C O R R E C T E D V E R S I O N

EDUCATION AND TRAINING COMMITTEE

Inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living

Melbourne — 31 August 2009

Members

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Chair: Mr G. Howard
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Witnesses

Ms R. Ramsden, manager, statewide programs, student wellbeing,

Ms K. Arcaro, assistant general manager, student wellbeing, and

Ms N. Lind, senior policy officer, student wellbeing, Department of Education and Early Childhood Development.

The CHAIR — I declare this hearing open. Today the committee is taking evidence in relation to its inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living. I advise all those presenting evidence to us today that all evidence, including any submissions, is subject to parliamentary privilege, which means you are able to be open and free with us in what you say.

The first group we hear from today is from the Department of Education and Early Childhood Development. I welcome Kris Arcaro who will open the hearing; and I also welcome Robyn Ramsden. We look forward to sharing some of your insights into where the department sits in helping to promote its skills and then we look forward to discussions.

Ms ARCARO — You have the handout and slides. I am the assistant general manager in the student wellbeing division. Robyn is the manager of our statewide programs area, which the carriage of a lot of the programs we will be talking about today.

Thank you for the opportunity to come along and share with you some of the things that the department is doing. We thought, in this presentation, we would take an approach of talking to you about our policy, and then move into some of the programs that we have got operating to support healthy living.

Firstly, we would like to say that we, as a department, think schools play a very important role in promoting health and wellbeing. We have got a large range of activity operating. The focus, in terms of health, for the work we do is on physical health, social health, emotional health; so it is not confined solely to physical health which some people might think of straightaway. We will talk later on about how that is reflected in the programs we deliver.

We believe schools are one part of the whole-of-community response in relation to this issue, so they play a very important role, but equally they work in partnership with parents and the broader school community around this issue, and our society as a whole. The schools have a commitment to establish strong partnerships where they can around these issues, whether it is with local sporting clubs, organisations — which we will touch on a bit later on — or indeed ourselves as central office staff. Our approach firmly embeds health promotion as the up-front activity, but where appropriate, where children or families are in need of some intervention strategies, we have certainly got things in place, but our key message is around promotion of health and wellbeing.

To support our activity in relation to this agenda we have got the student wellbeing division from which a lot of activity stems, but we have also got a couple of senior medical advisers in the department now that the office for children is part of our department, so it actually strengthens our policy role in relation to this issue. We have also got regional staff in each of our nine regional offices — up to three staff in some regional offices — who are also supporting this agenda.

To recap on some of the policies that drive this work, you are probably all aware of the blueprint for education; that really talks about ensuring that our young people will thrive, learn and grow to enjoy a productive, rewarding and fulfilling life, while contributing to their local and global communities and, very much within the blueprint, it talks about health as a key focus.

The other main policy driver of our work is the *Melbourne Declaration on Educational Goals for Young Australians* that states that young Australians should become successful, confident and creative learners with knowledge, skills, understanding and values to establish and maintain healthy, satisfying lives. Within those policy frameworks, the relationship between health, wellbeing and learning is really important for us.

The department has a corporate plan that drives its work and is up-front in the areas about all Victorian children having the best start in life to achieve optimal health, development and wellbeing and talking about improving the outcomes for disadvantaged young Victorians. When we talk about disadvantage, we are broadly defining that as those children with disabilities, those who are homeless, in out-of-home care or who are impacted by socioeconomic conditions, so it is broadly captivating.

Also, the other major policy that drives our work is the government schools reference guide, and within that we have got a whole section on health support planning and promotion, and schools would look to that advice in relation to specific health issues. Advice within that guide is promoted through our bulletins and circulars that go out to schools.

We also have, operating in the department, the Victorian Essential Learning Standards through which all Victorian students receive health education, and the health and physical education domain are the key areas that relate to this particular inquiry. We also have mandated time for physical and sport education, and you are probably aware that that is undergoing review at the moment, but it does mandate that prep to year 3 have 20 to 30 minutes of physical education a day, years 4 to 6 have 3 hours a week of physical education and sport with a minimal provision of 50 per cent for physical education; and years 7 to 10 have 100 minutes per week each for physical education and sport education; so it is really trying to promote health and wellbeing through those elements as well.

I might at this point hand over to Robyn to talk about the effective schools model which is another overarching framework through which we embed this kind of work.

Ms RAMSDEN — The effective schools model provides schools with a constant framework through which to embed their whole-school projects, such as health promoting schools. The Department of Education and Early Childhood Development has gone through significant reform, and this framework tends to focus on elements around leadership and professional learning for teachers as well as incorporating the other elements of the health promoting schools frameworks.

It was a way to provide leaders with some clearer direction around reform. It contains eight elements which, as you will see, are consistent with the health promoting schools framework, but as I said, it really does look at how a school can be effective with a focus on teaching and learning, because recent evidence suggests that the way the school is led and managed, the experience students have to participate and take responsibility for shaping policies, practices and procedures, and how teachers relate to and treat students, is really important around protecting health as well.

If we look at the model and look at the three elements of the health promoting schools framework, I will talk briefly about how that fits within the broader effective schools model. The model has a focus on leadership support and professional learning to secure purposeful learning that will equip students with knowledge and skills they can use in their everyday life, that includes health and wellbeing knowledge and skills and behaviour such as informed decision making, respect for others, peer support and community contribution.

There is also an element of the health promoting schools framework that looks at the school organisation ethos environment, and that is certainly in our effective schools model as well. The environment in which students work has an impact on learning. Student wellbeing policies, such as the Student Engagement Guidelines, Safe Schools are Effective Schools, and Supporting Sexual Diversity in Schools, support the models, stimulating a secure learning environment. These wellbeing policies ensure that school-based policies and practices, processes and staff-role modelling are consistent with and add value to the health education curriculum taught in the classroom.

The final element of the health promoting schools framework is the community links, partnerships and services, and the effective schools model also draws attention to this as an important part of an effective school. The partnerships are critical. Effective schools demonstrate clear and shared understanding of goals, and that shared understanding involves parents in the broader community. The department's health and wellbeing policies and initiatives promote local community and parent partnerships towards this shared vision of health and interest in wellbeing.

We very much acknowledge that there is growing evidence that health and education are inextricably linked, and that actively promoting health in schools can improve both the educational and the health outcomes. We know that the level of education, employment and occupation remain factors that are most significantly associated with inequalities, and therefore that provides a strong case for schools for contributing to the promotion of healthy community living to ensure the improvement of long-term health outcomes for the most vulnerable in our community.

We do maintain a close collaboration with the Department of Health and other key agencies to ensure consistency and a comprehensive approach for health and wellbeing outcomes. We have listed on the slide some of our key partnerships around this work

Currently we are working on a health and wellbeing services framework. Health and wellbeing services funded or delivered by the department play a key role in supporting children's health, and therefore the health and

wellbeing services framework seeks to strengthen services through the development of a common vision, shared principles, a focus on outcomes, including clarifying the roles of health and wellbeing services in providing health promotion services, and a forward action plan to better align and coordinate services in the future. The draft framework, in the form of a discussion paper, is about to be released for consultation.

The department, as Kris outlined earlier, has a raft of initiatives that support the work around health promotion. You will be familiar with the Go for Your Life initiatives. Our department is responsible for four. They are well taken up by schools, and we have a big uptake around the Healthy Start in Schools grants which are grants of up to $6000 for schools to help them create physical resources that promote healthy eating and physical activity. We have the Free Fruit Friday, which is an initiative to boost fruit and vegetable consumption by young Victorians. It provides schools with grants to purchase fresh fruit and vegetables for prep to year 2.

We have the Kitchen Garden project with Stephanie Alexander; more than 40 schools are involved in that project, and that has just become a national initiative. Victoria has been well regarded in the work it has done in that space; it is very successful. We also have the Healthy Canteen Kit, which is policy and resources to assist schools to implement the school canteen and food services policy. We support the Kids — Go for Your Life framework and we work closely around supporting schools there. The Kids — Go for Your Life award program helps schools to build whole-school approaches to physical activity and healthy eating. There is a lot of support around those initiatives, and our initiatives contribute to that.

School sport reorganisation, as Kris outlined, has been through a review. It caters for 400 000 students every year and draws on the voluntary contributions of teachers, parents, community and sporting associations. The review came up with a number of recommendations that will drive some improvement there around increased participation in school sport activities for students, a common organisation framework from prep to 12, stronger school community and sporting organisational partnerships to support healthy lifelong activity and increased opportunities for the department with school communities to recognise and support the voluntary contribution made by staff.

My unit is responsible also for drug education. We know that that is implemented in all Victorian schools and is usually located within a broader health and personal development curriculum. Government schools are required to provide 10 hours of drug education per year per year level, but we work with all school sectors, and it is strongly encouraged in all school sectors. The Catholic Education Office has advised that their schools are very close to ours; they have a very high take-up of schools around those 10 hours per year, per year level. While it occurs as part of the curriculum, it is also embedded in the general wellbeing and welfare policies of the school.

We have two evidence-based initiatives that contribute to effective whole-school approaches. They are the Drug Education Evaluation and Monitoring project where schools use a very well-regarded tool to evaluate their drug education in the schools and their student wellbeing practice to inform their planning, which they currently do every four years.

We are also undertaking a pilot which is based on the WA SHAHRP, School Health and Alcohol Harm Reduction project, which is well recognised as one of the only evidence-based approaches to reducing harm associated with alcohol and other drug use. We have four schools involved in a pilot at the moment, but we have done pre and post-testing and we are looking at the impact of that project not only on the knowledge and skills but also on the changes and behaviour of young people around drug use.

Sexuality education also comes under my unit. It works on a health promoting in schools framework, really the whole-school approach to sexuality education, and we have listed some links at the end that look more closely at the frameworks we use and how these curriculum areas are embedded in schools.

But again we work closely with the Department of Health to ensure strong sexual health promotion in school learning and teaching. We have a memorandum of understanding with the Department of Health to deliver not only teaching and learning but health promotion around sexuality education. We are part of the whole-of-government partnership around the mental health reform strategy. Of particular interest are reform area 1 — promoting mental health and wellbeing, and reform area 2 — early in life.

There are a number of strategies under way in a 10-year plan, but we have commenced creating a mental health promoting schools and early childhood settings action framework. There are already mental health promotion officers in DHS and there is work to move to a health promoting focus from more an intervention focus. There

is an alcohol awareness campaign flagged under this reform strategy to also better equip schools to identify and support children with social, emotional and behavioural difficulties, and again working on the partnerships to improve them.

