T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into the State Education System in Victoria

Melbourne – Wednesday 8 May 2024

MEMBERS

Trung Luu – Chair
Ryan Batchelor – Deputy Chair
Michael Galea
Renee Heath
Joe McCracken
Rachel Payne
Aiv Puglielli
Lee Tarlamis

PARTICIPATING MEMBERS

Melina Bath
John Berger
Georgie Crozier
Moira Deeming
David Ettershank
Wendy Lovell
Sarah Mansfield
Richard Welch

WITNESSES

Dr Stefan Gruenert, Chief Executive Officer, Odyssey House Victoria;

Professor Susan Sawyer, Director, and

Dr Jennifer Dam, Senior Project Coordinator, Education Initiatives, Centre for Adolescent Health, Royal Children's Hospital; and

Associate Professor Petra Staiger, School of Psychology, Deakin University.

The CHAIR: Welcome back to the Inquiry into the State Education System in Victoria. Joining us for this session we have people from Odyssey House and the Centre for Adolescent Health.

Before I continue, I just want to read this information to you. Regarding evidence, all evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provision of the Legislative Council's standing orders. Therefore the information provided during this hearing is protected by law. You are protected against any actions for what you say during this hearing, but if you go elsewhere and repeat the same thing, those comments may not be protected by this privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript following the hearing. The transcript will ultimately be made public and posted on the committee's website.

I will just quickly introduce the committee. I am Trung Luu, the Chair. To my left is Deputy Chair Mr Ryan Batchelor, as well as Mr Aiv Puglielli, Ms Melina Bath, Mr Joe McCracken and Mrs Moira Deeming.

Welcome. Thank you very much for your time. Could I just ask you to state your names, from left to right – just for recording purposes – and the organisation you are representing, please.

Petra STAIGER: Dr Petra Staiger, Deakin University.

Stefan GRUENERT: Stefan Gruenert, Odyssey House Victoria, and he/him pronouns.

Susan SAWYER: Professor Susan Sawyer, Director of the Centre for Adolescent Health at the Royal Children's Hospital.

Jennifer DAM: Jennifer Dam, Senior Project Coordinator at the Centre for Adolescent Health.

The CHAIR: Thank you. I will ask both groups to make a short opening statement, then we will open it up to the committee to ask some questions, if you would like to start.

Stefan GRUENERT: Sure. Obviously, you have read lots of submissions. We are mostly focused on student wellbeing and the impact that that can have on student engagement in schools, their learning outcomes, the stress of teachers and teacher retention. We have been operating a program in public schools in Victoria for about 15 years on a shoestring with some philanthropic support. We recently got some government money from the Commonwealth to expand that. We started in community schools where there was high need, and more recently we have been invited into some state mainstream schools. We appreciate that there are a lot of resources put into student wellbeing in wellbeing teams and, more recently, with mental health practitioners. What we have identified over many years, though, is that whenever drug and alcohol issues are present those more generic wellbeing teams in many of the schools do not cope well. We know that students, young people, do not go to referrals typically outside of the school, and so embedding some of our specialists in those schools has made a huge difference. And it is not just embedding the practitioners, but it is bringing a whole-of-school approach.

There are four or five elements that we see as being critical and effective. One is having the specialist staff in the schools – not paid as staff members, because there are different reporting and consent issues around that – and young people open up to those embedded staff with that credibility. Their capacity to do outreach – so after hours, in school holidays or during periods of disengagement we can go and find the kids; we can work with

them at home if there is stuff going on there. We also do support for the senior staff in the school, the management, around their drug and alcohol policies and how they manage people with drug and alcohol issues to ensure that it is collaborative, it does not further elevate or escalate behaviours and it is more likely to focus on their wellbeing and get them back to school and focused rather than being expelled, where they just have nowhere to go and they are more likely to go into youth homelessness, the justice system, that pathway that we have seen is too common. We also do school activities – camps, excursions, things like that – and that is a way of engaging at-risk kids to get to know us, and then they are more likely to open up to us. We support teaching staff with specialist parts of the curriculum where teachers feel out of their depth talking about drugs and alcohol. And that whole-of-school approach is what together allows the school to deal with this issue. We find that we do not have to do this continuously. In our experience a couple of years in a school makes a huge difference, and then we can move onto the next school – and that is typically one worker between a couple of schools, so it is a small investment.

