Looking at the health of school-age children in the ACT

Report No. 4

Standing Committee on Health

17 April 2003

Legislative Assembly for the Australian Capital Territory

Committee membership

Ms Kerrie Tucker MLA, Chair

Ms Karin MacDonald MLA, Deputy Chair

Mr Brendan Smyth MLA (discharged 18 February 2003)

Mrs Jacqui Burke MLA (appointed 18 February 2003)

Secretary: Ms Siobhán Leyne

Administration: Mrs Judy Moutia

Resolution of appointment

To examine matters related to hospitals, community, public and mental health, health promotion and disease prevention, disability services, drug and substance abuse and targeted health programs.

Terms of reference

The Committee will inquire into and report on the health of school-age children in the ACT with particular regard to:

- identifying current health status and emerging health issues;
- the relationship between social, emotional and physical health;
- mental health and body image, including gender influences and eating disorders;
- family, cultural and socio-economic influences;
- physical activity, diet and environment;
- current practice in schools to foster a culture of health and wellbeing;
- the role of government and non-government organisations in providing support;
- appropriate models for service delivery, and
- any related matter.

On 25 September 2002, the Legislative Assembly resolved that the Standing Committee on Health investigate the adequacy of children's television standards in relation to advertising to children with particular regard to 'junk food' advertising.

As a result the Committee added the following to the terms of reference for this inquiry:

- The adequacy of children's television standards in relation to food advertisements.

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Summary of recommendations

Recommendation 1

2.26. The Committee recommends that the Government ensure that its efforts to engage the community includes strategies to consult with, and listen to children and young people on matters that effect them.

Recommendation 2

2.34. The Committee commends its predecessor's report, Aboriginal and Torres Strait Islander Health in the ACT, and recommends that the Government implement the recommendations of that report as a matter of priority.

Recommendation 3

2.40. The Committee recommends that the Government provide an update on the progress of the implementation of the recommendations of the above reports, where this, or the previous, Government has already responded.

Recommendation 4

3.5. The Committee recommends that the Government investigate the possibility of increasing the number of full-service schools in areas of need, with on-site health and medical centres that offer free or low-cost, comprehensive health monitoring for all children.

Recommendation 5

3.44. The Committee recommends that the way physical education is approached in all schools be radically overhauled and incorporate the following points:

a) Rather than the prescribed mandatory time for physical activity there be a program for all students that teaches appropriate nutrition and exercise, following the principles of the *Health and Physical Education Curriculum Framework*.

b) Ranking grades for physical education units should be eliminated.

c) Students with proven participation in extracurricular sporting or other physical activities should be able to claim credit for these activities, rather than participate in physical education units, excluding the health education components of those units, which should remain mandatory.

d) The Department of Youth and Family Services assist schools to collaborate with community organisations to provide physical

d) activities, that focus on fun, not just competitive sports, particularly where schools do not have a dedicated physical education teacher.

e) Fitness testing against prescribed exercises should only be undertaken with extreme caution. Instead, if schools choose to follow this route, 'exercise as fun' programs that allow fitness assessments to be undertaken on the child's own ability should be implemented. Any results from these assessments should be only available to parents/carers.

Recommendation 6

3.91. The Committee recommends that a territory-wide nutrition strategy be developed for students at all levels, and including parents, in collaboration with those organisations already undertaking nutrition programs and other key organisations such as the Dietitians Association, the Heart Foundation and the Australasian College of Nutrition and Environmental Medicine.

3.92. The Committee further recommends that as part of the nutrition strategy there be a needs-analysis in all schools, including colleges, to determine whether there are students not having breakfast on a regular basis, and if this is the case, establish a universal breakfast program.

Recommendation 7

3.93. The Committee recommends that the Government require schools to minimise the sale and use of food containing high fats, high sugars, artificial colours, flavours and preservatives from ACT school canteens and, in consultation with appropriate experts, introduce an alternative menu which offers healthy choices in all school canteens. This requirement should also apply to contracts where school canteen services are outsourced.

Recommendation 8

3.94. The Committee recommends that the Government, as part of the Nutrition Strategy:

a) undertake an education program to increase awareness of the symptoms and effects of food intolerance in the community;

b) put in place a policy that when children are identified with behavioural problems, dietary management should be investigated and offered as a management option; and

c) offer dietary management as part of the rehabilitation process for juvenile offenders.

Recommendation 9

3.117. The Committee recommends that the ACT Government support the call for greater controls and restrictions on food advertising through the media to children and actively work towards achieving this goal.

Recommendation 10

3.118. The Committee recommends that the ACT Government form a working party with the States and Northern Territory to make representations to the Federal Government to enhance the Children's Televisions Standards to cover all children's television, including programs with a 'General' rating.

Recommendation 11

3.132. The Committee recommends that the Government establish youth health centres in Tuggeranong, Belconnen and Gungahlin, similar to The Junction Youth Health Service, to ensure that all young people have equitable access to affordable, confidential health care.

Recommendation 12

3.136. The Committee recommends that funding be provided for a youth health worker to visit each youth centre on a weekly basis to provide basic health advice and education programs.

Recommendation 13

3.137. The Committee recommends that the Government ensures that The Bay receives ongoing funding and that a similar service be established at, or accessible by, all ACT colleges.

Recommendation 14

3.140. The Committee recommends that the Government provide funding to refurbish all youth centres in need of modernisation.

Recommendation 15

3.161. The Committee recommends there be an independent evaluation of drug education programs delivered in schools by community, government and non-government agencies and that this evaluation be underpinned by the principles of harm minimisation and relevance to young people.

Recommendation 16

3.162. The Committee recommends that health promotion campaigns and education programs focussing on substance use be developed in consultation with young people in the target group and community service organisations to ensure their relevance and effectiveness.

Recommendation 17

3.163. The Committee recommends that a consistent approach should be defined for drug and alcohol education offered across all school sectors.

Recommendation 18

3.171. The Committee recommends that the Government undertake an education campaign highlighting the importance of the associations between children's bedding and asthma and the poorly ventilated cooking and asthma.

Recommendation 19

3.174. The Committee recommends that the Government undertake a literature review into the incidence of vitamin D deficiency and take appropriate action.

Recommendation 20

3.187. The Committee recommends that the Government undertake an education campaign on ways to reduce harmful substance emissions from normal household use.

Recommendation 21

3.188. The Committee recommends that the Government, as a matter of urgency, undertake an occupational health and safety audit of all Government schools which includes a chemical audit addressing all potential environmental hazards such as toxin levels and emissions from buildings and furnishings and chemicals used for cleaning and gardening.

3.189. The Committee further recommends that the Department of Youth and Family Services commit to a stronger oversight role to ensure that policies pertaining to environmental hazards, use of chemicals and safe building materials are adhered to by employed contractors and consultants.

Recommendation 22

3.190. The Committee recommends that the Government fund a comprehensive study on the environmental factors affecting the health of school-age children in the ACT, in consultation with key community and environmental groups, including the Commissioner for the Environment.

Recommendation 23

4.11. The Committee recommends that, as a matter of urgency, all schools (including colleges) be funded to employ a full time health and welfare officer to be responsible for counselling and co-ordinating health education. This funding should come from core funding, not a reallocation of existing resources.

Recommendation 24

4.19. The Committee recommends that a consistent approach be defined for mental health education and applied across all sectors, making use of those community organisations with proven expertise in the area. Programs should be developed and/or adopted in consultation with experts in this area.

4.20. The Committee further recommends that mental health programs should not only focus on mental health awareness, but be equally focussed on increasing help-seeking behaviour.

Recommendation 25

4.32. The Committee recommends that a 'human values' or philosophy program such as the successful program at Mawson Primary School be developed for implementation in all ACT primary schools.

Recommendation 26

4.60. The Committee recommends that the Government establish an early psychosis intervention centre in the ACT, based on the model of the Early Psychosis Prevention and Intervention Centre on Melbourne.

Recommendation 27

4.77. The Committee recommends that when a child has been diagnosed with behavioural difficulties, that there be a co-ordinated response by services to ensure that all possible avenues of treatment are offered to parents. This response should also look at wider measures such as including full-spectrum lighting in classrooms and dietary modification.

Recommendation 28

4.88. The Committee recommends that the Government work with students to develop healthy body image projects to be presented within the mainstream media.

Recommendation 29

4.93. The Committee recommends that the Government investigate the need to expand service delivery responses which provide counselling and support for young people with body image and eating issues.

Recommendation 30

4.118. The Committee recommends that a comprehensive program of peer-led safer-sex and sexuality education be developed and delivered equitably across all schools and offered to the Independent and Catholic school sectors to also deliver. The safer-sex education program should cover all behaviours, including those traditionally deemed to be 'homosexual' practices.

Recommendation 31

4.119. The Committee recommends that the Government fund the production and distribution of lesbian safer-sex information.

Recommendation 32

4.120. The Committee recommends that the Government allow free condom distribution in high schools and colleges by those groups undertaking safer-sex education.

Recommendation 33

4.121. The Committee recommends that condom vending machines be installed in all high schools and colleges, in consultation with students to determine appropriate locations.

Recommendation 34

4.139. The Committee recommends that representatives from all ACT Government schools participate in the "There's 2 in Every Classroom" project run by Sexual Health and Family Planning ACT, and that Government ensure that this project is appropriately resourced.

Recommendation 35

4.140. The Committee recommends that all ACT Government schools make greater efforts to reduce homophobia through the use of inclusive language and environment.

4.141. The Committee further recommends that the 'GILBerT's Friends' support group be widely publicised through all secondary schools.

Recommendation 36

4.151. The Committee recommends that the Government develop, in consultation with experts in the field, a professional development program for teachers to assist them in recognising the signs of sexual or other violence and to make appropriate referrals.

Recommendation 37

4.152. The Committee recommends that the Government, in partnership with community organisations, put in place comprehensive programs to address the needs of school-age children who are the victims of sexual assault. These programs should not only address short-term needs but aim to make systemic changes with a view to long-term outcomes for the child and family and break the cycle of intergenerational violence.

Recommendation 38

4.155. The Committee recommends that the Government provide additional funding to early intervention programs to provide support to children that have experienced violence in their lives.

Recommendation 39

4.156. The Committee recommends that the Government:

a) establish and resource a working party made up of representatives from areas including: law enforcement; health promotion; the women's sector; relevant community organisations; as well as educators and those responsible for the development of school curricula to develop and implement an across-the-board information and education campaign regarding all aspects of violence against women, including sexual

violence, with the view to including violence prevention education as part of the ACT Government school curriculum; and

b) build on this work with a broader community education and information campaign.

Recommendation 40

4.157. The Committee recommends that the Government, in the development of its Sustainable Transport Plan:

a) prioritise the maintenance of lighting in bus interchanges and other public spaces in its maintenance program; and

b) investigate the possibility of providing after-hours bus services with the flexibility to stop between bus stops in order to set passengers down as close to their homes as possible.

Recommendation 41

4.158. The committee recommends that:

a) the Government undertake research regarding sexual assault and public events in the ACT;

b) the Government develop and expand innovative strategies to educate children and young people about the impact of violence on individuals and the community;

c) event organisers be required to consult with a broad range of stakeholders, including young people, produce a safety plan to ensure events are safe for all members of the community;

d) increased funding be allocated to education campaigns aiming to address male and female stereotypes about violence against women; and

e) restricted alcohol use policies be enacted at all public events, and all staff serving liquor in the ACT be required to have completed an accredited responsible alcohol service training course.

Recommendation 42

4.170. The Committee recommends that the Government undertake a review of all anti-bullying programs used in schools, and in consultation with students, teachers, parents and experts in the field, develop and/or implement an existing program based on the principle of restorative justice in all schools.

Recommendation 43

4.177. The Committee recommends that the Government:

a) develop strategies to identify young carers and engage them in mainstream health services;

b) provide funding for in-home respite services specifically to allow young carers to attend activities that promote their social development and emotional wellbeing, and ensure transport is available for these activities;

c) better publicise the availability of support programs in schools and public space that young people frequent; and

d) adequately support those bodies engaged in support and advocacy for young carers.

Recommendation 44

5.41. The Committee recommends that the Government adopt the Gatehouse Project for implementation in all ACT Government high schools and colleges.

Recommendation 45

5.64. The Committee recommends that the Government investigate the possibility of implementing an early-years intervention project that provides parenting support and well as universal health and social support.

Recommendation 46

5.89. The Committee recommends that future civic design and planning includes measures to encourage active transport, physical exercise and discourage use of the car.

Recommendation 47

5.90. The Committee recommends that the Government sponsor a program, in conjunction with children and parents, to map safe walking and cycling routes to school and then assist in establishing programs to encourage use of these routes.

5.91. The Committee further recommends that in curriculum areas that cover transport systems, including 'road ready' courses that information about alternative, active transport methods is also included.

Recommendation 48

5.92. The Committee recommends that severe restrictions be placed on the use of cars in and around school zones when schools are in session and that the Government work with local school communities to develop safe, alternative school transport methods.

1. Introduction

1.1. In resolving to undertake this inquiry, the Committee agreed to look at a range of issues to do with the health of school-age children, whether they be actually attending school or not.

1.2. Due to the scope of this inquiry, and the scope of the work being undertaken in this area, the Committee has not been able to highlight all of the health issues facing children, nor all of the programs being run, to address these issues. Instead, the Committee has focussed on key areas highlighted through submissions.

1.3. Work in the areas of children's health is evolutionary and the Committee feels that this report is in no way a complete picture of the subject, but has attempted to provide the Government and community with areas for future investigation.

1.4. School-age children are a captive market for targeted health messages and testing. Repeatedly during this inquiry, the Committee heard evidence about the need to link schools and health providers to ensure that all children receive equality in health care.

1.5. The Committee has seen and heard of a number of programs in schools that are aimed at the health of school-age children and has become convinced over this inquiry that it is essential to provide and repeat consistent messages from pre-school years right through the secondary school years.

1.6. The Committee acknowledges the extent of work that is already being undertaken in this area by both the Government and non-government sectors. However there are systemic failings that need to be addressed, such as duplication in programs and different levels of access to health information.

1.7. The overwhelming majority of the submissions to this inquiry called for long-term, systemic approaches to children's health outcomes, rather than ad-hoc, short-term, political approaches. The Committee notes that in its submission to this inquiry, the Government agreed that ACT children will benefit from more integrated service delivery.

1.8. The Committee commends that work being undertaken in schools at their own initiative.

1.9. However, it is time to start holding discussions regarding the role of school-based management, funding of schools and alternative education models. More and more, schools are being forced to provide more than the traditional "three R's" and instead have becoming centres for holistic education, addressing the mental, physical and social health of their students.

1.10. The Committee believes that this will be a permanent shift in culture and has seen examples of how it has been fully implemented in schools, however in the ACT, support and resources have not followed this shift. There will be no better time than now to re-think how the education system operates within the health system and to create greater links and partnerships.

1.11. The current way that services are offered in schools seems to be fragmented, largely relying on the goodwill and energy of individual teachers. The full-service-school mentality needs to be reintegrated in schools in order to provide holistic services not only to students but also to the whole community.

1.12. The Committee heard repeatedly the pressure placed on teachers to include more and more changes into their curriculum, indeed the Committee itself has made numerous recommendations for changes that it sees necessary.

1.13. However, the Committee places a premise these recommendations by stating that schools need increased resources, particularly in the area of children's health. A number of the recommendations call on new and existing resources from within both health and education to be directed at holistic health and education models. The Committee also foresees that these changes are long-term, as they involve deeply embedding cultural changes.

1.14. During the term of this inquiry, the Australian Medical Association established a committee to look at children's health. This committees' charter is to bring together key people to look at childhood development and the factors affecting childhood health, including and beyond physical health.

1.15. The Committee welcomes the establishment of this committee which will be able to look at children's health with a level of medical expertise unavailable to this Committee.

1.16. The Government has already shown a commitment to listen to the outcomes of this inquiry in terms of children's physical fitness[1] and the Committee hopes that it can make the same commitment in regards to the other aspects of the report, particularly those where there have been high levels of input from young people.

1.17. The Committee also notes that the findings of this inquiry echoes many of the findings of the inquiry into adolescents and young adults at risk of not achieving satisfactory education and training outcomes, undertaken by the Standing Committee on Education, Community Services and Recreation of the Fourth Legislative Assembly for the ACT.

1.18. Overwhelmingly, the evidence suggests that in order to adequately address the health needs of school-age children, schools, the government and the community needs to rethink the way that we operate and start to collaborate more effectively in order to improve the health outcomes for children.

Conduct of the inquiry

1.19. Following the Committee's resolution on 21 March 2002 to conduct an inquiry into the health of school-age children in the ACT, advertisements detailing the inquiry's terms of reference were place in *The Canberra Times* and *The Chronicle* in April 2002. In addition, letters advising of the inquiry and inviting input were sent to organisations and individuals known to have an interest in the matter.

1.20. In response, the Committee received 32 submissions, 2 exhibits, heard from 47 witnesses at hearings and spoke to numerous others through the course of meetings and visits. A list of submissions is at Appendix 1 and a list of witnesses who gave evidence at public hearings is at Appendix 2.

1.21. The Committee visited the following organisations in the ACT:

- Woden Youth Centre
- The Canberra College
- Belconnen Community Service
- Mawson Primary School

[1] Minutes of Proceedings No. 33, Wednesday 25 September 2002, p. 331

1.22. The Committee met informally with the following groups in the ACT:

- ACT Government School Students Network on 31 July 2002 (Students Network);
- The Canberra College students and the College Health Cluster Network

1.23. The Committee met with the following people outside of the ACT:

- The Gatehouse Project, Centre for Adolescent Health, Melbourne Victoria
- Orygen Youth Health, Melbourne Victoria
- Best Start Project team, Department of Human Services, Melbourne Victoria

1.24. The Committee thanks those people who made submissions to this inquiry, the submissions were of an extremely high standard and for the most part saved a great deal of time and research for the Committee.

1.25. In some instances, the Committee has adopted recommendations of submitters as its own, and acknowledges these submissions for their recommendations.

1.26. The Committee was particularly impressed by the maturity and knowledge displayed by young people who participated in the inquiry and overwhelming received the message that policy planners, and the Government should make more effort to engage young people, including young children, in the processes for developing policy that affects them.

2. Overview

2.1. At the end of the June 2001 quarter, the ACT population was 321 680, of which 69 734 were children aged five to nineteen. This means that 20.91% of the ACT population are school-aged children. ACT children are 1.6% of the Australian child population – only second to the Northern Territory as the lowest percentage of total child population.[2] However, as a percentage of the Territory population, the ACT is on par with the rest of Australia.

2.2. While the growth rate is low at 1.2%, the number of births has remained relatively stable from the years 1995-96 to March 2002[3] and can therefore be projected that the number of children entering school over the next seven years will also be stable.

2.3. In comparison, the annual growth rate for Indigenous peoples Australia-wide was 2.3% for the period 1991 to 1996. Numbering approximately 3080 peoples, the Indigenous population in the ACT was just 1% of the total population. However, the Aboriginal and Torres Strait Islander population in Australia has a median age of 20 years – 40% of the total Indigenous population is aged 0-14 years.[4]

2.4. The highest proportion of children aged 0-14 years is in the Gungahlin-Hall and Tuggeranong regions[5].

2.5. The 2002 census undertaken by the Department of Education, Youth and Family Services shows that there were:

- 19 335 students enrolled in 66 ACT Government primary schools;
- 3 068 students enrolled in 3 ACT Government combined primary and high schools;
- 8 626 students enrolled in 14 ACT Government high school;
- 6 276 students enrolled in 8 ACT Government secondary colleges;

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[2] Al-Yaman, F. *et al* Australia's Children: Their health and wellbeing 2002. Australian Institute of Health and Welfare © 2002, p. 15

[3] Australian Demographic Statistics, March Quarter 2002, p. 14, 18, 20, 24

[4] *Population special article – Aboriginal and Torres Strait Islander Australians: A Statistical profile from the 1996 Census* (Year Book Australia, 1999). Australian Bureau of Statistics, p. 3

[5] ibid.

- 285 students enrolled in 4 ACT Government special school; and
- 23 420 students enrolled in 44 non-Government schools, consisting of 26 systemic Catholic Schools, 3 Catholic Congregational schools and 15 independent schools.[6]

Current health status

2.6. While school-age children suffer a range of illnesses, on the whole, young people tend to be physically healthy but are 'particularly vulnerable to social and environmental illnesses'[7].

2.7. With this in mind, addressing the needs of school-age children's health must be undertaken in a holistic fashion.

2.8. The World Health Organisation (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[8]

2.9. WHO also states – "Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures."[9]

2.10. There is no way to separate physical, mental and social well being. An absence or detriment of any one affects the rest. In this report the Committee has addressed each aspect separately. However, it is important for the reader to recognise that when a topic crossed over all subject areas, the Committee had to make arbitrary decisions about where it appeared in the report, and this in no way diminishes its relevance in other areas.

Emerging health issues

2.11. The Committee was given a great deal of information regarding health issues for young people, but most concerning were the emerging

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[6] Submission 31, p. 6
[7] Submission 6
[8] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
[9] World Health Organisation policy document, *New Horizons in Health*, available at http://www.wpro.who.int/public/policy/horizon_toc.asp (accessed 22 August 2002, main link – www.wpro.who.int)

mental health issues, the increasing occurrence of overweight and obesity in very young children and the lack of basic living skills such as hygiene and cooking.

2.12. The lack of basic living skills in particular places an additional burden on schools to provide services not before felt necessary.

2.13. The YWCA also identifies Repetitive Strain Injury (RSI), cause by excessive computer usage, lack of sun protection and dehydration as key issues affecting the health of school-age children.

2.14. Concerning too, is the lack of health education once students reach college level. This leaves individual colleges – recognising not only the need, but the opportunity to promote health messages – to take the initiative to provide health education relying on the good will and enthusiasm of individual teachers.

2.15. Throughout this inquiry, a great deal of focus has been directed at obesity in children; by the media, various Australian governments, and governments world-wide.

2.16. Obesity is a serious issue for children as it not only has short-term effects but very serious long-term health implications. While in this report, the Committee has addressed the issue of childhood obesity, there are a range of mitigating factors which lie across many areas of the community which need to be addressed.

2.17. These include civic planning for pedestrians as well as motor vehicles; access to and education about nutrition and healthy eating; and the need to offer both competitive and non-competitive physical activity in schools; and to introduce an environment that encourages fun and exercise for health.

2.18. Nearly all of the submissions to this inquiry called for long-term systemic approaches to the taken on the health of children, recognising that childhood health outcomes have the ability to affect longevity, social inclusion and participation and later ill health.

2.19. While it should not be claimed that the health, education and community sectors are working in opposition to each other, they are not seen to be working effectively together to address the health needs of children.

2.20. The Government has articulated a vision for achieving more integrated and responsive services through its policy released in March

2003: *People, place and prosperity: a policy for sustainability in the ACT*. This policy sets the Government's commitment to a sustainable ACT, and particularly relevant to this report, the Government has committed to achieve this through:

- "Integrating social, environmental and economic factors in decision-making;
- taking a whole-of-government perspective;
- recognising that a strong and productive economy builds upon and is supported by a healthy environment and a healthy society;
- ensuring equity within and between generations;
- empowering people; and
- engaging the community."[10]

2.21. Children's health and education needs to be viewed within this framework. A short-term review of program duplication needs to be undertaken and long-term systemic vision for the health, education and community sectors needs to be developed in order to improve the physical, mental and social health of all young people.

