
# Education and Training Committee

# Final Report

# Inquiry into the Potential for Developing Opportunities for Schools to Become a Focus for Promoting Healthy Community Living

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Education and Training Committee

Inquiry into the Potential for Developing Opportunities for Schools to Become a Focus for Promoting Healthy Community Living

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# Education and Training Committee

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# Chair's foreword

From both the physical and the mental perspective, health is an issue of considerable importance for all. Childhood and adolescence is the time when we establish the behaviours and skills which are essential to a successful, healthy and happy adult life, and schools can play a vital role to support the development of these healthy life practices.

The Committee was impressed by the wide range of activities and strategies undertaken within Victorian schools to support and improve the health and wellbeing of not only school students, but also the broader school community. The Committee found that while these initiatives are mostly highly successful, schools may need assistance to better coordinate their programs and to approach healthy community living from a comprehensive whole-school perspective. In particular, the Committee has found that schools could benefit from access to health promotion workers to assist in the development, implementation and evaluation of school policies and health promotion initiatives. The Committee also believes that schools should have opportunities to celebrate and promote their health program successes to the broader community.

The Committee welcomed the substantial input to this inquiry from members of the health sector. This input provided highly valued advice to the inquiry and highlighted the many opportunities for the education and health sectors to work collaboratively to promote healthy community living.

This was the sixth and final major inquiry undertaken by the Education and Training Committee during the 56th Parliament. I wish to thank my fellow Committee members for supporting me as Chair of the Committee, and for their participation in this inquiry and commitment to all of the Committee's activities over the past four years.

Finally, I would also like to thank the staff of the Committee secretariat for their dedication and high quality work throughout this parliamentary term. This current inquiry has been a substantial undertaking for the staff who have coordinated the public hearing program, analysed a substantial body of evidence and assisted the Committee to produce this report.

Geoff Howard MP
Chair

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# Executive summary

## Chapter 1
## Introduction

The need for health promotion is now accepted worldwide. This new focus on preventative health means tackling negative health behaviours before they emerge. Governments have a range of strategies to deal with this, with schools increasingly being seen as an appropriate setting for delivering health promotion messages to children and teenagers, and their families.

The Committee found a consensus among the education and health sectors that schools have a legitimate and important role in promoting healthy community living. As is recognised worldwide, education and health are inextricably linked. Higher levels of education are associated with better employment outcomes, healthier lifestyles and higher levels of family and community wellbeing. Equally, good health and wellbeing is a necessary precondition for effective learning. Students with poorer health status have lower academic achievement than their healthier counterparts.

Schools have a number of key advantages as a setting for health promotion. They represent an effective way of universally targeting children and young people (and their families), who spend a significant proportion of time interacting with the school environment during and after school hours. Schools provide existing infrastructure for health promotion and have links to several influences on children's health, including family, peers and the local community. Schools can also provide a 'gateway' through which health information and messages can be conveyed to the wider community and a venue for the delivery of health related services and activities.

Nonetheless, the Committee found that schools often experience a range of challenges in delivering health promotion initiatives to the school and local community. These may include: the competing aims and interests of the health and education sectors; the sheer number of programs and initiatives on offer; the often ad hoc, short-term nature of programs and projects offered to schools; the lack of ongoing funding to ensure the sustainability of proven programs and initiatives; unrealistic expectations in terms of long-term health outcomes; variability in the quality and credibility of programs; inconsistencies in health messages presented in schools, homes and the broader community; and lack of coordination, communication and cooperation between various levels of government.

## Chapter 2
## The Health Promoting Schools framework

The Committee found a strong, worldwide trend over the past twenty to thirty years towards comprehensive, whole-school approaches aimed at improving and protecting the physical, mental, social and spiritual health of all members of the school community. The Committee examined this trend in the context of the internationally recognised Health Promoting Schools framework.

A health promoting school is a school community which undertakes a broad range of activities aimed at strengthening its capacity as a healthy setting for living, learning and working. The two key purposes of health promoting schools are: to enhance educational outcomes; and to facilitate action for health by building health knowledge and skills in the cognitive, social and behavioural domains.

There are six essential elements of a health promoting school: healthy school policies; physical environment; social environment; individual health skills and action competencies; community links; and health services. Health promoting schools are most effective when supported by an overarching government and/or local education authority policy, especially one established through a formal partnership between the health and education ministries.

Within the school, the first step in implementing the Health Promoting Schools framework is to achieve support of the school leadership team, and to then create a small group which is actively engaged in leading and coordinating health promotion actions and activities. It is essential that all stakeholders are represented on this group, including teachers, non-teaching staff, students, parents and community members. The group's task is to conduct an audit of current health promoting actions, establish agreed goals and develop strategies to achieve the goals within the capacity of the school's resources.

The Health Promoting Schools framework was introduced in Australia during the 1990s, and piloted in Victorian government schools from 1997 to 2000. Participants in the inquiry therefore generally had a high level of awareness and understanding of the model. The Committee found that many Victorian schools, communities and regional networks are currently trying to re-establish and strengthen the implementation of the Health Promoting Schools framework, with many inquiry participants arguing for its statewide implementation.

The Committee believes that the wider implementation of the Health Promoting Schools framework has the potential to achieve improved health and education outcomes for many Victorian school communities. The Committee therefore recommends that the Department of Education and Early Childhood Development review the development and implementation of the health promoting schools approach in Victoria. In doing so, the department should aim to: establish realistic goals and expectations for school health promotion; guide policy and practice at the regional and local level; facilitate effective collaboration between the health and education sectors; identify the health promotion competencies required by school staff to successfully implement health promotion programs; coordinate and sustain the wide range of health and wellbeing programs and services already being implemented in Victorian schools; ensure longer-term funding for proven school-based health promotion initiatives; and improve the dissemination of information about the effectiveness of health promotion activities within schools. The Committee believes that this work should be underpinned by a signed partnership agreement between the health and education departments and the establishment of an interdepartmental committee responsible for planning and implementing a coordinated approach to health promotion in schools.

The Committee also recommends that the Department of Education and Early Childhood Development implement a formal recognition and award program to acknowledge and celebrate outstanding achievements by schools, communities and individuals in promoting healthy community living.

# Chapter 3
# Curriculum, teaching and learning

Under the Health Promoting Schools model, health related curriculum and extra-curricular opportunities should be complemented by teaching and learning approaches which support health and wellbeing.

The Victorian Essential Learning Standards (VELS) outline the curriculum components that all Victorian students should learn during their time at school from prep to year 10. Although the VELS incorporate three essential learning strands, the Committee found that the Physical, Personal and Social Learning strand was of particular importance in the context of this inquiry. This strand includes four domains: Health and Physical Education; Interpersonal Development; Personal Learning; and Civics and Citizenship. Of these, health and wellbeing is covered explicitly within two key domains: the Health and Physical Education domain and the Interpersonal Development domain. These domains include the important dimensions of Movement and Physical Activity, Health Knowledge and Promotion, Building Social Relationships and Working in Teams.

The Committee found that the highly flexible structure of the VELS is a key advantage in the context of student health and wellbeing, as current and future health promotion initiatives can be easily incorporated into the curriculum. Nonetheless, for a whole-school approach to health and wellbeing to be successful, the support and commitment of the school leadership team, health and wellbeing champions and the other teaching and non-teaching staff are required. The Committee found that this can be achieved through the establishment of a school-based health and wellbeing team in all schools, backed up by appropriate professional learning opportunities for staff. The Committee believes that schools' health and wellbeing teams should also be supported by a network of health promotion coordinators who could best be based in the Department of Education and Early Childhood Development regional offices.

## Chapter 4
## School ethos and environment

A health promoting schools approach requires schools to move beyond traditional curriculum-based approaches to health promotion, and to consider a broad range of school-based factors. Throughout the inquiry, the Committee examined the various components of the school ethos and environment, as well as a range of specific programs aimed at promoting the physical and mental health of members of the school community.

The Committee found that education systems develop a wide range of policies and resources aimed at supporting health and wellbeing for all members of the school community. Within the Victorian government school system, these include the Effective Schools Model, Student Engagement Policy, School Accountability and Improvement Framework, Network Accountability and Improvement Framework and the Safe Schools are Effective Schools strategy. The Government Schools Reference Guide also provides advice for schools on a wide range of issues associated with health and wellbeing. School-based policies flow from these overarching policy frameworks.

The Committee found that although most Victorian schools have a number of policies which support health and wellbeing, often these policies have not been developed in a comprehensive and coordinated manner. The Committee heard that many schools would therefore benefit from assistance to audit their existing policies and develop a whole-school health promotion policy. The Committee notes that this work will be most effective when conducted in close consultation with all members of the school community, including teaching and non-teaching staff, students, parents and other community members.

The Committee notes that the physical environment represents one of the most tangible ways in which schools can demonstrate their commitment to supporting and improving the health and wellbeing of all members of their community. Schools can also enhance their social environment through a combination of the formal procedures and programs, extra-curricular activities and student welfare arrangements, as well as relationships within the school and partnerships with various members of the school and local community.

Throughout the inquiry, mental health and social wellbeing were repeatedly cited as health issues of extreme importance for schools. In particular, submissions and witnesses emphasised the importance of social relationships, anti-bullying policies and effective approaches for addressing the use of harmful substances. The Committee noted that the following programs have been recognised as best practice in responding to the mental health and social wellbeing needs of students: MindMatters, KidsMatter, the Gatehouse Project and Schools as Core Social Centres.

The Committee also received a substantial body of evidence covering various aspects of physical health. In particular, submissions outlined ways in which schools can encourage healthy eating, physical activity and sun safety as a means of achieving overall good health and preventing a wide range of diseases in later life. Some of the many programs and policies outlined during the inquiry included: school canteen policies, kitchen garden programs, breakfast programs, physical education and school sports, active travel programs, the Kids – Go For Your Life program and the SunSmart Schools program.

The Committee was pleased to note that the breadth and depth of health promotion programs currently available means that there is likely to be a suitable program to address the specific health needs of diverse school communities throughout Victoria. The Committee believes, however, that the sheer number of programs currently operating also presents various challenges for schools and the programs themselves. It appears that numerous programs and schools are all competing for a finite funding pool, and many beneficial programs are therefore not being embedded and sustained within schools. The Committee found that the most successful programs are those which are supported by high level government funding, which are retained and continue to evolve over a long period, and which are subject to ongoing monitoring and evaluation.

# Chapter 5
# Community links and partnerships

Perhaps one of the strongest themes to emerge during the inquiry was the importance of partnerships and community links in supporting school-based health promotion. Community links include the connections between the school and students' families, as well as the connections between the school and key local groups and individuals.

The Committee believes that it is very important to involve students, parents and families in making decisions about suitable health promotion activities for the school. This can be achieved through the establishment of a health promotion or school wellbeing team which is responsible for implementing a comprehensive, whole-school approach to health and wellbeing. Parents and families can also be involved in a range of health promoting activities initiated within schools, including accessing health information and services, participation in learning activities with students and participation in healthy eating or physical activities.

The Committee heard that health promotion in schools is most effective when it is supported by a range of partnerships at the local, regional and state level. The structure and purpose of partnerships vary considerably, ranging from networking arrangements through to formal collaborations. The Committee found that through these partnerships, Victorian schools access a wide range of community health services and health personnel, including immunisation services, health screening services, dental services, school nurses, health promotion workers, the School Focused Youth Service and Primary Care Partnerships. Many schools also have strong linkages with their local council, in recognition of the key role that local governments can play in building healthy public policy, creating supportive local environments and supporting school-based health promotion initiatives.

The Committee believes that it is essential that Victorian schools continue to develop and maintain effective partnerships with local health agencies, local government and the broader community, as a means of achieving optimal education and health outcomes for Victorian

students. The Committee recognises that this is sometimes time consuming and challenging for some schools, especially schools located in isolated areas and areas of socioeconomic disadvantage. The Committee therefore believes that the network of health promotion coordinators (as noted above) should be responsible for assisting the health and wellbeing teams of schools in their network to plan, develop, implement and evaluate their health promotion policies, strategies and programs.

# Recommendations

Recommendation 1:

That the Department of Education and Early Childhood Development, in consultation with the Department of Health, review the development and implementation of the health promoting schools approach in Victorian schools, with the aim of:

- establishing realistic goals and expectations for school health promotion;
- guiding policy and practice at the regional and local level;
- facilitating effective collaboration between the health and education sectors in planning, implementing and evaluating health promotion activities within schools;
- identifying the health promotion competencies required by school staff to successfully implement health promotion programs;
- coordinating and sustaining the wide range of health and wellbeing programs and services currently occurring in Victorian schools;
- ensuring longer-term funding for proven school-based health promotion programs and services; and
- improving the dissemination of information and evidence, including case studies and practical resources, about the effectiveness of health promotion activities within schools.

Recommendation 2:

That the Department of Education and Early Childhood Development and the Department of Health sign a Memorandum of Understanding outlining the goals, objectives, roles and responsibilities for health promotion within all Victorian schools.

Recommendation 3:

That the Victorian Government establish a high level interdepartmental committee responsible for planning and implementing a coordinated, systemic approach to health promotion within Victorian government, Catholic and independent schools.

Recommendation 4:

That the Department of Education and Early Childhood Development continue to promote strong partnerships between schools, early childhood services, health agencies and the broader community as a means of achieving optimal educational and health outcomes for Victorian students.

Recommendation 5:

That the Department of Education and Early Childhood Development, in consultation with the Catholic and independent education systems, work to ensure that all Victorian schools establish a health and wellbeing team responsible for:

- developing a whole-school health promotion policy;
- identifying the specific health needs of various groups within the school community;
- auditing how the school's policies and practices respond to the specific health needs within the school community;
- designing and implementing appropriate programs and strategies for responding to the priority health needs within the school community; and
- undertaking a triennial review of the school's success in implementing health promotion initiatives which respond to the current and emerging health needs within the school.

Recommendation 6:

That the Department of Education and Early Childhood Development establish a network of regionally based health promotion coordinators who are responsible for supporting the health and wellbeing teams of the schools in their network to plan, develop, implement and evaluate their health promotion policies, strategies and programs.

Recommendation 7:

That the Department of Education and Early Childhood Development, in consultation with the Department of Health, develop and promote a comprehensive suite of practical resources to assist schools seeking to apply the health promoting schools process.

Recommendation 8:

That the Department of Education and Early Childhood Development establish a comprehensive professional development program for teachers and school leaders to develop the advanced knowledge and skills required to plan, implement and evaluate school-based health promotion initiatives.

Recommendation 9:

That the Department of Education and Early Childhood Development implement a formal recognition and award program to acknowledge and celebrate outstanding achievements by schools, communities and individuals in promoting healthy community living.

# Chapter 1

# Introduction

> The prime function of schools is to maximise educational outcomes for their students. It is not their function to solve society's health issues. However, healthy students learn better and therefore schools have an obligation to address health to facilitate educational goals. Schools that undertake health from this perspective can achieve both health and education outcomes.[1]

1.1. The need for health promotion is now accepted worldwide. This new focus on preventative health means tackling negative health behaviours before they emerge. Governments have a range of strategies to deal with this, with schools increasingly being seen as an appropriate setting for delivering health promotion messages to children and teenagers, and their families. Therefore, the Committee was pleased to have this opportunity to undertake an inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living.

## Functions of the Education and Training Committee

1.2. The Education and Training Committee is constituted under the *Parliamentary Committees Act 2003*. The Committee's specific function under the Act is to:

> Inquire into, consider and report to the Parliament on any proposal, matter or thing concerned with education or training if the Committee is required or permitted to do so by or under the Act.

1.3. The Education and Training Committee comprises seven members of Parliament, with five drawn from the Legislative Assembly and two from the Legislative Council. Mr Geoff Howard MP chairs the Committee.

## Terms of reference

1.4. On Thursday 4 December 2008 the Legislative Assembly referred to the Education and Training Committee an inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living.

1.5. The terms of reference for the inquiry are as follows.

> To the Education and Training Committee — for inquiry consideration and report no later than 1 July 2010 on the potential for developing opportunities for schools to become a focus for promoting healthy community living, in particular:
>
> a) existing activities carried out by schools to promote holistic healthy living within their school communities involving healthy eating, active lifestyles, sun smart awareness and appreciation of the effects of harmful substances;

[1] Professor L. St Leger, Written Submission, July 2009, 1.

b) successful programs which have been instituted in schools in other states or internationally;

c) identify whether it is appropriate for the State to encourage schools to extend health programs to be directed at the broader school community and, if so, what the most effective and efficient approaches are;

d) opportunities for linking with community leaders and forming partnerships with business and community organisations;

e) existing broader health promotion policies and activities; and

f) how school-based activities could relate and coordinate with these to maximise impact and efficiency.

1.6. On 8 June 2010, the Legislative Assembly agreed to extend the reporting date for the inquiry until 7 October 2010.

## Inquiry methodology

1.7. The terms of reference were advertised in *The Age* and *Herald Sun* during June 2009, as well as local and regional papers during June 2010. They were also advertised in the Department of Education and Early Childhood Development's monthly magazine, *Shine*.

1.8. In June 2009, the Committee wrote to a broad range of organisations and individuals in the health and education sectors, advising them of the terms of reference and inviting written submissions. In April 2010, the Committee wrote to the Department of Education and Early Childhood Development regional directors, Primary Care Partnerships and schools involved in a pilot of the Health Promoting Schools framework, inviting responses to the terms of reference and a series of targeted research questions. Similar correspondence was sent to local councils, community health services and the School Focused Youth Service during May 2010.

1.9. The Committee received 159 written submissions to the inquiry (refer Appendix A). Submissions came from government agencies, local government, Primary Care Partnerships, community health agencies, health promotion bodies, researchers, parents and teachers.

1.10. Public hearings were held on 31 August 2009, 5 October 2009, 16 November 2009 and 21 June 2010 involving 43 witnesses (refer Appendix B). Participants included representatives of the Department of Education and Early Childhood Development, various health promotion bodies, Primary Care Partnerships and school-based health promotion programs.

1.11. In September 2009, the Committee met with representatives of the Queensland Department of Education and Training, Queensland Health and the University of Queensland (refer Appendix C). During October 2009, the Committee travelled to New Zealand to meet with a range of health promotion bodies and to visit best practice health promoting schools (refer Appendix D).

## Health and health promotion

1.12. The World Health Organisation defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.[2] A person's health can be determined by biomedical and genetic factors, health behaviours, socioeconomic factors, and environmental factors.[3] Although genetic factors are out of the control of governments, health behaviours, socioeconomic factors and environmental factors are within the scope of influence of health professionals and governments.

1.13. The social determinants of health are of particular importance when designing health interventions. The World Health Organisation describes the social determinants of health as:

> The conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.[4]

1.14. In 2005, the World Health Organisation established the Commission on Social Determinants of Health to provide advice for governments on ways of addressing the impact of the social determinants of health on communities. The commission's final report was launched in August 2008, and contained three overarching recommendations, namely to: improve daily living conditions; tackle the inequitable distribution of power, money and resources; and measure and understand the problem and assess the impact of action.[5]

### Defining health promotion

1.15. Health promotion can be defined as 'the process of enabling people to increase control over the determinants of their health'.[6] The aim of health promotion is to work with individuals, communities and organisations to increase control over and improve their health.

1.16. Health promotion seeks to enhance the health and wellbeing of population groups and their members by preventing and/or reducing untimely morbidity and mortality. It involves mediating between people and their environment, combining personal choice with social responsibility, for people to create a healthier future. Health promotion can include:

- working with people, not on them;
- addressing all aspects of health (physical, mental, spiritual);
- collaborating with the local community and their issues;

[2] World Health Organisation, 'About WHO in SEAR, Constitution of the World Health Organisation.' http://www.searo.who.int/en/Section898/Section1441.htm (accessed 5 August 2010).
[3] Australian Institute of Health and Welfare, *Australia's Health 2008: the eleventh biennial health report of the Australian Institute of Health and Welfare* (Canberra: Australian Institute of Health and Welfare, 2008), 4.
[4] World Health Organisation. 'Social determinants of health,' http://www.who.int/social_determinants/en/ (accessed 11 August 2010).
[5] ibid.
[6] Dr E. Bruce, Vice-President, Australian Health Promotion Association (Victorian Branch), Transcript of Evidence, Public Hearing, Melbourne, 31 August 2009, 12.

- addressing the underlying and immediate causes of health (the determinants of health);
- working with both individuals and population groups;
- emphasising the positive aspects of health;
- being concerned with healthy lifestyles;
- incorporating all levels and sectors of society and the environment;
- emphasising partnerships and alliances between groups and sectors;
- building the capacity of people through education, training and work opportunities; and
- being innovative and addressing challenges.[7]

1.17. Worldwide, governments are increasingly focusing on health promotion as the tool not only to change unhealthy behaviours but, more importantly, to create healthy behaviours at a young age. This is supported by the 1986 Ottawa Charter for Health Promotion, which stresses the importance of: building healthy public policy; creating a supportive environment; strengthening community action; developing personal skills; and reorienting health services.[8] This is achieved through the strategies of advocating, enabling and mediating through the settings in which people live.

1.18. As outlined by one world leading expert on health promotion in schools, Professor Lawrence St Leger, some commonly used approaches to health promotion include:

- Awareness raising: Increasing the public and individual's knowledge of the issue, usually through media campaigns and publications.
- Regulation and policies: Passing laws and developing policies to prevent health endangering practices (eg. pesticides in food) and to promote good health (eg. seat belt legislation, smoke free areas).
- Education: Equipping people of all ages with the knowledge and skills necessary to look after their own health and the health of others (eg. learning about disease transmission, skills in food purchase and preparation, skills in stress management, learning to drive a car safely).
- Advocacy: Enabling individuals and groups to lobby for changes which prevent ill-health and promote opportunities for health to be advanced (eg. lobbying for non-smoking work environments, vehicle safety).
- Mediation: Facilitating the balance between groups with differing interests in the pursuit of health (eg. between the proponents of processed food and unprocessed food).

[7] Lawrence St Leger, *Health Promotion and Health Education in Schools – Trends, Effectiveness and Possibilities* (Noble Park North: Royal Automobile Club of Victoria (RACV) Ltd, 2006), 3.
[8] World Health Organisation, 'Health Promotion Action Means.' http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html (accessed 11 August 2010).

- Resources and services: The development of appropriate resources and services which enable people to access information and facilities which will enhance their health (eg. electronic and print material to support drug management, telephone advisory services).[9]

1.19. The above approaches are adopted by governments and health agencies worldwide as the tools for changing or preventing unhealthy behaviours. Schools are often a focus for health promotion as they provide an opportunity for promoting healthy life practices to children and preventing unhealthy behaviours from forming.

## Government strategies aimed at health promotion

1.20. There are a range of national and state based strategies aimed at population health and health promotion. As noted in a recent report by the National Preventative Health Taskforce, the health system has traditionally focused on treating people after they become unwell, resulting in vast social and economic costs associated with chronic disease.[10] Today, however, governments see the importance of preventing the behaviours which cause many of the chronic health problems experienced by members of the community.

### *National Preventative Health Strategy*

1.21. The National Preventative Health Strategy was launched on 1 September 2009. It outlines the major health concerns which can be prevented through health promotion and behavioural change. Strategies have been developed to deal with three main unhealthy behaviours. Obesity, tobacco and alcohol have been identified as causing adverse health effects and creating significant costs to the community. For example:

- The expected growth in the prevalence of obesity is the major reason for projections that, by 2023, type 2 diabetes will become the leading cause of disease burden for males and the second leading cause for females. If this occurs, annual healthcare costs for type 2 diabetes will increase from $1.3 billion in 2002–03 to $8 billion by 2032.

- Around half of the 2.9 million Australian adults who currently smoke on a daily basis and who continue to smoke for a prolonged period will die early; half will die in middle age. Smoking related illness costs up to $5.7 billion per year in lost productivity.

- In 2004–05 the harmful consumption of alcohol resulted in huge costs to the community. They include costs attributable to crime ($1.6 billion), health effects ($1.9 billion), productivity loss in the workplace ($3.5 billion), loss of productivity in the home ($1.5 billion) and road trauma ($2.2 billion).[11]

[9] Lawrence St Leger, *Health Promotion and Health Education in Schools – Trends, Effectiveness and Possibilities* (Noble Park North: Royal Automobile Club of Victoria (RACV) Ltd, 2006), 5.

[10] Australian Government Preventative Health Taskforce, *Taking Preventative Action – A Response to Australia: The Healthiest Country by 2020 – The Report of the National Preventative Health Taskforce* (Canberra: Commonwealth of Australia, 2010), 5.

[11] Australian Government Preventative Health Taskforce, *Australia the Healthiest Country by 2020 – National Preventative Health Strategy – the roadmap for action* (Canberra: Commonwealth of Australia, 2009), 8.

*National Partnership Agreement on Preventive Health*

1.22. The National Preventative Health Strategy is supported by the National Partnership Agreement on Preventive Health which was agreed to by the Council of Australian Governments (COAG) in November 2008. The partnership agreement aims to address the rising prevalence of lifestyle related chronic diseases, by:

- laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and
- supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.[12]

1.23. The National Partnership Agreement on Preventive Health includes a series of outputs and performance benchmarks relating to healthy children, healthy workers, healthy communities, industry partnership, social marketing and enabling infrastructure. The benchmarks applicable to children include:

- Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of children at healthy weight returned to baseline level by 2015.
- Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2013; 0.6 for fruits and 1.5 for vegetables by 2015.
- Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each state by five per cent by 2013; by 15 per cent by 2015.[13]

1.24. The national targets are supported by a series of funding and reward payments to the states and territories. Each jurisdiction is free to decide how the funding will be allocated and what programs will be developed in order to achieve the targets and subsequent reward payments.

*VicHealth – Strategic priorities 2009 to 2013*

1.25. The primary agency for health promotion in Victoria is the Victorian Health Promotion Foundation, known as VicHealth. The agency identifies six health priorities in its Strategy and Business Plan for 2009 to 2013, namely:

- reducing smoking;
- improving nutrition;
- reducing harm from alcohol;
- increasing physical activity;
- increasing social and economic participation; and

[12] Council of Australian Governments, *National Partnership Agreement on Preventive Health* (Barton: COAG, 2008), 3.
[13] ibid., 8.

– reducing harm from UV exposure.[14]

1.26. The above priorities are supported by a series of key results areas relating to: health inequalities; participation; nutrition, tobacco, alcohol and UV; and knowledge, communications and business operations.[15]

*The Victorian Child and Adolescent Monitoring System*

1.27. The Victorian Child and Adolescent Monitoring System (VCAMS) is a cross-government initiative that aims to monitor the wellbeing of 0 to 18 year-olds in Victoria, and to ensure a coordinated approach to sharing information across agencies to enable more effective policy making. It provides a common basis for setting objectives and planning across the whole-of-government to advance the wellbeing of Victoria's children, through monitoring and reporting on how children are faring.[16]

1.28. The VCAMS consists of 35 endorsed outcomes for Victoria's children and adolescents which are supported by 150 associated indicators. The indicators were developed following a review of national and international research, consultation with academic experts and practitioners, and consideration of best practice. Some of the outcomes relate to the child directly, and others relate to key factors that influence child wellbeing: the family, the community and services and supports.[17]

1.29. The Children's Services Coordination Board is responsible for endorsing the VCAMS. It brings together key decision makers including the Chief Commissioner for Police and the Secretaries of the Departments of Premier and Cabinet, Treasury and Finance, Education and Early Childhood Development, Human Services, Planning and Community Development and Justice.[18] Primary responsibility for the measurement and collection of the data resides with the Department of Education and Early Childhood Development, the Department of Human Services and the Department of Health.

1.30. The Committee notes that the VCAMS provides a useful tool for the developers of health promotion initiatives, as it highlights the issues of concern for government, as well as the expected outcomes. For example, the key outcome for children relating to healthy weight is supported by indicators for the proportion of children who are overweight and obese and the proportion of children who are underweight. Similarly, the outcome relating to adequate nutrition includes an indicator for the proportion of children and young people who eat the minimum recommended serves of fruit and vegetables every day. Consequently, developers of health promotion initiatives relating to healthy eating and physical activity can build these indicators into both their program design and their monitoring and evaluation regime.

[14] VicHeath, V*icHealth strategy and business plan 2009–2013: Promoting health and preventing illness* (Carlton: VicHealth, 2009), 10.
[15] ibid.
[16] Data, Outcomes and Evaluation Division, Department of Education and Early Childhood Development (Victoria), 'VCAMS–the Victorian Child and Adolescent Monitoring System,' *Child Outcomes Bulletin Issue 2* (Melbourne: DEECD, October 2009), 1.
[17] ibid.
[18] Department of Education and Early Childhood Development (Victoria), 'Children's Services Coordination Board.' http://www.education.vic.gov.au/about/directions/children/cscb.htm (accessed 23 August 2010).