At the time of writing the submission we did not have access to the evaluation report, which has just landed this week, which is why I have brought Associate Professor Staiger along from Deakin, who led that evaluation and is certainly happy to answer questions around the impact and the feedback from students and any other questions you might have about that.

The CHAIR: Just with the evaluation, are you able to make it available for us as well – the results?

Petra STAIGER: Yes. I have got it right here. I just happen to have it.

Stefan GRUENERT: And we will send it through electronically to you.

Petra STAIGER: I will send you an electronic version as well, yes.

The CHAIR: Thank you. Is there anything else you want to add?

Petra STAIGER: Yes. Look, just a few things. By nature I am a quantitative researcher, but I am actually going to read out a qualitative quote, because it is from an assistant principal and it just captures really what I have experienced in doing the evaluation of this.

[QUOTE AWAITING VERIFICATION]

> I have been in this space for a really long time, and I have just never seen anything work as well as this does for alcohol and drug issues, both for the young people, for their social networks and for changing things in families that have been in the addiction cycle for generations. Shifting outside of that is remarkable.

This was an assistant principal. You will be able to read another 71 pages in the report. This was an implementation evaluation; there has already been an outcome evaluation of the program. Like this principal, I have been around for many decades in the drug and alcohol space, and I have not really seen a program that has the impact that this has for the minimal resources, when you think about what is required. It is so far-reaching – I think that is the thing – because it has the outreach, the capacity for families, the embedding elements of all the different components. And yes, I am saying this quite independently. It is very impressive.

The CHAIR: Thank you. Professor, would you like to make an opening statement before we ask questions?

Susan SAWYER: Sure. I am an experienced clinician. I have worked for 30 years with young people and in doing so have seen young people with a whole host of health issues, working with their families, and we have spent a large part working with schools. As a centre of excellence, our centre has had a 30-year history of working at the interface of health and education settings. We ran the first randomised controlled trial, the Gatehouse project**,** of a health intervention in schools which changed the very way that school communities worked. So we come from this history of health and education and trying to understand how they might come together in schools.

The focus of our submission is very much around this notion of health-promoting schools. It is WHO language, but it is really thinking about how we can bring an integrated, strategic and coherent approach to thinking about schools as a system of multiple moving parts, moving from primary prevention through to then programs for kids with more established problems, and recognising that in doing that currently, let us be frank, it is a bit of a dog's breakfast in most places of the world. It is not just in Victoria; it is no criticism of the Victorian system. But the health-promoting schools framework is a way of being able to understand that education and health are

actually just two sides of the same coin and recognise that wellbeing and connection to school lie at the heart of students' educational outcomes. It is what schools are wanting, and as a health professional, I also know that kids getting the highest level of education they can is critical to informing their future wellbeing and their future contribution.

Yet as schools currently operate, I would argue, and our research would demonstrate this, that at its most basic level there is a mismatch in language and the terminology we use. People talk about a crisis of mental health, and yet schools talk about wellbeing and do not refer to mental health. Schools do not know how to integrate so many different elements. At the moment, we are seeing gender-based violence is the problem du jour, as I call it, but next month it will be drug and alcohol issues and the month after that it will be something new. The risk is that governments will identify perhaps somewhat piecemeal responses to fund, which as individual programs are often excellent, without an overarching framework of integration and particularly then linking that back to a monitoring framework where individual regions are able to see the outcomes and track their students, not just at a national level in terms of PISA, as with the earlier question, but at a much more localised level.

We are not sufficiently clear then about what we need to invest in, and I think the health-promoting schools framework is a very strategic and integrated approach that allows the different moving parts in the system to come together so we can achieve better alignment of government policies, government investments, school policies, schools' social and physical environments, pedagogy in the school and the learning environment within the classroom and the programs that are run within that curriculum, as well as then the specific health services that might be delivered.

