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

EDUCATION AND TRAINING COMMITTEE

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

Melbourne — 21 June 2010

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Ms L. Senior, health promotion officer, and

Ms M. Palmer, health promotion manager, eastern access community health, Outer East Primary Care Partnership;

Ms A. Collett, health promotion coordinator, Central Highlands Primary Care Partnership;

Ms K. Brown, health promotion coordinator, Kingston Bayside Primary Care Partnership;

Ms A. Moore, health promotion coordinator, and

Ms E. Harris, health promotions team leader, Peninsula Health, Frankston Mornington Peninsula Primary Care Partnership;

Ms A. Somerville, director, G21 Health and Wellbeing, G21 Geelong Region Alliance; and

Ms R. Whiffen, prevention and promotion coordinator, HealthWest.

The CHAIR — I am pleased to declare this hearing of the Education and Training Committee formally open. As you are all aware, we are hearing evidence today in regard to our inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living. I wish to advise you all that the evidence you provide to us today, including any submissions that you have made, is subject to parliamentary privilege. You will know that means that you can say anything without having the fear of being sued. I do not know whether that is relevant necessarily!

Thank you all for coming along today. It has been terrific to receive a number of submissions from various primary care partnerships around the state in regard to this inquiry. We have been particularly keen to meet with some of the primary care partnerships today to hear from you a little bit more detail about what your involvement with schools is, what is working well, what are the challenges and what might need to happen into the future to ensure that what is happening can be sustainable. As we are preparing our report we will be looking to make recommendations, so it is what suggestions you might have that we could put in our recommendations to help us with our inquiry.

I expect that what might be the best way to go is if we hear from each of the primary care partnerships first about what their involvement with schools has been, and hear from you firstly a brief summation of some of the things you are doing and some of your responses to those issues I have raised. Once we have heard from all of you, then we can enter into a bit more of a dialogue to tease out some of those issues that are of interest to you. I hope that sounds okay.

Ms MOORE — My name is Amy Moore. I am from the Frankston Mornington Peninsula Primary Care Partnership. I am the health promotion coordinator with the PCP. Did you want to hear a little bit about — —

The CHAIR — We might just move down first so we can get a sense of who everybody is, thanks Amy.

Ms SOMERVILLE — I am Anne Somerville from G21, which is a regionally based organisation in Geelong covering the Barwon subregion.

Ms WHIFFEN — I am Rachel Whiffen, the health promotion coordinator at HealthWest Partnership, which is an alliance of health and wellbeing organisations in the western suburbs region of Melbourne.

Ms HARRIS — My name is Emma Harris. I am here for the Frankston Mornington Peninsula Primary Care Partnership, and I am the team leader for health promotion at Peninsula Health.

Ms PALMER — I am Maggie Palmer, and I am here from the Outer East Primary Care Partnership. I am the health promotion manager at Eastern Access Community Health.

Ms SENIOR — I am Liz Senior. I am representing Outer Eastern Primary Care Partnership. I work at EACH social and community health, and I am a health promotion officer.

Ms COLLETT — I am Anita Collett from Central Highlands Primary Care Partnership.

The CHAIR — Shall we start with Frankston? I do not know who wants to talk first, Amy or Emma.

Ms HARRIS — Do you want me to cover what we are doing currently?

The CHAIR — Yes, that would be a good starting point.

Ms HARRIS — At the moment in terms of work that we do with school, we work with a few primary schools and also some secondary schools. In terms of the work that has been done to date, it has tended to focus on particular projects for a period of time. There is stuff around food nutrition and physical activity. We also have a sexual health nurse who works with some of the secondary schools in terms of providing a clinic and also working with teachers in terms of supporting them to deliver in the curriculum area.

Up until now that is what we have done. I do not necessarily think that is the best model that we can do. What tends to happen in terms of them being one-off projects is as soon as something comes along in terms of literacy, numeracy and education, the enthusiasm drops off the health and wellbeing things, because it is not integrated into the curriculum or integrated across the school. Also, once we move on to another issue area the momentum for the first one drops off. In our area we are looking at introducing a different model to work in

with schools in terms of looking at social environments and how to support building resilience so that when a school is helped to identify key issues for itself and its community it can apply the same consistent approaches to those no matter what the issue is. Amy, did you want to add anything?

Ms MOORE — In terms of the primary care partnership's perspective, there are a couple of individuals, member agencies and organisations that have, as Emma said, worked with the schools. From our perspective it is really about better integrating — as Emma was saying — with the needs of these individual schools, and we would be interested in exploring what health promoting schools as a framework might be able to support that process as opposed to these one-off forums, programs or events.

The CHAIR — We might move on to Geelong.

Ms SOMERVILLE — Okay. G21 is a regional organisation, so it covers five local government areas, and as a result picks up a number of schools as well as having a lot of central schools in Geelong. G21 has a health and wellbeing pillar, which I am part of, as well as an education pillar. It has eight pillars that look across regional planning needs and project development for the region. The education and health and wellbeing pillars have this year spent a lot of time working together to look at what might be the best models for schools and working on health and wellbeing within schools as well as connecting school communities to the broader community.

The three areas that we have done some work together on are essentially trying to look at early years and understand what is going on for schools and school communities with the development around services being sited at schools and a lot of that new development around child care needs et cetera, opening up school environments and how that is best done, rather than it becoming just a set of co-located services. Our early years group is looking particularly with an equity lens to try to address disadvantage in particular rather than just look at the universal set of services that are coming out through the Department of Education and Early Childhood Development.

The other key area that has been looked at around school environment and health and wellbeing is around mental health and wellbeing. Again, a lot of the health services were feeding back the need for schools to understand and have good mental health literacy rather than just general health literacy as to what were the viable service systems, what were the issues and how to deal with some of those issues early on. It is about trying to open up some of the models around early intervention and health promotion for schools and school communities, not to expect them to become part of that health service system but know how to perhaps interact with it a lot better and perhaps earlier as well as advise parents and families.

The other area that we have been pretty interested in looking at has had a bit more of a secondary school focus, but not only that — some work with young students, and young men in particular, around problem gambling, mental health and alcohol and drug issues. Again, not looking at individual treatment models but where there are episodes of need or things incurring for that person, starting to build resilience into how young people are dealt with as well as personal development programs within schools et cetera.

Youth workers are often brought into a school to do individual talks et cetera. They tend to talk about what happens when everything goes wrong rather than about strengthening health and wellbeing. We are trying to concentrate much more on that end of the continuum, if you like, and to look at how health and wellbeing can interact with other parts of a family's life in terms of their prosperity or their change in circumstances or their need to build resilience at particular times.

The model we have developed across the two areas is very much a life course approach model, so taking the educational milestones that are important for educational staff and teaching staff to address the health and wellbeing milestones and where vulnerability and at-risk behaviours factors play out in that, so trying to get a way to talk about that across the two sectors, if you like. Our work has been much more, if you like, at a strategic level. There are probably 50 member agencies just within health and wellbeing and then more broadly in G21. There are definitely a lot of projects on the ground that work with individual schools and individual health services et cetera that have terrific models. We are trying to work more at a level of 'How do we actually reshape the system so people are not seeing the fences as being quite so high or so thick?'.

The CHAIR — Rachel?