On respectful relationships, under the Premier's $17.7 million initiative to promote respect, build more resilient communities and address alcohol-related violence among young people, we have a significant range of initiatives under way to enhance respectful relationships education in schools. There are five elements. We are reviewing our Safe Schools are Effective Schools anti-bullying policy to provide a more comprehensive framework for developing safe and respectful school environments. We are developing a violence prevention demonstration program in collaboration with selected schools and community organisations. We have education curriculum guidance and materials for schools under way and who are implementing professional teacher learning, an initiative that is looking at the effectiveness of the policy framework and curriculum guidance that we provide.

I am sure you will have some questions for us because that has been a very quick snapshot of the raft of things that we are working in, but in conclusion the concept of health promoting schools as a component of a comprehensive whole-of-community approach contributes to significant outcomes, and the department recognises and works towards that. The concepts have been incorporated into the term whole-of-school approach and into the effective schools model, which was implemented by this government as an improvement element of blueprint 1 for government schools.

We have tried to provide a comprehensive framework that incorporates the range of things that schools need to do under the effective schools model, but it certainly strongly acknowledges the work of the health promoting schools framework and all the other initiatives and frameworks that are out there to give a cohesive message to schools to deal with the range of frameworks that come their way and make sense of them.

The CHAIR — It certainly does cover a broad range of areas of health promoting schools.

Ms RAMSDEN — It does.

Mr ELASMAR — Kris, the first question for me is years 4 to 6 have 3 hours a week of physical and sport education. Then we go to years 7 to 10, which have less than 2 hours of physical and sport education. How do you explain this; why has it dropped?

Ms ARCARO — I suppose that has to do with the multiple demands. Can I ask Naomi to come to the table? She has actually been working in this area and has been part of the review. She is also another policy officer within our division.

Ms LIND — For years 7 to 10 it is 100 minutes of physical education a week and 100 minutes of sport per week.

Mr ELASMAR — So it is 200 minutes, you are saying?

Ms LIND — Yes.

Mr HALL — Why is that being reviewed? I think you mentioned, Kris, that it was currently under review. What is the reason for that?

Ms ARCARO — I think there are some issues sometimes around implementation, so I think it is about looking at why it is there and being able to give a particular focus in the future to try to reissue a message to schools about how important it is for young people to be healthy and active in school, and also to try to bring the physical education and sport education together, because they have been operating as two separate programs and initiatives in schools — physical education being controlled by the VELS but sport education also being controlled by outside organisations. So it is about trying to bring them closer together and working them so that they have common goals. Is there anything to add to that, Naomi?

Ms LIND — The mandated times for physical education were introduced in the early or mid-90s from what was known as the Moneghetti review, which was an overarching review into physical and sport education in schools, and it was felt that it was time to revisit that and re-look at those recommendations for primary schools in particular. At the same time there was a review into school sport undertaken as well to look at how the

organisation of school sport was going and whether there was a more effective way to deliver school sport and interschool sport opportunities for students.

Mr HALL — Can I ask about that review process? Is it anything to do with a crowded curriculum issue that we deal with particularly at secondary level, and also is the issue about availability of resources, particularly of qualified teachers, to deliver such programs; is that also part of the consideration of the review?

Ms LIND — I do not have the terms of reference with me for that review. It was done by another area of our department, although we were involved, but I cannot remember. I know it was looking at the qualification of teachers. All primary teachers are qualified to teach all subject areas, so it was looking at the support and the professional development of those teachers. The review has only been about primary school physical education at this stage.

The CHAIR — Can I ask with regard to that as to whether there is some checking to see that all schools meet those mandated requirements?

Ms LIND — Yes, schools report through the school compliance checklist on their meeting a whole raft of education policy requirements.

The CHAIR — So we are satisfied that all schools meet those levels?

Ms LIND — I am not familiar with the most recent data from that compliance checklist.

Ms ARCARO — There could be some improvement, I imagine, in some areas. On the school compliance checklist, schools report in to that, and then there is a bit of an audit done. Where there are issues the department does follow-up either with particular schools or by going back to the policy areas to follow up.

Mr HALL — With regard to that, Chair, I think it might be helpful if we were able to get the terms of reference of that review. You said you did not have them with you, but if you are able to provide the terms of reference and any background information as to why the review is being undertaken, I think that would help us in our deliberations.

Ms ARCARO — Okay.

The CHAIR — I was going to say in terms of broadening out the health promotion concept so that it is not just affecting students that teachers' involvement and parental involvement would seem to be a key part of the process of trying to embed a healthy culture. I am wondering what comment you can make in terms of what schools are doing to include teachers, or whether you can give us examples of schools that seem to be doing a particularly good job or some of the programs that you have come across that broaden it out to include parents or even the broader community as well as teachers.

Ms RAMSDEN — I think it is a bit of a two-way process. In some cases we work as part of a whole-of-community approach to promoting health in particular issues. There might be broader campaigns that are going on, and the school is part of that and we are working mainly with students, but in other cases — I can think of some drug education examples — we are actually looking to also include parents who are role models around, say, alcohol use, for example. We are very mindful that anything we do with students is not in isolation of the broader community, because we are trying to influence as well as be part of the whole community.

We have worked in this space for a long time and it is very difficult, often, to find ways to do this effectively, because we know that in this day and age we cannot get parents along, for example, to a 10-hour program. But, for example, the DEVS program — the Drug Education in Victorian Schools program that I talked about earlier — contains homework components; so with every lessen that the student does, he or she is required to go home and talk about those issues with the parents so that the parents are also getting the information. And certainly I can think of a whole range of the initiatives that we have along those lines.

It is very important that staff have good professional learning so that they are also imparting healthy messages and promoting health in line with the rest of the community. Body image is one that comes to mind. Inadvertently we send messages to young people around thinness. It is not just a health teacher that needs to be aware of that fact; it is all teachers. Good professional development for teachers is an important part of what school does, and that is why we think the effective schools model works better, because we are talking about

leadership; and the effective schools model is really all about leadership. School leaders need to be aware of their responsibility around these issues.

Ms ARCARO — Can I just add, in relation to the respect for relationships initiative, which is a new policy, we are working across government, but the recognition in that program is that schools are not only places where teachers and young people are, but they are workplaces. Schools are actually hubs of the community and link out and work with community organisations, so our approach within this strategy will be around all those components — young people, teachers as employees, and also about parents — and our policies, programs and initiatives need to cover all of those people.

Ms LIND — There are some good examples from the Kitchen Garden program of community response or involvement, and many of the schools have a community element to their garden or they have involved parents in booking afternoons or evenings. One school in particular has a great program with the dads and the young boys in the school, and they have a dads and sons cooking evening once a term. That has been a really good avenue for involving not only the teachers but the families and the community in maintaining and looking after the gardens as well as the kitchens.

Mr KOTSIRAS — Kris, for how many years have you worked in the position you are in now?

Ms ARCARO — Three years.

Mr KOTSIRAS — And Robyn?

Ms RAMSDEN — Nine years.

Mr KOTSIRAS — In those three and nine years you will have come across many initiatives that the department has trialled. Do you have any evidence that they have been working in terms of the wellbeing of students, in terms of students obesity? Have they worked?

Ms ARCARO — We have student opinion surveys in schools, which we use as an evidence base for the impact of our programs, so they are more about social and emotional wellbeing rather than physical health necessarily, but we certainly do look at that data and look at how young people are feeling in their schools and how they are going. Whilst we cannot say particular initiatives have had a particular impact, we can say that these initiatives have contributed to a set of outcomes.

In terms of the Go for Your Life initiatives, which obviously have a particular impact on one's physical health and wellbeing, we are evaluating them in terms of behavioural change and those sorts of things; so we do monitor them.

Ms RAMSDEN — A report is due shortly from the evaluation of Kids — Go for Your Life.

Mr KOTSIRAS — You do not know of any data, though, which shows a decrease in obesity in students, as a result?

Mr HERBERT — Has there been more sporting activity, perhaps?

Ms ARCARO — The department has the Victorian outcomes for children framework, so there is a whole range of indicators in there which talk about obesity and physical health, mental health and so forth; so that is a way to monitor things. Therefore we cannot attribute necessarily individuals programs, but we can say, in general, that this is how children are faring, and look at what we have happening in our schools and how that might make a contribution to either decreasing or increasing it.

Ms RAMSDEN — It is really important that whatever we do is evidence based. There is so much asked of schools these days that we cannot afford to be trialling things that are not evidence-based and not integrating them into what schools are currently doing. So as the evidence base increases out there about what is effective, that is the thing around which we try to provide professional learning for teachers.

These are the things that we need to focus on because these are the things that work. And we know that one-off programs or initiatives do not work well with the outsider coming into the school, for example. There is a place for programs and outside professionals to support the work of the teachers, but we know that what the teachers

do is the most effective and it needs to be integrated into what the school does. We very much draw on the evidence base as we design these new initiatives, because we cannot ask schools to do any more unless we know that the research says there is an impact for young people. We are certainly moving much more towards an evidence-based approach and evaluating what we do. We are awaiting the evaluation from the Kids — Go for Your Life program. But, for example, the Drug Education in Victorian Schools program is exactly that. We feel that if we provide drug education for students, they will be better informed and make better decisions, so now we are looking at what we are doing pre and post-testing to see if these things make an impact.

Mr KOTSIRAS — In your nine years there has not been any research undertaken to see the success or failure of any particular initiative?

Ms RAMSDEN — There certainly has been, in a more broad sense, and that is what we have drawn on to form the best practice approaches that we use in schools. We have talked about things like the health promoting schools framework. We have to work in these three areas in order to make an impact. We have to work on teaching and learning, on the school environment and on partnerships. Therefore in everything we do we try to incorporate those elements. It is complex. There is lots going on and lots of issues to deal with.

Mr HERBERT — National curriculum is used fairly prominently. Where does this area fit into the commonwealth negotiations and discussions about a national approach in terms of education in curriculum? Is it part of those discussions or is it part of some other forum for national consistency?

Ms ARCARO — That area does not actually sit within our division, so I would have to take that on notice and go back to the department to seek the view from Di Peck or Daryl around that point.

Mr HALL — I have three quick questions. First of all, in respect of the Free Fruit on Friday program, what has been the uptake level with that? How many schools are currently in that program?

Ms ARCARO — It is very popular.

Ms LIND — We had a staged implementation of the project. Robyn has the data of where we are up to at the moment. We have about 88 per cent of student involvement at the moment. I cannot remember the exact number of schools, I think it is approximately 1010 schools currently involved, which is the number we have budgeted for in this financial year. We will expend all of our budget at this point in time, and then we will be bringing more schools on board next year for the final year of the project. So it has been very good.