2.22. Equally as important, the Government needs to start to listen to young people on matters that affect them. The Committee spoke to children as young as ten, and up to college age, who all said that they wanted to have a greater say in the issues that effect them. In general young people felt powerless to change the matters that affect them, whether it be how sex and drug education is delivered, advertising on television, or their vision for the future and how the country is run.

2.23. Our children and young people are intelligent, engaged and thoughtful about these matters – and they are the ones living in their world, all we can do is observe it. The Committee feels that we have an obligation to listen to what children and young people have to say.

2.24. The Committee calls on the Government to remember in its vision of sustainability that when engaging the community, that the community includes children and young people. Ensuring that children and young

[10] ACT Government, People place and prosperity: a policy for sustainability in the ACT., p. 13-14

people can contribute to decision-making will also assist in turning 'generational equity' into a reality.

2.25. The Committee is aware that there is a Ministerial Youth Council which is available to advise the relevant minister on matters affecting young people and commends its work, however the Committee is loathe to see this council become the 'catch-all' for consultation with young people.

Recommendation 1

2.26. The Committee recommends that the Government ensure that its efforts to engage the community includes strategies to consult with, and listen to children and young people on matters that effect them.

Aboriginal and Torres Strait Islander health issues

2.27. The Committee had difficulty speaking to Indigenous people in relation to this inquiry. Members of the Indigenous community and organisations told the Secretary to this Committee that they were tired of being repeatedly asked for input with no real outcomes being shown. This is in part because of inadequate action implementing previous Committee reports.

2.28. The Standing Committee on Health and Community Care of the Fourth Legislative Assembly undertook a major inquiry into Aboriginal Health in the ACT, which was tabled in the Assembly in August 2001.[11]

2.29. The report looks at a range of issues effecting Indigenous health, which is acknowledged to be significantly disadvantaged compared to non-Indigenous Australians. The factors effecting poor Indigenous health outcomes include "specific health risk factors such as smoking or diet" and "social disadvantage including poverty, high rates of social racism, high rates of substance abuse, low self esteem, loss of culture and disintegration of family ties, just to name a few".[12]

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[11] Aboriginal and Torres Strait Islander health in the ACT, Report 10 if the Standing Committee on Health and Community Care can be found at www.legassembly.act.gov.au/committees

[12] ibid., p. 13

2.30. The other factors effecting Indigenous health as discussed in the above report include 'unemployment, housing, violence, racism, limited self determination and poor self-esteem' and the relationship between reconciliation and health.

2.31. If a child cannot rely on safe and secure housing, a carer with a reliable income and has to contend with violence, racism and the other issues facing Indigenous peoples, there is no doubt that their health will be compromised.

2.32. The report clearly points to the need for Indigenous health services to be operated and directed by Indigenous peoples. While many of the health issues are concurrent with those that effect the rest of the population, the ways that Indigenous health issues need to be addressed are unique.

2.33. The ACT Council of Social Services has also called for the implementation of the Fourth Assembly's Standing Committee on Health and Community Care's report into Aboriginal and Torres Straight Islander health recognising the fact that indigenous people are among the most disadvantaged of the community.[13]

Recommendation 2

2.34. The Committee commends its predecessor's report, Aboriginal and Torres Strait Islander Health in the ACT, and recommends that the Government implement the recommendations of that report as a matter of priority.

2.35. The Committee notes that the Government supports the majority of the recommendations of this report, however is yet to see what action is being taken to implement the recommendations. The recommendations of this report are reproduced at Appendix 3.

Children with a disability

2.36. Whilst the Committee has not gone into detail regarding children with a disability in this report, the report equally applies to both children with and without disabilities.

[13] Transcript of evidence, 15 August 2002, p. 164

2.37. The Committee received no submissions from the disability sector, or from parents or carers of children with a disability. However, this does not detract from the pressing need to provide appropriate services in this area.

2.38. The Committee also did not want to duplicate work already undertaken regarding services for children with disabilities, and the other recent work undertaken in review of disability services in the ACT.

2.39. Namely:

- recognising the interrelated nature of education and health outcomes – the Standing Committee on Education, Community Services and Recreation of the Fourth Legislative Assembly's report *Educational Services for Students with a Disability*[14] (December 1999);

- the Standing Committee on Health and Community Care of the Fourth Legislative Assembly's report *Respite Care Services in the ACT*[15] (March 2000);

- the report of the *Board of Inquiry into Disability Services* (December 2001, known as the Gallop report)[16]; and

- the report on the *Inquiry into ACT Education Funding* (January 2003, known as the Connors report)[17]

2.43. The Committee does not want to pre-empt the response of the Government to the Connors report, however urges the Government to consistently revisit the recommendations of these reports to ensure that services for children with disabilities are being adequately provided.

[14] Available from http://www.legassembly.act.gov.au/
[15] Available from http://www.legassembly.act.gov.au/
[16] For further information go to: http://www.dhcs.act.gov.au/
[17] Available from http://www.educationfundinginquiry.act.gov.au/index.htm

Recommendation 3

2.40. The Committee recommends that the Government provide an update on the progress of the implementation of the recommendations of the above reports, where this, or the previous, Government has already responded.

3. Physical well-being

3.1. Children tend to be physically healthy, but suffer a range of illnesses or disorders common to childhood, such as asthma, allergy, vaccine-preventable diseases such as measles and mumps, conduct disorders, overweight and obesity and oral health considerations such as tooth decay and loss.

3.2. Adolescents continue to suffer the same range of illness, but have additional burden related to lifestyle factors such as tobacco, alcohol and substance misuse, physical inactivity, sun exposure and sexual activity.

3.3. The likelihood of children having had comprehensive health screening, including sight and hearing tests and dental screening varies according to family circumstance. Children who speak English at home with one or both parents employed are more likely to have comprehensive health screening prior to and throughout school years.[18]

3.4. As stated elsewhere in the report, the 'captive market' of children in schools provides an ideal opportunity for comprehensive health monitoring for all children. This will reduce the inequity in the access to and provision of basic health care. See also Chapter 5.

Recommendation 4

3.5. The Committee recommends that the Government investigate the possibility of increasing the number of full-service schools in areas of need, with on-site health and medical centres that offer free or low-cost, comprehensive health monitoring for all children.

Physical activity

3.6. The need for appropriate physical activity is clear. Physical inactivity is now the "second biggest preventable cause of death behind tobacco."[19] While there is no systemic data regarding rates of physical activity for children taken nationally, the National Health Foundation points out that 43% of adults have insufficient levels of physical activity

[18] Submission 31, p. 7
[19] Submission 16, p. 3

and 21% of boys and 23% of girls aged 10-17 years are overweight or obese.[20]

3.7. Research undertaken over the past three years in ACT schools indicates that, in children aged five to twelve in a comparison of data taken in 1985 and 2002[21], average height is relatively stable, while average weight has increased as has average body mass index. In the sample group, the ability of children to perform standing long jump as an indication of upper/lower body co-ordination and strength has also significantly decreased since 1985.[22]

3.8. Children today tend to engage in activities that use less physical energy, such as computer games and watching television, and tend to be driven to activities when they may once have walked or ridden bicycles. The community needs to address ways to encourage spontaneous physical activity for children, adolescents and adults alike. (See also chapter 4.)

3.9. Not only does physical activity contribute to good physical health, "it has also been associated with good mental health and … good self-esteem".[23]

Physical education

3.10. The Committee heard convincing evidence that the way physical education is approached in the school setting needs to be radically overhauled. Presently it is alienating many students due to its competitive and exhibitory nature.

3.11. A witness to the public hearings proposed that physical education be incorporated into the curriculum and teachers supported by professional development to deliver effective health and physical education programs, particularly at the primary school level where there are very few dedicated physical education teachers.[24]

3.12. This however, places additional demands on teachers to implement programs that need to be supported by parents and carers in order to

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[20] ibid., p. 3
[21] 1985 data taken by the Australian Council of Health, Physical Education and Recreation, 2002 data taken by Smart Start.
[22] Transcript of Evidence, 20 June 2002, p. 36
[23] Al Yaman *et al*., p. 277
[24] Transcript of Evidence, 20 June 2002, p. 41

succeed. There is no use in teaching children appropriate physical activity if they are not encouraged in the home to engage in it as well.

3.13. The Committee heard compelling evidence from Kylie Easton, a year 10 student in Canberra regarding physical education in high-school.

3.14. Ms Easton gave evidence regarding the impact on mental health as a result of compulsory physical education:

> "Lots of students in my year I talked to about this were very upset about how they were being treated by their classmates because of the way they performed in PE. Some of them have even cut themselves off from their peers altogether.
>
> With depression rates rising steadily, we should be looking for a cause, but here's one that's staring us in the face and everyone seems to just ignore it."[25]

3.15. Surely this is not an acceptable situation in which to place young people.
Ms Easton recognised the benefits of regular physical exercise, but felt that the way it was undertaken in high school was not just damaging, but ineffective.

3.16. Ms Easton also pointed out that playing competitive team sports does not provide a good grounding in exercise to combat obesity, which is her understanding of why physical education is compulsory. She suggested that instead of compulsory physical education, all students in the upper years of high school receive regular health and nutrition classes so students learn in a supportive environment about appropriate diet and exercise, and students be given credit for activity undertaken outside of school.

3.17. Another fact of concern to the Committee, and pointed out by Ms Easton, is that all students are made to compete against each other in physical education, whereas in other subjects, such as Mathematics and English, classes are levelled so that students are in classes with others of the same ability.

3.18. The Committee agrees that competitive team sports do not promote fitness, nor do they teach students how to maintain a healthy lifestyle post-schooling. The Government submission to this inquiry states that

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[25] Transcript of Evidence, 15 August 2002, p. 188

the aim of the *Health and Physical Education Curriculum Framework* is to "give students the knowledge and practical skills to meet these needs [health and physical education] and help develop a better quality of life"[26].

3.19. The Framework requires mandatory times to be devoted to the areas of health, physical education and sport/recreation. The Committee agrees that this framework is a good basis for the development of physical education programs, but is concerned through formal and anecdotal evidence received that it is not being implemented with its full intent, or it is being implemented in superficial ways like requiring mandatory times to be devoted to physical activity.

3.20. The Committee also heard evidence that this is because schools do not have the resources to implement more complex programs.

Mandatory physical activity times

3.21. The ACT Department of Youth and Family Services policy *Health, Physical Education and Sport* sets out the mandatory times for physical education:

Kindergarten to Year 2	20 to 30 minutes of physical activity per day
Year 3 to Year 6	Minimum 150 minutes per week active physical education or sport
Year 7 to Year 10	Minimum 150 minutes per week active physical education, including sport

3.22. This requirement came from an election promise of the Liberal Government elected in 1995 and although the Minister at the time claimed that it was not the Government's intention to only promote competitive sports[27], this is what has occurred in many schools.

3.23. When debating the topic of mandatory physical activity times, the then Minister for Education repeatedly referred[28] to a December 1992 Senate Standing Committee on Environment, Recreation and the Arts

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[26] Submission 31, p. 14
[27] 1995, Week 5, Hansard, page 1331-3. Available from www.hansard.act.gov.au
[28] ibid.

report which called for a "greater political commitment to address the problems associated with the provision of quality physical education"[29].

3.24. The Committee is concerned that mandatory times for physical education unnecessarily politicised the issue, and is a simplistic solution to the complex problem of providing appropriate and engaging physical activities for children.

3.25. In saying this, the Committee is not discounting the value of regular physical education, and does not believe that there is any political opposition to physical education. However the Committee feels that by mandating times for physical activity, specifically including sport, teachers are not given enough scope to cater for the needs and requirements of their students.

3.26. While there is a place for competitive team sports in schools, it should not be the only thing that is offered. The Committee does not believe that the mandatory time for physical activities necessarily delivers best practice.

3.27. A culture exists in schools where the benefits of physical activity are recognised. By removing the mandatory times requirement, schools can be more innovative in how physical education is approached, for example, through use of tools like physical education credits, and can therefore make better use of existing resources.

3.28. Submitters[30] also recognise that resources are a major barrier to providing appropriate physical education. This is something that needs to be appropriately addressed, rather than applying 'quick-fix' political solutions like mandatory physical activity times.

Fitness testing

3.29. While the Committee accepts the value of comparative data in assessing the fitness of school-age children, evidence from children themselves suggest that a more appropriate way of measuring fitness should be undertaken. Certainly, fitness testing is a way of identifying children at a high-risk of developing illnesses due to a lack of physical activity, but this can be as easily achieved through other methods.

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[29] Senate Standing Committee on Environment, Recreation and the Arts *Physical and Sport Education*, December 1992, p. xiii
[30] Submission 14, Submission 15

3.30. Even a proponent of fitness testing agreed that children mature at different rates and that recommendations should not be made about what level a child should be at other than relative to themselves.[31] While the Committee understands and agrees with this, it also recognises that it would be difficult for a child to conceptualise, particularly while made to perform tests in front of a group of their peers.

3.31. The Committee is concerned that fitness testing is currently undertaken in such a manner that it is exhibitory and damaging to young people's self-esteem.

3.32. One young teenager (in Year 7) reported to the Committee that results of fitness testing in her school were posted on the class notice board and it became a popular source of information for bullies. Asked if she would be more comfortable if the information was held only be the teacher, she reported that she felt there was no way to keep the information confidential in a school setting.[32]

3.33. Ms Easton gave evidence that fitness testing was applied to grading in an unrealistic manner:

> "My sports teachers all refuse to mark on participation, and examine purely on physical ability…
>
> … a fifth of our grade is completely devoted to how well we perform in fitness. I think we run 1½ kilometres and we have to do it in a certain time, otherwise we automatically fail. You're not even given a chance to improve. It's an automatic failure if you're over a certain time. Other than that, the grades are very defined. Even if you make a two-minute improvement, it doesn't affect your grade. It can still be an E. You can still fail even though you've improved lots.
>
> We also have a fitness test called the beep test. You run laps of the hall or the gym to a tape that's played, and you have to make it to the other end before the beep or you have to stop. Again, they don't take into consideration improvement. It's just how well you do by level."[33]

3.34. Again, it is the exhibitory nature of this fitness testing that creates difficulties:

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[31] Transcript of evidence, 20 June 2002 p. 43
[32] Anecdotal evidence, ACT Government School Students Network, 31 July 2002
[33] Transcript of Evidence, 15 August 2002, p. 188, 189

> "It's [fitness testing] normally [in front of] the whole class. Sometimes we do it according to sex, but I don't find that helps a lot. I find the criticism comes more from the same sex than the opposite sex. The boys tend to pick on other boys and the girls pick on other girls. It's always in front of the other students, which again leads to low self-esteem and depression."[34]

3.35. The Committee could see clearly how upsetting this situation was for
Ms Easton, who felt that she was not able to compete for awards or other recognition because of the negative impact of fitness testing grading. From talking to other young people, the Committee knows that Ms Easton is not alone in this situation.

3.36. We should not ignore the evidence given by young people – surely no benefit is to be derived from exercise perceived as punishment or that which is sets up poorer-performing children for consistent failure.

3.37. Recognising the importance of physical and health education, the Committee does not believe that it should be eliminated entirely, but a different approach needs to be taken, and options such as ungraded pass/fail, and physical activity credits be considered. The focus of physical education should not be on immediate physical activity, but on achieving and maintaining physical fitness for life.

3.38. A student spoke to the Committee about a program her school had negotiated with the local gym, allowing discounted memberships. This student felt that this was more appropriate, particularly for girls, who could work privately with a fitness instructor and receive expert advice particular to their needs.

3.39. There are a number of community sporting organisations, able to work collaboratively with the ACT school system, to assist in providing alternatives to the traditional approach of competitive physical education.

3.40. The Committee heard from Fitness ACT about the program 'Exercise is Fun' which has been developed and aims to make fitness fun, to get children moving and to improve fitness as a natural side-effect of increased activity.

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[34] ibid., p. 190

3.41. The program is described as not being sport, which is inherently competitive, but being exercise which is non-competitive, but that gets the heart rate up. The program includes sessions on stretching and teaching children how to move, and body awareness.[35]

3.42. Rather than focussing on increasing physical fitness and body measurements, the program focuses on having fun by becoming more active, working on the premise that once children are having fun moving they are more likely to include this in their daily lives.

3.43. The additional benefit of this program was that as funding was being sought for the pilot, it would not cost a school or student to participate. The Committee has grave concerns about fitness programs that charge schools or students to participate as it sets up another inequity and disincentive to increase health through fitness.

Recommendation 5

3.44. The Committee recommends that the way physical education is approached in all schools be radically overhauled and incorporate the following points:

a) **Rather than the prescribed mandatory time for physical activity there be a program for all students that teaches appropriate nutrition and exercise, following the principles of the *Health and Physical Education Curriculum Framework*.**

b) **Ranking grades for physical education units should be eliminated.**

c) **Students with proven participation in extracurricular sporting or other physical activities should be able to claim credit for these activities, rather than participate in physical education units, excluding the health education components of those units, which should remain mandatory.**

d) **The Department of Youth and Family Services assist schools to collaborate with community organisations to provide physical activities, that focus on fun, not just competitive sports,**

[35] Uncorrected proof transcript of evidence, 27 February 2003, p. 284

particularly where schools do not have a dedicated physical education teacher.

e) **Fitness testing against prescribed exercises should only be undertaken with extreme caution. Instead, if schools choose to follow this route, 'exercise as fun' programs that allow fitness assessments to be undertaken on the child's own ability should be implemented. Any results from these assessments should be only available to parents/carers.**

Obesity

3.45. Australia-wide, the number of children presenting as overweight or obese is increasing at an alarming rate. Figures below show that the percentage of children identified as overweight or obese has more than doubled in the fifteen years to 2000.

Percentage of children overweight or obese in Australia[36]

	1985	1995	2000
Boys aged 7-11 years	11%	15%	25%
Girls aged 7-11 years	12%	25%	30%

3.46. Obese children have a 25-50% chance of progressing to adult obesity and this risk can increase to 78% for older obese adolescents. Consequences include:

- "Estimates place the direct annual cost of obesity in Australia between $680-$1239 million;
- Obese adults who were obese adolescents have higher levels of weight-related ill health and a higher risk of early death than those who became obese in adulthood;

[36] Dr Kirsty Douglas, Senior Lecturer, Academic Unit of General Practice and Community Care. *Facing the future: Fatness and fitness. An obesity seminar for the ACT*

- Childhood obesity can lead to orthopaedic conditions due to postural imbalance and excessive weight-bearing upon joints;

- Obesity impacts on the psychosocial functioning and well-being of children with studies showing a consistent relationship between levels of overweight and dissatisfaction with their bodies as well as with their levels of self-esteem'. [37]

3.47. There are numerous theories on the causes of obesity in children, including:

- Genetic factors, although this affects a very small percentage of the population;

- Increased energy intake and decreased energy output and increased consumption of high-fat foods; and

- Less physical activity and a perception of decreased physical safety in public spaces, particularly for children.

3.48. Some of these aspects are addressed elsewhere in this report.

3.49. It was pointed out to the Committee that

> in the modern Western world there are two countries [that] are singled out as not having the same obesity problems: France and Holland. … In France they love their food and eat it in food segments, not between meals and in Holland they all ride bikes. There is both an exercise component and a component of maintaining an eating time and a not-eating time.[38]

3.50. Obesity summits in NSW, Victoria and the ACT have pointed to a range of likely solutions such as actions focussing on the population as a whole in a similar manner to drink driving, and anti-smoking campaigns; target lifestyle factors including environmental social and cultural factors; interventions at the individual, family and local community level to change behaviour; and encouraging use of active transport.

3.51. Solutions to address obesity need to be systemic, and not only focussed on the symptom of obesity, but be focussed at cultural change targeting the causes of overweight and obesity. Solutions need to be

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[37] From – NSW Childhood Obesity Summit Communiqué, 12 September 2002
[38] Transcript of evidence, 3 October 2002, p. 214

aimed at a national level targeted through the media, at the food industry, the community, schools, parents and individuals.

3.52. A scheme run in New Zealand encourages doctors to provide 'green prescriptions' for walking, running, jogging, swimming or other exercise. Six months after formal written or verbal advice from a GP, it was found that 52% of people maintained an increase in physical activity.[39]

3.53. The Committee notes that the Government has opened the dialogue regarding obesity in the ACT with a public forum held on 31 October 2002 and hopes that this continues with work in collaboration with all the states and territories.

3.54. However the Committee is concerned that the constant dialogue about obesity in children could compound cultural obsession with weight and although it is essential that this issue be appropriately addressed the Committee would like to see it done in such a way that does not encourage children to be unhealthily concerned about their weight.

3.55. Diabetes is a concerning long-term effect of obesity. Currently children are primarily affected by Type 1 diabetes, known as juvenile diabetes, which is insulin dependent and believed to be caused by both genetic and environmental factors.

3.56. However, increasing numbers of children in the United States and the United Kingdom are being diagnosed with Type 2 diabetes, which has classically been known as late-onset, or adult, diabetes.

> "Risk factors for Type 2 diabetes include older age, obesity, family history of diabetes, physical inactivity and ethnicity. … The emergence of Type 2 diabetes in children has been linked to lifestyle factors such as little exercise and to obesity in children of certain ethnic backgrounds."[40]

3.57. As yet, there is no solid data on the incidence of Type 2 diabetes in children, however Diabetes Australia has a total of 524 people under seventeen registered with the National Diabetes Services Scheme who are non-insulin users and therefore can be reasonably assumed to have type 2 diabetes. This figure includes a total of eight children in the ACT.

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[39] Professor Boyd Swinburn, *Strategies to reduce obesity, what works?* Presentation at ACT Obesity Seminar 31 October 2002.
[40] Al Yaman *et al*., p. 165

3.58. World-wide trends would expect this figure to increase. The long-term effects of Type 2 diabetes can be anything from chronic infections to nerve damage leading to amputation; blindness; renal and heart failure and this is particularly concerning when applied to young people.

Nutrition

3.59. Proper nutrition is an integral part of healthcare. "Diet has been linked to many chronic diseases including cardiovascular disease, some cancers and diabetes mellitus as well as iron deficiency, anaemia, osteoporosis, dental [cavities] and a range of digestive disorders. There is growing local and international evidence that major diet related risk factors for chronic disease begin in childhood."[41]

3.60. The National Nutrition Survey found that "inadequate consumption of fruit and vegetables is responsible for 2.7% of the total burden of disease among Australians."[42] and on the day prior to the survey a significant percentage of children ate no fruit or vegetables.