Ms WHIFFEN — As I said, HealthWest is based in the western metropolitan region of Melbourne and, like G21, we cover five local government areas in the west. Our work with schools has really been twofold. The first is direct work with schools via our member agencies, which are mainly community health centres, women's health and local government organisations, extending from their leisure, planning and their youth services. That is looking at specific initiatives mainly around supporting schools and linking into the Go for Your Life program which is very much focused on physical activity and being able to access fruit and vegies. It is about healthy eating, and really supporting schools — the teachers, the wellbeing officers, the principals — in running particular projects and initiatives that link those schools into, I guess, access to that work on an ongoing basis. So not a one-off but really ensuring it is embedded into school policies, into canteens and into curriculums and so forth. Likewise, it can be said for issues around sexual and reproductive health and mental health services as well.

The second part of our work is really around supporting those organisations that work very directly with schools around their own capacity and their expertise to ensure they are undertaking the right processes and to ensure that initiatives actually meet the needs of the school community. It is supporting the workers around appropriate planning, needs and assessment, engaging with schools and evaluating school initiatives to make sure what they hope to achieve is being achieved. The way we do that is through developing population health profile reports, training and a lot of information sharing. The actual practitioners are sharing their information and sharing their learning. In particular in the west we have a very dynamic and diverse community from low socioeconomic and cultural backgrounds. We have a lot of people with refugee backgrounds and from inner urban areas but also from the growth areas like Wyndham and Melton. Practitioners are really supporting each other around working more closely with schools.

That has been a lot of our work. More and more we link in around mental health and, like Anne said, around some of the work of resilience, particularly with a focus on young people aged between 12 and 18 years into being socially connected, and using some of those health messages around health eating and physical activity as a way of actually creating those links to communities. That has been our work for the last few years.

The CHAIR — Okay. We might move on to the outer east. Maggie Palmer?

Ms PALMER — I am going to speak about the community health service, and Deborah Cocks, who is from the PCP, might be able to talk a bit more about the broader membership of the PCP. We are a relatively new project, and we a relatively new team in the eastern region. As our strategic health promotion overall approach we are using a settings and place-based approach, and one of the settings we have identified for health promotion work has been schools. We have a three to five-year pilot project, so our focus has been around the health promoting skills framework, but looking at applying the evidence, both from Australia and internationally, to our pilot schools, and also looking to evaluate the project in terms of health and wellbeing outcomes and indicators. The project has really concentrated on looking at young people's sense of pride in their school, their sense of belonging and links to the community, the community's knowledge of the school and what the school does.

Coming from Scotland, we have applied some of the models from there. There are three pilots, and Liz will speak some more about the operational aspect of the pilot projects. We have gold star, silver star and not so silver star schools. We have gone for quality rather than quantity, so we have three schools — two primary and a secondary school — that we are working with. In terms of our health promotion, as a community health service we are looking at reorientating our services, and in reorientating them we have actually designated a person — one EFT — to the health promoting schools project, which is Liz. Liz has been seconded to one of the schools. She sits in the school and is part of the school team. We have been looking at how that model works in comparison to the other two schools that we are working with.

We are working with Bayswater North Primary School on a community renewal project, which is one of the state-funded projects. Our school sits within the community renewal site, so we have actually been able to explore the impact on community and the community's impact on the school through the community renewal steering committee and through the community renewal strategic partnerships committee, and education and many other agencies actually sit round that table. The work we have been concentrating on has been around environments for health and infrastructure rather than projects and programs. We have done a fair bit of school profiling — collecting baseline data — so we are able to measure and monitor any changes that are going on. I will let Liz talk a bit more about the detail.

The CHAIR — Liz is also from Outer East.

Ms SENIOR — As Maggie said, I work with three local schools. I am based at Bayswater North one day a week — they have given me an office and a computer — and that is probably the school where I have been most successful in becoming part of the school and initiating health promotion projects. We are using the health promoting schools framework in all three of the schools, and again I think the relationships I have with the school reflect how well that has been embraced.

Bayswater North has really embraced it to a very great extent; because I am based there one day a week the principal and the assistant principal have taken it on big time. The other two schools have embraced it to varying degrees. It has very much been the willingness of the leadership of the schools to embrace the health promoting schools framework and run with it that has dictated how successful the program has been and how much it has become embedded within the school.

The CHAIR — Are they primary schools?

Ms SENIOR — Two primary schools and one secondary school.

Mr HERBERT — Which ones are they?

Ms SENIOR — Bayswater North Primary School — I suppose it is okay to mention them — Maroondah Secondary College and Tinternvale Primary School.

We started off by doing an audit with all these schools. We did an assets-based audit where we asked the school: what are the good things you think about your school? What do you like about your school? What would you like to see change in your school? We surveyed the entire school community — or particularly in Bayswater North we surveyed the entire school community. We surveyed the teachers, the parents and the students to find out what the issues were. As a result of that survey, we have got some plans: we have got a healthy eating and canteen plan, a staff health plan and a physical activity plan, because those were the things that were identified out of the audit. Out of those plans have come some projects, some ideas and some things that we are working on.

We have done that in Maroondah, perhaps not quite to the same extent. I did do an audit with some students, and I have talked extensively with the principal and some members of the senior leadership team, and perhaps to less of an extent at Tinternvale. Tinternvale merged last year with another school and it had quite a lot of things going on as a result of that. So they came to me and asked me to do a specific project around values — they re-did all of their values.

To a certain extent the work is driven by the school. It is asking the school, 'What would you like me to do?' rather than saying, 'I am here to work with your canteen. I am here to do this for you'. We are saying to the schools, 'What can I offer you? What areas would you like me to work on? We are going to a use a health promoting schools multimodal model to try and get change'. When I have gone into all of these schools I have first spoken to the staff, I have spoken to the school council, I have spoken to parent teacher associations to try and get everybody on board so everybody knows what I am doing. I stress that I am not there to run classes. I have had some teachers ask me if I will come in and run some classes. I stress that I am not a teacher: 'You are the ones with the education qualifications. You are the experts in that area. I am here to try to change culture and environment and to be used as a resource'. So to varying degrees the schools have taken that on.

The CHAIR — Okay, thank you, Liz. I will come back to you in a moment.

Welcome, Kirsty Brown. Sorry, you were not here when we did our initial welcome. Do you just want to let us know a little bit about what Kingston Bayside Primary Care Partnership is doing and we will go from there?

Ms BROWN — Sure. My apologies for being late; I had a few issues with train cancellations. My role is as a health promotion coordinator with the Kingston Bayside Primary Care Partnership. Our role in schools primarily over the last three years has been that of one of the community demonstration sites for one of the health promoting communities being active and eating well projects funded through the Department of Health and the Department of Planning and Community Development. That project is nearing its completion next week — on 30 June.

Our target group for that project was 0–12 years, so we had a primary school-age focus, and we were particularly interested in working with our residents in the public housing estates in the city of Bayside and around the Clayton South-Clarinda area in the city of Kingston, so a population that had quite a high level of diversity and people from different backgrounds.

We probably had four primary intervention primary schools. We worked very closely with Sandringham Primary School, Sandringham East Primary School, Clarinda Primary School and Westall Primary School. Primarily our work through that project was around supporting the schools with the implementation of the Kids Go For Your Life award. A lot of policy development support was provided to the schools. We offered a number of grant programs, which proved to be a very successful incentive for the engagement of those schools. We provided them with funds which primarily went to purchasing equipment and infrastructure to support physical activity in those schools.

Running it through the primary care partnership platform was certainly very successful for us. That enabled us to have a number of agencies through local government and community health become particularly engaged with those schools. Some of the outcomes that we have had come up through the evaluation were the strengthened partnerships that schools identified with local councils primarily and other local services in particular. I think that was a real strength, because we do not have a designated resource for a person who has responsibility. So it has been really trying to identify key people within agencies to have a role in supporting schools, and also schools becoming aware of what other resources are out there to support them in their health promotion work.

