,000! What I would say to you is this: you cannot buy your way out of behavioural problems. The coin of behavioural change is behavioural change, not dollars. Certainly you can provide context, which will help, but in the end behavioural change has to be done in that coin.

Ms CALVERT: I think that is an appropriate point. It ties in with the coinage and currency of what we are worth. Can I just take this opportunity to thank our three speakers? There are just two other groups that I want to thank. First of all, there is the staff of the Commission and of the joint Committee on Children and Young People, who really have, I think, worked very hard to make the day flow as smoothly as it has. I just want to thank them. Finally, I would really like to thank you, the audience, for coming along and for staying for the whole day. It is terrific to see you all here. As I said, the whole of the process has been recorded. It will be on both the joint committee website and on the Commission's website. I have just spoken to Peter, and he said he will put linkages on the Parenting website to the studies that have been talked about today, so we will give him a couple of days to do that. And do not forget the bibliography is going to be available out the front as well for those people who want it. Last but not least, all have a safe journey home. Thank you.

EXTRACTS OF THE MINUTES OF THE COMMITTEE ON CHILDREN AND YOUNG PEOPLE

The relevant Minutes of the Committee on Children and Young People are included:

Meeting No. 5 Wednesday 31 January 2001

Meeting No. 6 Wednesday 30 May 2001

Meeting No. 7 Friday 1 June 2001

No. 5

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., WEDNESDAY 31 JANUARY 2001
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Ms Burnswoods	Ms Andrews
Mr Corbett	Mr Campbell
Mr Harwin	Mr Webb
Mr Primrose	Mr O'Doherty

Also in attendance: Mr Faulks, Committee Manager.

1. Election of Acting Chairman

The Chairman and other Members were delayed to inclement weather. Pursuant to the Legislative Assembly Standing Order 325, on the motion of Mr Webb, seconded Mr Corbett:

> 'That in the absence of the Chairman, Ms Burnswoods be the Acting Chairman.'

Passed unanimously.

2. Apologies

Apologies were received from Ms Beamer, Mr Smith and Mr Tsang.

3. Previous Minutes

On the motion of Mr Harwin, seconded by Mr Corbett, the minutes of meeting No. 4, having been distributed previously, were accepted unanimously as being a true and accurate record.

4. Chairman's report

Seminar on well being in children

The Chairman reported that in correspondence with the Commissioner for Children and Young People, it has been proposed that the Committee host a public seminar with the Commission for Children and Young People on "Well being: Through a Child's Developmental Stages" on Wednesday 7 March 2001, in the Parliament House Theatrette, between 9:00 a.m. and 5:00 p.m..

On the motion of Mr Primrose, seconded Ms Burnswoods:

'That

(i) the Committee host a public seminar with the Commission for Children and Young People on "Well being: Through a Child's Developmental Stages";

(ii) the possibility of the proposed seminar date being moved to a non-Sitting day be examined;

(iii) the proceedings of the seminar form a report of the Committee; and

(iv) subject to the preceding, the arrangements for the seminar be at the discretion of the Chairman.'

Passed unanimously.

5. General business

There being no further business, the Committee adjourned at 1:05 p.m.

Chairman **Manager**

No. 6

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

9:00 A.M., WEDNESDAY 30 MAY 2001
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Ms Burnswoods	Mr Campbell
Mr Primrose	Ms Andrews
Mr Harwin	Mr Webb
Mr Tsang	Mr Smith
	Ms Beamer

The Chairman, Mr Campbell, presiding.

Also in attendance: Mr Faulks, Committee Manager, and Ms Brdaroska, Committee Officer.

1. Apologies

Apologies were received from Mr Corbett and Mr O'Doherty.

2. Previous Minutes

On the motion of Mr Burnswoods, seconded by Mr Primrose, the minutes of meeting No. 5, having been distributed previously, were accepted unanimously as being a true and accurate record.

3. Chair's report

Seminar on well being in children

The Chairman reported that the Committee had hosted a public seminar with the Commission for Children and Young People on "Children's wellbeing: Through a Child's Developmental Stages" on Wednesday 7 March 2001, at Parliament House. A draft report of this seminar is being prepared.

4. General business

There being no further business, the Committee adjourned at 9:40 a.m.

Chairman **Manager**

No. 7

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

11:00 A.M., FRIDAY 1 JUNE 2001
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Ms Burnswoods	Mr Campbell
Mr Tsang	Ms Andrews
Mr Harwin	Ms Beamer
	Mr Smith

The Chairman, Mr Campbell, presiding.

Also in attendance: Mr Faulks, Committee Manager, and Ms Brdaroska, Committee Officer.

1. Apologies

Apologies were received from Mr Primrose, Mr Corbett, Mr Webb, and Mr O'Doherty.

2. Previous Minutes

On the motion of Ms Burnswoods, seconded by Mr Smith, the minutes of meeting No. 6, having been distributed previously, were accepted unanimously as being a true and accurate record.

3. Chair's report

Inquiry into the use of prescription drugs and medications in children and young people

The Committee confirmed that the dates for the first public hearings for this inquiry were Monday 18 June 2001 and Tuesday 3 July 2001.

4. Consideration of the Chair's draft report: Consideration of Chair's draft report: "The Development of Wellbeing in Children – Some Aspects of Research and Comment on Child and Adolescent Development. Proceedings of a Seminar, Parliament House, Sydney, 7 March 2001".

The Chair presented the draft report: Consideration of Chair's draft report: "The Development of Wellbeing in Children – Some Aspects of Research and Comment on Child and Adolescent Development. Proceedings of a Seminar, Parliament House, Sydney, 7 March 2001". (Report 3/52).

The draft report, have previously been distributed to Members, was accepted as being read.

The Committee proceeded to deliberate on the draft report in globo:

On the motion of Mr Smith, seconded Mr Harwin:

> That the draft report: The Development of Wellbeing in Children – Some Aspects of Research and Comment on Child and Adolescent Development. Proceedings of a Seminar, Parliament House, Sydney, 7 March 2001", be read and agreed to.

Passed unanimously.

On the motion of Ms Burnswoods, seconded Ms Andrews:

> That the draft report: The Development of Wellbeing in Children – Some Aspects of Research and Comment on Child and Adolescent Development. Proceedings of a Seminar, Parliament House, Sydney, 7 March 2001" be accepted as a report of the Committee on Children and Young People, and that it be signed by the Chair and presented to the House.

Passed unanimously.

On the motion of Mr Harwin, seconded Ms Andrews:

> That the Chair and Manager be permitted to correct any stylistic, typographical and grammatical errors in the report.

Passed unanimously.

5. General business

Cover of Committee reports
The Committee agreed that the covers of the published Committee reports should feature the design and artwork of children and young people, and requested the Manager to develop a template for the cover motifs.

There being no further business, the Committee adjourned at 11:15 a.m.

Chairman **Manager**

REPORTS OF THE COMMITTEE ON CHILDREN AND YOUNG PEOPLE

The first steps ... Review of the first annual report of the Commission for Children and Young People, for the 1999-2000 financial year. (Report 1/52, May 2001).

The global agenda for children - what role is there for us? Michael Jarman - The 1st Macquarie Street Lecture for Children and Young People, 6 April 2001. (Report 2/52, May 2001).

The development of wellbeing in children – some aspects of research and comment on child and adolescent development? (Report 3/52, June 2001).

Committee on Children and Young People
Parliament House, Macquarie Street
SYDNEY NSW 2000
Ph. (02) 9230 2161 Fax (02) 9230 2928
e-mail: children@parliament.nsw.gov.au
www.parliament.nsw.gov.au/gi/commits/children