The CHAIR: Thank you. Any comments?

Jennifer DAM: I think that was very comprehensive. I would just add that at its most basic level it gives a common language as well to talk about these issues so that when we do all come into a room together we can be on the same page and be talking about things with the same language, which really helps to make things more cohesive as well.

The CHAIR: Thank you. Thank you for your opening statement. I will now open up to the panel. Deputy Chair, would you like to start?

Ryan BATCHELOR: Thanks, Chair. Thanks, everyone, for coming in. I might start, Professor Sawyer, with riffing on this kind of mismatch of language and integration. One of the tools that the department uses to make sure that schools have got a plan and a strategy is the FISO, the framework for improving student outcomes – I love a good acronym.

Susan SAWYER: Yes, it is pretty awful, isn't it?

Ryan BATCHELOR: It is all right, but it is mystifying, I think, to many who are participating in it – particularly as a parent who has been through the process a couple of times on school council. How well do you think that mental health wellbeing is being integrated into this planning framework that the department expects all schools to use?

Susan SAWYER: I think there has been a distinct improvement in FISO over the previous approaches, in that the language of wellbeing is included and student wellbeing is acknowledged as an important outcome of schools. As I said, it is really important that it is there.

Ryan BATCHELOR: So you think that has changed?

Susan SAWYER: That is a change, and that is a distinct improvement from what it has been. But the language of wellbeing is very broad and means different things to different people, so I think without the specification of bringing that down to then thinking about how we are actually going to address that strategically across all of those levers, from policy through to programs that schools have, the risk is it becomes a language that is talked about without necessarily having traction on the ground.

Ryan BATCHELOR: We run the risk of wellbeing being something that no-one really understands.

Susan SAWYER: Yes, and I would put that absolutely really practically in focus. So the current government funded as an election promise a program that is now known as 'doctors in secondary schools'. It

aimed to put doctors and nurses in the most disadvantaged schools in the state. I am very supportive of the program. I was a bit cynical initially. I am now a major supporter of the program. The same government has implemented mental health practitioners in schools, which is a program I am also very supportive of. But these two programs sit distinctly; they report through to different arms. If they actually work on the ground in a school, it is as a result of the individuals coming together who, again, speak very different languages. Jen was involved in rolling out a training program of health-promoting schools in Victoria recently to try and come together with this shared language, and it was very clear within that that people were sort of all over the place, and that means that then you can be swayed. Again, you will get someone selling a program that would seem to be a really good program – 'You've got a problem in this area, so let's do this.' Well, how do we balance that with what else we might be doing? How do we sustain these? Without this more strategic approach which is evidence informed, I think we are at risk of just floating and – what is the word I am looking for – sort of flowing in the wind a bit.

Ryan BATCHELOR: It is interesting you mention these really third-party providers who are coming in and pitching programs aimed at improving wellbeing to schools. Do you have anything to say about how they work, about how well schools are equipped to understand the efficacy of the external providers?

Susan SAWYER: There have been some web-based platforms which have been funded which have tried to bring attention to what evidence-based programs are available, and that is to be commended because most schools are not in a position of having the expertise that Petra might have, for example, to understand what is truly an evidence-based program. So the fact that the previous Dean was talking about the longitudinal study they are doing and looking at retention from that is to be really celebrated. But I think that more broadly this is where, rather than funding individual programs, how can we actually fund the workforce that sits within a school so that, for example, the mental health practitioners who are currently funded to do both mental health promotion and mental health care – clinical care of kids with bums on seats – how can they possibly spend any time on health promotion when you have got so much demand from kids with current crises?

So the risk is that no-one is doing the mental health promotion. Then you buy a program that comes in to do that work for you without it then being more broadly integrated within the school. I think the interest that I have in health-promoting schools, again, is about this framework for how we get the alignment, the leverage and the understanding of those different component parts within a school to have them better oiled and to have them better aligning and getting leverage from what one is doing to another. My concern is that there are some excellent programs, but unless they are really embedded in – and I really like the sound of the BRACE program, because there is someone there for a longer period of time rather than coming in and doing sort of a quick teaching something or other, which I do not think is nearly as effective.