## Schools as a setting for health promotion

1.31. The Committee found a consensus among the education and health sectors that schools have a legitimate and important role in promoting healthy community living. Indeed, a number of participants commented on the perhaps outdated terms of reference for the inquiry and their implication that schools are not already a key focus for promoting healthy community living. HeartKids Victoria stated that 'it could perhaps be argued that rather than schools taking a role in promoting healthy living, it is their community responsibility to do so'.[19]

### The link between education and health

1.32. As is recognised worldwide, education and health are inextricably linked.[20] Higher levels of education are associated with better employment, healthier lifestyles and higher levels of family and community wellbeing.[21]

1.33. Early school leaving is associated with risk behaviours such as smoking, risk conditions such as obesity, and chronic diseases in adulthood such as cardiovascular disease.[22] In contrast, young people who attend school have a better chance of good health, while those who feel good about their school and who are connected to significant adults are less likely to undertake high risk behaviours and are likely to have better learning outcomes.[23] Put simply, 'education outcomes are a key social determinant of overall mental health and physical health'.[24]

1.34. While education is important for health, so is health and wellbeing a necessary precondition for effective learning. Children and young people with poorer health status (including poorer vision and hearing, chronic physical illness and mental illness) have lower academic achievement than their healthier counterparts.[25] A number of other risk behaviours in which schools can try to intervene, such as truancy, drug use at school, bullying and low levels of academic achievement, have also been shown to be linked with poorer health.[26]

1.35. The Committee recognises that there are a wide range of risk factors which can lead to poorer health outcomes for children and adolescents (and their families). Some of these include unemployment, poverty, social exclusion, exposure to harmful substances, and lack of access to healthy foods, health services or supportive social networks. Additionally, a significant proportion of ill-health is directly related to personal choices about nutrition, exercise, the use of legal and illegal substances, interpersonal relationships and other social behaviours. Evidence shows, however, that health promotion within schools can increase the capacity of students to

[19] HeartKids Victoria, Written Submission, July 2009, 3.
[20] Lawrence St Leger and others, *Promoting Health in Schools: from Evidence to Action* (France: International Union for Health Promotion and Education, 2010), 1.
[21] Department of Health (Western Australia), Written Submission, July 2009, 8.
[22] Australian Health Promoting Schools Association, commissioned by the Australian Government Department of Health and Family Services, *A national framework for health promoting schools (2000–2003)* (Canberra: DHFS, 2001), 10.
[23] Lawrence St Leger and others, *Promoting Health in Schools: from Evidence to Action* (France: International Union for Health Promotion and Education, 2010), 1.
[24] VicHealth, Written Submission, July 2009, 2.
[25] Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 5.
[26] ibid.

influence their environment and to take responsibility for the life decisions they make.[27]

1.36. The Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association argued that 'incorporating the evidence on the social determinants of health into the planning of education will benefit the whole community, reduce health inequalities and minimise the long-term costs of health care'.[28]

1.37. A submission from the Northern Territory Government recognised schools as a unique setting for improving the knowledge, skills and confidence of young people to understand and act upon their own health needs as they move from a stage of dependency during their schooling years to the independency of adulthood.[29] It identified a range of significant health issues (including mental health disorders, injury, chronic diseases and sexual health) which could be addressed in the short, medium and long term through effective school-based health promotion and primary prevention strategies. It also suggested that school-based health promotion could influence a range of risk factors that are common to Australian youth, such as smoking, alcohol abuse, obesity and sedentary behaviour.[30]

1.38. A number of participants argued that given the interdependence of education and health outcomes, health promotion should be considered a core function of schools, with some even suggesting that health outcomes should be considered equally important as academic outcomes. The City of Boroondara made a submission which typified such views:

> Schools play a key role in the promotion of mental and physical health for their students, which will have a direct impact on the health of families and the wider community. Schools have a major responsibility for student wellbeing and this is equally important as academic outcomes. Young people who do not have their emotional and social needs cared for by the school will not achieve their learning outcomes.[31]

1.39. Similar views have been supported by policy makers internationally. A recent paper published by the International Union for Health Promotion and Education noted that because healthy young people are more likely to learn effectively, health promotion can assist schools to meet their targets in educational attainment, as well as meet their social aims.[32]

### The advantages of schools as a setting for promoting child and adolescent health

1.40. The Committee believes that schools represent the most effective way of universally targeting children and young people and their families. Schools can be the most stable, predictable, safe and potentially nurturing environments available for children, while also acting as a health resource for communities.[33] Further, students spend a

[27] Australian Health Promoting Schools Association, commissioned by the Australian Government Department of Health and Family Services, *A national framework for health promoting schools (2000–2003)* (Canberra: DHFS, 2001), 12.
[28] Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association, Written Submission, July 2009, 9.
[29] Department of Education and Training and Department Health and Families (Northern Territory), Written Submission, July 2009, 5.
[30] ibid.
[31] City of Boroondara, Written Submission, July 2009, 6.
[32] Lawrence St Leger and others, *Promoting Health in Schools: from Evidence to Action* (France: International Union for Health Promotion and Education, 2010), 1.
[33] Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association, Written Submission, July 2009, 2.

significant proportion of their time at school, and interacting with the school environment during and after school hours.

1.41. The Committee heard that there are several factors unique to schools that make them an appropriate setting for enhancing the health and wellbeing of children. Some of these were summarised in a submission from the Western Australian Department of Health:

- Schools have an existing infrastructure incorporating educational opportunities, staff trained in the provision of education, environmental services, various structures and supports that can reinforce health messages, and existing links to community-based agencies and support services. Health promotion can therefore be cost effectively incorporated into this pre-existing structure.
- Schools have links to several influences on children's health, including family, peers and the local community. This access puts schools in an ideal position from which to initiate interaction between key influences on children's health behaviours, to create supportive environments and reinforce messages from outside the school setting.
- Schools provide an opportunity to reach all children, regardless of socioeconomic background, ethnicity or geography.[34]

1.42. Other advantages of schools as a setting for health promotion were identified by HealthWest Partnership, which noted that there is capacity for flexibility within the school setting to respond to emerging health issues in a community,[35] and Cardinia Shire Council, which stated that 'facilitating schools to be involved with health and wellbeing further supports the notion that health and wellbeing is everyone's business and not restricted to a medical model of health and 'ill-health' service provision'.[36]

1.43. The Committee notes that the above factors make schools an ideal setting not only for the promotion of health messages and development of health literacy among students, but also as a setting for immunisations, health screening and early intervention provided by school nursing, medical and oral health services.

### The role of schools in promoting broader community health

1.44. The terms of reference for the inquiry required the Committee to 'identify whether it is appropriate for the State to encourage schools to extend health programs to be directed at the broader school community'.

1.45. Various participants outlined their strong support for schools having a role in promoting healthy living to the wider community.[37] Some noted the role of schools in acting as a 'gateway' through which health information and messages can be conveyed to the wider community, while others outlined how schools can be used as

[34] Department of Health (Western Australia), Written Submission, July 2009, 9.
[35] HealthWest Partnership, Written Submission, July 2009, 1.
[36] Cardinia Shire Council, Written Submission, July 2009, 5.
[37] For example, HealthWest Partnership, Written Submission, July 2009, 1; Eating Disorders Foundation of Victoria (Eating Disorders Victoria), Written Submission, July 2009, 7; Mr T. Harper, Chief Executive Officer, VicHealth, Transcript of Evidence, Public Hearing, Melbourne, 16 November 2009, 2; Jean Hailes Foundation for Women's Health, Written Submission, July 2009, 8; Catholic Education Office Melbourne, Written Submission, August 2009, 2.

a setting for health promotion programs which target various groups within the community. Mindmatters argued that 'schools are not separate from their community they are part of their community'.[38]

1.46. Submissions identified a wide range of specific initiatives where schools could extend health promotion programs to the broader community. These were summarised by Moreland City Council as follows: provision of garden space for growing vegetables and fruit trees; provision of sporting grounds and facilities for organised sports; provision of after-hours access to play space for unstructured recreation; provision of meeting rooms for groups to meet after school hours, including halls, art rooms and libraries; provision of schools as a location to provide programs for parents including physical activity classes and access to nutritious food; and opportunities to build social connections not just with parents from the school but also the local neighbourhood.[39]

1.47. Various submissions cautioned that it is only appropriate for the government to encourage schools to extend health programs to the broader school community where they are provided with adequate resources to do so. Submissions suggested that this includes: adequate funding; professional development for teachers; resources and support to build capacity; guidelines and support regarding implementation and running of programs; and flexibility to adapt the programs to suit the specific issues and demographics of the school community.[40]

1.48. The Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association acknowledged that schools themselves are not resourced and do not have appropriately trained staff to take on the role of promoting health in the broader community. They suggested that instead, 'strong partnerships between the health, welfare and education sectors are required in order to establish effective pathways between the range of health related organisations/services and schools and their communities'.[41]

### Challenges for effective health promotion within schools

1.49. The Committee found that despite widespread agreement about the benefits of health promotion activities within schools, there are a range of factors which can inhibit the implementation or effectiveness of health promotion initiatives. The barriers mentioned most frequently during the inquiry were:

- the competing aims and interests of the health and education sectors;
- the often ad hoc, short-term nature of programs and projects offered to schools;
- the lack of ongoing funding to ensure the sustainability of proven programs and initiatives;
- unrealistic expectations;

[38] MindMatters, Principals Australia, Written Submission, July 2009, 4.
[39] Moreland City Council, Written Submission, June 2010, 2.
[40] For example, Women's Health Victoria, Written Submission, July 2009, 7; Victorian Alcohol and Drug Association, Written Submission, July 2009, 2; Wyndham City Council, Written Submission, July 2009, 2.
[41] Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association, Written Submission, July 2009, 5.

- the extensive number of programs available to schools and the associated difficulties for schools and teachers to assess and prioritise programs;
- failure to take a whole-school approach;
- variability in the quality and credibility of programs;
- inconsistency in health messages presented in schools, homes and the broader community;
- the structure and organisation of secondary schools and their curriculum; and
- lack of coordination, communication and cooperation between various levels of government.

1.50. The Committee notes that short-term, issue-based health programs and projects have very limited success in terms of long-term health and education outcomes. The key finding of the inquiry is the need for improved structures and systems to support school-based health promotion that operate at the state, regional and local levels. Many participants in the inquiry felt that this could best be achieved through the internationally recognised Health Promoting Schools framework, as discussed throughout the following chapters.

# Chapter 2

# The Health Promoting Schools framework

> The health care system does a great job with health care problems once they have emerged, but in terms of shaping attitudes and behaviours, particularly those at an early age, we need to be doing that in those cultural settings where young people spend most of their time.[42]

2.1. Worldwide, there is growing understanding of the role of schools in the health and wellbeing of individuals, their families and the community. This has been coupled with a trend towards comprehensive, whole-school approaches aimed at improving and/or protecting the physical, mental, social and spiritual health of all members of the school community. The Committee examined these trends in the context of the internationally recognised Health Promoting Schools framework in which a school undertakes a broad range of activities aimed at strengthening its capacity as a healthy setting for living, learning and working.

## Health promoting schools

2.2. A health promoting school is 'a school community that takes action and places priority on creating an environment that will have the best possible impact on the health of students, staff and the wider school community'.[43] A health promoting school takes action to 'promote and protect the health of its members, where health encompasses the dimensions of social, physical, intellectual, mental and emotional wellbeing'.[44] There are two key purposes of health promoting schools: to enhance educational outcomes; and to facilitate action for health by building health knowledge and skills in the cognitive, social and behavioural domains.[45]

2.3. Building on the principles outlined in the Ottawa Charter for Health Promotion, the International Union for Health Promotion and Education sets out a number of principles for health promoting schools.[46] First, a health promoting school promotes the health and wellbeing of students and staff, enhances the learning outcomes of students, and upholds social justice and equity concepts. Health promoting schools provide a safe and supportive environment for all members of the school community, facilitate student participation and empowerment, and collaborate with parents and the local community. They also link health and education issues and systems, and integrate health into the school's ongoing activities, curriculum and assessment

[42] Mr T. Harper, Chief Executive Officer, VicHealth, Transcript of Evidence, Public Hearing, Melbourne, 16 November 2009, 5.
[43] Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 4.
[44] ibid.
[45] International Union for Health Promotion and Education, *Achieving health promoting schools: guidelines for promoting health in schools* (France: IUHPE, 2009), 1.
[46] ibid.

standards. Finally, a health promoting school sets realistic goals based on accurate data and sound scientific evidence, and seeks continuous improvement through ongoing monitoring and evaluation.[47]

## Essential elements of promoting health in schools

2.4. The International Union for Health Promotion and Education has identified six essential elements of a health promoting school, namely: healthy school policies; physical environment; social environment; individual health skills and action competencies; community links; and health services. These elements can be summarised as follows:

- Healthy school policies: These are clearly defined in documents or in accepted practices that promote health and wellbeing. Many policies promote health and wellbeing eg. policies that enable healthy food practices to occur at school; policies which discourage bullying.

- The school's physical environment: The physical environment refers to the buildings, grounds and equipment in and surrounding the school, such as: the building design and location; the provision of natural light and adequate shade; the creation of space for physical activity; and facilities for learning and healthy eating.

  The physical environment also refers to: basic amenities such as maintenance and sanitation practices that prevent transmission of disease; safe drinking water availability; air cleanliness; as well as any environmental, biological or chemical contaminants detrimental to health.

- The school's social environment: The social environment of the school is a combination of the quality of the relationships among and between staff and students. It is influenced by the relationships with parents and the wider community.

- Individual health skills and action competencies: This refers to both the formal and informal curriculum and associated activities, where students gain age-related knowledge, understandings, skills and experiences, which enable them to build competencies in taking action to improve the health and wellbeing of themselves and others in their community, and which enhances their learning outcomes.

- Community links: Community links are the connections between the school and the students' families plus the connections between the school and key local groups and individuals. Appropriate consultation and participation with these stakeholders enhances the health promoting school and provides students and staff with a context and support for their actions.

- Health Services: These are the local and regional school-based or school-linked services, which have a responsibility for child and adolescent health care and promotion, through the provision of direct services to students (including those with special needs). They include: screening and assessment by licensed and qualified practitioners; and mental health services (including

[47] ibid.

counselling) to promote students' social and emotional development, to prevent or reduce barriers to intellectual development and learning, to reduce or prevent mental, emotional, and psychological stress and disturbances, and to improve social interactions for all students.[48]

## The process for developing a health promoting school

2.5. The International Union for Health Promotion and Education has developed a set of guidelines for health promoting schools, which outline the various stages involved in establishing health promotion within schools.[49] The guidelines emphasise that establishing a health promoting school is not a time limited project; it is a process of change, development and evolution that builds a healthy school community. The guidelines therefore suggest allowing three to four years to complete specific goals:

> … everything cannot be changed at once and if the goals and strategies are realistic, then substantial change can occur in 3–4 years.[50]

2.6. At the outset, there must be a supportive government and/or local education authority policy for health promoting schools. The guidelines note that where there are supportive policies for health promoting schools by national, regional or local authorities, it is easier for schools to embrace the concept.[51] International experience has shown, however, that in a number of countries the initiative for health promoting schools has come initially from the school community, leading to later policy adoption at the national level.[52]

2.7. Within the school, the first step in implementing the Health Promoting Schools framework is to achieve administrative and senior management support. Health promoting schools is a whole-school approach and, as such, needs to have ongoing support and commitment from school leaders.[53] The next step is to create a small group which is actively engaged in leading and coordinating health promotion actions and activities. It is essential that all key stakeholders are represented on this group, including teachers, non-teaching staff, students, parents and community members. The guidelines for promoting health in schools state that health promoting schools 'begin well if the workload is shared and all key groups are involved in decision making and implementation'.[54]

2.8. The health promotion group's first task is to conduct an audit of current health promoting actions according to the six essential components of the Health Promoting Schools framework. The group can then establish agreed goals and develop strategies to achieve the goals within the capacity of the school's resources. The guidelines also suggest developing a Health Promoting School Charter which symbolises the commitment of the school, sets out the school's principles and targets, and enables the school to celebrate its achievements in health promotion.[55] Celebration of milestones such as the creation of the Health Promoting Schools Charter or implementation of a new health promotion policy helps to affirm the

[48] ibid., 3.
[49] ibid., 1.
[50] ibid., 2.
[51] ibid., 1.
[52] ibid.
[53] ibid.
[54] ibid.
[55] ibid.

concept of health promoting schools in the minds of the school and its local community and senior officials.[56]

2.9. The health promoting schools guidelines recognise that staff must think about activities outside the classroom as being equally as important as activities within it. It is therefore essential that staff have ongoing opportunities to attend professional development programs and to be able to present and discuss their school's initiatives with others.[57]

### Sustaining health promotion initiatives within schools

2.10. The International Union for Health Promotion and Education guidelines outline a range of factors that have been demonstrated to be necessary for sustaining the efforts and achievements of the first few years over the following five to seven years.

2.11. One of the first factors in sustaining health promotion efforts in schools is ensuring there is a continuous active commitment and demonstrable support by governments and relevant jurisdictions to the ongoing implementation, renewal, monitoring and evaluation of the health promoting strategy.[58] The International Union for Health Promotion and Education guidelines identify that a signed partnership between health and education ministries of a national government has been an effective way of formalising this commitment.[59] Linked to this is the need to ensure that monitoring and evaluation services in the education sector view health promotion as an integral part of the life of the school and that it is reflected in the performance indicators. Likewise, the monitoring and evaluation services in the health sector must view student learning and success as an integral part of health promotion and reflect this in their performance indicators.[60]

2.12. Another essential factor to ensure the sustainability of health promoting initiatives is to establish and integrate all the elements and actions of the health promoting strategy as core components to the working of the school. Schools should review and refresh after each three to four years. They should also maintain a coordinating group with a designated leader to oversee and drive the strategy. This group should have continuity of some members, as well as the regular addition of new personnel.[61] The guidelines also highlight the need to ensure that most of the new and ongoing initiatives involve most of the staff and students in consultation and implementation.[62] Schools should also seek and maintain recognition for health promotion actions both within and outside the school.[63]

2.13. Various resources are also essential to sustaining health promotion efforts within schools. This includes ensuring there is time and resources for appropriate capacity building of staff and key partners.[64]

[56] ibid., 2.
[57] ibid.
[58] ibid.
[59] ibid.
[60] ibid.
[61] ibid.
[62] ibid.
[63] ibid.
[64] ibid.

## The Health Promoting Schools framework in Australia

2.14. The Committee is aware that the Health Promoting Schools framework is not a new approach to health promotion within schools nationally and internationally. The adoption of a health promoting school approach was recommended by the National Health and Medical Research Council in 1996, and the Australian Health Promoting Schools Association supports health promoting schools as a best practice framework for school health promotion, and for inter-sectoral collaboration for health in schools.[65] A 1997 report found that 'every state and territory education system either used or recognised the term health promoting school and were on some level promoting the concept within school communities'.[66] Similarly, 'health departments or health foundations have funded initiatives in health promoting schools'.[67]

2.15. It is therefore unsurprising that there was a high level of awareness of the health promoting schools model among participants in the inquiry. Over sixty written submissions explicitly mentioned the Health Promoting Schools framework,[68] while many other submissions and witnesses described similar models with a whole-school approach to health promotion.

### The national model

2.16. The Australian Health Promoting Schools Association was established in 1994. It developed out of the Australian Association for Healthy School Communities and the Network for Healthy School Communities.[69] The association aims to initiate and support ways of establishing in schools, a broad view of health consistent with the Ottawa Charter for Health Promotion, and to promote nationally the concept of health promoting schools through collaboration among existing agencies, professional associations, government departments and student and parent groups.

[65] Australian Health Promoting Schools Association, commissioned by the Australian Government Department of Health and Family Services, *A national framework for health promoting schools (2000–2003)* (Canberra: DHFS, 2001), 10.

[66] Jeff Northfield and others, *School Based Health Promotion Across Australia* (Sydney: Australian Health Promoting Schools Association, 1997), 5.

[67] ibid.

[68] Submissions noting the Health Promoting Schools framework include: AFL Victoria; The Alannah and Madeline Foundation; Australian Drug Foundation; Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association; Bayswater North Community Renewal Project; Bentleigh Bayside Community Health; Camp Hill Primary School; Cardinia Shire Council; Caulfield Community Health Service; City of Boroondara; Darebin City Council; Dental Health Services Victoria; Department of Education and Children's Services (South Australia); Department of Education and Department of Health and Human Services (Tasmania); Department of Education and Training (Queensland); Department of Education and Training and Department of Health and Families (Northern Territory); Department of Health (New South Wales); Department of Health (Western Australia); EACH – Social and Community Health; Eating Disorders Foundation of Victoria (Eating Disorders Victoria); Family Planning Victoria; Foundation 49; Frankston City Council; Glenelg Healthy Schools Network, Portland District Health; HealthWest Partnership; Healthy Kids School Canteen Association; Heart Foundation (Victoria); The Home Grown Project; Inner East Primary Care Partnership; Kids – Go For Your Life, Cancer Council Victoria and Diabetes Australia (Victoria); Knox City Council; Macedon Ranges Shire Council; MindMatters, Principals Australia; Moyne Health Services; Northeast Health Wangaratta; Northern Metropolitan Region, Department of Education and Early Childhood Development (Victoria); Nutrition Australia (Victorian Division); Outer East Health and Community Support Alliance; Peninsula Health – Community Health: Quit Victoria; School Focused Youth Service; Southern Health; SunSmart, Cancer Council Victoria; VicHealth; Victorian Healthcare Association; Wellington Primary Care Partnership; Western Metropolitan Region, Department of Education and Early Childhood Development (Victoria); Women's Health Victoria.

[69] Australian Health Promoting Schools Association, 'About us.' http://www.ahpsa.org.au/pages/about.php (accessed 8 July 2010).

2.17. In 1997, the Commonwealth Department of Health and Family Services commissioned the Australian Health Promoting Schools Association to develop a national framework for health promoting schools. The association developed a framework which was depicted as three overlapping elements: (1) curriculum, teaching and learning; (2) school organisation, ethos and environment; and (3) partnerships and services.[70]

2.18. The purpose of the national Health Promoting Schools framework was to guide interaction between the health and education sectors in order to promote health gains for children and young Australians. In particular, the framework was designed to:

- enhance coordination between the education and health sectors, and between different levels of government and the non-government sector;
- guide policy and infrastructure development at a national, state and local level;
- set priorities to inform national, state and local planning and guide strategies, programs and initiatives; and
- promote sustainable national and state health promoting school activity and strengthen community-based involvement.[71]

2.19. As part of the National Health Promoting Schools Initiative, the Australian Health Promoting Schools Association, through a consultative process with input from all states and territories, developed a vision statement in 1997 that 'all children in Australia will belong to school communities which are committed to promoting lifelong learning, health and wellbeing'.[72] The vision is based on the following principles:

- Health and learning: Good health supports lifelong learning, living and wellbeing.
- Supportive, safe environment: Students grow and learn in a safe, caring, responsive and empowering environment.
- Holistic (ecological) approach: Health promoting schools view health holistically, addressing the physical, social, mental, intellectual and spiritual dimensions of health through comprehensive programs.
- Social justice: Equal access to education opportunities by male and female students from all population groups is essential for promoting quality of life.
- Linking curriculum, environment and community: Health promoting schools ensure a coordinated, comprehensive approach to learning by linking curriculum with the school ethos/environment and the community.

[70] Australian Health Promoting Schools Association, commissioned by the Australian Government Department of Health and Family Services, *A national framework for health promoting schools (2000–2003)* (Canberra: DHFS, 2001), 7.
[71] ibid., 6.
[72] ibid., 14–15.

- School community engagement: Health promoting schools are inclusive – the whole school community of students, parents, staff and local agencies are engaged in school activities.
- Respect for all: Active participation is based on respecting skills, values and experiences of parents, students, staff and members of the school community.
- Staff and parent wellbeing: Staff and parent wellbeing is integral to health promoting school activity.
- Active participation and empowerment: Individuals and the community are empowered through collaboration, participatory decision making and personal action.
- Partnerships: Partnerships result in action which is more effective, efficient and sustainable.
- Health literacy: Addressing health literacy is an important component of a health promoting school.
- Diversity: The contribution of diverse cultures and groups is sought, welcomed, supported and valued.[73]

2.20. According to a report commissioned by the Commonwealth Department of Health and Family Services, evidence from the early implementation of the health promoting schools approach was promising, with positive impacts arising in the social and physical environments of various schools, staff development, school lunch provision, exercise programs, aspects of health related behaviour such as dietary intake, and aspects of health such as fitness.[74] There was also evidence that the approach is able to impact positively on aspects of mental and social wellbeing such as self-esteem and bullying, which had previously proved difficult to influence.[75]

2.21. The Committee was unable to undertake a comprehensive analysis of the different approaches towards the health promoting schools philosophy across Australia. However, submissions from governments throughout Australia reveal that the Health Promoting Schools framework has evolved in various forms in different jurisdictions. While some jurisdictions, including Western Australia, Queensland, the Northern Territory and South Australia, have clear statements or resources associated with the Health Promoting Schools framework, other jurisdictions appear to have incorporated the framework's underlying principles into their broader education policies and programs.

[73] ibid., 10.
[74] ibid., 11.
[75] ibid.

2.22. Of interest, the Committee identified a number of formal agreements covering health promotion within schools between relevant ministries in Australia. Such agreements may cover a broad commitment to health promotion within schools, or focus on a specific health promoting project. For example, in Western Australia, a Memorandum of Understanding between the Department of Education and Training and the Department of Health underpins the delivery of school health services in public schools and clearly articulates the nature of school health services in a broader health promoting schools context. The Memorandum of Understanding includes the establishment of local agreements between District Education Offices and Area Health Services.[76] In South Australia, a Memorandum of Agreement with South Australia Health and the Department of Education and Children's Services has been signed for the Eat Well Be Active primary schools project.[77]

2.23. Some of the other health promoting schools activities and approaches currently operating in various jurisdictions across Australia include: establishment of a health promoting schools unit within the education department; development and promotion of quality health promoting schools resources; the existence of formal health promoting schools networks; the employment of health promoting schools coordinators in various government departments and health organisations; the establishment of grant schemes for schools to undertake health promoting schools projects and activities; inclusion of the health promoting schools concept within broader education policies and frameworks; the existence of coordinated networks of government and non-government agencies working collaboratively on school-based projects; and school nurse programs that have an explicit health promotion function. Additionally, a number of jurisdictions provide awards to recognise the achievements of schools and/or communities in promoting healthy community living.

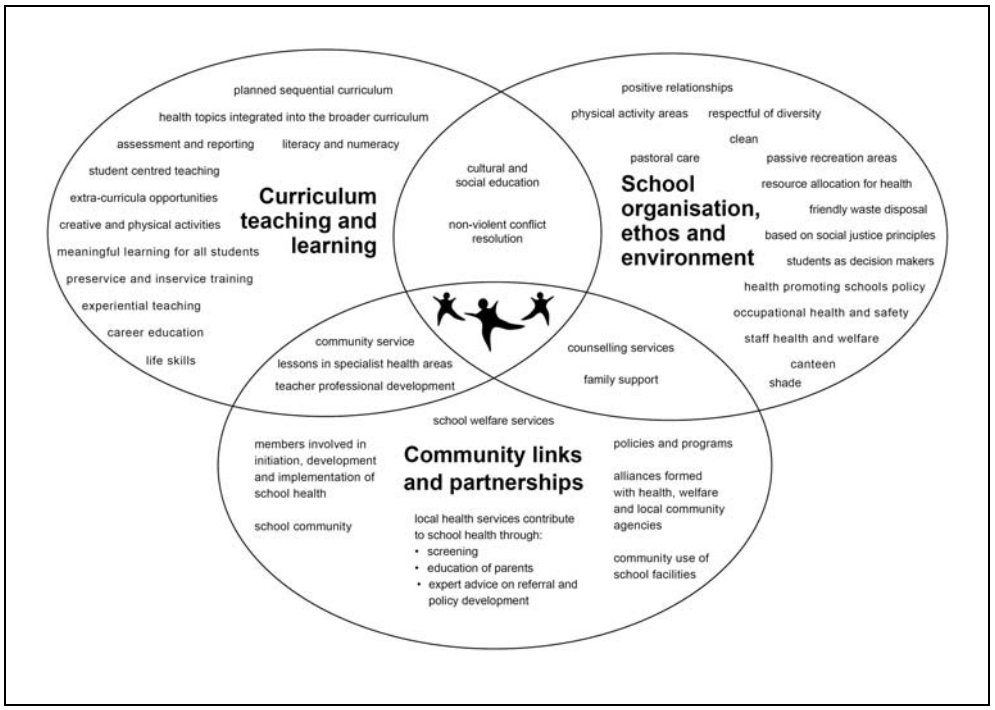
### The Victorian Health Promoting Schools Project

2.24. The Health Promoting Schools model was first introduced into Victorian schools in 1997, through a collaborative project between Deakin University and the (then) Department of Education, Employment and Training. The objective of the project was to establish an interactive network of health promoting schools and to strengthen the capacity of schools to be healthy settings for living, learning and working.[78] VicHealth funded the Health Promoting Schools Project from 1997 to late 2000.[79]

2.25. The framework used in the pilot project is shown in Figure 2.1.

[76] Department of Health (Western Australia), Written Submission, July 2009, 10.
[77] Department of Education and Children's Services (South Australia), Written Submission, July 2009, 3–4.
[78] Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 1.
[79] Damien Ridge and others, 'Finding a place for health in the schooling process: A challenge for education,' *Australian Journal of Education* 46, no 1 (June 2002): 21–22.

Figure 2.1 Health Promoting Schools Framework




Source: Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 8.

2.26. A diverse range of 100 schools were chosen for inclusion in the Health Promoting Schools Project, based on criteria such as location, past school health initiatives, level (primary and secondary) and system (government, Catholic and independent).[80] Formal evaluation and feedback was provided to schools during the project.[81]

2.27. At the commencement of the project in May 1997, a major survey of health promoting schools activity in Victoria found that while there was activity which fell within the health promoting schools concept in all surveyed schools, only a small number were very involved in actively becoming a health promoting school.[82] At this time, more than 85 per cent of schools reported having policies on gender equity, classroom safety, discrimination and bullying, and over 70 per cent of respondents felt that their school always provided a safe, stimulating and welcoming environment.[83] A need for greater parent participation in school policy development and decision making was identified, and community links and partnerships were identified as an area that is particularly challenging.[84] More than 50 per cent of respondents reported that students gained a basic understanding relevant to their age and culture of physical activity, personal safety, nutrition, road safety and relationships, however, a basic understanding of mental health, sexual health and consumer health were judged as unsatisfactory.[85]

[80] ibid., 22.
[81] ibid.
[82] Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 12.
[83] ibid.
[84] ibid.
[85] ibid.

2.28. During the project, schools were expected to set priorities for action, and plan and then implement health promotion projects in their schools over a one-year period. In order to encourage a holistic approach, the project provided a range of resources including a tool for staff to audit what was already happening in their schools in terms of: health practices and policies; professional development for teachers; funding for teacher release time; assistance in strategic planning; and various support resources such as regular newsletters and a guidebook. According to schools that participated in interviews following the project, the audit turned out to be a valuable educative exercise in that it revealed the different components of school life that can shape health, what the school was doing, and what still needed to be done.[86]

2.29. Throughout the pilot, the (then) Department of Education, Employment and Training developed and maintained a health promoting schools website. The website included: latest research findings; resources to address health related issues such as bullying and drug education; case studies of school activities; contacts and news of in-service activities; copies of the health promoting schools newsletters; and discussion opportunities. Although the website no longer operates, some of the material remains available through PANDORA, Australia's Web Archive.[87]

2.30. At the conclusion of the project, a guide was produced outlining a series of case studies showing the ways in which 15 participating schools had developed health promoting schools responses appropriate to their particular contexts. The case studies highlight a broad range of health promoting activities undertaken during the Health Promoting Schools Project. Practices and policies were prominent around staff health and welfare, positive school relationships and student mental health.[88] Some of the specific activities included:

- health promoting schools as a school charter priority or policy statement;
- promoting positive/healthy relationships;
- student behaviour policies;
- student attendance;
- resilience programs;
- anti-bullying programs;
- stress management;
- staff wellbeing;
- individual school drug education strategies;
- healthy canteen food;
- developing a 'passive' garden for student relaxation; and
- lending outdoor equipment.[89]

[86] Damien Ridge and others, 'Finding a place for health in the schooling process: A challenge for education,' *Australian Journal of Education* 46, no 1 (June 2002): 24.
[87] PANDORA, Australia's Web Archive, 'Health Promoting Schools,' Department of Education, Employment and Training (Victoria), http://pandora.nla.gov.au/tep/67717.
[88] Damien Ridge and others, 'Finding a place for health in the schooling process: A challenge for education,' *Australian Journal of Education* 46, no 1 (June 2002): 25.
[89] ibid.

