LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON PUBLIC ACCOUNTS

(Reference: Inquiry into Auditor-General's Performance Audit Reports July – December 2022)

Members:

MRS E KIKKERT (Chair)
MR M PETTERSSON (Deputy Chair)
MR A BRADDOCK

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 5 JULY 2023

Secretary to the committee:
Ms S Milne (Ph: 620 50435)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 20 May 2013

The committee met at 3.04 pm.

SQUIRE, DR SARAH, Head of Knowledge, Research and Policy, Butterfly Foundation
BIRD, MS HELEN, Manager, Education Services, Butterfly Foundation

THE CHAIR: Good afternoon and welcome to this public hearing of the Public Accounts Committee for its inquiry into the Auditor-General's performance audit reports, July to December 2022. This afternoon the committee will be hearing from the Butterfly Foundation, the Minister for Health and officials from ACT Health as well as the Chief Minister and the City Renewal Authority.

The committee wishes to acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal people. The committee wishes to acknowledge and respect their continuing culture and the contribution they make to the life of the city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

The proceedings today are being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses used these words, "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

We welcome our witnesses from the Butterfly Foundation for today. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Please confirm that you understand the implications of the statement and that you agree to comply with it.

Dr Squire: Yes, I understand; thank you.

THE CHAIR: Would you like to make an opening statement?

Dr Squire: Yes, please. I have a four-minute statement if that is okay.

THE CHAIR: Absolutely.

Dr Squire: Good afternoon, everyone, and thank you for the opportunity to speak today and to provide this brief opening statement. I will be appearing today, hopefully soon, with my colleague Helen Bird. Helen is the manager of Butterfly Foundation's Education Services. I speak from the land of the Wurundjeri people of the Kulin nation and Helen, who, hopefully, will be joining us soon, speaks from the land of the Garigal people.

I would like to provide a short summary of where we think positive steps can be taken to improve the development, delivery and evaluation of preventative health programs for children in the ACT.

To start, I will provide some context. Weight stigma starts developing early in childhood, with children as young as three years old attributing negative qualities to

images of children with larger bodies and attributing positive qualities to images of children with thinner bodies.

Body dissatisfaction also starts young, often in response to appearance-based teasing during the primary school years. By the teen years, almost 70 per cent of children in Australia have experienced appearance-related teasing.

Our recently released Body Kind Youth Survey report, which I have tabled for the committee today, shows that 90 per cent of children in Australia aged 12 to 18 report concern about their body image.

Body dissatisfaction is one of the strongest predictors of the development of an eating disorder. Body dissatisfaction is also associated with several other negative life outcomes, such as poor quality of life, poor academic performance, depression and anxiety.

We were very pleased to see the Auditor-General's performance audit report acknowledge the potentially harmful nature of weight-based terminology and the review of literature on the complex relationship between weight and health and the impact of weight stigma.

In short, we support all of the recommendations in the audit report and, in the spirit of those recommendations, we recommend four areas for particular attention by the ACT government.

Firstly, the content of all healthy eating and physical activity promotion and program interventions should be aligned with best practice in the prevention of eating disorders and body image issues. Physical health promotion campaigns should not feature weight stigmatising language; avoid presenting weight as a personal choice which is easily controlled; and avoid promotion of dichotomise thinking and the framing of food as healthy versus unhealthy or good versus bad. Program interventions should include modifiable risk and protective factors involved in the development of body dissatisfaction.

Secondly, evaluations of nutritional education and physical activity programs for children should include body image, disordered eating and eating disorders in their outcome measures. These programs also offer opportunities for early detection and early intervention in relation to disordered eating and eating disorders.

Thirdly, we recommend the adoption of our Butterfly Body Bright program within all ACT government schools and the promotion of our Body Kind programs within all ACT secondary schools. Education settings are ideal environments for creating awareness, building resilience, reducing stigma, developing self and body confidence and encouraging help seeking among children and young people.

Finally, we are currently campaigning to the federal government for the establishment of a national body image inquiry. It has been 14 years since the commonwealth has invested in a strategic national approach to body image. So we would welcome the support of ACT parliamentarians in amplifying our call for this inquiry.

Thank you again for the invitation to speak today.

THE CHAIR: Thank you, Dr Squire. I understand, from your submission, Dr Squire, that the Butterfly Foundation provides some programs to schools. Have you in the past provided programs to any of the ACT public schools?

Dr Squires: Yes. We have a number of ACT public schools registered for our Butterfly Body Bright program, which is our universal whole-of-school body image program. It is not an eating disorder prevention program, as such, for that age, but it is around the promotion of positive body image.

If you want to know the exact number or who those schools are, I will have to take that question on notice. But I would be happy to find that information and share it with you. I would also need to check how many ACT public schools are involved in our secondary school program, which is our Body Kind program, where we have basically a whole month of activities that run across September every year that secondary schools can get involved in—and there are some new initiatives as part of that this year.

THE CHAIR: How long has that program been going on for?

Dr Squire: This is where I need Helen to join. Body Kind has been going on for, I think, around 15 years. It had a different name up until a couple of years ago; it was called Love Your Body Week or Love Your Body Month. So a change of language has come about as a result of changes in how we talk about bodies in terms of the body positivity movement.

Butterfly Body Bright was launched in 2021 after a pilot program in a couple of schools. We gathered some pretty solid evaluation evidence on the basis of a couple of those lessons and interviews with teaching staff as well. So Butterfly Body Bright is relatively new. It is the first of its kind in Australia.

We were lucky enough to get funding in the federal budget—not the one just gone but the previous one—from the federal government to roll that out nationally. As a result of that funding, we have been promoting the program across every state and territory in Australia, and we now have over 550 schools enrolled in that in just a fairly short amount of time.

THE CHAIR: That is wonderful, Dr Squire. I meant specifically here in Canberra. How long have the programs been available to the ACT public schools?

Dr Squire: I will have to take that on notice, unless Helen's audio is working and she can join us.

Ms Bird: I can hear you. Can you hear me?

Dr Squire: Yes, I can.

THE CHAIR: Welcome, Helen.

Ms Bird: I am so sorry.

THE CHAIR: That is okay. We did notice you were trying. We are thankful for your willingness.

Ms Bird: Okay. What was that question again, please?

THE CHAIR: I was just wondering how long the Butterfly Foundation has been involved with the ACT public schools? Dr Squire mentioned some of the programs that are available. So I was just wondering how long it has been going on for?

Ms Bird: We have been offering our services across Australia since 2006. We do not do a huge amount of face-to-face work in the ACT. We offer virtual delivery of our programs and the free programs that Sarah just mentioned, our Butterfly Body Bright and our Body Kind school programs.

Butterfly Body Bright has been around for about two years now and our Body Kind Schools Initiative has been available for something like five years now. We know that ACT schools are accessing those programs.

THE CHAIR: Okay; so it is a virtual program. Are these only for teachers?

Ms Bird: We offer a range of services. We offer student presentations, and we can deliver those face to face and virtually. For locations such as the ACT, it would be a virtual presentation generally.

In addition to our youth presentations, we offer teacher training, educator workshops and professional development programs and parent seminars. We also offer programs that schools can adopt themselves, such as the Butterfly Body Bright program and the Body Kind Schools Initiative. So there is a range of services and programs. Some of them are accessed online, some of them can be delivered virtually and some of them are delivered face to face.

THE CHAIR: I am more interested in how it is delivered to the students of ACT primary schools and secondary schools. Is it more face to face or is it more virtual?

Ms Bird: I would say it is more virtual. The Butterfly Body Bright is a school led program. So the teacher would deliver the Butterfly Body Bright program into the schools themselves. We provide access to online training for those teachers. That online training unlocks a suite of curriculum learning materials for the teacher to deliver into the classroom themselves.

It also gives them some ideas and strategies around how they can create a whole school environment that supports positive body image and healthy relationships with eating and exercise. So the Butterfly Body Bright program is something that the school accesses and delivers to their students. It really embeds it within their curriculum and their ethos.

THE CHAIR: Thank you so much, Helen.

MR PETTERSSON: It is somewhat timely that you are here, because the territory-wide model of care for eating disorders was released just a few days ago. Were you involved in the development of that?

Dr Squire: Butterfly has a role under our current contract with the commonwealth government Department of Health and Aged Care, and under that contract we are tasked with providing advice to all states and territories that have been funded by the commonwealth to develop residential eating disorder facilities.

We have provided advice—is probably the best way to describe it. We have not actually been involved in designing it ourselves. Our outgoing CEO has been involved with members of the ACT government who are working on the delivery of the facility. We have also been sitting on a number of formal advisory groups as well.

