LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH

(Reference: health of school-aged children)

Members:

MS K TUCKER (The Chair)
MR B SMYTH
MS K MacDONALD

TRANSCRIPT OF EVIDENCE

CANBERRA

FRIDAY, 28 JUNE 2002

Secretary to the committee:
Ms S Leyne (Ph: 62050490)

By authority of the Legislative Assembly for the Australian Capital Territory

The committee met at 2.03 pm.

BRENDA MORRISON was called.

THE CHAIR: I declare open this public hearing of the Standing Committee on Health, and welcome Dr Brenda Morrison from the Australian National University's Centre for Restorative Justice. I wish to alert you to conditions associated with giving evidence before this committee. You should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections, but also certain responsibilities. It means that you are protected from certain legal actions, such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Mr Smyth has joined us, so we can commence. Before you begin to speak, would you state your name and the capacity in which you appear, please?

Dr Morrison: Good afternoon. I am Dr Brenda Morrison, the Acting Director of the Centre for Restorative Justice at the ANU, although I am currently on maternity leave. Shall I just begin?

THE CHAIR: Yes, please.

Dr Morrison: First of all, I have to acknowledge that the work, the results of which I will present today, has been done largely on a collaborative basis. My colleagues Eliza Ahmed and Valerie Braithwaite, who hoped to be here, send their apologies. Their work is involved in what I will be talking about today. All the data that I will be presenting today were collected here in the ACT. We have been collecting data related to issues of justice and health since about 1986.

My initial position is that I believe that justice is at the heart of the health promotion movement. That was the position taken a couple of years ago by the International Conference on Health Promotion and Education. I will leave a copy for you of an article that talks about that issue, putting justice at the centre of health promotion and education. That not only touches the issue of access and distribution of resources, but it also touches on how injustice affects our health and wellbeing.

The theme of the next conference, which is going to be in 2004 in Melbourne, and is back to back with a national conference, is to be valuing diversity: reshaping power. That brings me to restorative justice, because restorative justice is largely about reshaping power imbalances, or addressing power imbalances within society.

For the benefit of the committee, restorative justice is a process of empowering people. That is what it aims to do. Sometimes it achieves this, through different processes, and sometimes it does not. However, its aim is to empower people in communities and integrate individuals back into communities. When individuals are disenfranchised or alienated from communities, that is when their wellbeing breaks down in many different ways. It is about reshaping power imbalances.

I have a handout for you that I would just like to talk you through, because it will help you understand what I am talking about. I am going to borrow something from this book, *Restorative Justice in Civil Society.*

THE CHAIR: Who wrote that?

Dr Morrison: It was edited by Heather Strang and John Braithwaite. It contains the proceedings of a conference that was held three years ago, here in the ACT.

THE CHAIR: Who is the publisher?

Dr Morrison: The publisher is Cambridge University Press.

(Books were then shown.)

Dr Morrison: In restorative justice processes, what we aim to do is get away from that balancing act or seesaw that we have been riding between rehabilitation and punishment, or social control versus support and rehabilitation. The editors of this book put the two sides of that seesaw on two different axes. As you can see, on one axis there is control, whether that be low or high, and then there is support, low or high.

When we have low support and low control, that is when we are neglectful. That is characterised by indifference and a passive approach to the situation. However, when we are high on control, but low on support, that is when we are generally punitive, stigmatising and authoritarian. When we are high on support, but low on control, we can often be permissive. That is often a therapeutic or protective approach to the individual or community.

When we have high support and control, that is when we can be restorative, because restorative justice values both accountability and support. It is largely collaborative and reintegrative, and that collaboration can be with different individuals or different groups. It is getting the right collaboration that is important: it can't involve just anybody. Who is there and who says what is very important. Unless we get the collaborative part right, we may not be able to get into the reintegrative part.

Another way that the editors have looked at that, on the next page, is that the neglectful approach is doing nothing, the punitive approach is doing something to someone, the permissive approach is doing something for someone—and that is often not helpful either—and the restorative approach is doing something with someone. That is about building effective partnerships to support individuals and communities.

That is really what restorative justice is: it brings together a group of stakeholders, and getting that dynamic right is really important. We think that, at the heart of restorative justice, the emotion of shame is very important. I will not go into the theory of that, but it is all available here in another book by Cambridge University Press.

The data in this book is all from the ACT, whether it be from the reintegrative shaming experiment or the second part of the book, which is on bullying and shame management. That was all taken from some 1986 data collected here. Then, on the basis of those data,

Professor John Braithwaite has redeveloped different aspects of his reintegrative shaming theory.

Because we believe that shame management is central to the process of understanding justice and health—wellbeing—we look to that in the context of bullying. Restorative justice is about rebuilding and reshaping power imbalances, and the definition of bullying is the systematic abuse of power. Both incorporate power, and so we believe that restorative justice is particularly important and relevant to addressing issues of bullying.

We also know that bullying has severe health consequences through the work of Ken Rigby and others, done in Adelaide. We know that victims of bullying have higher levels of stress, higher somatic illnesses, and higher incidences of depression, suicidal ideation and suicide itself. In fact, bullies also have a propensity to experience those same problems, but the symptoms of those problems usually only emerge later in their lives. Those who are bullies at a young age are more likely to be depressed in their later years. Our work is developing both theory and practice on all these ideas, but today I am going to focus more on the practice side of things.

When we looked at shame management in relation to bullying, there are usually three clusters of variables that we look at when we are predicting bullying and other forms of antisocial behaviour: family variables, school variables and individual difference variables. We found that they were all important in predicting bullying. However, we found that a better predictor was something that consolidated some of those other factors, which was what we call shame management. Shame management can go one of two ways: we can acknowledge shame over a wrongdoing, or we can displace the shame over a wrongdoing.

What you can see from this diagram is that, when we have a tendency to acknowledge our shame over a wrongdoing, that is negatively correlated with bullying but, when we displace our shame over a wrongdoing, that is positively correlated with bullying.

MR SMYTH: Sorry, before you turn the page, when you talk about shame management, is this for the person who is being bullied or for the person who is perpetrating the bullying?

Dr Morrison: It is shame management for the individual who has perpetrated the bullying, who has acted in a wrongful way.

MR SMYTH: If they acknowledge that it was wrong to do, they see bullying negatively.

Dr Morrison: Yes, that is right.

THE CHAIR: Are you saying that they are less likely to be bullies if they feel ashamed?

Dr Morrison: Bullies do not feel shame.

THE CHAIR: Are you saying that the capacity to feel shame will be a predictor of whether or not a person is a bully?

Dr Morrison: That is right, yes. It is correlated, yes. We will get onto a little bit more of that later. Acknowledging shame means feeling shame, taking responsibility for that shame and making appropriate amends. When we go through that sort of cycle, we are less likely to be bullies and we are less likely to be victims, but I am not going to focus on that right now.

When we displace shame, that is when we go into the modes of retaliatory anger, externalised blame and displaced anger. That is when we hit or kick another person or object. The work of Thomas Scheff discusses internalised shame-rage cycles. When we do not acknowledge our shame and discharge it, the shame remains internalised and then it becomes anger.

That is exactly what the staff of the Secret Service came up with when they looked at the school shootings in the United States. They interviewed a number of the perpetrators of school shootings in the United States and they looked at those same factors again—family factors, individual difference factors and school factors—and they could not come up with a systematic pattern that predicted who would be the next school shooter. Some came from all-American families, some came from foster homes; some were straight-A students, some were failing; some had a good group of friends, some did not.

The only thing that they had in common was that they were depressed, and the reason they were depressed was that they were bullied at school. Scheff and others would argue that this is the shame-rage cycle manifesting itself.

THE CHAIR: Sorry for interrupting, but are you also talking about the shame experienced by the person who has been bullied?

Dr Morrison: No. Well, yes, then I am talking about the shame, yes.

THE CHAIR: They are ashamed of being bullied and of not being able to deal with it, so they internalise it as rage, and then—

Dr Morrison: That is right.

MR SMYTH: And rage becomes revenge.

Dr Morrison: That is right. We have a typology of how both victims and bullies feel shame, and I am going to get onto that next. However, I just wanted to go back to depression, because it is becoming an overriding theme in the understanding of bullying and other health-related problems.

Last year's report from the World Health Organisation predicted that depressive orders will rank as the world's leading cause of disability ahead of heart disease, cancer, and HIV and AIDS by the year 2020. Because of that, I think depression is a thing that we have to look at very carefully. The report also said that the obstacle that stops people from getting help is not a lack of resources, it is the stigma associated with depression. Most people still see it as a character flaw, rather than something that comes out of a certain social dynamic. We have to re-educate people about those issues as well.

Now, I have mentioned that shame is manifest differently in different sorts of people—classified into bullies, victims and non-bullies non-victims. On the next page, again looking at that topology of taking on accountability and responsibility, with feelings of support and acceptedness being high and low, what we found is that victims are eager to take on responsibility, but they often do not feel supported in their social environments.

Bullies, on the other hand, find a way to feel psychologically supported, but they do not take on accountability or responsibility for their behaviour. There is also a classification that is called the bully-victim, and this category captures the worst of both of those other groups. Like the bullies, they do not take on responsibility for their behaviour and, like the victims, they do not feel supported. The healthy non-victims non-bullies do feel supported and do take on responsibility.

When we developed this typology we then went to the clinical literature and, indeed, through the work of Helen Brock Lewis and others, we found that these clinicians were already talking about the ways that these four different groups work through shame. Victims are caught up in cycles of persistent shame. Because they have been socially invalidated, as they feel disrespected, their shame is persistent, and they are constantly looking for ways to be accepted and involved in communities.

Bullies bypass their shame. They develop other reference groups and different ways of thinking about their roles, so that shame can be bypassed. Bully victims are caught up in something called "denied bypass shame". In some sense they know that they should feel shame, but they do not go through the appropriate steps to discharge the shame in a healthy way. The non-victims non-bullies are able to say sorry and make appropriate amends, and thus their shame is discharged and is no longer internalised.

We are pretty happy about that mapping process. The tricky thing, though, is that what some people would take from that chart is: "We need to get more social support for victims, because that is what they are lacking. We just have to get tough on the bullies to make them more responsible and accountable." It is not so easy. It is really a subtle dynamic, and those two processes always have to go hand-in-hand with the support and responsibility.

Because the bullies are able to bypass their shame, we have to get that shame to the surface first by inviting the right group of people together and working through it effectively. In a sense that shame is still there. It is internalised and we have to get it to the surface, and that involves getting the right people together and achieving the right dynamic.

On the other hand, for victims we tend to go into more of a protection-type mode, as I said in the protective box on that social discipline window. We do not want victims to remain victims. If we constantly protect them, that is not good either: they have to take on responsibility for what has happened in their lives as well.

That is where we are coming from. The interventions that we are developing revolve around helping students and adults to work through their shame and become responsible and resilient citizens. A lot of that can be seen in how they resolve conflict and wrongdoing in their everyday lives.

Restorative justice has been around for a while, and it is usually understood in the context of conferencing. Conferencing at schools has been trialled largely in Queensland, and to some extent in New South Wales, with promising but tentative results. Even though a lot of money has been spent, I think the results have been less than optimal for a large number of reasons. I took the principles on which conferencing and other restorative practices were based, and I developed an early intervention program, because what you really want to do is change the cultural dynamic of a school or a community to which people belong.

It is in that context that you are really going to change someone's behaviour. It is more promising than just throwing in a conference every now and then. Conferencing is effective, but it is more effective when it is appropriate for both the culture and the community, and when people have an idea of what to expect out of the whole process.

This is a proactive process that we developed. We call it the responsible citizenship program. The trial was funded by the Institute of Criminology and the institute put out a short paper on it, which I can leave with you. I will also leave a little crime fact sheet.

Basically, the responsible citizenship program was about building respect, consideration and participation for the participants. We asked the students when it was hardest to practise these three things, and they said it was when they were in conflict. We said, "It is important for us to learn other ways to resolve conflict," so we also taught them how to resolve conflicts productively based on principles of restorative justice. Then, at the very end, after all this jargon, we asked them, "What does RCP really mean?" We told them, "It stands for Really Cool Person, and that is what each and every one of you are," and we gave them little badges and they thought that was the best thing ever.