Percentage of children who do not eat fruit of vegetables[43]

	Ate no fruit	Ate no vegetables
Girls aged 2-7	30%	20% (2-5 years)
Boys aged 2-7	30%	32% (2-3 years)
Girls aged 12-15	42%	14%
Boys aged 12-15	50%	21%

3.61. There is also clear evidence that "unsatisfactory dietary intake is linked to slower recall, decreased concentration and overall poorer performance."[44]

3.62. Although health is a key learning area, "it is the experience of local dietitians that teachers are not supported through policy initiatives and

[41] Submission 16, p.1
[42] Al Yaman *et al*., p. 273
[43] ibid.
[44] Thow, AM. Exploring the relationship between school-aged children's diet and learning: Implications for the ACT. Unpublished. May 2002, p. vi

training to promote positive nutrition messages and develop food skills in the classroom."[45]

3.63. There are a number of school-based programs aimed at improving the nutritional outcomes of school-age children, for example;

- school-based breakfast programs;
- nutrition education programs; i.e.:
  - *Tuckatalk in schools* – aimed at improving food and nutrition skills of children, parents and teachers; and
  - *Funky Foods for Life* – hands-on project teaching nutrition, cooking, budgeting and other skills needed to prepare healthy foods;
- healthy school canteens programs.[46]

3.64. Evidence has shown that programs such as the '*Tuckatalk*' and '*Funky Foods*' programs are effective and the experience of these programs should be applied to the Territory-wide strategy for a nutrition program, as discussed below.

3.65. School canteens are often the focus of nutrition messages.[47] However this can ignore a large percentage of children who bring food from home (which may or may not be nutritious) and create a conflict between the nutritional needs of students and the canteen's role as a fundraiser. In the words of the Heart Foundation:

> The school canteen plays an important role in the majority of school communities. It provides a food service to students and staff, allows for active involvement of parents and in many cases raises much needed funds for other education necessities. The canteen is often the major source of additional funds to the school, particularly at secondary level and this often causes conflict between health educators and the parent bodies who administer school food services.[48]

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[45] Submission 4, p. 3
[46] Thow, AM., p. 18-20
[47] Submission 4, p. 3
[48] Submission 16, p. 1

3.66. Mr Thomas Bode, a student at North Ainslie Primary School, put it more succinctly:

> The school is also introducing some healthy food into the canteen … but they give you some junk food there so the canteen does not go out of business.[49]

3.67. "The eight highest sales of canteen items are: chicken nuggets/burger, hash browns, sausage rolls, meat pies, pizza, hotdogs, flavoured milk, and flavoured mineral water."[50] An anecdotal comment was made to the Committee that even where canteens are making effort to provide only healthy foods, students simply leave the school grounds to go to the local shops.

3.68. Firstly, it is useless teaching children appropriate nutrition messages and then encouraging unhealthy eating practices. School communities need to address this issue – this includes parents, teachers, students and the local shopping centres that profit from students.

3.69. Secondly, it is time to get serious about adequately funding schools so that they can focus on what they are intended to do – educate and care for the health and wellbeing of children and stop letting schools rely on canteen sales and cake stalls, or as happens in the United States, corporate sponsorship, for funding.

3.70. Children themselves are keen to see appropriate role modelling:

> "Having warnings on food would be good as well, because kids who are overweight eat that kind of thing because it tastes good, not because it smells good. It does smell good, but most of the time it tastes good, too, because of all the additives and preservatives and stuff." (Ms Neist)

> "Children are basically the future, but that also applies to adults, because they are role models for us. I know that, when people eat less food, they have a big impact on their children, because their children think, 'I want to grow up like my parents', and so they will eat what their parents eat. With foods, and with cigarettes for adults, the warnings on some packets are actually very small and so they do not stand out. If people see more warnings on foods and read them more often, then

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[49] Transcript of Evidence, 23 August 2002, p. 199
[50] Submission 16, p. 2

they will know what they are actually eating, whether it tastes good or not." (Ms Pippa Finlay)[51]

3.71. Once students reach college it is more difficult to exert control over their eating habits. However it was consistently reported to the Committee that the 'no-breakfast' syndrome is common amongst college-age students. It is widely acknowledged that lack of appropriate nourishment impedes learning.

3.72. Several reasons are reported for this: lack of time; parent who leave for work too early to prepare breakfast; consistently getting up too late to prepare breakfast; lack of hunger at breakfast time; and in the worst cases, homelessness.[52]

3.73. It was reported anecdotally to the Committee during a meeting with college students that the pressures on students are so great that if the choice was between getting up early enough to eat a proper breakfast, or getting extra sleep in the morning, that sleep was the preferred choice.

3.74. Skipping breakfast has been associated with negative effects on cognitive functioning; subclinical eating disorder; and overweight and obesity. It has been suggested that skipping breakfast leads to poor food choices for the remainder of the day. Girls are more likely to skip breakfast than boys.[53]

3.75. There are already free breakfast programs running in some ACT schools. A survey conducted by the Australian Education Union found that 34 percent of ACT primary school respondents run some form of breakfast program, and seventeen percent provide breakfast to all students on one to five days per week. Fifty percent of respondent high schools provided breakfast on the basis of need. [54]

3.76. These programs are funded by a mixture of the schools, church organisations, local supermarkets, and businesses. Thirty percent of respondent schools identified that there was a need for a breakfast program but both staff and physical resources prevented it from being developed.[55]

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[51] Transcript of Evidence, 23 August 2002, pp. 195-212
[52] Mr Dudley Horscroft, Correspondence to the Committee, 10 September 2002
[53] Al Yaman *et al*., p. 276, 277
[54] Submission 15, p. 6
[55] ibid.

3.77. Universal programs, providing breakfast to all children, are more effective than targeted strategies providing breakfast to only certain students "because they do not further stigmatise children from disadvantaged backgrounds and are associated with higher compliance rates" [56].

3.78. Studies have also shown "consumption of breakfast to improve the problem-solving ability of even well-nourished, middle-class nine to ten year old children"[57].

3.79. Targeted programs also add a cost for screening, and may not identify all children at risk for poor dietary intake. Universal programs have the advantage of being able to promote and teach good nutrition for all children.

3.80. The Committee believes that universal breakfast programs, such as that at Narrabundah Primary School, which has a "Breakfast Café" in a spare classroom for senior students, can also promote socialisation and be a venue for other pastoral care activities, and therefore benefit students in numerous ways.

3.81. School-based breakfast programs "are also often used to demonstrate healthy food choices and to offer nutrition education in a practical way"[58]. For example, the food served at the Narrabundah Primary School "Breakfast Café" is "based on the concept of 'brain food' and includes protein sources (such as milk, cheese and peanut butter), as well as fruit, vegetables and bread"[59].

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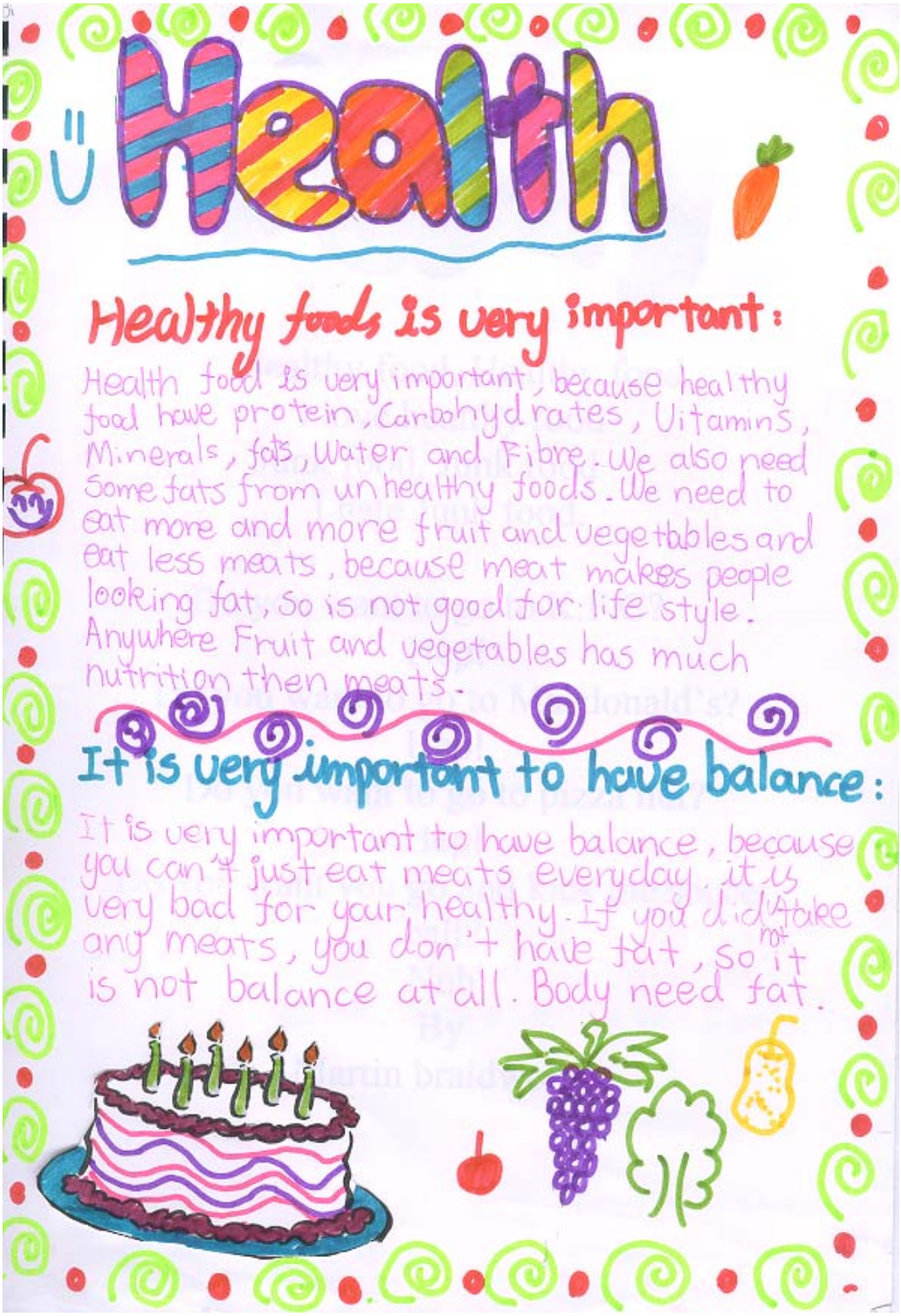
[56] Thow, A-M., p. 16
[57] ibid., p 5 as in Pollitt 1995
[58] ibid., p. 16
[59] ibid., p. 17



'A child's perspective on health'[60]

[60] Submission 27

Food intolerance

3.82. Children are particularly susceptible to the effects of chemicals in food and in many instances express intolerance to certain foods through bad behaviour, poor school performance, chronic and in the worst cases, severe illness.

3.83. The Committee received a number of submissions in relation to food intolerance. These submissions told story after story of the chaos brought to lives of families with one or more children with food intolerance.

3.84. One story tells of a six year-old boy who, after eating a very small amount of snack biscuits became irrational and uncontrollable, physically violent towards his friends and family and suffered headaches, skin irritation and eczema.[61] While this is an extreme case, it does illustrate the effects that food additives are capable of producing.

3.85. The Committee is concerned that children with reactions to food additives or intolerance are being wrongly diagnosed as having behavioural difficulties. Sue Dengate, of the Food Tolerance Network calls for school canteens to adopt a 'low additive' menu.

> The academic performance of 1.1 million schoolchildren improved by 16% after meals were changed in 803 New York City Public Schools to remove artificial colours and some preservatives. The number of students classified as learning disabled simultaneously fell from 125 000 to 74 000 in just one year. No other changes in school programs for the learning disabled were initiated in that year.[62]

3.86. While the introduction of a 'low additive' canteen menu will not affect those children who bring food from home, it will be beneficial in addressing the nutrition needs of all students who buy from the canteen.

3.87. As suggested by submitters, studies have also shown a link between food intolerance or nutritional deficits and juvenile crime. "Five controlled studies in the US have … found that correcting dietary deficiencies or imbalances by dietary manipulation or by multivitamin and mineral supplements produced substantial and highly statistically significant reduction in the incidence of violent disorders, and therefore a

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[61] Submission 12
[62] Submission 9, p. 1

major contribution towards rehabilitation." Similar research has been echoed in the United Kingdom.[63]

3.88. The levels of additives and dyes in foods is of concern, particularly if they have the potential to drastically change children's behaviour. The use of dyes in food has "increased four-fold in the past four decades"[64]. The Committee cannot see any logical reason for this other than to change the appearance of food, dyes do not contribute a nutritional benefit.

3.89. The Committee would like to see a low-additive menu introduced into all ACT schools, including the canteen, school camps and trips and rewards (such as sweets) used by teachers. The Committee would also like to see Government organisations treating children with behavioural difficulties to investigate and offer dietary management as a treatment option.

3.90. A suggested 'low additive' menu is at Appendix 4.

Recommendation 6

3.91. The Committee recommends that a territory-wide nutrition strategy be developed for students at all levels, and including parents, in collaboration with those organisations already undertaking nutrition programs and other key organisations such as the Dietitians Association, the Heart Foundation and the Australasian College of Nutrition and Environmental Medicine.

3.92. The Committee further recommends that as part of the nutrition strategy there be a needs-analysis in all schools, including colleges, to determine whether there are students not having breakfast on a regular basis, and if this is the case, establish a universal breakfast program.

Recommendation 7

3.93. The Committee recommends that the Government require schools to minimise the sale and use of food containing high fats, high sugars, artificial colours, flavours and preservatives from ACT

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[63] Bryce-Smyth, D (1996). Crime and Nourishment. [Online]. Network. [1996, March 15]

[64] Submission 9, p. 2

school canteens and, in consultation with appropriate experts, introduce an alternative menu which offers healthy choices in all school canteens. This requirement should also apply to contracts where school canteen services are outsourced.

Recommendation 8

3.94. The Committee recommends that the Government, as part of the Nutrition Strategy:

a) **undertake an education program to increase awareness of the symptoms and effects of food intolerance in the community;**

b) **put in place a policy that when children are identified with behavioural problems, dietary management should be investigated and offered as a management option; and**

c) **offer dietary management as part of the rehabilitation process for juvenile offenders.**

Television advertising

3.95. Increase in television viewing and computer usage has been show to have links with increased obesity due to sedentary behaviour in children. Increased television viewing has a double impact as children are exposed to advertising of unhealthy foods.

3.96. A recent study undertaken into advertising on children's television found that fast food and confectionery is being promoted at the expense of healthy eating and of 544 advertisements promoting food products broadcast in 63 hours of C and G classified programs, 80% were for 'nutritionally marginal' foods.[65]

3.97. This study also found that many of these advertisements promoted toy offers or other premium offers as the dominant factor rather than incidental to the main product, as the Children Television Standards require.

3.98. Many children cannot easily differentiate between foods and products that are or are not healthy. The above study cited an example of an advertisement showing animated figures squeezing fruit into a

[65] Zuppa, J. Flinders Journal: July 30-August 12 2001.

confectionery which in actual fact does not contain any fruit, just fruit flavouring.

3.99. Australian Broadcasting Authority regulates what can be shown on television to children and gives programs and advertisements appropriate classifications.

3.100. The 'C' (Children's) and 'P' (Pre-school) classifications refer to a children's program "which:

(a) is made specifically for children or groups of children within the pre-school or primary school age range;

(b) is entertaining;

(c) is well produced using significant resources to ensure a high standard of script, cast, direction, editing, shooting, sound and other production elements;

(d) enhances a child's understanding and experience; and

(e) is appropriate for Australian children."[66]

3.101. Commercials are not permitted during P classified programs, and only five minutes of commercials are permitted for every thirty minutes of C classified program material, except for those drama programs broadcast between 6:00pm and 8:30pm when no more than 13 minutes of advertising may be shown every hour.[67]

3.102. There are clear guidelines as to the type and content of advertising to be shown during children's programming. There must be a clear separation to the child viewer, of advertisements and sponsorship announcements (CTS15); during 30 minutes of C programming, advertisements must not be repeated more than twice (CTS16); advertisements must not mislead or deceive children (CTS17) and must accurately represent the product or service advertised (CTS19); and advertisements must not be designed to pressure children to ask for products or services.

3.103. The Committee is satisfied that, if adhered to, these requirements are satisfactory in limiting the advertising shown to children during C and P rated programs.

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[66] CTS2, Children's Television Standards, Australian Broadcasting Authority
[67] CTS13, CTS 14

3.104. In looking at a television program guide, where most parents and carers would receive programming and classification information, the three commercial television stations broadcast 30 minutes each of P and C programs on a weekday (29 October 2002). On a weekend day (2 November 2002), one commercial station broadcast one hour, the second two and a half hours, and the third 30 minutes of C programs.[68]

3.105. In contrast, 'G' (General) rated programs targeted at children (excluding news, current affairs and sports programming) were broadcast for one hour to four hours on the same weekday and one hour to six and a half hours on the same weekend day.

3.106. The commercial television code of practice defines material classified G as not necessarily intended for children, but must be suitable for children to watch unsupervised. There are limits placed on violence, sex and nudity, language, drugs, suicide, social or domestic conflict, imitable and dangerous behaviour and those effects that may cause distress to children.[69]

3.107. All commercials broadcast in the G program hours must also comply with the G classification.[70] These commercials are not subject to the Children's Television Standards but have the same audience.

3.108. It is widely acknowledged that advertising to children is problematic, not only in terms of food, but also in terms of stereotyping body image[71], gender role development and antisocial behaviour[72]. Sweden, Greece, Belgium, Denmark, Ireland, Italy, Poland and Norway all have bans or restrictions on television advertising to children and there is a push to extend this across the European Union[73].

3.109. Just as convincing to the Committee was the evidence given by a group of year 5/6 students from Ainslie Primary School.[74]

3.110. Ms Elizabeth Neist said:

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[68] The Guide, October 20-November 3 2002, *The Canberra Times*
[69] Commercial Television code of practice, Australian Broadcasting Authority.
[70] ibid.
[71] *Effects of advertising on stereotyping body image*, Young Media Australia. 2002.
[72] Hoek, J and Laurence, K. *Television advertisin to children: An Analysis of selected New Zealand commercials* in Marketing Bulletin, 1993, 4, 19-29.
[73] *An ISBA briefing paper – May 2002. Issue: Advertising to children*. ISBA May 2002.
[74] Transcript of Evidence, 23 August 2002, pp. 195-212

> "Everyday problems like food and advertising, self-esteem and body image are pretty big for kids my age. I see eight-year-old kids trying to keep up with 15-year-old girls, and that is pretty sad. Because adults often misunderstand us, we have problems when they make rules and decisions for us that really don't help us. They don't know what we want and need because they don't ask us."[75]

3.111. Mr Julian Ingall said:

> "I think that not enough people are eating healthy food because they listen to ads on TV that get them to buy healthy food by twisting their minds around. The ads say things like, "This food has 25 per cent less fat than most spreads," when most spreads have lots of fat anyway, so it hasn't really reduced it by much. The government has some control over what goes on TV, so I think they should put restrictions on ads that target children about food. By not controlling the adverts, the government is directly contributing to the poor health of many children."

3.112. These children recognise that television advertisements are negatively affecting their health, self-esteem and food choices but feel powerless to control what they are exposed to. However they do have ideas on how children can be better targeted by the media, and government:

> "What we really need is some huge campaign using famous people to get kids up off their butts and motivated to be healthy. They are also going to have to get adults to set good examples so that children think it is really good to exercise, and then they will probably do it more. There are probably heaps of things the government could do, and I think children should be involved in what it is doing. After all, it is our future they are dealing with." (Mr Ingall)[76]

3.113. They were also keen to see greater explanation and role modelling of positive behaviours.

3.114. This issue needs to be addressed at a Federal level because changes need to be made to the requirements for advertisements shown to children during G rated programming, however the ACT Government and community can play an integral role in lobbying for such changes.

3.115. The Committee supports the call by the Victorian citizen's panel of the *A Healthy Balance: Victorians Respond to Obesity* forum and the recommendation of the NSW Childhood Obesity Summit calling on the Federal Government to place restrictions and/or greater controls on food advertising to children.

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[75] ibid.
[76] ibid.

3.116. Television advertising has a powerful effect on children, as anyone who has had much contact with children will be able to attest, however allowing such detrimental levels of advertising also sends a very powerful message about the value of corporations over the value of the welfare of children.

Recommendation 9

3.117. The Committee recommends that the ACT Government support the call for greater controls and restrictions on food advertising through the media to children and actively work towards achieving this goal.

Recommendation 10

3.118. The Committee recommends that the ACT Government form a working party with the States and Northern Territory to make representations to the Federal Government to enhance the Children's Televisions Standards to cover all children's television, including programs with a 'General' rating.

Access to medical care

3.119. As has been well documented in the media and through other Committee inquiries[77] that the ACT has a shortage of approximately fifty general practitioners (GPs). This makes access to appropriate medical care generally very difficult, but more so for young people and adolescents who find it otherwise difficult to access medical care.

3.120. Young people find it difficult to access medical care for many reasons including:

- financial constraints, compounded by the reduction in bulk-billed services;
- the physical surgery settings are not set up to accommodate young people;
- the perception that doctors, nurses and reception staff are judgmental; and

[77] Select Committee on Estimates 2001-2002

- the inability to reach surgeries in suburban locations.

3.121. GPs are in an ideal position to address the whole-of-life issues affecting a young person's health. But many report difficulties that young people have in keeping appointments, or making appointments appropriate to the length of time they need to discuss all of their issues.[78] It is obvious to the Committee that the traditional model of health care does not suit young people, particularly those from disadvantaged backgrounds.

3.122. The Committee heard of two models that were working particularly well in the ACT for the provision of health care to young people.

3.123. The Junction Youth Health Service is established as a youth-specific health service where young people can access a youth worker, counsellor, nurse or doctor. As staff are salaried, a Medicare card is not needed and there are no fees for up-front services. However as it is located in Civic, it is difficult for young people outside of the inner suburbs to access.

3.124. 'The Bay', located at the Canberra College was recommended to the Committee numerous times, by health professionals, young people and teachers alike as a good health model for youth health services.

3.125. "'The Bay' is a suite of rooms at both campus sites of The Canberra College which are designed to enable students, staff, parents and community members to access a diverse range of career, health and social services and agencies in a safe, friendly and accessible way.[79]

3.126. Services on offer, when available, include:

- Jobs Pathways Program – Quest Solutions
- YWCA Canberra Youth Outreach Support Service (CYOSS)
- Weston Creek Youth Program (youth worker)
- Indigenous Education Unit/Indigenous Employment
- Canberra Sexual Health Centre
- Centrelink

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[78] Transcript of evidence, 20 June 2002, p. 31
[79] Submission 17

- Woden Youth Centre
- Nurse
- Doctor
- Mental Health Foundation
- Drug Referral and Information Centre
- Chaplain

3.127. 'The Bay' is extremely popular with students. It operates on a 'drop-in' basis, allowing students to access free, confidential medical and social support.

3.128. Narrabundah College has a similar system established and seeks to regularly have agencies on site to help students with issues such as homelessness, mental health issues, drug and alcohol related problems, sexual health and relationship issues and employment.

3.129. This program, like The Bay, is popular because it allows students to access services in a confidential manner in an environment which the students are comfortable.

3.130. While these models are ideal, the Committee acknowledges that with the GP shortage in the ACT finding adequate staffing for these youth health services may not be possible. However the Committee heard that there are a range of other youth-friendly measures that GPs can undertake and encourages the Government to work with the Division of General Practice to ensure that there is a youth friendly health centre or GP location in each of the major town centres.