We have been asked to provide advice, based on where we are with Wandi Nerida, which we opened back in 2021. Obviously this an entirely new form of care. We have shared information around the Wandi Nerida model of care with all states and territories and provided as much support as we can, including support around building design and those sorts of things, including what is working well at Wandi Nerida and what we may have done differently or what different states and territories might want to think about when they are putting together the plans for what the centre looks like as well as the clinical model of care.

MR PETTERSSON: As legislators trying to provide some oversight of these program as they roll out, are there particular areas that we should be attuned to make sure that they are operating as intended?

Dr Squire: Are you talking about eating disorders, body image or—

MR PETTERSSON: You referenced quite specifically the inpatient eating disorder clinic but I am also interested more broadly about the territory-wide model of care.

Dr Squire: We have an ongoing evaluation with Wandi Nerida up on the Sunshine Coast. We have got a clinical evaluation team and an economic evaluation team working together. Those two projects are commonwealth government funded and we are administering them for the commonwealth. They are collecting a whole range of data on a series of national indicators that have been set out by the technical advisory group on eating disorders, which is administered by the commonwealth. So they are collecting data on all of those things, and that will give us a picture of how this new model of care is working in terms of outcomes—short term, on discharge and then in three- and six-month follow-ups.

As part of that, the clinical team is also collecting qualitative data. So we are looking at the themes that are emerging there. On the basis of what has come through so far, which has not been published, I can say that participants—we do not call people patients; we call them participants—at Wandi Nerida have basically shared how critical it is being in the space of Wandi Nerida, which is in the hinterland on the Sunshine Coast and is surrounded by bushland.

There are also some adjunct therapy programs—for example, equine assisted

programs. So we are looking at developing urban space in relation to those. There is also permaculture programs—so getting people out in the garden, connected with nature—as well as the clinical model of care with the groups, with eating together, and individual sessions with psychiatrists, psychology and dieticians. So I guess the advice might be to think beyond what standard clinical care is and to think about what adjunctive therapies you might also offer. There is also a yoga space as well, for example.

Given that residential care is such a new concept in Australia, it is a good opportunity to trial some additional things that we know from broader research really do support mental health and wellbeing and how they might be added into that model of care.

The other thing that has come out strongly is the fact that we have recovery navigators at Wandi Nerida. These are non-clinical staff members, many of whom have their own lived experience of recovering from an eating disorder. They are there to support people. So it is very different to a hospital setting. The difference there is that it is a more holistic person-centred form of care. That is probably all I can say on that point.

Certainly these residential centres are an opportunity to do something that has not been done in Australia before. It will take it a while to assess and get the evidence in and see how well that is working But, so far, the indications are, both on the quantitative and the qualitative, that it is working. But we will need to wait for our evaluations to be complete, including the economic evaluation.

But we are hoping that, compared to treatment as usual, we see some really good results. Obviously, it is a huge investment of money to develop and then run a residential facility. But it may well be that it saves money in the long term, given that often people with eating disorders will be in and out of hospitals across many years, and obviously there is cost to that—an individual cost as well as a cost to families and cost to the public health system.

MR PETTERSSON: Thank you. That was very thorough.

MR BRADDOCK: I am interested in preventative health. I note in your submission you talk about the importance of alignment. But I am also thinking in terms of having a plan in place that actually incorporates the whole spectrum, starting from preventative health for the entire population to prevent these disorders starting in the first place. Could you talk me through the importance of that alignment and that planning to connect up?

Dr Squire: Yes. I might kick off and then go to Helen for maybe some specifics in terms of how we do that work at Butterfly. In general, our view is that supporting positive body image is essential right from the beginning of life. By that, I mean supporting women who are pregnant. We know that pregnancy and the post-partum period is a risk factor for women who might have had an eating disorder when they were younger which might then reoccur at that time with all changes in the body, the adjustment to becoming a parent and that sort of thing. It is really important to support parents in those transition periods. It is same for menopause, at the other end of life. That can be another time when women are susceptible to developing eating disorders for the first time or having them start again.

It is important to support parents in terms of how they talk about their bodies, how they talk to their children about their bodies, about food, about physical movement and about how they eat, and avoiding, as I said in my opening statement, moralising around food. There is a lot of that. Sometimes we see some of that in public health campaigns that are funded by governments, and that can be harmful.

It is also a missed opportunity, because, from our perspective, there are ways of talking about bodies, embodiment and moving—moving for joy—that do not involve potentially harmful approaches, such as approaches that are highly focused on the BMI, for example, as the be-all and end-all measurement. There are a lot of issues with that.

I might hand over to Helen now to say a few words around how we incorporate some of that messaging in our programs, just to give you an indication of what that might look like as part of a broader strategy.

Ms Bird: All of our programs really focus on what we know in terms of the risk and protective factors for body dissatisfaction and disordered eating. We are really trying to help young people and the parents and the educators that are supporting them, by giving them some tools and strategies to have a more positive and accepting relationship with their body, with their eating and with their physical activity behaviours.

When it comes to eating, we are trying to help young people understand, yes, it is important what we eat, but we are trying to teach them about how to eat—how to have that relationship with food where all foods have a valid role as part of a balanced diet, where young people see that they can eat flexibly, without rigidity and rules and can see food as a source of pleasure and enjoyment and that it is not just for nutrition or fuelling purposes.

We are trying to help them to learn to block out some of the really unhelpful messaging that they hear that is fuelled by diet culture and by social media—which they have 24-hour-a-day access to—that is telling them how to eat and that, in order to have a certain type of body, they need to restrict their eating or heavily control their eating and exercise behaviours.

So we are helping young people to try and tune in to their bodies and to listen to their hunger and fullness cues and be a little bit more compassionate in the way that they approach their bodies and their life really. There is just so much pressure coming at them. We want them to see that they are so much more than their body, that their body is probably the least interesting thing about them, and to identify all the other things in their life that give them purpose and passion. Appearance probably really should not be too high up on that list but, unfortunately for many, it is.

MR BRADDOCK: A follow up question is: how do you reach out to those who the most vulnerable in the community due to poverty, where it is really challenging for them to have the time and money to be able to invest in healthy eating and healthy activities?

Dr Squire: In terms of reaching out, it is important to note that a number of what we provide is free. As Helen mentioned, we do have some sort of fee-for-service offerings through schools, for example, but we also provide a number of free webinars every year for parents, educators or other people that work in schools and things for youth as well. Obviously, having free programs is good. We can always do with more funding to provide programs and initiatives for free, so it is genuinely universal.

In terms of the how, it is about incorporating positive messages around embodiment through general preventative health programs. We, at one point, would love to be invited to be part of the development of any physical health programs, whether that is around physical activity or healthy eating. We want to make sure that any messages that are going out there, particularly to children, who are the most vulnerable, are not inadvertently doing harm by promoting things like restrictive eating or the idea that some foods are bad and you should never have them and some foods are good and you should have those. Those sorts of concepts are sort of really heavily embedded in our culture. They come out in the playground in terms of appearance-based teasing that happens.

It has to be done through those larger public health campaigns. It cannot just rely on people like Butterfly. We are a charity, and we cannot reach everyone in Australia.

We were really pleased to see in the audit report a focus on food insecurity. People may not realise, but food security is associated with the development of eating disorders. Some work by a woman called Carolyn Becker, an academic in the US, has established that link. So preventative health has to also intersect with policies that lift people out of poverty, whether that is employment or whether it is social security at the federal level. Housing obviously is a state responsibility. So there are a number of ways, I think, that the ACT government could be more interconnected in how it approaches these things.

Helen, I was wondering if you might take this opportunity to share some of the findings from our Body Kind Youth Survey, because there was some analysis done around body dissatisfaction across different socioeconomic groups.

Ms Bird: Our Body Kind Youth Survey was the first large-scale survey that we have done in Australia. We had over 1,600 young people respond from all states and territories, including the ACT. We found very high rates of body dissatisfaction and body image concerns in young people, but particularly our LGBTQI youth and gender diverse youth.

Interestingly, body dissatisfaction actually seemed to be more closely correlated to higher socioeconomic status areas than lower socioeconomic status areas. That may be because of greater access to social media or different types of comparisons that children in those areas are making with their peers and the opportunities they have to make those comparisons.

But, across the board, young people are telling us that they are really struggling with their body image and it is impacting not just their eating disorder risk but every aspect of their life. Something like 50 per cent of young people told us that it would impact them going to school, putting their hand up in class and engaging in their learning.