We call these the reaction principles, and that is how we taught the participants to resolve conflicts productively. It is about repairing the harm done, expecting the best from others, acknowledging your feelings and the harm done, caring for others, and taking responsibility for your feelings and behaviour.

Because I think evaluation is important to all this, and because everybody loves their own program, we needed to take a step back from it to evaluate it. We asked both the facilitators and the students to rate the students' feelings of respect. We asked students, "How much did other students respect you in today's activities?" We asked them this at the end of every single program day.

The students' feelings that others respected them increased from 5 to 5.2 over the course of the program. Their feelings that others considered their ideas increased from 3.4 to 5.2 over the course of the program, and their feelings that others allowed them to participate increased from 4.3 to 5.7 over the course of the program. Facilitators also showed increases, but their ratings were slightly lower in most cases.

We thought that was good from the students' perspective. We also wanted to look at how they managed their shame. We wanted to know if victims would have less feelings of rejection and, indeed, this figure dropped from 33 per cent of students feeling rejected by others following a wrongdoing before the program, to only 20 per cent of students after the program. In terms of their self-reported shame displacement strategies, 27 per cent of

the students reported using shame displacement strategies at the beginning of the program, but only 13 per cent reported that they would use them at the end.

We were fairly optimistic about that. Unfortunately, we did not have the means to have control groups and the like, so another trial would be optimal.

THE CHAIR: Was that in Canberra?

Dr Morrison: Yes, at Hawker Primary.

THE CHAIR: How long was the course?

Dr Morrison: It was 10 sessions of one hour each.

There is a short report of that program in this Institute of Criminology paper, but I also have a book coming out through Federation Press, which will talk more about it.

THE CHAIR: About that particular ACT trial?

Dr Morrison: Yes, it talks about restorative justice in schools, but the case study I provide is the Hawker study, because it has been systematically and quite rigorously evaluated.

THE CHAIR: I do not want to cut you off. Finish your presentation please, and then we will ask the questions.

Dr Morrison: That is about it for now. The other thing that I wanted to highlight is that we have also developed something called youth development circles, which capitalise on the principles of restorative justice. They have not been trialled yet in the ACT, but I know a number of schools that are interested in it. It basically builds circles of care around individuals, and I think it may be particularly effective for some students at risk.

Some of the data that came out of the RISE study, when we isolated just the cases that happen in schools, were found to be useful for addressing school-related issues. This is another working paper that we have just brought out, and it is about how restorative justice can be used with substance abuse.

MR SMYTH: What was the outcome of that?

Dr Morrison: Which one?

MR SMYTH: The restorative justice and substance abuse paper.

Dr Morrison: There was no trial. It is just a proposal.

MR SMYTH: Okay.

Dr Morrison: That is about it. All our work actually fits well with this new policy coming out through the department of education.

MS MacDONALD: ACT?

Dr Morrison: Yes. That policy recommends what the education department calls programs for low-need support, medium-need support and high-need support people. We have always argued that it is important to have primary interventions—interventions such as the program that I ran at Hawker—that target the entire school community, so that everyone learns about productive conflict resolution.

Medium-need support programs are what we call secondary interventions, which target small groups of people, and maybe substance abuse or something similar. Tertiary interventions are more intensive and are basically one on one, and would be something like a restorative justice conference that brings together a wider community of care for an individual, including family, sometimes football coaches, and anybody who is meaningful, significant or respected member in the student at risk's view.

Just to sum up, we of course need more research and development on all these ideas. The interesting thing about restorative justice is that, because the theory and practice are growing hand in hand, we cannot just develop a program and then just hand it down again and again. Because there are sound principles and theories behind it, what teachers and community groups can do with it is take those and develop their own practices, those that meet their needs and resources.

One teacher's program was evaluated by one of my students last year. I have not mentioned it yet today, but she took the training on restorative justice and then developed something called "group time". She did this by using the principles and thinking behind the practice of restorative justice to develop something for herself. She achieved remarkable changes for the students in her class at Mount Neighbour Primary School, and it was just remarkable to see that.

Group-level bullying went down. We did not shift individual-level bullying, but I think that we could have done something there if we included the family more. Group-type bullying has less to do with family background. Individual bullying has more to do with family background. She is now out at Tharwa Primary School again developing something new, because she now teaches a younger age group.

More research and development along those lines is needed, but monitoring and evaluation is really important, too. Through all this, I think there are always three levels of support that are needed: programs to support students, professional development to support teachers and parents talking about behavioural change, and data to support decision making.

THE CHAIR: Thank you. That is very, very interesting. We are out of time. I will allow just a couple of quick questions, if you would like to ask some.

MR SMYTH: Back at the start you mentioned that the health outcomes of bullying were increased depression, leading to increased suicide, and you mentioned a type of disease that I didn't catch.

Dr Morrison: Somatic illness, which is everything from stomach aches and colds to just about anything. Ken Rigby has a very good book on that. Actually, Ken Rigby has a new book out that has a whole chapter on health and bullying, and he even cites our work very nicely too.

THE CHAIR: Can you just tell me quickly what happened in Queensland?

Dr Morrison: A few years ago now, they did a huge trial of conferencing in schools, and they trained hundreds and hundreds of teachers from different schools throughout Queensland. Then they all went back to their schools, and some did conferencing and some didn't. It is very hard for someone, who is trained to think about behavioural management over the course of a week, to go back to a school and just implement a program. It is very hard to sustain something like that.

So, despite the resources that were ploughed into that, not a lot of conferencing happened. However, for the conferencing that did occur, there are two reports, on a trial and a pilot. The conferencing that was run was found to be effective. The authors of the reports only evaluated people who did do a conference. That is a problem for the evaluation, because we do not know about all those that were put forward, but never got up.

They just did an evaluation of the conferences that were run, and they found the process most effective in addressing issues of assaults and bullying because, they said, it addressed the power imbalances that are inherent in both assaults and bullying.

THE CHAIR: We did do an inquiry about five years ago on violence in schools and, when we asked people why they didn't seek help when they were being bullied, the general response was because it would have made it worse. So it is very important that there is a program that is going to work, and that people know it will work. You spoke about the responsible citizenship program, and you have given us information on that. Then there is this person at Mount Neighbour who developed her own response to the concept of restorative justice. In terms of where the committee can go with that, we can just contact you further if we want to, after we have looked at your material.

Dr Morrison: I have the two reports that came out of Queensland as well.

THE CHAIR: Well, that might be useful to show us what not to do, if there were difficulties.

Dr Morrison: I have a chapter in this book and I talk about it there. Actually, two of the people who were heavily involved in the Queensland program wrote a chapter in this book as well.

THE CHAIR: Okay, did they do an evaluation in that?

Dr Morrison: Yes.

THE CHAIR: All right. We can look at that. We had better not continue, as fascinating as it is. I appreciate your help very much. It is very interesting. Thank you.

ALEXANDRA CAHILL,

TIM MOORE and

MELANIE GREENHALGH

were called.

THE CHAIR: I would like to welcome you all to this hearing of the Health Committee. The first thing I need to do is just let you know about certain—what's the word; I need to find a word to say this properly—requirements or conditions around evidence. You should understand that these hearings are legal proceedings of the Legislative Assembly and are protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing.

It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Thank you. Could you all state your name and the capacity in which you appear before we begin.

Ms Cahill: Alex Cahill. I'm from the Youth Coalition of the ACT. I'm the Projects and Policy Officer.

Mr Moore: Tim Moore, Coordinator of Cyclops ACT, a service for young carers.

Mrs Greenhalgh: Melanie Greenhalgh, Coordinator of the Junction Youth Health Service, which is auspiced by Anglicare.

THE CHAIR: Thank you very much, and thanks for coming and speaking to the committee. Would you like to address us.

Ms Cahill: We wish to start by giving an overview of the issues involved in raising the health status of school-aged children. We will then open it to discussion and question time.

As a society we face an unfamiliar range of hazards to human health from the various global environmental changes. We therefore need to integrate this prospect into our future thinking, planning and prevention policies, without allowing current health issues to be diminished.

The Youth Coalition of the ACT is the peak body for youth affairs and represents the interests of young people aged between 12 and 18 years and those who work with them. In making our address to the standing committee inquiring into the health of school-aged children, we will be directly addressing the issues of children and young people aged between 12 and 18.

Good health does not happen automatically. Ongoing positive investments are needed for a child to grow and develop into an adult member of the community. If for whatever reason this investment is not made, the resilient will cope, but many will not.

Children and young people are the most vulnerable. They are dependent on their families and on the larger community to ensure that health needs are met. Much of the ill health of children and young people is potentially preventable. A wide range of social, cultural, economic and environmental determinants influence the health of children and young people.

One factor, as stated in the ACTCOSS poverty task group report, is poverty. One participant said, "Poverty means feeling bad about yourself because you can't provide for your children." Another participant said, with particular reference to the health of children, "Poverty means that I can't afford the medication, special diets and special clothing needs for my child."

Although many of the factors affecting health are outside the control of the health sector, it is proposed that greater collaboration between all sectors that impinge upon and impact upon children and young people's health be developed.

Young people need care and support so that they can learn to manage their own health needs. This care and support needs to come not only from the health sector but also from the broader community in areas such as education, housing and secure participation in the work force. The cyclical and interconnected nature of health needs to be debated by the whole community, enabling us to identify health indicators as systems failures rather than failures of the individual.

Recently the United Nations Assembly held a special session on children. International governments and country representatives agreed to several areas of importance in relation to issues for children and young people. A draft resolution was collated. This was entitled "A World Fit for Children". Endorsement of this document committed heads of states and governments to achieving a set of targets and benchmarks for children by the year 2010. Australia is a signatory to this document.

This document highlighted four main principles for children in the coming decade in relation to the health of school-aged children, including promoting healthy lives and providing quality education. Key recommendations in promoting healthy lives were development and implementation of national early childhood development policies and programs to ensure the enhancement of children's physical, social, emotional, spiritual and cognitive development, and development and implementation of national health policies and programs for adolescents, including goals and indicators to promote physical and mental health.

The key components of providing quality education were to ensure that the learning needs of all young people are met through access to appropriate learning and life skills programs, and to improve all aspects of the quality of education so that children and young people achieve recognised, measurable learning outcomes, especially in numeracy, literacy and essential life skills.

Health and physical education is one of the eight key learning areas of the national curriculum to which all states and territories are signatories. In turn, each state or territory develops its own curriculum that reflects local requirements. Health comprises a compulsory part of the curriculum in all states, yet there is often the tendency for school health promotion and education to be accorded a low priority in what is increasingly an overcrowded curriculum.

Many teachers have poor skill development and knowledge of the skills required to develop and deliver quality school health promotion programs associated with integrated health promotion frameworks. Current mainstream education needs to acknowledge that the core business of schools is education of students, and that the achievement of health behavioural goals may only be peripheral to this core business.

Collaboration between the government and the non-government sectors to assess the gaps within school health and health promotion needs to be considered, so that health does not drop off the agenda of the schooling environment. To achieve this, school health promotion needs to be based on partnerships between teachers and students, the school community and parents, health practitioners, youth workers and youth health services. Schools also need to be resourced in terms of material and human resourcing, and to allocate sufficient time to health education and promotion.

The three key areas that must be addressed in relation to health promotion and the health of children in schools are the provision of policy support and guidance within the school infrastructure, the provision of extra funding in resources in relation to new programs and current infrastructures within the school, and professional development activities with regard to teachers, involving youth workers in teacher training programs.

To achieve these goals and address key health areas, schools need to acknowledge: the ineffectiveness of one-off unsupported interventions with schools, especially talks to students by health practitioners; the limitations in schools in achieving health behavioural goals due to lack of training and resourcing; and, finally, the need to develop school health services in ways that are well connected to other elements of comprehensive school programs. Such services have a role in meeting the needs of high-risk students and students with special needs.