3.131. Young people over the age of fourteen are able to consent to medical treatment, but parents/guardians can access their medical records until they reach the age of sixteen[80]. This may further discourage young people to see medical assistance from the 'family doctor' and is another reason to facilitate the establishment of youth health centres.

Recommendation 11

[80] Transcript of evidence, 20 June 2002, p. 33

3.132. The Committee recommends that the Government establish youth health centres in Tuggeranong, Belconnen and Gungahlin, similar to The Junction Youth Health Service, to ensure that all young people have equitable access to affordable, confidential health care.

3.133. Staff at the Woden Youth Centre told to Committee that a local club delivers free meals once per week, but further support is needed in order to get health messages across. Of a care group of seventy young people attending the centre, not one is a non-smoker, drug use is high as are mental health issues.

3.134. An officer from Centrelink was attending the youth centre on a weekly basis to assist young people in filling in forms and claiming benefits – allowing an income, which is imperative to receiving appropriate health care. Unfortunately when the individual officer left Centrelink, these visits stopped.

3.135. Luckily, the youth centre is able to link into The Bay, however the youth workers at the centre suggested that a youth health worker who regularly visits youth centres, runs education programs on health issues such as nutrition, sexually transmitted diseases, and even basic hygiene would also prove useful and effective.

Recommendation 12

3.136. The Committee recommends that funding be provided for a youth health worker to visit each youth centre on a weekly basis to provide basic health advice and education programs.

Recommendation 13

3.137. The Committee recommends that the Government ensures that The Bay receives ongoing funding and that a similar service be established at, or accessible by, all ACT colleges.

3.138. Finally, the Committee saw first hand the state of the Woden Youth Centre, which is in desperate need of refurbishment to update it and make it more attractive. It is disrespectful to the young people who use the centre to leave it in a condition that the Committee is sure most adults would not choose to socialise in.

3.139. Youth centres are an integral part of the social network for young people and the committee feels that it would show trust and respect to young people to provide centres that show them they are valued. The Committee also believes that any updates to youth centres should be done in consultation with and in co-operation with young people so that they take ownership of the project, and making use of the opportunity to teach skills or introduce trades.

Recommendation 14

3.140. The Committee recommends that the Government provide funding to refurbish all youth centres in need of modernisation.

Substance use

3.141. The Committee heard evidence that the use of licit and illicit drugs starts as young as seven or eight through children being encouraged to take a sip of alcohol, or having access to cigarettes and boasting about this experimenting, pressuring peers to do the same. Drug use at school is not the result of "behaviour by nefarious characters" as is commonly believed, but is perpetrated by young people who have accessed licit and illicit drugs in their home.[81]

3.142. Directions ACT raised concerns that the use of licit drugs (such as aspirin or paracetamol) has become so normalised in social behaviour that this in itself encourages illicit drug use, including the use of legally prescribed drugs, in an illicit manner.

3.143. Licit drug use is also a major issue for young people who are encouraged to drink caffeine through sports drinks, soft drinks, tea and coffee which can be particularly damaging for young people as they are still growing.

3.144. Substance misuse leads to "poor personal relationships; reduced ability to learn and participate in school activities; increased absenteeism; cost of maintaining alcohol and drug use – which can often lead to criminal behaviour to acquire money"[82] subsequently involving young people in the legal system, and further compromising their lives and health outcomes.

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[81] ibid., p. 8
[82] Submission 2, p. 4

3.145. Over 50% of secondary school students that have used substances, nine out of ten have tried alcohol, over 50% have used tobacco and 5% have used needles to inject an illicit substance.[83]

3.146. Resources and efforts regarding substance use are being focussed at the point when young people are already entrenched in the culture rather than identifying why there is the need to experiment with drugs and what can be done to intervene at an earlier stage.[84]

3.147. Directions ACT offers an on-site counsellor to all colleges for one day per week and access to that counsellor has increased dramatically[85]. The Committee also heard anecdotal evidence from college students that this service was genuinely appreciated for the confidentiality and maturity with which the students are treated, and therefore extremely popular.

3.148. Students also appreciate the 'real facts' given to them by the Directions ACT counsellor. It was explained to the Committee by one college student that if young people are going to experiment with drugs they are just going to use whatever is available to them and so they need real information on the short- and long-term effects, and how to minimise them.[86]

3.149. It became apparent to the Committee that drug education varied between schools. Ms Karen Harmon, from Directions ACT reported being asked, when entering some schools to undertake drug education, not to talk about 'hard-core' drugs such as heroin, amphetamines and cocaine[87].

3.150. Paradoxically, the Committee also received evidence from year 5/6 students at North Ainslie Primary School, which made clear that these students had received a comprehensive education on these 'hard-core' drugs and their effects.[88]

3.151. It seems to the Committee that there are many effective programs, but there is no overall co-ordination of which agencies are going into schools or consistency in information provided. It was also apparent that

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[83] Submission 2, 1999 ACT Secondary Schools' Alcohol and Drug Survey
[84] Transcript of evidence, 20 June 2002, p. 9
[85] ibid.
[86] Anecdotal evidence, meeting at The Canberra College, 26 August 2002.
[87] Transcript of evidence, 20 June 2002, p. 10
[88] Submission 27

many of these programs that were outside of the core curriculum and depended on the expertise and drive of individual teachers.

3.152. Ms Harmon told the Committee that the different levels of education, and the fact that private schools seem to miss out on a lot of informed health education, is apparent in the young people who access Directions ACT.[89]

3.153. From anecdotal evidence, the Committee is also concerned that some programs being delivered are irrelevant to young people and that any programs should be developed in consultation with the young people they are meant to target.

3.154. Additionally, while there are many programs targeted at combating substance use by young people, Directions ACT reports that:

> "on the face of it – it appears that there are just too many agencies involved and there is little or no collaboration. There have been many instances when [Directions] have learned of activities that have taken place or are planned for implementation well after the fact. These are often in competition or conflict with our own activities."

3.155. Concerns were also expressed to the Committee that drug education took place too late, and by the mid-teens, patterns of drug use had already been established.

3.156. Young people told the Committee[90] that the current series of health promotion ads targeting binge drinking and drug use are sending the wrong message and are ineffective. The retribution ads such as those used for drink driving and smoking are far more effective. It is a concern if health promotion messages are being developed without consultation.

3.157. This was reiterated in evidence from young people –

> Get rid of the idea of bad things—indeed, bad drugs, bad sex, bad smoking et cetera. Many of us feel that doing something risqué is much more exciting than doing something acceptable, and thus more youths are likely to experiment with the bad things. We are not saying that we should legalise drugs and alcohol. We are just saying that by telling youths that "drugs are bad" and "do not drink" is not as effective as saying, "Make

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[89] Transcript of evidence, 20 June 2002, p. 13
[90] Anecdotal evidence, meeting at The Canberra College. 26 August 2002.

> your own choices but know all the risks." This "bad things" attitude also puts parents in the wrong frame of mind and reduces their ability to remain open-minded and their ability to communicate and support their children and, thus, to help them through to the best answer and response.[91]

3.158. Young people have proven again and again to this Committee how engaged they are in their health and the issues that effect them. Those developing education programs and health promotion messages of any type should make a point to do so in consultation with the young people in their target group.

3.159. The Committee asked the Government what involvement young people had in developing programs. The Committee was told that:

> Drug education curriculum scope and sequences based on the ACT Health and Physical Education Curriculum Frameworks ensures information is developmentally and socially appropriate for students. At secondary level, students have been trained to deliver units of work in consultation with drug education officers and school-based teachers on drugs to junior students.[92] [sic]

3.160. The Committee is pleased that senior students are involved in drug education delivery, however feels that more effort need to be made to involve students in developing programs in the first instance.

Recommendation 15

3.161. The Committee recommends there be an independent evaluation of drug education programs delivered in schools by community, government and non-government agencies and that this evaluation be underpinned by the principles of harm minimisation and relevance to young people.

Recommendation 16

3.162. The Committee recommends that health promotion campaigns and education programs focussing on substance use be developed in consultation with young people in the target group and community service organisations to ensure their relevance and effectiveness.

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[91] Transcript of evidence, 3 October 2002, p. 255
[92] Correspondence from Minister for Education, 1 August 2002

Recommendation 17

3.163. The Committee recommends that a consistent approach should be defined for drug and alcohol education offered across all school sectors.

Asthma and allergy

3.164. Australia has one of the highest rates of asthma in the world, with 27 percent of children aged six to seven reporting asthma wheeze. This figure is slightly higher in the ACT where there seems to be a higher rate of hay fever and rye grass allergy.[93]

3.165. Because Canberra does have this high grass pollen load, it is important that other outdoor pollution is kept at a low level[94], particularly in areas children frequent.

3.166. However, while the ACT appears to have higher levels of allergies to air-borne pollen is than elsewhere in Australia, the Committee also heard evidence that indoor pollutants are equally important to consider when addressing childhood asthma.

3.167. Bedding is particularly important when looking at indoor causes of children's asthma, as it contains high concentrations of dust mites and children spend up to eight hours, a third of their day, with bedding just centimetres from their face. Research has found that synthetic bedding holds five to eight times more dust mites than modern feather bedding.[95]

3.168. Indoor heating and home gas appliance use also contributes to asthma and allergy. "There is quite an amount of literature available suggesting that high exposure to fossil fuel combustion products is not only detrimental to the airways of individuals, but also it might enhance allergic responses"[96].

3.169. While heating tends to be appropriately vented, gas-cooking appliances used inappropriately can lead to high levels of nitrogen dioxide pollutants. It is important that exhaust fan systems are used appropriately.

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[93] Transcript of evidence, 20 June 2002, p. 22
[94] ibid., p. 27
[95] ibid. p. 27
[96] ibid., p. 25

3.170. Canberra has the additional issue of the use of wood-fuelled heaters, which is an additional level of outdoor pollution aggravating asthma and allergy in the winter months, which reiterates the need to keep other outdoor pollutants at a low level.

Recommendation 18

3.171. The Committee recommends that the Government undertake an education campaign highlighting the importance of the associations between children's bedding and asthma and the poorly ventilated cooking and asthma.

3.172. The Committee also heard evidence that vitamin D is an important factor in building the immune system and sun exposure is one way that it is synthesised to be used appropriately by the body. It has been found that lack of vitamin D contribute to immunological disorders such as diabetes and asthma.

3.173. To this end, it was suggested to the Committee that schools review their 'hats-on' policy for the winter period so that children get appropriate sun exposure to assist immunological development.[97] The incidence of vitamin D deficiency has also been highlighted in the media recently and the Committee feels that there is a need for further review of this issue.

Recommendation 19

3.174. The Committee recommends that the Government undertake a literature review into the incidence of vitamin D deficiency and take appropriate action.

Environment

3.175. The Committee heard from a range of witnesses about the environmental impacts on health and has addressed these issues throughout this report.

3.176. All children are exposed to environmental factors be they in the immediate environment such as bedding and home surrounds, the wider school environment, or other global influences. Children are more

[97] Transcript of evidence, 20 June 2002, p. 28

susceptible to adverse environmental impact, given their smaller size, and rapid growth and development.

3.177. When looking at the influences in children's health, Government, schools, the community and parents need to consider the whole environment as an immediate influence on children's health.

3.178. There is a lack of information in Australia on the impact of "environmental factors such as air quality, soil and water contamination" on the health of Australians.[98] The Committee believes that such studies need to be undertaken as a matter of priority.

3.179. The National Pollution Inventory reports on estimated substance emissions as collected by participating jurisdictions. An overview of two locations in the ACT – the 2601 postcode area (City) and the 2903 postcode area (Wanniassa) finds 57 substances from 21 and 19 sources respectively.[99]

3.180. These sources include motor vehicles; architectural surface coatings; solid fuel burning; domestic/commercial solvents/aerosols; liquid fuel burning (domestic); and others such as cigarettes; barbecues; and gaseous fuel burning (domestic).[100]

3.181. Toxins in the environment can cause headaches, nausea, dizziness, eye, nose and throat irritation, inability to concentrate and irritations, in the longer term they have been linked to cancer, anaemia, birth and reproductive problems and liver and kidney disease.[101]

3.182. Evidence also suggested that air quality and other environmental factors can have an impact on the health and behaviour of children with attention deficit hyperactivity disorder.[102]

3.183. The National Occupational Health and Safety Strategy 2002-2012, signed by Simon Corbell MLA the then Minister for Industrial Relations, sets a national priority for action as the prevention of occupational disease more effectively. It provides that employers must provide a safe environment, employees must work in a safe manner and that manufacturers and suppliers must provide safe products and equipment.

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[98] Glover, J et al, Volume 9, p. 66
[99] National Pollution Inventory, found at www.npi.gov.au
[100] ibid.
[101] Transcript of evidence, 15 August 2002, p. 109
[102] ibid., p. 135

3.184. The Committee considers that the Government has a responsibility to not only provide safe schools for children, but safe working environments for teachers. However the Committee received evidence that chemical audits are not being taken seriously, and records are not being kept on the type and nature of furnishings used in school renovations.[103]

3.185. There are numerous resources to assist schools to undertake a chemical audit[104] and should the Government fail to act on the following recommendation, the Committee encourages schools and school communities to take an active role in leading the push to remove or reduce toxic threats to children's health.

3.186. The Committee notes that the Government does have policies in place regarding the use of chemicals in schools, including for pest control and cleaning and those chemicals used in class such as science and art. However, this policy needs to be extended to cover ventilation, insulation, use of low-emission building materials and furnishings and food additives.

[103] ibid.
[104] See www.toolsforhealthyschools.org

Recommendation 20

3.187. The Committee recommends that the Government undertake an education campaign on ways to reduce harmful substance emissions from normal household use.

Recommendation 21

3.188. The Committee recommends that the Government, as a matter of urgency, undertake an occupational health and safety audit of all Government schools which includes a chemical audit addressing all potential environmental hazards such as toxin levels and emissions from buildings and furnishings and chemicals used for cleaning and gardening.

3.189. The Committee further recommends that the Department of Youth and Family Services commit to a stronger oversight role to ensure that policies pertaining to environmental hazards, use of chemicals and safe building materials are adhered to by employed contractors and consultants.

Recommendation 22

3.190. The Committee recommends that the Government fund a comprehensive study on the environmental factors affecting the health of school-age children in the ACT, in consultation with key community and environmental groups, including the Commissioner for the Environment.

4. Mental well-being

4.1. Children suffer a range of mental health problems, including diagnosed mental illnesses, depression and conduct or behavioural disorders. There are genetic links to certain mental illnesses, but social and environmental experiences are also recognised as contributors to mental health.

4.2. Risk factors include: individual factors; family and social factors; school context; life events and situations; community and cultural factors. Australia-wide, it is estimated that 15% of children aged 4-17 years have some form of mental health problem.[105]

4.3. Unfortunately there still seems to be a great deal of blame involved when dealing with children with a mental health problem and a refusal to admit to problems, or a medicalisation of those problems when they are recognised. Indeed, witness told the Committee about a report of a mental health worker medicating a thirteen year old for depression, because 'depression is our core business'.

4.4. It is time to stop thinking of depression, or any other mental illness as a business of the health industry and time to start putting in place mechanisms to support young people so they can avoid entering the system.

4.5. Early investment in preventing health problems is estimated to save seven dollars for every dollar invested.[106] Investments need to be made now in order to not only save future health and education budgets, but to ensure that all children have a strong foundation from which to lead healthy and happy lives.

4.6. There is a serious lack of funding for school counsellors. Indeed, there is an overall lack of school counsellors. To qualify to become a school counsellor in the ACT there is an onerous process that acts as a deterrent to already stretched teachers[107].

4.7. Schools often only have access to a counsellor for part of a day or week. The counsellors are unable to get to know children well and track

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[105] Al-Yaman *et al*, p. 193 and Transcript of evidence, 3 October 2002, p. 237
[106] Transcript of evidence, 15 August 2002, p. 114
[107] ibid., p. 181

their progress and are only able to deal with crisis on the day they are present at the school.

4.8. The Committee heard evidence that school counsellors are often used as punishment, were unable be trusted (i.e. will tell parents or peers of concerns), or are brought in to solve the slightest conflict. However, as a whole, students reported to the Committee that they would use counselling services, if they were available within the school, and if the counsellor was seen as a part of the school community.

4.9. With the increasing prevalence of mental illness, mental health and other health issues, there is an urgent need to fully fund school counselling services to ensure that a full-time counsellor is available at each primary and high school and college in the ACT. However, this role needs to be carefully targeted and not used as a form of punishment. The person in this role needs to be actively involved in school activities – research has shown that "PE teachers and people who are involved with the kids directly are the ones they're more likely to open up to"[108].

4.10. It was also put to the committee that this role should also be responsible for overseeing an implementing welfare programs and health education to ensure that all students are receiving consistent education throughout the schooling years.

Recommendation 23

4.11. The Committee recommends that, as a matter of urgency, all schools (including colleges) be funded to employ a full time health and welfare officer to be responsible for counselling and co-ordinating health education. This funding should come from core funding, not a reallocation of existing resources.

Help-seeking and resilience

4.12. In their 2002 report on contacts with the telephone counselling service, the Kids Help Line reports that nationally, the six main problems reported by girls were interpersonal relationships, bullying, child abuse, pregnancy, mental health and grief. For boys the top six were interpersonal relationships, bullying, sexual activity, drug use, child abuse and homelessness.

[108] ibid., p. 179

4.13. In the ACT, the top reasons for contact were relationships (peer, family and partner), bullying, pregnancy, child abuse, loss and grief, homelessness, sexual activity and drug and alcohol abuse.[109]

4.14. Contacting help services is seen as an effective coping behaviour. Other forms of coping are avoidant coping (drug and alcohol use or excessive work or exercise) or emotion-focussed coping (getting caught up in emotions and working into an emotional state). While help-seeking can be positive, young people need to be taught what type of services are appropriate to access. For example, seeking help from their friends, girls tend to amplify each other's distress.[110]

4.15. While there are a plethora of programs aimed at raising awareness of mental health problems and mental illness, these do not show solid evidence of effectively increasing help-seeking. Regardless, a program that does focus on the whole school becoming mental-health-promoting, does benefit students.

4.16. The Committee heard from students that suicide is a major concern, both for them and for their friends, yet also heard that you "can't get into schools and use the 'suicide' word"[111]. As with the prohibition in some school of mentioning 'hard-core' drugs in drug and alcohol education, the Committee can see no logic in avoiding the word 'suicide', particularly when there is evidence "to show that if you ask people about suicide it does not increase suicidal behaviour".[112]

4.17. Again, as with drug and alcohol education, there appears to be no co-ordination of mental health education, with students and professionals reporting to the Committee varying experiences of education programs.

4.18. There needs to be a strategic level co-ordination of what programs students are being offered. The Committee understands that there is always a time of testing pilot programs to ensure their effectiveness, however the Committee also feels that the ad-hoc approach to mental health education is not useful.

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[109] Kids Help Line Infosheets – Statistical summary 2002 and Australian Capital Territory 2002.
[110] Transcript of evidence, 15 August 2002, p. 176
[111] ibid., p. 185
[112] ibid., p. 185

Recommendation 24

4.19. The Committee recommends that a consistent approach be defined for mental health education and applied across all sectors, making use of those community organisations with proven expertise in the area. Programs should be developed and/or adopted in consultation with experts in this area.

4.20. The Committee further recommends that mental health programs should not only focus on mental health awareness, but be equally focussed on increasing help-seeking behaviour.

4.21. Mental health programs also need to focus on building resilience, giving young people almost a moral toolbox from which they can draw skills and methods of coping. It has been found that a barrier to help seeking is a

> lack of emotional competence, that is, not having the language or skills to recognise, interprets and share emotional experiences inhibits help-seeking. Boys are particularly poor at recognising their emotional state and having a vocabulary to explain it.[113]

4.22. Knowing how we process information, events and experiences is essential to how we cope with life experience. The Committee questions *– are we giving our young people the right ingredients to make positive judgements for their mental wellbeing?*

4.23. The Committee heard from young people that the answer to this question is no.

> People keep telling us what we should be like, yet there is a lack of information telling us or supporting us in how to live with the world that we find ourselves in, and most importantly how to do this safely. For example, more needs to be done in providing the information or the skills for young people to be able to handle situations such as peer pressure, emotions and self-hatred. We are often told not to put up with problems and we know that they are out there, but many of us lack the

[113] Dr Debra Rickwood, Head, Centre for Applied Psychology, University of Canberra, presentation paper, 15 August 2002, p. 5

knowledge of what we can do about them, and thus are often forced to live with them literally on our own.[114]

4.24. The Committee heard evidence of philosophy being taught in schools to teach children to think and communicate with others. Young people need to be taught how to develop their own reference points and their own thinking processes, so when they are confronted with decisions, they can draw on their own resources.

4.25. Investigating the concept of philosophy in schools, the Committee visited Mawson Primary School which has incorporated a 'Self Awareness through Human Values'[115] program into the daily curriculum of the entire school. The intended outcome of the program is a balanced individual who:

- Has a greater emotional intelligence;
- Is more capable of coping with the rigours of life;
- Is empowered to make better choices in life (including the ability to say no);
- Is more employable as he/she grows into adulthood;
- Accepts people different from themselves;
- Respects their parents, teachers, elders and each other and law and order;
- Gives service to the community, particularly those less fortunate then themselves;
- Develops good health habits and good behaviour;
- Acquires academic skills and growth;
- Works with and lives in a society efficiently and harmoniously; and
- Develops discrimination and wisdom to conduct themselves with humility and gentleness.

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[114] Transcript of Evidence, 3 October 2002, p. 254
[115] www.mawsonps.act.edu.au

4.26. The program has a core set of values based on the key values of righteousness, peace, truth, love and non-violence which permeates the entire culture, language and attitude of the school. Every two weeks, the school focuses on teaching a new value. On the day that the Committee visited the school it observed an kindergarten class learning about kindness through storytelling, and a year 3/4 class learning about kindness through a guided meditation.

4.27. The program is similar to programs run in schools teaching philosophy, which teaches children to think, discuss, question and develop their own moral guide.

4.28. The Committee also spoke to year 5/6 students about the program and was impressed by their grasp of the concepts, and the emotional intelligence displayed by the students, in particular the boys. Indeed, in contrast to other groups of young people that the Committee spoke to, the boys in this group were more vocal than the girls. Students reported that they:

- Felt valued and loved at the school;
- Incorporated the values into other aspect of their lives, including home and social activities;
- Had greater skill to communicate their feelings;
- Were more accepting of people who are different to them; and
- Were more able to deal with stress and conflict in a productive manner.

4.29. The school is fortunate through circumstance to have a full-time teacher dedicated to developing and implementing this program, and who is also available to work individually with children, working on values that, as individuals, they may find particularly difficult to express.

4.30. The Committee was impressed by this program, however holds concerns for these children when entering high school, going from an emotionally-aware environment to an environment that is not necessarily so, and at a developmental time when young people particularly need support.

4.31. The children themselves expressed this concern, but as one student pointed out, they at least now had a good basis to deal with problems when they arose. However the Committee feels that a program like this

implemented in all ACT Government primary schools would be a good precursor to the Gatehouse Project as discussed in Chapter 5.

Recommendation 25

4.32. The Committee recommends that a 'human values' or philosophy program such as the successful program at Mawson Primary School be developed for implementation in all ACT primary schools.