Those things mean that we really do have to make sure that the programs that we have in place around preventative health address and support the body image of young people and certainly make sure that they do no harm.

MR BRADDOCK: Thank you.

THE CHAIR: Thank you, Dr Squire and Helen. Before we finish, is there anything you would like to add?

Dr Squire: Nothing from me—only just to thank you again for the opportunity to appear. We would be really pleased if any of the officials in the ACT Department of Health want to chat about anything we have raised. We are always happy to engage and to get more involved in preventative health. So thank you. Helen, did you have anything?

Ms Bird: No, I did not—just to accept my apologies again for the lack of my appearance on screen.

THE CHAIR: That is all right, Helen. Thank you so much.

Ms Bird: Thank you.

THE CHAIR: Thank you so much, Dr Squire. Have a great day, both of you.

Short suspension.

STEPHEN-SMITH, MS RACHEL, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health
CROSS, MS REBECCA, Director-General, ACT Health Directorate
COLEMAN, DR KERRYN, Chief Health Officer, Population Health Policy, ACT Health Directorate

THE CHAIR: We now welcome the Minister for Health and officials from ACT Health. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Please confirm that you understand the implications of the statement and that you agree to comply with it.

Ms Stephen-Smith: I have read and acknowledge the privilege statement.

Ms Cross: I have read and acknowledge the privilege statement.

Dr Coleman: I have read and acknowledge the privilege statement.

THE CHAIR: Thank you. Would you like to make an opening statement?

Ms Stephen-Smith: Yes, if the committee wants one. Thank you very much for inviting us to talk today. The government has welcomed the ACT Childhood Healthy Eating and Active Living Programs Audit and the findings. We want to start by thanking the Auditor-General's Office for the thorough review that it conducted of the ACT government activities to support childhood healthy eating and active living between 2014 and 2021.

I do note that the audit found the ACT government has delivered a range of investments in healthy eating and active living programs for children and that further action, through the Preventative Health Action Plan and evaluation of existing programs, would improve health outcomes for children. Importantly, I think the recommendations shine a spotlight on the importance of prevention and the contribution this makes to long-term health and wellbeing, starting from the early years.

The government is continuing its efforts to prevent chronic disease at all stages of life. Prevention is a key focus in the early years, with the whole-of-government action guided by both the Healthy Canberra Plan, a Preventative Health Plan through 2020-2025, and also the Best Start for Canberra's Children, the First 1,000 Days Strategy.

The Preventative Health Plan includes actions which aim to support childhood healthy eating and active living, with a specific focus area on supporting children and families. Children's health and wellbeing is supported through a range of services and programs, including services offered by primary care providers and the many community led programs and initiatives in the ACT.

I note again that the Auditor-General's report was looking at activities between 2014 and 2021. But, since 2020, the government has made progress in achieving some of

the strategic actions which support childhood health and wellbeing. We have implemented policies such as Set Up for Success, the three-year-old preschool, which aims to give all children the best possible start in life and the fairest opportunities to learn. And obviously there is more to Set Up for Success than three-year-old preschool, but that is the key action out of that.

Schools have the Fresh Taste Program, which aims to embed healthy food and drink culture in schools and builds the capacity of educators to deliver high-quality, informed evidence informed nutrition education. School-based healthy eating and active living programs implemented by the ACT government do not use weight-based language and focus on improving the school food environment as a whole.

We also launched, in 2022, a program called, Game Changes, which aims to reduce children's exposure to unhealthy food and drink marketing in junior sport settings—so trying to build partnerships between sporting organisations and sponsors who are not associated with unhealthy food and drinks but have a different association.

In terms of the specific audit recommendations and the Preventative Health Plan, the findings of the audit emphasise the need to maintain our efforts to support the health and wellbeing of children in the ACT, with a focus on prevention and supporting children and families who, for many reasons, might actually find this difficult.

I am pleased to say that in the 2023-24 budget, we have included $473,000 to expand the Paediatric Weight Management Program to better support children in the community with better nutrition, through additional allied health support. That directly responds to one of the recommendations in the Auditor-General's report.

The ACT government is also developing the second Preventative Health Action Plan for 2023-2025. Community consultation is currently open on that until 28 July this year. We want to hear feedback about actions that can support children and young people in our community to stay healthy.

The team has taken careful note of the audit findings and has focused conversations on hearing from diverse community members, as we know that a greater burden of disease is experienced by some population groups than others.

I also want to acknowledge and thank the Butterfly Foundation and Obesity Collective for lodging submissions supporting the audit's findings of the importance of addressing weight stigma, as we recognise that this presents a significant barrier to accessing support.

The government acknowledges the potential harms of weight stigma and discrimination. Professional learning in public hospitals includes weight stigma relation information, and we will continue to work to address this through ongoing education of ACT government staff.

Those are just some of the steps the government is working on to address the findings and to work through the key whole-of-government initiatives. We are obviously happy to take questions. Thank you.

THE CHAIR: Thank you, Minister. I would like to talk a little bit about the School Kid's Intervention Program. I understand it started off in 2015. Was that a pilot?

Dr Coleman: Can I check which school kids program we are talking about? We have—

THE CHAIR: The School Kid's Intervention Program, SKIP, which is mentioned in the Auditor-General's report.

Ms Cross: It is a CHS-based service.

Dr Coleman: Yes.

Ms Stephen-Smith: Unfortunately, we do not have anyone from Canberra Health Services here today. We can take the question on notice to provide you with some more information in relation to that, if we cannot get it for you pretty quickly.

THE CHAIR: Okay. I have lots of questions about the School Kid's Intervention Program. Is it probably best then to write the questions for you and send them?

Ms Stephen-Smith: We will try to get some answers to your questions to come through—

THE CHAIR: Okay. I was just wondering whether it started off as a pilot. How much was the funding for that first year, in 2015 and then how much funding was received every year after that that it continued to be in a pilot mode for the remainder of the forthcoming years, from 2015? I have loads of questions. I think I will just write them out if nobody is here.

Ms Stephen-Smith: Yes; they sound like the kinds of questions that we are probably going to have to take on notice anyway. The Canberra Health Services website does have a fair bit of information about what the program does, what to expect et cetera.

THE CHAIR: Yes, I know that.

Ms Stephen-Smith: It is an ongoing program—

THE CHAIR: Yes; I know that. However, the Auditor-General did report in our inquiry, when we spoke to him, that the SKIP, the School Kid's Intervention Program, is able to treat around 25 to 40 children annually. But he suspects there are a lot more children who are on the waiting list to be seen in this program. I just wanted to know to what extent that is. But nobody here can answer my questions—bummer! That is from Canberra Health Services, right?

Ms Stephen-Smith: Yes; so apologies for that.

THE CHAIR: There is a particular department in your area of Canberra Health Services that is not here to answer those SKIP questions?

Ms Stephen-Smith: No. So we will take that on notice and we will also take on

notice the relationship between SKIP and the Paediatric Weight Management Program that we have invested more funding into in the budget, because I suspect that that is part of the same initiative. But we will double check that.

THE CHAIR: Okay. Thank you.

MR PETTERSSON: I was hoping the committee could get an update on the development of the second action plan. What have you heard from the community so far?

Ms Stephen-Smith: Dr Coleman can help you with that one.

Dr Coleman: I will waffle a little bit at the start. I wonder if Christine has any specific detail. Consultation does not finish until the end of July. We have been actively seeking feedback, both through YourSay and some targeted priority group conversations, and have received some feedback around that area. In particular, we were interested in focusing on youth and children, so we have been working with some of the schools on how we may hear some of that feedback. Have I given you enough time to speak in a little bit more detail?

Ms Murray: Thank you, and thank you very much for the question. As Dr Coleman has indicated, we are right in the throes of that consultation. As you would expect, sitting across the table from me, we have absolutely picked up some really intensive work with some of our community sector organisations. We are running not only the YourSay survey that you have seen on the website but also what we refer to as kitchen table conversations, where there are in-depth conversations with community groups and committee organisations taking the lead in those conversations.

As you would imagine, they are relatively focus specific. When I am having conversations with the multicultural community in relation to leading those, there are some really good findings coming back as they relate to the multicultural community, for example. They are specific, targeted forums that we are running, and we will make sure that we have great representation from people like our Butterfly group attending that as well.

As Dr Coleman said, we are really picking up on some of the findings that we had in the audit report, such as: how do we balance that fine line between weight stigma and having honest and robust conversations? How do we make sure that services are culturally appropriate and accessible? How do we make sure that young people are feeling fully engaged and informed enough to access the services that they require, and to know that they exist?