2.31. Schools reported a wide range of achievements stemming from involvement in the Health Promoting Schools Project. These included: greater awareness of and skills in health promotion; better learning outcomes; better student participation; increased perceptions of student and teacher wellbeing; better coordinated and more comprehensive health promotion approaches; improved social environments; and better links with the community.[90] As observed by Ridge et al, 'many of these kinds of changes are really about better, more effective schools'.[91]

2.32. In the post-project audit, 93 per cent of the project schools indicated that they felt they were 'better equipped to implement education system policies and requirements concerning student welfare', and 69 per cent indicated that they felt their teaching was more student centred.[92]

2.33. Table 2.1 shows a range of reported changes that case study schools attributed to the Health Promoting School Project.

Table 2.1 Reported changes attributed to the Health Promoting School Project

| Changes for students | Changes for the school | Changes in community links |
|---|---|---|
| • increased awareness of health issues<br>• greater student responsibility for actions<br>• improved student learning outcomes<br>• increased physical activity<br>• sense of being cared for and belonging<br>• happier students<br>• greater student involvement in decision making | • increased awareness of health promotion and related issues<br>• dissemination of HPS ideas and learning to wider staff body<br>• better physical environment<br>• improved relationships<br>• better 'atmosphere' in school<br>• better organisation of health promotion activities<br>• better mediation of conflicts<br>• better staff morale<br>• move towards more proactive health strategies<br>• development of school health curriculum<br>• development of health related policies<br>• incorporation of health into the school charter | • networking with local schools<br>• establishment of new links with local agencies<br>• greater knowledge and use of wider service system<br>• moves to formalise links with outside agencies<br>• greater parent satisfaction in the school<br>• greater involvement of parents in school life<br>• community involvement in school projects |

Source: Damien Ridge and others, 'Finding a place for health in the schooling process: A challenge for education,' *Australian Journal of Education* 46, no 1 (June 2002): 26.

2.34. A study of the perceived outcomes of the Health Promoting Schools Project reported 'some shift away from the reliance on school staff time and expertise and a focus on the curriculum to a greater involvement of community agencies and partnerships with the health sector'.[93] Ridge et al stated that this happened 'because the project broadened awareness of the wider community/agencies/services available to

[90] ibid.
[91] ibid., 26.
[92] ibid.
[93] ibid., 27.

schools, and a range of relationships and partnerships were initiated or enhanced in project schools'.[94]

2.35. Importantly, the project evaluation illustrated 'how ownership of the school contribution to health can shift from externally developed programs and curriculum descriptions towards school-based development of initiatives, policies and procedures'.[95] The health promotion projects in schools 'tended to become located around issues that were pertinent to schools and already taking up time', for example, violence and staff welfare.[96] Over 90 per cent of project schools in the post-intervention audit indicated that the Health Promoting Schools Project linked in with other projects already occurring within the school and that it provided impetus and momentum to extend on previous and current work:

> There was a sense that being involved in the HPS project helped people to reconceptualise and reorganise their activities to find better ways forward and to add value to their work. Additionally many interviewees considered that the HPS project provided an opportunity to bring specific projects together under the one umbrella for a more unified and coordinated approach to health promotion.[97]

2.36. The qualitative analysis suggested that 'those who had a strong sense of what their school was trying to achieve in the long term, and who understood how different projects could be coordinated to increase effectiveness and save time, were best able to adapt the multitude of short-term projects (with varying agendas) that come into their schools to their own benefit and use the Health Promoting Schools framework to their best advantage'.[98] Ridge et al concluded that 'in any effective health promotion activity in schools, the agenda needs to be driven primarily by an education sector that has demonstrated it can embrace holistic approaches to health, with the health sector acting as partner and facilitator'.[99]

### Current Victorian experiences with the Health Promoting Schools model

2.37. The Committee found that despite the above pilot of the Health Promoting Schools model, together with a high level of understanding of the model among education and health sector stakeholders, the health promoting schools philosophy is not formally or consistently implemented in the Victorian school sector. Nonetheless, the Committee was pleased to receive a small number of submissions outlining current health promoting schools initiatives in Victorian schools.

2.38. A written submission from EACH – Social and Community Health (based in Melbourne's eastern region) outlined in detail its Health Promotion Team's experience with the Health Promoting Schools framework. The team has a health promotion officer dedicated to the education setting, with the main focus being a five-year health promoting schools pilot project (set to run until 2013). The project is supervised by the team's health promotion manager who has worked in the Scottish health promoting schools arena for over ten years.[100]

[94] ibid.
[95] ibid., 28.
[96] ibid.
[97] ibid., 29.
[98] ibid.
[99] ibid., 31.
[100] EACH – Social and Community Health, Written Submission, June 2010, 2.

2.39. EACH – Social and Community Health stated that the most important learning from its pilot project has been the creation of a dedicated specialist health promotion in schools position.[101] This position, in working across three pilot schools, has concentrated on the following key health promotion action areas: partnerships; guidance and support; building capacity for the ongoing development and implementation of the Health Promoting Schools framework; and monitoring and evaluation.[102] The team's other key learnings include:

- Developing relationships and laying the project foundations take time and are resource intensive in the early stages, but are nonetheless crucial and should not be rushed or forced.
- Consultation with the students, staff, parents and carers and wider community agencies creates a strong sense of ownership of the project within the school. It is important to work with and alongside the school and community and allow the project to be driven by the partnership process rather than as an individual or agency agenda.
- Leadership is extremely important in enabling the project.
- Engaging secondary school students proved to be very challenging and required intensive resources, persistence and patience.
- It is important to start where the school is at – going in with a preset agenda does not work.
- It is important for the school to have tangible outcomes.
- Publicity, recognition and reward proved to be great incentives for the school community.[103]

2.40. The Committee notes that the above learnings are similar to those experienced in the various regions and schools visited during investigations in New Zealand.

2.41. Glenelg Healthy Schools Network provided a submission outlining its experience in assisting schools to implement the Health Promoting Schools framework in Glenelg Shire. The network was established in 2006 by lead agency Portland District Health and involves collaborative partnerships with schools, teachers, youth workers and a broad range of health sector staff from a range of organisations. The network noted that it has had particular success in health promotion within primary schools:

> From experience we can comment that primary schools are an excellent forum for change and many programs such as Kids – Go For Your Life and Get a Taste of This have been successfully implemented in our schools by involving the broader school community (parents, teachers, health workers, clubs and groups). Indeed, primary schools in our shire that made efforts to involve these people were more receptive to new ideas, achieved more and more readily took on board health messages.[104]

[101] ibid., 10.
[102] ibid., 10–11.
[103] ibid., 9–10.
[104] Glenelg Healthy Schools Network, Portland District Health, Written Submission, July 2009, 2.

2.42. Moyne Health Services told that Committee that it is also in the process of establishing a collaborative network of partnerships to apply the Health Promoting Schools framework at a local level. Organisations involved in this partnership include Warrnambool Schools Network, South West Healthcare, Terang/Mortlake Health Service, Brophy Family and Youth Services, Barwon South West Women's Health Network, Moyne Shire Council and South West Primary Care Partnership.[105]

2.43. Camp Hill Primary School also made a written submission outlining its experiences with the Health Promoting Schools framework. The school has found the framework to be 'extremely helpful' in developing a culture of healthy living within the school community:

> The framework has raised awareness within the school community of the importance of leading a healthy lifestyle and the benefits that can have both physically and emotionally. Implicitly the framework has also strengthened ties within the community as parents, students, teachers and members of the broader community come together to participate in the many health promoting activities initiated by the school. The framework has also provided an impetus for the school to become involved in other state or local programs such as Kids – Go For Your Life, Ride2School, Travel Smart and Streets Alive.[106]

2.44. The Committee believes the above examples represent only a sampling of schools and partnerships currently applying the Health Promoting Schools framework in Victoria. A submission from the Department of Education and Early Childhood Development's Hume regional office suggested that many schools in its region have been operating under the Health Promoting Schools model since 1997,[107] while the Northern Metropolitan office outlined how the Health Promoting Schools framework is used by secondary school nurses within the region.[108]

### Future development of the Health Promoting Schools model

2.45. Various submissions to the inquiry recommended statewide implementation of the Health Promoting Schools framework in Victoria. Organisations recommending the implementation of the Health Promoting Schools model were largely from within the health sector and included: the Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association,[109] Bentleigh Bayside Community Health,[110] Cardinia Shire Council,[111] Dental Health Services Victoria,[112] EACH – Social and Community Health,[113] Foundation 49,[114] The Home Grown Project,[115] Nutrition Australia (Victorian Division),[116] South West Primary Care Partnership,[117] Victorian Healthcare Association[118] and Wellington Primary Care Partnership.[119]

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[105] Moyne Health Services, Written Submission, June 2010, 1.
[106] Camp Hill Primary School, Written Submission, April 2010, 2.
[107] Hume Region, Department of Education and Early Childhood Development (Victoria), Written Submission, May 2010, 2.
[108] Northern Metropolitan Region, Department of Education and Early Childhood Development (Victoria), Written Submission, May 2010, 2.
[109] Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association, Written Submission, July 2009, 4.
[110] Bentleigh Bayside Community Health, Written Submission, June 2010, 6.
[111] Cardinia Shire Council, Written Submission, July 2009, 5.
[112] Dental Health Services Victoria, Written Submission, July 2009.
[113] EACH – Social and Community Health, Written Submission, June 2010, 10.
[114] Foundation 49, Written Submission, August 2009, 7–8.
[115] The Home Grown Project, Written Submission, July 2009, 9.
[116] Nutrition Australia (Victorian Division), Written Submission, August 2009, 35.
[117] South West Primary Care Partnership, Written Submission, May 2010, 3.
[118] Victorian Healthcare Association, Written Submission, July 2009, 4.
[119] Wellington Primary Care Partnership, Written Submission, June 2010, 4.

2.46. The views presented by organisations supporting statewide implementation of the Health Promoting Schools framework are well represented by a submission from the Heart Foundation:

> … the Heart Foundation recommends that the Committee examine the 'Health Promoting Schools' model with a view to endorsing its implementation in Victoria. Health Promoting Schools is an internationally recognised and widely used model to best guide health promotion in the school setting yet despite this, its implementation is somewhat lagging in this state. This inquiry presents an ideal opportunity for Victoria to introduce a comprehensive and system-wide approach to better health in the school setting.[120]

2.47. The Victorian Healthcare Association similarly recommended that the Committee's inquiry should 'result in a contemporary Victorian framework of core values and principles relevant to the health promoting schools approach'. It noted that the framework should provide schools, health services and other stakeholders with the relevant tools, guidance and knowledge to implement a health promoting schools approach, while allowing for sufficient flexibility for local decision making.[121] It noted that this will require 'substantial, long-term funding mechanisms that facilitate these processes'.[122]

2.48. The Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association suggested that the benefits of investing in the health promoting school concept could be 'very significant'.[123] They believe that a 'state and regionally managed holistic "healthy schools program" will provide the one entry point into the education sector and encourage and promote high quality initiatives that are based on good evidence and ultimately add value to existing curriculum initiatives, and broader features of school society such as ethos and culture'.[124] They stated:

> A Health Promoting School framework across Victoria warrants further widespread implementation via Health and Education department collaboration. This is not a prescriptive approach, but requires a basis of core values and principles that enable the reflection of local cultural, organisational and political considerations. This must be supported by high level leadership and appropriate resourcing.[125]

2.49. The Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association suggested that one of the foundations for effective implementation of the Health Promoting Schools framework would be strategies that clearly establish the expectations of what schools must accomplish in order to participate in health promoting schools, and which also provide a clear direction in terms of what specific actions are required. They therefore recommended that the Victorian Government develop a health promoting school 'status indicator' by 2015 which forms a component of accreditation and reporting guidelines. They suggested that this status be realistic, achievable and measurable, and annually audited.[126]

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[120] Heart Foundation (Victoria), Written Submission, July 2009, 2.
[121] Victorian Healthcare Association, Written Submission, July 2009, 4.
[122] ibid.
[123] Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association, Written Submission, July 2009, 7.
[124] ibid., 4.
[125] ibid., 7.
[126] ibid., 6.

2.50. The Committee notes that other countries have introduced similar indicators and targets for participation in health promoting schools initiatives. For example, the UK Government set a target that all schools would be participating in the National Healthy Schools Program by 2009, and that 75 per cent of schools would have achieved National Healthy School Status.[127] Similarly, the Scottish Executive set a target in 2002 that all schools in Scotland were to be health promoting schools by 2007. In the same year, the Scottish Health Promoting Schools Unit was established by the Scottish Executive, in partnership with the Health Education Board for Scotland (now NHS Health Scotland), Learning and Teaching Scotland and the Convention of Scottish Local Authorities.[128]

2.51. The Committee recognises the Health Promoting Schools framework as a comprehensive and useful tool for schools seeking to implement a whole-school approach to health promotion. The framework is an international best practice approach to health promotion within schools which is well understood and accepted within the Victorian health community. It is less clear, however, how well the framework is understood, accepted and utilised within the schools sector.

2.52. The Committee therefore recommends that the Department of Education and Early Childhood Development review the development and implementation of the Health Promoting Schools framework in Victorian schools, with the aim of:

- establishing realistic goals and expectations for school health promotion;
- guiding policy and practice at the regional and local level;
- facilitating effective collaboration between the health and education sectors in planning, implementing and evaluating health promotion activities within schools;
- identifying the health promotion competencies required by school staff to successfully implement health promotion programs;
- coordinating and sustaining the wide range of health and wellbeing programs and services currently occurring in Victorian schools;
- ensuring longer-term funding for proven school-based health promotion programs and services; and
- improving the dissemination of information and evidence, including case studies and practical resources, about the effectiveness of health promotion activities within schools.

2.53. The Committee believes that the above work should be underpinned by a signed partnership agreement between the health and education departments, and the establishment of a high level interdepartmental committee responsible for planning and implementing a coordinated, systemic approach to health promotion within Victorian government, Catholic and independent schools.

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[127] ibid., 10.

[128] Learning and Teaching Scotland, 'Background.' http://www.ltscotland.org.uk/healthpromotingschools/practitioners/nationalguidance/background.asp (accessed 9 July 2010).

## Conclusion

2.54. A central focus of the Committee's inquiry was the International Union for Health Promotion and Education's Health Promoting Schools framework. Health promoting school communities aim to make a positive contribution to health and learning through the interrelationships between three important areas: curriculum, teaching and learning practices; school organisation, ethos and environment; and partnerships and services. The Health Promoting Schools framework has been successfully implemented by governments worldwide, and was presented as international best practice throughout the Committee's inquiry.

2.55. The Committee found that most Victorian schools are already involved in a varied range of health promotion programs, activities and services. In some instances, schools and local networks are formally applying the Health Promoting Schools framework. The Committee welcomes these initiatives and believes that through a more systemic approach, primary and secondary schools across Victoria could be assisted to better plan, organise and implement their health education, health promotion programs and student welfare initiatives.

# Chapter 3

# Curriculum, teaching and learning

> We need school leaders to provide encouragement, guidance and support to ensure the curriculum is implemented as planned, to ensure that teachers have access to ongoing support and to ensure that the program is adapted as developments…emerge.[129]

3.1. Curriculum, teaching and learning practices are an essential, and perhaps the most easily understood, component of health promotion within schools. The curriculum encompasses the knowledge and skills taught in the classroom, planned sequential learning and assessment and reporting structures, as well as extra-curricular opportunities covering creative and physical activities. Under the Health Promoting Schools model, the health related curriculum and extra-curricular opportunities should be complemented by teaching and learning approaches which support health and wellbeing. This involves student centred, meaningful learning experiences for all students, the integration of health and wellbeing concepts into pre-service teacher training and ongoing professional learning opportunities for all teaching staff.

## Health related curriculum

3.2. Schools are able to contribute to the health of students through the development of general intellectual skills, which equip young people to deal with the range of health situations and decisions which face us all. These skills include:

- literacy skills to gain access-related knowledge and be active in seeking out and investigating health services and products;
- reasoning and decision making skills to make judgements and decisions concerning health; and
- empathy and social understanding to contribute to the achievement of health by others.[130]

3.3. The following sections describe the overall structure of Victoria's curriculum and how it supports schools to implement their health education objectives.

[129] Ms Y. Kelley, Manager, Education, Communication and Resource, Family Planning Victoria, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 27.

[130] Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 9.

## The Victorian Essential Learning Standards

3.4. The Victorian Essential Learning Standards (VELS) outline the curriculum components that all Victorian students should learn during their time at school from prep to year 10. They provide a set of common statewide standards which schools use to plan student learning programs, assess student progress and report to parents.

3.5. The VELS differ from traditional curricula by including knowledge and skills in the areas of physical, social and personal learning. Skills which are transferable across all areas of study such as thinking and communication are also included. The VELS encourage a flexible and creative approach to learning.[131]

3.6. The VELS are organised into three connected areas of learning called 'strands'. The content and skills covered in each of the strands are important to the development of well-rounded and confident young people. Learning that occurs within each strand includes:

- Physical, personal and social learning: Students learn about themselves and their place in society. They learn how to stay healthy and active. Students develop skills in building social relationships and working with others. They take responsibility for their learning, and learn about their rights and responsibilities as global citizens.
- Discipline-based learning: Students learn the knowledge, skills and behaviours in the arts, English, humanities, mathematics, science and other languages.
- Interdisciplinary learning: Students explore different ways of thinking, solving problems and communicating. They learn to use a range of technologies to plan, analyse, evaluate and present their work. Students learn about creativity, design principles and processes.[132]

3.7. Under the VELS, teaching activities may draw on elements from each of the three strands so that learning becomes more meaningful for students. This integrated focus on knowledge, skills and behaviours in the process of physical, personal and social growth, in the disciplines, and across the curriculum helps to develop deep understanding which students can transfer to new and different circumstances.[133]

3.8. Each of the three strands contain a varying number of domains, which are themselves split into dimensions. Each of the domains include standards which outline the essential knowledge, skills and behaviours students are expected to demonstrate within each domain, as well as learning focus statements suggesting learning experiences that are based on the standards.[134]

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[131] Victorian Curriculum and Assessment Authority, 'Overview of the Victorian Essential Learning Standards,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/overview/index.html (accessed 26 July 2010).
[132] Victorian Curriculum and Assessment Authority, 'Strands, Domains and Dimensions,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/overview/strands.html (accessed 26 July 2010).
[133] Victorian Curriculum and Assessment Authority, 'Structure of the VELS,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/parents/structure.html (accessed 26 July 2010).
[134] Victorian Curriculum and Assessment Authority, 'Standards and Learning Focus Statements,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/overview/standards.html (accessed 26 July 2010).

3.9. Students progress through six levels within the VELS as they complete prep to year 10, with concepts being introduced with increasing levels of difficulty or at appropriate times during the progression through school.

3.10. The Committee recognises that all three strands of the VELS are essential for the development, health and wellbeing of students and other members of the school community. It notes, however, that the Physical, Personal and Social Learning strand is of particular importance in the context of this inquiry.

3.11. The Physical, Personal and Social Learning strand has four domains: Health and Physical Education; Interpersonal Development; Personal Learning; and Civics and Citizenship. Of these, health and wellbeing is covered explicitly within two key domains:

- the Health and Physical Education domain, which comprises the dimensions of Movement and Physical Activity and Health Knowledge and Promotion; and
- the Interpersonal Development domain, which comprises the dimensions of Building Social Relationships and Working in Teams.

### The Health and Physical Education domain

3.12. The Health and Physical Education domain provides students with the knowledge, skills and behaviours to enable them to achieve a degree of autonomy in developing and maintaining their physical, mental, social and emotional health. This domain focuses on the importance of a healthy lifestyle and physical activity in the lives of individuals and groups in our society. It promotes the potential for lifelong participation in physical activity through the development of motor skills and movement competence, health related physical fitness and sport education.[135]

*Movement and Physical Activity*

3.13. The Movement and Physical Activity dimension focuses on the important role that physical activity, sport and recreation need to play in the lives of all Australians by providing opportunities for challenge, personal growth, enjoyment and fitness. It promotes involvement in a manner that reflects awareness that everyone has the right to participate in a healthy and active lifestyle. It develops students' confidence in using movement skills and strategies to increase their motivation to become active, as well as improve their performance and maintain a level of fitness that allows them to participate in physical activity without undue fatigue.[136]

3.14. Students' involvement in physical activity can take many forms, ranging from individual, non-competitive activity through to competitive team games. Emphasis is placed on combining motor skills and tactical knowledge to improve individual and team performance. Students progress from the development of basic motor skills to the performance of complex movement patterns that form part of team games. They learn how developing physical capacity in areas such as strength, flexibility and endurance is related to both fitness and physical performance.[137]

[135] Victorian Curriculum and Assessment Authority, 'Introduction to Health and Physical Education,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/hpe/intro.html (accessed 26 July 2010).
[136] ibid.
[137] ibid.

3.15. Students progress from learning simple rules and procedures to enable them to participate in movement and physical activity safely, to using equipment safely and confidently. Students undertake a variety of roles when participating in sports such as umpire, coach, player and administrator and assume responsibility for the organisation of aspects of a sporting competition.[138]

*Health Knowledge and Promotion*

3.16. The Health Knowledge and Promotion dimension explores the developmental changes that occur throughout the human lifespan beginning with the health needs necessary to promote and maintain growth and development, followed by discussion of significant transitions across the lifespan including puberty, to gaining an understanding of human sexuality and factors that influence its expression. The exploration of human development also includes a focus on the establishment of personal identity, factors that shape identity and the validity of stereotypes.[139]

3.17. Students also develop an understanding of the right to be safe and explore the concepts of challenge, risk and safety. In addition, they identify the harms associated with particular situations and behaviours and how to take action to minimise these harms.[140]

3.18. Through the provision of health knowledge, this dimension develops an understanding of the importance of personal and community actions in promoting health and knowledge about the factors that promote and protect the physical, social, mental and emotional health of individuals, families and communities. Students investigate issues ranging from individual lifestyle choices to provision of health services by both government and non-government bodies. In investigating these issues, students explore differing perspectives and develop informed positions.[141]

3.19. The Health Knowledge and Promotion dimension also examines the role of food in meeting dietary needs and the factors that influence food choice. Students progress from learning about the importance of eating a variety of foods to understanding the role of a healthy diet in the prevention of disease.[142]

### The Interpersonal Development domain

3.20. The Interpersonal Development domain supports students to initiate, maintain and manage positive social relationships with a range of people in a range of contexts. Relationships with peers and adults at the school provide students with opportunities for reflection and growth. Adults at the school can reinforce this learning by providing positive role models. Interactions should be positive, fair, respectful and friendly and be supported by a classroom culture which is open, honest and accepting.[143]

3.21. The Interpersonal Development domain provides students with learning opportunities and experiences that will support their learning across the curriculum, particularly in relation to working in teams where collaboration and cooperation, sharing resources and completing agreed tasks on time are highlighted. Learning related to building

[138] ibid.
[139] ibid.
[140] ibid.
[141] ibid.
[142] ibid.
[143] Victorian Curriculum and Assessment Authority, 'Introduction to Interpersonal Development,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/interpersonal/intro.html (accessed 3 August 2010).

social relationships encourages students to maintain positive learning environments across their learning programs.

*Building Social Relationships*

3.22. Building effective social relationships and relating well to others requires individuals to be empathetic, and to be able to deal effectively with their own emotions and inner moods. It also requires them to be aware of the social conventions and responsibilities that underpin the formation of effective relationships.[144]

3.23. The Building Social Relationships dimension gradually develops an understanding of social relationships, moving from the basic concept of friends and appropriate social behaviours at the start of primary school (level 1) to a complex understanding of social norms and behaviours by the end of the compulsory years of schooling (level 6). It supports students to initiate, maintain and manage positive social relationships with a diverse range of people in a range of contexts. Students learn about and practise the social conventions which underpin relationships and learn how to act in socially responsible ways. Strategies for understanding, managing and resolving conflict are also an important focus.[145]

*Working in Teams*

3.24. As working in teams is vital for social, academic and career success, students should develop this important skill while at school. The Working in Teams dimension requires individuals to be able to balance commitment to the group and its norms with their own needs. This requires competence in presenting their own ideas and listening to those of others, approaching topics from different viewpoints, and understanding their specific role and responsibilities in relation to those of others and the overall team goal.[146]

## Integrating health promotion within the VELS

3.25. In the context of this inquiry, one of the key advantages of the VELS is its highly flexible structure. As noted by the Victorian Curriculum and Assessment Authority, this allows current and future health promotion initiatives (including health promoting schools, drug education, water safety, Go For Your Life, road safety and MindMatters) to be easily incorporated into the VELS.[147]

3.26. Nonetheless, a common issue for schools, which was mentioned in many submissions, was the concept of the 'crowded curriculum'.[148] Contributors suggested that schools often find it difficult to cover health promotion in addition to traditional core subjects,[149] particularly where they see these programs as being alternative to, rather than part of, mainstream education.[150]

[144] ibid.
[145] Victorian Curriculum and Assessment Authority, 'Structure of the Interpersonal Development Domain,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/interpersonal/structure.html (accessed 3 August 2010).
[146] Victorian Curriculum and Assessment Authority, 'Introduction to Interpersonal Development,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/interpersonal/intro.html (accessed 3 August 2010).
[147] Victorian Curriculum and Assessment Authority, 'Safety and sensitive issues in Health and Physical Education,' Victorian Essential Learning Standards. http://vels.vcaa.vic.edu.au/hpe/safety.html (accessed 3 August 2010).
[148] For example, Australian Drug Foundation, Written Submission, July 2009, 5; The Alannah and Madeline Foundation, Written Submission, August 2009, 15; City of Greater Geelong, Written Submission, June 2010, 2.
[149] Australian Drug Foundation, Written Submission, July 2009, 5.
[150] Moorabool Shire Council, Written Submission, June 2010, 1.

3.27. Consequently, there was strong support throughout the inquiry for health promotion initiatives which can be integrated into the existing curriculum. The Victorian Healthcare Association stated:

> School staff must be supported in recognising that emotional health and wellbeing of young people is part of the core business for schools and that the ability to form and sustain relationships, problem solve, and seek help are the cornerstones of health and wellbeing. These skills must be taught in schools, layer upon layer, year after year from prep to year 12 and schools must be given the resources to make this possible.[151]

3.28. The Alannah and Madeline Foundation similarly noted:

> Programs that are embedded in the curriculum and the general life of the school are more effective than add-on programs. A barrier to the sustaining of any new school initiative is the already-crowded curriculum, and teachers' perception that their core business is solely to help students achieve curriculum outcomes. However, if teachers can be brought to see that health promoting initiatives – including social and emotional learning – can also achieve curriculum outcomes, then the new initiatives are more likely to be maintained over time and hence be more cost effective.[152]

3.29. Given this, the Committee found that some of the most successful health promotion initiatives have been those which provide tailored curriculum resources that assist teachers to incorporate important health messages into class activities. For example, the MindMatters activities and content have been linked to the relevant curriculum from each state,[153] while the SunSmart program provides tailored literacy and numeracy tasks for each level of primary school.[154] Similarly, a submission from Quit Victoria highlighted anti-smoking resources and activities which could be used within the Health and Physical Education, English and Communications domains of the VELS,[155] and Professor George Patton described how the Gatehouse Project used English classes as the vehicle for promoting social connectedness and resilience among secondary school students.[156]

## The teaching workforce

3.30. Teachers are key figures in the lives of children, youth and local communities, are often in a position to facilitate the development of resilience, and can have a favourable impact on children's lives.[157] As noted by the Australian Health Promoting Schools Association, 'health education programs are consistently more effective when they are delivered by trained teachers operating with adequate curriculum time and resources; and where the programs are supported by the school community'.[158]

### School leadership

3.31. The International Union for Health Promotion and Education guidelines for health promotion in schools emphasise that a whole-school approach to health and

[151] Victorian Healthcare Association, Written Submission, July 2009, 4.
[152] The Alannah and Madeline Foundation, Written Submission, August 2009, 15.
[153] MindMatters, 'Curriculum Links.' http://www.mindmatters.edu.au/whole_school_approach/curriculum_links/curriculum_links.html (accessed 13 August 2010).
[154] SunSmart, 'Primary school curriculum resources.' http://www.sunsmart.com.au/protecting_others/at_school/e6_p6_schools/activity_pages_for_primary_students (accessed 5 August 2010).
[155] Quit Victoria, Written Submission, July 2009, 1.
[156] Professor G. Patton, Director of Adolescent Health Research, Centre for Adolescent Health, University of Melbourne, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 5.
[157] Australian Health Promoting Schools Association, commissioned by the Australian Government Department of Health and Family Services, *A national framework for health promoting schools (2000–2003)* (Canberra: DHFS, 2001), 12.
[158] ibid.

wellbeing needs to have ongoing support and commitment from school leaders, including head-teachers or school directors, managers and administrators.[159]

3.32. The importance of school leadership was a consistent theme during the inquiry. Southern Grampians Primary Care Partnership was one of many participants to note the positive impact of having the endorsement of school leaders for a school's health promotion activities:

> Participating schools need to be positive about the approach with endorsement from the principal, leadership team and school council. It is our experience that schools whose leaders support the program and who present enthusiastic, energetic and supportive staff for involvement in projects experience significantly more impressive outcomes for the school community and their students than schools who are less supportive and creative in their participation.[160]

3.33. Similar views were presented by a range of other participants, including Dental Health Services Victoria,[161] HealthWest Partnership,[162] The Alannah and Madeline Foundation[163] and Baw Baw Shire Council.[164] Ms Liz Senior, a school-based health promotion worker employed by Eastern Access Community Health, noted that it is extremely difficult to work in schools if the principal is not supportive of the health promoting schools philosophy:

> From our perspective, we would not actually work with schools unless the principal and senior leadership team were pretty much on board, because I actually think it is a waste of time. When I look at the schools that I am in…the schools where the principal and the senior leadership team have embraced the idea to a greater extent have been the schools that have been most successful. My least successful school is the one where I have engaged the least with the principal. You need very much to get your senior leadership on board, or it is very, very difficult.[165]

3.34. A submission from Outer East Health and Community Support Alliance also discussed leadership as being 'critical'. It stated that it 'would like to see the Victorian Government create opportunities for principals to become leaders in the areas of health, wellbeing and community connectedness'.[166] The alliance suggested that a change in the ways schools are measured will allow principals to start integrating health promotion principles into their school culture. It noted that to achieve this, further training and capacity building will be required. It suggested that principals be supported by school-based health promotion workers and opportunities to undertake postgraduate qualifications in student health and wellbeing.