4.33. There is a need to address mental health education as a cultural issue. Research is showing that highly individualistic societies ("placing the individual at the centre of a framework of values, norms and beliefs in an ethic of self-centredness and self-gratification") actually leads to poorer health outcomes because of the negative impact on a person's psychosocial wellbeing.[116]

4.34. Research as found that "large linear increases in anxiety and neuroticism occurred in US children and college students between the 1950s and 1990s, which were linked to declining social connectedness and increasing individualism; economic factors such as poverty and unemployment appeared not to be involved"[117].

4.35. Lack of social connectedness was raised repeatedly throughout this inquiry, both by academics and the community sector, as a major factor in the negative health outcomes of young people.

4.36. It is time to urgently and seriously address this issue. Again, the Gatehouse Project has been recommended to the Committee by academics and the community sector, and this is discussed further in Chapter 5.

4.37. The Committee heard from the Messengers Program and the Bungee Program both of which seek to build resilience in young people who suffer from or show indications of depression or anxiety.

4.38. The Messengers Program does this through use of art, creative writing and performance. The program takes participants, referred by schools or identified by the program manager, through a process of

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[116] Eckersley, R. 2002, Future visions for children's wellbeing, in Prior, M (ed) *investing in our Children: Developing a research agenda*, Academy of Social Sciences in Australia, proceeding of workshop, Melobourne 29-30 May 2002.
[117] ibid., p. 3

putting their own perspective on their life environment and putting that perspective into artistic form. Because of this process and its safe environment, young people are able to disclose and work through their issues.[118]

4.39. The Bungee program is a "youth resilience program … [providing] early intervention to children and youth, aged 5 to 18 years, with mild or moderate mental health issues and disorders through one to one counselling, support, skills group work (gender, anger, stress and body image) and mainstream activity"[119].

4.40. The Bungee program also offers support for parents/carers through parenting workshops, counselling and referrals within the Belconnen Community Service.

4.41. However there is generally a lack of funding for such programs, given that they are amongst the only programs for children and young people with mild to moderate mental health issues. Staff of the Bungee program reported to the Committee that they were picking up a lot of kids that were unable to access the Child and Adolescent Mental Health Service, which does not have the resources to cater for mild to moderate problems.

4.42. Programs such as Bungee and Messengers need to be adequately funded and replicated all over Canberra to try to capture children and young people before they enter into the mental health system.

4.43. Mental health workers also told the Committee that resilience programs were needed across Canberra, to try to prevent engagement in the mental health system and to relieve currently over-burdened mental health service.[120]

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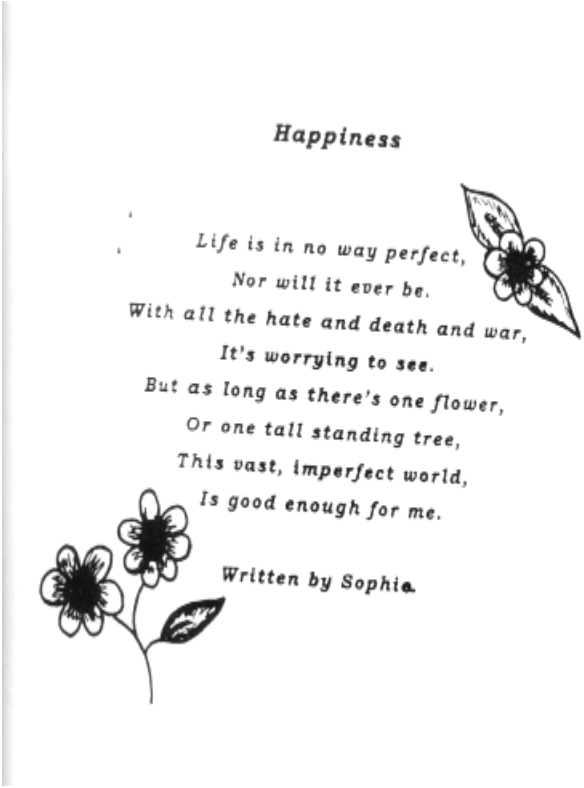
[118] Uncorrected proof transcript of evidence, 27 February 2003, p. 273

[119] Correspondence to the Committee dated 13 May 2002 from Ms S. Moskwa, Belconnen Community Service Inc.

[120] Tour of mental health services, 4 October 2002



Happiness

Life is in no way perfect,
Nor will it ever be.
With all the hate and death and war,
It's worrying to see.
But as long as there's one flower,
Or one tall standing tree,
This vast, imperfect world,
Is good enough for me.

Written by Sophie

'Teen writing'[121]

Mental illness

4.44. Mental health problems such as depression, bipolar disorder and psychosis affect one in four young people. There is convincing evidence that early treatment of these disorders can reduce their impact and burden and may even "reduce their prevalence, by delaying the onset of illness, reducing the time spent living with a disability, or accelerating recovery."[122]

4.45. There is national and international evidence that treatment of early psychosis can improve health outcomes, slow the onset of illness, including the onset of episodes related to the illness and slow, if not prevent, relapse.

4.46. The early treatment of psychosis remains controversial, with clinicians expressing doubt as to whether individuals treated would have ever gone on to develop a mental illness.

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[121] *Happiness* in 'US' by Messenger program participants
[122] Edwards, J. and PD McGorry, Implementing early intervention in psychosis. © 2002 Martin Dunitz Ltd., p. 2

4.47. If a young person is displaying symptoms of mental illness there is a need for "treatment for their disabling or distressing symptoms, regardless of the [potential] long-term outcome or diagnosis"[123].

4.48. However, as discussed above, young people are reluctant to seek help for mental illness for a number of reasons:

- "Poor knowledge of the features of mental disorders and their treatability;
- denial that a problem exists;
- belief that the problem can be solved without help;
- magico-religious explanatory models of mental illness;
- the stigma and shame associated with mental illness;
- lack of confidence in health professionals and the treatments they provide;
- lack of knowledge of resources;
- trivialising or minimising the severity of problems; and
- a desire to confine the problem within existing networks."[124]

4.49. The Committee acknowledges that the mental illness education programs currently delivered in ACT schools goes some way to reducing the stigmatisation of mental illnesses.

4.50. The Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne provides:

> a specialist, comprehensive early intervention program for young people with psychosis living in the Western Region of Melbourne. The program accepts young people aged 15 to 29 experiencing their "first treated episode" of psychosis (those who have received more than six months of pharmacological treatment for psychosis in the past are referred elsewhere). Treatment at EPPIC typically spans an 18 month period for

[123] Edwards, J., p. 5
[124] ibid., p. 19

most clients. For clients who enter the program at age 15 or 16, treatment may be extended until they reach 18 years of age.[125]

4.51. EPPIC has an independent inpatient unit, thus ensuring that young people entering the unit are not inappropriately housed with older patients with more advanced psychosis.

4.52. First contact with EPPIC is by a Youth Access Team, which can provide in-home or other location service, but ensures that the young person is engaged and informed at each step of the process. Referrals are accepted from anyone involved in the individual's life, including friends, family, and schools.[126]

4.53. The Committee believes that this is key to getting young people to access these services. There are anecdotal stories told of families having lobbied for services but none put in place – families and those living full-time with a young person know their behavioural patterns intimately and need to have the autonomy to refer directly to mental health services.

4.54. The staff of Orygen Youth Health (overseeing EPPIC) reported to the Committee that 50% of patients have co-morbid drug and alcohol problems and could not imagine treatment of psychosis without treatment of substance use.

4.55. Taking on board the early intervention model of psychosis treatment will be a shift in culture and requires significant investment in infrastructure, however the Committee is convinced from the evidence heard at Orygen Youth Health that it is an effective model.

4.56. Currently there isn't a dedicated youth psychiatric facility, although there are facilities within The Canberra Hospital psychiatric unit specifically for young people, however the Committee does not see this as acceptable. The Committee is also unconvinced that this service is capable of managing an adolescent client with dual diagnosis of mental illness and substance use.

4.57. In speaking to Mental Health ACT officers[127], the Committee was told that the EPPIC model has not yet been proven and therefore it would not be implemented in the ACT. However, the Director of Orygen Youth Health, when questioned on this assertion pointed out that EPPIC had

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[125] www.orygen.org.au
[126] Meeting with Orygen Youth Health Centre. 8 October 2002.
[127] Tour of mental health services, 4 October 2002

been successfully operating since 1984, and 18 years of practice, and international support, not to mention numerous scientific and medical papers, proved that it was working.

4.58. Indeed, the Committee was presented with a conference brochure from the 3rd International Conference on Early Psychosis – Australia, Canada, Germany, Norway, the United Kingdom, the USA, Denmark, Finland, France, and The Netherlands alone were represented on the organising committees. The United Kingdom is so convinced by the success of this model that fifty teams covering the whole of England have been put in place for early intervention service for 15 to 25 year olds.

4.59. The Committee does not understand the reluctance of the ACT mental health system to engage in preventative health models, particularly in the face of overwhelming international evidence and does not accept the claim that the early intervention, or the EPPIC model has not yet been proven.

Recommendation 26

4.60. The Committee recommends that the Government establish an early psychosis intervention centre in the ACT, based on the model of the Early Psychosis Prevention and Intervention Centre on Melbourne.

4.61. While the Committee understands that it will take a great deal of infrastructure, support and cultural change to implement this model, and there will be a degree of resistance from the existing mental health system, it believes that it is imperative that an early intervention model is implemented as early as possible.

Attention Deficit Hyperactivity Disorder

4.62. Attention deficit hyperactivity disorder (ADHD), or attention deficit disorder (ADD) as it is also known, is recognised in the DSM-IV[128], but not in the ICD-10[129]. However, the ICD-10 recognises hyperkinetic disorders "characterised by: early onset; a combination of overactive, poorly modulated behaviour with marked inattention and lack

[128] DSM-IV: *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition*
[129] ICD-10: *The International Statistical Classification of Diseases and Related Health Problems, tenth revision*

of persistent task involvement; and pervasiveness over situations and persistence over time of these behavioural characteristics."[130]

4.63. In this context, the Committee will refer to this disorder by the commonly used term of attention deficit hyperactivity disorder (ADHD).

4.64. There is no doubt that ADHD can be disruptive and stressful not only for the child affected, but the child's family, peers and school. There have been links between ADHD and substance abuse, increase school behaviour problems, police contact, and suicidal behaviour and an increased use of "clinical, educational welfare and justice services".[131]

4.65. The Committee does not question the validity of a diagnosis of ADHD, but questions the current methods of treatment, and apparent reliance on medication.

4.66. Mr Richard Windsor, of the Canberra/Queanbeyan ADHD Support Group, expressed concerns about ADHD being treated as a purely behavioural problem and instead suggests that "it is in fact a complex neurological disorder involving failure of normal pathways in the brain to develop, [or] failure of normal metabolic processes in the brain to proceed."[132]

4.67. Certainly the use of medication to treat children with ADHD does indicate something more complex than a behavioural disorder. Mr Windsor outlined a number of other circumstances for the Committee where treatment and or lifestyle changes had reduced or eliminated the use of medication. These include:

- reduction of stresses (i.e. changing school/teachers);
- dietary changes – particularly removal of food additives, and addressing food allergies and sensitivities;
- introduction of full-spectrum lighting (lighting that is as close to natural sunlight as possible) in classrooms;
- addressing noise levels in classrooms (i.e. design classrooms with noise-abatement measures such as carpeting); and

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[130] The ICD-10 Classification of Mental and Behavioural Disorders World Health Organization, Geneva, 1992, as on www.mental-health-matters.com/disorders, accessed 13 January 2002

[131] Al-Yaman *et al*, p. 196

[132] Transcript of evidence, 15 August 2002, p. 130

- assessment and treatment of visual and auditory processing.[133]

4.68. Clearly, there is the need for a co-ordinated response to the diagnosis of behavioural difficulties.

4.69. The Committee is also concerned that medication is being used as a first option for dealing with children with behavioural disorders. This is not to say that medication is not an invaluable and essential tool in treating ADHD, however, as seen through the evidence received on food intolerance and sexual abuse, ADHD-like behaviour can have its root in many causes that should be addressed before resorting to medication.

4.70. A survey of all Australian General Paediatricians and Child and Adolescent Psychiatrists in late 2000, and released in 2002, concluded that while a broad range of psychotroptic medications are being used for children, the majority of prescribers also "use a range of adjunctive therapies to help children with emotional behaviour disturbance."[134]

4.71. The Committee is heartened by this evidence, but is concerned that of respondents to this survey, 14% expressed comments or concern regarding overprescribing, and 12% regarding lack of access to services.[135]

4.72. The survey concluded that there is a need for improved training of paediatricians and child psychiatrists in the optimal use of psychotroptic medication and there is a need for improved access to services.

4.73. The Committee heard evidence that some psychotroptic medications used for attention deficit hyperactivity disorders (such as Ritalin) are being traded and used illicitly but there is a need for more research in this area to ascertain the extent of this problem. Directions ACT raised concerns that young people were being placed directly on medication without other, non-chemical, alternatives being explored.[136]

4.74. While the ADHD support group felt that the trading of psychotroptic medications is inconsequential, they suggested that any trading could be reduced or eliminated by the addition of Ritalin and its slow-release derivatives to the PBS list. This would eliminate the need

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[133] ibid.
[134] Exhibit 2
[135] ibid.
[136] Transcript of evidence, 20 June 2002, p. 11

for children to take their medication to school with them and allow parents to supervise a once-daily dosage.[137]

4.75. The Committee shares the concerns of Directions ACT about the use of medication without the exploration of non-chemical alternatives and is further concerned that the culture of treating behavioural difficulties first with medication and later with other interventions is leading to a culture of self-medicating to cope with problems.

4.76. Throughout this report, the Committee discusses the need for long-term systemic responses to address health issues, and feels that the same applies in this instance.

Recommendation 27

4.77. The Committee recommends that when a child has been diagnosed with behavioural difficulties, that there be a co-ordinated response by services to ensure that all possible avenues of treatment are offered to parents. This response should also look at wider measures such as including full-spectrum lighting in classrooms and dietary modification.

Body image

4.78. The YWCA has identified children as young as eight years old becoming increasingly aware of their body image and sensitive to cultural and peer, family and school messages about their appearance. Body image, and related eating disorders predominantly affect girls.

4.79. The Throsby Place Eating Disorders Unit reports that 48 percent of its clients are between the ages of eleven and 20, and that to the year 30 June 2002 there has been a 30 percent increase in clients.[138]

4.80. "The media, fashion, cosmetic, plastic surgery and even toy industries"[139] are all identified as having a significant influence on cultural beliefs of the 'ideal' body shape. However body image extends beyond body shape to the ideal clothes, make-up and hairstyle. Body image refers to the entire way we present ourselves to society, which is

[137] Transcript of evidence, 15 August 2002, p. 140
[138] Submission 31, p. 12
[139] Submission 18, p. 5

constantly telling both men and women that they can always look better, and try harder.

> Pre-adolescent and early adolescent girls are repeatedly told that they must adapt to socially acceptable norms. These norms include so-called "feminine" qualities: compliance, taking care of others, subduing their independent voices, and, of course, looking good. Since a woman's sense of self is so influenced by how she sees herself in relationships, she puts extra effort in trying to be the person she thinks others want her to be. Gilligan, et al. empahsizes the "loss of autonomous voice" that happens around age 13. Peers play an important role in this. Being accepted means adapting to one's perception of the expectations of one's peers--or at least it feels that way. And of course sexuality enters in--feeling attractive also means gaining the desired person's attention.[140]

4.81. The images that are presented are often unrealistic, and unhealthy for the majority of women. Young girls are more susceptible to this pressure, as they have the added pressures of conforming to peer groups in the school setting.

4.82. Ms Emily Scott from North Ainslie Primary School told the Committee:

> "If you have low self-esteem or think that you are fat, it can be a problem that is sometimes caused by the media. People who see boys and girls on TV who are somewhat like Barbie dolls start to believe that they have to be thin and beautiful to have friends or be popular.
>
> Girls are still going to great extremes with diet and exercise so that they can look good and be popular. The media must be stopped. We have to get the message across that it's okay to be yourself. I think that all the things in life that suggest we have to be thin should be banned. There should definitely be laws to control the things that damage children's lives.
>
> There are some kids out there who don't have any friends so, when people tease them, they believe the stuff that they've been told when they've been teased. Of course, they think, "Nobody will like me anyway", and they don't even try to

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[140] Gilligan, Carol, "In a Different Voice: Psychological Theory and Women's Development". Cambridge, MA: Harvard University Press, 1982 as on www.wellesley.edu/Health/BodyImage

> make friends. Then they are totally sucked into everything that they see [on television]."[141]

4.83. This evidence was repeated by high school students –

> There are few average girl images within the media. The images of girls are generally negative and any imperfections are airbrushed out of the pictures, and thus an artificial image is portrayed to youth. People talk about changing this, yet these stereotypes are still in our faces 24 hours a day, seven days a week. This shows youth that we do in fact live in a superficial world and thus many are not happy with the results. This leads to pressure, violence, self-hatred or drugs. For example, lots of young people exercise not to be healthy but to be thin or muscular. This can often lead to eating disorders such as anorexia nervosa or bulimia. This excessive worry about body image is not gender-biased. We see it as relatively consistent between both males and females. The outward effects are different.[142]

4.84. The Committee is concerned about the availability of pro-anorexia websites promoting anorexia as a life-style choice. So not only are girls and young women being told overwhelmingly by the media to change their appearance, those who do succumb to anorexia, bulimia or other eating disorders can readily access assistance to facilitate the progress of the disease.

4.85. There is an urgent need for health promotion messages to promote a healthy body image to the entire community. While there is a need to specifically target girls and young women in schools, health promotion messages must be run in the mainstream media, to combat the constant imagery of and pressure to conform with 'the perfect body'.

4.86. A counsellor described to the Committee eating disorders as a mental holocaust, and that young women are "so intimidated by the idea of being fat that it [being fat] means they won't fit in at all."[143] Young women see unrealistic images in the media and battle to replicate them further skewing their reality of appropriate body shape and size.

4.87. The Committee would like to see local media, in particularly television stations, allocate a portion of their 'local content' requirement

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[141] Transcript of evidence, 23 August 2002, p. 199, 202
[142] Transcript of evidence, 3 October 2002, p. 254
[143] ibid., p. 224

to this issue through promoting projects devised by young people to promote a healthy body image.

Recommendation 28

4.88. The Committee recommends that the Government work with students to develop healthy body image projects to be presented within the mainstream media.

4.89. When speaking to the ACT Government Schools Student Network, the Committee heard from students about the prevalence of eating disorders amongst their peers. The majority felt that while there was appropriate help available, people (generally girls) tended to talk to their peers first.

4.90. The students expressed a desire to have more information about how to constructively help their friends, rather than being too afraid to talk about it, as is presently the case. Some students reported having to tell their friends to go and talk to someone else as they felt so ill-equipped to deal with the problem, or had similar problems of their own and did not want to engage in it.

4.91. The Committee heard that there is a need for proper, targeted counselling on body image and eating disorders, and that mental health services are so stretched dealing with patients in crisis that they are rarely able to take on clients pre-crisis therefore clients who cannot afford private counselling find it extremely difficult to receive help.[144]

4.92. The Select Committee on the Status of Women found that although there are programs and support groups run by the Women's Centre for Health Matters, there is still a degree of unmet need in regards to counselling and support[145]. The Committee concurs with recommendation of the Select Committee on this issue.

Recommendation 29

4.93. The Committee recommends that the Government investigate the need to expand service delivery responses which provide

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[144] ibid.

[145] Report of the Select Committee on the Status of Women in the ACT. November 2002, p. 14

counselling and support for young people with body image and eating issues.

Sexuality

4.94. Sexuality development can be a difficult and confusing time for most young people.

4.95. The Committee heard evidence that twenty percent of year 10 students and 48% of year twelve students had had sexual intercourse.[146] It is essential that these children receive appropriate and reliable information about safer sex and the risks associated with sexually transmitted infections (STIs).

4.96. Sexual Health and Family Planning ACT[147] (SHFPACT) expressed concerns to the Committee that while secondary school students have a good knowledge of HIV, their perception of their own risk of STI infection and their knowledge of STIs is poor.[148]

4.97. The most common STI in the ACT is chlamydia, with a 200% increase in diagnoses in 2001 to 2002 – young people are largely over-represented in this group.[149]

4.98. Victorian figures show that 15 to 29 year olds represent 76% of 2001 chlamydia notifications. According to SHFPACT the pattern is likely to be similar in the ACT.[150]

4.99. It was made clear to the Committee by young people that safer-sex education as currently delivered is largely irrelevant and ignores the reality of their experience – either being delivered inappropriately or too late.

4.100. It was also clear that there was disparity between individual schools about how this education was being delivered. Some students reported receiving quite comprehensive education, including information on same-sex practices, while other students were given minimal information, which they said was largely useless.

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[146] Transcript of evidence, 28 June 2002, p. 74
[147] Formerly Family Planning ACT
[148] Transcript of evidence, 28 June 2002, p. 75
[149] ibid., p. 74
[150] ibid., p. 74

4.101. It was also reported to the Committee that there is a dearth of printed information about lesbian safer-sex practices.

4.102. That deemed 'homosexual' sexual practice is not the exclusive domain of gay and lesbian people, and all sexual practices that hold a risk of STI transmission need to be covered in safer-sex education, in such a manner that does not further marginalise gay and lesbian youth.

4.103. The Students Network suggested that safer-sex and sexuality education be delivered in the early years of high school and that it provide complete and relevant information. The Network members also suggested that it be delivered by someone closer to their own age, like a first-year university student or young teacher.[151]

4.104. The Committee heard evidence from a group of young people developing a youth publication on social issues. The group wanted to supply condoms in the book because through surveys of over five hundred students at a range of Government and non-Government schools they found that young people are still ashamed to buy condoms and so felt that provision of free condoms through their publication would be appropriate. The group also felt that it was appropriate that condom machines be installed in schools.[152]

4.105. The supply of free condoms with the publication was intended to fill a need identified by solid evidence given by their peers, but the sponsor of the publication, Health**pact**, did not allow the condoms to be included.

4.106. The Committee questioned Health**pact** on this decision and was told that staff recommended that condoms not be included because:

- "it was possible that the books/condoms could reach children much younger than the intended age group leading to inappropriate use;
- some parents may construe the provision of condoms as an incitement to early sex and respond negatively to the providers of the books (including schools); and
- condoms are now readily available to young people through chemists, youth agencies, some community agencies and

[151] Informal discussions held 31 July 2002 with ACT Government Schools Student Network.
[152] Transcript of evidence, 3 October 2002, p. 257

> health agencies and that distribution of them is now much wider and more accessible than in earlier years."[153]

4.107. Curious as to the Government's policy on condom distribution, The Committee then asked the Minister for Health to respond to this letter. The Acting Minister for Health replied that it is Government policy that "sexually active young people should have easy and appropriate access to condoms", and that access is available through "pharmacies, supermarkets, youth centres and health services" [154].

4.108. In the face of evidence by young people that they were largely too embarrassed to buy condoms either from shops or health clinics, the Committee does not accept the reasoning put forth by Health**pact** and the Acting Minister for Health.