Some of the conversations have been incredibly rich so far. We are only in the first throes. We have another four or five forums to roll out. But there is positive engagement and a real depth of interest and understanding in relation to that population and health preventative health promotion and keeping people away from the crisis end and having a really a valuable conversation.

MR PETTERSSON: Do you get similar amounts of interest in the different priority areas?

Ms Murray: It is difficult to answer that question because we have not got the conclusion in relation to all of the feedback from the kitchen table conversations. We have got some great engagement from our short, snippet, postcard-type YourSay interactions, which is those one sentence-type responses. We have another five or six forums that we are specifically rolling out with particular cohort communities, so we will probably know more then. Clearly, we have engaged with these people because they were first on the list. But we probably will not be able to provide that level of detail until we fully run through the complete consultation and get really deep and meaningful conversation, led by the sector.

MR PETTERSSON: Thank you.

MR BRADDOCK: The Auditor-General's recommendation No 6, on food relief and financial support for active living, was not agreed by the government. I respect that you have to set the scope for your preventative health plan somewhere, but there is still some good work here that should be done by the ACT government, whether it is part of the preventative health plan or elsewhere. Is that work being performed? If so, how and who by?

Ms Stephen-Smith: Yes. The reasoning for not agreeing to that recommendation, which is a full cabinet decision, is laid out in the government response. It is really around the fact that food relief and financial support sit within emergency management, which sits in the responsibility of Minister Davidson, as Assistant Minister for Families and Community Services. That is a separate stream of funding.

We are not disagreeing with the principle that we need to continue to put a focus on ensuring that we are addressing food security and poverty in our community. Indeed, we continue to do that, and some of that was laid out in the government's response. It is solely about the fact that this sits in a different stream of work, with a different focus and a different minister.

One of the challenges that we face in preventative health is that it is everything. If you were going to talk about the social determinants of health then you would include housing policy and you would include a whole range of other social determinants and the plan would be completely unmanageable and unworkable. You have to draw a line around what this plan is going to do, noting that it sits alongside a whole lot of other work across government. This is work that is being progressed in Minister Davidson's portfolio.

MR BRADDOCK: Okay. That leads to my next question. How do you ensure that preventative health influences government decisions, whether they are on school crossing supervisors or the active travel program? What are the connections to make sure that that is happening?

Dr Coleman: I am happy to talk to that. Thank you for the question, because it is a really important part of the preventative health portfolio. In public health one of our passions is looking at how you get the whole of government and the whole of the community involved in delivering these aspects. We do have really strong cross-government collaboration and we do have high level and more working group

meetings under which these plans are prepared and delivered. For example, this response, as well as the plan itself, resulted from multiple cross-government meetings, moving forward.

The mid-term review, which I am not sure if you are aware of, which looked at how the cross-government collaborations performed to deliver on the first part of the action plan, acknowledged that, unfortunately, COVID had impacted on our ability to deliver in that space. It did make a recommendation for us to re-engage and have another look at that.

Through our second term of delivering the Preventive Health Plan, there are two sets of engagement that we really need to look at. Firstly, how do we strengthen collaboration, when we need to, from a cross-government perspective? Part of it is to focus less on the Preventive Health Plan and more to embed those aspects into the other plans that sit out there. From a population health preventative perception, what we really want to do is change those systems and that environment. We want EPSDD to include in all their planning work: are they going to have playgrounds and where are we going to have open grass? Our job, through our liaisons and cross-consultation, is to embed those policies in those documents as well.

The second component of that, I think, that we need to own is our stakeholder and external consultations and engagement. We did so well for the first two plans that came out. Then, due to fires and COVID, this one really did not have the momentum that it should have done. We are developing an external communication engagements plan specifically for implementing this second part of the preventative health action plan, and this consultation strategy is the first part of that.

MR BRADDOCK: Would this include the evaluation of proposals or ideas before they are approved, and also afterwards to see whether they met their preventative health objectives?

Dr Coleman: I think we absolutely all agree that there is some room for improvement in our evaluation and monitoring component. We have done some really strong process evaluation in terms of working out how well we have actually implemented our options and our procedures. We are probably doing a little bit less well in measuring impact. I think, though, that that is a really complex area. We know, as the minister has said, that impacts on overweight, on healthy eating and on activity are so complex and multifaceted. How do we measure that? What is the contribution? But we need to try. Part of the second prevention action plan is to update and ensure that our monitoring and evaluation plan is as rigorous as possible and to look at which components we can measure, including some of those aspects that you mentioned. Some other options may be put forward. If they are included then there will need to be evaluation associated with those.

MR BRADDOCK: Thank you.

THE CHAIR: Can I please draw your attention to the key findings, at 2.28 in the Auditor-General's report. In the middle it talks about the strategic actions, and it is referring to the ACT Preventive Health Plan. It says:

> The strategic actions are broadly aligned to the National Preventive Health Strategy 2021-2030 and the Australian National Obesity Strategy 2022-2032 and are consistent with better practice in designing and implementing preventive health interventions. However, the strategic actions do not address, or otherwise acknowledge, improved early access to specialist healthcare services for children with atypical eating or activity behaviours, atypical weight gain and related health concerns.

I am just wondering: why was it not included in the ACT Preventive Health Plan? Or was it just not picked up?

Dr Coleman: That is a very specific question.

THE CHAIR: Indeed.

Dr Coleman: Do you have that in front of you?

Ms Murray: I have just got open in front of me the particular—

THE CHAIR: The key finding?

Ms Murray: Yes. It is such a big question.

THE CHAIR: Yes. Why does the ACT Preventive Health Plan not address improved early access to specialist healthcare services for children with eating disorders, weight gain and related health concerns?

Ms Stephen-Smith: I think that comes back to the question of what the Preventive Health Plan is about. We need to recognise that the ACT Preventive Health Plan is not only about healthy eating and active living, and it is not only about children and young people. It is quite a broad preventative plan that has a number of different streams of focus. Each of those streams of focus could not encompass every single thing. One of the streams of focus is reducing risk taking and risky activity. There are streams of focus around tobacco and alcohol and other drug use. To include everything that could possibly have been included within each of those streams would have meant that the Preventive Health Plan was 1,000 pages long, which is completely unwieldy.

In terms of access to clinical services, there are other pieces of work around clinical services planning, across Women, Youth and Children. We have the ACT Health Services Plan that looks at access to clinical services. Within that, we have the Child and Adolescent Clinical Services Plan, which is being finalised at the moment by the Child and Adolescent Clinical Services Expert Panel.

I take the point that the Auditor-General is making that access to clinical services can be a secondary prevention mechanism, but it is not necessarily a health promotion primary prevention mechanism. I cannot specifically answer the question as to why officials at the time drew the line when they did, when they were developing the plan. We take the point from the Auditor-General that you can draw that line more widely and that access to early supports is really critical. That is a focus across a lot of our planning, including the Best Start for Canberra's Children: the First 1,000 Days

Strategy. We want to be able to get in early, but it is a question of where that objective and that clinical services planning is articulated. It is not all going to be articulated in the same plan.

THE CHAIR: Thank you, Minister. But, really, the Auditor-General's remark is a very simple statement. It is about having improved early access to specialist healthcare services for children. A plan identifies the area that needs strengthening, the areas that are weak within a family, within a school community or within a child. Then you provide a plan for easy access to a specialist. There was nothing on that in the ACT Preventive Health Plan. It will not take hundreds of pages to identify how to access specialist health in this area—possibly just a paragraph or even a sentence. Is it because there was no specialist healthcare provider available at the time or there was a lack? Therefore, you did not add it into the plan. It is a very simple statement.

Ms Stephen-Smith: You can say that about many things: that we could have added a paragraph here and a paragraph there, and a sentence here and a sentence there. Then the whole thing loses its structure and becomes quite unwieldy and lacks focus on health prevention and promotion, which is really where this strategy is focused. I take the point that the Auditor-General has made that we could do that. As we go through the review of the preventative health strategy and action Plan, we will look at that.

You have made the point that it is about access to clinical services. That is exactly what our clinical services planning is all about: improving access to clinical services. There is a sort of Venn diagram, where the two overlap, where we want our Preventive Health Plan to acknowledge that there is a place for secondary prevention, when health promotion and keeping people entirely healthy without having to access clinical services is not enough. You need to access those clinical services. It is where you put that focus. That is certainly something we can take into account.