I guess one of the things we also learnt from the schools through the evaluation was that they identified with that project, particularly with its focus around healthy eating and physical activity; they took it up and engaged with it because it aligned with their organisational goals. They said to us that so many programs and projects and initiatives come across their table that they have the opportunity to engage with, but unless they actually align with the organisation and values of that school, it is very difficult for them to take them on. I guess that also highlighted to us that the schools we were working with were all, in a way, the converted schools, because they already had the buy-in and the belief about what we are actually wanting them to do.

We realise that over our next three-year period, while we obviously want to continue to develop the relationships with those four schools, we want to reach some of the harder to reach schools that may not have the buy-in, the leadership and the champions within the schools already driving this work. Similarly, someone mentioned earlier that we need to continue to build our priorities around physical activity and healthy eating, but to increase the focus on mental health as well. A lot of the findings that came out of the evaluation of a lot of our initiatives, while they were designed around healthy eating and physical activity, were that it was the social connectedness elements that people wanted and got out of them. That will be our direction with the schools for the next few years.

The CHAIR — Okay. Thanks, Kirsty. Lastly, in terms of our first round, Anita Collett from the Central Highlands.

Ms COLLETT — I guess the work that the primary care partnership has done in relation to schools has been around the community hubs development. That is around schools becoming community hubs and the interaction between the relationships in community and family and how that would be integrated together. We have done a series of forums with schools, agencies, local government and anyone who is interested. I guess from those the main things that have come up have been around governance, records and privacy and forming and continuing to build on the relationships, given that everyone comes from a different perspective.

The health promotion network has three priority areas: healthy lifestyles, mental wellbeing and sexual and reproductive health — much the same as the themes I have heard from the rest of the representatives here. Problem gambling, drug and alcohol, the SSMART ASSK program that has been piloted in a school very successfully, physical activity and access to nutrition and foods are the programs that running and lots of agencies are delivering them. We are trying not to go into schools to do one-off programs. We are trying to look at whole-of-school approaches, and that is generally being guided by the Grampians Mental Health and Wellbeing Network, who are representatives from CAMHS and the school-focused youth service in the Department of Health and Department of Education and Early Childhood Development.

They are working together and they are guiding the frameworks for everyone who works in schools. For example, they are saying that MindMatters and KidsMatter are frameworks/programs that they want to see developed, so the focus is on those. As everyone has been saying, it is around getting the curriculum standards rights, getting the policy changes and getting the parents engaged and a whole-of-community response. At the end of 2006 Schools and Agencies Working Together Resource was developed — I am not sure if you are interested in looking at that — and it was because people were finding that they did not know basic stuff around if an agency was going into a school and the teacher left the room, that was not actually acceptable behaviour. So that was developed. I do not if you want to see that or not.

As part of the sexual and reproductive health strategy, there is a puberty project, there is the White Ribbon and there is some cyberbullying stuff that is being developed at the moment across the region.

The CHAIR — Okay. Have some people on this side of the table got some questions they want to ask?

Mr HERBERT — I do. Can I just start off with a very quick overview from all of you. Funding — it seems that there are different types of programs operating. Are all your funding sources from the health department? What are your main funding sources for working with schools? Just a quick snapshot, or someone may want to summarise it.

Ms MOORE — I suppose from a primary care partnership perspective we are funded through the Department of Health; however, we also represent a number of agencies and organisations, as was covered — local government, community health and other community services like Anglicare.

Mr HERBERT — But in general there are no funding streams directly from education in that area. So does that mean you tend not to work with the education regional office strongly?

Ms WHIFFEN — We do have a link with our regional office, but it is really at an information-sharing level; it is not a lot to do with funding or committee work.

Mr HERBERT — So it tends not to be systemic education; it tends be health work. Secondly, do you work with non-government schools? Are you funded from non-government schools or just from government schools?

Ms COLLETT — We have been working with the Catholic Education Office to work with our schools.

Ms WHIFFEN — Likewise.

Mr HERBERT — What percentage, roughly — I know there are a lot of quick questions; a snapshot sort of thing — you all mentioned a few schools; I am not sure of the size of the region that each network covers. What percentage of schools do you think you would be actually working with in each of your catchment areas? Would it be 10 per cent?

Ms SENIOR — Ours would be less; I only work with three schools.

Ms COLLETT — Ours would be more.

Mr HERBERT — Yours would be a few per cent, and yours would be — —

The CHAIR — Central Highlands — what are you suggesting?

Ms COLLETT — Probably more: over 50 per cent, I would say. We have got the Smiles 4 Miles and that is the most — —

Mr HERBERT — In a meaningful manner.

Ms COLLETT — In a meaningful manner, I would say most of the schools are say at 50 per cent or less; in a meaningful manner.

Ms SENIOR — We only work with three schools.

Ms HARRIS — Ours would be about 20 — if that, about 15.

Mr HERBERT — Yes, 15 to 20 per cent from?

Ms HARRIS — Mornington Peninsula.

Ms WHIFFEN — Ten to 15 per cent — HealthWest.

Mr HERBERT — So in general there is a small percentage which is program-based or sign-in for schools to come on board, or there are specific issues about those schools that you work with.

Ms PALMER — We have used it around addressing inequity, all our schools are around a disadvantaged criteria. We would — —

Mr HERBERT — But in general, apart from Central Highlands, it is not a systemic approach to a whole range of issues.

Ms WHIFFEN — That is correct.

Mr HERBERT — With the changes in national health, which seem to be focusing on large medical-type areas — I am sure you have been helping everyone on this — would you see it as a natural kind of progression for the community health area to move more into the preventative side and make working with schools stronger? Is that a kind of natural progression with what is happening, or not? Was that too big a question?

Ms SOMERVILLE — I will play with the big question. I think the important thing is that the health promotion and community strengthening work — and it crosses both the education department and community and planning development as well, and regional development for us in the non-metropolitan areas. The links there in terms of creating health and wellbeing are huge. Schools are one of those elements. Schools are an important element of that. If we continue just with the sector in a vertical way, it will not change very much because there is too much machinery behind that and different aims entirely about education and health and wellbeing aims to be honest.

I think it has to be at the community level, at a grassroots level, that some of that systemic change does occur to open up opportunities for shared funding rather than project funding only, or it will almost defeat the service sort of arrangement with health through education; it just does not — —

Mr HERBERT — Or a systemic fee for service as opposed to — —

Ms SOMERVILLE — Yes. With the reform, one of the key things around preventative health is that has dropped down the agenda at the moment. What we have found is that the really good opportunities are fading quite dramatically. At state government level it would be interesting to see what happens with primary care partnership, where a lot of work that is funded at the moment does fit into the national structure for primary care, but that is not health promotion and community wellbeing, and that work is yet to be told in a sense where it may be rehomed and how it may gain some strength in being rehomed rather than just tacked into. It is the last dot point on the seven points of what a primary health care organisation — the Medicare Locals — is supposed to do. Again, that suggests where it will sit in priority.

Mr HERBERT — I asked before our executive officer how schools were chosen; I was listening. A lot of it is around specific health issues or rurality, isolation then the work bit. I am interested in the mainstream big suburban areas where kids have the natural problems of mental health — they are a generic kind of thing; eating is a generic, kind of healthy living et cetera — but when we were in New Zealand, the New Zealand model is where they outsource the healthy schools to basically community health providers. One of the issues that they raised was that there was difficulty earlier on in particular. They did not realise they had to pay greater attention to the fact that the health and education sectors were completely different sectors with different aims, different drivers and different timetables — that is, one has got to get educational outcomes — and that there was a need for some awareness building before you started a program. Have you got any comment on that in terms of your experience?