Schools have a vital role to play in health and the well-being of young people. The social and academic aspects of school are a challenge to any child. Monitoring and improving the health status of young people are amongst the most important goals in youth health policy and future development.

As quoted in the UNICEF report Health Series 1998, the consequences of increasing pressures of family life are beginning to show up in some disturbing statistics for almost all industrialised countries. Many nations are witnessing a steady rise in school drop-out rates and under-performance. These statistics reflect the increase in reporting cases of physical and sexual abuse of children, teenage violence and suicide. The Youth Coalition believes that the ACT government needs to implement and develop a set of local health priorities and principles which reflect national health priorities. That would enable and support action to address the known determinants of child and adolescent health.

As stated in the *Health Promotion Journal* of the ACT in 1998, "a renewed emphasis on developing inter-sectoral collaboration to achieve state and territory national goals for health and well-being must be achieved". Some four years later, the Youth Coalition of the ACT and its members again call for the ACT government to act upon these recommendations, and those expressed in this presentation. Thank you.

THE CHAIR: Thank you very much. Do you want to make comments as well?

Mrs Greenhalgh: Tim may want to make some but I was more interested in the questions that the committee may have had in relation to other submissions it had received that we may be able to give advice on, and probably to express my deepest apologies for not being able to make a written submission—it just didn't happen.

THE CHAIR: That's fine. I know you're fully occupied.

Mrs Greenhalgh: Yes, sorry. I don't know if you want to open up to questions.

Mr Moore: I've got a paper on young carers and the impacts of health for these young people, so it's obviously a bit more specific. So if you had any questions specifically on Alex's presentation first, and then I'll talk about young carers—or I can do it around the other way.

MR SMYTH: Can you go back about three pages in your presentation—you ran through a list of things that we need to address. It's the one that had the word "spiritual" in it. It's three or four pages back.

Ms Cahill: Key recommendations in promoting healthy lives were development and implementation of national early childhood development policies and programs to ensure the enhancement of a child's physical, social, emotional, spiritual and cognitive development.

Mrs Greenhalgh: I think that's an interesting comment. I think now we've moved forward in the debate to be able to automatically, when we're talking about health, be thinking about the social determinants of health and how that interacts with the individual and their environment. I think, however, in terms of our practice we aren't there yet. We still, I think, believe that we're working with individuals in an environment of shame, blame—asking people to change their circumstances without necessarily having the skill development to do that.

Certainly with young people, particularly the age group that the Junction focuses on, which would be high-school/college-age children, I believe that they experience quite a deep sense of pressure around having to change their circumstances, and being a little bit lost in a physical, emotional, spiritual sense about how to actually achieve that. That's a large part of what we are trying to achieve with them.

We talk a lot about the social determinants—and everybody's happy to bandy that idea around—but I still think we're working in silos to address those concerns. So somebody is working on the physical aspect of their health—whether we're talking about the GP, or the hospitals and emergency departments—and somebody else is working on the emotional side of it with counselling services and those sorts of things.

The Junction comes across barriers to the way we work with young people all the time. Somebody's saying, "Well, we don't want to take responsibility for that because we're not really interested in the housing aspects of this young person's life." Well, the reality is that we all have to be concerned about that aspect of their lives, and we all have to—

MS MacDONALD: Taking a holistic approach.

Mrs Greenhalgh: It is. As much as we talk about it, because that is the philosophy of the Junction—and the whole team works with that theory—we quite often hit a lot of barriers, and that's a frustration that that team puts out. We'd like our young people to be able to access a range of supports—and they can within our building—but obviously we can't be everything to everyone.

MS MacDONALD: Yes, once they walk out the door it's not necessarily extended in society.

Mrs Greenhalgh: Yes. But you're trying to bring people into the fold of that practice rather than thought, and there's some resistance there.

THE CHAIR: Mr Smyth, are you finished with that question, or did you want to pursue it more?

MR SMYTH: I'd love to pursue it more. Richard Eckersley last week told us about what he called putting in place the ability to help kids develop what he called their moral compass. It's interesting that you use the word "spiritual". Obviously some of it's socio-economic, but is there something at the core of what you encounter? Is it a spiritual loss, is it emotional loss or is it just a combination across the board—different strokes for different folks?

Mrs Greenhalgh: People will have different ideas, I suppose, because we all come from different skills and backgrounds, but when we look at the Junction we talk about spirituality and how we foster that within young people. Quite often that's about assisting young people to identify—whether you call it their morals, which young people I think steer away from, because that's seen to be quite a stiff approach to their values, their belief system.

The reality is that a lot of the young people that we work with, which is actually a small representation of the young population in Canberra, don't believe in themselves. Nobody has actually ever put the time in to let them know that they are worthy of love, affection and comfort that perhaps isn't directly linked to sex.

THE CHAIR: Maybe even respect might be nice.

Mrs Greenhalgh: Yes.

THE CHAIR: Did you hear the evidence of the previous witness?

Mrs Greenhalgh: Yes.

THE CHAIR: I'd be interested to know if you had a comment on that just in terms of the incidence of depression and the relationship between that and also what you just said in terms of people feeling alienated—the impact of having been put into an institutional environment, which is basically what a school is, as well as possibly and potentially in a home environment where abuse of power is basically their experience of life. I guess I'm interested to know if you think that's a major issue in looking at health of school-aged children. It seems to me, listening to that evidence, that is quite central in some ways in terms of people's capacity to be resilient and to know there's a safe place to go if something is basically totally unacceptable—whether it's how the teacher treats you or something else. That's the other thing; it can be about the system itself. It can be abusive.

Mrs Greenhalgh: Exactly. And we see that in children's development through particularly the ACT government system; it's very obvious who will eventually go on and in which particular environment children thrive. Some children thrive having one teacher for that whole year, and it's usually because they get on very well with them; they have a respect for one another, and that teacher's fostering in them a belief that they are fantastic, they've got terrific attributes that they promote to the rest of the class, and that's fantastic.

Some children cannot stand to be in that environment, and when they get to high school they start to get it. They have seven different teachers across the day, they're not in the one classroom, they're chopping and changing, and they get to be socially interactive between them, and probably a bit naughty and do those sorts of things and develop friendships and thrive in that environment.

Many of them go on to a college environment where pretty much it's prep for university in Canberra. That's what it's about. It's about being able to work independently, with little or no direction in some instances, and you see children that thrive in the development of that. There are others that resist it the whole way through, and at different levels. They loved being in the one classroom, having one teacher, having a fantastic relationship and a safety net in that place. That was their safe place, particularly if home isn't fantastic. Then they get bandied around and they have to form seven different relationships in a day and it's too hard. It's too difficult. Then they're asked to just be a mini-adult, and maybe they're not ready.

Ms Cahill: I guess my best example of that—because I participated in the full service schools program and worked in a school in far north Queensland within that—was when I was working with most of the young people who'd been identified as at risk. What the teachers couldn't understand was this: I would have them for an hour a week over a couple of months and they'd come back to me and say, "Well, the behaviour's still there," like nothing's changed. I'd say, "Well, I'm sorry. I've been working with them for three months and they've been exposed to abuse for 13 years, but I am trying." But also I used to say to the teachers, "We only support them within the school environment as much as we can for seven hours a day." So there is, what, 16-17 hours that that child has to often go home and fend for themselves—seven hours out of 17; it's not enough. Do you know what I mean? Also, the school environment offers support, I think, in a very institutionalised way.

MS MacDONALD: It's very structured.

Mrs Greenhalgh: It's very scripted.

Ms Cahill: Yes. And teachers feel that they're doing—

MS MacDONALD: You know what to expect. You know that first thing you'll have assembly, the next thing you'll do this, and you have maths first thing in the morning, et cetera.

Mrs Greenhalgh: That's right.

Ms Cahill: But one important issue that I had was that one of the teachers had a big issue with one of the young men and he just kept saying to me, "I've tried this, I've done that, I don't have time, he's out of my classroom." I said to him, "Have you ever asked him what his favourite colour was?" He said, "I've got 30 kids in my class, I don't have time to do that." I said, "What's your favourite colour?" He said, "Blue." I said, "How long did that take?". What that did was actually showed that I cared about him, not his academics, not his behaviour. It just showed that I care about him.

As Mel said, a lot of young people have never been in a situation where someone has said to them, "Hey, I really like you"—like the previous presenter said—"You're a really cool person." I thought that was beautiful, because often that's all a lot of young people need to hear: "Hey, I really like you." Also, separating them as a person from their behaviour is very important.

Mr Moore: I think, from my experience in alt-ed programs, particularly a youth education program like Youth in the City, that's very much the situation with many of the students there. They're the young people that schools and the society have always said, "You're not going to achieve. You're not going to achieve." Yet in a situation where they're getting support, where they're getting care from both the teacher and the support workers there, they're thriving and they're achieving in ways that they would never have been able to before. So it is very much about the environment and about having those people there who do have that faith and do have that belief that there are inherent skills and goodness within that young person.

Ms Cahill: Separating the behaviour.

Mr Moore: Absolutely.

MS MacDONALD: How much of a role would you say the feeling of belonging plays?

Mrs Greenhalgh: I was going to say it's about community. If you think about a child that is able to achieve in our society, they will have had a sense of belonging to their family. That sense of belonging will usually involve a friend and extended family network around that particular family that they feel connected to. They're not just connected to mum and dad, or mum, or just dad; they have this whole other surround around them. Then they get into school and whether they become good at sport, or they become good at chess, or debating, or whatever it may be, a child that's supported in a stable family environment will be allowed to pursue those particular interests that they have. Again, it's extending their sense of community, and they belong.

If you have a child that thinks, "I don't think my family's right, but nobody else is saying that they're not, so I'm just going to hang out in here; I'm just going to go with the flow," when they get to school and they don't function in the capacity of 9 till 3—we do assembly, we do the health hustle, now we're doing maths, now we're doing reading, now we're doing this, and there's no flexibility in that—they start thinking, "I don't belong here either."

MS MacDONALD: If they're not the sporting type or they're not the—

Mrs Greenhalgh: Yes. If they're not the sporting type and their teacher is fully into sport, and that is a part of every day and they're the last to get picked on that team—and it's a great joke in movies; that's a reality in the school playground—they don't belong.

MS MacDONALD: I know, I've been there.

Mrs Greenhalgh: They get to high school and they haven't formed fantastic friendship groups. All of a sudden the clique is the clique and they're either hanging onto a clique—they know they don't belong; they're faking it the whole time—or they've just been left behind. They're the ones that get laughed at and picked on, the banana gets put into their bag, and they get pushed off the school bus. They don't belong.

Ms Cahill: Which is the depression stuff, like the previous speaker—

Mrs Greenhalgh: The depression stuff, and also high links to substance abuse—"How do I become cool?"

Mr Moore: Tony Vincent from Jesuit Social Services wrote a book called *Unequal for Life.* In it he looked more at lack of connectedness as being a precursor to violence, to child abuse, to poor health status, to poor education status, and saw that that lack of connectedness was really one of the most powerful factors. He was able—I'm not sure how—to get statistics from DOCS, the family services department, in a whole range of different areas. He was really able to correlate areas where the communities had a high level of resilience within themselves, but also a high level of connectedness. He showed that, even within pockets where there wasn't social disadvantage, there was a high incidence of abuse, neglect and poor health status. It was as a result of that lack of connection with family, with community, and with the environment within which they live. So it was quite striking, that sort of information.

Ms Cahill: Which leads to no connectedness within themselves.

Mr Moore: Absolutely.

Ms Cahill: So no stability, no sense of self.

MR SMYTH: Is there a relationship between the number of siblings?

Mr Moore: I think the connection within the family unit was a determinant. But more important was that family's connection to the community—be it neighbours, be it local service providers; but, more importantly, other people, be they volunteers or people within that community responding to the needs of the community. Some of the

suggestions that he made were very much about fostering relationships rather than having a lot of people coming in providing services and then leaving because it wasn't community focused and community driven.

MS MacDONALD: I heard somebody saying on the radio that, with Canberra being the way it is and you often don't have the extended families in Canberra, if you're a first-time mother or a young mother, you don't necessarily have the people that you can actually call on to say, "How do I do this? The baby won't stop crying." I don't know if you can comment, but do you think that's a situation which is getting worse in Canberra or is it about the same as it's always been? Is it a Canberra phenomenon, or is it a societal phenomenon?