Dr Coleman: One of the consultations that is occurring during this period of time is with the chair of the Child and Adolescent Clinical Service Expert Panel to look at exactly that: what should be included in the Preventive Health Plan, but what would be better placed in other plans that directly deal with clinical services delivery and clinical services? Just because it is not in this plan does not mean that it is not recognised as important and is not in another location. Some of our decisions, as the minister was saying, involve talking to other parts of the organisation which own other parts of plans, where their leadership is more focused on how you deliver what you are trying to achieve with that. Sometimes it is about identifying those linkages and where it is most appropriate to put that piece of work.

THE CHAIR: How many specialist healthcare services are there available for a child who may be experiencing atypical eating or activity behaviours, atypical weight gain or related health concerns? How many specialists would be available for those children to be referred to?

Ms Stephen-Smith: I do not think we can answer that question specifically, because a lot of those services would be in the private sector and it would be about people talking to their general practitioner.

I might ask Kirsty to come up to the table to talk to the role of primary care here,

because this is, at first blush, a role for primary care. As you have pointed to, we have the SKIP program. We have invested additional resources into that area in the ACT, in the most recent budget, to address the growing need for that service and the demand that you have already talked about.

We welcome the Auditor-General's finding identifying that maybe we have not quite captured that Venn diagram overlap and that we should do that as we work through the next iteration of the action plan. Kirsty is well placed to talk about what is actually out there in the primary care space, which would be the place that most families and children would start their journey—

THE CHAIR: Thank you, Minister. Can I just clarify: Minister, did you say there was funding for SKIP in the last budget?

Ms Stephen-Smith: Yes. We put in extra funding. I am just trying to get confirmation that SKIP is the same program—

THE CHAIR: Okay.

Ms Stephen-Smith: But, yes, as I said at the beginning, we put an additional $473,000 in this budget to expand the paediatric weight management program to support children in the community with better nutrition through additional allied health support.

THE CHAIR: Right. But you are not sure if that is linked to SKIP?

Ms Stephen-Smith: I am pretty sure it is the same program, but we have not described it that way in my notes. I am just asking someone to check that that is in fact the same program.

THE CHAIR: Okay. Thank you. I appreciate that.

Prof Douglas: It is primary prevention and then the next step is really primary care. If somebody is initially showing abnormal weight gain or risky behaviour then their first port of call is usually their GP. GPs are well trained to deal with this in the first instance, primarily because they often know the context of the family, the socio-economic situation of the family, their capacity to engage with healthcare services and their capacity to change eating habits et cetera. So the initial analysis would often be done in the primary care setting. That is one of the reasons why the ACT Kindergarten Health Check delivers results to nominated GPs, when parents nominate GPs.

Then only a much smaller proportion of those people would require referral into tertiary services. The GPs may access either private or publicly funded allied health, particularly nutrition and sometimes psychology, to help them. Again, through the Kindergarten Health Check program, we work with the Capital Health Network, the primary health network, to formulate a list of both public and private providers of allied health that have got a child focus.

We work to make sure we have good communication with GPs so that they have a full

and up-to-date list of the resources they can draw on. We know that over 85 per cent—it is close to 90 per cent—of all children in their first year of full-time education have a nominated GP that they can call on. It has been quite stable over the last 10 years that between eight and 12 per cent of the population do not nominate a GP or a general practice. They are obviously more at risk. We know that most GPs feel comfortable having those first discussions with families around risky eating.

THE CHAIR: Thank you. With the cost of living rising, a lot of families that I know of are not going to their GPs because bulk-billing is non-existent for many families in their local area. What are their other options if they cannot go to see a GP for that particular issue?

Prof Douglas: Look, I challenge you that the bulk-billing is not available. We know that—

THE CHAIR: It is available. It is available. It is just very difficult for a lot of families to access it. In Charnwood there is only one doctor that does bulk-billing, and her waitlist means that an appointment is months away.

Prof Douglas: I acknowledge that that is the very commonly held belief. But the MBS data shows us that over 65 per cent of all consultations in the ACT are bulk-billed. GPs do not advertise that they bulk-bill because it makes their situation very financially challenging. But consistently we have seen that the bulk-billing rate is about 65 per cent. If you look at children under the age of 15, it goes up to about 75 per cent. If you look at a further subgroup of people who need chronic disease management plans, people who have chronic disease, then it is close to 90 per cent.

We have this dichotomy between the reality of what is happening—because GPs generally want to help people and make it easy for them to access health care—versus how GPs are promoting themselves because they are finding it increasingly difficult to remain financially viable. If they advertise that they bulk-bill, they will immediately be swamped by everybody who expects every consultation to be bulk-billed, and they will run the risk of going out the back door.

THE CHAIR: Okay. Thank you. That is not the reality for my constituents, but I appreciate that. What is the reality for these constituents of mine is that they cannot see a GP who bulk-bills due to the length of the wait for them. If they want to see a doctor to help support their child, what are the other options for them? Do they see a paediatrician? What is their other option?

Prof Douglas: Paediatricians in the Australian health system are only accessed by referral from a GP—

THE CHAIR: Referral.

Prof Douglas: because GPs are the gatekeepers to the other specialists—

THE CHAIR: And how many paediatricians do we have, to see these children who are in need of help with their eating disorders?

Ms Stephen-Smith: We know that there is a shortage of paediatricians nationally and in the ACT. We certainly hear that. That is in both the private and the public sector. Canberra Health Services has done a really good job of recruiting to its paediatric team just recently, but it is a challenge. We certainly hear from people in the community that getting into a private paediatrician is quite a challenge.

We have also put some significant additional funding resources into eating disorders programs recently in the ACT government. There is the hub that Canberra Health Services runs, the early intervention program—which, if memory serves me correctly, is run by CatholicCare, now Marymead CatholicCare—and we are building a residential eating disorder facility.

There is a lot of focus on eating disorders when it comes to overweight and unhealthy eating. That referral pathway that Professor Douglas talked about is potentially into the private sector. I think Professor Douglas also talked about a range of allied health professionals. It is not necessarily about getting in to see a private paediatrician. It might be getting in to see a private dietitian, nutritionist or other allied health specialist that might be able to support that.

I can confirm that the program that we have put that additional $473,000 into in the budget is SKIP. That is an additional 0.6 full-time equivalent allied health position into that program. My understanding is—and I will correct this if it is not right—that that is effectively doubling the capacity of the program. It is a direct response to the Auditor-General's observations about that program.

The other thing I would just mention in relation to bulk-billing—not to get bogged down in a conversation about bulk-billing—is that the commonwealth government, in the last budget, tripled the incentive for bulk-billing for children under the age of 16 as well. So we might see that flowing through and making a difference in terms of access for families to primary care, after the decade of neglect.

THE CHAIR: Thank you. But my specific question was: how many paediatricians are available for these kids who are in need of help with their eating disorders?

Ms Stephen-Smith: I do not have the specific number of paediatricians in the ACT—

THE CHAIR: Can you please take that on notice, Minister?

Ms Stephen-Smith: Yes. We could probably find the number of paediatricians who are registered professionals in the ACT, yes.

THE CHAIR: Yes. Within the public sector, though.

Ms Stephen-Smith: We can take on notice within the public sector, yes.

THE CHAIR: Yes.

Ms Stephen-Smith: We can tell you how many paediatricians there are, but that is not going to tell you how many paediatricians a child with a specific eating disorder—

THE CHAIR: That is what I am asking for.

Ms Stephen-Smith: is going to be able to be referred to. That is not really the way that we describe these programs. And, as Professor Douglas said, a lot of families will be accessing care in the primary care and private specialist sector, and it is not only paediatricians. It might be more helpful to say, "What are the pathways into support through Canberra Health Services and what is their capacity?" Is that helpful?

THE CHAIR: Yes. If there is a paediatrician there that could help and serve a child in need of help with their eating disorder who cannot afford to see a private paediatrician—that is what I am asking for.

Ms Stephen-Smith: Yes. As I have just said, SKIP is exactly designed to support these—

THE CHAIR: That is the preventative work. But if they cannot be treated—

Ms Stephen-Smith: No. It is a referral program that can—

THE CHAIR: I just want to know how many paediatricians are available to see them. That is all. It is a simple question.

Ms Stephen-Smith: What I am trying to say is that it might not necessarily be a paediatrician. It might be a paediatrician or it might be a dietitian. This is actually an allied health professional program, because if you are talking about children and young people who have been diagnosed as overweight or obese by a doctor or another health professional, their first port of call is likely to be allied health, not necessarily a paediatrician.

THE CHAIR: Okay, then; so how many allied health service providers are there to support these young people with eating disorders?