[159] International Union for Health Promotion and Education, *Achieving health promoting schools: guidelines for promoting health in schools* (France: IUHPE, 2009), 2.
[160] Southern Grampians Primary Care Partnership, Written Submission, July 2009, 3.
[161] Dental Health Services Victoria, Written Submission, July 2009, 5.
[162] HealthWest Partnership, Written Submission, July 2009, 2.
[163] The Alannah and Madeline Foundation, Written Submission, August 2009, 15.
[164] Baw Baw Shire Council, Written Submission, July 2009, 1.
[165] Ms L. Senior, Health Promotion Officer, EACH – Social and Community Health, Transcript of Evidence, Public Hearing, Melbourne, 21 June 2010, 11.
[166] Outer East Health and Community Support Alliance, Written Submission, July 2009, 14.

## Health and wellbeing champions

3.35. Many contributors noted that the need for strong leadership also extends to the need for a champion within the school, to consistently remind staff and students of the importance of health promotion messages. For example, Peninsula Health stated that a school champion is required to get the drive and momentum of a program running throughout a school. It noted that the school champion does this by encouraging other teachers and working closely with outside organisations to ensure that a project is successful.[167] Other participants to highlight the role and importance of health and wellbeing champions included the Victorian Healthcare Association,[168] Wellington Primary Care Partnership[169] and a representative of the SunSmart program.[170]

3.36. As evidenced by the Health Promoting Schools framework, one means of ensuring leadership support and creating school champions, is the establishment of a core team with responsibility for health promotion within the school. Having a health and wellbeing team also helps to reduce the likelihood of health promotion initiatives being disrupted by staff changes or departures. A submission from HealthWest Partnership supported the establishment and adequate resourcing of student wellbeing teams, either within each school or across a region:

> This concept extends on the school nurse and welfare officer programs, where appropriately qualified and trained staff implement health and wellbeing programs with students and teachers. It is believed that a central health and wellbeing team will ensure more coordinated implementation of programs, act as a central contact point for teachers, students, school boards and community partners, and the skills required to undertake such work. It is noted that these teams would need to be resourced adequately and have commitment for principals, teaching staff, school boards, parents and government to be integrated into the school environments.[171]

3.37. Under the Health Promoting Schools framework, these school-based health and wellbeing teams should include representatives of the teaching and non-teaching staff, parent and student bodies and local community members. The team is responsible for leading and coordinating health promotion actions. This starts with an audit of current health promoting actions, establishing agreed goals and strategies, implementing programs and initiatives, reviewing progress and incorporating the results of program evaluations into future programs and activities.

3.38. The Committee met with a number of health promoting schools teams during its investigations in New Zealand. It observed that these teams typically comprised a small group of enthusiastic teachers, parents, students and other staff (such as student welfare officers, school nurses and chaplains), as well as other prominent community members. The teams were supported by a local health promotion coordinator who helped guide the team during the establishment phase and linked schools with their local health and other relevant services.

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[167] Peninsula Health – Community Health, Written Submission, August 2009, 4.
[168] Victorian Healthcare Association, Written Submission, July 2009, 4.
[169] Wellington Primary Care Partnership, Written Submission, June 2010, 3.
[170] Ms J. Osborne, Schools and Early Childhood Coordinator, SunSmart, Cancer Council Victoria, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 33.
[171] HealthWest Partnership, Written Submission, July 2009, 2.

3.39. The Committee found that the concept of a health and wellbeing team is also established in many Victorian schools, either through the application of the Health Promoting Schools framework, or as part of a specific health promotion initiative. A good example is provided by the MindMatters program, which involves a core team comprising school leadership and staff, as well as community members, school nurses, parents and students.[172] The core team attends professional development activities which provide schools with the tools for implementing a whole-school approach to mental health. Another example of a core team can be found in the Kids – Go For Your Life program which uses a committee within the school to decide on the appropriate policies and the curriculum or environmental changes which need to be implemented in order to achieve award status.[173]

3.40. The Committee believes that multidisciplinary, school-based health and wellbeing teams are an essential mechanism for ensuring a comprehensive and coordinated approach to health and wellbeing in Victorian schools. The Committee believes that all schools should establish such a team, which has responsibility for identifying the health issues of most concern for the school, identifying the most appropriate means of addressing these concerns, implementing programs and incorporating the results of evaluation into future programs. The Committee notes, however, that these teams will not be successful unless supported by colleagues who have a strong knowledge base and willingness to undertake the health promoting schools approach.

### Professional learning

3.41. The Committee is aware that health promotion activities are seen by many schools as adding to their already full workload. Effective school and community health promotion places high skill demands on teachers, because much work is outside the classroom and is student led.[174] While teachers are experts in educating and working with children, it cannot be expected that they will automatically have a deep understanding of health promotion, prevention and early intervention.[175]

3.42. The School of Public Health and Preventive Medicine at Monash University commented on the difficulties for teachers in implementing whole-school approaches to health, noting that 'teachers are rarely skilled in the technical and conceptual frameworks, program logic, or evaluation of community-based health promotion programs'.[176] It recommended that the education sector, in collaboration with the health sector, identify the health promotion competencies required by school staff to successfully implement health promotion programs.[177] Southwest Primary Care Partnership suggested that existing health promotion qualifications (including short courses and degree courses) could be tailored to meet the needs of the education sector.[178]

[172] Ms V. Archdall, Victorian State Project Officer, MindMatters, Principals Australia, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 10.
[173] Kids – Go For Your Life, Cancer Council Victoria and Diabetes Australia (Victoria), Written Submission, July 2009, 1.
[174] Professor L. St Leger, Written Submission, July 2009, 4.
[175] Outer East Health and Community Support Alliance, Written Submission, July 2009, 14.
[176] School of Public Health and Preventive Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University, Written Submission, July 2009, 1.
[177] ibid., 9.
[178] SouthWest Primary Care Partnership, Written Submission, May 2010, 3.

3.43. A range of participants identified the need for cohesive professional development activities which help to ensure that teachers base their activities, policies and behaviour on evidence-based information.[179] Some suggested that the need for professional development is particularly strong for sensitive issues such as sexuality education[180] or drug education.[181]

3.44. VicHealth and the Outer East Health and Community Support Alliance highlighted the priority given to advanced professional learning within the Catholic education system. For example, the Catholic Education Office Melbourne sponsors school leaders to undertake the Postgraduate Certificate in Education (Inclusive Schooling) at the Australian Catholic University and the Master of Education (Student Wellbeing) at the University of Melbourne.[182] There are now 800 teachers in Victorian Catholic schools with the Master of Education (Student Wellbeing), ensuring that student wellbeing is a key consideration for Catholic schools.[183]

3.45. In addition to professional development activities, some submissions and witnesses suggested that there is a need for pre-service teacher education to address health promotion,[184] with Dental Health Services arguing that 'teachers should graduate with the expectation that promoting health is one of their many roles'.[185] The Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association supported health promotion modules being included in both primary and secondary teaching degrees. They suggested that this could be modelled from the existing Monash University health promotion short course.[186]

3.46. Importantly, submissions were consistent in the view that teacher training and ongoing professional development are only part of the solution for ensuring that the school-based workforce has the knowledge and competencies required for effective health promotion. Effective support systems must also be set up to provide teachers with access to health experts for advice and support. This could be achieved through a range of strategies, such as mentoring or supervision, having an in-school health promotion worker, or by having strong referral systems and partnerships.[187]

[179] For example, Cardinia Shire Council, Written Submission, July 2009, 6; Department of Health (Western Australia), Written Submission, July 2009, 9; The Alannah and Madeline Foundation, Written Submission, August 2009, 16–17; Outer East Health and Community Support Alliance, Written Submission, July 2009, 14.
[180] Family Planning Victoria, Written Submission, July 2009, 13.
[181] Australian Drug Foundation, Written Submission, July 2009, 5.
[182] VicHealth, Written Submission, July 2009, 12; Outer East Health and Community Support Alliance, Written Submission, July 2009, 9.
[183] Outer East Health and Community Support Alliance, Written Submission, July 2009, 9.
[184] For example, The Alannah and Madeline Foundation, Written Submission, August 2009, 16; Ballarat Community Health, Written Submission, September 2009, 7; Healthy Kids School Canteen Association, Written Submission, August 2009, 4; Quit Victoria, Written Submission, July 2009, 2.
[185] Dental Health Services Victoria, Written Submission, July 2009, 5.
[186] Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association, Written Submission, July 2009, 10.
[187] Outer East Health and Community Support Alliance, Written Submission, July 2009, 14.

## Conclusion

3.47. The VELS cover a range of health related curriculum content, as well as the development of interpersonal and social skills, which together contribute to the physical, mental and emotional health of Victorian students. Importantly, the flexible structure of the VELS provides a suitable basis for incorporating health promotion initiatives in a cross-curricular way. The Committee found that this structure contributes to the success of many health promotion initiatives in schools, particularly where program designers have tailored their activities and curriculum resources to the VELS requirements and stages of learning.

3.48. The Committee also found that the approaches to teaching and learning adopted within a school have a key influence on the level of commitment to and success of health promotion initiatives. In particular, the Committee found that health promotion in schools works best where it has the support of the school leadership and other staff, especially through the establishment of a health and wellbeing team. Additionally, health promotion needs to be supported by appropriate professional development opportunities for the teaching workforce and other school-based staff.

# Chapter 4
# School ethos and environment

> Students can reach their full educational potential only when they are happy, healthy and safe and where a positive school culture exists to engage and support them in their learning.[188]

4.1. A health promoting schools approach requires schools to move beyond traditional curriculum-based approaches to health promotion, and to consider a broad range of school-based factors. The school ethos and environment are very important, as they underpin the way the school views itself and its student body. The ethos of a school is a web of interconnecting components, including school policies and procedures, cultural values and the social and physical environments. It is about the climate, atmosphere or feeling of a school and the way this impacts upon students' learning and teachers' work.[189]

## Components of the school ethos and environment

4.2. Throughout the inquiry, the Committee received evidence relating to how various components of a school's ethos and environment contribute to the health and wellbeing of all members of the school community. These included the policies and practices developed by schools to support the broader educational policies and frameworks established by education authorities, as well as a multitude of factors which together comprise the school's physical and social environment.

### Healthy school policies

4.3. In order to comply with the registration requirements set out by the Victorian Registration and Qualifications Authority, schools must have policies and procedures in place that provide students with a safe learning environment where the risk of harm is minimised and students feel physically and emotionally secure. Student engagement and wellbeing is one of the three key student outcomes that schools and networks are accountable for under the Department of Education and Early Childhood Development's school and network accountability and improvement frameworks.[190] Consequently, the Committee was able to identify a wide range of policies and practices in Victorian schools which are aimed at supporting health and wellbeing for all members of the school community.

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[188] Knox City Council, Written Submission, July 2009, 2.

[189] Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 10.

[190] Department of Education and Early Childhood Development (Victoria), *Effective Schools are Engaging Schools: Student Engagement Policy Guidelines*, (Melbourne: Student Wellbeing and Support Division, Office of Government School Education, DEECD, 2009), 5.

*Department of Education and Early Childhood Development policies and resources*

4.4. The Department of Education and Early Childhood Development has established a number of broad policies and frameworks which support a school's operations. Key among these is the Effective Schools Model, which is designed to provide schools with a constant framework through which to embed their whole-school projects, such as health promoting schools. The eight elements of the Effective Schools Model are: professional leadership; focus on teaching and learning; purposeful teaching; shared vision and goals; high expectations of all learners; accountability; learning communities; and stimulating and secure learning environment.[191]

4.5. The Committee notes that the Effective Schools Model extends to other policy areas for schools which are also relevant to the inquiry, including 'Effective Schools are Engaging Schools – Student Engagement Policy Guidelines' (2009) and the 'Safe Schools are Effective Schools' strategy (2006).

4.6. All Victorian government schools are required to develop a Student Engagement Policy, with this requirement listed on the School Compliance Checklist from 2010. The Student Engagement Policy articulates the school community's shared expectations in the areas of student engagement, attendance and behaviour. Student engagement can be defined as three interrelated components: behavioural, emotional and cognitive.[192]

4.7. The Student Engagement Policy supports the rights and articulates the expectations of every member of the school community to engage in and promote a safe and inclusive educational environment. The policy should support a school's capacity to respond to individual student circumstances, such as when a student begins to disengage from their learning, their regular attendance is not consistent or when they fail to demonstrate positive behaviours. The policy achieves this by outlining a series of processes, actions and consequences developed in consultation with the school community.[193]

4.8. Each school's Student Engagement Policy should cover the following components:

- school profile statement;
- whole-school prevention statement;
- rights and responsibilities;
- shared expectations;
- principals, teachers and student support staff;
- students;
- parents/carers; and

[191] Department of Education and Early Childhood Development (Victoria), 'Effective Schools.' http://www.education.vic.gov.au/about/directions/blueprint1/es/default.htm (accessed 9 August 2010).
[192] Department of Education and Early Childhood Development (Victoria), *Effective Schools are Engaging Schools: Student Engagement Policy Guidelines*, (Melbourne: Student Wellbeing and Support Division, Office of Government School Education, DEECD, 2009), 7.
[193] ibid., 5.

- school actions/consequences.[194]

4.9. The Student Engagement Policy is complemented by the 'Safe Schools are Effective Schools' strategy. This strategy was developed as a response to the National Safe Schools Framework, which consists of a set of nationally agreed principles for a safe and supportive school environment, including appropriate responses to address issues of bullying, violence, harassment and child abuse and neglect.[195] The 'Safe Schools are Effective Schools' strategy is underpinned by the eight key elements of the Effective Schools Model, and has received strong support from community organisations such as the Alannah and Madeline Foundation.[196]

4.10. Another key resource published by the Department of Education and Early Childhood Development to assist schools to develop and implement appropriate school-based policies is the Victorian Government Schools Reference Guide. Some of the topics covered in the guide of key relevance to the inquiry include: occupational health and safety, student attendance, student health, student safety and risk management.[197]

*School-based policies*

4.11. The Committee identified a wide range of school-based policies which flow from the overarching policies and programs of an education system. Some of the typical health and wellbeing policies seen in Victorian schools include: healthy canteens; anti-smoking policies; use of alcohol and other drugs; gender equity; first aid; sun protection; classroom safety; critical incident policies for dealing with death, suicide, fire, accidents and other emergency situations; reported or suspected child abuse; environmentally friendly resource use and waste disposal; staff health and welfare; immunisations; safety of playground equipment; sexual harassment; anti-bullying policies; and welfare and discipline.

4.12. The Committee heard that school-based health and wellbeing policies must be integrated with other activities within the school, and even the local community. Ideally, health and wellbeing policies will support the health messages communicated in the classroom and within the broader community. Additionally, healthy behaviours should be modelled by staff and other adults.

4.13. The Committee found that although most Victorian schools have a number of policies which support health and wellbeing, often these policies have not been developed in a comprehensive or coordinated manner. The Committee heard that many schools would therefore benefit from assistance in auditing their existing policies, including formal written policies, as well as those which are generally accepted within the school but which have not yet been formally recorded.[198] The Committee heard that this could be achieved by either providing key staff with time release to review and

[194] ibid.

[195] Australian Government Department of Education, Employment and Workplace Relations, 'National Safe Schools Framework.' http://www.dest.gov.au/sectors/school_education/publications_resources/profiles/national_safe_schools_framework.htm (accessed 9 August 2010).

[196] The Alannah and Madeline Foundation, Written Submission, August 2009, 13.

[197] Department of Education and Early Childhood Development (Victoria), 'Victorian Government Schools Reference Guide, A–Z Topic Index,' http://www.education.vic.gov.au/management/governance/referenceguide/index/default.htm (accessed 6 August 2010).

[198] Transcript of Evidence, Public Hearing, Melbourne, 21 June 2010.

formalise their school's policies and practices, or by providing outside assistance, such as through a health promotion worker, to lead and develop this work.[199]

4.14. The Committee believes that school-based health and wellbeing policies will be most effective when they have been developed in close consultation between all members of the school community, including teaching and non-teaching staff, students, parents and other community members. Indeed, the Committee believes that student empowerment and the involvement of parents, families and other community members was a key to the success of the Health Promoting Schools initiative examined in New Zealand.

4.15. The Committee also believes that all Victorian schools should develop an overarching health promotion policy which outlines the school's commitment to health promotion, its specific health promotion goals and its processes for engaging the school community in a health promoting philosophy.

### The physical environment

4.16. The physical environment represents one of the most tangible ways in which schools can demonstrate their commitment to supporting and improving the health and wellbeing of all members of their community. The physical environment includes the design, layout and quality of the buildings, and indoor and outdoor facilities. The physical environment should not only ensure the physical safety for those who learn, work and play there, but also support the mental health and wellbeing of the school community.

4.17. The Committee acknowledges that schools spend a great deal of time and other resources ensuring a pleasant physical environment for their staff and students. During investigations in New Zealand, staff and students took great pride in demonstrating how their implementation of a health promoting schools approach had resulted in a much improved physical environment for staff and students. Some of the common physical features or improvements in the schools visited included: general improvements to the quality of buildings and facilities (eg. new building designs, new equipment, re-painting, new carpet, improved display areas); kitchen and community gardens; improved toilet facilities; improved quality of drinking water; sun safety measures; a variety of different playground areas to support physical activity and restful recreation; and playground murals and artworks.[200] Other factors for schools to consider may include: traffic safety in the area immediately surrounding the school; protection from unauthorised visitors to the school; and cleaning and maintenance arrangements.

### The social environment

4.18. The social environment of a school is a mix of the school's formal procedures and programs, extra-curricular activities, pastoral and student welfare arrangements, relationships between people in the school and their partnership with parents and the community.[201] As noted by a Victorian guide to health promoting schools, the quality of relationships among staff, among students and between staff and students is

[199] ibid.
[200] Site visits to schools, Rotorua and Auckland, 21–22 October 2009.
[201] Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 10.

particularly influential, as is the relationship between parents and the school (which in turn is set within the context of the wider community). The guide notes that the social environment is also influenced by senior staff from within the school and by health and education personnel who visit the school, all of whom provide role models for students and staff by the attitudes and values they display in their social behaviour.[202]

4.19. The Victorian guide to health promoting schools suggested that a positive social environment for learning may be characterised by low staff absenteeism, acceptance of individual diversity within classrooms, high expectation of student achievement and classroom discipline structures that allow all students to contribute to the group. A positive social environment will also encourage the development of skills such as decision making, problem solving and appropriate risk taking.[203]

4.20. Specific practices which can help to create a positive social environment include:

- teachers are supportive of and respectful towards students;
- students are encouraged to participate in school decision making processes;
- students are encouraged to be active participants in the learning process;
- the school actively discourages physical and verbal violence among students and between students and staff;
- positive creative arts (music, art, drama and dance), physical activity and academic experiences for all students are promoted;
- students feel a sense of belonging to the school;
- the school reflects the cultural values of the school community;
- students with special learning or social needs are identified and supported appropriately;
- the school provides a safe, stimulating and welcoming environment;
- parents are regularly informed and have the opportunity to participate in school activities;
- the school values and encourages contributions by students, staff, parents and the community to the life of the school; and
- the curriculum provides opportunities for students to learn about cultural, religious and racial diversity.[204]

[202] ibid., 53.
[203] ibid., 10.
[204] ibid., 53.

4.21. Many of the submissions to the inquiry commented on the importance of the social relationships within a school. In particular, the importance of social connectedness in ensuring student mental health and wellbeing and subsequent academic performance was highlighted.

4.22. The Committee notes that resources from the Department of Education and Early Childhood Development, including the Student Engagement Policy Guidelines and Safe Schools are Effective Schools strategy, provide useful guidance for schools seeking to develop a supportive social environment. Additionally, there are a range of programs and resources provided by various non-government organisations which can also assist schools to evaluate and improve the social environment.

## Supporting mental health and social wellbeing in schools

4.23. During the inquiry, mental health was repeatedly cited as a health topic of extreme importance for schools.[205] Although the definitions or aims for mental health and social wellbeing varied (covering concepts such as social connectedness, resilience and social emotional learning), the underlying concept remained the same. A student without stable mental health and a sense of wellbeing will find it difficult to participate in school, from both the educational and social perspective. Thus, mental health and wellbeing is increasingly considered to be the core of a health promoting school.

### The importance of social relationships

4.24. Numerous submissions highlighted the importance of social relationships for success at school and the ability of children and young people to resist negative peer influences, particularly during the adolescent years. This issue was also discussed during a public hearing attended by Professor George Patton from the Centre for Adolescent Health, who stated:

> We talk about the paradox of adolescent health— stronger, fitter, faster, smarter— and yet a whole lot of things get worse, and they relate to emotion, emotional control, behaviour and lifestyle…we know that social connection at school promotes good educational outcomes. We believe it also promotes healthy behaviour and healthy emotional adjustment.[206]

4.25. During adolescence there are marked changes in attachment to family, school and peers, with disruption or insecurity in these relationships carrying a risk of social, emotional and behavioural problems. In contrast, a sense of school connection is associated with lower rates of substance use, sexual risk behaviour and emotional problems, as well as positive educational outcomes.[207] Consequently, programs which seek to enhance the relationships between students and their peers and teachers, can be expected to improve students' educational outcomes by reducing teenage risk behaviours.

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[205] For example, Professor L. St Leger, Written Submission, July 2009, 7; beyondblue: the national depression initiative, Written Submission, July 2009, 2; National Rural Health Students' Network, Written Submission, July 2009, 3; Foundation 49, Written Submission, August 2009, 6; Association of Independent Schools Victoria, Written Submission, August 2009, 2; Catholic Education Office, Melbourne, Written Submission, August 2009, 1, 4.

[206] Professor G. Patton, Director of Adolescent Health Research, Centre for Adolescent Health, University of Melbourne, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 2.

[207] George Patton and others, 'Promoting Social Inclusion in Schools: A Group-Randomised Trial of Effects on Student Health Risk Behavior and Well-Being,' *American Journal of Public Health* 96, no 9 (September 2006): 1585.

4.26. An adjunct to social connectedness at school is the link between behavioural issues, such as classroom disruptiveness and learning difficulties. Professor Patton told the Committee that identifying learning difficulties as they emerge in primary school may be one of the most effective means of maintaining student engagement, thereby preventing the opting out of learning which can flow through to secondary school.[208] This suggests that by improving student engagement and social connectedness, we can prevent the uptake of damaging behaviours and improve the long-term health outcomes of students, as well as achieve benefits within the classroom.

4.27. The Committee heard about a range of strategies employed by schools to enhance the social relationships within the school. For example, schools across Victoria have introduced buddy and/or mentoring programs as a means of engaging students and strengthening social relationships, particularly between younger students and older students or adults.[209] In addition, many of the approaches used to prevent bullying and discourage the use of harmful substances include components relating to social connectedness and relationships.

## Bullying

4.28. The Committee heard that bullying is an issue of increasing concern to schools. The Department of Education and Early Childhood Development defines bullying as when someone, or a group of people, who have more power at the time, deliberately upset or hurt another person on more than one occasion. Bullying includes: physical bullying such as hitting; verbal bullying such as name calling; and indirect bullying such as spreading rumours.[210]

4.29. Cyber bullying is an issue of particular concern for education authorities:

> Multimedia technologies have created new domains in which young people learn and interact. Technology such as mobile phones, SMS, in-phone cameras, emails and chat rooms can be an effective way to learn and a great way to communicate. Unfortunately some people use this technology to bully others by sending threatening or unwanted messages or spreading nasty rumours.[211]

4.30. The Department of Education and Early Childhood Development notes that bullying is distinct from situations where there is mutual conflict, social rejection or dislike (unless it is a repeated act and directed towards a specific person) and single episodes of nastiness or meanness or random acts of aggression or intimidation. Additionally, nastiness or physical aggression that is directed towards many different students is not the same as bullying, although since the school has a duty of care to provide students with a safe and supportive school environment, single episodes of nastiness or physical aggression should not be ignored or condoned.[212]

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[208] Professor G. Patton, Director of Adolescent Health Research, Centre for Adolescent Health, University of Melbourne, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 5.

[209] For example, Victorian Youth Mentoring Alliance, Written Submission, June 2009, 3–4; Open Family Australia, Written Submission, July 2009, 3; Academy of Sport Health and Education, Written Submission, August 2009, 2; Camp Hill Primary School, Written Submission, April 2010, 2–3.

[210] Department of Education and Early Childhood Development (Victoria), 'What is Bullying.' http://www.education.vic.gov.au/healthwellbeing/safety/bullying/what.htm (accessed 3 August 2010).

[211] Department of Education and Early Childhood Development (Victoria), 'Cyber Bullying.' http://www.education.vic.gov.au/healthwellbeing/safety/bullying/cyber/default.htm (accessed 3 August 2010).

[212] Department of Education and Early Childhood Development (Victoria), 'What is Bullying.' http://www.education.vic.gov.au/healthwellbeing/safety/bullying/what.htm (accessed 3 August 2010).

4.31. A submission from the Alannah and Madeline Foundation described the negative consequences of bullying. Victims of bullying have a higher likelihood than other young people of experiencing adverse health outcomes and social adjustment problems, while young people who are engaged in repeated bullying are more likely to engage in ongoing anti-social behaviour and criminality, have issues with substance abuse, demonstrate low academic achievement and be involved in future child and spouse abuse.[213] The Alannah and Madeline Foundation emphasised the need to address bullying within schools, as both victimised young people and those who take part in bullying across time may demonstrate lower levels of academic achievement than might otherwise have been expected.[214] The Committee also heard of cases in Australia and New Zealand where suicides have been linked to cyber and text bullying.[215]

4.32. The Department of Education and Early Childhood Development's website outlines a range of strategies for dealing with bullying, including basic strategies and more involved policies. These include:

- assertiveness training;
- restorative practices relating to social relationships, conflict resolution and other problem solving skills;
- bystander training where other students support or intervene on behalf of bullied students;
- the friendly schools and families program which uses the health promoting schools approach to promote pro-social behaviours and reduce bullying;
- buddy systems between older and younger children;
- the You can do it! Education program aimed at developing social, emotional and behavioural wellbeing; and
- school procedures and policies for dealing with students who bully, which complement the Safe Schools are Effective Schools strategy.[216]

4.33. The Committee learned about a number of programs designed to complement the anti-bullying policies implemented by schools. For example, the MindMatters program promotes a whole-school approach to bullying through its 'Dealing with Bullying and Harassment' resource. The resource suggests that school organisation factors may be more powerful determinants of behaviour than personal factors. The MindMatters resource states that a whole-school approach serves to support an environment where it is not acceptable to bully, and where the culture says it is okay to 'tell'. In this type of environment, the cycle of silence about bullying can be broken.[217]

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[213] The Alannah and Madeline Foundation, Written Submission, August 2009, 3.
[214] ibid.
[215] Meeting with Associate Professor Cynthia Kiro, Centre for Public Health Research and Dr Janis Carroll Lind, Senior Lecturer, College of Education, Massey University, Wellington, 20 October 2009.
[216] Department of Education and Early Childhood Development (Victoria), 'Strategies for Bullying Intervention.' http://www.education.vic.gov.au/healthwellbeing/safety/bullying/schoolstrategy.htm (accessed 3 August 2010).
[217] Helen Cahill, Pamela Morrison and Coosje Griffiths, for MindMatters, *A Whole School Approach to Dealing with Bullying and Harassment* (Canberra: Commonwealth of Australia, 2007), 11.

4.34. The Alannah and Madeline Foundation has developed a specific response to cyber bullying, through its eSmart Initiative. The initiative is based on a model of social change, intended to help schools, parents and communities identify, learn about and manage the problems of online and face-to-face bullying, identity theft, harassment and sexual predation using electronic means.[218] It is built on six relevant domains of action, namely: policies and practices; curriculum; caring school community; effective teacher practices; effective use of technologies; and family and community partnerships. Through a web portal, schools can access strategic guidelines and the best available resources to support them in completing actions in each domain.[219]

### The use of harmful substances

4.35. The Committee received a range of submissions from agencies involved in health promotion programs relating to harmful substances such as tobacco, alcohol and drugs. These included: QUIT Victoria, the Australian Drug Foundation, the Alcohol and other Drugs Council of Australia, the National Drug and Alcohol Research Centre, the Victorian Alcohol and Drug Association and VicHealth. While issues associated with harmful substances relate to both physical and mental health, the evidence received by the Committee focused almost exclusively on the links between mental health and the use of harmful substances.

4.36. QUIT Victoria, the peak body for smoking prevention in Victoria, advised the Committee that curriculum activities which only provide information about tobacco and the health effects of smoking have been proven to have no effect on the prevalence of smoking among adolescents.[220] Instead, QUIT Victoria advocates for activities which provide accurate information while also focusing on building resilience and highlighting psychosocial factors, such as effective ways of dealing with stress and pressure. Quit Victoria advised the Committee that these approaches can delay experimentation with smoking for several years.

4.37. The evidence from Quit Victoria was supported by the NSW Department of Health, which provided a written submission highlighting current research findings. It reported that teaching general competence skills (such as decision making, communication and problem solving) as part of smoking education programs builds a greater sense of self-worth and better enables young people to implement smoking refusal strategies.[221]

4.38. VicHealth noted similar arguments, while further noting that congruency between the health messages promoted in schools and the health related attitudes and behaviours that prevail in the broader school environment and community are critical for the effectiveness of school-based tobacco interventions.[222] It highlighted the importance of 'multi-modal programs', where methods combine curricular approaches with wider initiatives within and beyond the school, including programs for parents, schools, or communities and initiatives to change school policies about tobacco, or state policies about the taxation, sale, availability and use of tobacco.[223]

[218] The Alannah and Madeline Foundation, Written Submission, August 2009, 4–5.
[219] ibid., 5.
[220] Quit Victoria, Written Submission, July 2009, 3.
[221] Centre for Health Advancement, Department of Health (New South Wales), Written Submission, July 2009, 3.
[222] VicHealth, Written Submission, July 2009, 5.
[223] ibid.