Ms ARCARO — Very positive.

Ms LIND — There have been a lot of anecdotal reports from the schools about the impetus it has provided for them to initiate some broader healthy eating strategies and activities within their schools.

Mr HALL — I would find it helpful if you got back to us with the actual number of schools that are involved in that program; that would be great. The next thing I wanted to ask about was in respect to some commercially orientated programs in some regard that would fit neatly within some of the components of your student wellbeing. I give you, for example, two things: the Life Education van within a drugs policy framework; and another program which I have seen in schools is called You Can Do It!, which in part teaches respect, tolerance and self-esteem. They fit within some of the concepts that you have spoken about today. What is the department's role with respect to those sorts of programs? I know they are not mandated to schools, but what sort of advisory or support role do you play with respect to those types of programs?

Ms ARCARO — We fund Life Education several hundred thousand dollars a year to deliver that. Robyn's area works very closely with Life Education to ensure that what is happening there is consistent with our policy approach in relation to drug education, so there is a very close association — very supportive. In relation to programs like You Can Do It! et cetera, they are part of a suite of programs where we say to schools that they may opt in to those if they like. Whilst we provide broad policy frameworks and guidelines around ensuring schools are respectful, inclusive and safe environments, we say to schools, 'There are programs that you can buy in'. You Can Do It! is actually promoted as one of the projects in our Safe Schools are Effective Schools policy, for example. There are a number of policy frameworks where we talk about programs like that.

Mr HALL — My final question is in regard to traumatic events like bushfires et cetera and the impact that that has on kids at both primary and secondary level. What role does student wellbeing within the department play in respect to assisting and providing response to events like that?

Ms ARCARO — We have been very heavily involved in supporting the schools impacted by bushfires. Our area has been working as part of a whole-of-department committee around the response, working very closely with the emergency management area. We have been involved in anything from deploying additional SSSOs to schools in affected areas to coordinating responses from the public around support. That has been huge. Our general manager has actually been directly involved in managing the requests coming in from the public. We have got an ongoing role in monitoring how those schools are going through a relationship with our regional offices, and actually we are managing the additional eight case managers who have been put into regions on top of the SSSO support. There is a whole range of things. We have actually employed someone directly within our division to support the approach. It is a three-year appointment. We are working with commonwealth and other government departments around the psychosocial response.

Mr HALL — You reminded me, too, of one other point I was going to raise, and that is in respect to school chaplains. What role does the department play in terms of school chaplaincy.

Ms ARCARO — On school chaplaincy, we have got an agreement with ACCESS ministries, which actually supports schools to employ chaplains within their schools. It provides a professional learning, advocacy role for schools in relation to the employment of chaplains. Also we work closely with the commonwealth in terms of implementing the chaplaincy initiative and ensuring that schools are compliant with the guidelines, and ACCESS ministries has a role there. Through our annual survey we asked schools how many have a chaplain and what their role is. We actually monitor the number and what they are doing. ACCESS ministries has a quality-control role. We do not necessarily have that role.

Mr HALL — And the funding for those positions comes through schools themselves or local congregations?

Ms ARCARO — That is right. Schools have to raise half of the funding through local contributions. Those schools that have got the commonwealth dollars will be using that to employ chaplains. Our dollars to ACCESS ministries is to support the recruitment and quality control. Our dollars to ACCESS ministries is to support the recruitment and quality control.

Mr HERBERT — Finally, while you were talking I was thinking there is a lot here on the promotional side.

Ms ARCARO — Yes.

Mr HERBERT — What about in terms of the hard curriculum issues such as blood rules, teaching kids about how to avoid hepatitis, things that normal sporting programs would have in them — safe training practice, appropriate behaviour on the field, teaching about how you actually should engage in sporting activity in particular sports — do we have any guidelines that actually lay out the curriculum a bit more than the VELS might have?

Ms ARCARO — Are you able to answer that, because I would have said the VELS provide the guidelines?

Mr HERBERT — I am talking about mainly in secondary schools.

Ms LIND — Within the standards of the VELS, schools then develop the curriculum that they feel best delivers that material. Those topics can include the types of topics that you have spoken about. There are various resources that support schools to do that. We fund the association ACHPER.

Mr HERBERT — Are those resources on the website?

Ms LIND — No, most of them are independent types of ones, I think. We fund the Australian Council for Health, Physical Education and Recreation, which does all the professional learning for teachers around the delivery of the physical education curriculum.

Mr HERBERT — If it is diabetes or avoiding hepatitis, it is up to the schools; we do not have a standard in place?

Ms ARCARO — No, we have a section as part of the *Victorian Government Schools Reference Guide* called the health support planning guidelines. That provides information to raise awareness as well as some more detailed education about dealing with the health condition. It also provides templates such as management plans — that is, around health promotion, raising awareness and being able to intervene or manage a health-related disorder. That is a model that we developed from a South Australian model. It is very comprehensive.

Ms RAMSDEN — And we provide resources in, say, sexuality education and drug education where we will deal with a number of those issues that you have raised, which help schools to provide the curriculum materials to support those learnings.

Mr HERBERT — It is still a bit patchy. You could not say that diabetes is of epic proportions, that each secondary school was looking at diabetes and making kids aware.

Ms ARCARO — We have the health support planning guidelines which we promote to schools, which say, 'This is the information. This is the process.'.

Mr HERBERT — So it is up to the schools.

The CHAIR — Thank you. That makes a useful start to the inquiry. There may be issues that we wish to follow up with the department; we will be in touch in seeking further evidence or further details. Thank you very much for your contribution today.

Witnesses withdrew.

C O R R E C T E D V E R S I O N

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Witnesses

Dr E. Bruce, vice-president, and

Mr M. Cameron, secretary, Australian Health Promotion Association (Victorian branch); and

Assoc. Prof. B. Marshall, national vice-president, Australian Health Promoting Schools Association.

The CHAIR — We will now hear from representatives from the Australian Health Promoting Schools Association and the Australian Health Promotion Association. We have with us Dr Emma Bruce, Matt Cameron and Associate Professor Bernie Marshall. I do not know which of you is going to lead off in initiating a presentation to us in regard to the issue we are looking at, but we will follow it up with some discussion with you on from that.

Mr CAMERON — I will kick off. Thank you very much for having us and good afternoon. I am Matt Cameron, the secretary of the Victorian branch of the Australian Health Promotion Association, but I am here today specifically to represent the submission itself as one of the authors. Our submission was designed to provide a high-level perspective on some of the steps we consider important to the inquiry, and we have aimed to blend theory with practice, some potential with experience and vision with pragmatism. The fundamental position of our submission is that health, in its broadest sense, must be embedded within a range of social settings and networks within Victorian communities. Our joint association strongly supports the inquiry in its efforts, and we are very pleased to be able to add further information in our joint hearing today.

The Australian Health Promotion Association is represented by Dr Emma Bruce. We are the peak body for health promotion in Australia. The Australian Health Promoting Schools Association has a long history in the context of schools health and wellbeing nationally, represented today by Associate Professor Bernie Marshall. Emma will now provide a brief overview of the Australian Health Promotion Association's perspective before Bernie follows up with a more specific focus on schools and health, and then we look forward to opening it up for some questions. We are happy to provide further information at a later date, if necessary.

Dr BRUCE — I am currently the vice-president of the Australian Health Promotion Association's Victorian branch. As Matt suggested, our submission looks strategically at the overall approach — or what we would like to see included in the approach — to this inquiry and obviously the actions coming out of the inquiry. As Matt suggested, we are the peak body for health promotion in Australia.

In terms of a definition of health promotion, a widely used definition at the moment is that it is the process of enabling people to increase control over the determinants of their health. In particular, we like to focus on the social determinants of health, and that is a key focus for health promotion. Those are the conditions in which people are born, grow, live, work and age, and obviously they include schools. There is a lot of evidence to suggest that education is inextricably linked to health, and it is important to link the two to make sure that we are improving education as well as health outcomes at the same time.

Education is also a fundamental resource for disadvantaged communities, which are obviously more affected by the social determinants of health. Evidence suggests that more disadvantaged communities experience poorer health when compared to more affluent communities. Schools also have a huge impact on lifestyle factors — for example, physical activity and nutrition. Children obviously spend a huge amount of time in schools.

In order to address these social determinants and lifestyle factors in an effective way, health promotion actions are based on what is referred to as the Ottawa charter. There is evidence surrounding the creation of the charter which points to the need for interventions to have multiple levels. We should not place all our eggs in one basket with our interventions — for example, interventions at a policy level, the environmental level, community action, health information and risk assessment, to name a few. These have been shown to ensure the success and sustainability of outcomes with health promotion interventions.

In terms of this particular submission, we believe a multilevel approach needs to be taken when addressing the issue of schools becoming a focus for promoting healthy community living, addressing the social determinants of health and using multilevel interventions to ensure effective outcomes and sustainability. I will hand over to Bernie Marshall who will give us some more in-depth information about the health promoting schools association and how that relates to the inquiry.

Assoc. Prof. MARSHALL — I am the national vice-president of the Australian Health Promoting Schools Association. We are a peak body which is really not about delivering programs — we are very small in that context — but we are about trying to work across each of the states and territories to support people there who are working actively at those levels to have a greater national focus and to be a lobby body around the conditions that are necessary for successful school health initiatives. One of the major focuses for our work is to

try to embed models for school health that are actually likely to be effective, rather than models for school health that are simply add-on nice little programs that do not actually generate any evidence.

Emma mentioned before that, in essence, health promotion concentrates on multilevel intervention strategies. If we look at our success in tobacco, we did not get there in two years by running an ad on TV. We have had 25 or 30 years experience of operating at all sorts of levels with programs that complement one another. It is worth thinking about the tobacco example when we look at schools, not because of what they are doing about tobacco smoking but to think about how easy it is to generate evidence. I heard you discussing with Robyn and the department team a minute ago about where the evidence base is. Robyn was stressing that they want an evidence base, but often that is very difficult. If you look at our success in tobacco, we are down to a 16.6 per cent adult smoking rate now — one of the lowest in the world. It is pretty hard to say which of the interventions we have done over the last 25 years has actually contributed, or what percentage of that has contributed. It was actually the fact that we had lots of things running all the time and supporting one another that has had that impact. The same is true for schools.