Mrs Greenhalgh: No, I think it's rife. When you have a look at our community, historically what was community, I think what we're trying to find now is a new sense of community that doesn't involve women being in homes, where people are generally working and having families, and having to find a new sense of how to develop community. I really don't know what the solution is, because it takes a lot of energy on people's behalves to get involved. You can't expect to sit in your loungeroom, and have young children, and wait for it to come to you. I think that it takes the energy to get out and go and do that.

MS MacDONALD: Find the support networks.

Mrs Greenhalgh: Yes. I have a look at an example of a young family that we've been doing some work with. Both the parents are trying to work, and they're under 25, and they have two small children, one of which is five, one of which is three. The five-year-old at the moment hates mum—and dad—because she can't do school canteen because she can't get away from work to do it because it's an inflexible arrangement and her work doesn't permit it. Her mum can't go to the school assemblies when they're singing, like the other mums.

So, in terms of that child being in a school environment, you're starting to feel that you're out of place. The children probably aren't talking about how many parents weren't there. Those children are focusing on how many parents were there, and just assuming that because they saw five parents that everyone's mum and dad was there except for theirs. That's a real struggle for them, because that's a part of that child's community, and they're not there, and that child's suffering as a result. So they're trying to think of alternative strategies around that. But I think it's a national phenomenon.

Mr Moore: To railroad discussion to young carers, obviously that's one issue.

Mrs Greenhalgh: He does this all the time!

Mr Moore: A lot of the families that I've spoken to where there's caring, where there's someone in the family with enormous responsibility, that breakdown of the family has huge impacts because, traditionally, grandparents or aunts and uncles or whoever can come in and take some of that pressure off. In the climate that we've got now—and I don't think it's just the ACT—that extended family support isn't there, which means that parents are often having to take that on. More often in the situation where both

parents are needing and wanting to work the responsibilities are then placed on the child, which obviously has great impacts for these families in particular.

A lot of young carers and their families have said, especially around illness and disability, that the rest of the communities aren't responding any more, because illness and disability have got the stigmas attached to them, which means that community support is quite low because people don't necessarily want to be involved in that sort of area.

So that breakdown of the family has an impact, and also the breakdown of that sense of community. Whereas in the past communities seem to have responded more positively to families where there was some sort of disability, that's sort of breaking up a bit and it's quite ironic that at the same time, as a result of the de-institutionalisation, more people with illness and disabilities are put into the community. So the families are therefore struggling as a result of that phenomenon. So it is quite difficult, but it's very much as a result of those traditional institutions, the family and the wider community.

THE CHAIR: I notice that you spoke about the need for youth policy. That's actually come up before, with indicators and so on. So I just want to let you know that we've certainly taken that on board, and that other people have mentioned that.

But if we have this idea of a policy—and you talked about an international process that's occurring as well—would you see that the indicators are already pretty well developed, or do you see a need for us to do local work in deciding what are the really relevant indicators for our community? I'm assuming government would have to develop targets and time frames, et cetera. But do you think there's local work needed on indicators?

Ms Cahill: Yes, I think so, because I think all different cities or areas have their own issues, and I think you have to develop the local priorities that reflect national ones as well. They go hand in hand. Do you know what I mean? I think it would have to be conducted in that way.

MR SMYTH: I want to get on to the policy thing again—the physical, emotional, social, spiritual and cognitive. What do you mean by "cognitive"?

Ms Cahill: The learning development at school.

MR SMYTH: We don't have a policy on how people learn?

Ms Cahill: I guess it's looking at opening that up, that there are different ways of learning, because I think mainstream education tends to focus on set ways of learning. Not all children are visual, they may be—

Mrs Greenhalgh: Not all children are auditive.

Ms Cahill: That's what I'm talking about, that there are lots of different ways of developing a child's learning skills, not just through reading and writing.

MR SMYTH: Are we teaching them, even in the mainstream way that we do currently, to learn properly?

Ms Cahill: That's a loaded question.

MR SMYTH: Well, I think it gets to the guts of what we're talking about, because I don't think we are.

Ms Cahill: No.

Mrs Greenhalgh: I think that the first part there that you need to do is acknowledge the different learning styles, and actually you need to do some work investigating how it is that a child learns. Quite often, when you get a gifted teacher in the classroom, she will make the effort to do that over the period of learning.

THE CHAIR: Or he.

Mrs Greenhalgh: Or he, sorry—well, it's female-dominated, except at the management level. I'll make that clear. So he or she will learn those different styles and actually try to accommodate and encourage children and young people to learn and play in ways that will actually allow them to retain that information. Again, that's in very special circumstances where, again, you're relying on an individual personality to have a passion about what it is they do.

Ms Cahill: For example, if you look at a Steiner school, they don't actually encourage children to read other books; they actually encourage them to learn how to write, so the first reading they ever do is their own writing, and I think that's wonderful. I think that's really interesting.

MR SMYTH: I know the move where we've got kids that aren't good readers is not to go back to ABCs; they actually as a first step are now taking them back to the gym, where they're developing their fine motor skills. The old adage that you've got to crawl before you walk is actually true.

Ms Cahill: A lot of literacy and numeracy stuff also goes back to what we were saying before: if you don't have a spiritual base or a stable base inside yourself, if you don't have self-esteem, it's very hard to learn because you're so afraid of making mistakes that it's much easier to just to put it aside and not even address those issues.

MR SMYTH: All right, that brings Richard Eckersley up again and what he said last week about this moral compass. So teaching of, say, comparative religion in schools is good. Some of our primary schools are teaching philosophy, so they're actually teaching kids how to think, and logic it out rather than rote learn it out.

Ms Cahill: Exactly.

THE CHAIR: But if kids are feeling shitty about themselves then that's not about them doing that; that's about looking at the adults around them that are treating them in a way that makes them feel like that, isn't it?

MR SMYTH: But some of it is that the kids don't get the example from the adults and we've got to give them the toolkit so that they can actually develop their own ways of working out what's—

THE CHAIR: Yes, and a sense of justice.

MR SMYTH: What's right, what's wrong, a sense of justice and all those other things.

Mrs Greenhalgh: That's right, and you can do that by exploring. Some of the most simple things that we do are: this end of the room is strongly agreed; this end of the room is strongly disagreed. All right. And you do it at the beginning of your course and then you do it at the end, and then you say to people, "It's okay to think differently from one another; it's okay for you to strongly agree that at the time all such and such should be put in jail." Somebody else stands at the other end and you actually get into that, and then you get them to have a debate about why I believe this.

When they start saying, "It's because my dad said that de de da," you can say, "Okay." Somebody else says, "Well, my mum doesn't say that" or "My dad says" and they start looking at—

MR SMYTH: So it's about giving them the toolkit so they can build their own theory of life and actually learn how to defend it and expand it, and change it and justify—

Mrs Greenhalgh: That's right. Those in a stable family are invited to have those discussions around the dinner table. "I said such and such to this boy," and you get challenged on it across the table.

MS MacDONALD: Do you have an ambivalence corner?

Mrs Greenhalgh: Yes, we do; that's the middle.

MS MacDONALD: My parents don't care.

Ms Cahill: Responding to your point before, Kerrie, about the adults that are surrounding the children: I think the scariest thing I witnessed within the education system when I was working at the school was that the new teachers had just come out of university, obviously with new initiatives, new ways of working with young children, and they were sort of given a mentor as one of the heads of department who'd been in the system for 20 to 30 years. I saw the change in that young teacher over a six-month period of time; they were working exactly the same as the head of department was, who'd been in the system for 20 years.

To me that was a really scary process, that even the teacher didn't feel confident enough to stand up against the system and say, "This is not right. I've actually got new ways of doing this," because they were always told, "It doesn't work; tried it before. This is the way you do it."

THE CHAIR: Well, that's why I find the last evidence interesting. That acronym for real cool person, that stood for responsible citizen program, interests me because I think it's about actually, in an interactive way, dealing with those issues of respect and

acceptance of different views and so on. But I do wonder what happens to a child that has that experience and then goes home—

Mrs Greenhalgh: And then tries it at home and home challenges it.

THE CHAIR: It would become very difficult. But I think that's where we should stop. Thank you very much for addressing the committee.

Mr Moore: In a month's time—hopefully sooner than that—Carers Australia will be releasing a report on young carers and impacts. Do you mind if the ACT Young Carers Network came and then gave evidence on that report, also just adding to the information you'll be taking today?

THE CHAIR: I think the committee would probably welcome that. Is that correct?

MR SMYTH: We'd love to see that.

THE CHAIR: So that's fine.

ROSE COSTELLOE was called.

THE CHAIR: Thank you for taking the time to address the committee. You should understand that these hearings are legal proceedings of the Legislative Assembly protected by parliamentary privilege. That gives you certain protections but also certain responsibilities. It means that you're protected from certain legal action such as being sued for defamation for what you say at this public hearing. It also means that you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter. Before we start could you please state your name.

Ms Costelloe: Rose Costelloe.

THE CHAIR: You're appearing on behalf of yourself, as I understand it.

Ms Costelloe: That's right, yes.

THE CHAIR: We have already received part of your information. We're treating that as an exhibit that will help inform the committee in their work. If you'd like to address the committee, that would be great.

Ms Costelloe: Thanks for inviting me today, Kerrie. Kerrie invited me along to speak with you. I preferred doing that to writing an application, because of the time factor at the moment in my life. That was following her visit to the ACT health promoting schools website which we launched in March this year. We developed it through a Healthpact grant.

I come from an arts background. I've been working in community cultural development for nigh on 30-odd years and shifted over quite easily to community development work in health in 1999 through taking up a position with Healthpact as the project officer of their pilot health promoting schools project in the Tuggeranong Valley, which involved four schools and went for two years. It was a very well funded project, and funded to succeed.

At the end of that pilot MacKillop Catholic College, which was one of the participating schools, invited me to stay on as a consultant. Kambah High, which was another participating school, invited me to take part in the development of the ACT health promoting schools web site. I've worked in this area for nigh on three years now. I was pleased Kerrie invited me to come along, because I think it is a very cost-effective and well-coordinated, effective way of servicing the health needs of our schools and their communities.

Do you know what the health promoting schools model is, or should I explain it to you?

MR SMYTH: I think I know.

Ms Costelloe: You know, yes, because you were involved in the rewards. Health promoting schools is a World Health Organisation model that was developed in the 1980s in Europe. The guts of it is bringing families, students and staff together to look at

their health issues, to look at the resources available to them in their school community and outside their school community to bring to bear. It sounds pretty dry, but it's a very effective way of addressing a range of health issues. It offers a model for families to be involved in schools. In that sense it offers scope for schools to tackle some of the health issues of their staff as well as the adults in their community.

We know from our dealings with kids in school that kids who smoke usually come from families who smoke. So there's not much point dealing with the kids who smoke unless we talk to the families as well. If we start saying to the kids that they're idiots for doing it, we're not doing them much of a service or giving them a way to deal with the fact that they go home to a smoke-filled house every night or that their families smoke and they're probably quite sensible, normal people, and they do it for the same reasons as their kids do—largely stress related.

The school setting offers a way of looking at health, which is what you're looking at. What is involved in the school setting is the curriculum that's taught. The kids can come out of school having a whole bunch of skills that they can implement in their daily lives. One of the basic skills you learn in primary school is washing your hands. Recent US military research discovered that if people wash their hands properly—and that's not just under the tap and under the drier, but with soap, washing your thumbs and your nails—five times a day, the rate of cross-infection drops dramatically, and with it the rate of ill health. Kids learn things like that at school. So curriculum in school offers great scope for learning about a range of illnesses and a range of preventative health approaches.

The social and physical environment in a school also contributes to the health and wellbeing of young people. I'll use the smoking example, because it's one we all know. If you've got a lot of places in schools that are shut off from view, you can get a lot of kids hanging out there smoking. One of the most obvious things to do if you want to cut down smoking in a school is to knock down the toilet block. The trouble is: what would you do then?