4.109. The Committee also heard evidence that organisations undertaking safer-sex education in schools are unable to distribute condoms and if they are used in demonstrations they are to ensure that no student takes one and none are left behind in the school.[155]

4.110. The Committee finds this wholly unacceptable. Young people are having sex, and the rate of chlamydia infection alone, let alone the risk of other STIs and teen pregnancy, should be enough to convince policy makers that the current stance on condom distribution does not work. Preventing access to free condoms is not going to stop young people from having sex.

4.111. If young people are unable, through embarrassment or lack of finances to purchase condoms, then they simply will not use them. As the Committee has heard repeatedly from young people in all forums, they do not want to be told by adults what not to do, they want to know the risks and consequences of their behaviour so they can make their own, informed decisions.

4.112. The Committee does not believe that easier access to condoms would be an 'incitement to early sex' and believes that we should give young people a lot more credit for their ability to make intelligent, informed decisions. International research as shown that "those young people who go through sexuality education are in fact more likely to

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[153] Correspondence to the Committee from Chair, Health**pact**, 13 December 2002
[154] Correspondence to the Committee from Acting Minister for Health, 6 January 2003
[155] Transcript of evidence, 28 June 2002, p. 78

delay sexual activity, and more likely to have fewer numbers of sexual partners when they do commence sexual activity"[156].

4.113. Finally, the Committee discussed the concept of inappropriate condom use, and other than water-bombs, could not conceptualise what inappropriate use means. Regardless, even if young people are playing with condoms as water bombs, at least they are becoming familiar with them and may be less intimidated by using them when they do become sexually active.

4.114. It is Government policy to allow condom vending machines in secondary colleges, however these are under-utilised due to a lack of privacy and anonymity.[157] The Committee received advice that the machines were generally located in toilets, and when under-utilised, the companies providing the machines have removed them.[158]

4.115. If, as the evidence from young people suggests, they are too embarrassed to buy condoms from retailers, then it is understandable why the lack of anonymity and privacy through the location of the machines in toilets, leads to their under-utilisation.

4.116. The Committee is concerned if this is used as an excuse to remove condom vending machines entirely from schools, as young people have identified that the machines would be an effective method of condom distribution, however they must be located appropriately to afford maximum privacy.

4.117. The United Nations Population Fund, as part of the Joint United Nations Programme on HIV/AIDS, identifies condom programming as an integral part of the strategy to fight HIV and other STIs. The key issues to address in supply of condoms include: addressing and meeting diverse user needs; creating a supportive political and socio-cultural environment; and making channels of distribution appropriate to user needs.[159]

Recommendation 30

4.118. The Committee recommends that a comprehensive program of peer-led safer-sex and sexuality education be developed and delivered

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[156] ibid., p. 77
[157] 2002 Week 4 Hansard (11 April)., p. 1024
[158] Correspondence to the Secretary, 28 March 2003
[159] United Nations Population Fund *Condom programming for HIV prevention*. Available from www.unfpa.org.

equitably across all schools and offered to the Independent and Catholic school sectors to also deliver. The safer-sex education program should cover all behaviours, including those traditionally deemed to be 'homosexual' practices.

Recommendation 31

4.119. The Committee recommends that the Government fund the production and distribution of lesbian safer-sex information.

Recommendation 32

4.120. The Committee recommends that the Government allow free condom distribution in high schools and colleges by those groups undertaking safer-sex education.

Recommendation 33

4.121. The Committee recommends that condom vending machines be installed in all high schools and colleges, in consultation with students to determine appropriate locations.

4.122. The Committee heard that there is a trend amongst teenagers that it is "cool for girls to be bisexual" and considerable pressure is placed on girls to be seen kissing other girls at parties and social events – this pressure is primarily from boys in the peer group. [160]

4.123. The Committee is concerned that this demonstrates a lack of understanding about healthy sexuality development. The period of sexuality development and awareness is a difficult enough time for young people, both opposite and same-sex attracted and no additional pressures are needed.

4.124. For same-sex attracted youth, the school environment can become an unsafe place to be, particularly if they are unable to talk to teachers or school counsellors about the issues they are facing.

4.125. SHFPACT reports that:

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[160] Informal discussions held 31 July 2002 with ACT Government Schools Student Network

> "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."[161]

4.126. Indeed, young gay men are 3.7 times more likely to attempt suicide than are young heterosexual men.[162]

4.127. Gay, lesbian and bisexual students in ACT schools report intolerance, victimisation and a pervading culture that constantly reaffirms heterosexuality as the acceptable norm.

4.128. It is this culture that reinforces intolerance and victimisation. It includes

> homophobic language and … not taking down homophobic graffiti – just an environment that is not friendly towards gay and lesbian youth. That language and that environment is basically a constant affirmation, especially if it is a school environment, that a gay person is not worth anything, that their sexual orientation effectively devalues them as human beings.[163]

4.129. Young people themselves recognise that "we need to find ways to make everyone feel equal and accepted within our schooling system."[164] Simple measures include putting up posters with anti-homophobia messages throughout the school – and ensuring that they remain up and free of graffiti – reducing the use of homophobic language and talking about gay and lesbian people as part of normal society, instead of just another topic to be covered.

4.130. It is not just gay, lesbian and bisexual students that are affected, but also children of gay and lesbian parents, or those that have gay, lesbian or bisexual friends and family. A homophobic environment directly affects all of these people.

4.131. The Committee heard evidence that intolerance of homosexuality in private schools was particularly high, not only from students, but from the school itself. A peer survey found that "in a lot of the private schools run by churches that homosexuality wasn't acceptable at all in the

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[161] Transcript of evidence, 28 June 2002, p. 76
[162] ibid., p. 76
[163] Transcript of evidence, 15 August 2002, p. 143-144
[164] Transcript of evidence, 3 October 2002, p. 254

school."[165] The Committee also heard evidence of lesbian students being suspended from a Catholic following an untrue report of them kissing in the corridor of the school.[166]

4.132. While this report cannot be confirmed, representatives from the Catholic Education Office told the Committee that similar behaviour from heterosexual or homosexual couples would not be tolerated.

> In reality there would not be a public statement to say that it was okay; or posters put up in schools normalising same-sex relationships, as there would not be posters put up in schools about heterosexual relationships. It would all be dealt with within pastoral care about the dignity of the individual and that relationships need to uphold that, and it would be dealt with in general.[167]

4.133. The Committee understands that the Catholic system has a particular religious ethos to uphold, but is concerned about the welfare of same-sex attracted youth in Catholic schools.

4.134. The Committee is not asking Catholic schools to 'promote' same-sex relationships, but would like to see greater efforts to reduce homophobia, in the spirit of tolerance and acceptance of all people. The Committee encourages the Catholic Education Office to consider involving teachers in the 'There's 2 Every Classroom' project discussed below.

4.135. The Committee commends the work of SHFPACT in establishing the 'There's 2 Every Classroom' project and the 'GILBerT's friends' youth support group in response to the above evidence.

4.136. The 'There's 2 Every Classroom' project is a training program for teachers, school counsellors and youth workers which "promotes heath and increases the awareness of the needs of gay, lesbian, bisexual and transgender students[168]. The Committee is concerned about the reported low take-up of this valuable project, and fears that those most in need of this training are not undertaking it.

4.137. The 'GILBerT's friends' youth support group is a peer-led group for same-sex attracted youth, with the following objectives -

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[165] ibid., p. 257
[166] Transcript of evidence, 15 August 2002, p. 149
[167] ibid., p. 154
[168] Transcript of evidence, 28 June 2002, p. 76

1. To develop a caring, informative, non-discriminatory environment that is conducive to the exploration of sexuality by GLBT [gay, lesbian, bisexual, transgender] young people and peer facilitators.

2. To involve lesbian, gay, bisexual and transgender young people in information sharing and harm reduction strategies.

3. To prioritise young people identified as disadvantaged due to social and economic circumstances in participating in these strategies

4. To raise awareness of the health needs and issues of lesbian, gay and bisexual young people within SHFPACT and partner organisations.

5. To increase access of lesbian, gay, bisexual and transgender young people to health and support services.

6. To develop peer facilitators' skills in facilitating a GLBT Youth Space providing support and delivering individual and group information on key health issues

7. To create an environment that is conducive to young GLBT needs and issues.[169]

4.138. The Committee heard evidence that this group is effective and would like to see greater promotion of it, particularly through secondary schools.

Recommendation 34

4.139. The Committee recommends that representatives from all ACT Government schools participate in the "There's 2 in Every Classroom" project run by Sexual Health and Family Planning ACT, and that Government ensure that this project is appropriately resourced.

Recommendation 35

[169] Sexual Health and Family Planning ACT, "Gilbert's Friends" – GLBT safe space overview.

4.140. The Committee recommends that all ACT Government schools make greater efforts to reduce homophobia through the use of inclusive language and environment.

4.141. The Committee further recommends that the 'GILBerT's Friends' support group be widely publicised through all secondary schools.

Sexual Assault and Violence

4.142. One in four girls and one in six boys will have a sexually abusive experience by the time turn 18. They go on to report life-long physical, mental and social ill health.

4.143. The Select Committee on the Status of Women found that patterns of violence are handed down from generation to generation – "children exposed to or have witnessed violence are more likely to become both the victims and the perpetrators of domestic violence in the future"[170].

4.144. Sexual assault affects children's health and wellbeing psychologically, behaviourally, academically and sexually as well as interpersonal relationships, self-perception, spirituality and perpetration of subsequent violence.

4.145. Psychological consequences of sexual assault in children include:

> extreme and repetitive nightmares and other sleep disturbances; anxiety; panic attack; depression; depressive symptoms; prolonged bouts of sadness; social withdrawal; unusually high levels of anger and aggression; feelings of guilt and shame; dissociative disorders including DID, ADD and ADHD; phobias; general fearfulness and specific fears; psychosomatic complaints including headaches and stomach aches; bedwetting; excessive blinking; faecal soiling; negative body concepts; obsessive-compulsive disorders and disorders in cognition; and shattered assumptions about the world.[171]

4.146. These consequences carry over into adulthood, with anywhere between 20 and 84 percent of people in the drug rehabilitation and support services with a history of sexual assault, 50-60 percent of

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[170] Report of the Select Committee on the Status of Women in the ACT, p. 81
[171] Transcript of evidence, 15 August 2002, p. 92

psychiatric inpatients and 40-60 percent of outpatients reporting childhood physical or sexual abuse and 82-94 percent of survivors of sexual abuse later developing post traumatic stress disorder.[172]

4.147. Physical effects, supported by research and experience of workers in the field include sleep disorders,

> gonorrhoea; genital warts; chlamydia and genital herpes. Some of these untreated infections can cause damage and infertility, gastrointestinal problems, migraines, breathing difficulty, hypertension, aches and pains, rashes, allergy and poor hygiene resulting in poor overall heath, including infected gums and mouth. That is often related to the child's wanting to be as awful as they can so that a person will not abuse them, particularly when they're being told they're beautiful or lovely.[173]

4.148. These conditions also persist into adulthood. Finally, behavioural difficulties also occur in victims of sexual abuse.

> Sexual abuse adds stress and disrupts the psychological equilibrium of normal development. It disrupts self-control, the ability to self-regulate, so that many children have great difficulty in self-regulating. They are very distressed and over the top, and can easily become upset about minor things. Two-thirds of sexually abused children have behavioural adjustment problems. Some are anxious and fearful and some are aggressive and angry. They have problems with eating, self-harm, risk-taking behaviour and accidental harm. They are accident-prone—there's a very strong relationship between accident-prone children and sexual abuse.
>
> Substance abuse, particularly of tobacco, occurs even in young children and primary school-aged children. … Extreme shyness or overt friendliness occurs—one or the other—as do regressive behaviour, suicidal thoughts and attempts, early use of drugs, alcohol and other substances, eating disorders, obesity, school-aged pregnancy, and self-mutilation, which also includes burning and other self-destructive behaviour. That occurs in primary school-aged children as well.
>
> … Delinquency and prostitution occurs in older children, and some down to the age of about 11. They might be doing that

[172] ibid., p. 95-96
[173] ibid., p. 93

> for money, for people in the neighbourhood. Many of these consequences manifest at adolescence, but are quite evident in younger children as well.
>
> Studies show that sexual abuse and other forms of child abuse have a detrimental effect on the child's school performance. Over and over, research indicates that abused children demonstrate reduced intellectual functioning, and poor school performance that can have long-term consequences. Sexually abused children may display lower overall school performances, lower test scores, frequent grade … frequent disciplinary referrals and a high number of suspensions, and they work and learn at lower average levels than other children. They have a weak orientation to vocational and educational goals. Lack of concentration is a major contributor to all of that: they tend to dissociate a lot in class and miss what's going on.[174]

4.149. Because of the behaviour difficulties experienced by victims of sexual abuse, these children can be mistakenly diagnosed with ADHD or other psychological disorders and medicated. This is a short-term solution, which does not treat the underlying cause of the problem. The Canberra Rape Crisis Centre reported a lack of acknowledgement by parts of the health sector that sexual assault could be the root cause of many physical, mental and behaviour difficulties and a willingness to medicate in cases where long-term treatment could avoid a reliance on medication.

4.150. While it may be too late to prevent the abuse in many cases, there are effective treatment options available through counselling and other supports for children who have been victims of abuse. Early intervention may prevent later ill health, substance abuse, violence, criminal activity and later perpetration of sexual abuse.

Recommendation 36

4.151. The Committee recommends that the Government develop, in consultation with experts in the field, a professional development program for teachers to assist them in recognising the signs of sexual or other violence and to make appropriate referrals.

Recommendation 37

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[174] ibid., p. 93-94

4.152. The Committee recommends that the Government, in partnership with community organisations, put in place comprehensive programs to address the needs of school-age children who are the victims of sexual assault. These programs should not only address short-term needs but aim to make systemic changes with a view to long-term outcomes for the child and family and break the cycle of intergenerational violence.

4.153. As children become more independent, socialising independently of parents and in public spaces with increased use of public transport, the risk of physical and sexual violence also increases. There is a need for education campaigns, particularly directed at young males, regarding violence in public space and sexual violence against young women.

4.154. The Select Committee of the Status of Women did a great deal of work regarding violence perpetrated against women, and therefore their children, and regarding safety in public places. This Committee has chosen not to replicate this work, but has adopted recommendations 44 to 47 of the resulting report, with minor enhancements[175].

Recommendation 38

4.155. The Committee recommends that the Government provide additional funding to early intervention programs to provide support to children that have experienced violence in their lives.

Recommendation 39

4.156. The Committee recommends that the Government:

a) establish and resource a working party made up of representatives from areas including: law enforcement; health promotion; the women's sector; relevant community organisations; as well as educators and those responsible for the development of school curricula to develop and implement an across-the-board information and education campaign regarding all aspects of violence against women, including sexual violence, with the view

[175] The report of the Select Committee on the Status of Women can be found online at www.legassembly.act.gov.au/committees

to including violence prevention education as part of the ACT Government school curriculum; and

b) build on this work with a broader community education and information campaign.

Recommendation 40

4.157. The Committee recommends that the Government, in the development of its Sustainable Transport Plan:

a) prioritise the maintenance of lighting in bus interchanges and other public spaces in its maintenance program; and

b) investigate the possibility of providing after-hours bus services with the flexibility to stop between bus stops in order to set passengers down as close to their homes as possible.

Recommendation 41

4.158. The committee recommends that:

a) the Government undertake research regarding sexual assault and public events in the ACT;

b) the Government develop and expand innovative strategies to educate children and young people about the impact of violence on individuals and the community;

c) event organisers be required to consult with a broad range of stakeholders, including young people, produce a safety plan to ensure events are safe for all members of the community;

d) increased funding be allocated to education campaigns aiming to address male and female stereotypes about violence against women; and

e) restricted alcohol use policies be enacted at all public events, and all staff serving liquor in the ACT be required to have completed an accredited responsible alcohol service training course.

Bullying

4.159. The Committee acknowledged that bullying is a large part of schooling experience even before collecting any substantial evidence regarding its occurrence. However in the process of speaking with young people from primary school to college age, the fact that bullying occurs and is prevalent was repeated continuously.

4.160. Childhood bullying is a risk factor for a range of problems that continue into adulthood. It is a risk factor associated with "delinquent and criminal behaviour and non-completion of school for bullies and higher levels of stress, anxiety, depression and illness and a higher tendency to suicide" for victims.[176]

4.161. In fact, schoolyard bullying is an insidious form of physical and emotional violence directed towards children by their peers, the like of which would not be tolerated in adult settings. The Committee acknowledges that workplace, social and family bullying does take place but, in the context of this report, finds the overt physical and emotional bullying that children face of particular concern.

4.162. Australia-wide 50% of children report being bullied at least once and 20% report being bullied at least once per week. Figures also show that reported bullying is higher in primary school with exception for the early years of secondary school when reported bullying is higher than the final year of primary school.[177]

4.163. The Committee did not seek a litany of examples from young people, but it generally came through in their testimony. Acknowledging the mental health issues associated with bullying, the Committee instead sought positive, achievable processes to address these negative behaviours.

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[176] Graycar, A. February 2002 in *Trends and issues in crime and criminal justice* No. 219. Australian Institute of Criminology (Canberra)

[177] Morrison, B. Unpublished. From bullying to responsible citizenship: A Restorative approach to building safe school communities. P. 10

4.164. The Committee is particularly engaged with the restorative justice approach to resolving conflict. As explained to the Committee, there are several approaches to addressing bullying: the neglectful approach is to do nothing; the punitive approach is to do something to someone; the permissive approach is to do something for someone; and the restorative approach is to do something with someone.[178]

4.165. Restorative justice involves teaching bullies and victims how to resolve conflicts constructively within a supportive environment. For bullies it may mean working with them to help them learn how to feel shame about their actions so they can relate to how the victim may feel and choose to change their behaviour. This means reintegrative shaming where the action is not condoned, but the person is offered respect and forgiveness.

4.166. For victims it may mean helping them to learn how not to internalise the shame the feel about being bullied and how to develop wider support structures.[179] It needs to bring in the wider community of people who are meaningful to the child, such as family, teachers, sporting coaches, and carers.

4.167. Restorative justice needs to be in an environment of high support and collaboration in order to work.[180] In the school setting, restorative justice involves changing the culture of a classroom, school or community to establish an environment that does not condone bullying in any way.

4.168. Restorative justice processes can be applied to social co-operation, competition and conflict resolution[181]. Applied not as a solution to bullying, but as an integral part of the school culture, a restorative justice approach can strengthen the school community to systemically reduce bullying, rather than only address individual instances of bullying.

4.169. The Committee is aware that restorative justice approaches to bullying are already used in some ACT schools. However as a principle, it needs to be applied across all aspects of the school.

Recommendation 42

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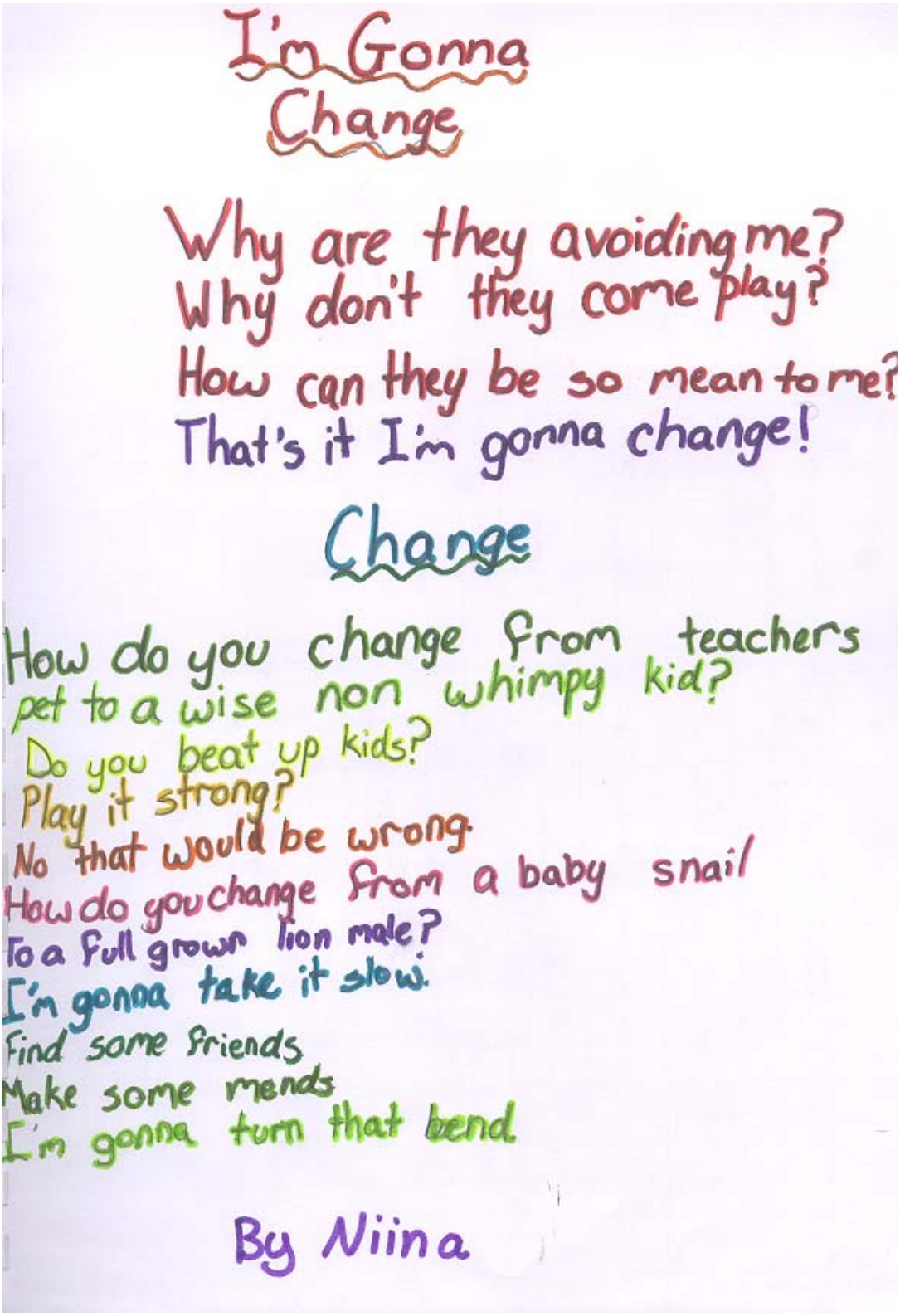
[178] Transcript of evidence, 28 June 2002, p. 46.
[179] ibid., p. 49
[180] ibid., p. 46
[181] Morrison, B. Unpublished. p. 26

4.170. The Committee recommends that the Government undertake a review of all anti-bullying programs used in schools, and in consultation with students, teachers, parents and experts in the field, develop and/or implement an existing program based on the principle of restorative justice in all schools.



I'm Gonna Change

Why are they avoiding me?
Why don't they come play?
How can they be so mean to me?
That's it I'm gonna change!

Change

How do you change from teachers pet to a wise non whimpy kid?
Do you beat up kids?
Play it strong?
No that would be wrong
How do you change from a baby snail
To a full grown lion male?
I'm gonna take it slow.
Find some friends
Make some mends
I'm gonna turn that bend

By Niina

'Bullying'[182]

[182] Submission 27

Young carers

4.171. The Committee received a submission from Cyclops ACT, outlining the needs of young carers. Young carers not only take on an enormous burden of caring for a family member, but in many cases have the additional burden of looking after their own needs.