4.39. The experience from the tobacco sector was also supported by submissions from the anti-alcohol and drugs bodies. Additionally, the Committee was advised that abstinence programs are not effective at preventing alcohol and drug use among teens,[224] and that harm minimisation programs are more effective at lowering or preventing the use of drugs and alcohol by young people.[225]

4.40. The Committee notes that harm minimisation is the approach advocated in the National Principles for School Drug Education and supported by the Department of Education and Early Childhood Development. The principles state that effective drug education programs should:

- increase students' knowledge, social and life skills, and refusal skills towards licit and illicit drug use;
- include content relevant to young people's experiences and interests;
- contain highly interactive pedagogies that engage students in problem solving and critical thinking;
- commence activities prior to initial experimentation and continue as young people mature;
- provide significant coverage of relevant issues complemented by follow up booster sessions;
- position drug education within a broader health and personal learning curriculum that focuses, amongst other things, on mental health issues such as stress and coping;
- respond to cultural and social needs of the school community; and
- engage parents where possible.[226]

4.41. Notably, all of the submissions and witnesses commenting on harmful substances emphasised the need for whole-school approaches targeting overall mental health and wellbeing, rather than short-term project-based approaches which seek to address a single health behaviour. Some of the programs identified as best practice are outlined in the following section.

### Best practice programs addressing mental health and social wellbeing

4.42. Mental health initiatives in schools seek to build the social, emotional and spiritual wellbeing of students to enable them to achieve education and health goals and to interact with their peers, teachers, family and community in ways that are respectful and just. International evidence shows that successful mental health initiatives:

- are well designed and grounded in tested theory and practice;
- link the school, home and community;

[224] Ms R. McClean, Policy and Conference Advisor, Australian Drug Foundation, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 22.
[225] National Drug and Alcohol Research Centre, University of New South Wales, Written Submission, July 2009, 2; Australian Drug Foundation, Written Submission, July 2009, 3.
[226] Department of Education and Early Childhood Development (Victoria), 'Drug Education.' http://www.education.vic.gov.au/studentlearning/programs/drugeducation/default.htm (accessed 5 August 2010).

- address the school ecology and environment;
- combine a consistency in behavioural change goals through connecting students, teachers, family and community;
- foster respectful and supportive relationships among students, teachers and parents;
- use interactive learning and teaching approaches; and
- increase the connections for each student. [227]

4.43. The Committee was made aware of a range of programs targeting the important issue of mental health and social wellbeing in schools. Key among these were: MindMatters (secondary schools) and KidsMatter (primary schools); the Gatehouse Project; and the Schools as Core Social Centres program.

*MindMatters*

4.44. One of the most prominent programs dealing with mental health and social wellbeing in schools is MindMatters, which has been funded by the federal Department of Health and Ageing since 2000. The program is administered and managed by Principals Australia.

4.45. MindMatters is a resource and professional development program supporting Australian secondary schools in promoting and protecting the mental health and social and emotional wellbeing of all members of school communities.[228] It is designed as a whole-school approach in which mental health and wellbeing is integrated into the existing school curriculum.[229] A key impetus for MindMatters was the fact that teachers were often unsure how to tackle the delicate issues relating to mental health within the classroom.[230]

4.46. The Committee heard that a key focus of MindMatters is building protective factors for young people. As stated by Ms Jill Pearman, the national team coordinator for MindMatters, the program is:

> Trying to help build connection to school, to result in educational attainment but also a sense of worth, a sense of who the student is and how they connect and feel a sense of belonging, thereby reducing mental health problems.[231]

4.47. Specifically, MindMatters aims to:

- embed promotion, prevention and early intervention activities for mental health and wellbeing in Australian secondary schools;
- enhance the development of school environments where young people feel safe, valued, engaged and purposeful;
- develop the social and emotional skills required to meet life's challenges;

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[227] Lawrence St Leger and others, *Promoting Health in Schools: from Evidence to Action* (France: International Union for Health Promotion and Education, 2010), 8.
[228] MindMatters, 'Home Page.' http://www.mindmatters.edu.au/default.asp (accessed 3 August 2010).
[229] Ms V. Archdall, Victorian State Project Officer, MindMatters, Principals Australia, Transcript of Evidence, Public Hearing, Melbourne, October 5 2009, 10.
[230] ibid.
[231] Ms J. Pearman, National Team Coordinator, MindMatters, Principals Australia, Transcript of Evidence, Public Hearing, Melbourne, October 5 2009, 12.

- help school communities create a climate of positive mental health and wellbeing;
- develop strategies to enable a continuum of support for students with additional needs in relation to mental health and wellbeing; and
- enable schools to better collaborate with families and the health sector.[232]

4.48. MindMatters enjoys extensive coverage within Australian secondary schools: staff from 82 per cent of schools with secondary student enrolments have attended MindMatters professional development, including over 120,000 Australian and international participants; 71 per cent of Australian secondary schools have used MindMatters, with 52 per cent continuing to use it as a curriculum resource; and 18 per cent of schools use MindMatters as their key organiser for mental health promotion.[233]

4.49. A wide range of stakeholders acknowledged the success of MindMatters in Victorian schools. The Committee notes that much of this success can be attributed to the whole-school approach adopted by MindMatters, as well as its ability to address many of the challenges faced by schools when seeking to implement health and wellbeing programs. For example, MindMatters recognised the already full curriculum program within schools and therefore set out to create a program which could be integrated into the existing curriculum, rather than creating new content areas.[234] MindMatters is also unique in that although it is funded through the health department, it has been developed by educationalists with an interest in health. This has contributed the necessary intersection between the different language and concepts used by the health and education sectors.[235]

4.50. Other factors which were identified as contributing to the success of MindMatters included the longevity of the program (resulting in positive word of mouth and greater take-up among schools), the use of a core team comprising a wide range of school and community members to implement the program, and its use of partnerships and community links. Importantly, the Committee notes that MindMatters has been continually evaluated, resulting in enhancements and additions to the program, as well as continuation of the funding for the program itself.[236]

*KidsMatter*

4.51. Where MindMatters tackles mental health and social wellbeing issues within secondary schools, the more recently introduced KidsMatter is the complementary program for early childhood services and primary schools. KidsMatter is sponsored by several agencies, including the federal Department of Health and Ageing, *beyondblue*, the Australian Psychological Society, the Australian Principals Association's Professional Development Council and the Australian Rotary Health Research Fund.

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[232] MindMatters, Principals Australia, Written Submission, July 2009, 10.
[233] ibid., 2–3.
[234] Ms V. Archdall, Victorian State Project Officer, MindMatters, Principals Australia, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 10.
[235] Ms L. Walker, Executive Manager, Participation and Equity for Health, VicHealth, Transcript of Evidence, Public Hearing, Melbourne, 16 November 2009, 8.
[236] Ms J. Pearman, National Team Coordinator, MindMatters, Principals Australia, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 12.

4.52. The KidsMatter initiative aims to improve the mental health and wellbeing of primary school students, reduce mental health problems amongst students and achieve greater support for students experiencing mental health problems.[237]

4.53. Drawing on the latest international research, the KidsMatter framework and implementation focus on four key areas where schools can really make a difference. These comprise:

- A positive school community: A positive school community enables staff, students, families and community members to work together to support children's wellbeing. It promotes feelings of belonging and connectedness, which are very important for positive mental health.
- Social and emotional learning for students: Social and emotional learning is about learning how to manage feelings, handle relationships and solve problems. By systematically teaching children social and emotional skills, schools can support children's positive mental health and benefit their learning.
- Parenting support and education: Schools can play an important role in helping to provide parents and carers with information regarding children's development and wellbeing. They can also facilitate access to services that provide parenting support.
- Early intervention for students experiencing mental health difficulties: By being aware of the kinds of mental health difficulties that affect children and what kinds of support are available, schools can help children and their families to access early intervention services and get the help they need.[238]

4.54. The Centre for Analysis of Educational Futures, Flinders University evaluated the two-year trial of KidsMatter over 2006 to 2008. The evaluation found evidence of change related to all four components of the framework. It found statistically and practically significant improvement in students' measured mental health, in terms of both reduced mental health difficulties and increased mental health strengths. Importantly, there was greater impact for students who were rated as having higher levels of mental health difficulties at the start of the trial, and for some measures, schools which had done the program for two years (rather than one year) showed greater effects.[239]

4.55. Given the success of the trial program, formal implementation has now been rolled out to more schools across Australia, with support materials also available on the KidsMatter website for any other school which is interested.

[237] beyondblue: the national depression initiative, Written Submission, July 2009, 3.
[238] ibid.
[239] Phillip Slee and others for KidsMatter, *KidsMatter Evaluation Final Report, Executive Summary* (Adelaide: Centre for Analysis of Educational Futures, Flinders University, 2009), 4.

*The Gatehouse Project*

4.56. A number of submissions to the inquiry made note of the Gatehouse Project, which was run by the Centre for Adolescent Health, University of Melbourne between 1996 and 2002, and sponsored by VicHealth.[240]

4.57. The Gatehouse Project was designed to build the capacity of schools to promote emotional wellbeing. It assists schools to develop strategies for reducing risk factors and enhancing protective factors in the school environment. The curriculum materials and whole-school strategy used in the project focus particularly on enhancing students' sense of connectedness to school and increasing students' skills and knowledge for dealing with the everyday life challenges.[241]

4.58. The Gatehouse Project provides schools with strong conceptual and operational frameworks to enhance understanding of adolescent mental health needs, as well as an evidence-based process for planning, implementing and evaluating a practical intervention.[242] The conceptual framework of the Gatehouse Project approach emphasises the importance of healthy attachments or a sense of positive connection with teachers and peers. It identifies three key areas of action: building a sense of security and trust; enhancing communication and social connectedness; and building a sense of positive regard through valued participation in aspects of school life. The operational framework for the project draws on the Health Promoting Schools framework by recognising the need to address the three areas of action at all levels of school operations.[243]

4.59. The Gatehouse Project approach provides a five-step evidence-based process, through which schools work to build on existing policies, programs and practices and develop new policies, programs and practices that promote connectedness to school. This involves:

- establishing an Adolescent Health Team to coordinate the planning, implementation and evaluation of strategies;
- reviewing policies, programs and practices to identify priorities for action, including use of data from the Gatehouse Project Adolescent Health Survey;
- planning strategies to address areas identified in the review;
- training and implementation, developing a program of professional development and training for members of the school community to equip them to implement the chosen strategies; and
- monitoring and evaluation of the process of implementation, with a view to informing future cycles of review, planning and change.[244]

[240] For example, VicHealth, Written Submission, July 2009, 7; Quit Victoria, Written Submission, July 2009, 4; Victorian Alcohol and Drug Association, Written Submission, July 2009, 3; Eating Disorders Foundation of Victoria (Eating Disorders Victoria), Written Submission, August 2009, 6.

[241] Royal Children's Hospital, 'The Project,' Gatehouse Project. http://www.rch.org.au/gatehouseproject/project/index.cfm?doc_id=174 (accessed 3 August 2010).

[242] Royal Children's Hospital, 'The Program,' Gatehouse Project. http://www.rch.org.au/gatehouseproject/project/index.cfm?doc_id=397 (accessed 3 August 2010).

[243] ibid.

[244] ibid.

4.60. In line with best practice described throughout the inquiry, the Gatehouse Project linked health and education, sat within existing health and education policy frameworks, and built on the work schools were already doing. As noted above, the project also provided a strong, accessible framework and process which meet the needs of individual school communities, and had measurable outcomes.[245]

4.61. Importantly, the Gatehouse Project used survey data to identify priority areas for intervention.[246] The school-based team was then assisted by a consultant to select and implement appropriate interventions. Intervention elements ranged from establishing an inclusive classroom environment to creating opportunities for student participation in school life beyond the classroom, and included implementing a student curriculum that teaches interpersonal communication and emotional management.[247]

4.62. The Gatehouse Project combines individual-focused and environment-focused approaches. The individual-focused approach aims to help students develop and refine an understanding of challenges and stresses experienced by most young people, the range of emotional reactions to these and to extend their repertoire of cognitive and social skills for dealing with them.[248] The environment-focused approach encourages and equips schools to examine the policies, practices and programs of the school across a range of environments in which young people might find themselves, to see where risk factors might be reduced and protective factors enhanced.[249] In responding to these factors, the Gatehouse Project considers both the context of the classroom and the content of the curriculum.

4.63. Professor Patton told the Committee that the Gatehouse Project was extremely effective at reducing the usage of alcohol, tobacco and cannabis (down around 20%) and reducing anti-social behaviours such as theft, interpersonal violence and property damage (down around 25%). In addition, the rate of early sexual intercourse by 13 to 14 year-olds was reduced by half.[250]

4.64. The Committee heard that in common with many other successful health promotion initiatives, the Gatehouse Project was not fully integrated into all secondary schools due to the lack of funding following the initial pilot. As noted by Mr Todd Harper, Chief Executive Officer, VicHealth, it is not always easy to 'scale up' programs which have been successful, because there is not always the money available.[251] Various stakeholders noted this as a significant limitation, as the most effective school and community health related actions occur over at least five to seven years before any significant change is achieved.

[245] ibid.
[246] Centre for Adolescent Health, University of Melbourne, Written Submission, July 2009, 1.
[247] Professor George Patton and others, 'Promoting Social Inclusion in Schools: A Group-Randomised Trial of Effects on Student Health Risk Behavior and Well-Being,' *American Journal of Public Health* 96, no 9 (September 2006): 1582.
[248] Royal Children's Hospital, 'The Program,' Gatehouse Project. http://www.rch.org.au/gatehouseproject/project/theprogram/index.cfm?doc_id=397 (accessed 3 August 2010).
[249] ibid.
[250] Professor G. Patton, Director of Adolescent Health Research, Centre for Adolescent Health, University of Melbourne, Transcript of Evidence, Public Hearing, Melbourne, 5 October 2009, 3.
[251] Mr T. Harper, Chief Executive Officer, VicHealth, Transcript of Evidence, Public Hearing, Melbourne, 16 November 2009, 4.

4.65. The Committee notes that although the project timeframe has expired, Gatehouse Project materials including school case studies, team guidelines and teaching materials remain available on the Royal Children's Hospital website.[252]

*Schools as Core Social Centres*

4.66. The Committee heard that the Catholic Education Office has also adopted an effective approach to social connectedness and wellbeing, supported by funding from VicHealth. The Schools as Core Social Centres project aims to: promote an understanding of the links between wellbeing and improved learning outcomes; support the development of a whole-school approach to student wellbeing; and increase the capacity of schools and communities through the development of collaborative partnerships.[253]

4.67. The Schools as Core Social Centres project began as a trial in 2002, in part as a response to the findings of the 1997 Suicide Prevention Taskforce and also as a response to the 2001 OECD report *Schooling for Tomorrow: What Schools for the Future?*

4.68. The project commenced as a pilot project in a cluster of three schools, but has now expanded to cover eight clusters and 26 schools across Melbourne, with over 7,200 students participating.[254] Consistent with the health promoting schools approach, schools are provided with audit tools to assess school leadership, school staff and students, and parents and community.

4.69. The Schools as Core Social Centres project has five key outcome areas: learning outcomes; attitudes to school including student management; parent connectedness; social emotional learning; and community partnerships.[255] A 2007 progress report found that all participating schools had demonstrated progress in all of these key areas.[256] In 2007, a research stage commenced with a focus on local, national and international literature, as well as the development of a framework to implement Schools as a Core Social Centre across the broader education community and health and education sectors.[257]

4.70. As an added element to the Schools as Core Social Centres program, the Catholic Education Office Melbourne has appointed student wellbeing coordinators to work in 255 primary schools across Melbourne. The coordinators are part of the leadership team and are responsible for ensuring positive learning outcomes, as well as the health and wellbeing of staff, students and the wider community.[258] The coordinators also receive high level and sustained professional development, with the Catholic Education Office Melbourne sponsoring participation in the Postgraduate Certificate in Education (Inclusive Schooling) at the Australian Catholic University and the Master of Education (Student Wellbeing) at the University of Melbourne.[259]

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[252] Royal Children's Hospital, 'Resources,' Gatehouse Project. http://www.rch.org.au/gatehouseproject/resources/index.cfm?doc_id=175 (accessed 29 July 2009).
[253] Catholic Education Office Melbourne, *Schools as Core Social Centre: Progress Report, July 2007* (East Melbourne: CEOM, 2007), 3.
[254] VicHealth, Written Submission, July 2009, 12.
[255] Catholic Education Office Melbourne, *Schools as Core Social Centres: Progress Report, July 2007* (East Melbourne: CEOM, 2007), 5.
[256] ibid.
[257] ibid., 4.
[258] Catholic Education Office Melbourne, Written Submission, August 2009, 2.
[259] VicHealth, Written Submission, July 2009, 12–13.

4.71. An adjunct to the Schools as Core Social Centres program is the Student Wellbeing Action Partnership (SWAP), which is a ten-year collaboration between the University of Melbourne's Graduate School of Education and the Catholic Education Office Melbourne. The SWAP website provides extensive resources and information on research and professional development opportunities for teachers.[260]

## Supporting physical health in schools

4.72. The Committee received a substantial body of evidence covering various aspects of physical health. In particular, submissions outlined ways in which schools can encourage healthy eating, physical activity and sun safety, as a means of achieving overall good health and preventing a wide range of diseases in later life.

### Healthy eating

4.73. Healthy eating was an issue of strong interest during the inquiry, mainly due to concerns about the increasing rates of obesity and diabetes among children. However, the nutritional issues that affect children are far more diverse, and include: growth; bone health and development; dental health; eating disorders and body image; mood, concentration and learning; development of food preferences, tastes, eating habits and skills; promotion of heath and prevention of lifestyle disease; and nutritional adequacy.[261]

4.74. The Committee noted that at least a third of a students' daily food intake is consumed while at school. Participants in the inquiry therefore argued that schools should aim to influence students' eating behaviours through a range of policies and practices, as well as through healthy eating messages delivered through the curriculum. In particular, participants identified opportunities to influence eating behaviours through school canteen policies, kitchen garden programs and breakfast programs.

#### *School canteen policies*

4.75. The quality of food available through school canteens (and other outlets targeting children and young people) has been a topic of community discussion over recent years. Research indicates that students who use school canteens consume far more energy dense foods such as fast foods, packaged snacks, soft drinks and confectionary than children who do not use the school canteen.[262]

4.76. Community and health sector concerns about the role of the school canteen and the quality of food provided in schools has led to governments worldwide developing school canteen policies. While some such policies provide guidance for schools seeking to offer healthy food choices, some jurisdictions have developed mandatory guidelines, or even legislated, on the food that may or may not be provided in schools. Such guidelines generally cover school canteens, fundraising activities, vending machines and/or food served at the school's social or other events.

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[260] The University of Melbourne, 'Partners in Student Wellbeing since 1990,' Student Wellbeing Action Partnership. http://www.edfac.unimelb.edu.au/swap/ (accessed 3 August 2010).

[261] Department of Education and Early Childhood Development (Victoria), 'Why is Healthy Food in Schools Important?' http://www.education.vic.gov.au/management/schooloperations/healthycanteen/background/schools.htm (accessed 3 August 2010).

[262] Nutrition Australia (Victorian Division), Written Submission, September 2009, 6.

4.77. The Department of Education and Early Childhood Development describes the role and influence of the school canteen in the following way:

> In addition to the provision of nutritious food, the canteen has an important role within the broader school environment in complementing the knowledge, skills and behaviours about healthy eating and lifestyles that are taught in the classroom. The food provided within the school environment has a considerable influence on the development of children's long-term eating habits, food preferences and attitudes towards food. The school canteen can play an important role in promoting healthy foods and creating a school culture of healthy eating. This can extend beyond the school environment and influence food choices within the family and community and enhance the social and multicultural aspects of food and eating.[263]

4.78. The department has therefore recommended that a school's food services and curriculum programs on healthy eating be complementary, noting that positive peer pressure within the education setting can create a culture in which nutritious foods and a healthy lifestyle are actively chosen. The department states that this culture should permeate the entire school environment and can have an impact on choices made by students about food consumption when they are not at school.[264]

4.79. The Department of Education and Early Childhood Development states that a healthy school food service should provide foods which reflect the Dietary Guidelines for Children and Adolescents in Australia, which were developed by the National Health and Medical Research Council in 2003. Food provided within a school should encourage students to:

- enjoy a wide variety of nutritious foods;
- eat plenty of vegetables, legumes, fruits, breads and cereals;
- include lean meat, fish, poultry and/or alternatives;
- include milks, yoghurt, cheeses;
- choose water as a drink;
- limit saturated fats and moderate total fat intake;
- choose foods low in salt; and
- consume only moderate amounts of sugars and foods containing added sugars.[265]

4.80. The Committee found that a popular approach to incorporating these national food guidelines is the 'traffic light' approach which recommends the categorisation of food as green (have plenty), amber (select carefully) and red (occasional).

4.81. Nutrition Australia advised the Committee of a range of programs which it operates with the aim of maximising the healthy content of the food provided in Victorian schools. Its main program is the Healthy Canteen Advisory Service, which is funded

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[263] Department of Education and Early Childhood Development (Victoria), 'Why is Healthy Food in Schools Important?' http://www.education.vic.gov.au/management/schooloperations/healthycanteen/background/schools.htm (accessed 3 August 2010).

[264] Department of Education and Early Childhood Development (Victoria), 'Whole-school Approach to Healthy Eating.' http://www.education.vic.gov.au/management/schooloperations/healthycanteen/policy/wholeschool.htm (accessed 13 September 2010).

[265] Department of Education and Early Childhood Development (Victoria), 'What Foods Should be Provided?' http://www.education.vic.gov.au/management/schooloperations/healthycanteen/policy/whatfood.htm (accessed 12 July 2010).

by the Victorian Department of Human Services and designed to support the Kids – Go For Your Life program. The Healthy Canteen Advisory Service provides a range of services and resources, including: workshops and training, menu assessments and a dedicated website for schools; phone advice, information sessions and advice on product development for the food industry; and an information line, resource kits and professional development sessions for health professionals.[266]

4.82. Nutrition Australia reported that it is currently unable to accommodate the many requests for help that it receives from secondary school canteens, as its funding is generally targeted towards primary schools.[267] Although resources for primary schools may have some advice for secondary schools, they do not necessarily reflect the nutritional needs and food preferences of older children, or the more complex role of the secondary school canteen, which is likely to be open more frequently, cater for a much larger student cohort and have a greater expectation of profit.[268]

4.83. The Committee acknowledges that a common issue for schools is the perception that unhealthy foods are more popular and therefore more profitable for a school. However, the Department of Education and Early Childhood Development notes that although profits may initially decrease following the introduction of a healthy eating policy due to the need for investment in equipment and staff, many schools have reported subsequent increases in profits, partly attributable to parents being more willing to allow children to buy lunch when they know it will be healthy.[269] The department further notes that effective management is the best way to ensure a profitable school canteen.

4.84. The Committee heard that another successful approach to ensuring the profitability of a healthy school canteen is the involvement of students in the development of the canteen policy and menus and the day-to-day running of the school canteen. This is most successful where the school canteen is considered within the context of a comprehensive, healthy school philosophy.

*Kitchen gardens*

4.85. One of the most popular activities for schools seeking to influence the eating behaviours of members of the school community is the establishment of kitchen gardens. The Committee heard about a number of such programs, including the Stephanie Alexander Kitchen Garden Program, the Home Grown Project and the Edible Classrooms School Garden Program.

4.86. The common goal of kitchen garden programs is to assist students to gain the knowledge and skills to promote healthy eating and lifestyles. Participants gain skills in growing, harvesting, preparing and sharing fresh seasonal food in their schools, while gaining an appreciation of environmental, conservation and sustainability issues.

4.87. As noted in a submission from the Stephanie Alexander Kitchen Garden Foundation, students involved in kitchen garden programs experience a range of benefits, including:

[266] Nutrition Australia (Victorian Division), Written Submission, September 2009, 10.
[267] ibid., 9.
[268] ibid., 42.
[269] Department of Education and Early Childhood Development (Victoria), 'Frequently Asked Questions: About the Kit.' http://www.education.vic.gov.au/management/schooloperations/healthycanteen/faqs.htm (accessed 12 July 2010).

- enjoying delicious meals made from food they have grown and prepared themselves;
- becoming familiar with a broad selection of fruit, vegetables and grains;
- developing knowledge and skills in maintaining a productive kitchen garden;
- learning a range of cooking and food preparation skills;
- arranging tables for sharing meals with friends, teachers and school community members;
- working cooperatively in the garden and kitchen;
- experiencing improved self-esteem through the achievement of purposeful tasks;
- understanding the essential, interdependent roles played by sunlight, soil, water and insects in growing and harvesting food, and the importance of conserving and protecting these elements;
- implementing practices that maximise productivity and sustainability, such as mulching, composting, crop rotation and companion planting; and
- becoming informed and discerning food consumers who link practices and concepts learnt in the kitchen and garden with all areas of the curriculum.[270]

4.88. The Committee found that the various kitchen garden programs have been successful in encouraging children to eat a wide range of fresh and nutritious food. A submission from Cultivating Community also described some of the benefits of such programs in terms of social cohesion and inclusiveness within the school community:

> Gardening is a non-competitive environment where everyone achieves, no matter what task is at hand. Working alongside peers provides a sense of team work and community spirit. Garden working bees are a time when strengthening of that community spirit has enabled people from all walks of life to contribute to their school site and create a sense of pride in a job done together. The social cohesion and inclusiveness has rippled through school communities and the garden becomes a social hub for sharing fresh, seasonal food, sharing seeds, growing things together, creating art together.[271]

4.89. Additionally, kitchen garden programs often have flow on benefits to the broader school and local community. For example, students take home useful skills and information that can be used in the home, while local community members can benefit through volunteering to assist with and participate in the program. Volunteers participating in the Edible Classrooms School Garden Program include retirees, chefs, university students, part-time workers and parents. The project also sometimes hosts university placements for students wishing to use the project in their research and studies.[272]

[270] Stephanie Alexander Kitchen Garden Foundation, Written Submission, July 2009, 1.
[271] Edible Classrooms School Garden Program, Cultivating Community, Written Submission, July 2009, 9.
[272] ibid., 6.

4.90. Cultivating Community also noted how kitchen garden programs can engage culturally and linguistically diverse communities:

> The social health benefits have long lasting and far reaching benefits. For example, a number of our garden projects have provided a comfortable platform for learning about and wider acceptance of multicultural practices around food and lifestyles. For example, through harvest festival celebrations and links with local community gardens, the diverse community immediate to schools are able to share their cultural heritage and knowledge.[273]

4.91. The Stephanie Alexander Kitchen Garden Foundation noted that for many school communities, particularly those in regional areas, the school's kitchen and garden become a centre for social activity, and can influence the character of the community.[274] In some schools, parents and community members who participate as volunteers in the program have achieved qualifications in food management from local adult education centres, leading to employment opportunities for the participants.[275] Cultivating Community also noted the involvement of local community members in the Edible Classrooms School Garden Program:

> Neighbours are very important to keep happy in the local school environment. We have developed strong and mutually beneficial relationships with neighbours, especially over holidays. The neighbours look after gardens and grounds and benefit from the bounty that can be had from a productive garden.[276]

4.92. Importantly, the submission from Cultivating Community noted the growing body of international and Australian based evidence that 'edible school gardens can break down cultural barriers, provide therapeutic benefits to students with learning and behavioral difficulties and assist to address obesity, nutrition and active learning'.[277]

4.93. Submissions from the various kitchen garden programs (and other stakeholders involved in these programs) identified two key challenges in sustaining their programs in schools: funding and volunteer staffing. The Stephanie Alexander Kitchen Garden Program requires schools to source funding to employ part-time chefs and gardeners, establish gardens and kitchens, purchase equipment and supplementary ingredients and pay for increased energy use.[278] While the Home Grown Project and the Edible Classrooms School Garden Program aim to overcome such barriers at the school level, the programs nonetheless require ongoing program level funding provided by governments and/or the corporate sector. These programs are therefore seeking government endorsement and support for the diversity of models in which schools can integrate school garden programs into their curriculum and equitable, ongoing funding accessible for all schools to deliver a kitchen garden program.[279]

4.94. The Committee notes that the benefits of kitchen garden programs can be complemented and reinforced by a range of other food related initiatives. For example, the Food Design Challenge is run annually by Home Economics Victoria for students in all year levels. Participating students learn how to prepare and cook a range of food items, handle food safely, apply healthy eating principles and develop

[273] ibid., 9.
[274] Stephanie Alexander Kitchen Garden Foundation, Written Submission, July 2009, 2.
[275] ibid.
[276] Edible Classrooms School Garden Program, Cultivating Community, Written Submission, July 2009, 9.
[277] ibid., 8.
[278] Stephanie Alexander Kitchen Garden Foundation, Written Submission, July 2009, 4.
[279] The Home Grown Project, Written Submission, July 2009, 9; Edible Classrooms School Garden Program, Cultivating Community, Written Submission, July 2009, 14.

their sensory awareness.[280] Underpinning these practical aspects are the creative, social and emotional dimensions to the students' experiences, achievements and wellbeing.

*Breakfast programs*

4.95. The Committee heard that the food consumed at breakfast is even more important than lunch, as it sets the pattern for energy and concentration levels throughout the day. Unfortunately, however, many Victorian students arrive at school without having eaten a healthy breakfast. This may be due to a range of reasons, either because the family does not have the means to provide a healthy breakfast, or because a young person either does not understand the importance of eating breakfast, or does not prioritise the time required to prepare and enjoy a nutritious morning meal.

4.96. The Committee found that some Victorian schools have developed breakfast programs as a way of ensuring that students come to classes with the energy and nutrition required to learn effectively. Often, these programs are supported by local councils, community health organisations and/or charitable organisations.