The physical environment can lead to good health or it can be lead to bad health. For example, shade is a huge issue in schools these days with skin cancer, especially in the ACT because we're so high up.

The social environment relates to stuff like bullying and harassment which go on in our schools. That is very well documented. This is especially so of attractive kids or kids who are different to the other kids. Lots of work is being done about bullying and harassment in schools between schoolchildren, between staff members and schoolchildren and between staff members and other staff members. Interesting work is being done there.

The other aspect of the school setting is what community services are available to schools. I don't need to tell you what those services are, because you've got them all coming here and talking to you over the next few days. I imagine you've got just about every health service in the ACT coming along. Those are the services that health promoting schools accesses.

When MacKillop developed a smoking cessation program called Unhooked, we contacted the Cancer Council and they came to every one of our development meetings. They're involved in the piloting of the program and the documentation of the project as well. A whole range of services—Family Planning, you name it—can become involved in school settings and bring valuable research and information into the setting.

Community involvement is huge. The scope for it and the barriers to it are also huge. Parents want to become involved in their kids' education, but often there's a whole lot of factors militating against that, the largest one being that most parents, apart from the huge number of unemployed people in Canberra, work. Often school functions and school interviews and so on between parents and teachers don't occur in work friendly hours. So it's down to schools and their staff to work outside school hours to enable that to happen. Unless flexibility is afforded by employers—meaning DECS, the CEO and the Independent Schools Association—that's not likely to happen. But it does happen, as we know, and it's a really important thing.

There is also a shifting barrier. Teachers think that parents don't care, because they see their kids coming to school stoned, they see them coming to school without breakfast or they see them coming to school with lice. They think the parents are bastards who don't care. Vice versa, parents look at teachers and think that they're standing on pedestals making judgments about them and their kids. Those barriers are quite real, but a good developing project can break down a whole lot of that by bringing staff and parents together. The whole notion behind health promoting schools is staff and parents working hand in hand for the benefit of the kids, as well as for the adults' own benefit.

The basic tools you use in the health promoting schools process is surveying those three key stakeholders—the kids, the families and the staff—and auditing what the school offers. You're looking at what the health issues are. By and large, in my work in the ACT in health promoting schools, the issues are largely drugs—which include tobacco, alcohol, illegal and prescription drugs—and nutrition, which covers what the school curriculum offers, what the kids cook in cooking classes and what's offered in the canteen. Is it all just high fat, sugar and salt content food or is there's a balanced choice menu?

Another growing area of great concern which you must have heard about—it's in your papers—concerns eating disorders and the relationship of nutrition and food to eating disorders, which sometimes are quite peripheral.

Another issue that comes up time and again is sun protection, skin protection. At MacKillop and Kambah we've put into what we call Wellspring a whole bag of issues to do largely with wellbeing, which is one of those dreadful catchphrases in health at the moment. Wellspring relates to some mental health issues but also non-mental health issues such as material deprivation and emotional deprivation, which cut across all classes. The research I've done in Canberra indicates that kids from extremely wealthy public service backgrounds can be emotionally deprived kids who don't spend a lot of time with their families and that kids who come from single-parent families can be just bowling along in life.

In Wellspring, issues that families identify in staff include anger, bad behaviour, depression, sadness. I'll get back to them in more detail in a minute.

Other issues are safety and environmental issues. I'll get into a bit more detail about them in a minute.

Once you get those issues coming up, you can look at what the school already does in those areas. It's surprising that schools are often doing a heap. In my view, teachers and support staff in schools are champions. They're at the frontline of what's going on in our society, which is meant to be a fabulous technological revolution that's going to lead to more leisure but is in fact, as is becoming increasingly more obvious, leading to high unemployment and high rates of depression. That is not just technology but a whole bag of global changes that are going on now.

What you look at then is what the school has to offer and what it's already doing and what the community services have to offer—what you've got in your community. In Canberra we're pretty well resourced. We're not in a whole range of areas. For example, for kids with huge behaviour or psychological problems there's really only one place they can go, which is Galilee, and once they've been to Galilee and done their time there there's not really anywhere else. In New South Wales they have five places where kids in great trouble like that can go. They make the difference between letting a kid move along a path to criminality or self-harm and intervening in a positive way that makes some difference to that kid. We're pretty well resourced in most areas, but there are some big gaps still.

So that's the model—surveying, auditing and then, once you've got your picture of what's available to bring to bear on the issues, planning and action. You work together with your kids, your families and your staff.

There is a pivotal role for research. It isn't just a matter of people saying, "I've got a good idea. Let's do it this way." There's a lot of stuff available now, particularly on the Internet. Technology is a double-edged sword. It's got great aspects as well as some dismaying results. Current information about a range of health-related issues can be accessed within school settings as well as through service-based organisations. There are ways of approaching issues that are proactive, preventive and empowering rather than illth focused. I don't know whether you've been exposed to the term "illth. It's the opposite of health; its ill. A lot of our approach to wellbeing and health is an illth approach—we're very sick; we've got all these problems. Often after the horse has bolted, expensive experts are brought in to maintain programs that ordinary people wouldn't have a hope of maintaining, whether they wanted to or not.

The Health promoting schools model is a model that can be adopted. It isn't a mickey mouse dumbing-down program. It is based on solid research and facts.

Another area is ongoing consultation. Consultation is time consuming. A lot of politicians don't like consultation. I won't go down that path. A lot of politicians do like consultation, and we've seen some fantastic results. One of the articles I gave you is one I wrote about a process undertaken by Berkeley University in the early 1990s, at the behest of the Californian government, to develop a resource for poor families in California to access health services.

They developed a fabulous design by Saatchi and Saatchi, a beautiful million dollar resource. Being a research organisation, they decided they'd better test it with the punters. When they tested it with the punters, the poor families in California, they said, "It's rubbish. We don't want to know that information. Those people don't look like us." They were asked, "Okay, what do you want to know? Let's get some pictures of you in there." They spent another year consulting with poor people in California to find out what it was. They got some fantastic results from that. There's a lot of stuff on the Internet about that project and the resource they produced, in different languages.

Consultation is great. It needs to be offered in an open-ended framework so that you're not saying, "We've got these issues of drugs, nutrition and sun protection. We want to know what you think about them." Some people might be experiencing vastly different health issues. Aboriginal communities or migrant communities are very specific and very interconnected with a whole range of things. They don't neatly fit into the box of drugs or the box of mental health issues. That's where your consultation is invaluable. It can draw out those specifics. It's fascinating too if you're working in that area. Once you get up a program that's soundly based on consultation, people use it and it works. Time and time again it has been shown that that happens.

Solutions should come from within communities, recognising social capital where it exists. A lot of garbage is talked about social capital in the ACT. I get offended by it. I don't know how many projects I've worked on that have been funded by government and have started to succeed after 18 months or two years when, whoops, the fashion has changed. My projects are always very well researched and always very successful. So recognising social capital where it exists and continuing to support and resource its growth are important.

We should be moving away from imposing more rules or laws from the Legislative Assembly and putting financial and human resources into enabling staff, students and their families to take real time to consider the model and put time into addressing their health needs in positive and practical ways.

Where is health promoting schools happening? All over the world, in developing and developed countries. There are 300 health promoting schools in China. There was a Chinese delegation of six people at the national health promoting schools conference in May in Queensland that I went to. They're doing really impressive work.

It's happening all over Australia throughout schools, supported by states and territories and the national Health Promoting Schools Association, so there's a big network of websites and information.

In the ACT it's happening through the Healthpact pilot program, which involved Lanyon and Kambah high schools, Mount Neighbour Primary and MacKillop. It was funded to succeed and was inclusive of the three systems of education. It wasn't just government education and it wasn't just private. It was inclusive and people talked to each other.

I guess you are aware of the long-term Commonwealth-funded drug education program that DECS, the CEO and the Independent Schools Association are supporting and implementing in the ACT. You might not know that the Commonwealth national framework for sexual health will be introduced shortly. Again, that is based on

longitudinal research into the sexual lives of young people in Australia. It's framed within an action research health promoting schools model. That will be implemented next term by DECS, the Catholic Education Office and the Independent Schools Association. I did have some examples. If you'd like to jot the web site address down, you'll get some nice examples there. I saw in the stuff you sent me that you would like to see examples. It's www.acthps.org.au.

MR SMYTH: The spread of health promoting schools across the ACT from the pilot is a good thing?

Ms Costelloe: I think the pilot helped a bit, but I think the DECS program, the drug education program, has been the largest proliferator, because there are two people on the staff in DECS and Louise Stokes at the CEO to go out to schools and to assist them. I think that's encouraging. They're doing in-service PD training of local convenors within schools and getting a lot of support for people.

MR SMYTH: You said the pilot was funded to succeed.

Ms Costelloe: Yes.

MR SMYTH: What does that mean?

Ms Costelloe: Each of the four schools was given $4,000, largely for the use of teacher release. Staff were able to take time out to look at the model and to start the work of engaging with their families and with their students. I don't know how well you guys know schools these days, but they're up against it for time. wise and Staff do lots more than they're paid for. The schools were given money to release them for time to pursue research, study and implementation of a new model which isn't inimical to their existing work processes but which supports them and unwraps things they're already doing. One of the big things in schools is morale. They're up against it. They're in the frontline of what's going on in our communities.

MR SMYTH: Was the $4,000 for the schools adequate?

Ms Costelloe: For a two-year project, I think so. All of the schools spent it. I've tabled the report, so you can look in there. Yes, they did find it very useful. They said it that if they hadn't had that money they wouldn't have been able to do what they did. They all did champion projects. They didn't just start on the consultation survey, auditing and planning; they actually engaged in projects.

MacKillop, for example, started their drug policy way before anyone else in Canberra. Kambah did Caring for Kambah Day, which was a whole environmental thing where the families and the kids got together and painted seats, planted trees, put seating around trees, cleaned up the classrooms, put murals on walls—beautiful stuff. They made the school beautiful and a nice place to be. If you have been to a lot of government schools, you will know that they can be pretty dismaying places to be in.

MR SMYTH: The competition that Healthpact promoted—

Ms Costelloe: Healthpact didn't promote that. Healthpact wrote a number of letters querying the wisdom of a competition around the health promoting schools model. The Health promoting schools model is based very soundly on cooperation, collaboration and a notion of working together, not against each other.

MR SMYTH: Sorry, I meant Healthy Cities. Was the competition worth while in getting people out and rewarding them for success?

Ms Costelloe: I don't know about that.

MR SMYTH: Or would the money have been better spent by putting it into the schools?

Ms Costelloe: My personal view—and I think you'll find letters from Healthpact on record as well—is that money is better spent resourcing all of the schools, perhaps in regions. I made some recommendations at the end of the pilot. I would like to see regional support for schools. At the moment Jennifer Armstrong at DECS and Chris Conti are the only two people supporting 300 schools in the ACT, including preschools. That's nuts. That's not funding to succeed, is it? They're doing a brilliant job, but they're not going to last for long. One of the things about schools and about people and kids is continuity, not a dyslexic notion of the people coming and going out of their lives all the time, coming in with energy and dying or leaving, as in DOCS in New South Wales.

THE CHAIR: We'd better wrap up. We're well over time. Thank you very much. I appreciate it.

MICHAEL FLOOD was called.

THE CHAIR: Before we start, you should understand that these hearings are legal proceedings of the Legislative Assembly, protected by parliamentary privilege. That gives you certain protections, but also certain responsibilities. It means you are protected from certain legal action, such as being sued for defamation for what you say at this public hearing. It also means you have a responsibility to tell the committee the truth. Giving false or misleading evidence will be treated by the Assembly as a serious matter.

Thank you for coming to address the committee. Would you state your name and the capacity in which you appear, please.

Dr Flood: My name is Michael Flood. I am the Sexual Health Promotion Coordinator at Family Planning ACT.

THE CHAIR: Thank you. Would you like to address the committee?