Ryan BATCHELOR: Thanks. I have some questions for Odyssey House, but I will come back at the end if we get time.

The CHAIR: If we get time, we will come back to you. Ms Bath.

Melina BATH: Thank you. Thanks, Chair. Thank you very much for your expertise, your passion, your lifelong commitment to young people and the health of young people, and I have many questions. I will start off if I can with you, Professor Susan. In country Victoria it is often hard to get a doctor in the town, let alone in the school. It is often hard to get into a mental health practitioner in the region. So I guess I would put that to you because we have got 1500-plus state schools. How can remote schools, regional schools or disadvantaged schools wherever they are get an off-the-shelf health-promoting school? Does it come as a package? So kind of drill down – how do we promote this? How do we go, 'This is a great idea, government – roll it out'?

Susan SAWYER: A health-promoting school is not a package. That is not what it is. It is not getting –

Jennifer DAM: It is a way of doing things.

Melina BATH: But how do schools in Orbost or wherever – Wonthaggi – work it out?

Susan SAWYER: It is probably about providing some training to school leaders and to people in key roles in schools to help them understand what it is that schools can be doing and how they can function, how they can identify resources within their community. It is not about expecting teachers to be mental health providers at all.

Jennifer DAM: Yes, absolutely. I would also add that in a lot of cases schools are already doing a lot of activities that you would consider part of health promoting schools, so this is very much us looking at what is already happening and building on those strengths in order to build capacity. This is not a starting from zero point. In conversations with some regional schools, there are some fantastic initiatives already happening. For example, it is much harder for them to have access to health practitioners and doctors, but from one conversation with a school, they were bringing in services and having a day event where they focus on health and wellbeing and then bring in a bunch of different practitioners to speak to students and be a part of the school for that day. So there are different ways that those things are happening already, which will provide great ideas for building on that in the future as well.

Susan SAWYER: There is also telehealth, and the thing that we have learned in telehealth is the access to urban-based resources in a way that – I am not at all convinced that necessarily schools are utilising them as they could. I think you are right in recognising that the issues for country schools are greater than for urban schools, but I think that the framework can be the same, and so a health promoting school approach is a way of thinking. It is not a program. Yes, there could be investment in preservice education; that is certainly one thing that we would be recommending. But this is an approach which is as much about wanting to ensure the wellbeing of teachers as much as students, and it is a way of helping school communities to understand what they might choose to prioritise and why. That is where again local data about local schools I think really matters. I mean, there are some particular ways of being within a school, so it is also ensuring that student voices are part of that. It is listening to young people and young people's feedback about what they think is working well in the school and what they think could be changed, would perhaps be one example where it does not cost you anything to do, apart from perhaps some of the convening around that.

Melina BATH: Thank you. So it is nuancing what is there; it is working with leadership, staff, students, parents –

Susan SAWYER: Communities.

Melina BATH: And then government. Where is this happening well? Let us talk about the doctors in schools program. Where is this happening well and how have you in your capacity influenced that or provided that technical and philosophical support?

Susan SAWYER: I think it is happening well in individual schools currently where there is passionate leadership, typically from principals or from individual school welfare coordinators. So there are some examples where it is happening well, but it is reliant on those individuals. We did some work with the World Health Organization before we were invited to lead the work to develop the global standards. We did a systematic review of over 10,000 studies looking globally, not just in Victoria or Australia but globally, at what were the barriers and enablers to health promoting schools. What was very apparent was that the enablers are passionate teachers who are committed to doing the right thing, supportive principals, a policy environment, but the challenge when those people get burnt out or move on is that there is not a sustainable structure. So the notion of health promoting schools and putting in place those eight global standards that we talked about in the report is a framework for thinking about how you would actually ensure the sustainability of that approach. It is very conceptual, and it is hard to sell it in ways that – it is not about, 'If you invest $10 million here, you will get this outcome'; it is a way of thinking conceptually, and it is about helping schools to do and understand differently what they are already doing and just helping them to think differently about how they might fill some of those gaps.