The CHAIR — Who wants to start?

Ms MOORE — There are different languages that are spoken. We find this even within health promotion, I suppose, that we tend to speak at times a different language to other colleagues in the health system. You can imagine even then with the education sector — —

You are absolutely spot on, I would say, in the New Zealand experience. I think we would find exactly the same thing — that is, we need to do a lot of groundwork first around common language and understandings.

Ms WHIFFEN — I think also it relates to systemic structures in that a lot of the work that primary care partnerships do community health. Women's health is funded through the Department of Health, and there is an expectation from funding from departments that you work with schools at these groups — often they are families — so there is a driver there at that community level to work with schools, but I do not think there is a readiness from the education, whether that be schools or the education department, because of that not conflict but about that dual interest in education and learning outcomes and schools necessarily being resourced to be able to respond to work with communities. Often it is one teacher, one wellbeing officer within a school, therefore you risk that loss from a systemic point of view of any work that has been doing.

Ms SENIOR — With one of the schools we worked with we had a health promotion schools day, which was like a professional development for the teachers. All the staff went to a little retreat up at Olinda, and the idea was to try to get us all on the same page so the teachers understood about the health promotion schools and how education and health are inextricably linked so that everyone understood what was going on and we were all working to the same idea.

Ms PALMER — Some of the evidence that is coming out from overseas is around partnerships and linking those partnerships to make them inextricably linked, and having a shared vision, a shared agenda and a shared pathway of addressing the educational outcomes and at the same time the health and wellbeing outcomes. I think what we are struggling with is trying to do something from a bottom-up approach. We do not have the resources, so we need strong leadership and strong guidance at government level to say, 'These are the people who need to be sitting around the table; these are the people who need to be working together'. You need to be sitting down and having a shared language and a shared agenda, and that does not just include health and education. We have businesses — such as Bunnings — which sit in our partnerships, and we have NGOs with charities who are working with us, so it really is about looking at a systems approach. I think that is one of the key themes in order to drive the health promoting schools agenda.

Ms HARRIS — I worked in Health Promoting Schools in the UK — in England and Scotland. England has a slightly different model of Health Promoting Schools, but both of them are driven from the top. The key turning point for us in England was the white paper called *Every Child Matters*, which sets out five key components that every child should be entitled to. Those key components align very much to what Health Promoting Schools was doing, therefore the inspectoral body — —

I know education is set up slightly differently here. The criteria they gave schools to demonstrate was aligned to *Every Child Matters*, therefore schools were encouraged to adopt a Health Promoting Schools approach, because it helped them to do it in a systematic way. It was actually because it came from a white paper around how we need to work with children that then schools' health and education saw that actually they needed both partners to work together in order to implement that effectively.

Mr HERBERT — Just finishing off on the preliminary data, schools need to understand what the major health things are, but really for individual workers and organisations — primary care or community health organisations that work in schools — there needs to be a starting point of a bit of professional development so that you understand what the curriculum is and what the time frames are; otherwise you explain and you have a lot of mixed data. Is that a fair point?

Ms HARRIS — That is crucial. If you are working in an education setting, you need to understand how education works and how schools work. In terms of health, the risk sometimes can be that if practitioners do not have proper development professional development, they can see themselves as becoming curriculum experts. That is where the line used to be drawn. A line needs to be drawn because they are not curriculum deliverers; they are there to support that happening.

Mr HERBERT — Clearly defined goals and outcomes.

Ms HARRIS — Yes.

The CHAIR — Kirsty?

Ms BROWN — I think it is still really important that strong leadership comes from the department of education. One of the things that we found was that even within a strong partnership you need to provide as much education as you can to, say, the PCPs and community health in working with schools. If it is just relying on us trying to gradually chip away at engaged schools, it takes a long time. We have often commented that we are three years into a project working intensively with four schools and now we are at a point where we feel we are ready to start the project, but we have really got the momentum; it is there now. The external evaluators were appointed by Deakin University, and one of the challenges early in the project across the six community demonstration projects across the state was that they were finding having to buy into the evaluation from Deakin was being problematic within the schools, so they ended up developing some joint letters that came from, I know, Jim Hyde with the Department of Health. I am not sure who, but one of the senior people within the department was sent directly to the principals requesting their involvement and demonstrating their support for the project and really encouraging their involvement. That really helped as an incentive, because I guess it came from the leadership from the department of education, as well as just us as external from the health sector coming to them, so that really helped.

Ms SENIOR — I would agree with that, too. With one of the schools it has almost taken me a year just to get everyone on the same page — meeting, talking, consulting, discussing what we are going to do. I felt like I was not doing anything, but it actually was very important. It almost took a year before we actually started to actually physically do something. It was relationship building, making sure everybody understood what I was doing there and everybody was happy. Winning people's hearts and minds is very important, or else you will just fall over later on.

Mr HALL — Thank you all for your time and comments. First of all I was thinking about who actually makes the contact between your organisations and the schools that you work with. Is it the schools that are knocking on your door and queuing up to seek your advice and assistance, or is it the other way around?

Ms PALMER — For us it was actually the other way around. It was within our strategic approach to health promotion — as I mentioned, the settings-based, evidence-based approach — so we were looking at ways in which we would work across various settings to address the health promotion agenda. Schools were naturally — and education was naturally — one of those settings. For us it was about raising the profile a bit and the benefits of becoming a health promotion school and the benefits of working within a partnership framework. We actually had a forum where we had an expert from Deakin come in. We invited all of the schools in the area to come in and have a listen, and then we asked people to put their hands up for this new pilot schools project, and that is how it worked for us.

Initially schools made contact with the community health service for a service — for counselling or for sexual health services — but would not think to come to talk about culture or values or building partnerships or community links. That has been something they have seen that has been quite different. Health promotion is quite different than if you need psychological services or whatever else. That is how it has worked for us.

Ms WHIFFEN — From HealthWest's perspective it would have been 50-50 with schools — schools getting in contact with local services, but then also a service saying, 'We've got this opportunity to work with schools', and then the schools self-identifying that they are at a stage of readiness to link in and then coming back. It has been twofold.

Ms SOMERVILLE — In terms of G21, we do not work directly with schools at all; member agencies do. But on the executive that actually steers the plan we have the executive officer of the LLEN, and they are obviously funded to work with all the schools. We use that network, through education and learning and training. We also have the assistant regional director involved in the planning work.

The CHAIR — Of education?

Ms SOMERVILLE — Of education. And we have very senior representatives from health and human services and DPCD. As a result, we keep trying to have this conversation about how to operate across those individual sectoral barriers for the benefit of the region. We are still working through some of that.

The biggest thing that we have, though, is that schools want to operate in the now. I can understand that; they have got kids in rooms now and they have got parents knocking at doors now. We keep saying that we actually cannot do that sort of work. So it is that tension about trying to do the awareness building — 'What is it that you need? What is it that we say? What do you hear?' — and work on that for sometime. But at this point in time there is no mandated shared agenda, so health and wellbeing gets developed in schools in whatever way a school feels it can meet that agenda as directed by education, rather than a cross-government approach to it.

Mr HALL — And I think that is part of the purpose of this inquiry — to largely see if there can be some formalised structure rather than an ad hoc, school-by-school basis. Anita, you said you work with schools, and that 50 per cent — around about half — of your schools get involved to some extent. How have you found contact between your organisation and the schools? How has that been generated to the level that you have achieved?