Dr Flood: Indeed. What I am going to do is focus on four emerging health issues for school-aged children that Family Planning is concerned about. Our awareness of these issues arises in a number of ways. One of those is through our contact with school-aged children who come to our clinical services, who come to our clinic seeking advice or information. Also the school education program, in which I and other members of our education section are involved, and our contact with doctors, nurses and other health professionals has made us aware of these issues.

I mentioned four issues. The first one is sexually transmitted infections. Rates of sexually transmitted infections are increasing in the ACT, and they are concentrated among young people. You might think that our school-aged children are too young to really face the risk of a sexually transmitted infection, but the research we have shows that that is not true.

For example, a recent national survey suggested that 20 per cent of year 10 students, so one in five year 10 students, had had sexual intercourse, and one in two, 48 per cent, of year 12 students had had sexual intercourse. Regardless of your feelings about school-aged children being sexually active, the facts are that one in five by the end of year 10, and one in two by the end of year 12 have had sexual intercourse.

The most common sexually transmitted infection (STI) in the ACT is chlamydia, which can cause infertility in both women and men. There were 226 chlamydia diagnoses last year, and 119 the year before, so there was a 200 per cent increase last year over the year before. It is particularly worrying that the bulk of those diagnoses were among young people.

We do not have age breakdowns for ACT diagnoses of chlamydia, or at least Family Planning doesn't. However, in Victoria, at least, 15 to 29 year olds accounted for 76 per cent of chlamydia notifications in 2001. There is every reason to think that ACT patterns are likely to be similar, so chlamydia is likely to be concentrated among younger sexually active people. Young people are also over-represented among those being diagnosed with genital warts, genital herpes and other STIs.

MR SMYTH: Is there a breakdown available of male and female statistics?

Dr Flood: I will see if I can find those figures. I was not able to find decent age-stratified and gender-stratified stats. Essentially, what you get are annual cumulative stats, such as the total number of diagnoses in the ACT, and it is much harder to get the breakdown. *Communicable Diseases Intelligence* sometimes wants to charge for those figures, and that becomes a barrier.

School-aged children certainly are at risk of sexually transmitted infections and, as I said, those infections can have long-term consequences for their fertility, but also for their physical health and their relationships. What is troubling for Family Planning is that most secondary school students do not see themselves as at risk of being infected with STIs. Generally, they have good knowledge of HIV, but their knowledge of STIs, of sexually transmitted infections, is poor.

For example, most 16 year olds cannot name two or more STIs, they cannot identify symptoms for particular STIs, they cannot name the symptoms for which they should seek help, and they do not know that they could have an STI without having any symptoms. Family Planning believes there is much more work to be done to raise the awareness of school-aged children about sexually transmitted infections.

The second issue is homophobia and same-sex-attracted young people. We know that about one in 10 secondary school students is not exclusively heterosexual. One in 10 students is sexually attracted either to only the same sex, or to both sexes. This is not the same as saying that one in 10 students is gay, or one in 10 students is lesbian. This simply says that one in 10 students is not exclusively heterosexual. They are either attracted to both sexes or to only their own sex.

Again, there was a national survey in every state and territory in Australia of 3,000 young people in years 10 and 12. Eight to 9 per cent of those 3,000 young people had experienced sexual attraction to the same sex. In fact, 3 per cent said that they were exclusively attracted only to the same sex, so some proportion of those will grow up to be gay or lesbian, one might think.

While 10 per cent of secondary school-aged children are attracted to the same sex, typically they are marginalised, they are silenced, and they are culturally invisible. In the ACT, there are almost no support services for same-sex-attracted young people. In schools, same-sex-attracted young people are routinely told that their feelings and desires are disgusting, dangerous and unnatural, just a phase or non-existent. They are denied some of the rights and privileges available to those in heterosexual relationships, and they are subject to verbal and physical harassments and beatings.

Homophobia means fear and hatred of homosexuals, and incorporates anti-homosexual beliefs and prejudices. Homophobia is pervasive in ACT schools, it is institutionalised in the curriculum, and it is common in the wider community. Family Planning ran focus groups among same-sex-attracted school-aged children in 2000, and it found that those children feel very unsafe at school. They reported never hearing positive messages about same-sex attraction or homosexuality, or indeed hearing any information at all. Some of

those children tried to talk to teachers or counsellors about the issues they faced, and they were either silenced or fobbed off.

The result of these patterns is that school-aged children who are same-sex attracted show rates of depression, self-harm, and suicidal ideation—thoughts of suicide—higher than those among heterosexual youth. For example, gay young men are 3.7 times more likely to attempt suicide than heterosexual young men. Gay and lesbian students in schools show isolation, confusion, marginalisation, lowered self-esteem and poor school performance; high rates of personal stress, dropping out of school, homelessness, drug and alcohol abuse, and suicide.

There is, of course, a positive and supportive adult gay and lesbian community. However, adolescent gay men and lesbians have far less access to that than do adults. Typically they are too young to get into a gay bar, for example. They are too poor to do that. Most gay and lesbian groups cater for older individuals.

Recognising these health issues, Family Planning ACT began a project in 2000 called "the two in every classroom project". The two in every classroom project promotes the health and increases awareness of the needs of gay, lesbian, bisexual, and transgender young people. It began with those focus groups I mentioned—running focus groups with school-aged, same-sex-attracted youth. It then developed and implemented training programs for teachers, school counsellors and youth workers, and that work continues.

This year, Family Planning ACT began running a support group for same-sex-attracted school-aged children, and this meets fortnightly on the Family Planning premises. I have attended the last two meetings of this group. This group provides a space in which young people can meet, share stories and problems, and build small communities of support and health. It is also meant to improve access to clinical services and information. That is why we meet on Family Planning premises. That is to better serve the health needs of those same-sex-attracted school-aged children.

MR SMYTH: How many students are attending?

Dr Flood: The numbers are between about seven and 12.

MR SMYTH: Good.

Dr Flood: Yes. It is a fortnightly evening meeting. In fact, one of the next meetings is not going to be at Family Planning, because they are having a movie night that is going to be at someone's house. That will be a social event, but they will continue to have the meetings at Family Planning.

Family Planning, recognising the problems that face same-sex-attracted school-aged children, believes that it is critical for school curricula to acknowledge and address sexual diversity, and for school anti-bullying programs to include homophobia in their understanding of bullying, and in their policies in response to bullying, given that homophobia is often the content of, and the motivator for, some forms of bullying.

The third issue is access to comprehensive sexuality education. Sexual and reproductive health is a key element in school-aged children's health, wellbeing and empowerment.

What does sexual health mean? Some basic things that sexual health can include are feeling comfortable and assured about the changes of puberty, and the changing nature of relationships and emotions associated with those changes; having the personal skills and confidence to resist pressure to have sexual relationships before one is ready; having respect for the needs and views of others and for the different nature of others; feeling happy and supported in one's sexual identity; having correct information about fertility and contraception; and feeling able to use that information in personal decision making.

We also know that sexuality education has benefits, both for school-aged children and for the wider community. For school-aged children, such education enhances their personal development, their self-esteem and maturity, their personal decision-making skills and their self-management skills. School-aged children who participate in appropriate sexuality education become more knowledgeable, more aware and more self-confident about themselves and their social relationships.

Sexuality education also benefits the community in that it lowers rates of STIs, reduces the numbers of unplanned and unwanted pregnancies, lowers the numbers of sexuality-related health problems, and lowers rates of sexual violence.

Adolescence, of course, is the period when many young people first become sexually active, and I remind you of those statistics I mentioned earlier. Therefore, it is important to foster healthy practices and healthy understandings from the start, so they are more likely to be sustained throughout adult life.

Family Planning is aware that some parents and teachers are concerned that providing sexuality education, for example, in high schools or in colleges, will lead to earlier or increased sexual activity. However, a recent comprehensive literature review of, I think, something like 47 studies in a number of countries found no evidence to suggest this. In fact, this review of studies found that sexuality education leads to a delay in the onset of sexual activity. It leads to reduced numbers of sexual partners, reduced numbers of unplanned pregnancies and reduced STI rates.

In other words, those young people who go through sexuality education are in fact more likely to delay sexual activity, and more likely to have fewer numbers of sexual partners when they do commence sexual activity. They are also more likely, when they do become sexually active, to avoid unwanted pregnancies and sexually transmitted infections.

Family Planning ACT provides sexuality education in Canberra schools. On puberty, contraception and pregnancy, on STIs and HIV, and on healthy and unhealthy relationships. We also provide professional development training to teachers, so teachers themselves are better equipped.

One of the standing committee's terms of reference is current practice in schools, and Family Planning ACT is concerned that, while sexuality education is part of the national curricula, Canberra schools face a range of difficulties in implementing and maintaining sexuality education.

For example, there is insufficient support for professional development among teachers. This is echoing the point of your previous participant. Teachers are faced with unrealistic and excessive curricular demands. Teachers are burdened with all sorts of social issues, as I am sure you are aware. Yet, given that we know that sexuality education is part of what is critical for children's long-term resilience and health, Family Planning, like everyone else, is saying that teachers should take this on.

Department of education policies quite rightly support the provision of information to school-aged children on pregnancy, contraception, STIs and HIV, so department of education policies quite rightly say, "Yes, this should be taught." Yet, there is a contradiction in department of education policies, because those young people who are sexually active and who wish to protect themselves and their partners from pregnancy and disease find that they are barred from accessing condoms in schools.

The department of education policy on AIDS education and condoms—in fact I have appended that to what I have given you—states that condoms are not to be made available in ACT primary or high schools, either directly or through vending machines, nor are outside agencies allowed to make condoms available. For example, if we demonstrate how a condom should be correctly applied, we have to make sure that all the condoms we use are then removed from the classroom at the end of the session.

The policy, in fact, has this strange focus on promiscuity. The word promiscuity appears in a few places throughout the page. There seems to be that assumption—that mistaken and debunked assumption, I would say—that discussing safe sex and making condoms available will somehow encourage sexual activity. We know that the reverse is true.

A worthwhile comparison can be made with the United States. In the United States, state laws decree in over 30 states that only abstinence can be taught in schools, that school students must be taught, "Just say no", and that is where the lesson should end. The United States, not by coincidence, also has the highest rate of teenage pregnancy in the Western world. In fact, its rates of teenage pregnancy are 10 times that of Australia.

MS MacDONALD: Do we have any stats on their rates of STDs and STIs?

Dr Flood: They are very high, again certainly higher than Australia, but not 10 times as high as those in Australia. The rates of teenage pregnancy are, though. The evidence seems to be that appropriate sexuality education does not encourage sexual activity, and in fact encourages delayed sexual activity and a smaller number of partners. In fact, promoting abstinence-only sexuality education means that you end up leaving students in the dark, and they end up making do with what they can, and getting pregnant and contracting disease.

Family Planning echoes the calls of a number of others over the last few months for condoms to be made available to ACT senior school students, for years 10, 11 and 12, through vending machines, but also free in counselling and home rooms. I believe it was Roslyn Dundas who was calling for this earlier this year.

THE CHAIR: The minister said they were available, but no-one was using them or something, but that would have been just in colleges, I think.

MS MacDONALD: Yes, she asked the question about colleges and high schools.

THE CHAIR: How do you separate year 10 from the rest of the high school?

Dr Flood: I was thinking about that when I wrote that this morning, and thinking that that is tricky. Speaking for myself, rather than for Family Planning, I have no problem with—

THE CHAIR: Just general availability in high schools.

Dr Flood: Yes, in high schools and colleges, given that, by the end of year 10, one in five students has had sexual intercourse, and they are not all doing that simply in year 10. I suppose I support a sort of harm reduction or harm minimisation approach, and I do not believe that making condoms available will lead to increased sexual activity among year 7, 8 and 9 students. It may lead to the occasional water bomb, but that is probably about as bad as it will get.

Ms MacDONALD: That is what the teachers are really concerned about.

Dr Flood: There are much more dangerous objects around for the students to pitch at teachers.

MR SMYTH: Zinc and a bit of sulphuric acid and you can do all sorts of things, get expelled from school even.

Dr Flood: Balloons are freely available. The final issue I will address—and it may be one of the hardest ones—is sexual coercion and sexual assault.