Melina BATH: Thank you. I am sorry – obviously my time is up, but it may come around again.

Aiv PUGLIELLI: Hi. Thank you all for coming in. I was actually going to start with the Centre for Adolescent Health, but I feel like it has been going the other way, so I will start with the joint submission from representatives from Odyssey House. You refer to and often work a lot in relation to substance use with young people and your submission goes into detail in various ways into that. Something that is also being investigated at the moment by the Parliament is the issue of vaping, and substance use broadly for young people is a very serious issue – there is chroming and a range of things that occur. What is your view to how best – both in recommendations in the school setting that can come out of this inquiry but also potentially for future inquiries that are ongoing, what changes would you want to see to better care for young people and deal with this issue of substance use in those cohorts?

Stefan GRUENERT: Well, firstly I would acknowledge that vaping is part of substance use and that is an absolutely critical issue in many schools. I have also sat on school council for the last four years and I know how the leadership team has grappled with this, and that principals across the network are thinking this through. I would also acknowledge that the sort of approach being spoken about by the Centre for Adolescent Health is really critical for helping each school have a framework and a structure to identify what are the critical issues in that particular school, because I think they are different from one region to the next depending on the cultural mix of the school, the number of kids identifying as LGBTQI, with substance use more so in some areas and less in others. We are certainly seeing our program that we have been developing as something that complements the schools that need it – it is not needed everywhere – and a framework that helps a school approach it in an integrated way which is really important.

When it comes to vaping, often vaping is the reason a lot of young people are coming to the attention of either the wellbeing team or the staff or having behavioural issues in schools. In the schools where we have been able to go in and support that whole of school approach it is like, 'Oh, this kid's vaping, come and talk to them.' The vaping is often just the tip of an iceberg. If they have been picked up in the toilets or bathrooms by the monitors or cameras or whatever they are not going to usually share a lot more about that, except when our youth drug and alcohol workers have gone in. We understand that 'Okay you're using cannabis as well, you're getting drunk every weekend in pretty high risk ways,' and they will tell us a whole lot of other stuff, including the drug use that is happening at their home and in their networks. So often that is just the entry into what is happening for a student, and as we have seen with most drug use, there is usually a sort of a gateway or an escalation amongst young people – not everyone who vapes is going to go on to use everything else.

I think many schools have struggled to understand or think through how they deal with a behavioural issue or something that they are banning in schools in a way that does not take over a whole school or escalate issues, especially when it is a large proportion of young people and there are people swapping vapes and leaving campus to do that. That is a big issue, and I think that is where our workers have helped the leadership team to think of a whole-of-school approach to this where every element of that is integrated and it goes from that prevention and early intervention earlier in the curriculum in the program all the way through to the early intervention when people are using.

We have got numerous stories of young people who, you know, when we talked about the impacts on their bodies and others, and once they started expressing them, made really sensible choices around that and decided to cut off networks and stop using. I have got a story of a young woman who came from a family with lots of drug and alcohol use, and from year 7 she was using cannabis – the school did not know about that – and vaping was part of it. She started smoking ice for a year until it actually became identified in that school. She wrote us a letter – and I will not go into it; I could share the letter – just amazed at how connecting with someone who actually wanted to hear about it and understand what was going on has transformed her life. She signed it 'Tara, the girl who thought things could never change'. She just could not believe she would be able to give up her use. So the vaping and those things are real opportunities in the school environment to intervene early before it escalates into other drug types. I do not know if you want to add anything.

Petra STAIGER: Yes. I think that early intervention just fits in with that whole framework. I think vaping is such an issue for a lot of the teachers who are spending a lot of time now dealing with that, coming out of the classroom, in and out. That came up actually – some of the children and young people giving feedback said, 'Everyone is vaping; it is a real big issue.' And one of the things that really came out in some of the interviews was their lack of information about the health consequences of vaping, because where they are getting all their information, as we all know, is social media. It all looks cool, and everyone is doing it. But we are not able to counter that as yet, and this is where, conveniently, the BRACE clinicians who are experts in substance use were able to say, 'Do you know that you can't tell how much nicotine is in a vape? So you could be smoking a pack of cigarettes in one.'