Ms COLLETT — Like G21, we do not work directly, but the member agencies do. I would say there is probably 50-50 contact. It is about that they very much want the service when they want it, if there is an issue. I think the agencies are continuously trying to do that — 'This is long term, we will support you in your role. This isn't just a one-off thing; this is something we want you to have, and support you in' — sort of thing, rather than just delivering sex education or something. Do you know what I mean?

Mr HALL — Liz and Kirsty, you both said that the programs in schools were very much dependent on schools themselves having the champions to drive the program at a school level. Is that the key to successful health and wellbeing and structures within schools and communities, to have those local champions from within?

Ms BROWN — With certainly the schools that we have worked with, where there has been a champion who has really believed in the issue that we have been trying to work with and who has been able to drive that internally, it has certainly made our work a lot easier. When that person has been the principal, it has made it even easier. We have been able to achieve greater change in the schools where that key person was the principal.

Ms SENIOR — 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, as I think I said earlier, 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, really.

Ms HARRIS — And while it is important to have a key driver in a school, one of the next steps that is really fundamentally important is to then broaden that out to some sort of team. Because if that one person leaves, then the whole thing falls down because everyone sees it as their responsibility. While you need that initial driver, it also needs to then be built into the whole school, or once they have gone the whole thing will fall back down to where it started.

Ms SENIOR — I have actually got a health promoting schools committee in one of my most successful schools. Again, that is exactly what you are saying. I have a group of people who are pretty passionate about the whole thing. There are parents on it, and we are driving it forward so it does not just depend on me.

Ms SOMERVILLE — The other thing I will just add is that the one thing we have in common is some sort of evidence base — people want to work from some sort of good data and to know what they want to improve about it. We are mirroring the State of Victoria's Children report for the region. That has certainly got the interest of the regional office and centrally the education department, because they say, 'Okay, what do you know? What is the baseline here? What has to be better, and what actually can we not make better until these other things occur?'.

That has already created, if you like, a shared conversation of how to go about this rather than just, 'Can you do something about health care? Will you improve your physical activity and deal with looking at reducing symptoms and that sort of thing?'. That is what we can do. We can build evidence and suggest how the whole community might address this evidence and what matters here, but making sure it does not become a shame file.

Mr HALL — That leads me to my next question. Reading many of the submissions, some from your organisations and some from related organisations, suggests that there is a lack of resources in schools to initiate good health and wellbeing programs within schools. Is that generally your view, and if so, what do schools actually need to become good schools for health and wellbeing models that extend beyond a school to community, and get that whole-of-school and whole-of-community sort of focus? What do they need?

Ms PALMER — I think one of the key things is that there needs to be a recognition that health and wellbeing outcomes are as important as literacy and numeracy outcomes. It is the idea that academic subjects are more important than health and wellbeing programs. Health and wellbeing programs are a bit more nebulous, maybe a bit less structured, than having a defined approach to maths or English. From here it would be that there is a mandate saying, 'We will be looking at the health and wellbeing outcomes of the pupils at the school. We will be looking at the quality of the programs that you are applying in this area around community health and wellbeing, and we will be looking at other things that contribute to health and wellbeing such as the partnerships you have with other agencies, infrastructure and other things outside of the community'.

I think it is the idea that health and wellbeing is something that is just added on. 'It is the responsibility of the health and wellbeing teacher or teams; it is not mine, I am a math teacher'. It is the idea that parents and volunteers also have a very strong role, and you do not actually need to be a qualified professional to be able to contribute to the wellbeing of the child and the community. I think if I was asking, it would be a sense that we are looking closely. These are important outcomes, and we want good-quality evidence-based programs, and we want to be able to evaluate them and monitor them in the same way as we do with all the academic subjects. Schools are concerned with how they look in terms of where they are in the league tables, but nowhere in the league tables is there anything saying, 'These kids are resilient, well-rounded and they enjoy school' and those kinds of things, or that they have good mental health.

Ms HARRIS — In terms of the actual curriculum delivery part of wellbeing, teachers are not always given the full support or training they need in order to deliver. You have subjects such as sexual health and reproduction, drug education and alcohol, and sometimes teachers do not have the confidence or feel they have the skills to address those subjects. Again, it is done as a tack-on; if you can get someone in to do it for you that is good, and we can shut the door and we can tick it off and not worry about it again. It is not from the pastoral side; it is around curriculum delivery and the support teachers are given in terms of meeting the needs of the students within the curriculum as well.

Mr HALL — Do those schools extend to activity and healthy eating as well?

Ms HARRIS — Just in my experience I think you can do things like physical activity and healthy eating on a superficial level and they can stay quite safe. If you delve into them, they are much more complex, but for schools they are quite nice fluffy, good-feel things.

When it comes to sexual health and drugs and alcohol, it is far more 'Where are the boundaries? What do I do? How do I get this across properly?'. I think they are ones that sometimes teaching staff without the experience tend to shy away from, and then what is actually delivered in the classroom is not what the young people need. That is quite often where we get those one-off calls for the sexual health nurse — 'Can you come and run the session for us?', which does not build teachers' capacity to be able to do it the next year. If you work in that way, you end up providing the same service year after year, just for a different set of students.

Ms COLLETT — But it is fair to say that generally I think teachers would like to be able to concentrate on student wellbeing and that, but they are just so busy. When you want to try to talk to a group of teachers, you have to try to get on the agenda in the morning at 8.30 a.m., or at between 3.30 p.m. and 5.30 p.m., or if you try to ring them to organise something during the day, it is — 'Ring me back between period 1 and 2', and you think, 'What time is period 1 and 2?'. It is really even that practical stuff. It goes to what was mentioned before, that there is the language and the expectation. Even anecdotally people have said they have gone in to run anger management programs and you can hear the teacher yelling at the class next door.

It becomes quite complex. It is around: what is their core function and where is the integration? They want to control a class of 45 or 30 rowdy 14-year-olds; what strategies have they got that fit in with good mental health and wellbeing? You know what I mean?

Mr ELASMAR — On this one, you have talked about a survey. Who participated in the survey? Was it children and the teachers or the parents? Who participated in that? And how often do you conduct that survey?

Ms SENIOR — The initial survey I was talking about was the health promoting schools audit, and the ideas have come from a Queensland-based health promotion, *Health Promoting Schools Toolbox* documents. We just did an audit at the schools. The questions we asked were: what are the good things about the school?; what would you like to see changed? — and I actually gave them a little Likert scale; how healthy do you think this school is? That was just a one-off that I did to try to identify issues and things that the school would like to work on. I plan to repeat that audit later on and do some more focus groups and evaluations to see if we have shifted along the line. That was a one-off.

I did something similar in the secondary schools, perhaps not as comprehensive. I did a visioning exercise with years 7 and 8, which was a very interesting experience. I said I did an audit with the principal and the student welfare coordinator. It probably was not a structured audit. But we went through and worked out what the school was doing, what they would like to concentrate on and what their issues were. I did not actually survey the teachers or the parents at the secondary schools; it was more the visioning with the students. From the students it actually came out that the school environment was a big concern, the actual physical environment.

Mr ELASMAR — Sorry, Peter.

Mr HALL — That is all right.

Ms BROWN — As far as resources go, we did not focus so much on curriculum delivery in a classroom; we focused very much on supporting schools at the environment policy level, development and infrastructure. Certainly one of the things we found was the barriers of having any one staff within a school to have the capacity to allocate time for policy development. We ended up funding each of our school staff for less time so they could actually take some of their leadership teachers offline to spend a few days formalising their policies and things. A lot of the time their practices were already there to enable them to qualify for the Kids Go for Your Life program but there just was not the time to actually put the policies in place, because there are no designated health-promoting staff or roles within the school to do that.