4.97. A submission from Forest Hill College outlined its experience with a 'breakfast bar'. A significant proportion of students at the school come from low-income families who may have difficulty providing a healthy breakfast. A survey at the school found that potentially 25 per cent of students were not having breakfast, and significant proportions of students were feeling tired prior to coming to school and/or reported feeling hungry during lessons.[281] Significantly, the numbers of students who did not eat breakfast rose as students progressed through the school levels.[282]

4.98. In response, the school established the breakfast bar with three key aims: promote and increase the healthy breakfast concept; positively influence habit formation; and impact connectedness and relationships across the school.[283]

4.99. The primary target group for Forest Hill College's breakfast bar is students who attend school without having eaten a healthy breakfast. This target group includes students with low motivation or interest in breakfast, students who have few familial supports in having breakfast, those who get up late and who do not prioritise breakfast, and students who require guidance to make healthy life choices.[284]

4.100. Another target group for the breakfast bar is students in need of connectedness and who need encouragement or assistance in extending their support network. Forest Hill College advised the Committee that the relaxed and informal environment of the breakfast bar enables students to develop friendships, thereby building interpersonal skills and confidence. It noted that students who are on the fringe of the school community (including students who are culturally diverse, self-harmers and those suffering from depressed mood or depressive disorders) are accepted in the non-threatening breakfast bar environment.[285]

[280] Home Economics Victoria, Written Submission, July 2009, 2.
[281] Forest Hill College, Written Submission, July 2009, 7.
[282] ibid., 3.
[283] ibid.
[284] ibid., 4.
[285] ibid., 5.

4.101. There have been many positive outcomes of the breakfast bar program at Forest Hill College. More students are eating breakfast prior to commencing lessons and teachers report improvements in students' behaviour. Additionally, the program has resulted in the building of relationships across year levels, with students reporting increases in social connectedness.[286]

4.102. Nonetheless, Forest Hill College has experienced a range of challenges in sustaining the breakfast bar program. Resourcing the project has continued to be time consuming and at times frustrating, with the school regularly seeking funding and support through appropriate government programs, Rotary Clubs and local businesses. Additionally, staffing needs to remain a continued focus to ensure the program is sustainable.

4.103. A submission from the Western Australian Department of Health made note of that state's School Breakfast Program, which is run by Foodbank WA.[287] The program commenced in 2001 with 17 schools and, since then, the program has reached over 360 schools across metropolitan, rural and remote Western Australia. By mid-2010, the program was serving nearly 36,500 breakfasts per week at 277 schools.[288] The Western Australian Department of Health noted the benefits of the program around improved health, school attendance and related measures.[289]

4.104. Participation in Western Australia's School Breakfast Program is free for schools, and the foods supplied under the program comply with the Department of Education's Healthy Food and Drink Policy. Typical foods supplied through the program include canned fruit in natural syrup, wheat biscuits, baked beans and spaghetti and UHT milk. Where possible, the program also makes fresh produce available to schools, including fresh fruit and vegetables, bread, milk and yoghurt. The Committee notes that a similar program based in Victoria would greatly assist schools seeking to provide school breakfast programs.

4.105. The Committee welcomes the initiative taken by some Victorian schools to ensure their students have access to a nutritious breakfast. The Committee believes that such schools could be assisted if there was greater coordination of breakfast programs at the local or regional level. The Committee notes, however, that when planning such initiatives, schools and other stakeholders should be aware of some additional factors, including the possibility of less needy children seeking to access some breakfast programs, the possible stigma attached to attending certain programs and/or the need to have adequate supervision in the school grounds for students attending the breakfast program.

[286] ibid., 1–4.
[287] Department of Health (Western Australia), Written Submission, July 2009, 4.
[288] Foodbank WA Inc, 'About School Breakfast Program,' School Breakfast Program. http://www.schoolbreakfastprogram.com.au/index.php?option=com_content&view=article&id=50&Itemid=57 (accessed 11 August 2010).
[289] Department of Health (Western Australia), Written Submission, July 2009, 7.

## Physical activity

4.106. According to VicHealth, physical activity is ranked second only to tobacco control in being the most important factor in health promotion and disease prevention in Australia.[290] The decreasing levels of physical activity in children, often due to increases in sedentary behaviour such as watching TV or playing computer games, are a factor in increasing levels of obesity. Importantly for schools, the patterns of physical activity set in childhood are often carried through into adulthood.

4.107. The Committee is aware that physical activity has a range of important benefits for children beyond weight management. Physical activity contributes to positive self-esteem, skill development, skeletal health, healthy development and cardiovascular health. It has also been shown to improve students' concentration, memory, behaviour and academic performance.[291] Research has found that academic performance at school is enhanced by physical activity, through increased cerebral blood flow, enhanced arousal level, changed hormone secretion and improved self-esteem.[292] There is also evidence that increasing physical education classes during school can lead to improvements on cognitive tests across all age groups, but particularly for primary and early secondary students.[293]

### *Physical education*

4.108. The Department of Education and Early Childhood Development recognises that physical activity is a key component for the development of healthy learners. It notes that structured physical education is essential for raising participation rates of young people in physical activity, raising young people's levels of physical competency, and redressing the declining level of health and fitness among many young people.[294]

4.109. As noted by Tennis Victoria and Netball Victoria, physical education classes are essential for the development of basic coordination and motor skills, such as running, jumping, throwing, catching and balancing, which are necessary for an active life and for future sporting activity.[295]

4.110. Acknowledging this, the Department of Education and Early Childhood Development has developed guidelines for participation in physical activity during the school week. For students in prep to year 3, this includes 20 to 30 minutes of physical education per day. For years 4 to 6, the department requires students to participate in three hours of physical education and sport, with a minimum provision of 50 per cent for physical education. For secondary students, the requirement is for 100 minutes of physical education and 100 minutes of sport per week.[296]

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[290] VicHealth, 'How to create active communities.' http://www.vichealth.vic.gov.au/Programs-and-Projects/Physical-Activity.aspx (accessed 10 August 2010).

[291] Victorian Primary Schools' Sports Association and Victorian Secondary Schools' Sports Association, Written Submission, July 2009, 3–4.

[292] Terry Dwyer and others, 'Relation of academic performance to physical activity and fitness in children,' *Pediatric Exercise Science* 13 (2001): 225.

[293] Benjamin Sibley and Jennifer Etnier, 'The relationship between physical activity and cognition in children: a meta-analysis,' *Pediatric Exercise Science* 15 (2003): 245.

[294] Department of Education and Early Childhood Development (Victoria), *Improving School Sport and Physical Education in your school*, (Melbourne: Student Learning Division, Office of Government School Education, DEECD, 2009), 3.

[295] Tennis Victoria, Written Submission, July 2009, 2; Netball Victoria, Written Submission, July 2009, 2.

[296] Department of Education and Early Childhood Development (Victoria), *Improving School Sport and Physical Education in your school*, (Melbourne: Student Learning Division, Office of Government School Education, DEECD, 2009), 3.

*School sports*

4.111. The Committee heard that school sports and after school programs provide an important opportunity for increasing the levels of physical activity among children and young people. School Sport Victoria[297] advised the Committee that around 400,000 students participate in school sports in Victoria every year,[298] with around 1,800 primary and 400 secondary schools currently allied with the association.[299]

4.112. School Sport Victoria argued that school sport is the vehicle that enables daily and lifelong healthy living practices that are transferred between school, home and the local community. It suggested that by instilling school sport values in an educative setting, students are given opportunities to develop their strategic capacity to make informed decisions in leading healthy and active lives. School Sport Victoria also noted that school sport values include leadership, respect, fairness, responsibility and resilience, and that it also instils an ongoing desire to be healthy and active community members.[300]

4.113. The Committee notes that partnerships are a key feature of a successful school sport program. As outlined by School Sport Victoria, schools with a strong sport program work with their local communities, parents, local councils and the business community. Strong school sports programs feature partnerships with local and state sporting bodies, with sporting clinics, come and try days and specialised coaching.[301]

4.114. Schools collaborate across local and regional areas in a variety of organisational models to participate in regular competition that culminates in state championships. Students who excel are given opportunities to experience higher levels of competition and coaching expertise. Schools involved in these partnerships have greater access to facilities, venues, expertise and staff professional development.[302]

4.115. Darebin Community Health suggested that partnerships between local sporting clubs and schools are particularly important in areas of socioeconomic disadvantage, as many children from this population group report skill, transport and cost as barriers to participating in regular after school and weekend sporting activities.[303]

*After school sports programs*

4.116. The Committee was made aware that another forum for children's physical activity is after school programs.

4.117. One of the main examples after school sports programs is the Australian Sport Commission's Active After School Communities program, which has been operating nationally since 2005. This program has been found to provide significant benefits to children, schools and local communities across the country and is recognised as a successful practical example of utilising schools as a pivotal focal point for

[297] School Sport Victoria is the peak body for school sports in Victoria. It was created in 2010 through a merger of the Victorian Primary Schools' Sports Association and the Victorian Secondary Schools' Sports Association.
[298] Victorian Primary Schools' Sports Association and Victorian Secondary Schools' Sport Association, Written Submission, July 2009, 2.
[299] Mr B. Allen, President, Victorian Primary Schools' Sports Association, Transcript of Evidence, Public Hearing, Melbourne, 16 November 2009, 32.
[300] Victorian Primary Schools' Sports Association and Victorian Secondary Schools' Sport Association, Written Submission, July 2009, 2.
[301] ibid., 3.
[302] ibid.
[303] Darebin Community Health, Written Submission, July 2009, 3.

communities to enable many health related benefits to be achieved.[304] The objectives of the program are to:

- enhance the physical activity levels of Australian primary school children thorugh a nationally coordinated program;
- provide increased opportunities for inclusive participation in quality, safe and fun sport and other structured physical activities; and
- stimulate local community involvement in sport and other structured physical activity.[305]

4.118. The Active After School Communities program was estasblished by the Australian Sports Commission as a response to an eroding community sport base and the subsequent implications for the health of the community. Key societal changes identfied as contributing to the decline included:

- primary school-age children across Australia becoming less active and subsequently less healthy;
- the motor skills competencies of children being poor, in large part as a result of the continuing decline of physical education and sport in Australian schools;
- work patterns changing, and thereby reducing opportunities for families to support their children's out of school activities, whether in sport or other areas;
- opportunities for children to be physically active in the home setting diminshing as families become increasingly mindful of the dangers of leaving children to play in unsupervised settings; and
- screen-based leisure time activities becoming increasingly popular.[306]

4.119. The Active After School Communities program is delivered as a free program through participating primary schools and outside school hours care services during the after school hours (3.00pm to 5.30pm). It aims to engage traditionally inactive children in sport and other structured physical activities, and through a positive and fun experience, develop a love of sport that inspires them to join a local sporting club.[307]

4.120. The Active After School Communities program is currently running at capacity, with 150,000 children taking part each term in 3,250 schools and after school centres across all regions in Australia, including 820 schools and after school centres in Victoria. On average, every child who participates in the program receives 80 free sports programs, 80 free healthy afternoon snacks, a qualified coach, access to sports equipment and a supervisor.[308]

4.121. An evaluation of the Active After School Communities program indicated that parental factors are extremely influential in their children's sport and other structured physical activty experiences. The main barriers to participation identified by parents

[304] Australian Sports Commission, Written Submission, July 2009, 1.
[305] ibid., 1–2.
[306] ibid., 1.
[307] ibid.
[308] ibid., 2.

include time constraints, cost, transportation issues, lack of awareness of opportunities and other non-physical competing interests and activities.[309] The research found that these barriers are more easily overcome through the Active After School Communities program due to the convenience of its connection to school and after school centres.

4.122. Case studies conducted in communities involved in the Active After School Communities program have summarised the key strengths of the program to be:

- the program is free and is delivered at schools, which avoids financial and transport/accessiblity problems for parents;
- the program emphasises fun, safe, confidence building activities reflective of best practice for delivery of physical activity to primary school aged children;
- holding the program at consistent times and days increases accessibility for families;
- schools value the funding for equipment and training that they otherwise would not have;
- the program improves links between educational institutions in the community, for example through using secondary school students as community coaches; and
- the program stimulates development of community links between schools and parents as well as other institutions such as local colleges.[310]

4.123. An added benefit of the Active After School Communities program has been its capacity to enhance the skills of teachers and provide resources which could then be utilised within curriculum time to support the delivery of physical education sessions.[311] The Australian Sports Commission reports that since participating in the program more than three quarters of participating schools and outside school hours care services agreed that their organisation had improved its ability to support and encourage student participation in structured physical activity.[312]

*Active travel*

4.124. Active travel programs are another strategy used by schools seeking to increase the level of physical activity among students. Active travel refers to walking, cycling, skating or scooting, rather than using a car or public transport as a means of travel. Active travel strategies are supported by VicHealth, which aims to increase the proportion of children walking or cycling to school on most days of the week from 30 per cent to 60 per cent.[313]

4.125. The concept of active travel was referred to in many submissions to the inquiry, particularly those from local councils. Many councils outlined their involvement in active travel programs, as well as their role in planning for active travel as a key part

[309] ibid.
[310] ibid., 3.
[311] ibid.
[312] ibid.
[313] VicHealth, 'Active and safe travel to school.' http://www.vichealth.vic.gov.au/en/Programs-and-Projects/Physical-Activity/Active-and-Safe-Travel-to-School.aspx (accessed 3 August 2010).

of their Municipal Public Health Plans, generally through improvements to walking and cycling tracks and pedestrian crossings within their municipality.[314] Some of the most common active travel programs include the Walking School Bus, Ride2School, Streets Ahead and Pedal Pods.

4.126. VicHealth recognises a wide range of benefits of the Walking School Bus program for students, parents, the school and the local community. Walking school buses can assist children to: get to school safely, conveniently and on time; get regular physical activity and exercise; gain a sense of independence; develop as individuals through involvement in a responsible and disciplined activity; experience being part of a group or team; learn about traffic safety and good road sense; become more familiar with their own neighbourhood and surroundings; have a chance to build friendships; have fun getting to school; and arrive at school alert and ready to learn. For parents, the key benefits include feeling confident that their children are healthier, saving money, getting children to school safely and on time and reducing pressure to accompany children to school every day.[315]

4.127. Importantly, the Walking School Bus and other active travel programs provide a range of community benefits. These include: easing congestion around the school grounds; providing a safer, non-polluting and sustainable transport alternative; encouraging a sense of community as families get to know each other and their children become friends; and bringing more people onto the street who are interested in the safety and security of the community.[316]

4.128. A specific example of the potential unexpected community benefits arising from the Walking School Bus program comes from the City of Port Phillip, which instituted a pedestrian safety research project. The Greenlight Project considered whether changes needed to be made to the cycling of lights at pedestrian crossings on major roads as a means of encouraging walking.[317] The study findings pointed to a need for longer green light times for pedestrians and the introduction of a head start for pedestrians on turning traffic, at all signalised crossings on walking school bus routes throughout Victoria. The study also noted the opportunity to apply these changes to other locations where there are high pedestrian demands or more vulnerable pedestrians.[318]

4.129. The Committee heard that despite the advantages of active travel programs, these programs typically experience a range of challenges. For example, a 2007 review of the Walking School Bus conducted by VicHealth found the following:

[314] For example, Cardinia Shire Council, Written Submission, July 2009, 1; Brimbank City Council, Written Submission, August 2009, 1; City of Greater Geelong, Written Submission, June 2010, 1; City of Stonnington, Written Submission, July 2010; Darebin City Council, Written Submission, August 2009, 2; Frankston City Council, Written Submission, July 2009, 1; Greater Shepparton City Council, Written Submission, June 2010, 4; Maribyrnong City Council, Written Submission, June 2010, 2.

[315] VicHealth, 'Walking School Bus.' http://www.vichealth.vic.gov.au/en/Programs-and-Projects/Physical-Activity/Active-and-Safe-Travel-to-School/Walking-School-Bus.aspx# (accessed 3 August 2010).

[316] ibid.

[317] VicHealth, 'Active and safe travel to school.' http://www.vichealth.vic.gov.au/en/Programs-and-Projects/Physical-Activity/Active-and-Safe-Travel-to-School.aspx#1 (accessed 3 August 2010).

[318] City of Port Phillip and VicHealth in partnership with City of Greater Geelong and City of Bayside, *The Greenlight Project: Re-directing pedestrian priority at signalised crossings on major roads*, (St Kilda: City of Port Phillip, 2005), 1.

- Walking buses are resource intensive to establish and maintain.
- Its lengthy implementation chain, limited funding and the need to effect real change to physical environments outside school provided challenges to the program model.
- Walking School Bus is beset by many volunteer issues, particularly volunteer recruitment and retention. Volunteer issues slowed the expansion of the program in many areas and have caused some established programs to cease.
- As a stand-alone program, Walking School Bus is too structured and inflexible, generally operates in isolation from other transport initiatives, and does not allow for whole-of-community approaches to increasing the level of children's active transport to and from school.
- Walking School Bus mainly caters for younger students (prep to year 4) and most walking buses do not operate every day or to and from school.
- The Walking School Bus did not make significant inroads into increasing the number of children who independently walk/cycle to school.
- Some schools do not see travel to school as a school issue.[319]

4.130. The above challenges were reinforced in a range of submissions to the inquiry. The Committee found that these challenges apply not only to the Walking School Bus and other active travel programs, but also to many other health promotion programs involving schools.

### The Kids – Go For Your Life program

4.131. The Committee found that the most popular program seeking to improve and promote physical health among primary school students in Victoria is Kids – Go For Your Life. Significantly, this program integrates health promotion initiatives seeking to address both healthy eating and physical activity. Kids – Go For Your Life is funded by the Victorian Government and managed by Diabetes Australia (Victorian branch) and Cancer Council Victoria.

4.132. Kids – Go For Your Life supports healthy eating and physical activity through an award program which provides a comprehensive, yet simple, guide for schools and early childhood services to create healthy environments for children to enjoy being active and eating well every day.[320]

4.133. The Committee notes that award schemes have become popular among various countries to monitor systems and recognise achievement. The evaluation of award schemes has demonstrated award-related changes related to children's health behaviours and the culture and organisation of schools. Award schemes provide a structured framework, health related targets and provide external support.[321]

[319] VicHealth, 'Walking School Bus.' http://www.vichealth.vic.gov.au/en/Programs-and-Projects/Physical-Activity/Active-and-Safe-Travel-to-School/Walking-School-Bus.aspx# (accessed 3 August 2010).
[320] Kids – Go For Your Life, Cancer Council Victoria and Diabetes Australia (Victoria), Written Submission, July 2009, 1.
[321] ibid., 3.

4.134. Schools and early childhood services join the Kids – Go For Your Life program as members and receive a range of free resources, training and support as they work through a number of criteria to improve their policies and practices and become awarded. Once awarded, schools and services receive a sign for their front gate to show to their community their commitment to children's healthy eating and physical activity.[322] Schools renew their award status every two years, ensuring an ongoing commitment to and assessment of student and school needs.

4.135. The Kids – Go For Your Life program is based on six key messages that make healthy eating and physical activity a fun and engaging learning experience for children and adults (refer Figure 4.1).[323] Through these six clear messages, schools are able to institute consistent policies across all aspects of the school – curriculum, environment and external community links – and have a clearer framework for selecting appropriate health promoting programs.

Figure 4.1 Six key messages of Kids – Go For Your Life

| |
|---|
| Tap into Water Everyday<br>For healthy bodies and teeth, children need to drink water and limit sweet drinks. Reduce sweet drinks including fruit juice, fruit drinks, soft drinks, flavoured mineral water, cordials, sport drinks, energy drinks and flavoured milk. |
| Turn Off, Switch to Play<br>Screen activities include watching television, computers and playing electronic games. Children need active play! So limit screen time, and make sure they have time to be active every day. |
| Plant Fruit and Veg in Your Lunchbox<br>Fruit and vegetables provide essential nutrients for healthy eyes, skin, hair and protect against many diseases. Colourful and crunchy vegetables and fruit should be an enjoyable part of every child's day. |
| Move, Play and Go<br>Being physically active promotes many benefits for children including increased fitness, coordination and motor skills, confidence, self-esteem and academic performance. |
| Limit 'Sometimes' Foods<br>Foods and drinks high in fat, sugar and salt should only be consumed 'sometimes'. Too many 'sometimes' foods replace nutritious foods children need and may lead to health problems. |
| Stride and Ride<br>Walking and riding to school is a great way to get fit and prepare children for a day of learning. Fewer cars on the road are also better for the environment and make the roads around services and schools safer. |

Source: Go For Your Life, 'Healthy message campaign,' Kids – Go For Your Life. http://www.goforyourlife.vic.gov.au/hav/articles.nsf/practitioners/Healthy_message_campaign?OpenDocument (accessed 3 August 2010).

[322] ibid., 1.

[323] Go For Your Life, 'Who we are and what we do,' Kids – Go For Your Life. http://www.goforyourlife.vic.gov.au/hav/articles.nsf/pracpages/Kids_Go_for_your_life?open (accessed 3 August 2010).

4.136. Kids – Go For Your Life is about creating healthy habits for life using a joint approach with teachers, principals, service staff and especially parents.[324] The specific requirements to meet the award criteria include:

- allowing and encouraging all students to bring a water bottle to class and to use their bottle during physical education and sport;
- having a defined fruit and vegetable break during the day;
- removing high sugar drinks and confectionary as defined by the Department of Education and Early Childhood Development's School Canteen and other Food Services Policy, limiting the availability of chips and fried foods to no more than two occasions per term, and requesting school community members not to bring these foods or drinks to school;
- complying with the Department of Education and Early Childhood Development's mandated times for physical education and sport, and having a system that enables students to regularly access play equipment during breaks; and
- promoting walking or riding through a whole-of-school activity at least one day per term.[325]

4.137. In addition, schools are expected to incorporate key components of the International Union for Health Promotion and Education's health promoting schools approach to supporting healthy eating and physical activity. This aspect requires schools to have a whole-school curriculum plan (which reflects the Victorian Essential Learning Standards) that encourages healthy eating and daily physical activity during and outside school hours. They must also have a policy endorsed by the school council or board which incorporates all of the award criteria. Families must be informed of these policies and provided with information to assist them to meet policy requirements.[326]

4.138. Kids – Go For Your Life currently works with over 925 primary schools across Victoria who have joined as members of the program. This represents 55 per cent of government primary schools, 40 per cent of all Catholic schools and 13 per cent of all independent schools. Schools that are members of Kids – Go For Your Life are therefore influencing the health behaviours of over 215,000 children, represented across 98 per cent of all local government areas.[327]

4.139. The Committee believes that the above data demonstrate the broad acceptability and feasibility of the Kids – Go For Your Life program to engage schools and create healthy changes to their policies and practices. Further evidence of the program's success is demonstrated by two other Australian states licensing the program and implementing it within their jurisdiction.[328]

[324] ibid.
[325] Go For Your Life, 'Healthy Primary Schools.' Available on the Kids – Go For Your Life website, http://www.goforyourlife.vic.gov.au/hav/admin.nsf/Images/How_to_meet_Award_Criteria.pdf/$File/How_to_meet_Award_Criteria.pdf.
[326] ibid.
[327] Kids – Go For Your Life, Cancer Council Victoria and Diabetes Australia (Victoria), Written Submission, July 2009, 2.
[328] ibid.

4.140. Nonetheless, the Committee would be interested to see a breakdown of the participating schools to ensure that the program is equally accessible for schools with different levels of socioeconomic advantage. Darebin Community Health suggested that in common with many other health promotion initiatives, the implementation of Kids – Go For Your Life is 'dependent on the school's capacity to allocate resources' and that 'schools need support for this work, especially schools located in areas of disadvantage'.[329]

4.141. The Committee recognises Kids – Go For Your Life as a best practice health promotion program which applies the principles outlined in the Health Promoting Schools framework. One of the key aims of Kids – Go For Your Life is to provide leadership and coordinate health promoting efforts across Victoria, while building the capacity of local communities to respond to localised issues.[330] Numerous participants in the inquiry recognised its success, highlighting Kids – Go For Your Life as an example of a large-scale, well funded program that is sufficiently entrenched in the education community to achieve results.

4.142. Kids – Go For Your Life partners with like-minded organisations that provide support to schools, and has signed memorandums of understandings with Nutrition Australia's Canteen Advisory Service, Home Economics Victoria's Fruit + Veg in Schools program and Bicycle Victoria's Ride2School program. Kids – Go For Your Life provides an overarching framework for change and works closely with these programs to coordinate work across the school setting.[331]

4.143. The Committee notes the recommendation from the Kids – Go For Your Life program that future Department of Education and Early Childhood Development and Department of Health funding and programs which focus on healthy eating and physical activity within primary schools be linked to Kids – Go For Your Life. The Committee agrees that this would lead to a more coordinated approach across Victoria, reduce confusion between programs and potentially lead to greater school engagement.[332]

### Sun safety

4.144. Sun safety was one of the specific health issues identified in the terms of reference for this inquiry. Overexposure to UV radiation can cause skin damage, eye damage and skin cancer. Australia has one of the highest skin cancer incidence and mortality rates in the world. Over 1,600 Australians die from skin cancer each year, with at least two in three Australians being diagnosed with skin cancer before 70 years of age.[333]

4.145. It is important to note, however, that UV radiation is also the best natural source of vitamin D, which is important for the development and maintenance of healthy bones, muscles and teeth and for general health. For best health, it is therefore important to

[329] Darebin Community Health, Written Submission, July 2009, 2.
[330] Go For Your Life, 'Leadership and Coordination,' Kids – Go For Your Life. http://www.goforyourlife.vic.gov.au/hav/articles.nsf/practitioners/Leadership_and_Coordination?Open (accessed 12 August 2010).
[331] Kids – Go For Your Life, Cancer Council Victoria and Diabetes Australia (Victoria), Written Submission, July 2009, 2.
[332] ibid., 4.
[333] SunSmart, Cancer Council Victoria, Written Submission, July 2009, 1.

take a balanced approach to UV exposure that reflects the varying levels of UV throughout the year and across Victoria.[334]

4.146. UV protection is an important health issue for the Victorian Government that has been prioritised for action in Victoria's Cancer Action Plan (2008). The plan outlines a specific target for a comprehensive UV protection strategy to be developed, including agreed approaches to target children, teenagers and young adults, with a focus on secondary school students. The plan acknowledges that more needs to be done, noting that particular efforts need to be made to engage young people and other population groups that have not sustained adequate levels of sun protection behaviours. Protection from UV exposure has also been identified as a key priority for VicHealth over the period 2009 to 2012.

4.147. As noted in a submission from the Cancer Council Victoria, schools can play an integral role in helping to reduce future skin cancer rates. The most damage due to UV exposure occurs during the early years, and children usually attend schools when UV levels are high. Schools can play a significant role by creating sun safe environments and changing behaviours through education and role modelling.[335]

4.148. The Cancer Council Victoria advised the Committee that a simple means of reducing UV exposure in a relatively inexpensive and long-lasting way is the provision of shaded areas in recreation spaces. This is important as research indicates that shade alone can reduce overall exposure to UV radiation by up to 75 per cent.[336] In addition, purpose-built shade-sail intervention in schools has been shown to increase students' use of shaded areas.[337]

4.149. Importantly, in accordance with the *Occupational Health and Safety Act 2004*, schools have a duty of care to provide a safe environment that minimises health risks for staff, students and visitors. This includes taking proper steps to reduce the known health risks associated with exposure to UV for staff and students who spend time on outdoor activities. Occupational health and safety UV risk controls consider the school environment (developing shade and modifying highly reflective surfaces), outdoor programming schedules and school uniform / dress codes.[338]

*SunSmart Schools Program*

4.150. The highly successful SunSmart program, which is jointly funded by the Cancer Council Victoria and VicHealth, is the main vehicle for sun safety promotion in Victoria. It leads the world in promoting a balance between the benefits and harms of UV radiation. The Sunsmart Schools Program is an example of the Health Promoting Schools model in practice.

4.151. The SunSmart Schools program is a non-mandatory membership program promoting sun-safe practices in the school setting to help ensure the risk of skin cancer is reduced and adequate vitamin D levels are maintained. The program incorporates features of the health promoting schools approach into its membership criteria including:

[334] VicHealth, 'UV Protection.' http://www.vichealth.vic.gov.au/Programs-and-Projects/UV-Protection.aspx (accessed 6 August 2010).
[335] SunSmart, Cancer Council Victoria, Written Submission, July 2009, 1.
[336] ibid, 5.
[337] ibid.
[338] ibid., 1.

- engaging the support of key stakeholders to ensure consistency of messages and policies;
- implementing a comprehensive SunSmart policy at appropriate times during the year and ensuring the entire school community is involved and committed;
- considering the outdoor environment and the availability and use of shade;
- integrating UV radiation and sun protection lessons into the curriculum and providing appropriate information for students, staff and families;
- encouraging appropriate sun protective behaviours through role modelling;
- ensuring a combination of sun protective behaviours are used for all outdoor activities and events; and
- regularly reviewing the effectiveness of the policy.[339]

4.152. In 1993, 12 Victorian primary schools agreed to participate in a Victorian SunSmart Schools pilot program and, by 2009, the number had increased to 1,446 (representing 88% of Victorian primary schools). This is the highest participation rate of any state or territory in Australia. Special education schools have also steadily increased their SunSmart membership with 52 per cent now participating in the program.[340]

4.153. Elements of the SunSmart Schools Program have also been adopted in other countries with high skin cancer rates, such as the United States, United Kingdom and New Zealand.[341] A submission from the Cancer Council Victoria noted that a key factor in the SunSmart Schools program's success is ensuring work is underpinned by solid research and evaluation, and that it is responsive to community needs.[342]

4.154. The Committee notes that although the SunSmart program has extensive coverage in primary schools, it has been more difficult to engage secondary schools in sun safety messages. As noted by the Cancer Council Victoria, adolescents are significantly less likely than adults to use most forms of sun protection (hats, clothing, shade, sunglasses) and, as a consequence, are more likely to be sunburnt. Particular efforts therefore need to be made to engage young people and other population groups that have not sustained adequate levels of sun protection behaviours, such as secondary school children.[343]

4.155. The Cancer Council Victoria's Secondary Sun Protection program was first implemented in 2007, with 59 schools now registered. The program takes the focus off hats by emphasising use of a combination of sun protection strategies. A policy template was developed for schools registering with the Sun Protection Program, which allows schools to choose which sun protection strategies they will focus on initially, and includes explanatory notes and practical tips on what has worked well in other schools.[344]

[339] ibid., 2.
[340] ibid.
[341] ibid., 3.
[342] ibid., 4.
[343] ibid., 5.
[344] ibid., 3.