4.172. It is estimated that ten percent of Australia's children and youth are young carers for a family member and of this number, approximately five percent are the primary care-giver. Young carers are responsible for providing health care treatment, emotional and physical support and maintenance of a household, sometimes with younger siblings.

4.173. Research has shown that while caring can be a rewarding experience, it has been linked to a decrease in physical health and an increase in "the incidence of emotional distress and psychological illness".[183]

4.174. Young carers are also isolated from their peers, and can often miss the opportunities afforded to other young people impacting on their overall short- and long-term psychosocial and emotional development.

4.175. In most cases, it would be detrimental to remove young carers from their home environment, even given the large responsibilities they hold. Instead, young carers "need appropriate information, support, [and] access to … flexible and affordable services"[184].

4.176. The Committee supports the recommendations of Cyclops ACT to this inquiry, and thus makes the following recommendation.

Recommendation 43

4.177. The Committee recommends that the Government:

a) develop strategies to identify young carers and engage them in mainstream health services;

b) provide funding for in-home respite services specifically to allow young carers to attend activities that promote their social development and emotional wellbeing, and ensure transport is available for these activities;

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[183] Submission 22, p. 5
[184] ibid., p. 7

c) better publicise the availability of support programs in schools and public space that young people frequent; and

d) adequately support those bodies engaged in support and advocacy for young carers.

5. Social well-being

5.1. Health – including the perception of health – relies on social connectivity. The more engaged in the community that individuals are, the more likely they are to have positive mental and physical health outcomes.

5.2. It is widely recognised that people who are socially or economically disadvantaged have significantly decreased health outcomes. The most disadvantaged groups have the most use of primary and secondary health services and make the least use of preventative services.[185] 'Socioeconomic status also influences the type and quantity of food purchased and opportunities for participation in physical activity and sport' and economically disadvantaged families show evidence of higher levels of behavioural and emotional problems.[186]

5.3. The ACT has lower than the national average of low income families reflecting a younger age structure and lower proportions of retired families.[187] However, access to income by young people is limited and this places them in an economically disadvantaged group, particularly if they are unable to access money for preventative healthcare through parents or carers.

5.4. Living in a one-parent, step- or blended family is also a risk factor for poorer health and wellbeing because of the risk factors associated with these families – such as lower income, and parental stress. Poor family cohesion (the ability of families to get along) is also seen as a risk factor for poor mental health outcomes.[188]

5.5. When addressing the health of young people, we (meaning Government), schools, caregivers and communities, need also to address the social context of the world we are living in.

5.6. As discussed in Chapter 4, studies have shown that there is a high correlation between individualism and youth suicide, particularly with young males.[189]

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[185] Glover, J. et al, Social health atlas of Australia. 2nd Edition, Open Book Publishers (1999) p. 1 available from www.publichealth.gov.au
[186] Submission 15, p. 2
[187] Glover, J. op. Cit. Volume 9, p. 24
[188] Al-Yaman *et al*, p. 256
[189] Mr Richard Eckersley, Transcript of Evidence, 20 June 2002, p. 17

> If the health issues facing young people are occurring within a social world that's getting better, then you can legitimately focus on those ones that are perceivedd to be at risk. If, on the other hand, their world generally is deteriorating, then you've got to look at the much broader social, economic and cultural factors that are shaping the lives of young people today.
>
> … there is evidence that suggests that things are getting tougher for young people generally… a wide range of evidence that their emotioal and physical wellbeing is deteriorating.[190]

5.7. We are still operating within a 'shame and blame' culture where people are expected to take responsibility for circumstance affecting their health, such as poverty, and low educational attainment and make changes to these circumstances, without being provided the skills to do so. This is particularly difficult for young people who not only may not have skills learned at home, but do not have life experience.

5.8. The Junction Youth Health Service reports that young people "experience quite a deep sense of pressure around having to change their circumstances, and being quite a bit lost in a physical, emotional and spiritual sense about how to actually achieve that."[191]

5.9. This is discussed throughout the report, and is why the Committee has continuously referred back to the Gatehouse project, discussed below, and the Mawson Primary School human values program discussed in Chapter 4. Both of these programs provide a social setting which fosters physical, spiritual, emotional and social growth and development, and community connectedness.

Schooling

5.10. School performance has been shown to strongly correlate with family economic and social advantage. "Socioeconomic status is the strongest predicator of educational outcomes" research showing that "as parental income declined, poor academic outcomes increased."[192]

5.11. Poor education outcomes in turn lead to lower income-generating capacity and maintenance of socioeconomic disadvantage creating a

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[190] Transcript of evidence, 20 June 2002, p. 16
[191] Transcript of Evidence, 28 June 2002, p. 57
[192] Submission 15, p. 2

continuum of the cycle of economic disadvantage which becomes difficult to improve upon.

5.12. Children with low general heath are likely to have lower education outcomes as their ability to engage in schooling is compromised. The inability to engage in schooling not only affects education outcomes, but social development, employability and the ability to participate in the community.

5.13. There are a range of programs provided in schools aimed at health promotion. All ACT Government and non-Government schools have the opportunity to participate in the Health Promoting Schools framework as defined by the world health organisation and formalised in the Ottawa Charter and in the ACT supported by Health**pact**.

5.14. The objective of this model is to "develop an environment where students, their families and the school staff can look at what their health issues are, decide on courses of action and walk together to get to where they want to be"[193].

5.15. The health promoting schools model incorporates philosophical and practical ideas to create a healthy school community. It includes school health policies, the physical environment, the social environment, community relationships, personal health skills and health services.

5.16. Submitters to this inquiry rated the health promoting schools model highly however expressed concerns that many of the activities seem dependent on the enthusiasm and commitment of individual teachers, particularly at the college level.

5.17. The Committee is concerned that while the health promoting schools model is comprehensive, schools are not being adequately resourced to implement it fully.

5.18. The Australian Education Union (AEU) reports the following barriers to effective health promotion in schools as:

- teachers and other school staff lack the specific knowledge and skills required to involve health, especially mental health issues, in the curriculum;

- lack of space in an already crowded curriculum;

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[193] Exhibit 1, p. 1

- lack of relevant and reliable resources;
- student and parent values and attitudes towards mental health promotion;
- low status of general and mental health education in the curriculum;
- lack of continuity and commitment from teachers from year to year; and
- the crisis driven and individual approach to mental health issues in schools.[194]

5.19. The ACT Council of Parents and Citizens Association submitted that schools and teachers need to be able to:

- "improve professional monitoring of crucial health parameters in the school context;
- increase the knowledge of teachers and other school personnel of the existing patterns of health and educational inequalities in Australia, and to increase their understanding of health problems and their capacity to detect early signs of health problems; and
- increase the capacity of schools to refer students to appropriate preventative and treatment services.[195]

5.20. The Committee heard the same reflected consistently from teachers.

5.21. The AEU reports the following areas requiring improvement[196]:

- professional development;
- resources;
- curriculum time and space;
- funding for outside programs to be involved in schools;

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[194] Submission 15, p. 5. As taken from the Youth Research Centre and Centre for Social Health 1996.
[195] Submission 14, p. 6
[196] ibid., p. 5

- liaison with other schools;
- involvement of parents and the community;
- the status given to the links between physical and mental health; and
- a whole-school and interdisciplinary approach.

5.22. Models such as the health promoting schools framework cannot work over the longer term without embedded cultural change.

Schools building communities

5.23. In the context of health promoting schools, there is a role for schools to take a more active role in the community, but only if they are adequately resourced to do so. All suburbs in Canberra have a school of some sort at its hub. Nothing has proved this more than the January 2003 fire crisis in Canberra. Schools were used as the central evacuation, meeting and information points and the community naturally gravitated towards them.

5.24. They are easily accessible on major roads and bus stops and have the necessary infrastructure already in place to support a multi-agency approach to supporting families and have children as a captive market for 11 to13 years and so are a privileged site for child health monitoring and treatment.

5.25. 'The Bay' as highlighted in Chapter 4, is an example of an effective multi-agency approach to addressing the health and welfare needs of students.

5.26. By addressing the health needs of the community within the school grounds, agencies have the ability to identify problems and assist entire families. These 'full service schools' would reduce some of the burden on teachers of providing the dual pastoral role that they are currently expected to perform. See Recommendation 4.

5.27. Full service schools not only involve the community in schools, for example providing on-site health services, but also involve schools in the community through greater links with community organisations and other training institutions to assist students to develop skills and/or a trade. This helps young people who otherwise might not have finished school to

stay in school whilst developing skills that will make them more employable in the future.

5.28. While there are issues to address in terms of strangers in schools, these are not insurmountable obstacles and should not be used as an excuse not to address this issue.

5.29. ACT schools have also had the ability to participate in the 'Schools as Communities' program, "premised on the theories and beliefs that:

- families are the wellspring of social capital;
- community infrastructure and social support are critical determinants of the wellbeing of families;
- the importance of prevention and early intervention;
- resilience can be strengthened in children and young people; and
- the value of school-linked and school-based services for at risk children and families."[197]

5.30. However, the schools as communities project has focussed on one-off projects rather than systemic cultural change. While the Committee believes that this is a promising start, it would like to see a more universal program implemented into schools.

5.31. "Students that feel supported by and connected to the school they attend have better levels of emotional health and lower levels of ill or mental health"[198]. The health promoting schools model has been conceptualised by the Centre for Adolescent Health at the Royal Children's Hospital (Melbourne) into the Gatehouse Project[199].

5.32. The Gatehouse Project is a practical whole-of-school strategy, which can be used in individual schools or whole school systems. In summary:

> The strategy uses a conceptual framework [Appendix 5] which emphasises the importance of a sense of positive connection with teachers, peers and learning for student well-being. It therefore locates mental health promotion within the core

[197] Submission 16, p. 16
[198] Transcript of Evidence, 3 October 2002, p. 239
[199] For further information see www.gatehouseproject.com

> business of the school: connectedness to school and engagement with learning. The project has identified three priority areas for action: building a sense of **security** and trust; enhancing skills and opportunities for **communication** and social connectedness; and building a sense of **positive regard** through valued participation in school life.
>
> Recognising that our health and well-being is affected not only by our own decisions and actions, but also by our interactions with others within the context in which we find ourselves, in includes both individual-focussed and environment focussed components. Drawing on the Health Promoting Schools framework, the strategy seeks to support schools to make changes in social and learning environments, introduce relevant and important skills through the curriculum, and strengthen the structures and processes that promote links between schools and their communities.[200]

5.33. The project recognises that "health outcomes are compromised in situations when students feel victimised, socially isolated, bored, and when they do not feel noticed or valued"[201].

5.34. It seeks whole-school change through multi-level intervention with classroom and curriculum strategies; whole school strategies; and school-community partnerships. It establishes an 'adolescent health team' comprising of staff (including the principal or other member of the leadership team), students, parents and community members to lead the process - firstly, reviewing all school policies and practices and auditing the entire student body to identify key focus areas.

5.35. It also ensures that everyone at the school, including students, staff, teachers and parents feel valued. A submitter noted that the welfare of teachers is often forgotten when addressing the mental health needs of students, and "it stands to reason that happy, resourced teachers are in a much better position to make a more productive learning environment"[202].

5.36. This is a long-term strategy and process to change the entire school culture, and it needs commitment on behalf of everyone involved.

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[200] Glover, Dr S. *et al. The Gatehouse project: Promoting emotional well-being: Team guidelines for wholes school change*. © 2002 Centre for Adolescent Health, Melbourne VIC., p. 5
[201] Glover S, *et al*., p. 7
[202] Transcript of evidence, 3 October 2002, p. 243

However, those schools involved in the pilot project started with small steps to make immediate difference, for example:

- teachers remembering to smile at all students on a daily basis;
- reorganising classrooms for team-based work;
- developing a school logo and song; and
- involvement in community events.

5.37. While the support structure provided by the Centre for Adolescent Health has now ended, 26 of the original public schools, and 45 schools in the Victorian Catholic system (out of a possible 60) have continued the project. Five schools in New South Wales have also adopted the project.

5.38. Evaluation of the original project found that there was sustained decreased substance use, however no decrease in incidents of bullying and depression. The project team expressed to the Committee that this would slowly change as the school culture continued to evolve as new cohorts of students entered.

5.39. This project was initially implemented in high-schools, but ideally, it needs to start at the primary school level, before patterns of bullying and victimisation are established, which is why the Committee has recommended a program similar to the Mawson Primary School human values program be implemented in every ACT primary school as a precursor to an extensive project in the latter school years.

5.40. While these programs need to implemented systemically throughout all schools, they do allow the autonomy for individual schools to tailor them to their own settings and individual needs – but must be supported at the Departmental level and adequately resourced.

Recommendation 44

5.41. The Committee recommends that the Government adopt the Gatehouse Project for implementation in all ACT Government high schools and colleges.

Families

5.42. As with schooling, "the socioeconomic conditions of the family and the mental status of parents and carers" has been clearly associated

with the health of children. “Living in a one-parent, step- or blended [families] is a risk factor for poorer health and wellbeing” due to a lower socioeconomic status and increased parental stress. [203]

5.43. The ACT Council of Social Service (ACTCOSS) reports that 38% of those living in poverty in the ACT are children. The three most disadvantaged groups are indigenous people, single parent families and people with or living with someone with a disability.[204]

5.44. “Recent [Australian Council for Educational Research] data shows that, on average, in their year 12 results, kids from indigenous backgrounds score 15 points lower than the average, and that kids from Asian backgrounds score 15 points higher. This means that family and community background in Australia can make a 30-point difference in your [Tertiary Entrance Rank] score.”[205]

5.45. Additionally, “two aspects of family functioning – family discord and parental disciplinary style – were significant risk factors for children’s poor mental health.”[206]

5.46. Government and community support for families, whatever their make-up, is needed in order to provide a safe, supportive environment for children.

5.47. The Committee agrees with ACTCOSS health promotion is imperative to improving community health outcomes and standards. However, as ACTCOSS points out, too often health promotion has been targeted at the middle class, and there needs to be a greater focus on those living at a disadvantage. Health promotion messages cannot just focus on issues like smoking and healthy eating, but also need to address housing and education.

5.48. Housing is an important determinant in health. This has been recognised consistently by academics and Governments, and while it translates into policy, does not necessarily translate into action.

5.49. A 2001 study by the National Centre for Social and Economic Modelling (NATSEM) found that:

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[203] Al-Yaman *et al*. 2002., p. 253, 256
[204] Transcript of evidence, 15 August 2002, p. 163
[205] ibid., p. 120
[206] Al-Yaman *et al*. 2002., p. 262

> housing tenure was … independently associated with self-assessed health status, the number of serious conditions reported, health service use and smoking. Renters were more likely to report fair or poor health; have a serious health condition; have visited a GP in the last two weeks and to be smokers."[207]

5.50. Housing costs can impose constraints on money left for food purchase, and poor quality housing and overcrowding can limit food preparation options.

5.51. Overcrowding is recognised as a particular problem in housing for indigenous peoples who tend to live with extended families rather than discreet family groups. Overcrowding can not only negatively effect mental health and well being, but has been shown as a "major determinant on the prevalence of respiratory infection/ pneumonia in children and affecting access to washing facilities, toilets; the efficiency of the waste water system; and access to food storage, preparation and cooking facilities".[208]

5.52. Overcrowding leads to the inevitable wear and tear on housing, which can lead to eviction and further participation in the cycle of homelessness.

Building community

5.53. Overwhelming, expert witnesses, teachers and community organisations have submitted to the Committee that the lack of 'community connectedness' is a fundamental problem facing the health of young people, particularly in terms of mental health.

5.54. A feeling of isolation has been shown to have an impact on people's health. "People need to be part of a community and to be linked to the community in different ways, because that helps them get on in education. It helps people get a job. It helps them to get on and be successful."[209]

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[207] Submission 19

[208] House of Representative Standing Committee on Aboriginal and Torres Strait Islander Affairs, report *We can do it! The needs of Urban Dwelling Aboriginal and Torres Strait Islander peoples*., p. 140-141

[209] Transcript of evidence, 15 August 2003, p. 167

5.55. It was put to the Committee that the most important thing schools can do for their students is to create a culture where everyone is loved and valued. The Committee saw examples, such as at Mawson Primary School, and heard methods, such as The Gatehouse Project, about how this can be achieved.

5.56. It is time for the community, the Government, schools and other stakeholders to address the issue of how to build connected communities.

5.57. There are organisations that that have been established to support or establish links between the government, non-government, private and community sector. For example, the Committee received a submission from an organisation[210] that operates an electronic referral system between schools, police, general practitioners, childcare services and social services.

5.58. Individuals are referred to this system only with their consent, but once referred, can be cross-referred to any one of the thousands of social support services already existing in Canberra.

5.59. Unfortunately, the Committee has heard that because of tight funding arrangements, organisations are often in competition for funds and therefore can find it difficult to work in collaboration. The Committee commends the work of those organisations working to facilitate co-ordination between agencies and/or referrals between agencies.

5.60. Early intervention supporting families is seen as a key to improving the health and education outcomes of children, and research has shown that a child's own capacity to parent is greatly affected by their experience of being parented. A universal program of early intervention and support would capture those families at risk of becoming isolated and trapped in the cycles of poor health and educational attainment.

> "The ongoing development of the relationship between government and community organisations means that parents and caregivers can be provided with the support they need to be positive role models and pass on skills to children and young people. Programmes need to provide a holistic strengths based approach and target prevention strategies as well as crisis support."[211]

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[210] Submission 25
[211] Submission 18

5.61. The Victorian government's Best Start project is addressing the early years, "based on the principles of reducing the impact of disadvantage (from any cause) and enhancing the life chances of all children"[212].

5.62. The project draws together parents, government, service providers and community resources to provide:

- access to quality antenatal care;
- support for parents to care for their children;
- opportunities for good quality play, learning, childcare, pre-school and early education experiences for children, before school and during the first three years of school;
- support for parents to strengthen their skills and capacity to promote the development and early learning of their children;
- access by parents to adult literacy and numeracy education and other adult and further education related services;
- health care for both child and parent, including health information;
- support for all children and families in the transition from pre-school to school with a particular focus on those with special needs;
- recognition of the key role of schools as a hub within communities and a natural focal point for the integrated provision of services to children and their families;
- outreach and home-based services for those in most need;
- promoting safe, nurturing and child-friendly community environments; and
- promoting appropriate housing.[213]

5.63. This project echoes similar projects being undertaken world-wide. It recognises that not only is early intervention key to improving

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[212] Best Start Program Overview, p. 2
[213] ibid., p. 3

children's health outcomes, but the community is key to providing effective early intervention and existing services are being changed or reoriented to reflect this.

Recommendation 45

5.64. The Committee recommends that the Government investigate the possibility of implementing an early-years intervention project that provides parenting support and well as universal health and social support.

5.65. However the concept of building communities, extends beyond service provision or school services, to include the concept of empowering individuals in a community context.

5.66. For example, the reduction in public space creates less opportunity for young people to meet and create a community. The push towards private space, such as large shopping malls where there is less space to sit and socialise, and move-on powers held by private operators, create a divide between young, economically disadvantaged people, and the economically advantaged people who are welcomed into such places.

5.67. 'The Mall' in Brisbane's city centre is an effective blend of public and private space, which allows for community gathering and is close and accessible by public transport. While the refurbishment of the Canberra Centre has attempted a similar concept, it is still largely private space, and does not offer much opportunity for young people to socialise.

5.68. The Government needs to consider the provision of accessible, inviting, public space that allows communities to meet and socialise spontaneously beyond the constraints of organised activity.

Transport

5.69. The Conservation Council of the South East Region and Canberra raised concerns with the Committee about the increasing reliance on the car as a primary mode of transport creating additional hazards for pedestrians and cyclists in terms of increased traffic risk and environmental pollution.[214]

[214] Submission 7

5.70. The Committee shares the Council's concerns that increased exposure to traffic and the resulting environmental and noise pollution will impact on the respiratory health and the learning abilities and speech acquisition of children, particularly given that the majority of schools in Canberra are on major suburban thoroughfares.

5.71. A body of research has been undertaken in the United Kingdom regarding the impact of the decrease in independent travel to school as a contributing factor not only to obesity in children but to the deprivation of fundamental learning and development opportunities.

5.72. The research, which has been anecdotally echoed in Australia[215], states -

> "Between 1970 and 1990 the proportion of nine to eleven year olds who were allowed to travel independently to school fell from nine in eleven to about one in eleven. In a very short period of time, a major and largely unnoticed social revolution has deprived children of a significant element of independent learning, socialisation and environmental learning experience."[216]

5.73. This research further goes on to state -

> "Escorting children in Britain in 1990 occupied 1,305 million hours of adult time. Much of this was female adult time thus imposing an additional time burden on women as a result of the inadequacies of the social environment and the transport system."[217]

5.74. The Committee is concerned that the additional time burden created by a changing transport system, is an additional source of stress for already busy families therefore negatively impacting on the health and well-being of children.

5.75. In fact, the National Cycling Strategy reveal that 61 percent of all travel to work or school by car in Australia was for distances under 10 kilometres, 35 percent under five kilometres and 5 percent of people

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[215] Transcript of Evidence, 20 June 23002, p. 2, Ms Nicola Davies
[216] Whitelegg, J. © 1997 Critical mass: Transport, environment and society in the twenty-first century. Pluto Press (London) p. 23
[217] ibid.

drove less than one kilometre[218]. A strategy to reduce use of the private motor vehicle as a primary mode of transport will provide benefits across whole spectrums of society.

5.76. There needs to be severe restrictions placed on the use of cars in and around school zones when schools are in session, including peak before and after school times, in consideration of not only the risk of traffic accident, but also the external environment of the school in terms of noise and other pollution.

5.77. Measure to address this include:

- instituting traffic-free zones around schools, which in turn requires students to walk from parking/drop-off points and encourages children in the local area to walk to school rather than be driven;
- developing co-operatives of parents to car-pool children to school or to walk with larger groups of children; and
- encouraging use of dedicated school-bus transport systems.

5.78. There is a perception that pedestrian travel is increasingly unsafe. Indeed, the less pedestrian traffic, the less safe pedestrians are likely to feel.

5.79. Pedestrian involvement in traffic accidents is high, being the most common specific cause of death of children aged one to fourteen although this risk diminishes significantly after the age of five. The total rate of death from traffic accident per 100 000 children age one to fourteen is 7.9, with 6.4 being children in the one to four age range.[219]

5.80. However current patterns of transport are not sustainable, infrastructure to support use of the private motor vehicle has been built at the cost of alternative transport options.[220]

5.81. Canberra has seen this by the decline of local shopping centres and their replacement by large town centres, which can be some distance from suburban areas. This discourages or prevents children from engaging in spontaneous activity, or being responsible to run errands for the family

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[218] *Australia cycling: The National Strategy, 1999-2004*., p. 3. Available from www.abc.dotars.gov.au
[219] Al-Yaman *et al*, p. 36
[220] Healthy Transport, Healthy People, The Warren Centre for Advanced Engineering: Sustainable Transport in Sustainable Cities Project. June 2002, p. 16

(i.e. buying milk/bread), something which implies trust and responsibility and important for children's social and emotional development.