What we know with schools is that they can be very effective, particularly around young people's mental health, but also around physical activity and nutrition. Their evidence around drug issues is touch and go, it is divided, but certainly schools can make an impact around children's mental health, and they have a great impact because of the way they operate them — an immediate impact on mental health — but also around physical activity and nutrition. What we find there is the approach is not to have a little program here or a little program there; it is in fact having complementary programs that operate with sustained length to actually have some impact, operating them with parents and with community organisations.

The model of school health we operate from says that if we actually want to make an impact on children's health — and we will come back to the broader community in a minute — then we need to concentrate on what goes on in the classroom and what gets taught, and not just what but how. In other words, we know the relationship between children — student to student and student to teachers — is very important in the learning process, particularly around mental health outcomes, but they have links into physical activity and nutrition, given a whole range of issues around body image, physical fitness et cetera. It is the teaching, it is what happens in the classroom and it is what happens in the school as an institution. That is What are its policies? What are its practices? What sorts of role modelling do staff have? What sort of social environment exists within a school? What sort of physical environment exists and how does that link to the school's impact on its children?

The third area we concentrate on is to say that schools cannot do this alone. Schools need to be part of communities, to have links with children's families, with other sectors of the community and also with the health and welfare sector broadly. We try to put forward a model about effective interventions. I have brought with me, and I will leave for you, a WHO review of the evidence of effectiveness of school health interventions and also a very simple little one about the evidence base, about what works in relation to mental health, physical activity, nutrition and sexual health. Basically, what both of these documents say is that the more you move away from quick, one-off programs to sustained — as Emma said — multilevel, multi-strategy interventions, the closer you get to having a good impact through interventions.

Our message is that we need really strong partnerships between health and education, and not just at the school level but more broadly to sustain this. We need to link schools in with their communities and so impact with children's families, and we need to fund programs that run for long enough to actually have some impact. Often our experience is that we get quick funding for a nice project that runs for one or two years and then it disappears. Schools are good at waiting for the next project to come along to get a bit more funding. But there is no continuity; there is no overall systematic framework within which school health operates generally right across the country.

We know that the context for success is to have good partnerships, not only locally but also at departmental levels. We know that you need strong leadership within schools, regionally and statewide. We know that programs need to be long term with sustained funding and sustained implementation. And we know, as the department said, they need to be programs where there is some evidence of effectiveness. One of the things that frustrates us as an organisation is that many schools get involved in lots of activities which take up time, energy and resources but are never going to actually produce any benefit because they are always too small to ever do anything. We would rather schools do less but do it better in terms of in terms of their impact around school health initiatives.

The CHAIR — Thank you, that is a very good potted overview. I noticed that you suggested in your submission having some sort of strategy or providing some sort of assessment models that would give schools ratings. How do Victorian schools rate at the moment in terms of those basic ones at least, of physical activity, dietary, health promotion activity and the mental health ones?

Assoc. Prof. MARSHALL — I was going to say, 'Ask the department that' in one sense because, certainly from our — —

The CHAIR — I would say we are doing well.

Assoc. Prof. MARSHALL — We do not go into schools and evaluate them or run programs directly for them. We are working with a range of bodies, and through my work at Deakin University I have been involved with a lot of school health initiatives over the years. The areas that most funding are the areas where they are most successful, so schools are doing a pretty good job around physical activity and nutrition, and they are doing a better job now around mental health, particularly around bullying issues, because they have actually had some leadership and some demands around them in those areas. Schools are less comfortable about areas that are a bit less mainstream, so grief and loss. You were asking before about emergency procedures. Schools are not so certain how to respond to the bushfire situation or suicides amongst children — there was the Geelong case. There is enormous difficulty in responding effectively in that context. I think individual schools are variable, but as a system we are not so good at having a cohesive, long-term agenda around that.

Mr HALL — Thank you for your presentation this afternoon; we appreciate it. A general question I will ask first of all is: given that by the time they reach the age of 16 a child has probably spent about 10 per cent of their lifetime hours in the classroom, how important do you think the role of the school is in a child's health and wellbeing?

Dr BRUCE — Massive. I think it is quite substantial, absolutely, in relation to the environment, teachers, peers, all of those sorts of things — impacts on mental health, nutrition and physical activity; the things we have talked about. They have a big impact in terms of readiness for adulthood, those sorts of things and those skills. They can have a definite impact on those sorts of things as well. It is a huge impact.

Mr HALL — No matter how good the program is in a school, can that not be negated to a fair degree by the home environment, for example? We teach kids things in schools nowadays but they go home and have fried food for tea when they have been banned from eating that sort of stuff in school canteens et cetera.

Assoc. Prof. MARSHALL — And clearly this inquiry is central on that. How do we use schools as a way of working with healthy communities? Part of it is that it is not one or the other, it is about all of these aspects. We are not going to suddenly only use schools to address community health. Clearly it is the marriage between those things.

You are right. If you look at just the school years, the percentage of time that children spend at school goes up to about 17 per cent or 18 per cent by the time you get to those later years, but it is much lower than most people expect. When I talk to my education students, and I have just had a group of primary teachers all morning, they think children spend a huge percentage of their time at school. But when you think that, it is only 40 weeks of the year, five days a week, 9 until 3.30; it is not a huge amount. But it does bring with it after-school programs and the links they can have. Although that is the formal thing, the informal takes it a reasonable amount higher.

But you are right; it is about the way schools link with families. And that is why we say: stop having little programs. The third area of the ones we stressed in our submission was your links and partnership with families and the community. You need to be that sort of centre which provides some focus around the way in which children's health is constructed within that community.

I do not know whether you have been talking to or received a submission from the Catholic Education Office. They have a program called Schools as Core Social Centres that has been funded by VicHealth. That is all about not having a nice program where the parents get invited into see the kids at school or whatever, it was meant to ask how do we really develop substantial relationships between the school, children and families in those communities? A lot of that has been around engaging in physical activity in the community and building links — particularly in low-income areas where a number of their schools have been, in Fitzroy and public housing areas — between those families and community resources around physical activity. So the school

becomes a really good resource, not because the teachers are going to teach the kids who will go home and teach the parents — there is a bit of that — but because of the relationships between schools and communities, and that was part of what we said in our submission. We should be leveraging the relationships between schools and their communities to add benefit and to add extra activity around that. The Catholic Education Office's program has been very effective in building substantial relationships with families, and through that relationship being able to link those families into broader activities with mental health and physical health.

Mr HALL — Thanks. That is obviously an area we will follow up. I was going to ask about the issue of public schools, independent schools, Catholic schools. Do any do it better? Are there any sort of models, apart from the one you have just mentioned, that can guide us in terms of this inquiry?

Assoc. Prof. MARSHALL — I would not want to say there is any difference between them. There are good examples of schools all over the place, and clearly the resourcing levels at schools are more critical, but that is not necessarily to do with them being Catholic, public or independent.

Mr HALL — Are there any states that do it better than others across Australia?

Assoc. Prof. MARSHALL — Queensland has done it better. I think there have been some states they have put much more focus on schools. Victoria is not good. Invariably what we get is the health sector will fund a project, education accepts it, runs with it while it is running, and then there is nothing left at the end. That is not necessarily a criticism of education, but one of the things we do not spend a lot of time doing is looking at the relationships between health and education. They speak different languages, they have different priorities. It is very hard to have a partnership.

The last time we did a big project for VicHealth as Deakin University nearly 10 years ago we went into in partnership with education because we actually wanted education to engage and not simply to host the project. It was vaguely successful. We could second education department staff. We had an office in Treasury Place; it was integrated in it. We did have some impact on the student wellbeing frameworks that were being developed, but by and large that project disappeared at the end and there was not much legacy. One of the difficulties we face is to actually build up, and that is why it is good that you are looking broadly at this. What is the relationship from the ministers down — MOUs — between what is now the Department of Health and education around the approach and a sustained integrated approach that you will want to use?

Queensland has put a lot of money over the years into school health, but again it has gone in through health to the education sector. That has done a lot of capacity building. Emma mentioned training up teachers. Having a work force that is competent in these areas is really important, remembering the fact that teachers are primarily there to teach; they are not there to run community health programs.

But it is very difficult to work with schools unless you are putting some money in. I can leave my desk at Deakin now and come in here for a couple of hours and I can just get on with my work when I go back. Teachers cannot. Somebody has got to cover them. If you want them to come to half a day of training, if you want them to get involved with a community project, if you want to get them involved with another school on something, they have got to be bought out. You have got to apply CRT to get them out to do those things, so we do need money to lubricate that system in a way that we do not in the health sector as much.

I do a lot of work in community health and people send their staff along. We will meet for a half day or a day or whatever and do a lot of development work. Education is different in needing to have people replaced on the ground.

Mr CAMERON — And Victoria, probably in our perspective, is one of the leaders in terms of health promotion within Australia. We may be slightly biased, but that is partially because of some of the infrastructure that is already around such as local governments having municipal public health plans, and we have VicHealth and a large number of community health centres across Victoria, whether they are integrated within public health services or stand alone. There is a lot of infrastructure already there to build upon in terms of partnerships and moving forward. There is definitely something there to work with.

Dr BRUCE — There is definitely potential.

Assoc. Prof. MARSHALL — The other thing we have been good at doing in the health sector is primary care partnerships. I do not know whether anybody has brought them up with you. They are alliances of, let us say, 15 to 25 agencies or organisations that are broadly concerned with health welfare and cover two to three local government areas. Sitting around it it has local government, it has the health sector, it has government-funded community health services, but it will also have Anglicare and a whole range of health and welfare agencies sitting around that. Education does not link into those usually; you might want to find out if there are any that do.

Dr BRUCE — There are some odd examples of schools linking in.

Assoc. Prof. MARSHALL — And maybe the school-focused youth services link in. They are bringing a whole range of health and welfare bodies together around the one table. DHS has been good in giving them some specific funding to facilitate those primary care partnerships but also saying that funding for community health broadly will have a focus on collaborative projects that arise out of those primary care partnerships. In other words they put money into saying, 'We want you to work collaboratively and get together'. The carrot is there to say the money is allocated to productive partnerships which are trying to close gaps, not duplicate but be effective within local communities. Trying to have some dedicated funding around health and education partnerships would be effective, but we need something which actually has some sustainability to it. Often we have had projects that will pop up and disappear in a year or two, or schools get into them for a year and then they are onto the next one. We do not have a sustained framework, and one of the statements in our submission was about saying that we really need something which embeds ongoing partnerships as part of the system rather than an add-on to the system.

Mr CAMERON — And it is also important to embed that locally. It is better to solve local problems with local solutions, so having those PCPs there is probably a good example.