We know that girls and young women are at greater risk of physical and sexual violence than older women. The ABS national survey showed that 19 per cent—that is one in five—women aged 18 to 24 had experienced an incidence of violence in the last 12 months. It is very hard to find statistics for school-aged girls and boys, apart from those on sexual harassment. However, this and other studies did suggest that, for young women, that is women 25 and under, the risk of violence is three to four times that of the risk for women overall.

We do know, though, that school-aged girls and young women are subject to sexual harassment in schools and elsewhere, and subject to sexual assault. Typically this is perpetrated by males who are known to them, notwithstanding the stereotype of stranger danger.

Physical and sexual violence is a health issue in the bluntest possible sense. Among young women who report that they have been in a violent relationship, three-quarters have been slapped, kicked, hit with a fist, or something else that could hurt them, and half had been beaten, choked or shot at. Close to three-quarters had sustained injuries, and 16 per cent had broken bones, burns, broken teeth or had suffered miscarriages, so these are not necessarily playful slaps. It is also troubling that among school-aged boys, there is a disturbingly high level of support for the acceptability of forcing a girl into sex in certain situations.

For example, the Brisbane study showed that one in three year 9 boys believed that it was okay for a boy to hold a girl down and force her to have sexual intercourse if she has led him on. One in three boys ticked "yes" to that being acceptable. If the girl had led him on, it was acceptable for him to hold her down and force her to have sexual intercourse. One in five boys were not sure.

In a more recent survey of 15 to 25-year-old males, nearly a third agreed that it was okay for a male to force a female to have sex, again in one or more of a range of situations. You have a degree of tolerance for this violence. It is not the majority who believe this, it is one in three or one in five, but it is still a troublingly high percentage.

Family Planning ACT, in collaboration with the Domestic Violence Crisis Service and the Canberra Rape Crisis Centre, has been running violence prevention education in schools, high schools and colleges. This work needs greater support. It is often bitsy, isolated work and sometimes it is in response to unrealistic expectations that we can come in, run a 45-minute workshop and thus reconstruct an entire school.

For me, one issue that is particularly important is that often the work focuses on teaching girls how to be more assertive, how to say no, how to avoid dangerous situations and so on. I think we also need to invite boys to take responsibility for building non-violent and healthy relationships, and indeed to show boys the ways in which their interests are also at stake, in terms of the likelihood of their having respectful, healthy, trusting relationships.

To wrap up, in relation to the goal of assessing and promoting the health of school-aged children, I think there are important reasons to include sexual and reproductive health. A substantial proportion of school-aged children are sexually active and the vast majority, of course, will become so in their adult lives. Young people are at heightened risk of contracting STIs. The consequences of early and unplanned pregnancy are serious for young people, and are particularly limiting for them. They are also at greater risk of physical and sexual violence.

Finally, school-aged children are at a critical age. They are at the age in which they form the understandings and values which will shape their future social and sexual relations, so appropriate and effective sexuality education is an important aspect of their health needs. Thanks.

THE CHAIR: Thank you.

MS MacDONALD: I do not actually have a question.

MR SMYTH: Is it possible to get a list of those 47 surveys overseas?

Dr Flood: What I have given you is the relevant study by Grunseit at al. In the middle of those references cited is the one by Anne Grunseit, who is a Melbourne researcher. If you want, though, we have that journal, and I would be happy to send it to you.

MR SMYTH: Yes, if you would, that would be fine.

THE CHAIR: I am interested in your comment about the programs in schools currently attempting to deal with bullying. Have you any idea how many actually do include homophobia or sexuality issues?

Dr Flood: Family Planning has just put together a web register of all the bullying programs in the ACT. It is not a project in which I was involved, but my impression was that the majority did not address homophobia as an aspect of bullying.

THE CHAIR: That is a bit of an oversight.

Dr Flood: Yes. I should say this is a register of bullying programs by any organisation in Canberra, so Family Planning certainly sees it as critical.

THE CHAIR: Is that something we could find on the Family Planning web page?

Dr Flood: Yes. I can send you the details of that as well.

THE CHAIR: That would be interesting actually.

MR SMYTH: Siobhan might contact Brenda and find out whether they included it in their program. That would be very interesting.

Dr Flood: Brenda would certainly be familiar with the bullying register too.

THE CHAIR: Okay. I would like to pursue this further, but we really cannot, I'm afraid. I appreciate your help very much. It has been very useful. Thank you.

MAUREEN CANE and

LEE MAIDEN

were called.

THE CHAIR: Did you hear me read out before the statement about these proceedings being legal proceedings of the Assembly? Are you happy with that or do you want me to read it out again?

Mrs Maiden: No, we heard it.

THE CHAIR: Okay. We will commence straightaway. Sorry to have kept you waiting; I know that we are running a bit behind time. Please state your name and capacity in which you appear.

Ms Cane: My name is Maureen Cane. I am the chief executive officer of Communities@Work Inc.

Mrs Maiden: I am Lee Maiden and I am the program manager for school-age care at Communities@Work Inc.

THE CHAIR: Would you would like to address the committee?

Ms Cane: Yes, thank you. As you know, we did put in a brief submission. I know that you have had a lot on your plate and it is getting late.

THE CHAIR: No, take your full time. We are only 15 minutes over, so take the 20 minutes or half an hour that we were going to give you.

Ms Cane: Thank you very much. To clarify again who we are, just in case it has not been clear to everybody, Communities@Work Inc. is the new name of the Tuggeranong Community Service and the Weston Creek Community Service, which have now come together as one new organisation. In fact, from the point of view of money and staff, it becomes complete and official on 1 July 2002.

As we note in the submission, we currently operate 12 before and after-school care programs in the ACT, which is approximately 10 per cent, actually rather more than 10 per cent, of all the programs in the ACT, and we run two school holiday programs currently. Just to give you another feel for the numbers that we deal with, we average between 250 and 300 children on a daily basis who participate in before and after-school care programs, which is quite a number. We have programs in nine of the 18 public schools in the Tuggeranong Valley.

What we have found in putting programs on is that, where there is clear mutual understanding and respect between the educators on the one hand and our carers on the other, it makes our programs far more effective with respect to assisting the children who are there in the programs, particularly in the sense that if we are aware of issues that have happened during a school day, especially among children who have additional needs or

children with challenging behaviours, if our staff are aware of those things, then it makes it much more likely that they will be able to cope with issues that might arise during the hours that the children are there at school.

We regard cooperation and a cooperative and collaborative approach between educators and carers as highly desirable and as something that should be encouraged. We do not meet it all the time, unfortunately. Occasionally we have situations where 3 o'clock is basically the end of it for some teachers—and, quite frankly, I can't blame them in a number of circumstances—but where, in fact, time is taken or effort is taken to talk to us about what is going on in a daily and everyday sense, it makes things much better for children in our care over that period of time.

We also have a situation where both the nature of the venue for our programs and the equipment available can also almost make or break how good our services might be. One of the things that we have recommended here is that, when the government is considering school upgradings or new schools, the value of the before and after-school care programs which often happen in those schools be acknowledged right up front. Their needs may be for facilities, preferably an identified facility within the school framework, to be taken into account. For example, we are going to be writing to the minister for education, Simon Corbell, to urge him to make sure that in the new school complex that is going to be built in Gungahlin the needs of where there almost certainly will be an after-school care program, if not a before-school care program as well, be taken into account up front.

We are not necessarily talking about additional funds here. We are talking really about an attitudinal thing. It is a question of coming to grips with the fact that these programs do happen in many schools across the ACT, but sometimes, unfortunately, their needs are not taken into account, and hence both for staff and for children the outcomes aren't quite as good as they may be.

I am going to stop there. I am going to ask my colleague to elaborate on some of those points from an everyday experience point of view.

Mrs Maiden: Thank you. As Maureen said, the facilities are probably our strongest issue here. We only focus on primary age children. All of our programs are in primary schools. There aren't any after-school care programs available for high school children. I know that that is of concern to lots of families whose children go into high school, that they still don't feel that they are ready to be left alone.

Within our program, the venues for the nine schools we have vary from a school hall to a room that the school has allocated to us because they don't need that room any more, maybe because of the size of the school, or they do put a lot of importance on what we do. They are the programs that work really well, because the school has acknowledged that that is an important part of what they do. The children in those programs are usually very settled and you can walk into the program and feel that the children are happy and everything is working well.

A child that goes to before-school care may start at 7.30 in the morning, have before-school care, be at school all day and then go to after-school care in a hall where there might be 60 children and it is loud. They may have had a stressful day. They may have

issues that we don't know about because there isn't that collaboration between teachers and after-school care. A child might be having lots of difficulties in an area and we don't know that. That child comes to the program and exhibits challenging behaviours and quite unacceptable behaviours. When we start following through with those issues and try to help that family, we find out all those things are happening in the school as well, but we are not invited into that area, which is something on which we think there needs to be a bit more collaboration. There needs to be a partnership there.

Also, one of the recommendations was that after-school care fit into a school budget somehow, that training for their teachers in behaviour management, putting together policies, all those sorts of things that affect the children, should be part of our program as well, because they are the children that we are caring for in the afternoon, but in many cases, as Maureen said, 3 o'clock comes along and they are no longer their children.

THE CHAIR: What sorts of qualifications do people need to do after-school care?

Mrs Maiden: The coordinators of the program need their teaching degree or have to have a diploma in children's services. A lot of our coordinators have their teaching, so they are qualified, but they are not given the information they need about the children.

THE CHAIR: I understand.

MR SMYTH: There is a lack of continuity.

Mrs Maiden: Yes. I understand the situation from the schools' perspective as well. They are very busy. They have teachers get to a point in the day where there are other things they need to do. We have approached schools to be part of staff meetings, things like that, but even that is not so easy to do.

THE CHAIR: That would happen in the morning, too, wouldn't it? If the people doing the morning care know that a kid is in a bad space, they could let the teachers know so that that would be taken into account.

Mrs Maiden: I was reading some of the recommendations of the P&C. I know that behaviour management comes up in everything and is something that has been a focus of lots of schools, that they have particular strategies that they use. We try to follow up on what strategies they are using so that we can train our staff as well, but if they were included in that training it would be helpful to the children, because they would have that continuity from when they get to school to when they go home, be it before-school care, after-school care or within school; they would know that people are working together for their wellbeing.

The other area is the special needs subsidy scheme. We receive $13 an hour for a staff member to support a child with special needs within our programs. We have lots of children in our programs. I have about eight that are funded at the moment, and five of those children actually come from Malkara. They are transported from Malkara to our after-school care program, so the school certainly does not acknowledge the fact that that child fits into their school at all because they are using our after-school care program. At one program we have the disabled toilets don't even have hot water, and that child needs

to be changed regularly, which makes it very difficult, with the funding only being that $13. It is a wonderful scheme and we acknowledge that it is a wonderful scheme.

Ms Cane: It is a Commonwealth scheme. Essentially, what happens is that we actually have to hire another staff member so that it is one-on-one with a child with disabilities. Basically, as an organisation, we have taken the line that we will subsidise it. That is basically what happens because we receive $13 an hour for the staffer, but it costs us well over $15 an hour, plus on-costs. It is a good program. Clearly, it is something that the sector is lobbying the federal government about. But our concern is more that there is stress on the child being transported and then at the school itself the facilities really are not adequate and we have situations where our staff are literally nappy-changing a rather large child on the floor and things like that. That makes things very tough for individuals.

MR SMYTH: How many of the schools have deficient facilities?

Mrs Maiden: Mount Neighbour, because they have a special needs unit within the school, have a change area that is suitable, but it is not within our program. Two staff have to leave the program and go out of the room down to a change area to change the child and then bring him back, so I have to have additional staff within that program because our licensing requirements are that two staff members always be together.

MS MacDONALD: For how long does the after-school program go?

Mrs Maiden: It begins at 3 pm when the school finishes and goes until 6 pm.

MS MacDONALD: I imagine that in that time two to three nappy changes may occur.

Mrs Maiden: At one of the schools where there isn't hot water, we have had a special change table made for that child and we pay for those things as well. I have to be careful that my staff are not going to injure themselves, so we have to cover those sorts of areas. But there is no hot water in the disabled toilet.