4.156. The program also aims to:

- Use celebrities as role models. Cricket Victoria allowed the captains of the men's and women's state teams to act as ambassadors at the launch of the Sun Protection Program, and provided a cricket clinic to one of the first schools to register.
- Educate with a focus on real life examples of young people with skin cancer. Based on the suggestions of students, the 'Real Stories' resource was developed using television current affairs segments which featured young people with skin cancer. An evaluation of this resource is currently underway.
- Approach school councils and principals, emphasising duty of care.
- Advocate to government to provide additional funding for shade in schools. This has included working with the Department of Education and Early Childhood Development in the implementation of shade as part of the Building the Education Revolution program.[345]

## Conclusion

4.157. The Committee was interested to uncover the vast number of diverse programs, projects and initiatives operating within Victorian schools with the aim of improving or promoting the health and wellbeing of staff, students, parents and other members of the school community. While health promotion has often been associated with healthy eating and physical activity, the Committee found that secondary schools in particular, are equally, if not more likely to value programs aimed at mental health and social wellbeing. The Committee was pleased to note that the breadth and depth of health promotion programs currently available means that there is likely to be health promotion programs available to meet the specific needs of diverse school communities.

4.158. The Committee finds, however, that the number of programs currently operating in Victorian schools also presents a challenge. It appears that various programs and schools are all competing for a finite funding pool, and many beneficial programs are therefore not being embedded and sustained within schools. The programs which are most successful are those which are supported by high level government funding, which are retained and continue to evolve over a long period, and which are subject to ongoing monitoring and evaluation. Additionally, implementation of individual programs at the school level appears to be most effective when integrated within a comprehensive health promoting schools approach.

[345] ibid.

# Chapter 5

# Community links and partnerships

> Partnerships are an important vehicle for bringing together a diversity of skills and resources for more effective health promotion outcomes. Partnerships can increase the efficiency of the health and community service system by making the best use of different but complementary resources.[346]

5.1. Perhaps one of the strongest themes to emerge during the inquiry was the importance of partnerships and community links in supporting school-based health promotion. Community links include the connections between the school and the students' families, as well as the connections between the school and key local groups and individuals. As noted by the Health Promoting Schools model, appropriate consultation and participation with these stakeholders enhances a whole-school approach to health promotion, and provides students and staff with a context and support for their actions.[347] Local partnerships and community links can be supported through various partnerships at the national, state and regional levels.

## Connections between schools and families

5.2. Parents and families have the first and most enduring impact on children's learning and development, health, safety and wellbeing.[348] The Blueprint for Education and Early Childhood Development states that 'their role must be valued and they must be supported by the whole community to provide positive, stimulating environments for children's intellectual and social development'.[349]

5.3. The Committee recognises that there are a range of benefits for schools in being proactive in their efforts to actively engage parents in their programs, decision making and the life of the school. These include:

- increased skills and expertise in planning and implementing health promoting activities;
- increased understanding among parents and families about health issues and the approaches being adopted by the school;
- reinforcement and support at home for the knowledge and skills being developed at school; and

[346] VicHealth, *The Partnership Analysis Tool: For Partners in Health Promotion* (Carlton: VicHealth, 2005), 1.
[347] International Union for Health Promotion and Education, *Achieving health promoting schools: guidelines for promoting health in schools* (France: IUHPE, 2009), 1.
[348] Department of Education and Early Childhood Development (Victoria), *Blueprint for Education and Early Childhood Development* (Melbourne: DEECD, 2008), 28.
[349] ibid.

- active practical support in various areas, which may require additional human resourcing.[350]

5.4. The Committee believes that it is very important to involve students, parents and families in making decisions about suitable health promotion activities for the school. This can be achieved through the establishment of a health promotion or school wellbeing committee which is responsible for implementing a comprehensive, whole-school approach to health and wellbeing. It is important that decisions respond to the needs of culturally and linguistically diverse members of the school community, as well as the socioeconomic circumstances of students and their families.

5.5. The Committee heard about a range of ways in which parents can be engaged in health promoting activities initiated within schools. These include: surveying parents about how various aspects of the school environment support or detract from healthy behaviours; having a drop-in centre set aside for parents to attend meetings or access health information and services; running information sessions or workshops on health topics relevant to the local community; providing a range of health related resources which can be taken into the home; communicating health promoting messages through school newsletters and websites; developing learning activities for students and their families which form part of the formal curriculum or homework; involving parents in kitchen garden and community garden programs; and promoting a range of sporting and recreational activities for students and their families based at the school and/or using local community facilities.

## Links between schools and local organisations

5.6. The Committee found that health promotion in schools is most effective when it is supported by a range of partnerships at the local, regional and state level. This is consistent with the Blueprint for Education and Early Childhood Development, which proposes actions at both a systems level (developing partnership frameworks and infrastructure) and a community level (establishing local partnerships) to enable effective and sustainable school–community partnerships.

5.7. VicHealth recognises four main types of partnerships in health promotion, ranging on a continuum from networking through to collaboration:

- Networking involves the exchange of information for mutual benefit. This requires little time and trust between partners. For example, youth services within a local government area may meet monthly to provide an update on their work and discuss issues that affect young people.

- Coordinating involves exchanging information and altering activities for a common purpose. For example, the youth services may meet and plan a coordinated campaign to lobby the council for more youth-specific services.

- Cooperating involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, high level of trust between partners and sharing the turf between agencies. For example, a group of

[350] Deakin University and Department of Education, Employment and Training (Victoria), *Health Promoting Schools In Action: A guide for schools* (Melbourne: Deakin University, DEET and VicHealth, 2000), 11.

secondary schools may pool some resources with a youth welfare agency to run a 'Diversity Week' as a way of combating violence and discrimination.

– Collaborating includes the activities described above, and enhancing the capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their turf to another agency to create a better or more seamless service system. For example, a group of schools may fund a youth agency to establish a full-time position to coordinate a Diversity Week, provide professional development for teachers and train student peer mediators in conflict resolution.[351]

5.8. As noted by VicHealth, a partnership will need to become more embedded in the core work of the agencies involved as it moves towards collaboration, leading to resource and structural implications. However, not all partnerships will or should move to collaboration.[352]

## Links between schools and local health services

5.9. The Committee notes that schools access a wide range of local and regional school-based or school-linked services which have a responsibility for child and adolescent health care and promotion through the provision of direct services to students. Specific examples of the extensive range of stakeholders and local health related resources, facilities or services identified during the inquiry as working in partnership with Victorian schools include community health services, hospitals, local GPs, mental health services, welfare agencies, self-help and support groups, alcohol and other drug services, youth housing services, family crisis services, local councils, local libraries, sport and recreation facilities, various clubs and associations and local police.

5.10. The following sections outline some of the main health services accessed by schools, as well as the role of key health personnel involved in delivering health care and health promotion services to schools.

### *Health services used by schools*

5.11. Immunisation services are one of the most common health services accessed by Victorian schools. Under the *Health Act 1958*, local councils are required to coordinate immunisation services for children in their municipality. Consequently, local councils in Victoria provide approximately 50 per cent of pre-school immunisations and nearly 100 per cent of school-age immunisations.[353] These include the hepatitis B, chickenpox and human papilloma virus vaccines at year 7 and the diphtheria, tetanus and pertussis vaccines at year 10.[354]

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[351] Adapted from Arthur T. Himmelman, 'on coalitions and the transformation of power relations: Collaborative betterment and collaborative empowerment,' *American Journal of Community Psychology* 29, no. 2 (2001), cited in VicHealth, *The Partnership Analysis Tool: For Partners in Health Promotion* (Carlton: VicHealth, 2005), 3.

[352] VicHealth, *The Partnership Analysis Tool: For Partners in Health Promotion* (Carlton: VicHealth, 2005), 3.

[353] Municipal Association of Victoria, 'About Immunisation.' http://www.mav.asn.au/CA256C2B000B597A/ListMaker?ReadForm&1=10-None~&2=0-PP+-+HS+-+Family+and+Children's+Services+-+Immunisation+-+TOC~&3=~&V=Listing~&K=TOC+Immunisation~&REFUNID=6BFA4A8E3BE95937CA25724B000FF53D~ (accessed 28 July 2010).

[354] Department of Health (Victoria), National Immunisation Program Schedule.' http://www.health.vic.gov.au/immunisation/fact-sheets/factsheets/schedule_victoria (accessed 28 July 2010).

5.12. Schools also regularly access health services to conduct screening for health issues such as vision and hearing. Poor eye sight or hearing can have obvious detrimental effects on the ability of students to learn effectively.

5.13. The Committee received a submission from Vision 2020 Australia, which is the peak body for the eye health and vision care sector. Vision 2020 Australia seeks to eliminate avoidable blindness and vision loss by the year 2020, and ensure that blindness and vision impairment are no longer barriers to full participation in the community.[355]

5.14. Vision 2020 Australia noted that the National Framework for Action to Promote Eye Health and Prevent Avoidable Blindness and Vision Loss places a responsibility on governments to encourage schools to promote eye health activities.[356] Activities should involve students and parents, wherever possible. Appropriate messages about eye health should include lifestyle factors, eye injury prevention and early detection.[357] Vision 2020 Australia outlined a range of existing programs and resources available to schools, including Sight for Kids, SunSmart, Sunnies for Sight Day and Optometrists Association Australia.

5.15. The School Dental Service provides regular dental care for all primary school children and for children in years 7 and 8 whose families have concession cards. Services are provided at either a mobile dental van or a community dental clinic. Care is available once every 12 to 24 months depending on treatment needs.[358]

5.16. The School Dental Service promotes the dental health of its clients to enable them to maintain healthy teeth for life. Dental therapists working under the general supervision of dentists provide dental examinations, dental health education and promotion and preventive dental care. Resources can be accessed through the School Dental Service by teachers for planning and conducting dental health education in the school.[359]

5.17. The Committee received a written submission from Dental Health Services Victoria, which has a long history of health promotion in Victorian schools. The submission outlined some of the organisation's recent school-based work, including the Smiling Schools project, a school nurses project known as The Mouth: Oral Health Information for Primary School Nurses and an interactive website, 'Defenders of the Tooth'.[360]

5.18. The Committee also received a variety of written submissions from organisations that are either aware of or provide information and health services addressing a range of health issues faced by schools. These include, for example, asthma, anaphylaxis, diabetes, cancer, childhood heart disease, eating disorders, physical or intellectual disabilities and mental health problems.

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[355] Vision 2020 Australia, Written Submission, July 2009, 1.
[356] ibid., 2.
[357] ibid., 2–3.
[358] Department of Education and Early Childhood Development (Victoria), 'Student Health,' s. 4.5, 76, *Government Schools Reference Guide*. Available on DEECD website, http://www.education.vic.gov.au/management/governance/referenceguide/enviro/4_5.htm.
[359] ibid.
[360] Dental Health Services Victoria, Written Submission, July 2009, 1, 3.

*School nurse programs*

5.19. Many submissions and witnesses provided evidence regarding the role of school nurses in school-based health promotion activities. The Department of Education and Early Childhood Development operates the Primary School Nursing Program and the Secondary School Nursing Program. In addition, schools may directly employ nurses to undertake a range of health functions.

5.20. The Primary School Nursing Program offers a free, universal screening service to prep children across the government, Catholic and independent school sectors and English Language Centres. It also provides assessment and support for children in years 1 to 6 where a parent, teacher or nurse identifies a concern. The Primary School Nursing Program is designed to identify children with potential health related learning difficulties and to respond to parent's concerns and observations about their children's health and wellbeing. Parents' concerns and observations are collected through the School Entrant Health Questionnaire at the commencement of the first year of school, and follow up health assessments are conducted as indicated.[361]

5.21. The Primary School Nursing Program employs registered nurses with expertise in the areas of normal child health and development to deliver a range of services, including:

- responding to health issues raised through the School Entrant Health Questionnaire;
- a vision screening test for children who have not previously been tested or the children whose parents or teachers are concerned about their vision;
- a hearing and oral health check for children where concerns have been identified;
- advice to parents and teachers;
- development of strategies to assist families in accessing specific local family support services;
- referral of identified conditions to another health service where appropriate for further assessment and treatment; and
- health education and health promotion.[362]

5.22. Primary school nurses provide parents, students, teachers and school communities with information and advice on a variety of child health and development issues, including: asthma management; accident and injury prevention; immunisation; nutrition; positive parenting; health and human development; and any other identified topics.

5.23. Through the Secondary School Nursing Program, the Department of Education and Early Childhood Development employs 100 nurses to provide services in 199 government secondary schools. The factors considered by the department when determining the schools eligible for a secondary school nurse include the Special

[361] Department of Education and Early Childhood Development (Victoria), 'Primary School Nursing,' School Nursing. http://www.education.vic.gov.au/healthwellbeing/health/schoolnursing/primschool/default.htm (accessed 4 August 2010).
[362] ibid.

Learning Needs Index, the Burden of Disease study, the Survey of Risk and Protective Factors and rural location/isolation. Due to the consideration of rurality and isolation, 50 per cent of nurses have been allocated to rural schools.[363]

5.24. The role of the secondary school nurse has three broad objectives: health promotion and primary prevention; early intervention; and intervention with students (which may include short-term counselling or referral and facilitation of access to community services).[364]

5.25. The objectives of the Secondary School Nursing Program are to:

- play a key role in reducing negative health outcomes and risk taking behaviours among young people, including drug and alcohol abuse, tobacco smoking, eating disorders, obesity, depression, suicide and injuries;
- focus on prevention of ill-health and problem behaviours by ensuring coordination between the school and community-based health and support services;
- support the school community in addressing contemporary health and social issues facing young people and their families;
- place nurses in areas of greatest health need and socioeconomic disadvantage;
- provide appropriate primary health care through professional clinical nursing, including assessment, care, referral and support; and
- establish collaborative working relationships to deal with any difficulties in students' transition from primary to secondary school.[365]

5.26. The role of the secondary school nurse is to build on initiatives that have already been developed in schools and provide appropriate preventative health care which addresses the sensitive and complex nature of health issues for young people, their families and school community. The role specifically encompasses:

- individual health counselling;
- health promotion and planning;
- school community development activities;
- small group work focusing on health related discussion and information; and
- a resource and referral service to assist young people in making healthy lifestyle choices.[366]

[363] Department of Education and Early Childhood Development (Victoria), 'Selection Criteria for SSN Program,' School Nursing. http://www.education.vic.gov.au/healthwellbeing//health/schoolnursing/secschool/selection.htm (accessed 4 August 2010).
[364] KPMG, for the Department of Education and Early Childhood Development (Victoria), *Review of the Secondary School Nursing program, Final report–Executive Summary* (Melbourne: DEECD, 2009), 2.
[365] Department of Education and Early Childhood Development (Victoria), 'Secondary School Nursing,' School Nursing. http://www.education.vic.gov.au/healthwellbeing//health/schoolnursing/secschool/default.htm (accessed 4 August 2010).
[366] Department of Education and Early Childhood Development (Victoria), 'Role of Nurses,' School Nursing. http://www.education.vic.gov.au/healthwellbeing//health/schoolnursing/secschool/nurses.htm (accessed 4 August 2010).

5.27. The involvement of the nurse is dependent on the needs of the school, however, it can encompass input into health related curriculum and policy, the delivery of health education in partnership with teachers, input into planning processes and the delivery of individual and group programs and events for students.[367] As a general rule, the secondary school nurse does not administer medication, conduct physical examinations, undertake long-term counselling about psychological, relationship or education problems or provide first aid.[368]

5.28. The secondary school nurse works as a member of the student welfare team to improve the health and wellbeing of students. The nurses work with staff in schools to produce an annual action plan which identifies the top three health issues prevalent in their school community and the priority health issues to be addressed during the year.[369] Input into the annual action plan is dependent on the operation of the school, however, the common approach is to seek views from students, school staff, the principal and the nurse. Quite often, external health plans are used to provide additional information on issues relevant to young people in the broader community. For example, the nurse and school staff will talk to local health agencies about issues they are planning to address for young people, or obtain a copy of the Municipal Public Health Plan to identify trends that will impact on the health of young people in the local area.[370]

*Health promotion workers*

5.29. Numerous submissions and witnesses identified the need for dedicated health promotion officers to work in partnership with schools to develop and implement whole-school approaches to health and wellbeing. They emphasised the need for these positions to be distinct from the role of school nurses, student welfare coordinators and other similar positions.

5.30. The role of health promotion workers was said to be supporting schools to embed health promotion principles, perhaps through becoming a health promoting school, advising on policy, curriculum, culture, partnerships and professional development, and working with the student welfare coordinators to coordinate health promotion programs. This is consistent with the Australian Health Promoting Schools Association's view of the health promotion worker's role as being 'responsible for the planning, development, implementation and evaluation of health promotion policies and projects, using a variety of strategies'.[371] The Outer East Health and Community Support Alliance suggested that a key part of the health promotion worker's role would be to help the school to undertake an audit of its strengths and needs.[372]

[367] ibid.

[368] Department of Human Services (Victoria), *Secondary School Nursing program brochure* (Melbourne: DHS, 2003), 1. Available on Department of Education and Early Childhood (Victoria) website, http://www.education.vic.gov.au/healthwellbeing/health/schoolnursing/publications.htm#H2N10068.

[369] Department of Education and Early Childhood Development (Victoria), 'Annual Action Plan,' School Nursing. http://www.education.vic.gov.au/healthwellbeing//health/schoolnursing/secschool/actionplan.htm (accessed 4 August 2010).

[370] Department of Education and Early Childhood Development (Victoria), 'Role of Nurses,' School Nursing. http://www.education.vic.gov.au/healthwellbeing//health/schoolnursing/secschool/nurses.htm (accessed 4 August 2010).

[371] Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association, Written Submission, July 2009, 9.

[372] Outer East Health and Community Support Alliance, Written Submission, July 2009, 17.

5.31. While there was unanimous support for greater emphasis on the health promotion role within schools, different stakeholders presented different approaches for achieving this. While some submissions and witnesses suggested that schools should have health promotion positions fully funded to work within the schools and as a resource for local communities, others suggested that a driver or project officer located outside of the school is required. The City of Greater Shepparton mentioned a number of potential models:

> We believe there is merit in funding a schools health promotion officer who will be able to work with the schools in identifying and implementing interventions to students and the school community. This position may be directly linked with the individual schools or facilitated through local governments or local health providers. Consideration would need to be made in terms of the individual coverage of each health promotion officer.[373]

5.32. Brimbank City Council similarly suggested that 'funding could be directed to schools and/or health promotion organisations to provide a dedicated resource to undertake health promotion initiatives in school settings'.[374] This was supported by the School of Public Health and Preventive Medicine at Monash University, which recommended that the health and education sectors collaborate to fund specific time in schools for appropriately skilled workers (health promotion practitioners) to holistically address the health of students, staff, parents and the broader community using the Health Promoting Schools framework.[375]

5.33. Various other submissions from the local government sector suggested that health promotion coordinators should be based within local councils. For example, Cardinia Shire Council suggested that a fully qualified health promotion officer should be located in local councils, designated to work with schools only. It suggested that this would encourage projects with a non-medical focus.[376] This was supported by Bayside City Council, which suggested that the Victorian Government could fund health promotion officers based at each local government to undertake health promotion programs in both schools and the community.[377] Bayside City Council emphasised that any funding arrangement should be universal (and not based on socioeconomic indicators) so that the entire population benefits.[378]

5.34. The Committee also examined some of the international models for school-based health promotion workers. In particular, it noted the New Zealand model where around 50 health promotion coordinators were employed by the Ministry of Health to assist schools to implement the Health Promoting Schools framework over a sustained period. This model allocated one health promotion coordinator to around 15 schools, with visits occurring once or twice per term once the concept was embedded within the school.[379]

5.35. The Committee was also interested in the Scottish model where the work of health promotion workers is underpinned by the *Schools (Health Promotion and Nutrition) (Scotland) Act 2007*. As such, there are a raft of formal partnerships and other arrangements to ensure that Scottish schools, working in partnership with local

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[373] Greater Shepparton City Council, Written Submission, June 2010, 8.
[374] Brimbank City Council, Written Submission, August 2009, 5.
[375] School of Public Health and Preventive Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University, Written Submission, July 2009, 8–9.
[376] Cardinia Shire Council, Written Submission, July 2009, 5.
[377] Bayside City Council, Written Submission, July 2009, 2.
[378] ibid.
[379] Meeting with representatives of Toi Te Ora – Public Health Service, Rotorua, 21 October 2009.

authorities, National Health Service boards and the wider community, are health promoting. In seeking to assist the development of the health promoting schools approach within the broader framework of policy initiatives, the Scottish Executive has established the Health Promoting Schools Unit, whose work is directed by a broad-based steering group drawn from policy makers, researchers and practitioners in the education and health services. The Committee heard that depending on the location of schools, health promotion coordinators can work with up to 40 schools each. This is possible due to the national mandate for health promoting schools, which means that health promotion coordinators do not have to constantly 'sell' the health promoting schools concept and convince schools and teachers of the importance of becoming involved.[380]

5.36. Irrespective of the models presented, all stakeholders noted the importance of establishing a partnership approach between the school, health promotion workers and a range of local health agencies. For example, Moyne Shire Council suggested that health promotion workers would need to work with local governments and appropriate health services in the community, that they would need links with early years settings, and that they could potentially be managed by a community-based committee.[381] Darebin City Council highlighted its successful experiences achieved through the establishment of committees comprised of local government, community service providers, school representatives and parents to assist in identifying local priorities and needs and working collectively to develop innovative solutions to address the needs.[382] A variety of other submissions similarly identified that an important aspect of the health promotion officer's role would be relationship building and the formation of partnerships with community groups, local businesses and health organisations.[383]

5.37. The Committee supports the development of a network of health promotion coordinators with a specific role in assisting schools to implement a whole-school approach to health and wellbeing. The Committee acknowledges arguments for potentially basing such roles within the local government or health sectors. The Committee believes, however, that health promotion coordinators are most likely to be embraced and integrated within schools if they are seen to have the endorsement of education systems. The Committee therefore suggests that a network of health promotion coordinators be employed by the Department of Education and Early Childhood Development's regional offices and allocated to each of the department's regional networks.

*School Focused Youth Service*

5.38. Various participants during the inquiry acknowledged the role of the School Focused Youth Service (SFYS) in health promotion within Victorian schools. The SFYS is a statewide initiative, established in 1998 as a joint initiative between the Department of Human Services and the then Department of Education. The SFYS partnership approach is to strengthen the capacity of local services, communities and schools to collaborate, develop and better coordinate stronger prevention and early intervention

[380] ibid.
[381] Moyne Shire Council, Written Submission, June 2009, 2.
[382] Darebin City Council, Written Submission, August 2009, 6.
[383] For example, School of Public Health and Preventive Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University, Written Submission, July 2009, 9; Outer East Health and Community Support Alliance, Written Submission, July 2009, 17; Darebin City Council, Written Submission, August 2009, 6.

strategies as part of a service continuum for vulnerable children and young people aged 10 to 18 years (with a focus on those aged 10 to 16 years).[384]

5.39. Under the SFYS, 41 school community clusters have been established across the state to ensure that services are coordinated and responsive to the needs of young people. Service models are consistent around the state, each with a coordinator and brokerage capacity to respond to gaps in service availability as identified by schools and the community. The SFYS links closely to schools and relevant community agencies within each cluster.[385]

5.40. The core objectives of the SFYS are to:

- establish collaborative structures and mechanisms between schools and the relevant youth services and community services which support young people, including welfare, health and mental health agencies;
- provide linkages for agencies and schools which have a client base of young people and which directly support young people;
- improve linkages, cohesiveness and integration of service provision for young people displaying 'at risk' behaviours who require support and intervention; and
- purchase services to meet gaps in the current service system as identified at the local level.[386]

5.41. The SFYS is required to develop close links with school support personnel located within government, Catholic and independent schools, and community agencies in contact with young people who are no longer connected to the school system. Developing these links enables identification of service gaps, development of strategies to respond to those gaps and the provision of a continuum of service intervention.[387]

5.42. The SFYS links with Better Youth Service Pilots, Local Learning and Employment Networks (LLENs), the school improvement agenda, regional educational networks and local area youth services planning.[388] Various submissions to the inquiry mentioned the involvement of the SFYS in a range of health promotion initiatives. These included statewide programs such as MindMatters, Kids – Go For Your Life and the Stephanie Alexander Kitchen Garden Program, as well as more localised programs.

5.43. Representatives of the SFYS commented that in their experience, 'it is imperative that all partnerships involving the health and education sectors develop a Memorandum of Understanding'.[389] They noted that the memorandum should clearly

[384] Service Development Division, Department of Education and Early Childhood Development (Victoria), *School Focused Youth Service, Program Guidelines 2009–11* (Melbourne: Communications Division, DEECD, 2009), 4.
[385] Department of Education and Early Childhood Development (Victoria), 'School Focused Youth Service.' http://www.education.vic.gov.au/healthwellbeing/wellbeing/sfyouthservices/default.htm (accessed 3 August 2010).
[386] ibid.
[387] ibid.
[388] Service Development Division, Department of Education and Early Childhood Development (Victoria), *School Focused Youth Service, Program Guidelines 2009–11* (Melbourne: Communications Division, DEECD, 2009), 4.
[389] School Focused Youth Service, Written Submission, June 2010, 4.

articulate all of the agreed actions and objectives as well as the roles and responsibilities of each partner.

5.44. The Committee notes that a recent evaluation of the SFYS found that the initiative has made a significant contribution towards: improved knowledge about issues and services in the community and school; development of partnerships, planning and programs between education and community sectors at the local community level; better peer relationships and communication skills; more positive attitudes to self, peers, teachers and school; positive changes in behaviours; improved attendance and engagement with school; and significant improvement in the current service system as a result of the identification of gaps and subsequent service development and/or purchase.[390]

*Primary Care Partnerships*

5.45. Another existing health related network identified during the inquiry was the Primary Care Partnerships, which were initiated in 2000. The Victorian Primary Care Partnership Strategy has led to the development of 31 Primary Care Partnerships among more than 800 health services and agencies across Victoria.

5.46. Primary Care Partnerships typically include hospitals, community health services, local government, aged care assessment services, women's health services, community drug treatment services, local ethno-specific health services, mental health services, disability services and Divisions of General Practice. The partnerships are growing and engaging with non-health agencies including police, schools and community and welfare groups.[391]

5.47. Primary Care Partnerships work in a wide range of priority areas, such as:

- promoting physical activity and active communities;
- promoting accessible and nutritious food;
- promoting mental health and wellbeing;
- reducing tobacco-related harm;
- reducing and minimising harm from alcohol and other drugs;
- safe environments to prevent unintentional injury; and
- sexual and reproductive health.[392]

5.48. Although driven by the vision of the Victorian Government, the partnerships operate at a local level. Their strength is the fact that they are community-based – that is, local partnerships meeting local needs.

[390] Service Development Division, Department of Education and Early Childhood Development (Victoria), *School Focused Youth Service, Program Guidelines 2009–11* (Melbourne: Communications Division, DEECD, 2009), 5.
[391] Department of Human Services (Victoria), *Primary Care Partnerships: Electronic revolution Supports better care* (Melbourne: DHS, 2008), 1.
[392] Department of Health (Victoria), 'Health Promotion Priority setting for 2007–2012,' Victorian Government Health Information. http://www.health.vic.gov.au/pcps/hp/priority_setting.htm (accessed 7 September 2010).

5.49. The Committee was pleased at the level of participation in the inquiry by Primary Care Partnerships across Victoria. Many of the partnerships (and their members) made submissions to the inquiry and seven partnerships were represented at a roundtable discussion with the Committee. The Committee found that many of the Primary Care Partnerships are already very active in health promotion within schools through a wide range of activities. For example, Campaspe Primary Care Partnership advised the Committee that it is involved in a range of school-based programs (such as Kids – Go For Your Life, TravelSmart and Sowing the Seeds of Wellbeing) and that four local secondary schools are implementing anti-bullying initiatives based on the partnership's Integrated Health Promotion Plan.[393]

5.50. A submission from Central West Gippsland Primary Care Partnership stated that its recent health promotion efforts have focused on mental wellbeing and building resilience. This activity has mainly been in primary schools and involved strategies such as healthy school policies, curriculum, teacher professional development and supporting schools to run healthy school programs and events.[394] Southern Grampians and Glenelg Primary Care Partnership has developed a healthy relationships program for year 9 students in conjunction with local secondary schools, Western District Health Service, the School Focused Youth Service, the Local Learning and Employment Network and other agencies. The aim of the program is to prevent family violence and sexual assault through increased understanding of healthy and unhealthy relationships, development of communication skills and awareness of, and links to, local services.[395]

5.51. The Committee found that while Primary Care Partnerships value the work they do with schools, they are currently experiencing a range of challenges when seeking to expand their health promotion activities. During a roundtable discussion, representatives from the Primary Care Partnerships emphasised a number of factors critical to the success of school-based health promotion. These included: the need for sustained funding of health promotion programs due to the time required to properly implement them within schools; the need for school leaders to embrace health promotion programs; and the need for mutual understanding between schools and health agencies about the purpose and expected outcomes of health promotion initiatives and their respective operating structures.[396]

### The role of local government in school-based health promotion

5.52. The local government sector was also well represented in evidence to the inquiry. The Committee received written submissions from the Municipal Association of Victoria, as well as 27 local councils.