Mr HERBERT — Just on your premise that you want extra funding for longer periods, it seems to me that in terms of health and schools, that is a core activity and should be viewed as a core activity. I would have thought that if additional funding is going in over and above the CRT money, the professional development money schools have over and above their core funding, it should be for short term and it should be only for projects that will lead to a more systemic take-up within the schools or the sector. I have a basic problem with a philosophy that says — and I know this is a basic university philosophy — fund us for everything extra we do when it comes to schools and what should be core activities. I will throw that in.

Assoc. Prof. MARSHALL — What is the core activity of schools is a very interesting question. I think you are right; there is no issue about schools having a duty of care and having a responsibility around student wellbeing while they are explicitly there, but it is not explicitly their agenda to reduce the obesity epidemic. That is a health sector responsibility. Schools will contribute to that explicitly through their curriculum, through the physical activity programs they run, but if we want them to do more substantial things than that, I do not disagree with short-term funding as long as it is part of something systematic and ongoing.

One of the good things about having projects in schools is that it really gives schools an opportunity to focus on something. It has a name, it has a start, a finish and an end. You actually expect it to produce something, it is not just something that dribbles on, so I certainly did not mean, Steve, that it is just in a bucket of money. But often we have had bits of projects that have come and gone and there is no systematic rollout of them.

Mr HERBERT — Take-up.

Assoc. Prof. MARSHALL — Yes, and I think you are right; if you have something that says, 'This is what we expect out of it. We want to see how you institutionalise these processes', so it is not a little add-on at the side, how do we institutionalise the outcomes of that? We have no problems on that at all.

Dr BRUCE — And I think at the moment schools are also struggling to address those sorts of things in terms of teaching capacity and those sorts of things, so that would have to be addressed as well in some way if health was going to be the domain of schools or something like that.

Mr HERBERT — You are with the teaching faculty?

Assoc. Prof. MARSHALL — No, I am in the health faculty.

Mr HERBERT — It is always very difficult for university teaching faculties, and you are at Deakin?

Assoc. Prof. MARSHALL — Yes.

Mr HERBERT — An excellent university. What goes on in teacher training, teacher education in terms of this health area? Is there much?

Assoc. Prof. MARSHALL — You will be speaking with Professor Lawrence St Leger in a minute. Lawrie and I co-taught a similar unit. We have been working intensively across one semester with primary education teachers about whole-school approaches, but they also have a whole-health and physical education units. They do a major sequence and half of that major sequence is around physical activity. Lawrie and I pick up the health part of it. There is a major student wellbeing program that is now running right through the education faculty at Deakin which is highly integrated now into not just a few topics that you teach about but really effective school approaches to their core business.

Mr HERBERT — Excellent, sounds good.

The CHAIR — Can I also ask about one of the big issues you raised? In regard to poorer families, dietary health may be more of a problem. Some of those mental health issues would also be expected to be more of a problem. Is there evidence to suggest that there needs to be greater resourcing for those families and schools dealing with a greater number of families from poorer areas? What can you suggest?

Assoc. Prof. MARSHALL — Certainly a number of schools have had breakfast programs. We know that kids who arrive at school hungry are not going to be able to function well educationally, let alone the health impacts of that. They are often difficult for schools to fund because how do you pay for those sorts of initiatives? A lot of schools are trying to get sponsorship from local businesses around them to actually be able to provide some food for children who are coming to school hungry.

Mental health — we did some research a few years ago looking at schools in low-income areas. One of the important points you make about schools has been their core business in health. For kids who have problematic home situations schools are probably the safest, most predictable, most protected aspect of their lives. Their friends are there, they get treated with respect, they get treated in a predictable manner, they know what is going to happen. Many schools play that fundamental role of protecting children's mental health because they are so stable, protective and safe, and students are very anxious to get back after the school holidays.

The other thing those schools told us is that they are a really good conduit between families and government services. I am thinking of when I was interviewing one of the principals down at one of the Moe primary schools. She said, 'If anybody from the government knocks on one of our families' doors here, they are there to take the kids away so nobody wants to interact with anybody.'. But the school has that link. The school can link families into a range of services in a way that is impossible otherwise. It is because, as we said before, of schools as core social centres, schools as part of their communities, schools as respected, schools as the parents see as being safe and interested in their kids' welfare. Schools in those areas take on a whole range of roles in linking the families into a whole range of support services.

Mr HALL — The commonwealth currently funds an after-school activities program, which I saw in Traralgon last week and got some information about. Do you have any views on that program? It basically provides a link therefore into various clubs and organisations.

Dr BRUCE — Is it around physical activity? Is it based on physical activity?

Mr HALL — Yes, physical activity. Basically it provides opportunities for kids to learn a skill — it might be squash, or it might be Tai Chi or whatever. It provides therefore a link ultimately to clubs within the town.

Dr BRUCE — I am not familiar enough with it to comment.

Assoc. Prof. MARSHALL — I think it would be variable, because again it has sort of just been let out to contract. There is not much of a valuation agenda attached to them. It is a service. They can clearly do good things by providing that physical activity and forming those links. As we said, from our perspective as a health promoting school, it is about enlarging those links between schools and their communities, and community physical activity is good. The problem that comes about is that the kids who are not fit and are not skilled do not

fit in easily with that transition. It is easy to set up programs with the local footy club that picks up on the kids who like playing footy. It is much harder to come up with opportunities for physical activity that take the unfit and the unskilled. So having programs which link a broader range of kids is excellent, but we also need to recognise that we need a broad range of physical activity to cater for the kids who we are most concerned about in terms of physical activity and health — the ones who are not doing it already, and it is very hard for them to make that jump.

Mr HALL — One of the success stories was a young lad who developed an interest in archery because they had a few local instructors come along. Then ultimately both dad and he joined the local archery club and pursued that interest.

Dr BRUCE — That is a great outcome.

Mr CAMERON — Some of the work of the National Preventative Health Taskforce might be useful there, which is being released shortly. I am not sure if you are aware of it, but it is being released by Professor Rob Moodie and his team. I think there is some stuff in there that may be of use.

The CHAIR — Good. If there are no other questions, thank you very much for your contribution today and the submission you have provided us with, which we will be able to look over later.

Witnesses withdrew.

C O R R E C T E D V E R S I O N

EDUCATION AND TRAINING COMMITTEE

Inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living

Melbourne — 31 August 2009

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Witness

Prof. L. St Leger.

The CHAIR — We welcome Professor Lawrence St Leger to speak to us now. You have provided us with a very helpful submission. If you would like to talk in general to the issues that you wish to share with us, we will have some discussion following that.

Prof. St LEGER — Thank you very much for the opportunity to make a verbal presentation and to respond to some of your comments and questions. As you know, I have sent in some documentation — fairly short. I am going to be referring to it.

I just want to open with some brief comments. There is a very considerable body of evidence about what works and what does not work around school health initiatives. It comes from both the health and education sectors. It is international, and there is a very large range of literature that has been generated over the last 25 years.

One of the common things in all the findings is that the most effective way to get any outcomes, whether they be in health or education, around school health initiatives is to work towards a thing called action competencies of students. Let me just explain what that might mean. If you take the Kitchen Garden program, which I believe to be very successful and well-grounded in theory, that particular program looks at building young people's skills in food preparation, designing menus, preparing food, buying food on a budget, reading labels, growing food, propagation, all of those sorts of things, as opposed to the old style of food and nutrition which was around the five food groups and around knowledge. We have seen a big shift in the last 10 years around this notion of school health being around action competencies rather than just around cognitive capacity. I am going to work a little bit with that in some of the comments I make.

It is very much about empowering students. We have seen this played out brilliantly in the Shape Up Europe program in 19 countries, 73 schools, 2300 students throughout Europe in the last three years where they have used that construct, and the outcomes are absolutely superb. Unashamedly Shape Up Europe is a program about addressing the obesity issue in Europe.

I want to draw your attention to the evidence-based guidelines that are international, which I sent in. These are funded by the Centres for Disease Control and Prevention in the US and through the International Union for Health Promotion and Health Education, which is headquartered in Paris. They are in seven languages. These took seven years to develop — a large amount of consultation right across the world. They are based on evidence. They are a framework or guidelines to assist schools, governments, different ministries et cetera on evidence-based practice. You can use an analogy with respect to the infection control guidelines that we have in the health-care system.

I also want to draw your attention to this document. I gave you almost the final draft of it, and I will leave this particular one, which is the one that is just about to be signed off by CDC. This has been four years in gestation; again, a large amount of consultation around the world. It is called *Promoting Health in Schools — From Evidence to Action* and was written primarily for the education sector. It has within it very interesting snippets about what does and what does not work around the different topics in health, as well as frameworks et cetera, and a very succinct reference list of mainly meta-analyses. Again, it has been through consultation, and I will not describe all the countries, but it has been derived from evidence and being with practitioners.

I also want to direct your attention to two books, and I am doing this because for people on parliamentary committees and inquiries, people like yourselves, it is difficult to get the evidence. I have been privileged enough to be around it for the last few years, and you would be grumpy with me if I did not let you see it.

This particular book, *Evidence of Health Promotion Effectiveness,* was asked for by the European Commission, and it wanted to have a look at the evidence of health promotion effectiveness right throughout the world. Many topics are in there. It talks about different settings. There is a chapter in there about schools as a setting and some superb topics: again, mental health, physical activity, food and eating, oral health et cetera. It was commissioned by the European Commission, and I believe it has had a significant impact on the policies in Europe.

This one, *Global Perspectives on Health Promotion Effectiveness,* came out in 2007. It is a weightier tome, and again it is people from around the world writing about the evidence of health promotion effectiveness, with some brilliant chapters around physical activity, mental health, food and eating. I am calling it 'food and eating' because this is what people do. Nutrition is post-swallowing, it is all the science, and with kids particularly we

have got to relate them to the reality of the world, which is eating and not so much nutrition. There is a chapter on schools, and there are chapters on different areas, again, evidence based.

Finally, before we have a discussion, I want to comment on my eight dot points. I did not want to give you a lengthy submission. I wanted to make it as succinct as possible and so I will make just a few comments on my eight dot points under the heading, 'Promoting health in school communities — some fundamental points from field-based evidence'.

In the first one I state that schools are not entities to solve society's health problems. You have probably heard this from other people. Sadly, though, traditionally health sectors in most countries see schools as appropriate settings to access a population group. That is okay; however, if we looked at school health in terms of maximising educational outcomes, we would rethink the way we did it. Healthy students will learn better, ipso facto the school has a responsibility to address health issues but not from a 'health' perspective and not around morbidity and mortality indicators, which is the health sector agenda.