5.82. By investigating approaches to encourage children to walk or cycle to school, and adults to walk or cycle to work for that matter, this would not only decrease the impact of traffic and risk of pedestrian accident, but also increase physical fitness and build community relationships.

5.83. A method to encourage safer travel to school is to audit common routes, identifying potential traffic hazards and how to eliminate or reduce them to encourage walking or cycling.[221] Pedal Power ACT also suggested a similar program, which would include children being involved in mapping safe routes to school.[222] The Queensland Government already runs such a program sponsoring a 'Ride to School Map' competition as a part of the state-wide Bike Week.

5.84. The Committee not only believes that involving children to plan independent travel would be empowering, but heard very convincing evidence that children want to be more involved in the issues that affect them.

5.85. College-students identified that driving and the pressures of college were the major factors in their reduction in exercise, as well as no longer having compulsory physical education as part of the curriculum.[223] Indeed, road ready programs in schools to assist students to obtain learner drivers licences do not address alternative modes of transport.

5.86. Overall, the Committee feels that there is convincing evidence to put in place strategies to reduce the reliance on the car as a primary mode of transport, particularly in terms of school transport.

> "Incorporating incidental physical activity that results from regular lifestyle behaviours has been found to be more cost effective than physical activity achieved through structured exercise programs. [Active transport] includes travel by foot, bicycles and other non-motorised vehicles. Use of public transport is also included, based on the assumption that it involves some walking or cycling to pick-up from and set-down at drop-off points."[224]

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[221] Submission 7, p. 2
[222] Transcript of evidence, 15 August 2002, p. 128
[223] Informal evidence form The Canberra College students, 26 August 2002
[224] Healthy Transport, Healthy People, p. 19

5.87. Increased use of active transport methods and therefore increased physical activity will have the added benefit of increased health outcomes through improved physical fitness, decreased levels of obesity and improved environmental outcomes.

5.88. Other practical measures may also need to be considered to address why children are not walking to school, such as the provision of lockers in schools so that students are not carrying large and heavy loads of books.

Recommendation 46

5.89. The Committee recommends that future civic design and planning includes measures to encourage active transport, physical exercise and discourage use of the car.

Recommendation 47

5.90. The Committee recommends that the Government sponsor a program, in conjunction with children and parents, to map safe walking and cycling routes to school and then assist in establishing programs to encourage use of these routes.

5.91. The Committee further recommends that in curriculum areas that cover transport systems, including 'road ready' courses that information about alternative, active transport methods is also included.

Recommendation 48

5.92. The Committee recommends that severe restrictions be placed on the use of cars in and around school zones when schools are in session and that the Government work with local school communities to develop safe, alternative school transport methods.

5.93. The Government and the community need to make a commitment to safe, sustainable, clean public transport systems.

6. Conclusion

6.1. This inquiry has consistently raised three major issues to be addressed in order to improve the health of school-age children:

- Firstly, children and young people are in need of a more connected society, through their schools, services, social groups and local community;
- Secondly, children and young people are in need of a 'moral toolbox' filled with the skills of help-seeking, resilience, coping, and the ability to analyse and express their emotions; and
- Finally, children and young people need to be able to engage in their world and the decisions that affect them. Policy planners, schools, and governments must ensure to take account of the views and needs expressed by children and young people.

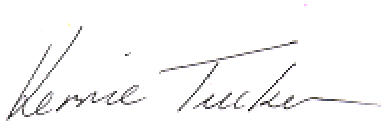
6.2. The Committee was been surprised by the overwhelming number of times that these three issues were raised by submitters, witnesses and others that the Committee heard from over the year of this inquiry.

6.3. Some worrying trends in the health of school-aged children have also been raised. Namely a decrease in physical activity, and an increase in poor dietary habits is leading to an ever-increasing instance of overweight and obesity, leading to other health disorders such as Type 2 diabetes, rarely before seen in young people.

6.4. Young people are also increasingly aware of their sexuality, which not only means that many are sexually active, it also means that they need to be aware of safer sexual practices. The young people the Committee spoke to were also tolerant of sexuality diversity and wanted their schools and community to make more effort to stop gay and lesbian youth being marginalised.

6.5. Solutions to these problems are long-term and systemic, however there are many models that the ACT can follow. The Committee has made recommendations for the Government, but individual schools, community groups and organisations may find that there is also scope for them to implement some of the Committee's findings.

6.6. Indeed, it is up to each member of society to keep playing a part to improve his or her world for the better. In the words of one witness, age eleven, "*children are basically the future, but that also applies to adults, because they are role models for us*".



Kerrie Tucker MLA
Chair
17 April 2003

Appendix 1 – Submissions received

1 Susan Bridgman

2 Karen Harman, DIRECTIONS ACT

3 Tony Shields, Pedal Power

4 Trish Ryan, Dietitians Association of Australia

5 Dr Tracey Soh, ACT Division of General Practice

6 Dr Ann Villiers

7 Nicola Davies, Conservation Council of the ACT

8 National Centre for Epidemiology and Public Health

9 Sue Dengate, Food Intolerance Network

10 Catholic Education Office

11 Ms Karen Caldwell

12 Ms Sheryl Sibley

13 Ms Kylie Easton

14 ACT Council of P&C Associations

15 Australian Education Union – ACT Branch

16 Heart Foundation of Australian – ACT Division

17 Marjory Smith, Board Chair, The Canberra College

18 Kasy Chambers, Executive Director, YWCA of Canberra

19 Ms Angela Seymour, ACT Shelter

20 Ms Anni Mather, Gaia Landscape Studio

21 Mr Peter Ross, Principal, Curtin Primary School

22 Mr Tim Moore, Cyclops

23 ACT Health Promotion Board

24 Ms Judy Chick, Flynn Primary School

25 Mr Tony Campbell, Executive Officer, SupportLink Systems Pty Ltd

26 Evatt Primary School Board

27 North Ainslie Primary School

28 Melrose High School

29 Narrabundah College

30 ACT Australian Council for Health, Physical Education and Recreation Committee

31 ACT Government

32 Year 3, Palmerston District Primary School

Exhibits received

1 Ms Rose Costello, Health Promoting Schools Project report and newsletter

2 Dr Daryl Efron, *The Prescribing of Psychotropic Medications for Children by Australian Paediatricians and Child Psychiatrists* and *Which Psychotropic Medications are being Prescribed for Australian Children?: A Survey of Practice in an Evidence Vacuum* (summary)

Appendix 2 – Witnesses at Public Hearings

On 20 June 2002

Ms Nicola Davies, Conservation Council of the South-East Region and Canberra;

Ms Karen Harman, DIRECTIONS ACT

Mr Richard Eckersley, National Centre for Epidemiology and Public Health

Dr Anne-Louise Ponsonby, National Centre for Epidemiology and Public Health

Dr Tracey Soh, ACT Division of General Practice

Mr Robert DeCastella, Smart Start

On 28 June 2002

Dr Brenda Morrison, ANU Centre for Restorative Justice

Ms Alex Cahill, Youth Coalition of the ACT

Mr Tim Moore, Cyclops

Ms Mel Greenhalgh, Junction Youth Health Service

Ms Rose Costello

Dr Michael Flood, Family Planning

Ms Maureen Cane, Communities @ Work

Ms Lee Mayden, Communities @ Work

On 15 August 2002

Ms Ruth Christie, Rape Crisis Centre

Mr Tim Bavinton, Service Assisting Male Survivors of Sexual Assault

Ms Annie Stanton, National Toxics Network

Dr Ian Morgan, President, ACT Council of P&C Associations Inc.

Mrs Robyn Cummins, Vice President, ACT Council of P&C Associations Inc.

Mr Tony Shield, Pedal Power

Mr Rod Katz, Pedal Power

Mr Richard Windsor, ADHD Support Group

Ms Beryl Gover, ADHD Support Group

Ms Peta Cox

Dr Michael Gaffney, Head of Education Services, Catholic Education Office

Dominique Marsh, Parent Participation Officer, Catholic Education Office

Mr Daniel Stubbs, Director, ACT Council of Social Services

Dr Sandra Lilburn, ACT Council of Social Services

Dr Debra Rickwood, University of Canberra

Ms Kylie Easton

On 23 August 2002

Miss Elizabeth Neist, North Ainslie Primary School

Mr Tom Bode, North Ainslie Primary School

Miss Pippa Finaly, North Ainslie Primary School

Miss Emily Scott, North Ainslie Primary School

Mr Julian Ingall, North Ainslie Primary School

On 3 October 2002

Dr Sue Packer, Community Paediatrician

Ms Maryanne Campbell, Senior Counsellor, Funnybone Counselling

Dr Anne Villiers

Ms Irmgard Reid, Educator Project Officer, Vision for Youth through kNowledge and Education

Ms Lisa Oxman, Project Officer and Educator, Vision for Youth through kNowledge and Education

Ms Lisa Brown, Managing Director, FYASCO

Ms Alana Lucas, Director of Human Resources, FYASCO

Mr David MacLellan, Sponsorship Manager, FYASCO

On 27 February 2003

Mr Garry Fry, Program Manager, Messengers Program

Ms Catherine Furner, Counsellor, Messengers Program

Dr Dion Klein, President, Fitness ACT

Ms Laura Aoun

Appendix 3 – Recommendations of the Standing Committee on Health and Community Care of the Fourth Assembly of the ACT's inquiry into *Aboriginal and Torres Strait Islander Health in the ACT*.

Those recommendations supported by the Government are indicated in italics.

Recommendation 1

The committee recommends that the ACT Government work with the Commonwealth to prioritise data collection efforts in relation to Aboriginal and Torres Strait Islander health. *Supported.*

Recommendation 2

The committee recommends that:

a) the Government consult with the ACT Aboriginal and Torres Strait Islander community to assess the value of establishing a community and cultural centre for Indigenous people; and

b) should this consultation find a sufficient level of support for such a centre, funding arrangements be developed to progress the proposal. *Supported.*

Recommendation 3

The committee recommends that the Government develop housing policies that reflect the special circumstances of the Indigenous population, ie a comprehensive Aboriginal Housing Policy which is informed by the Indigenous communities of the ACT and the housing sector. *Supported.*

Recommendation 4

The committee recommends that the Government design and develop public and community housing aimed directly at Indigenous families, particularly where women and children are escaping domestic violence. *Supported.*

Recommendation 5

The committee recommends that the Government provide advice, support and resources to facilitate the establishment of partnerships between the Indigenous Business Chamber, local Indigenous groups and individuals, the business community and the Government sector (both local and federal) that identify and help nurture entrepreneurial and employment opportunities for Aboriginal and Torres Strait Islander people. *Supported.*

Recommendation 6

The committee recommends that the Government examine the Violence in Indigenous Communities report to ensure that it has an appropriate range of programs and services in place for dealing with violence in the ACT Indigenous community. *Supported.*

Recommendation 7

The committee recommends that the Government:

a) provide post custodial accommodation which aims to keep families safe and to work towards healthy reintegration into the community;

b) develop early intervention programs with known populations whose needs are not being met within the current system e.g refuges;

c) provide outreach workers who maintain close links with a family in crisis, who can be a point of early intervention and work as advocates across the spectrum of health and welfare services that are required; and

d) develop a written, public domestic violence policy within ACT Housing. *Supported.*

Recommendation 8

The committee recommends that the Government consult with the Commonwealth and ATSIC to identify additional recurrent funding to improve the Canberra Rape Crisis Centre's capacity to provide effective services for Aboriginal and Torres Strait Islander people. *Supported.*

Recommendation 9

The committee recommends that the Government report to the Assembly on a regular basis about its performance in relation to the actions and outcomes outlined in the ACT Aboriginal and Torres Strait Islander Regional Health Plan. *Supported.*

Recommendation 10

The committee recommends that the ACT Government continue to support the principle of community control and that close consultation and negotiation takes place with the ACT Aboriginal community not only with regard to funding decisions but also in planning programs' timeframes, performance measures and outcomes. *Supported.*

Recommendation 11

The committee recommends that the Government advocate the broadest notion of community control in negotiations with state and federal counterparts regarding framework agreements and other Indigenous related policies. *Supported.*

Recommendation 12

The committee recommends that the ACT Government negotiate with NSW and the Commonwealth government to develop a funding package to create a practice manager position in Winnunga Nimmityjah. *Supported in principle.*

Recommendation 13

The committee recommends that the ACT Government increase its financial support to Winnunga Nimmityjah to allow for the expansion of services. *Supported in principle.*

Recommendation 14

The committee recommends that the ACT Government, in consultation with Winnunga Nimmityjah, make representations to the Commonwealth and NSW governments to identify joint funding for the development of a purpose built facility for Winnunga. *Supported in principle.*

Recommendation 15

The committee recommends that:

a) the Government in consultation and negotiation with Gugan Gulwan review the appropriateness of its new premises in Erindale over the next year to ensure that the location opens up access to the fullest extent possible for the Corporation's client group; and (*Supported.)*

b) should this review find Civic to be a more appropriate location the Government shall make provisions for relocating Gugan Gulwan. *(Not supported.)*

Recommendation 16

The committee recommends that the Government provide additional funding to Aboriginal-specific health and related services and make representations to the Commonwealth for increased ACT funding in this area. *Supported.*

Recommendation 17

The committee recommends that the Government consult with the ACT Aboriginal and Torres Strait Islander community to begin a systematised review of operating policies for all mainstream health services to ensure they are tailored to be culturally appropriate. *Supported.*

Recommendation 18

The committee recommends that the Government review all the processes at Canberra's hospitals in consultation with the ACT Aboriginal and Torres Strait Islander community to ensure that there is sufficient flexibility in their application and that operating processes and policies are culturally appropriate. *Supported.*

Recommendation 19

The committee recommends that the Government undertake vigorous efforts (and intensify existing programs) to expand the knowledge of cross cultural awareness and sensitivity across the entire health portfolio, particularly at the Canberra Hospital, this effort should be ongoing and reviewed periodically to determine where gaps exist. *Supported.*

Recommendation 20

The committee recommends that the Government consult with the various peak groups responsible for overseeing medical specialties to instigate Indigenous and other cross-cultural awareness training for health professionals across all specialties. *Supported.*

Recommendation 21

The committee recommends that the Government fund further designated ALO positions in mainstream health services in the ACT. *Supported.*

Recommendation 22

The committee recommends that the ACT Government consult with the Commonwealth and the local Aboriginal and Torres Strait Islander community to begin refining and implementing the strategies identified in the 1996 Winnunga report to the Commonwealth Department of Human Services and Health. *Supported.*

Recommendation 23

The committee recommends that the Government consult with Aboriginal community groups, the ACT Division of General Practice and the AMA to develop strategies to minimise the extent of 'doctor shopping' and to identify GPs that are misprescribing benzodiazapines and other potentially dangerous drugs. *Supported.*

Recommendation 24

The committee recommends that the Government, in consultation with the ACT Aboriginal and Torres Strait Islander community, instigate a review of admission policies for detoxification services and other processes to identify current barriers to Indigenous people and following the review, implement measures to remove the barriers. *Supported.*

Recommendation 25

The committee recommends that the Government allocate funds to consult with the ACT Aboriginal and Torres Strait Islander community to assess the different approaches for providing rehabilitation and detoxification services for Indigenous people and that this assessment should be auspiced by an Aboriginal Controlled organisation such as Winnunga Nimmityjah or Gugan Gulwan and should consider:

- how services can be better provided to support Aboriginal and Torres Strait Islander people who have had a drug addiction in the past and are released from prison;

- the value to the community of extending Gugan Gulwan's bush retreat program; and

- the capacity for family members of people seeking rehabilitation and detoxification to be involved in the treatment options and the capacity for a facility to offer support for family members as well as addicted persons. *Supported in principle.*

Recommendation 26

The committee recommends that following the assessment of Indigenous needs in relation to rehabilitation and detoxification services, the Government give funding priority to the proposals that arise out of the consultation. *Supported.*

Recommendation 27

The committee recommends that the Government consult with the ACT Aboriginal and Torres Strait Islander community to begin implementing Winnunga Nimmityjah's recommendations in relation to the Drug and Alcohol Program set out in the 1998 report, Understanding Indigenous Needs: How can the Alcohol and Drug Program better meet the needs of Indigenous people in the ACT region. *Supported.*

Recommendation 28

The committee recommends that the ACT Government through the Aboriginal and Torres Strait Islander Consultative Council develop proposals for sport, music, art and dance to provide activity for young Indigenous people and provide funds necessary to develop proposals and subsequent activity. *Supported in principle.*

Appendix 4 – Low additive school canteen menu

Suggested menu for ACT school canteens in order to minimise the sale and use of foods containing high fats, high sugar, artificial colours, flavours and preservatives.[225]

Menu

- All bread and rolls are preservative free
- Margarine is Nuttelex.

Hot food

- Homemade sausage rolls (recipe below)
- Pies (the lowest additive pie available)
- Mini pies (ditto)
- Tomato sauce
- Baked potatoes with sour cream
- or cheese
- Steak sandwich
- Fried rice, no MSG
- Hamburger with lettuce, tomato, beetroot, sauce
- Plain hamburger

Sandwiches and rolls

- Cashew paste
- Peanut butter
- Pear jam
- Vegemite
- Kraft cheese
- Philly cheese
- Mild cheese
- Baked beans
- Egg
- Egg and lettuce
- Curried egg
- Leg ham
- Sausage - beef
- Sausage - chicken
- Rissole
- Ham and salad
- Fresh chicken meat
- Chicken and salad
- Chicken and lettuce
- Tuna
- Salad
- Salad plate (Ham or chicken with egg/cheese/lettuce/carrot/tomato/cucumber/ capsicum)

[225] As taken from Submission 9

Extras
- Tomato/cucumber/onion/carrot/beetroot
- Mayonnaise/pickles/pear chutney
- Pocket bread, no preservatives, white or rye
- Rye
- Rolls, white
- Toasted sandwiches, extra

Sundries
- Muesli bars
- Rice cakes with spread
- Sultanas
- Rice bubble treats
- Fresh Fruit in season, includes *pears
- Magic cordial icecups
- Fruit juice icecups
- Plain water icecups
- Choc bars
- Peters Dixie icecream cups
- carob swirls
- Brumby's iced finger buns (without coconut)
- white marshmallows (each or packet)
- Granny's butterscotch (each)
- Glengarry shortbread (each)

Drinks
- 100% juice popper
- Plain milk 300 ml
- Flavoured milk (no artificial colours)
- Bottled spring water
- Fresh juice
- Soyaccino
- 7UP

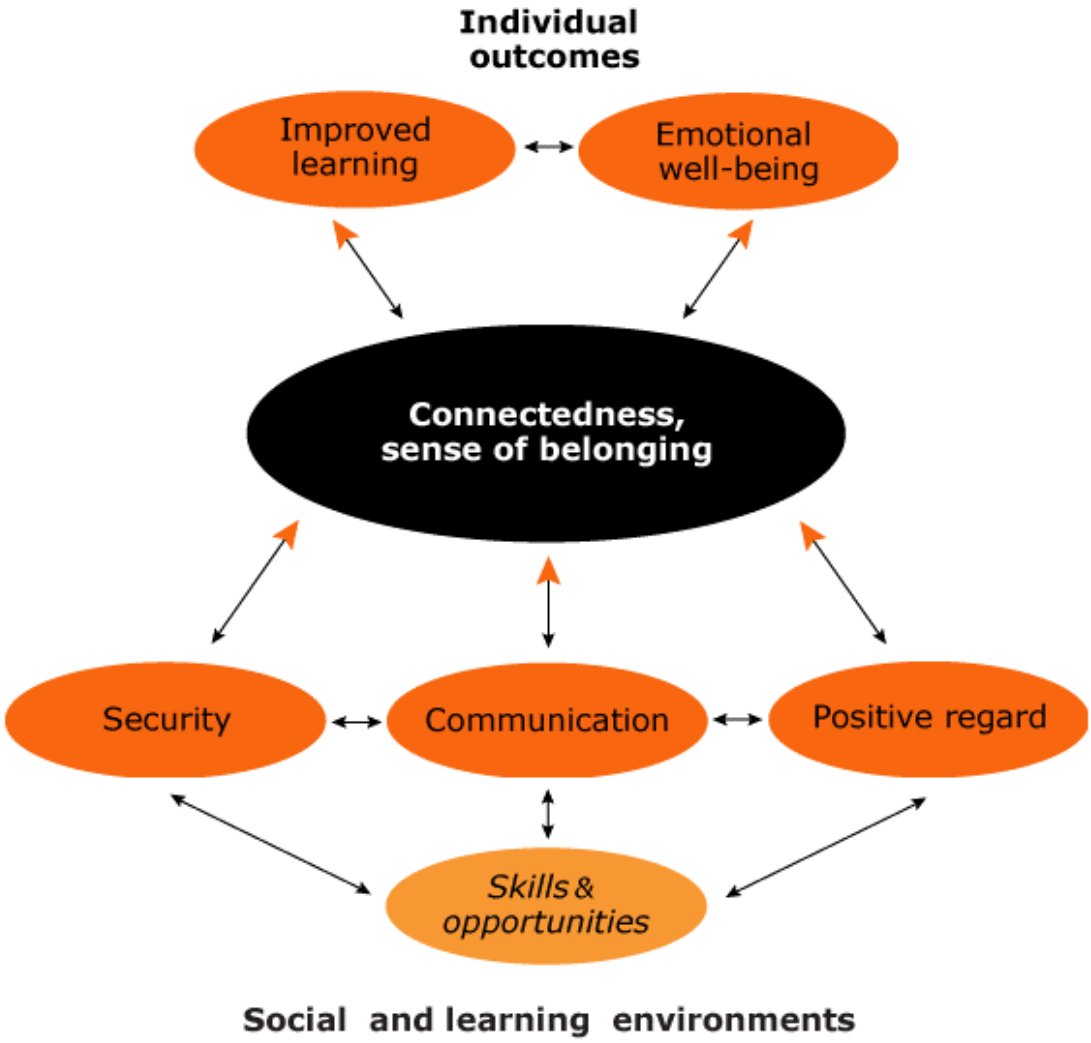
Cold food
- Hard boiled egg, free range
- Frozen yoghurt

School sausage rolls
<u>*Pastry*</u>
2 packets Pampas Butter Puff Pastry frozen sheets

Filling
1 kg mince
1 leek finely chopped in food processor then sautéed
4 cloves garlic crushed and sautéed
4 tsp sea salt
2 cups brown rice flour
2 eggs or 2 tbsp water

Mix all ingredients except meat in food processor for smooth mix and add to mince. Mix to a paste. Add extra water if necessary, up to a cup of water, to make the mixture moist like sausage mince. Cut frozen pastry sheet in half. Put mixture on the edge of the pastry, roll the pastry over. Seal with milk. Each pastry sheet makes 4 sausages rolls. Brush tops with milk. Place on baking tray. Bake at 220°C for 15 mins. Makes 26 rolls using 7 pastry sheets.

Appendix 5 – Gatehouse Project Conceptual Framework



Glover, S., Patton, G., Butler, H., Di Pietro, G., Begg, B. & Cahir, S. (2002) *The Gatehouse Project: Promoting Emotional Well-being: Team Guidelines for Whole School Change*, Centre for Adolescent Health, Melbourne.