The other thing that we found really beneficial was resourcing the infrastructure, because that provides a resource for the kids attending the school. Things like walking tracks actually become community assets that the community can then access out of school hours and on weekends for different sporting activities. Resourcing schools with infrastructure is a way of promoting them as a hub that can then be accessed by the entire community.

Ms WHIFFEN — Likewise with HealthWest, we have had to do something similar — funding teachers to take them offline to be able to participate.

Ms SENIOR — I have had a similar experience. We have not actually funded any teachers, but I have been doing a lot of the policy writing, in conjunction with the student welfare coordinator and assistant principal. Because the teachers are teaching they do not have time to do this. As I was saying to a school, 'You are doing everything to become a health promoting school; it is just not written down'. It is just taking that space to catalogue what they are doing.

Ms HARRIS — I have worked with schools before which have given managerial responsibility for doing the health and wellbeing and health promotion and also given extra teacher release periods to do that. They tended to be the schools that were more successful. I suppose they might have had the incentive to do it or the time to be able to do it as well.

Ms WHIFFEN — But again I think — feel free to say otherwise, other people — they then often very much rely on the values of the principal and of the senior leadership team within the school and them saying, 'We see this as important work'. Whereas other schools which, going by need and evidence and what students and families are saying, would like to be more involved in health promotion initiatives, with that bottom–up move they might not have that senior support to then be involved. It can be a tension there.

Mr HALL — I have one final question, before somebody else jumps the queue. You might want to think about this for a while. The question I ask is: what would make a difference? What is the one thing, or two

things, that would really make a difference and help our schools become what we want them to be — that is, to have a real focus on promoting health and wellbeing at school, in the family and beyond? What would make a difference? Perhaps you might also think about whether there are any best practice examples you might suggest that we visit, or talk to about how schools do it and link in with their communities. You may wish to hold those and think about that for a while.

Ms SOMERVILLE — Could I just respond? I think that one of the critical things we have learned from primary care partnerships that is transferable is that if you do put enough time and investment into the partnership building — but that does not come free — we can have an impact on subacute and acute over the years. In forming the health sector, which was part of the role of PCPs, looking across to our education colleagues, they are not funded to do that, there is no incentive — 'Why would I bother to understand that? All I have to do is work with student wellbeing', or student health — not their families, not their mothers, not their extended families or their neighbourhoods or any of those other things. There is no reason to talk to other people outside of the individual client relationship, if you like, which is with the student.

I think that is problematic for what we know about partnerships, when the research on partnerships says that everybody needs to be at the table, there needs to be agreed stuff, that everybody here has been speaking of. But education does not do that yet; it takes health and wellbeing back into itself and says, 'We will do our bit in this way', and somehow that is supposed to happen for the benefit of family and community and workplaces and parents not taking off time to attend to children and those other issues. Particularly in the mental health arena, that is becoming a hard area. People know what to do with physical illness and physical wellbeing-type issues in schools, but that very strange area around emotional and mental health wellbeing is an issue. So incentivising education should have external partnerships that mean something other than education, because they are absolutely critical. They are as monolithic, if you like, as the acute sector was in health. But that does not mean that people are not wanting to do something about that.

Ms HARRIS — I totally agree. The first thing that came to my mind was health and education having an effective partnership would make the biggest difference.

Ms PALMER — And the Scottish model has a Health Promoting Schools unit that is based on a partnership model. It has legislation, it has a lot of stuff that is mandated, and it has the *Being Well — Doing Well* document. That gives us a model of best practice. I think one of the key things is that if I could have anything on my wish list, it would be a long-term vision. Often funding and ideas are very short term; we do not actually get enough time. It is competitive tendering, so we are fighting each other for money — education is fighting health. So in terms of driving this agenda, if you are looking at the UK, they have been doing this for 20 years, so we are looking at a long-term vision. We are looking at a unit that has authority to power legislation, has resources and has a mandate that they must work together. The funding is joint and the outcomes must be joint, and it must be built around partnership. Because one of the challenges that health and education have is that funding is made available for schools and programs and everybody goes for it. And we are not actually good at going for it together, because our very existence is based on being able to identify funding to keep us going. So for me one of the things would be that competitive tendering is really not helpful.

The CHAIR — Other suggestions in terms of recommendations of key things we need to take up?

Ms COLLETT — I would really like to see the children consulted in the schools. I think that they could drive the process. I think that what they come up with is really innovative. I think that what we do often is say what we think they want. I think if they are consulted properly and not in a token way, as is often the case, they could drive the process really well.

Ms BROWN — Certainly for us it would be a case of whatever is decided to happen is adequately resourced, whether that is designated health-promoting workers or roles within every school, certainly at a minimum at a PCP level, that there are designated health promoting school officers. I think the partnership stuff is absolutely important, but one thing we have learnt is it still needs someone to drive and facilitate the partnership. If that resource is not there and there is not someone as a key contact on the ground — —

The CHAIR — In terms of Peter's other question, are there any schools that you think are doing some good things that might be useful for us to go and look at, or any other groups? The other question I was going to ask — are the agencies that are under your banner and working with the schools mostly community health

centres? You mentioned LLENs too as having a role. I am interested to just get feedback. Are there groups other than the community health centres that are playing a key role?

Ms BROWN — Local government.

Ms SOMERVILLE — And I think community support services, which are largely the non-government sector for human services, are very strong.

Ms MOORE — I think community renewal and what was raised earlier — that there was a site plan that was working well, and that would certainly be the experience that I witnessed in Frankston North in particular where the schools have really been able to be involved in the partnership and the work that is happening in the community and feel part of that community. Some of it is recognition of the school community being more than just the students but being the parents and the family and the teachers themselves — that is certainly a model that we might be interested to — —

Mr HALL — Is that a cluster of schools working together?

Ms BROWN — The community renewal model is based on geographical area, so there are a number of schools in that area as well as other services and local businesses.

Ms WHIFFEN — Likewise Laverton P–12, which is a community renewal site — there has recently been a merger of a primary and secondary school, but through that they have got co-located services for family, child services such child care and also employment services, so parents have access to school facilities as part of their employment training.

Ms SOMERVILLE — Corio Norlane is similar in terms of the renewal project, the redevelopment project.

Ms BROWN — We would also recommend Clarinda Primary School. They have a very diverse multicultural background at that school, but it is a school I guess where there has been very strong leadership. There has been very strong leadership from the principal. It has also had very strong support and buy-in from the mayor of one of our local government areas. That certainly I guess has been looking at the role of having leaders and champions, and it has also had very strong involvement by the parent community in that school.

The CHAIR — That has covered a good number of suggestions of possible schools. Are there are other partner organisations that are doing some good things that we ought to know about?

Ms HARRIS — The Frankston one — the Hastings renewal had all schools in the area sat around there as well. Western Port Secondary College, which is in Hastings, is doing some quite innovative stuff. They are also currently participating in a project with CASA around respectful relationships, which is integrating the whole-school approach to that as well.

Ms PALMER — And Bayswater North Primary School is one as well. Some of the stuff that Liz has been working around has been looking at and linking with TAFEs to support primary schools — so working with Swinburne University in terms of student placements to work on building the capacity of the schools and also working with Bunnings and other businesses to come together as well to contribute the whole of the agenda.