The second point I make there is that the most effective strategies and approaches right across the world, whether they be in developing countries or in the developed world, are to focus on young people and their action competencies — you could use the term 'empowerment'. Some of the best programs I have seen in food and eating are student led. Some of the most innovative work around drug reduction is student led, working with the local municipality and various agencies et cetera.

The whole Shape Up Europe program is based on this theoretical model of building young people's action competencies in negotiation, compromise, working in groups et cetera, with some lovely stories. Incidentally their website has all their case studies and stories printed; it is just terrific to look at it and read. It has got a lovely little summary of what works and what does not work — pages 39 to 41 — that is nice to get to, and it is all on their website.

The CHAIR — Which website is that?

Prof. St LEGER — This is Shape Up Europe; it is easy to access.

The third dot point: we have forgotten a lot about what makes a good school, what makes effective teaching, good leadership et cetera, and a health promoting school is a good school. You cannot get health promoting initiatives going unless the school meets good educational criteria, and so there is 30 years of evidence about what makes a good school, and a lot of the health promotion initiatives have failed because the school has not been following good educational principles and practices.

The most important health topic, if people want to think about health in terms of topics, is without a doubt mental health. The recent reviews for the Health Evidence Network have been mainly led by Oxford University and various people like Sarah Stewart-Brown. In her presentation recently to the international conference in Vilnius, Lithuania, she argued comprehensively about mental health as the way to go. That has been reinforced by the Gatehouse Project, our own brilliant initiative funded by VicHealth here in Melbourne, with 25 schools and a control group, and also Robert Blum's studies in the USA, where he has followed 94 000 kids from upper primary through to secondary and young adulthood. He and all the others who have done this say that the most important thing for young people in schools is to build their connections. The more connections they have with other kids in the school, horizontally at the same year level and vertically with buddy systems et cetera, the better.

We have actually seen changes in food and eating and some of the traditional health topics, such as obesity, with a mental health approach, without often mentioning some of the health problems. I can quote a whole lot of research where we have had health gains without the health topic being in there and of course wonderful educational gains.

No. 5: there is often dissonance between the education and health sectors about what school health is on about. We have VELS; all countries have a health curriculum, a framework, and they are similar. I have done reviews of many of them. The overlap is incredible. We have got the same areas, and the curriculum guidelines have words like 'identify', 'describe', 'understand', 'know about' — all the sorts of things that you would expect a school to do to build cognitive capacities.

The health sector wants behavioural changes, and rarely in the educational mandate for schools in its curriculum guidelines do you see behavioural words in terms of health behaviours. You may see a few in physical education — to be able to catch, throw, balance et cetera — but largely you do not see these. That is not a criticism of education. Education is primarily a cognitive pursuit. There is a training aspect and an affective domain; however, there is a dissonance, because the health sector comes in with morbidity and mortality — it is the drug model; an intervention — so in you go, and then you look for behavioural change measures. So there is often dissonance.

Effective school community health promotion puts a huge demand on teachers and resources, but most of the work is done outside the classroom. When it is done it underpins educational outcomes beautifully, and again I can talk about lots of evidence and stories.

The most effective school community health-related actions occur over at least five years. I make the point that dosage is important. When we go to our GP and we have got a bacterial infection the doctor will invariably say, 'Don't forget to take the full course of antibiotics'; rarely do we take two or three. Sadly in health we have projects, sometimes programs, over two or three years. You need five to seven years before you are going to get any change. You need some sustainability and some things built in. You do not teach literacy and numeracy over two years or three years, and so sadly a lot of schools are expected to get outcomes, and that is why many of their health-related outcomes are zero. It is not because of the fault of the school or perhaps the theoretical design of the program; the dosage is not there.

Finally, point 8: there are now tested, accepted and practical guidelines. It is very sad that most teachers in Victoria, even though these guidelines have been around, do not have access to these. The ministry was not aware of them until I went and visited them and said, 'Do you know about these?'. The answer was 'No'.

My opinion is that there is not a mechanism for dissemination of these to help schools in their practices. After all, you would know that most schools are fairly autonomous, whether they be state, Catholic or independent schools. It is sad that in many countries the distribution of these, or adaptations of them to make them culturally specific, have occurred and they have not occurred in our own state.

I do a lot of work in South Australia and many other countries, and it always worries me that things do not seem to be happening here. I am not laying any blame, but sadly we do not have enough people in the ministry and we do not have enough people aware of some of the evidence and what we need to do to help schools.

That is what I would say initially, and I am only too happy to respond to questions.

The CHAIR — To follow on from your last statement, could I ask what South Australia is doing differently to what we are doing here?

Prof. St LEGER — They are making things more accessible to their schools. They are looking at some initiatives in the regions. I have been assisting them in the northern suburbs — some of the poorer socioeconomic areas. I am about to assist them, over a year or so, in Port Augusta. Generally when I go over there, there is a greater familiarity with these sorts of things. There is also a very astute local government network which is doing some wonderful things working with schools.

We have some of this here. You might have heard of the JAM for Kids project, funded by the commonwealth — Just a Minute for Kids — that was auspiced by the City of Maribyrnong in collaboration with IBM, NAB and Ford. It is a wonderful example of how you can get kids, community and business working together with schools.

There is innovation happening here, but generally I do not find much support for schools from the ministry. Again I am not criticising the people; they are underresourced in terms of helping school communities and regions with evidence and steering them into projects, programs and ideas that may have been successful.

Mr DIXON — When the children arrive at primary school most of their learning happens in the first five years of their life. To what extent is that applicable to a healthy lifestyle and their health? In other words, are we just wasting time, or can we make real differences once they are actually in school if they have had those first five years where health has not been on the top of the list of the family or the community they have grown up in?

Prof. St LEGER — You all know about the early years and the importance of early years. Some of the best initiatives in promoting health in schools occur in the early years in primary schools. As you have probably seen from my brief CV, I work every year with the Hong Kong special region. Some nice funding has gone into that, and some brilliant work has been done in school communities. I would love to take you with me every time I go up there, and it happens elsewhere.

Clearly we have got to put much of our energy upstream rather than in year 10, 11 and 12. Primary schools are a little easier to work with than post-primary because the curriculum is more flexible and kids do not move from room to room to do subjects; they have an educational experience, and there are better chances of integration.

You are absolutely right. The evidence again — I go back to it — is overwhelming. The more the primary school does to build the competencies of kids, the more the kids feel as though they have got some say in how health is initiated within their family and school community and the better they are likely to be. The sad thing is that when they come into secondary schools they are at the bottom of the pecking order. I evaluated part of Mind Matters a few years ago, and some of the best secondary schools I saw were where they had many students in the first two or three years of secondary schools. That is all about mental health and building kids' self-esteem, connections and all that. I had better be careful and not tell you all the stories from everywhere.

The CHAIR — Some of that is very useful.

Mr HALL — Thank you, Lawrence, for your presentation and the submission you have made to us. With respect to the seventh point you made here about the most effective school-related outcomes and the need to have some sort of sustainability in programs to produce better outcomes, can you give us any practical or real examples of things that have worked well over a period of time and things that have not worked well because of the brief period of time in which they have been funded and implemented?

Prof. St LEGER — I will start with the not-so-good things. Generally drug education is probably down the bottom of the pecking order in terms of its effectiveness, but it tends to get most of the funding for reasons that all of us would understand. If only that funding was tweaked to build programs around mental health and wellbeing rather than health around drugs and substances.

Physical activity and sexuality are middle range in terms of effectiveness, but again the evidence is they only work if there is a prolonged period of time and if kids are active for several times during the day rather than the one-off session, and also if they get a chance to have a say in the activities and where they might design their own rules and games. It is even better if they are connected into a local community.

I heard you tell the little example in Gippsland. One of my research schools in Ballarat some years ago entered all the kids in the primary school in Saturday morning sport. It did not matter whether it was E grade, they got better connections with the parents and the kids learnt some skills. All of a sudden they went on and joined their clubs et cetera. There are lots of wonderful examples about this.

The difficulty is when you look to evaluate these things you are looking for dosage — I will use that word ' dosage' — that is, five to seven years to get any gains. You are looking for integration and connection with the curriculum rather than a project or something that is outside, otherwise you do not get buy-in from the whole school community. You are also looking for the kids to largely be involved in running it in collaboration with teachers and other people where they have got a sense of ownership.

In the work I have been doing in New Zealand at every school I go to I meet the health council. The first time I met the health council I assumed they would all be adults. This group were primary school kids, years 5 and 6. They took me on a tour of the school, took me to lunch and then said to me, 'Is there anything else?'. I said, 'I have loved all of this. I would love to meet the health council. This is why I am here'. They said, 'We are the health council'. You should have seen what that school was doing. It was just fabulous work. The teachers were the coaches, the mentors, the leaders, as were some of the people from the community health sector and other organisations. That is this whole business of action competencies and kids being in power.

The things that work are sufficient dosage and a mental health perspective. I will not rehash it, but there is a column in there headed 'What works', and it includes creating a climate where there are high expectations of students in their social interactions and educational attainments, and providing resources that complement the fundamental role of the teacher and which are of a sound theoretical and accurate factual basis; all of these.

We — and when I say 'we', there are about 300 who have developed this — have not put in what does not work. We have put in a heading, 'Issues which have the potential to inhibit'. If you read that, you will find out the things that do not work.

Mr HALL — I am not sure you were here when I mentioned previously to the first people who made submissions this afternoon programs like You Can Do It!, which is a program that some schools implement over the full life of the school where that teaches, in part, tolerance, self-esteem, confidence et cetera. They are the sorts of embedded programs over a sustained period of time that you argue work best.

Prof. St LEGER — Yes. People will ask me to look at some things. I will look at how long it goes for, whether it is of a sound theoretical basis, whether there is a focus on the students having a leadership role within it and if it has connections to home and community — all those sorts of tentacles go in that are reciprocated.

You will find that programs that are around some of those principles, if you like, will work provided all those factors are there. Sadly they are often funded as projects and then the school does another project and another external group — the environmental movement, for example — might get a guernsey for two or three years. The poor old schools have got all these projects. The curriculum is an area of contestation. Health is often one of the areas that is slotted in. The principal will say, 'We've probably done enough health for a few years. We had now better do something about the environment'.

Schools could rethink the way they do their health and environment. There is nothing much wrong with VELS or the framework of VELS, but a lot of these ideas actually add value to the core areas of numeracy and literacy. Again, I will not walk you through it, but you can imagine how that happens. A few of the Shape Up schools in Europe did surveys initially, and they would connect in with what the kids wanted about food and eating and what were the issues. They are now doing practical numeracy, and then they had to write letters. There is a lot of evidence about what works and what does not work, and the point you make is a very valid one.