Ms Stephen-Smith: SKIP, as I have said, with the investment in the budget, has an additional 0.6 FTE allied health worker in that program. My understanding is that that doubles the capacity of the program, but I will check on that. What we will take on notice is how many staff are associated with SKIP and what the capacity of that program is, in terms of the number of children and young people who can get into that specific program—

THE CHAIR: Thank you.

Ms Stephen-Smith: Is that helpful?

THE CHAIR: Yes. And their specific job title as well.

Ms Stephen-Smith: Yes.

THE CHAIR: Okay. I appreciate that. Thank you, Minister.

Ms Stephen-Smith: No worries.

MR PETTERSSON: I was hoping the committee could get the different health checks explained to it. What is the difference between the Kindergarten Health Check, the year 6 and the year 7 health surveys? What is their purpose? What data are we collecting?

Prof Douglas: I am happy to talk to the Kindergarten Health Check. The Kindergarten Health Check is done in kindergarten, which in the ACT is the first year of full-time education. It consists of a parental questionnaire that has a number of domains. That is completed at the beginning of the school year. Then the school health team goes out to the individual schools and conducts the physical health check component.

The parental health check component consists of demographic data. It consists of parental concerns about weight, eating, diet and activities. It then does a series of questions called the ISAAC questions, which is the International Study of Asthma and Allergies in Childhood, and that is because asthma is the most prevalent chronic disease in children of that age group. So it is a subtype of the ISAAC questions.

We do the parental evaluation of child development survey. We do the strengths and difficulties questionnaire. We do the adverse childhood experiences questionnaire and we ask some standard questions on physical activity and diet. All of the individual components are validated questionnaires in and of themselves. They have been chosen because they have national and/or international data that we can compare the ACT data to. So that is how that questionnaire is developed.

For the school health check, which is the physical health check component that is done by the school nurses, they go out to the individual schools. That can be done at any time in the school year. We do the schools that have the highest rates of vulnerable families at the beginning of the year, so it is closest to the parental questionnaire. The last ones are done in November. There can be a nine-month gap between when the parent fills out the questionnaire and the time of the completion of the physical health check.

The results of the parent questionnaire are collated and sent back to the parents because some of those questionnaires, the strengths and difficulty questionnaire, the adverse childhood experiences and the SDQ, need to be scored so that you can then see whether the child is at risk or not. If the parents have nominated a GP then the questionnaire results also get sent to the GP. It operates as both a clinical service delivery program, immediately giving feedback about that child and the health risks they face, but it also operates as a very important public health dataset so that we can monitor various aspects of child wellness over time.

MR PETTERSSON: How does that differ to the year 7 health survey?

Dr Coleman: I can do year 6 and year 7. Year 6 is a random sample of about 1,500 taken in year 6, taken every three years. There is a physical measurement component to that, as well as a student survey component. Physical measurement is to measure their BMI, their height and weight, and that is to give us a population assessment to be able to tell how we are going in progress with BMI. We also ask them to complete

questionnaires on diet and physical activity related factors. We collect that.

In the year 7 survey, which has been relatively recently introduced, it is a whole-of-year-7 questionnaire, where we look at a range of wellbeing aspects, including diet and sleep. The main tool of these is to help us to monitor these aspects across the board and to detect trends, and to both monitor what we are currently doing and where we need to intervene and change. There is also a mechanism to identify, similar to Kirsty's answer, whether there are any high-risk children in that, which will result in those being referred on and identified.

MR PETTERSSON: For those referrals and in those instances where the results are sent back to parents, is there any due diligence, double-checking, to make sure that actions are taken, if warranted?

Dr Coleman: Do you want to talk about kindy?

Prof Douglas: I am not sure I understand the question. There is certainly due diligence about making sure the right results go to the right parents—

MR PETTERSSON: Is there a follow-up to that? Let's say you do your measurements, get the kid's results, which show high BMI, and the letter gets sent off to parents. Is there a follow-up to make sure that the parents have done something?

Prof Douglas: No. The follow-up is the letter to the parents but also to the GP. The letter to the parents says, "This is the issue of concern. The results have also been sent to your GP. We suggest you follow up there." There is no checking to see if that has happened. One of the evaluations we would dearly like to do, to look at the outcomes, is to track some people over five years and say, "This was picked up at the Kindergarten Health Check. What were the actions that were taken as a result of that and what is the further outcome?" The advantage of having both the Kindergarten Health Check and the year 7 check as population samples is that we can, at least over a seven-year period, start to track what that cohort has been like.

Ms Stephen-Smith: The other opportunity that we have in mind is that, as we move towards universal preschool for three-year olds, we have been talking a bit about early intervention. There is the opportunity to get in at an earlier age. Kindergarten has been the first time we have been able to do a universal health check. We are looking at what are the opportunities with universal three-year-old preschool to get in and support children and their families earlier.

MR PETTERSSON: Wonderful.

Dr Coleman: I might also add that sometimes there is a negative associated with a feedback mechanism, in that we do run this as a voluntary check. If people do not want to participate, they do not need to do that. Sometimes there is a nervousness or an apprehension on the part of the families to be involved if individual identification comes out of that.

I think one of the things we are very aware of in designing and running these—and we have lots of communication with the Education Directorate, as well as the early

childhood educators—is where do we sit best to get the maximum value, for the individual and the family, as well as the population, to balance all those needs? Sometimes, for example, with the year 6 measurement, unless they flag as really high risk then it is very much a population-based indicator measurement.

MR PETTERSSON: Just on that, though, for those very high-risk identified youngsters, would there be follow-up? Is that what I am taking away from that answer? If there is someone that has red flag after red flag in the survey and the measurements, is there a follow-up there?

Dr Coleman: This is a one-off survey and a one-off measurement in a random sample of individuals in year 6. So we cannot rely on this in any way to identify individuals who are high risk. Remember, the high risk that we are measuring is chronic high-risk issues. We are not measuring for those acute issues which are dangerous from a particular mental health or an acute response aspect. If there are particular high-risk factors that we identify then there is communication back to the parent to identify—similarly to the kindy health check—that we encourage them to go and talk to their GP. Beyond that, it sits in the parents' hands.

Prof Douglas: For instance, in the Kindergarten Health Check, if they are flagged as high-risk we will contact the parents. If they are high risk and do not have a GP, we contact the parents and say, "We have identified something we think does need following up. Do you have a GP? Are you comfortable finding one? Can we facilitate that?" Particularly with the adverse childhood experiences questionnaire, which identifies significant adverse experiences, if we identify a high number of factors then they get a follow-up phone call from the research nurse or one of the GPs in the unit, to understand the context behind it. The vast majority of those who have been identified are children who are foster care and are now in a safe environment. We need to check that.

MR PETTERSSON: That sounds wonderful. Thank you.

MR BRADDOCK: Coming back to strategic monitoring and reporting, to get this clear, if something is in the plan, all ACT government directorates are responsible for reporting activities and evaluating outcomes to the ACT Health Directorate. Part of the challenge here is that, where something is not explicitly included in the plan, you are in the process of trying to improve the level of engagement of those areas to make sure it is influenced, let us say, by the preventive health plan. Will that also include influencing the choices being made at the start of the process? Also, would that involve giving advice or trying to evaluate what they are trying to achieve from a preventive health focus?

Dr Coleman: Can I clarify what you mean by the start of the program? Does that include—

MR BRADDOCK: In terms of when they are making decisions as to whether they need to invest in option A, which might be a school crossing, versus option B, which might be a food relief program, and they are having to make these choices. How is this being influenced by the preventive health objectives of the government?

Dr Coleman: I think there are a number of ways in which we are doing that. One of the big measures that the ACT government has implemented recently is the Wellbeing Framework which, from a preventive health perspective, identifies all of the social determinants, including the ones that we are particularly interested in from a health perspective. It is actually quite a complex consideration, when you have to make choices around which one you implement, and how.

The way that we try to do that is to talk about what we think and provide advice on from a health perspective, and where the benefits are from a range of different options, if we are discussing them around the table. Of course, other factors come into that decision. I think it is about complex decision-making, and preventive health is one aspect of that, and we influence that where we can. One of the evaluation pieces is around where and how we can strengthen that, using, for example, the Wellbeing Framework.

THE CHAIR: Can I draw your attention to 2.36 of the key findings? It talks about tackling weight stigma and discrimination. In the first three-year action plan, it does not include any strategic actions directed towards addressing weight stigma and discrimination, which has serious negative impacts on people's health and wellbeing. What are you doing to address this particular issue—not addressing the stigma and discrimination of weight gain?