Susan SAWYER: They are; they are incredibly addictive.

Ryan BATCHELOR: And other things.

Petra STAIGER: So they are getting very addicted and are really confused. Some of them do not even know. Some of them think, 'Oh, no, there's not much nicotine,' and they were saying, 'Yes, there is, and there are a whole lot of other toxins in there.' I think a lot of the time people think, 'Oh, young people don't care

about that,' but when you start to talk about how their skin is going to be affected and all these things like that, they are naturally shifting their thinking around that. That was something that came out in work that the BRACE clinicians did, so I think it is really important that we act on this quickly – because I think teachers are really struggling – by having those early interventions and that whole-of-school promotion. But also for those people who are more at that really problematic stage, doing a classroom approach and all that is not going to work. You do need to have at trained AOD clinician working with them, and you can then prevent all sorts of stuff.

Susan SAWYER: This is the exact point I am making. Whether you talk about vaping, whether you talk about gender-based violence, whether you talk about the wellbeing and mental health crises or whether you talk about the epidemic of eating disorders that we had during the pandemic, it does not matter what the health issue, each of these health issues affects students' engagement and learning, and to approach each of them in a piecemeal way does not make sense.

Stefan GRUENERT: You absolutely want a doctor or a nurse in the school reinforcing the messages and on board – the wellbeing team, the mental health workers, the leadership team –

Susan SAWYER: Yes, health teams in schools.

Stefan GRUENERT: and all of that to totally support the need, on whatever issue it is, to make sure it is integrated across the school and with the parents.

Susan SAWYER: Then when you bring the specialist folk in, such as your drug and alcohol workers, you are actually able to use them for a very specific purpose, so it is a much more efficient way of investing, rather than doing the sort of work that other folk could be doing within a school – for example, the mental health promotion person should be able to deal with basic drug and alcohol issues and should be able to have an approach to vaping as well.

Aiv PUGLIELLI: Thank you. Yes, it is a really important discussion.

The CHAIR: Thanks, Aiv. Joe.

Joe McCRACKEN: Thanks, everyone, for your contribution so far. It has been an interesting conversation. My first lot of questions are to the Centre for Adolescent Health. I do not mean to frame it this way, I mean it with respect, but it is hard for schools to take a whole-of-school approach on some things when – you know, with you guys saying 'a whole-of-school approach to wellbeing', there are other people who say, 'Oh, you've got to have a whole-of-school approach to healthy eating,' which is a health issue I know. But I have seen it in schools before where everyone says, 'You've got to have a whole-of-school approach for so many different things.' It ends up being siloed anyway, which is silly, and it should not be. I guess my question is: how do you think that is overcome when there are so many different things going on at schools, with people saying, 'You've got to have a whole-of-school approach to child safety and so on'? Do you get what I am saying?

Susan SAWYER: Yes, and I think that this is where, as you have articulated beautifully, schools are doing a whole lot of different things.

Joe McCRACKEN: Yes.

Susan SAWYER: Schools are doing activities, but they are often not getting the best value out of the activities. They might be doing something on school safety, and if that was tweaked a little bit, perhaps it could be extended to include, say, stuff on gender-based violence, with the focus perhaps not just on road traffic accidents and injury. That might be able to be broadened ever so slightly. You are absolutely right that schools currently are doing a multiplicity of different things, some of them under the name of a whole-of-school approach – not all of them, so I am pleased to hear that there is that language that is being increasingly used – but I think it is about trying to understand what it is that schools are currently doing and where that fits in terms of, 'Where are we supported by government policy, and where are we not?' You know, vaping is a really neat example of where things have developed so quickly that there is not yet that policy. What are schools needing to do to fill the gaps with the different health priority areas that they have got, and how do they then feel confident that they have the right line-up, whether it is staff involved, whether it is programs involved? But it is

around looking very intentionally around where some lines can be drawn to join those dots together, rather than necessarily adding new dots to the mix.