Ms Cane: They cart it there, don't they?

Mrs Maiden: Yes, they do.

MS MacDONALD: Is there an issue with the hot water that the schools might be concerned about? Is it just an issue that the schools might be concerned about the kids scalding themselves?

Mrs Maiden: More than likely. I would say that that would be an issue, but I am sure that you are able to put temperature settings on things like that.

THE CHAIR: You can get special temperature regulators.

Mrs Maiden: That is right. They are issues that make it difficult. As I said, at the schools where we have a room that we use for after-school care, the children arrive at 3 o'clock, the room is theirs, all of their art work is there, something maybe they started the day before, they say hello to their friends, they are feeling very comfortable. If they are a bit down, they are stressed or they have a problem at home, it is very comfortable

for them to talk to the staff; they have got places they can go. If it is a school hall, it is different; they go into a loud, noisy area. It doesn't matter how many children are in a school hall, it is loud. It doesn't matter what you do, it's loud when children are around.

MS MacDONALD: It can be pretty cold, too.

Mrs Maiden: That is right, and at 7.30 in the morning it is not always the nicest place to be. We have become a bit firmer on that. We have been approached by a couple of schools wanting to have before-school care programs, because the need is just growing, and we have decided that, unless they can give us a venue that we feel is suitable for those children, we shouldn't really run one because it is not fair.

Ms Cane: Essentially, what has happened in the past is that we would have received a fairly informal request and we have basically then run around and tried to meet that request in a rather willy-nilly fashion. We are not prepared to do that any longer.

THE CHAIR: When you say no as you want the accommodation to be of a reasonable standard, do they then find the means to provide it?

Ms Cane: We don't know yet, quite honestly, Kerrie.

THE CHAIR: Has that just started?

Ms Cane: No, what we have said is that, if they want us to do it, we will be happy to do it, but we want basically a formal request which will give us an idea of the demand and how they would regard how the children should be appropriately accommodated in a before-school environment. We think they will get back to us, actually, because the demand is definitely there, we are sure it is, but we are seeking to say to the school—

THE CHAIR: You are asking them what they think needs to happen.

Ms Cane: Yes.

THE CHAIR: Are you setting them some standards as well?

Mrs Maiden: Yes, we have been approaching the schools a lot more, making ourselves known a lot more, that we really want to work together, we need to work together, for this child. On any issues I am having with the behaviour of children, I am approaching the school and talking to them and finding out straightaway, "Wow, have you got that child, that child and that child in your program? No wonder you are having problems." The staff are doing a fabulous job helping these children. Lots of families are very stressed by the time they are picking up their children at 6 o'clock of an evening. If their child has had a bad day themselves and they have had phone calls from the school about the child's behaviour—

MS TUCKER: It is miserable, isn't it?

MR SMYTH: It is never-ending.

Mrs Maiden: An example is a father that I had to contact just recently because his child's behaviour was becoming of real concern, he was hurting other children. The father, from my conversation with him, just wasn't coping at all. That ended up going through Family Services. The school knew it was all happening. We have now been able to help the family. I think that behaviour management is our largest problem. The primary schools find that as well, but for us having the facilities that we have is not helping.

Ms Cane: They could be better. I think we should say, however, that there are several schools with whom we have dealings who have been just wonderful. It makes such a difference if we feel that we're all pulling together to have the appropriate environments for the children in after-school care.

THE CHAIR: It is about the culture within different schools.

Ms Cane: Yes.

THE CHAIR: Mount Neighbour was mentioned to us. I do not want to go into individual schools particularly, so please do not answer if it is difficult, but it was mentioned to us as a school where there was a responsible citizen program or something like it. It is probably not called that, but it was a restorative justice sort of program. I was interested to hear that that was being tried. Do you had any comments about that? Are you aware of that program at Mount Neighbour?

Ms Cane: I wasn't, no.

Mrs Maiden: At Monash Primary School there is a special needs unit as well. I think that seven of the children from that unit are now attending the after-school care because of the care that is provided. The families are feeling very trusting, the children love being there and the staff do a fantastic job. A few of the children have special needs subsidy scheme funding there and the families are so grateful for what the staff have been able to do, the care that their children are receiving and how their children are just going ahead in leaps and bounds.

Ms Cane: And Monash is where there is a special room, which is good.

Mrs Maiden: The headmaster is so supportive; he is wonderful. The whole school is supportive.

MR SMYTH: What is the ratio of staff to kids?

Mrs Maiden: One to eleven. The other problem we have is that we are licensed, which is great that we are, but our licensing requirements aren't those that fit in with the school. There might be a sandpit at the school, but the school doesn't have to cover it or maintain it, whereas our licensing requirements are that we do. So the children can use the sandpit through the day, but at 3 o'clock they cannot use it any more.

Ms Cane: There are some really practical issues which we feel that in this day and age we really shouldn't have.

Mrs Maiden: That is where collaboration would be just wonderful, if we were all working together.

Ms Cane: But we also do recognise that schools are up against it, as a previous speaker said, with respect to funding and things like that.

THE CHAIR: Yes, I understand that you are not coming from a position of blame, that they are constructive suggestions.

MR SMYTH: Is there a need for secondary school after-school care?

Mrs Maiden: There are families that say to us, "Where do I send my child next year when he starts high school as I am not prepared to leave him at home?" You can't put a high school child with family day care, either; so there is nowhere.

MR SMYTH: What is the indication of demand?

Mrs Maiden: I certainly haven't looked into that area at all.

Ms Cane: No, we haven't done any research into that area, quite honestly.

MR SMYTH: Would those kids be going home and be latchkey kids?

Ms Cane: I suppose there are youth centres. Presumably, they would take over, the drop-in centres and the youth centres.

THE CHAIR: Some use the youth centres. But there are all sorts of stories; they are instructed to go home and watch television and not go out. Parents are trying to ensure their safety by imprisoning them in some way and the kids just have to do the best they can.

MS MacDONALD: They ring the kids at a certain hour and come up with their own mechanisms for dealing with it.

Mrs Maiden: Of concern, too, is the number of schools, not just in the Tuggeranong Valley but in the ACT, that don't have these programs. Where are those children going, because the schools that we have our programs in are full or there are large numbers? For the schools that don't have it, where do those children go?

MR SMYTH: Do children go to after-school care only at the school at which they are during the day?

Mrs Maiden: For most of our programs. At Mount Neighbour, there are children from St Thomas, next door.

MR SMYTH: I think that the Holy Family kids go up to Fadden.

Mrs Maiden: That is right.

MR SMYTH: But between public schools, government schools, there is no transport?

Mrs Maiden: One child from a special needs unit at Richardson goes over to Chisholm, but the parent organises that transport. We don't actually organise any transport.

Ms Cane: I might just emphasise again one aspect that Lee touched on. We think that there could be more joint training done or development work done whereby you may have both teachers and carers in the same room. We have sought to be part of some of this training in the behaviour management area particularly, but again I think schools find that they are limited in the number of places that are available in certain training, so we haven't had much luck on that one. I think that that is something that could be very helpful. We think it could be very helpful to have a bit more collaboration on training plans and things like that. Again, we are not really talking lots of dollars here or anything; it is more to do with seeing it happening.

THE CHAIR: Do you know how many schools have after-school care and morning care?

Ms Cane: All told? There are about 112 programs, I think, in the ACT.

THE CHAIR: We have 300 schools, including preschools and colleges, so that it is less than half. Who sets up the after-school care?

Mrs Maiden: Some are by P&Cs. The one at Fadden is the P&C. If a P&C is running it, they have to have volunteers that will do all the bookkeeping or they pay a bookkeeper, but they have volunteers that manage the program, I think. We are approached, on occasions, by different schools, just from interest, to find out whether we might be interested in taking theirs over, just getting information fom us on how we operate, those sorts of things.

THE CHAIR: The program that is set up by the P&C is working to the P&C, so it is the P&C that will ensure standards and accountability in terms of the running of the after-school care or before-school care. There is not necessarily an expertise there to do that, so you could have a quite varying standard across Canberra.

Mrs Maiden: Because we are licensed, it certainly helps to a degree, but some of the schools do have problems with the P&C. The P&C changes often from year to year, so management changes.

Ms Cane: What we find useful in our organisation, because we are quite a large one, is that there is a backup and, if a staffer is away in one place, there is usually a way of covering requirements, plus we do put quite a lot of emphasis on staff development and staff training, which again, because we are large, we can pool.

THE CHAIR: How many do you have?

Ms Cane: Programs? Twelve at the moment

THE CHAIR: In schools.

Ms Cane: Yes. I think it is three before and nine after school at the moment. Again, as you know, we run quite a number of childcare centres as well.

THE CHAIR: I am sorry, I might have missed it, but I don't quite understand how it is that you are managing these after-school care programs in schools and why P&Cs set some up and you manage some. How did that happen?

Mrs Maiden: The school makes the decision. I have been in the position for over 12 months, but I know that the P&C set one up at Gordon and then were finding it too difficult to manage it themselves, so they then approached the Tuggeranong Community Service to see whether they would take it over. In other cases, the school possibly just approached TCS straightaway and said, "Will you manage this for us?"

THE CHAIR: Do they pay you to do that? How does that work?

Mrs Maiden: No, we pay them.

Ms Cane: Yes, we pay rent.

Mrs Maiden: We have to hire the facilities. We pay rent on the facilities and receive the facilities and that is about it.

THE CHAIR: And then you are funded by government to do that.

Mrs Maiden: No, purely funded by fees.

Ms Cane: Yes, it is self-sustaining on fees. It is all done on that basis.

MR SMYTH: What would I pay for an hour?

Mrs Maiden: It is $13 for the afternoon.

Ms Cane: Of course, you are eligible for child-care benefit.

MR SMYTH: Do the children bring their own afternoon tea or do you provide that?

Mrs Maiden: No, we supply the afternoon tea for the children.

MR SMYTH: Is there a comment that you would like to make on how kids approach that? Are some kids hungry? Is it the only fresh fruit some kids see?

Mrs Maiden: They eat lots. They line up quite excitedly of an afternoon. The staff try to vary it as much as possible so that they have interesting afternoon teas, but they are always very hungry. We spend a lot on food.

MR SMYTH: Is it a normal hunger?

Mrs Maiden: I think so. Having had children at school, yes, they are usually famished when they come home from school.

MR SMYTH: I was recently at Northside Community Services and they said that at some of their afternoon drop-in programs the kids are just ravenous because they haven't eaten all day.

THE CHAIR: They didn't have lunch?

Mrs Maiden: Some may not.

MR SMYTH: They didn't have lunch and didn't have breakfast. Some of the kids fill their pockets and take home food because it is the only source of food they see all day.

Mrs Maiden: We give breakfast as well to the children that come to before-school care. But with children, too, at lunchtimes often at school they are too busy to go and play and they may not eat or they might eat it all at morning tea time; I don't know. I haven't heard back from my staff that children were hungry because they weren't eating through the day, but then that maybe is not information we are getting either.

MS MacDONALD: But then again, the parents of the kids who are actually coming to your program are paying $13 for the afternoon, so you won't necessarily be getting the kids whose families are not providing them with food. Maybe I am making an incorrect assumption, but it is an assumption that I am making. Maybe the situation is different for the kids that are going to drop-in programs because there is no payment for those drop-in programs.

THE CHAIR: But you are right, Brendan: it came up in our kids at risk inquiry that there were children that were not getting breakfast and breakfast clubs have been set up. Do you have anything else to say?

Ms Cane: Just that we would be delighted if the committee wants to visit any of our programs. We would be really happy with that. We could organise quite a lot in a short space of time; you would be able to see a variety.

THE CHAIR: Thank you for the invitation.

Ms Cane: Come to one of the holiday programs, especially where they have the little motorbikes. It is just gorgeous. I think the programs do offer a lot of scope to do good things. One tends to talk about the negatives here, but there are lots of positives out there.

THE CHAIR: Yes, I am sure. Thank you very much.

Ms Cane: Thank you very much for your time.

The committee adjourned at 4.43 pm.