Ms Stephen-Smith: As we have talked about, the next action plan is currently out for consultation. All of the Auditor-General's findings and recommendations are being taken into account in the development of the second action plan.

Ms Murray: Certainly, as you would imagine, there has been a lot of conversation in the consultation stage. I want to flag that we are not purely relying on that consultation. Since we introduced the previous action plan, there has been a lot of work in this space from experts in the area and research in terms of how we actually address it. It is a really fine and careful line that we need to walk.

We hear from our colleagues who are experts in this area how that intersects with the different cohorts that we have talked about, how it intersects universally and what those impacts are. How do we maintain a really clear line of health promotion without compromising any of the mental health triggers in relation to the weight and stigma side of things?

This is something that we leverage into the National Obesity Strategy, which is again picked up by the Auditor-General's report, and that was informed by the voices of lived experience as well. How do we utilise the research that has progressed and advanced since the previous preventive health plan? How do we bring in the national work that is done in this space? How do we hear from our own community around what their experiences are, and how do we hear from the experts in these areas?

All of those things will be coming together to actually put something forward in this space in the new plan. That is the pathway for us in terms of our next steps. I am looking forward to working with key people on what that looks like and how that feels like.

Consistently, we want to be really careful and deliberate around our language. We need to be deliberate about how we have that supportive terminology. We need to influence, broad and wide, what that looks like and what that feels like. There are simple things that we can choose to do, such as starting to transition into talking about healthy weight and ranges of healthy weight, as opposed to some of the more stigmatising conversations. It is something that we need to step into, in that space.

Ms Stephen-Smith: The other point to make in relation to some of these findings is that the ACT Healthy Canberra plan, the preventive health plan, actually pre-dates the National Obesity Strategy. While the Auditor-General says that the first action plan is a missed report in which to include something, it is hard to include something that does not exist yet. I think it is appropriate to say, "Actually, we will include that in the next action plan," because the first action plan was actually finalised before the National Obesity Strategy was finalised.

THE CHAIR: What, if any, current campaigns or programs are there to address the issue of stigma and discrimination regarding weight gain? The new plan is not going to happen for quite some time. We acknowledge that. Are there any current campaigns or programs to address this particular issue?

Dr Coleman: I would like to acknowledge that this is a really complex area and we need to work across jurisdictions and nationally to make sure that we have a consistent message and approach in this space. What we have control over is ACT government employees. There is certainly work being done with clinicians in the Canberra Health Services and other health services space, to ensure that there is training in and understanding about how that is delivered.

We have less direct control over places like primary care, as well as the general aspect. Our mechanism for engaging in that space and trying to reach a national agreement is through the National Obesity Strategy. The ACT has consistently raised at the table that we would like to have some further discussions around how we manage this from a broader communication and messaging perspective.

Ms Stephen-Smith: Particularly, the office for professional leadership and education is progressing professional learning and guidelines around weight stigma. As Dr Coleman said, that is one part of the workforce. We can work with Capital Health Network around primary care as well and ensuring that that is consistent. If we can get that into the universities, so that students are getting that through their training program, that requires a national effort. We can work with our universities and our tertiary education providers. But if that can be a nationally consistent approach, that would be better. We obviously recruit staff and staff move between jurisdictions all the time.

THE CHAIR: I do not know whether I am asking a very simple question here. I do not think it requires a broad discussion with the other jurisdictions. What is the government doing to provide awareness campaign programs about weight gain or obesity within the general public? I do not think you need a conversation with other jurisdictions to do that, really. You are very capable of doing something like that—campaigning about raising the awareness of that and the stigma about it, and positive conversations and things like that.

Ms Murray: Certainly, Mrs Kikkert, we have quite a number of programs. They do not specifically target this; in itself, the research tells us that it is not going to be positively received. Actually, it is about turning it on its head and talking around what are healthy choices and what healthy eating looks like, and how we support people to fully understand some of those influences and drivers in terms of negative eating habits et cetera.

We are more than happy to share some examples of our broader health promotion work, which actually wraps this up. That could be through school programs, through more specifically targeted programs or through a really strong and positive message around healthy eating and healthy activity. Again the research is telling us that we need to focus on the words around healthy weight, around healthy choices, and stepping away from talking about the stigma of obesity.

It is about not stigmatising people who sit outside that healthy weight, which in itself creates something that is almost self-fulfilling. I am not the expert in the room; I apologise. I have some lived experience of that stigma. There are quite deliberative acts that we are taking in terms of our positive messages and positive programs which actually pick up that healthy approach to life and healthy engagement in terms of physical activity.

The broader part of that is monitoring processes and how we use that data to target and design the health promotion activities which focus on that positivity.

THE CHAIR: That is what I was coming to; specific programs and campaigns that you are trying to achieve to accomplish the goal of—

Ms Murray: The outcomes—

THE CHAIR: Yes.

Ms Murray: That is exactly right, Mrs Kikkert. Almost everything that we do in that health promotion space is actually around trying to show a better way and not overcomplicating a healthy lifestyle and what it takes to create that healthy lifestyle. That is embedded in all that we do.

THE CHAIR: Thank you. In the interest of time, we must end this session, although I would like to talk about it some more. Is there anything that you want to add before we finish? No? Thank you, Minister, for attending this afternoon and thank you to your officials, Dr Coleman, Ms Cross, Ms Murray and Professor Douglas.

Ms Stephen-Smith: Thank you very much.

Short suspension.

BARR, MR ANDREW, Chief Minister, Treasurer, Minister for Climate Action, Minister for Economic Development and Minister for Tourism
SNOW, MR MALCOLM, Chief Executive Officer, City Renewal Authority

THE CHAIR: Welcome, Chief Minister, and Mr Snow. I remind witnesses of the protections and obligations afforded by parliamentary privilege and draw your attention to the privilege statement. Please confirm that you understand the implications of the statement and that you agree to comply with it.

Mr Snow: I do.

THE CHAIR: Thank you. Would you like to make an opening statement?

Mr Snow: No, thank you.

MR PETTERSSON: I was hoping the committee could get an update on works currently underway.

Mr Snow: Yes. Practical completion on what I call the boardwalk, which is the extension all the way around to Acton Peninsula and to what we are now calling city beach, for want of a better term, has now been reached. There are some final variations to be considered to close out the financial aspect of all of that.

What has been happening concurrently for at least 12 months has been work on the design of the next stage, which is the park on top of the reclaimed area. Members would recall that we had permission to reclaim a section of the lake—2.8 hectares in total. That involved rock fill being literally dumped into that lake-bed area. It was quite a complicated civil engineering exercise. That gravel bed, 2.8 hectares of it, needs to now settle for approximately another 12 months—settle as in let the different layers of rock reach their point of settlement, final settlement—

MR PETTERSSON: That is behind the concrete walkway?

Mr Snow: Correct. Nearly behind the boardwalk, the park will virtually sit on top of that reclaimed area. To create the park, we need to change the levels. A significant amount of soil, fill, needs to be put on top of that gravel, which again introduces some interesting challenges around settlement. When you start loading up the rock—I am not an engineer; this is the simple explanation—that mass also puts downward pressure on the rock fill. We have to let that settle before the park construction can actually start.

Works applications have now been lodged with the NCA for the park design. A lot of work has gone on, and indeed a lot of further consultation with the community, the Dhawura Ngunnawal community council committee, and many others, to get that concept design to a point where my board have now approved it being the subject of a works application.

That was lodged, together with a separate works application for stormwater works. The stormwater works in that particular location are quite old and need to be upgraded

to not only service the rain that falls on the park but ultimately the estate behind the park. The park boundary to Parkes Way effectively becomes the land development area, which is the further stage. But significant stormwater augmentation works were the subject of a third application. All three, Mr Pettersson, have gone in together and the NCA is now assessing those.

MR PETTERSSON: Roughly—and I do not want to hold you to it—when do you think the park will be completed?

Mr Snow: We have now received budget funding in the latest budget, which we are very pleased about—a total of $35 million. Taking into account those time frames that I talked about, construction would not commence until the 2024-25 financial year; then we would expect at least an 18 to 24-month construction.

MR PETTERSSON: At the very start, you called it city beach. Is there any thought towards having a better name?

THE CHAIR: I like city beach! The question is: will you swim there?

Mr Snow: It is not quite Copacabana! That was literally a working title. We consulted extensively with ACT triathlon, and the hope is that even a winter solstice swim, but certainly triathlons, could be located in that particular spot. It is all in the name of making sure that we have an active park. This was a run-down, very underutilised part of the city centre. This whole project is about driving activity and supporting that activity. Ultimately, the park and the development behind it are enormous and very exciting opportunities to do that.