Mr HALL — Thank you. How important in your opinion are non-educational professionals like school-based nurses, for example, or chaplains in terms of the whole wellbeing of the school?

Prof. St LEGER — Important, provided their work is subordinate and complementary to the work of the teacher. Where they are seen as the experts giving the class on sex education, or if they are a school nurse talking about food and eating or whatever and the teacher is not involved and there is no connection back to the learning program, they have no impact. This is a challenge. I have just been invited again to talk to the school nurses about how to work that. Most of them actually know the principles of these sorts of things. Getting a spot in a secondary school is really difficult, because they get the problem spots. Getting a spot in a primary school is easier, because they are much more integrated into the program. There are some wonderful people out there. Their roles are not well understood. They could be more effective if the school community understood them more.

Mr HALL — In respect of the first and fourth dot point you made in respect of mental health and the importance of the building connections — and I agree entirely with that — the long time that it sometimes takes to build those connections and to grow self-confidence can be destroyed so quickly in the case of bullying or something like that in schools. Are there things that we can put in place to fireproof some of the good work that we do and to deter the loss of all that good work through a single incident of bullying?

Prof. St LEGER — I think the schools that address this pretty well can cope with the occasional incidents, which might be some negativity or whatever, if they have got a program in and they have got a mechanism.

I saw this in Girrawheen secondary school. It was a basket case school, according to the principal, when they started. It was a secondary school; it had no year 12. The students would not stay on. Bullying was endemic. It is a nice little example because it reflects on a lot of the principles. The school principal said, 'What should I do to get you to come to school regularly?'. They talked about activities and created a whole series of activities and worked with the community. They had mini-schools. He hand chose primary teachers to run the mini-schools, not secondary teachers. The secondary teachers were more the apprentices. The students made the school rules, and they were simple. It was a red and yellow card system. They took them through a process, and they signed off on it. They signed off on three things that all students would uphold, and this was done through consultation, the students with students: 'We will come on time. We will come prepared. We will participate'. I sat in classes

watching their school rules in operation. It was a tough school in a tough area, with wonderful teachers. All of a sudden attendance rates were higher, there was less bullying and visits by the police were fewer.

Cut to some years down the track when my sister-in-law who lives in WA sent me the Western Australian league tables of year 12 results. This school came in the top 20 and beat four of the most prestigious independent schools in year 12 results. The simple lesson in all of that was that when kids want to come to school, when they really want to get out of bed and come to school and when they want to learn, and when they have a say in their learning environment, they will learn brilliantly and a whole lot of other problems around bullying and the like will diminish, particularly if you teach them negotiation skills and problem-solving skills.

There have been lovely examples recently in many programs where they work with the local municipality to look at some of the issues going on in their town or in their city or their suburb. They have to think about negotiating, so they learn, if you like, citizenship stuff — what is a compromise, making a case, making an evidence-based argument. All of that complements the standard curriculum — looking at evidence, interpreting it, discussing it.

Again I could take you through stories. There is the wonderful story I will just mention of a poor suburb in Toronto where the 10-year-old kids, year 4, managed to get drugs off the street in the local community. I kid you not; it has been written up in many articles and journal publications. They did that in collaboration with the community health centre, the school community and working with the police et cetera. It was a two-year study, and they managed to get major changes because their big issue was not drugs, it was safety, and they constructed the issue in their terms. Those kids who came out of it had more wherewithal as, if you like, informed citizens at the age of 10 than those students who had been compliant and had sat there and been recipients of instruction.

Mr HALL — Those examples are your examples of empowerment.

Prof. St LEGER — They are examples of empowerment. As I said, I could run through these, but as an academic who has been responsible for and party to a number of international groups looking at the evidence — and we debate what the evidence is — I just need to reassure you that the evidence is overwhelming. It is not my opinion about these things; the evidence is very strong. We do not see enough of the evidence being disseminated to our practitioners, and we do not see enough of the evidence being understood and interpreted and reshaped and positioned and adapted to the local environment.

I make the plea: ministries of education and employers have an obligation to get the evidence out to the employees in ways that are appropriate. As you see from my CV, I chair the Cabrini Institute for health and medical research, and I am involved in a number of other organisations. The health sector generally gets the evidence to the practitioners. Sadly, in education in this domain — I cannot talk about some other areas — we have not been able to get the evidence out to people to be able to do these wonderful things. We know from the studies, the programs, the projects, that when they get some good theory and a little bit of money, they get some momentum, some consultants, whatever, wonderful things will happen. We have done cost-benefit analyses, and the returns are brilliant for the investment, but sadly the investment often finishes after three years.

That is a major plea to you to try to get our practitioners on the ground — and I am not talking just about teachers, but the principals, the parent communities, the school councils, the school nurses and chaplains and the people in different circles around school; get the evidence out to them and help them understand it in ways that are appropriate.

Mr ELASMAR — Talking about other countries, which country do you believe is leading the way in health promotion, and how do you compare Victoria to that country?

Prof. St LEGER — I have been to many. I have worked in Mongolia on six occasions, and it is tough and wonderful. Being a more totalitarian country, they mandated — I wrote guidelines for this particular region for WHO in 1995, and they were 30 pages. When I say 'wrote', I drafted them. We had all the member states, 32 member states, in the region. The more totalitarian ones like China and Mongolia mandated them for schools. They were guidelines. I kept saying, 'They are guidelines'. I saw some brilliant work in some very poor schools in Mongolia because they were following what were different sets of these but similar in many ways.

There is some wonderful work being done in Denmark — brilliant. I was privileged to see some superb work in many of the Canadian provinces. There is lovely work in New Zealand. They have got a wonderful health promoting schools network. There is infrastructure and some terrific stuff in New Zealand and great stuff around the regions. I go there every year. Last year I spent a week around Rotorua and saw just how the Maori community, the health sector and everyone is working together. I was privileged to work with the students. I worked with all the health councils for a day, and to hear these kids from the ages of 7 to 14 talking about issues that most adults cannot comprehend was just superb and what was going on in their schools.

Lovely work is being done throughout Europe and some terrific stuff in the States. There are some nice things going on in our own schools, but it is has often been dependent on VicHealth money or Healthway money in WA. Australia is often held up for its innovation, and we can get that. So there is a lot to learn. It was fascinating; we had two of the top gurus, Ian Young from Scotland and Bjarne Bruun Jensen from Denmark, present at the conference on health promoting schools last year in Adelaide, and over 300 people turned up to that. When they did their presentations there were some wonderful things being done. However, we ran out of funds — the usual story.

It is not all bad here; it is just that we have not provided people with some basic fundamentals to assist the innovation and creativity. We tend to provide them with problems to solve and packages. A package may be useful, but you let the school community choose the package where appropriate, because it might not be for them.

The CHAIR — It seems you are focusing on mental health as the top of the issue, and so the phys. ed. and the eating things — —

Prof. St LEGER — Yes, they all follow.

The CHAIR — They flow on rather than be the focus.

Prof. St LEGER — Yes. I could give you nice little stories where by cutting the curriculum teaching time and having kids being active, say, five or six times a day, you get better educational outcomes. With taking all the caffeine-based drinks out of the machines in the school, changing what they eat so that blood sugar levels do not go up and down during the day, you get better concentration et cetera. I mean, we have seen our schools do this. The governments mandate for safety in schools. I wish our governments would mandate for food safety in terms of biological variations in learning rather than leaving it to the school councils. That is just a quick little aside.

There is also a belief that school canteens are there to generate money to buy extra computers and things. They are there primarily as a health service, not as a money-generating exercise, and it is a fallacy to say that an unhealthy food generates the most money. I have seen canteens around the world with healthy options for kids, brilliantly organised and where the kids are involved, generating more money than when they had unhealthy food.

Mr ELASMAR — The parents really play a role, because, let us say, for most kids from year 1 to year 10 their parents prepare their lunch, so if the parents are not educated enough about what to prepare for their kids, you cannot blame the school, can you?

Prof. St LEGER — No, but in the provision of what food it serves the school needs to be very careful. The beaut thing about the Kitchen Garden program is that the kids are teaching their parents about healthy diets and often doing the food preparation at home. It is a lovely spin-off where you look at affecting the community.

The CHAIR — Thank you for your contribution, and the other material you have provided us with or directed us to will be very useful for us.

Prof. St LEGER — Thank you.

Witness withdrew.

C O R R E C T E D V E R S I O N

EDUCATION AND TRAINING COMMITTEE

Inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living

Melbourne — 31 August 2009

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Dr S. Honisett, manager, Kids — Go for Your Life.

The CHAIR — The last presentation in this public hearing is from Dr Suzy Honisett from Kids — Go for Your Life. Thank you for coming along. We have some material that was provided additionally, but we are pleased to hear from you to expand a little more on some of the programs you are promoting and to get further advice from you.

Dr HONISETT — Great, thank you. I thought I would start with just a short presentation and then allow lots of time for questions, but before I get into that presentation I want to say that we really welcome the inquiry by this committee and thank you for the opportunity to present today.

You have had a long day today, but you would have heard from previous speakers about the important role of schools in supporting and creating healthy behaviours for children and about the importance of a health promoting schools approach. I am not going to focus on these points in my presentation, except to say that I agree with and support those points.

You have my submission, so you know that Kids — Go for Your Life is the primary health promotion program under the Victorian government-funded Go for Your Life initiative. It aims to improve healthy eating and physical activity for children, and in doing so to reduce the risk of children becoming overweight or obese. To do this we work with schools as well as early childhood services using a health promoting schools approach to support healthy eating and physical activity through an award program. The award program is really there to support policy and practice changes within the primary school and early childhood environment. It is a comprehensive approach. It is based on evidence and best practice to improve healthy eating and physical activity. It works not only with schools but also with the broader community. The program is funded until June next year.

There are really two points I want to focus on in my presentation. Firstly, I want to speak about Kids — Go for Your Life and how this is an excellent model for promoting healthy community living through schools. Secondly, I want to present ways to further coordinate and support the work of this program through schools and the broader community to get better outcomes, not only for the program but for children's health and well-being.

There are really three reasons I present my first point, which is that Kids — Go for Your Life is an excellent model for healthy community living. The first and main reason is that the program works. Our research is showing that Kids — Go for Your Life award schools have a significantly higher rate of adoption of policies related to healthy eating and physical activity in comparison to those schools that are not awarded. They also have a significantly higher number of health promotion activities related to water, fruit and vegetable consumption, a reduction in unhealthy foods and drinks at school, active transport, a healthy eating curriculum and community engagement. The program is effective in improving policies and practices within a primary school environment.