Ms SOMERVILLE — Just as a different organisation, Leisure Networks, which is the local regional sports assembly, has done some very interesting work around working with disadvantaged schools and now has been funded by VicHealth to do a program around assisting 100 sporting clubs in the region to develop healthy environments. It is an interesting model that people attend something for, yet it is also a site for working with health and wellbeing. The amount of investment that VicHealth is putting into that will be substantial: $60 million over three years. It will be interesting to see how those clubs go — the incentive being signing up. They are doing a bit of infrastructure, they are doing in-house training, mentoring and uniforms — doing everything they can think of that we know helps build the whole package around health and wellbeing.

Ms COLLETT — Also the City of Ballarat, through the Strengthening Generations program, is doing a program around drug and alcohol awareness. That is with parents, students and venues. So it is quite innovative. It is called the SSMART ASSK program.

Mr HALL — Say that quickly!

The CHAIR — Yes, I have worked it out!

Ms COLLETT — That has got the venues quite actively involved with the schools.

The CHAIR — Okay, that is good. I was interested — it is a bit of a follow-up question — when you were talking about Bayswater North you said that you did the full discussion with the school about what were its priorities. Were there surprises, or did they in fact fit in with what you might have otherwise expected or fit in with some of the other things?

Ms SENIOR — It pretty much fitted in with the going concerns. Healthy eating in the canteen was a very big one, and physical activity was obviously a big one. A lot of them have been addressed through Go for Your Life, and many schools are also addressing them. I suppose another interesting one that came out was the teachers' health. They were actually concerned about their own physical health and their own mental health and wellbeing. For example, we have started a Pilates class for the school staff. There is quite a lot we can explore in that area. There is a lot of understanding among the teachers that unless they are well physically and emotionally it is going to be very difficult for them to also look after the students.

The CHAIR — I suppose once you work on that then you can work back to getting the idea, 'Well, if that is the case for you, then maybe it is the case for the kids too'.

Ms SENIOR — That is right. It makes sense, doesn't it?

Mr HALL — Also because teachers are very important role models.

Ms PALMER — It is the idea of anger management — it is that modelling: healthy behaviours and having a healthy environment and a healthy school culture.

Ms SENIOR — In the audit we got personal comments to questions like 'What do you like best about Bayswater North?' — 'My best thing is about Bayswater North is Mr So and So because he loves the kids and he just cares for them'. It came across quite strongly. Some teachers got nice remarks all the time. Obviously the strength of the relationship between the teachers and students — you just cannot say how important it is — is very, very, very important. We need to create environments where the teachers feel they can be supportive of the students, because if they have stressors going on and things are not going right for them, it is obviously difficult for them to be good, supportive teachers.

The CHAIR — I noticed in the recommendations that some of the PCPs put forward to us — I imagine they were in the recommendations — talked about the school nurse program, yet it has not been mentioned here. Is the school nurse program something that you link in with or you see as a component of this?

Ms COLLETT — It seems quite inconsistent. From my experience, some schools seem to have a nurse who deals with people falling over, and then other schools have nurses who are involved with the mental health and wellbeing-type programs. From my experience, it is not that consistent across the schools.

Ms PALMER — The secondary school nurses who have been trained in health promotion and have undertaken health promotion professional development are supposed to have more of a health-promoting role with the school. To my understanding, that is not the case for primary schools, which is a shame because primary schools are where the opportunity to promote health and wellbeing is at its greatest. There has been a shift where under the last government school nurses went from the Department of Health to the former Department of Education and Training, but it has been my sense that there has been no real integration of that nurse role within education; it has actually just been a geographical move — it has moved from this department to that department; it is not part of the education system or the school system. From the experience that we have had with the schools, it is not seen as an integral position within the school — it is the add-in for when you fall over or if somebody has a mental health issue or if there is cancer or if there is an unplanned pregnancy, it involves the school nurse, but there is no real sense that the school nurse actually sits at a strategic level and has a say in what health and wellbeing in the education sector is about. It has been traditional to have that sexual and reproduction and mental health clinical model rather than a social health and wellbeing model.

Ms SOMERVILLE — And lice and nits.

Ms HARRIS — One of my team has just started as a secondary school health nurse, so she is now sitting with education. The view of health promotion among the nurses she is working with is slightly different to hers because of where they have had that training — coming from an education stance. Her view in terms of what she was going to do in working in a school was very much from that strategic aspect. The school's view is that she will be the one that they get in to deliver the curriculum around sexual health. So there is also a discrepancy between how the secondary school nurse is viewed by education and how they are viewed by the school and then what their understanding of a health promotion approach is. From what I can see in terms of her experience, it is seen as being about promoting health rather than a health promotion approach, which is the systematic stuff that you are talking about around needs assessment, identifying and prioritising, planning and evaluating. It is more around being the go-to person and delivering topics that teachers do not want to deliver.

Ms SENIOR — And I would very much agree with that. One of the schools we are working at has some issues and they are continually frustrated because the teachers just want them to come in and deliver a project and then go out. We met with the principal of this particular school and he said basically, 'We just want you to do a program. Do not speak to me about it; I do not want to know about it'. We ended up not working with that school because we could see that we were not going to do any systematic or effective health promotion. He just wanted us to come in and then to go out.

Mr HERBERT — Are school nurses located full-time in a school?

Ms HARRIS — No.

Mr HERBERT — Where are they located, and how many are there nowadays?

Ms HARRIS — I do not know. They are located with the education department. They usually have an office at the — —

Mr HALL — Attached to the regional office.

Ms HARRIS — Yes, the region. I think they have one day in the office. Most of them are full-time, so they do 0.5 of that time in two schools. They will be two days in one school, two days in the other school and one day in the office.

Mr HERBERT — And then they rotate the schools in the region?

Ms HARRIS — No, the secondary nurses are assigned to those schools. You will have two schools that you are working with for two days a week and then one day — I think the Friday — ongoing, and they do not — —

Mr HERBERT — There must be a fair few in each regional office.

Ms PALMER — There are, but their roles are not maximised at all. There is great potential for that program to be — the thinking was that when health promotion became part of the remit and the training that — but the fall down is that education has not embraced the role in the way it could.

Ms WHIFFEN — Within HealthWest I think the school nurses we have been partnering with very much recognise that they have a limited capacity in terms of their role within their schools. But we have utilised their knowledge and expertise in being able to advocate around how some of the systems are barriers are to kids being able to access good health and community services and the needs of children and families. So using their knowledge and expertise to form some of our program planning, recognising they are really underresourced and are limited in their capacity, but we have their goodwill and they very much support that program.

Ms SOMERVILLE — The other thing that strikes me is that local government is mandated to produce an early-years planning framework, so it deals with that age group quite well for its community and expects to provide services to that age group. It has a health and wellbeing plan that its council has to sign up to. It does not have anything that addresses, if you like, working with older children or young people and families, so it is arbitrary whether a local government might be involved in that sort of work or need at a council level to take responsibility for that part of the school-based community. Again, it is the tiers of government as well as the different departments.

You end up with PCP funding walking trails rather than DSE or whoever else may be able to fund it because the planning is not integrated. There is no sense of, 'Okay, where is local government in your planning as a school', and local government being asked, 'Where are schools in your plans?' for instance. If we can do some of that, too. We are about to have a statewide health and wellbeing plan, and I have no idea whether that means the state education plan has got any opportunity to interact with that plan, for instance. What we end up trying to do is to build little rope bridges across that may or may not get you there, which is not useful between plans and between sectors.

The CHAIR — We are going to go to questions on this side of the fence. Are there any other suggestions you want to make in terms of recommendations, or things we have not covered yet that you want to leave with us before you go?