5.53. The Municipal Association of Victoria recognises that the distinct role that local governments play in health promotion helps to shape healthy and vibrant people, places, neighbourhoods and communities. The City of Ballarat summarised the role of councils in health promotion as follows: leadership and advocacy; policy and planning; information and awareness; service provision; and organisational development.[397] Central Goldfields Shire Council identified a similar range of roles,

[393] Campaspe Primary Care Partnership, Written Submission, July 2009, 1.
[394] Central West Gippsland Primary Care Partnership, Written Submission, July 2009, 1.
[395] Southern Grampians and Glenelg Primary Care Partnership, Written Submission, July 2009, 1.
[396] Transcript of Evidence, Public Hearing, Melbourne, 21 June 2010.
[397] City of Ballarat, Written Submission, June 2010, 3.

which it expanded to include: planning and developing partnerships and alliances; community strengthening and capacity building; and facilities and infrastructure.[398] As noted by the City of Greater Shepparton, the emphasis on these various health promotion activities will vary, depending on the issue being addressed.[399]

5.54. The City of Greater Geelong emphasised the partnership role of local councils, stating that their role is to support and collaborate with other organisations and agencies to address local, state and national health issues.[400] The Municipal Association of Victoria noted that local councils recognise the role of schools as settings for and key partners in health promotion.[401] It suggested that schools have become skilled at forming relationships with both the community and business sectors, and at working with local government to plan for the provision of education and community service delivery programs from school sites.[402]

*Building healthy public policy*

5.55. Councils develop public policies which articulate their position on health promotion and set directions for their communities. The most notable of these strategic documents include the Council Plan, the Municipal Public Health Plan and the Municipal Strategic Statement. Victorian councils have a legislated requirement to produce a Municipal Public Health Plan every four years. In partnership with the Victorian Government, all councils in Victoria have also prepared Municipal Early Years Plans since 2005. These plans are specifically designed to address the health, education and care needs of resident children aged from birth to eight years. The Committee found that through these types of strategic planning documents, schools are often identified as an important setting for community engagement and information sharing which can actively link with local government planning and initiatives.

5.56. A small number of councils noted that they include an explicit link between schools, council and local communities through their Municipal Public Health Plans,[403] with Moyne Shire Council suggesting that this could be formalised across the state.[404] Hume City Council indicated that it 'is willing to partner and cooperate with local schools to facilitate the development and implementation of health promotion initiatives', and that 'the school setting would provide a useful environment to focus relevant initiatives within the Municipal Public Health Plans'.[405]

5.57. Some councils felt, however, that Municipal Public Health Plans are perhaps not the best mechanism for supporting partnerships between councils, schools and other partners. Maribyrnong City Council stated that 'given the extent of health and socioeconomic disadvantage in Maribyrnong and the strategic focus and scope of Municipal Public Health Plans, it is unlikely that schools will be identified as a high priority in the short term'.[406] Central Goldfields Shire Council emphasised that the Municipal Public Health Plan does not operate in isolation and is linked with a range

[398] Central Goldfields Shire Council, Written Submission, June 2010, 2–3.
[399] Greater Shepparton City Council, Written Submission, June 2010, 2.
[400] City of Greater Geelong, Written Submission, June 2010, 1.
[401] Municipal Association of Victoria, Written Submission, June 2010, 1.
[402] ibid.
[403] For example, City of Ballarat, Written Submission, June 2010, 3; Moyne Shire Council, Written Submission, June 2009, 2; City of Greater Geelong, Written Submission, June 2010, 1.
[404] Moyne Shire Council, Written Submission, June 2009, 2.
[405] Hume City Council, Written Submission, June 2010, 7, 10.
[406] Maribyrnong City Council, Written Submission, June 2010, 2.

of other strategic and operational plans, some of which target children and young people in a range of health promoting activities.[407]

5.58. Other councils suggested that partnerships with schools are not necessarily a priority in all municipalities. For example, City of Stonnington noted that the high number of private schools attracting students from outside the municipality had implications for potential partnerships with schools, as there can be a community expectation that council programs should prioritise services to the resident community.[408]

5.59. South Gippsland Shire Council advised the Committee that due to limited resources it does not have the capacity to work extensively with schools.[409] The Municipal Association of Victoria argued, however, that the relationship between schools and local government is 'particularly critical for small rural and regional councils and communities who have limited capacity to deliver infrastructure and develop services to meet community needs now and into the future'.[410]

*Creating supportive environments*

5.60. The Municipal Association of Victoria noted that councils play a vital role in building healthy communities by the way they 'shape' the environment in which their community lives.[411] The way in which councils plan parks, roads, buildings and pathways and deliver services, all impact and affect their communities' health and wellbeing.[412] The Municipal Association of Victoria noted that these strategies have direct impact on schools – from where and how school infrastructure is built, to the road and bicycle networks that surround school sites.

5.61. The Municipal Association of Victoria also noted that local governments support the school environment through partnership and funding of school-based programs and services.[413] It advised the Committee that the state and federal governments regularly target funding to councils in order to manage health promotion projects and community development activities, 'because it is recognised that councils have strong local relationships that extend right across the service provider, community and business sectors'.[414] The Municipal Association of Victoria also suggested that councils are effective in recognising and utilising local community leaders or 'champions', and in facilitating networks of residents and professionals with common interests and goals.[415]

*Local government participation in school-based health promotion initiatives*

5.62. The Committee received evidence showing that councils across Victoria are involved in a diverse range of school-based health promotion initiatives.

5.63. The Municipal Association of Victoria identified the following range of programs and services provided by and/or contributed to by local governments: Streets Ahead Program, Walking School Bus, SunSmart programs and shade audits, immunisation

[407] Central Goldfields Shire Council, Written Submission, June 2010, 4.
[408] City of Stonnington, Written Submission, July 2010, 3.
[409] South Gippsland Shire Council, Written Submission, June 2010, 2.
[410] Municipal Association of Victoria, Written Submission, June 2010, 1.
[411] ibid., 2.
[412] ibid.
[413] ibid.
[414] ibid.
[415] ibid.

programs, alcohol and other drug programs, Kids – Go For Your Life, community leadership programs and outside school hours programs.[416]

5.64. Submissions from various councils detailed an even broader range of programs and services involving schools, including: Best Start and other early years initiatives, neighbourhood renewal initiatives, social infrastructure planning, youth services and supports, recreation, sport and physical activity programs, active transport and bicycle/road safety, healthy eating and/or breakfast programs, establishment of kitchen or community gardens and associated programs, life skills programs, sexual assault prevention programs, safe parties programs and oral health programs.

*Challenges and enablers for partnerships between local councils and schools*

5.65. Submissions from local councils identified a range of challenges that can often be experienced when seeking to partner with school communities to conduct health promotion projects or initiatives. The Municipal Association of Victoria stated that engaging schools is often difficult for councils as schools rarely have personnel with direct responsibility for building relationships with the local community, and individual schools have very limited resources to invest in projects aimed at the health and wellbeing of their students (other than those already covered in the curriculum).[417]

5.66. Expectedly, a number of councils indicated that resource limitations can prevent optimal partnership approaches for health promotion initiatives. For example, the City of Monash stated that while it works directly with some schools on projects, 'the issues of resourcing, appropriately trained staff and sustainability has been an ongoing issue and one which must be addressed'.[418] Bayside City Council argued that state government funding needs to be sustainable, as 'one-off funding creates a community expectation that local government should maintain the project after external funding ceases'.[419] South Gippsland Shire Council stated that the critical issue is ensuring that 'there are both resources for facilitation of such relationships and seed monies for innovative projects'.[420] It also noted that 'smaller councils are at a decided disadvantage to be able to be involved in more than basic services simply because of their limited financial ability'.[421]

5.67. Many councils identified other challenges beyond simply funding or resource limitations. Macedon Ranges Shire Council stated that partnership with community is currently not well understood or implemented within the school environment, and that mutual understanding is essential to the success of partnerships involving the health and education sectors.[422] Maribyrnong City Council noted that the capacity and culture for cross-sectoral planning, design and implementation of health promoting activities will vary across schools, health organisations and governments. It also suggested that partnerships 'imply that each sector is able to contribute equally to health promotion objectives' and may therefore 'raise expectations beyond capacity'.[423]

[416] ibid., 3.
[417] ibid.
[418] City of Monash, Written Submission, July 2010, 1.
[419] Bayside City Council, Written Submission, July 2009, 2.
[420] South Gippsland Shire Council, Written Submission, June 2010, 3.
[421] ibid.
[422] Macedon Ranges Shire Council, Written Submission, June 2010, 4.
[423] Maribyrnong City Council, Written Submission, June 2010, 3.

5.68. Hume City Council noted that functional relationships vary according to the school culture, parents and friends associations, school council interests and principal's values, suggesting that 'this would be a key concern in the implementation of municipal wide health promotion initiatives'.[424] It identified the following factors as potential partnership constraints: variance of school cultures and the autonomous nature of schools making each school partnership independent from other school partnerships; schools' perceptions of their role in community development and as host of community hubs; and inconsistent messages through externally provided services and activities in schools.[425]

5.69. Wyndham City Council suggested that there appears to be limited frameworks at a systems level to allow the development of partnerships. It suggested that some of the barriers associated with the status quo include:

- Schools are largely autonomous and often have varying priorities which can impact on the formation of community partnerships.
- The task of identifying the appropriate key contact within schools is currently problematic as this varies between schools.
- There appears to be limited accountability for schools centrally in relation to engaging with communities and, as a result, each school can have disparate approaches in this area.[426]

5.70. Wyndham City Council suggested that centrally defined frameworks, as proposed in the Blueprint for Education and Early Childhood Development, could create more consistency when trying to engage in effective partnerships with local schools. It argued, however, that it will be important that partnership frameworks are transparent (including the identification of key contacts) and adopted and applied by schools consistently.[427]

5.71. Another theme in the submissions from councils was that school–community partnerships will only be effective where a local need has been identified and supported by the local environment. For example, Macedon Ranges Shire Council stated that projects and programs 'imposed' on schools without discussion of local need are set to fail.[428] South Gippsland Shire Council made a similar point:

> Critically also, it must be recognised that centrally driven policies and programs can be problematic if they don't allow for flexibility and local variation. Community development principles imply that success is contingent on engaging people in organisations in a manner that respects local concerns and initiatives.[429]

5.72. In considering the wide range of potential partnership challenges or constraints, a number of councils identified various factors which they consider to be essential to the success of partnerships involving the health and education sectors and local government.[430] These include:

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[424] Hume City Council, Written Submission, June 2010, 9.
[425] ibid., 10.
[426] Wyndham City Council, Written Submission, July 2009, 3–4.
[427] ibid., 4.
[428] Macedon Ranges Shire Council, Written Submission, June 2010, 5.
[429] South Gippsland Shire Council, Written Submission, June 2010, 3.
[430] For example, Maribyrnong City Council, Written Submission, June 2010, 4; Greater Shepparton City Council, Written Submission, June 2010, 7; City of Greater Geelong, Written Submission, June 2010, 3.

- involve key partners, such as schools and local councils at the planning phase;
- create manageable expectations by creating a culture of collaboration;
- ensure there is a clear understanding of each partner's role in the partnership and ensure everyone involved in the school and council is aware of the aims and activities of the partnership;
- create a dedicated resource (staff and dedicated funds) towards inter-sectoral health promotion activities to change culture within and between schools and health agencies;
- create a supported structure for the planning, design and strategic conversation between sectors;
- create targeted health promotion activities across program areas, health promotion issues and place;
- adopt a whole-of-school approach rather than a classroom learning approach;
- adopt a whole-of-health approach rather than issue-specific responses;
- resource staff and capacity building opportunities within schools and local councils;
- ensure support from the Department of Education and Early Childhood Development for the implementation of specific programs and initiatives; and
- identify where health outcomes in schools can be most effective within the broad continuum of health promotion.

5.73. The Committee acknowledges the exemplary partnership models which have already been developed by some councils across the state. The Committee encourages this work to continue and suggests that councils formalise partnerships involving schools for the purpose of promoting healthy community living.

## Conclusion

5.74. The Committee found that community links and partnerships at the local, regional and state level are essential if schools are to meet their health promotion goals and support healthy community living. The Committee believes that such partnerships should be formalised through partnership agreements which set out the purpose, aims and objectives of the partnership, as well as the specific roles and responsibilities of each partner. The Committee believes that schools and their potential partners can be assisted in this task by the development of guidelines and resources outlining best practice in school-based health promotion. Additionally, the Committee believes that the Department of Education and Early Childhood Development should establish a network of health promotion coordinators who are responsible for assisting the health and wellbeing team of schools in their network to plan, develop, implement and evaluate their health promotion policies, strategies and programs.

# Appendix A

# Written submissions

| Name of individual/organisation | Date received |
|---|---|
| Ms Mary Madigan, Friends of Westernport | 6 June 2009 |
| Mr Colin McQueen, North Fitzroy | 7 June 2009 |
| Ms Glenys Hetherton, Teacher, Beaumaris | 8 June 2009 |
| Moyne Shire Council | 30 June 2009 |
| Victorian Youth Mentoring Alliance | 30 June 2009 |
| The Hon Tony Smith MP, Federal Member for Casey | 2 July 2009 |
| Professor Lawrence St Leger, Mount Waverley | 2 July 2009 |
| Department of Health (Western Australia) | 6 July 2009 |
| Australian Research Centre In Sex, Health and Society, La Trobe University | 8 July 2009 |
| Department of Health and Human Services (Tasmania) | 15 July 2009 |
| Mr David Lyons, School Youth Worker, Northland Secondary College | 15 July 2009 |
| Knox City Council | 17 July 2009 |
| Ms Mary McMahon Slater, Orbost | 21 July 2009 |
| Alcohol and Other Drugs Council of Australia | 21 July 2009 |
| Mr Andrew Lockwood-Penney, Kyneton | 21 July 2009 |
| Kids – Go For Your Life, Cancer Council Victoria and Diabetes Australia (Victoria) | 21 July 2009 |
| Kelly Sports | 22 July 2009 |
| Plenty Valley Community Health Ltd | 23 July 2009 |
| Centre for Health Advancement, Department of Health (New South Wales) | 24 July 2009 |

| Name of individual/organisation | Date received |
|---|---|
| East Gippsland Shire Council | 24 July 2009 |
| Vision 2020 Australia | 27 July 2009 |
| Women's Health Victoria | 27 July 2009 |
| Wheelchair Sports Victoria | 27 July 2009 |
| Victorian Primary Schools' Sports Association and Victorian Secondary Schools' Sports Association | 27 July 2009 |
| City of Boroondara | 28 July 2009 |
| School of Public Health and Preventive Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University | 28 July 2009 |
| Quit Victoria | 28 July 2009 |
| Stephanie Alexander Kitchen Garden Foundation | 29 July 2009 |
| Mrs Prue Oldham, Beaumaris | 29 July 2009 |
| Dr Ruth Schmidt Neven, Director, Centre for Child and Family Development | 29 July 2009 |
| Ms Judy Young, Vermont | 29 July 2009 |
| MindMatters, Principals Australia | 29 July 2009 |
| Scout Association of Australia, Victorian Branch (Scouts Victoria) | 30 July 2009 |
| The Home Grown Project | 30 July 2009 |
| Fresh For Kids Program, Sydney Markets Limited | 30 July 2009 |
| HealthWest Partnership | 30 July 2009 |
| Eat Well Tasmania Kids Coalition | 30 July 2009 |
| Campaspe Primary Care Partnership | 30 July 2009 |
| Victorian Alcohol and Drug Association | 30 July 2009 |
| Cardinia Shire Council | 30 July 2009 |
| Dental Health Services Victoria | 30 July 2009 |
| Open Family Australia | 30 July 2009 |
| SunSmart, Cancer Council Victoria | 30 July 2009 |
| Salt Shakers Inc | 30 July 2009 |

| Name of individual/organisation | Date received |
|---|---|
| Frankston City Council | 30 July 2009 |
| Outward Bound Australia | 30 July 2009 |
| Academy of Sport, Health and Education | 30 July 2009 |
| Bayswater North Community Renewal Project | 30 July 2009 |
| Baw Baw Shire Council | 30 July 2009 |
| Western Metropolitan Region, Department of Education and Early Childhood Development (Victoria) | 30 July 2009 |
| Family Planning Victoria | 30 July 2009 |
| Corio Norlane Development Advisory Board, Education Sub-Committee | 30 July 2009 |
| Victorian Health Promotion Foundation (VicHealth) | 30 July 2009 |
| Outer East Health and Community Support Alliance | 30 July 2009 |
| National Drug and Alcohol Research Centre, University of New South Wales | 30 July 2009 |
| HeartKids Victoria | 30 July 2009 |
| National Rural Health Students' Network | 30 July 2009 |
| Bayside City Council | 31 July 2009 |
| Ms Nicole Commbs, Division 1 Nurse-Victoria, Nerrim South | 31 July 2009 |
| Darebin Community Health | 31 July 2009 |
| City of Kingston | 31 July 2009 |
| Forest Hill College | 31 July 2009 |
| Department of Education and Training and Department of Health and Families (Northern Territory) | 31 July 2009 |
| Tennis Victoria | 31 July 2009 |
| Australian Drug Foundation | 31 July 2009 |
| Heart Foundation (Victoria) | 31 July 2009 |
| The Jean Hailes Foundation for Women's Health | 31 July 2009 |
| Aquatics and Recreation Victoria | 31 July 2009 |
| Mrs Kerrie Ternes, Teacher, Wantirna South | 31 July 2009 |

| Name of individual/organisation | Date received |
|---|---|
| Victorian Healthcare Association | 31 July 2009 |
| Access and Success, Victoria University | 31 July 2009 |
| City of Yarra | 31 July 2009 |
| Central West Gippsland Primary Care Partnership | 31 July 2009 |
| Southern Grampians and Glenelg Primary Care Partnership | 31 July 2009 |
| Obesity Policy Coalition | 31 July 2009 |
| Wyndham City Council | 31 July 2009 |
| beyondblue: the national depression initiative | 31 July 2009 |
| Centre for Adolescent Health, University of Melbourne | 31 July 2009 |
| Netball Victoria | 31 July 2009 |
| Glenelg Healthy Schools Network, Portland District Health | 31 July 2009 |
| Royal Children's Hospital Education Institute | 31 July 2009 |
| Inner East Primary Care Partnership | 31 July 2009 |
| Australian Health Promotion Association (Victorian Branch) and Australian Health Promoting Schools Association | 31 July 2009 |
| Home Economics Victoria | 31 July 2009 |
| AFL Victoria | 31 July 2009 |
| School Focused Youth Service, Hobsons Bay and Wyndham | 31 July 2009 |
| Australian Sports Commission | 31 July 2009 |
| Edible Classrooms School Garden Program, Cultivating Community | 31 July 2009 |
| University High School | 31 July 2009 |
| Healthy Kids School Canteen Association | 2 August 2009 |
| Ride2School Program, Bicycle Victoria | 3 August 2009 |
| Brimbank City Council | 3 August 2009 |
| Foundation 49 | 4 August 2009 |
| Darebin City Council | 4 August 2009 |
| Association of Independent Schools of Victoria | 5 August 2009 |

| Name of individual/organisation | Date received |
|---|---|
| Australian Education Union (Victorian Branch) | 5 August 2009 |
| Department of Education and Training (Western Australia) | 7 August 2009 |
| Peninsula Health – Community Health | 7 August 2009 |
| SA Health | 10 August 2009 |
| Department of Education (Tasmania) | 10 August 2009 |
| Eating Disorders Foundation of Victoria (Eating Disorders Victoria) | 14 August 2009 |
| Catholic Education Office Melbourne | 18 August 2009 |
| The Alannah and Madeline Foundation | 21 August 2009 |
| Department of Education and Children's Services (South Australia) | 21 August 2009 |
| The Hon Kon Vatskalis MLA, Minister for Health (Northern Territory) | 27 August 2009 |
| Victorian Catholic Schools Parent Body | 1 September 2009 |
| Nutrition Australia (Victorian Division) | 11 September 2009 |
| Ballarat Community Health | 13 September 2009 |
| Department of Education and Training (Queensland) | 8 October 2009 |
| A For Attitude Productions | 24 November 2009 |
| Northern Metropolitan Region, Department of Education and Early Childhood Development (Victoria) | 11 March 2010 |
| Camp Hill Primary School | 29 April 2010 |
| Ms Prue Stone, Executive Officer, East Gippsland Primary Care Partnership | 19 May 2010 |
| Hume Region, Department of Education and Early Childhood Development (Victoria) | 20 May 2010 |
| Southwest Primary Care Partnership | 27 May 2010 |
| Good2gr8 Transformational Coaching | 1 June 2010 |
| Bendigo Loddon Primary Care Partnership | 2 June 2010 |
| Northeast Health Wangaratta | 9 June 2010 |
| Mentone Grammar | 15 June 2010 |
| South Gippsland Shire Council | 22 June 2010 |

| Name of individual/organisation | Date received |
|---|---|
| Moyne Health Services | 23 June 2010 |
| Greater Shepparton City Council | 23 June 2010 |
| Ms Hazel Rauch, Black Rock | 24 June 2010 |
| Wellington Primary Care Partnership | 24 June 2010 |
| City of Greater Geelong | 24 June 2010 |
| Yarra Ranges Council Youth Services | 24 June 2010 |
| Macedon Ranges Shire Council | 25 June 2010 |
| City of Ballarat | 25 June 2010 |
| Moreland City Council | 25 June 2010 |
| Caulfield Community Health Service | 25 June 2010 |
| Central Goldfields Shire Council | 25 June 2010 |
| Gippsland Women's Health Service | 25 June 2010 |
| Hume City Council | 25 June 2010 |
| Moorabool Shire Council | 25 June 2010 |
| Bentleigh Bayside Community Health | 26 June 2010 |
| School Focused Youth Service | 28 June 2010 |
| Southern Health | 29 June 2010 |
| Maribyrnong City Council | 30 June 2010 |
| N. Barker, Clifton Hill | 30 June 2010 |
| Municipal Association of Victoria | 30 June 2010 |
| EACH – Social and Community Health | 30 June 2010 |
| City of Melbourne | 30 June 2010 |
| City of Monash | 5 July 2010 |
| City of Stonnington | 9 July 2010 |
| The Benchmarque Group | 16 July 2010 |
| Mildura Senior College | 21 July 2010 |
| St Albans Heights Primary School | 23 July 2010 |

| Name of individual/organisation | Date received |
|---|---|
| Yarra Valley Community Health | 23 July 2010 |
| The Brainary Australia | 28 July 2010 |
| Ms Martha Loaisiga | 29 July 2010 |
| Central Bayside Community Health Services | 29 July 2010 |
| Munchy Lunch Pty Ltd | 30 July 2010 |
| Ms Tracey Kaczmark, Keilor East | 30 July 2010 |
| Ms Eva Migdal, Lecturer and Course Coordinator, School of Health Science, RMIT University | 30 July 2010 |
| Ms Lynette Hughes, Corio | 30 July 2010 |
| Ms Robyn Hoinville, Registered Nurse Division 1 | 30 July 2010 |
| Wales Street Primary School | 2 August 2010 |
| Padua College | 5 August 2010 |
| Gembrook Primary School Council | 17 August 2010 |

# Appendix B

# Public hearings

## Melbourne, 31 August 2009

| Name | Position | Organisation |
|---|---|---|
| Ms Robyn Ramsden | Manager, Statwide Programs, Student Wellbeing Division | Department of Education and Early Childhood Development (Victoria) |
| Mr Kris Arcaro | Assistant General Manager, Student Wellbeing Division | Department of Education and Early Childhood Development (Victoria) |
| Ms Naomi Lind | Senior Policy Officer, Student Wellbeing Division | Department of Education and Early Childhood Development (Victoria) |
| Associate Professor Bernie Marshall | National Vice-President | Australian Health Promoting Schools Association |
| Dr Emma Bruce | Vice-President | Australian Health Promotion Association (Victorian Branch) |
| Mr Matt Cameron | Secretary | Australian Health Promotion Association (Victorian Branch) |
| Professor Lawrence St Leger | | |
| Dr Suzy Honisett | Manager | Kids – Go For Your Life |

## Melbourne, 5 October 2009

| Name | Position | Organisation |
|---|---|---|
| Professor George Patton | Director of Adolescent Health Research | Centre for Adolescent Health, University of Melbourne |
| Dr Sheryl Hemphill | Senior Research Fellow | Centre for Adolescent Health, University of Melbourne |
| Ms Jill Pearman | National Team Coordinator | MindMatters, Principals Australia |
| Ms Vivienne Archdall | Victorian State Project Officer | MindMatters, Principals Australia |

| | | |
|---|---|---|
| Mr Geoff Munro | National Policy Manager | Australian Drug Foundation |
| Ms Rosemary McClean | Policy and Conference Advisor | Australian Drug Foundation |
| Ms Yvonne Kelley | Manager, Education, Communication and Resource | Family Planning Victoria |
| Dr Kathy McNamee | Senior Medical Officer | Family Planning Victoria |
| Ms Sue Heward | Manager, SunSmart | Cancer Council Victoria |
| Ms Justine Osborne | Schools and Early Childhood Coordinator, SunSmart | Cancer Council Victoria |

## Melbourne, 16 November 2009

| Name | Position | Organisation |
|---|---|---|
| Mr Todd Harper | Chief Executive Officer | Victorian Health Promotion Foundation (VicHealth) |
| Ms Lyn Walker | Executive Manager, Participation and Equity for Health | Victorian Health Promotion Foundation (VicHealth) |
| Mr Trevor Carr | Chief Executive Officer | Victorian Healthcare Association |
| Mr Matt Cameron | Research and Policy Officer | Victorian Healthcare Association |
| Ms Marcia Gleeson | Professional Officer | Australian Nursing Federation |
| Mr Andrew Prendergast | Industrial Officer | Australian Nursing Federation |
| Ms Lyndel Armstrong | School Nurse, Secondary School Nurse Program | Department of Education and Early Childhood Development (Victoria) |
| Ms Jody Atkin | School Nurse, Secondary School Nurse Program | Department of Education and Early Childhood Development (Victoria) |
| Ms Merrin Sullivan | School Nurse, Primary School Nurse Program | Department of Education and Early Childhood Development (Victoria) |
| Mr Brad Allen | President | Victorian Primary Schools' Sports Association |
| Ms Robyn Miller | Executive Officer | Victorian Primary Schools' Sports Association |
| Mr Rob Carroll | President | Victorian Secondary Schools' Sports Association |
| Mr Nick Mooney | Acting Executive Officer | Victorian Secondary Schools' Sports Association |

| | | |
|---|---|---|
| Mr Warren McKelvie | Manager, School Sport Unit | Department of Education and Early Childhood Development (Victoria) |
| Ms Erin Prater | General Manager | The Home Grown Project |
| Mr Andrew Prater | Installations and Education Program Manager | The Home Grown Project |
| Mrs Berna Buzaglo | Committee of Management | The Home Grown Project |
| | Principal | Bayswater North Primary School |

## Melbourne, 21 June 2010

| | | |
|---|---|---|
| Ms Kirsty Brown | Health Promotion Coordinator | Kingston Bayside Primary Care Partnership |
| Ms Anita Collett | Health Promotion Coordinator | Central Highlands Primary Care Partnership |
| Ms Emma Harris | Health Promotions Team Leader, Peninsula Health | Frankston Mornington Peninsula Primary Care Partnership |
| Ms Amy Moore | Health Promotion Coordinator, Peninsula Health | Frankston Mornington Peninsula Primary Care Partnership |
| Ms Maggie Palmer | Health Promotion Manager | EACH – Social and Community Health |
| Ms Liz Senior | Health Promotion Officer, | EACH – Social and Community Health |
| Ms Anne Somerville | Director, G21 Health and Wellbeing | G21 Geelong Region Alliance |
| Ms Rachel Whiffen | Prevention and Promotion Coordinator | HealthWest |

# Appendix C

# Interstate investigations

| Meetings, Brisbane, 7 September 2009 | | |
|---|---|---|
| Name | Position | Organisation |
| Professor Doune Macdonald | Head, School of Human Movement Studies | University of Queensland |
| Mr Michael Tilse | Director, Health Promotion | Queensland Health |
| Ms Leith Sterling | Acting Executive Director, Student Services | Department of Education and Training (Queensland) |
| Ms Clare Grant | Principal Advisor, Student Services | Department of Education and Training (Queensland) |
| Dr Trish Glasby | Manager, Teaching and Learning | Department of Education and Training (Queensland) |

# Appendix D

# International investigations

The Committee undertook international investigations in New Zealand during the period 19 October to 23 October 2009. During these investigations, the Committee conducted meetings for two separate parliamentary inquiries: Inquiry into Skill Shortages in the Rail Industry; and Inquiry into the Potential for Developing Opportunities for Schools to Become a Focus for Promoting Healthy Community Living.

## WELLINGTON, 20 October 2009

### Health Sponsorship Council

Mr Ian Potter, Chief Executive Officer

### Agencies for Nutrition Action

Ms Nicola Chilcott, Executive Director

### Student Wellbeing Contract

Ms Barbara Watson, Advisor

### Cancer Society of New Zealand

Dr Jan Pearson, Health Promotion Manager

### Massey University

Dr Cynthia Kiro, Associate Professor, Centre for Public Health Research

Dr Janis Carroll Lind, Senior Lecturer, College of Education

### Department of Public Health, University of Otago

Dr Louise Signal, Director, Health Promotion and Policy, Research Unit

Dr Matthew Walton, Research Fellow

### Health Promoting Schools in New Zealand

Ms Heather Knewstubb, Team Leader, Health Promotion, Healthy Schools Team

## ROTORUA, 21 October 2009

### Toi Te Ora–Public Health Service

Ms Jen Murray, Health Promotion Manager

### Owhata Primary School

Tour and meeting with the Principal Mr Bob Stiles, teachers and students

### Selwyn Primary School

Tour and meeting with the Principal Mr Tony Pope, teachers and students

### Kaingaroa Forest Primary School

Tour and meeting with Mr Mike Jones, Principal, teachers and students

## AUCKLAND, 22 October 2009

### Health Promotion Forum of New Zealand

Ms Alison Blaiklock, Executive Director

### Health Promoting Schools, Auckland Regional Providers

Ms Emma Harris, Regional Coordinator

Ms Lorraine Bailey, Service Manager, Counties Manukau District Health Board

Ms Reena Reddy, Team Leader, Counties Manukau District Health Board

Ms Helene May, Operations Manager, Waitemata District Health Board

Ms Erica McKenzie, Team Coordinator, Waitemata District Health Board

Ms Natalie Burton, Team Coordinator, Auckland District Health Board

Ms Gaylene Leabourne, Advisor

Ms Rachel Rix Trott, Advisor

Ms Vicki Shepherd, Advisor

### Royal Road School

Tour and meeting with the Principal Mr Wayne Leighton, teachers and students

### Massey High School

Tour and meeting with the Principal Mr Bruce Ritchie, teachers and students

### National Heart Foundation of New Zealand

Ms Anna Martin, National Programme Manager, Schools and Early Childhood Education

Mr Bruce Waldin, Marketing Manager

Ms Monica Briggs, Education Setting Manager

Ms Ali Northridge, JRFH Manager

## Ministry of Health

Ms Andrea Rutene, HPS Issues Lead and Portfolio Manager

Ms Marlene Williams, Senior Portfolio Manager, Hamilton Office

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