MR BRADDOCK: I am interested in terms of the due diligence undertaken by the board whenever there is a machinery of government change, and you inherit projects. How do you ensure that the procurement practices to date have been satisfactory and that you are across all of the risks associated with that?

Mr Snow: Thank you for that question. It is a very good question. A salutary aspect of the Auditor-General's report was that, with respect to the authority, in accepting this legacy project, because it was a project that had been started a number of years beforehand by the former Land Development Agency, it really behoved the authority and the board, as the government's entity, to make sure that that due diligence was undertaken.

The contracts were afoot at that point. It was not as if we had the luxury, if I could use that word, to say that everything had to now stop because we had contractors underway. Nevertheless, I think your question is entirely appropriate. We acknowledge, and I think the government acknowledges in its response, the point about due diligence, if we were to ever accept a legacy project again. To be honest, that is quite unlikely because there are no other legacy projects that we are aware of. That is a big statement to make. Irrespective of whether it is a legacy project or not, the good practice of due diligence, and undertaking that due diligence for any major project or very public project, is important for us to do. The board, certainly when we have had conversations with them, have noted the need to do that more diligently.

MR BRADDOCK: The Auditor-General states that boards—which also refers to the City Renewal Authority board—have not equipped themselves adequately to fulfil their respective responsibilities for the project. Have you, subsequent to the Auditor-General's report, equipped the board so that they are able to do so?

Mr Snow: I think the board and the executive management team—the whole authority—have acknowledged the well-made point by the Auditor-General. I used the word "salutary"; I think that is entirely appropriate because, clearly, the board would not want to again be placed in a situation where that kind of criticism was levelled at it. I know it is completely committed, as is the whole authority, to avoiding a repetition of that kind of assertion.

MR BRADDOCK: What steps have been taken since the Auditor-General's report has been handed down, in terms of ensuring that you are appropriately equipped?

Mr Snow: In relation to all of the recommendations, I might begin by saying that six of those recommendations are already closed out. A seventh recommendation is about to reach a conclusion, where we will provide a chronological list of all of the variations that were related to that particular project to Tenders ACT.

The audit and risk committee of the board has had a particular focus on the matter you have just mentioned and have asked that the processes and procedures in relation to how contracts of this kind of significance are not only administered but also analysed in terms of those risks are brought to the audit and risk committee and ultimately on to the full board for discussion and ratification.

MR BRADDOCK: My next question is to you, Chief Minister. How have you communicated to other boards within the ACT government in terms of ensuring they are appropriately equipped to handle and exercise their due diligence in matters in this regard?

Mr Barr: Obviously, the government response to the audit report went before cabinet and went before the strategic board of the ACT government. That has the directors-general of each of the ACT government agencies. It goes there for coordination comments; I think that is the normal process with a cabinet submission. With respect to each director-general who has a board or entity that reports under the portfolio, in this instance CRA and SLA sit under the EPSDD portfolio more broadly, so they are aware.

The recommendations are very specific regarding a disbanded agency and new agencies taking responsibility for projects midway through, after a machinery of government change. There may be future machinery of government changes, but in terms of there being future projects in this context that are current entities, it is unlikely to be repeated.

In the future one could never rule out that there would not be an agency that is either amalgamated or divided, as was the case with CRA and SLA out of the old LDA. I think there will be ongoing lessons. The question of the extent to which this outlives the current personalities and leaders is one that sits with the public service around handing on corporate knowledge, for want of a better description. I can only guarantee

so much. Obviously, I will not be in this role forever, either. I can absolutely assure you of that.

It is well understood, in a contemporary public service and with contemporary machinery of government arrangements. As to whether this could happen again in 2075, you would like to think not, but I cannot rule out that risk at some point in the future, where there is a machinery of government change.

Mr Snow: Certainly, in speaking to the reform that has happened and the continuous improvement that has been undertaken in the authority, our program management office has completely reviewed the contract administration arrangements to make sure that all staff are not only aware of but abide by those updated improvements. That includes the relationship with the board and the timing and scope of the things that are taken to the board.

Mr Barr: It probably poses the question: what is the half-life of an audit recommendation? We would like to think it would be decades. Whether it is centuries is another matter.

MR BRADDOCK: Also, what is the ability of a board to exercise their due diligence on an ongoing basis? Thank you.

THE CHAIR: When this work was first predicted, it was going to cost $28 million. Obviously, it is a lot more than that. It has increased to about $46.8 million by 2020. I understand some of that is attributed to difficulties in getting some of the materials. Could you help the committee to understand why there has been that huge increase in cost?

Mr Snow: Yes. There were a number of critical variations that, depending on the timing of the handover of that particular stage, had been commenced by the former Land Development Agency. In relation to stage 1, which we would call Henry Rolland Park, I think there was acknowledgment that there had been an underestimation of the cost associated with that particular park. I would add better due diligence around understanding implications of working in the lake. It is effectively what I would call submarine work. It is costly.

The NCA also, in its approval, required the ACT government to achieve a certain standard or quality of finish, to a much higher specification than would be the case for, say, a normal park or an equivalent park elsewhere in the ACT. This is designated land; therefore the National Capital Authority had that kind of control.

I do not think that the higher specification of materials was adequately recognised. There was the cost of construction associated with the lake. A number of other variations related to the introduction of elements late in the day. One in particular, which was the subject of quite a significant variation, related to the picnic shelters, which were not part of the original design and were not costed. Those were felt to be important amenities within the park. Quite reasonably, the decision was taken that that was a design oversight. The NCA supported their inclusion. But they are reasonably significant structures and were quite costly.

The short answer is that there are a number of factors. Site conditions, material costs and late design variations have been the major contributors to those cost increases.

THE CHAIR: With the initial design of the entire project, was that designed by a different company? Was the design afterwards, which includes the picnic shelters, designed by a different company?

Mr Snow: The project, when it was under the control of the LDA, was called the city to lake project and it was a much bigger project than just the Acton waterfront. The decision was taken to proceed with the development of Acton waterfront as part of that city to lake plan. Architects and landscape architects were commissioned by the LDA to prepare that plan and to then advance that design work to specifically focus on the lake foreshore.

The landscape architect at that time was the landscape architect who continued to design and document Henry Rolland Park. That consultancy stayed on the project. Because it was afoot and worked up, that is the design that was actually implemented and approved by the NCA.

In relation to the next stages, where the CRA took over responsibility, we went through it. We concluded that contract and we went out to an open tender to get contractors for the park. But the design treatment effectively that started with Henry Rolland Park is the same design treatment. Again, the NCA, quite correctly, said, "You can't have two different types of treatments. You have to have the same design treatment." That essentially was for hard landscapes, such as concrete panels, the lake wall, the lighting—not soft landscape but primary or hard landscape, which was engineered.

The change in design consultants has already happened in relation to the park design. We are currently out with a tender to get a multi-professional team to then take that concept design, once it is approved by the NCA, and to work it up into tender drawings. There may well be another change, although we are currently contemplating how we would ensure the integrity of the concept design that is going to be approved by NCA is kept.

MR PETTERSSON: One of the things that the Auditor-General highlighted was that it was very hard for them to track down all of the different changes in the contracts. It is more of a whole-of-government question than a City Renewal Authority one, but are there any improvements that can be made to the publishing of contracts and requests for tender so that it is easier for people to follow along when there has been variation to contracts?

Mr Snow: Again, the authority believes that was a very sound recommendation. Certainly, the authority should have been better at that, not only in relation to making that information available in the public domain, but itself having accurate record keeping and contract administration documents.

You are right; they were frustrated that we could not identify key documents as part of their audit. Subsequently, some of those documents have been found and were provided, and the Auditor-General modified his recommendation. But that should

never have been the case. I agree that, from the very beginning, anyone—whether they are a member of the public or the Auditor-General—should be able to have a very clear trail of the way this contract was administered and the way that the project itself was managed.

THE CHAIR: Is there anything you would like to add before we finish?

Mr Snow: No, I do not think so; only that I think we have been diligent in responding to the auditor's recommendations. As we said in the covering letter to the Auditor-General, we are committed to continuous improvement in this space.

THE CHAIR: We appreciate that. Thank you, Mr Snow. Thank you, Mr Barr. On behalf of the committee, I would like to thank our witnesses who have appeared today. We also thank broadcasting and Hansard for their support. If a member wishes to ask questions on notice, please upload them to the parliament portal as soon as practicable and no later than five business days after the hearing. This hearing is now adjourned.

The committee adjourned at 4.55 pm.