Ms PALMER — Undergraduate training, teacher training, some emphasis and weight placed on developing skills and expertise around health and wellbeing. You need a degree to be a maths teacher and you do a five-day course to be a sexuality educator or whatever. That is an extreme, but the idea is that in terms of increasing the profile around health and wellbeing and partnership and community it needs to start as soon as you undertake your teacher training or as soon as you undertake your community nurse training or your skilled nurse training or whatever. It is actually starting to build bridges across the professions through the educational establishments — the TAFEs and different pathways.

The CHAIR — Good point.

Ms HARRIS — Some of the things are in place; it is just about making the links explicit. Education has student participation guidelines, I think they are called, which is all about student voice, about the importance of building resilience for young people in order to reach their full potential in terms of academic achievement and going on to further education. That is exactly what we are trying to do as well in terms of working on social determinants. As Maggie was saying, in the UK because there is that central system — one in England and one in Scotland as well — all the documentation that is delivered to schools comes from health and education together. The components in terms of learning are there and the components in terms of the health benefits are there. The things are already there; it is just about joining them together.

Ms BROWN — Just as a different angle on it, we do not really have any answers for you, but I guess when thinking about the rollout of any new approaches or models that you may be looking at, often things are rolled out in staged or piloting or demonstration areas. One of the things we have learnt is that in any of the work with schools there is often a push to have strong evaluation components and to really see where the evidence is that is behind different models and different ways of working. One of the things that we have had — with secondary but particularly with primary — is that there are really strong ethics implications that you run into with measurements and evaluation when doing research in primary schools, not so much looking at the environmental audits and policy development changes within schools, but if you want to get input from children. It would be really worthwhile at an early stage in the development to get some expertise from some of the senior research people and expertise from ethics committees, because that has been something that has plagued a lot of our community demonstration projects across the state. There has been a push for evidence and outcomes from the department and then we have been really constrained by ethics issues and had problems along the way.

Mr HERBERT — So you have agreed what the numbers are before you even start. Is that what you are saying?

Ms BROWN — Yes. I guess there has to be agreement between what you are going to be able to get through ethics, and that has to match what outcomes — evidence — you want demonstration projects or models to provide you with. Working with children is a challenging area, particularly the primary sector.

Ms PALMER — Both sectors have their own set. If you go to education, you will get their ethics committee and their set of ethical standards, and health has obviously got theirs.

Ms BROWN — And we have to get both. We have to get both sets of ethics committee's approvals.

Ms PALMER — And that is the challenge for — —

Mr HERBERT — If you have specific programs, can we stress the VCE students? It is a hugely difficult time for many students — the top end of adolescence puts a massive strain on them. They have often got confrontation with their parents. You could probably do some a questionnaire-type evaluation. You could probably do a straightforward thing that would not be too ethical, or if you wanted to increase — —

Ms BROWN — Any input you get from students has to have ethics approval, and that needs parental consent, and getting that consent process is — —

Mr HERBERT — Okay.

Ms BROWN — I am completely for evaluation — I think it is really important — but it is something that can be problematic in dealing with this population group and to have those conversations and get the right people around the table at the early stage to work through some of them.

Mr HERBERT — Is that under the current regime of how it operates? You could always change how things operate.

Ms SOMERVILLE — If it just a question of being asked what would make a difference and us not being particularly sure, it is also symptomatic of where we are up to in developing this sort of work, because we actually have not agreed on what we are trying to change. Trying to balance off what are the local needs and consulting at that very basic level where people are at, that is where we start all that sort of thing. But equally there is nothing standardised about it, so what are the three things that we know this generation is vulnerable to — or whatever — to work on? There is nothing like that, so you cannot start to build a shared measurement. We do not measure this work very well. We can tell you all sorts of activity.

Mr HERBERT — If you wanted to have an effect on osteoporosis, then it is a straightforward thing you would want to encourage maximum bone growth in young women for after they go through menopause. You could do something like that. We know that it is exercise and often the time when young women stop exercising — 'Do not drop down that calcium intake'. The bone growth is maximised from when it starts to deteriorate. Something like that though you could measure quite easily through a questionnaire of activity of young people. Are you saying that would have to have parental approval, too?

Ms PALMER — It would depend. I have done work where if I have used — —

Mr HERBERT — I just used that as an example.

Ms PALMER — Depending on the level of the surveys, the inducement will depend on the level of ethical requirement. I have not had to have ethics approval for a specific piece of work, and I have had to have it for others pieces of work. The other idea is that — —

Mr HERBERT — Is that clearly defined?

Ms PALMER — It is not clearly defined, and that is the minefield around it. The other thing is if you are using an evidence-based approach, the fact that it is evidence based is somebody has worked out somewhere before that it has actually worked somewhere before, so they have already measured it. In terms of applying evidence or if you are using a program, you can say, 'We know this works, because it has been evaluated by somebody else', so you might not need to evaluate it at a level where you require ethics approval.

Ms BROWN — There are ways you can get around this by justifying things, as we can do — quality assurance and other ways. We have had agencies that have gone and done small-scale work with schools and done some satisfaction survey-type things, and that is fine. I guess where we had demonstration projects that had Department of Health and department funding, because it was significantly funded through the department that was where they had to go through the both lots of ethics committees.

Ms SOMERVILLE — You are suggesting streamline that. It is still necessary.

Ms BROWN — Just get the right people on board now and have the discussion. We sort of jumped in, and the department has its expectations of what evidence it wanted us to come out and have measurements and demonstrate.

Mr HERBERT — You might not even have thought about it, did you?

Ms BROWN — But then when we got into it and then we started getting ethics approval, that is where it became quite problematic. It also created significant delays in implementation, because of waiting for ethics approval. I guess that is just a light to have on earlier rather than later.

The CHAIR — Okay. Any other issues?

Ms HARRIS — One other thing. I have only been here in Australia for six months. One of the things that strikes me is there are lots of funding opportunities that come out from people like VicHealth, Anglicare and all of those ones. There seems then to be — and this is just my experience — a tendency to try and develop projects or initiatives to try and fit that funding and then going out and trying to find communities or schools who will then be able to do that work to fit that funding, rather than the need being identified before being able to apply for funding.

Mr HERBERT — Work out what you want to do, then contract it out.

Ms HARRIS — Yes. You seem to be jumping from one thing to another depending on what funding streams are coming out.

Ms SOMERVILLE — If I could just qualify that a little, I think most funding streams these days do use evidence base, and that has been a very good development over recent years, because PCP is now 10 years old. It has developed that sort of culture quite strongly. There are assets that we hope do not lose with all the primary care reform.

Ms HARRIS — No. I guess what I am saying is sometimes you have got a need that you identify, and then you cannot get that — —

The CHAIR — And you end up being consistent in what you want to do, because — —

Ms PALMER — In the short term as well. You get funding for a year or 18 months but it is really not long enough to demonstrate anything, apart from at a very superficial level.

The CHAIR — All right. Thank you very much for the level of expertise you have shared with us this afternoon. It has been pretty helpful, and has strengthened our ideas and — —

Ms SOMERVILLE — Could I make an observation?

The CHAIR — Yes.

Ms SOMERVILLE — I find it really interesting the gender split today. I just had to say it. That in itself is interesting in terms of how you think about these things. Who is involved in the work is going to bring a particular lens to that.

Mr HERBERT — From our side of the fence — I will not talk about your side of the fence — it was a bit unfortunate because in the past the Education and Training Committee has been 50-50. For some reason it just worked out this time. You go through your parties and through the parties and those who were keen on education tended to be men. It is pretty simple.

Ms PALMER — And health is women.

Mr HERBERT — I would be interested to know what the health parliamentary committee's gender breakdown is.

The CHAIR — Thank you very much for your attendance. It is much appreciated.

Committee adjourned.