The second reason this is an excellent model is that Victorian parents and primary schools see the value of the program. For example, throughout the development of this program we interviewed many school principals and teachers to get their input into the development of the program. We found that they saw the program as very doable and they saw their role in implementing the program.

We currently have over 928 primary schools across Victoria involved in the program. That represents 55 per cent of Victoria's Government primary schools, 40 per cent of Victoria's Catholic schools and 14 per cent of Victoria's independent primary schools. Member schools are influencing the health and behaviours of over 216 000 Victorian children. Member schools are represented across 98 per cent of Victorian local governments. This shows that the program is acceptable and feasible for all schools, regardless of whether they are in a metropolitan, rural or regional area and regardless of their level of advantage or disadvantage. This data also demonstrates the acceptability and feasibility of the Kids — Go for Your Life award program to engage schools and create healthy changes to their policies and practices. Our target for the next financial year — that is, by the end of June 2010 — is to have 70 per cent of all Victorian government schools involved in the program.

That is a little bit about schools. We also know that when we surveyed parents, 97 per cent of those parents responded that they would support a program such as Kids — Go for Your Life being run through primary schools to help encourage healthy eating and physical activity. The value of this program is recognised not only by the schools — given the high uptake and involvement in it — but by the parents as well.

The third reason this is an excellent model to promote healthy community living is that the program provides a great deal of support outside of schools to promote children's healthy living. We have mobilised over 400 health professionals across nearly all local government areas in Victoria to work locally with schools and early childhood services. They are supporting schools and services to join the program and work through a process of changing policy and practice and become Kids — Go for Your Life award schools.

We have been funding 10 local governments over the last three years to influence local action around healthy eating and physical activity for children and, again, to support schools and services in their local government area to get involved in the program and make the relevant changes to their policy and practice. And we provide information to families about healthy eating and physical activity messages. From this we are seeing higher recognition of our messages by parents in Kids — Go for Your Life award schools. The recognition of those healthy messages is even higher in those schools that have been awarded for greater than nine months. The longer they are awarded, the greater the recognition of those healthy messages. This is a comprehensive approach to healthy eating and physical activity for children.

In summary of my first point, Kids is an excellent model for promoting healthy community living through schools because it works. Its value is recognised not only by schools but by parents, and it supports healthy living through the broader community.

This leads me to the second main point I want to talk about in my presentation today, and that is to present some ways to further coordinate and support this program through schools and the community to get better outcomes for children's health. We know, based on feedback from schools through the Kids — Go for Your Life program, that they are experiencing confusion and fatigue with the high number of programs and grants focusing on healthy eating and physical activity that are available — Healthy Start grants and Free Fruit Friday to name a few; you would have heard about some more today. It is a busy environment and with all of these programs coming separately to schools it can really create confusion and ultimately disengage schools and dilute programs that are evidence-based and shown to be effective and to provide defined and measurable outcomes for schools.

I briefly want to mention four ways we could improve the coordination of these programs and increase outcomes. Firstly, future Department of Education and Early Childhood Development and Department of Human Services funding and programs that focus on healthy eating and physical activity within primary schools be implemented in a consistent policy direction and used to drive involvement for schools in the Kids — Go for Your Life award program and to support them to meet all the policy and practice changes that are required for them to be awarded as Kids — Go for Your Life schools. This would lead to a more coordinated approach across Victoria, help to reduce confusion between programs and lead to greater school engagement around the issue.

The second way forward that I can see is through greater directives from the Department of Education and Early Childhood Development to be involved in this program. The most successful promotional campaign for increasing schools' involvement through the Kids — Go for Your Life program included a letter sent to all government schools that was co-signed by the ministers for health, education and children. The increased involvement directly attributable to these letters represented 34 per cent of our overall increase in government primary schools over that year. Greater support and directives from government are effective in increasing involvement.

Thirdly, dedicated staff being available within the regions to support the program. Greater membership and achievement in the Kids — Go for Your Life award could also be promoted by existing government staff, such as student health and wellbeing coordinators, school nurses and even regional education directors. Utilising these existing roles to promote and support the program would lead to greater engagement of schools in the program and therefore more schools with healthy policies and healthy practices supporting greater outcomes for the health and wellbeing of Victorian children.

My final point, which I see as very important, is that Kids — Go for Your Life is only funded until the end of June next year. It has been funded since 2005 but, as Lawrie mentioned in his presentation — I was not here for that presentation, but I am sure the previous presenters would say that we need an ongoing and sustained approach to the issue. I would suggest that funding for the Kids — Go for Your Life program continue and be

expanded from 2010 onwards. That concludes my short presentation. Thank you, once again, for the opportunity.

The CHAIR — Thank you, Suzy. You say you have got 55 per cent of government schools involved. With the 45 per cent who have not been, are we identifying a particular profile? Is there need then for government or other bodies to look at finding means of supporting those schools so they can be involved or so they wish to be involved?

Dr HONISETT — Yes and yes. To the first point, we know that there is quite a number of schools that are not involved so far. When we undertook our formative research for the program we interviewed schools that were involved and we interviewed schools that were not involved to really ascertain why. Why were they not getting involved? What keeps coming back to us is that time is an issue and priorities are an issue. We are not ever going to get, probably, 100 per cent of schools involved, but we can get higher than 55 per cent; that is for sure. Time and priorities are the main issues as to why they are not getting involved.

The second part of your question was what can we do to increase this rate. It really comes back to the second point in my presentation, which was the need for greater directives from education and government to say that this is an important program; we really need you involved. We need support on the ground through existing staff which is funded through government. We need to support the schools on the ground so that some of those time issues can be supported and assisted by on-the-ground staff to support the schools locally. I hope that answers your question.

The CHAIR — Yes, that is good. The other question I would like to follow up is you are focused on primary school years. What needs to happen then at secondary level to consolidate some of the things that might be going through your program?

Dr HONISETT — I think that is a really important point. The Kids — Go for Your Life program works with child care and kindergarten and primary schools, so we are getting a progression of learning and education and support that is happening for the very young right through to 12. Beyond that it really falls off. If we could have a progression beyond the program that works with secondary schools, that would create a continuum right through the education years of a child, which would be excellent and very beneficial of course.

Mr DIXON — Could you just tell us, Suzy, about the parents' involvement? I would imagine the things you are tackling are as much the things that happen at home as they are at school.

Dr HONISETT — That is right. It is a requirement of schools that join and become awarded that they set up a committee to work through the award program. That committee would generally revolve around the school council. Often we will have involvement by the student representation council so we have parents involved at that level. We also require schools to communicate and engage with parents around healthy eating and physical activity messages. One of the ways that they can do that is during transition periods. When new preps are coming to the school they are presenting to them about the policies that are required for the school and this is what is required to go in a lunch box or not go in a lunch box, or what we would encourage. We also ask them to communicate home to parents in their newsletters. That is where we are getting the significant increase in knowledge among parents around the healthy eating messages, through those streams.

Mr DIXON — How do you know you are getting that message through? You say you are getting the message through; how do you know that?

Dr HONISETT — We surveyed parents.

Mr DIXON — Okay.

Dr HONISETT — And we presented our healthy messages to determine whether they had actually seen them before, to really determine their recognition around those messages.

Mr ELASMAR — The survey would be taken every year to the parents or once in a blue moon?

Dr HONISETT — That is an interesting question. We are only funded until June next year, so we need to think this in terms of it being ongoing. Ideally it would be nice to undertake an ongoing survey on an annual basis to really see the progression of awareness and knowledge around that. That is what we would recommend.

Mr HALL — Suzy, if I walked through a school and there was a sign on the gate, 'Kids — Go for Your Life school', what things that are different would I see in that school compared to the one in the next suburb which is not one of your schools? What are the different things that I would notice in your school?

Dr HONISETT — Some of the criteria for the award program — perhaps if I talk through those it will give you an indication. Schools are required to ensure that children have water-only water bottles on their desks. They can be drinking water at any time through class. There are no other drinks that are allowed in that water bottle: not fruit juice, not cordial, but water-only water bottles. They would have a defined fruit and vegetable break at some time through the day. Their canteen would not be selling, in line with the education policy, confectionary, soft drink or fried foods. They are only allowed to serve fried foods twice per term. There are quite significant changes in their canteen. They would be adhering to their PE mandate, which is required anyway. They would have opportunities throughout recess and lunchtime when students are active — whether that is supported sports or supported games or lots of equipment being available. They would have very defined policies around healthy eating and physical activity, which is really important to ensure that those messages are sustained and ongoing in the school and picked up in the ethos of the way the organisation rolls out. They would be including healthy eating and physical activity right across their curriculum, and they would be engaging and promoting those messages to parents.

Mr HALL — Okay. Good-o. So you have only been going since 2005. Basically it was a five-year funding program?

Dr HONISETT — No, it was two and then three. The team and myself started at the start of 2006. We spent a year very much developing the program and trialling the program, and we started to roll that out from 2007. It is quite a short period of time in the scheme of things.

Mr HALL — While Go for Your Life has been a government program for a long period of time, the Kids — Go for Your Life has only been around since, as you said, 2005 when you started developing the program. Was it an initiative of government, or was it the Cancer Council and Diabetes Australia?

Dr HONISETT — It was an initiative of government to fund it, and obviously the Cancer Council and Diabetes Australia won that tender and developed the program from there and has been managing it and evaluating it from then.

Mr HALL — As schools have signed on to the program have they stayed with the program? Have you had much changeover?

Dr HONISETT — We actually ask them to renew their award every two years, so it is not just tick and go; it is coming back to it on a regular basis to say, 'Yes, we are still doing that'. When we evaluated the program what we found was that they are becoming awarded, meeting those minimum standards, and then over time they are adding to that and growing in terms of the healthy eating and physical activities that they are doing.

Mr HALL — So your review is being undertaken at the moment — —

Dr HONISETT — The evaluation?

Mr HALL — The evaluation, yes. Who is undertaking that?

Dr HONISETT — Melbourne University is undertaking the evaluation. We also have an economic evaluation of the program that is being done by Deakin University.

Mr HALL — That evaluation is for the government? Have they undertaken that? Or have you undertaken that evaluation?

Dr HONISETT — It is part of the program. It is important for us to have a very defined feedback loop for the program so that we can continue to learn and refine the program and ensure that it is working. There is no point doing it if it does not work.

The CHAIR — That has been very helpful, Suzy. Thank you.

Committee adjourned.