Joe McCRACKEN: Yes. And I guess establishing a framework around that would be a challenge given that different schools in different contexts have different needs, and those needs –

Susan SAWYER: I would argue not at all. Sorry to interrupt, but the Gatehouse project was a research project which did just that. It worked in individual schools. It was led by Professor George Patton in the late 1990s – randomised controlled trial, highest level of evidence. There was a school health team of researchers, experts in education, who worked with individual schools and helped schools to prioritise what actions they were going to do, and every school did something different. The outcome was extraordinary: improvements in terms of lower rates of smoking, lower rates of alcohol, lower rates of early onset unsafe sexual activity – very dramatic improvements. So you can do it, which was why I was interjecting.

Joe McCRACKEN: Well, I am encouraged to hear that you can do it, but, well, it is clearly not widespread.

Susan SAWYER: No, it is not, and that is why we have said that this is not widespread currently.

Joe McCRACKEN: And that is probably what I am trying to draw down to. As you say, if the evidence base is there to say this is a great initiative, why do you think it is not widespread and, I guess, what do you think the barriers are to that implementation of it being widespread?

Susan SAWYER: Would you want to take a go? I mean, I would say we do not have coaches in schools, so we do not have people whose role is to pull together and convene in that way.

Jennifer DAM: Even general knowledge and understanding around what health promotion is and why it matters, so this idea of creating opportunities for people to make decisions about their health and empowering them with the resources that they need to be able to do that – so literacy around that for students as well as teachers. But I would very much say in response to your earlier question as well, I agree, you are absolutely right that there are so many different things that are happening, but part of the issue is not having that integration across schools means that people are not coming together to have a shared understanding of what the issues are as well. So then resources are used in disparate ways.

Stefan GRUENERT: And wasted at times.

Joe McCRACKEN: I think the point you said before about the fact that doctors and nurses come into a school through one stream and then mental health clinicians might come in through another stream – from a school perspective it would be so much easier, I can imagine, if there was just one point of contact rather than having to go from there to there to there to there to get whatever support services might be needed.

Susan SAWYER: Well, it is a health and wellbeing team that many schools put together because that is how they manage their different resources. So a number of schools have that – but again, depending on what those elements are, not all schools have a Doctors in Secondary Schools program, not all schools have a drug and alcohol worker available to them. So there are moving parts, but certainly we would be advocating for school health teams, but thinking about how we actually, if you like, take it up a level to look at the oversight of that team. What knowledge do they need, and knowledge about what the health issues are in their community? We have got a recent study that we are about to publish where it is describing the incredible rate of vaping in 20-year-olds – far, far higher than tobacco smoking, for example. But we know that that is not consistent in every region of Victoria. And so ensuring access to an evidence base about what the issues are in a school I think is really important and then holding schools accountable as well – 'What are you doing? What interventions are you doing?'

Joe McCRACKEN: Yes. I appreciate that. It was a good conversation. Thank you.

The CHAIR: Moira?

Moira DEEMING: Thank you. Thanks so much. It is really interesting. I am really excited. It sounds like an amazing, really targeted project that you guys have organised there. I am really curious about one particular topic. I have just got a quick question first. You mentioned – and please forgive me if I am not phrasing it

correctly – that the kids would be more willing to open up because you have different reporting and consent standards. I just wanted to understand what you meant by that.

Stefan GRUENERT: I think this goes to the issue of when some part of the wellbeing team is a staff member in the school, there are certain expectations around what information they share. When you have got visiting or embedded staff that come from outside of the school environment, then generally there are different expectations and understandings of what information is shared and when. Obviously, if there is risk and harm to the individual or others, there are always limitations to confidentiality, but it is different in schools when you are a school staff member versus someone embedded. I think this goes to the heart of what we are trying to say in our submission. We saw that even the implementation of this program was much easier when the leadership team had a whole-of-school understanding of health and wellbeing, where they could prioritise which of the issues were critical to their school, and they then said, 'We want this in the school, and we're going to help you embed it fully across and complement everything else we're doing.' When that happens, they understand – this specialist expertise, whether it be doctors or nurses or, in our case, drug and alcohol workers – they cannot have it in the school and they have got to bring it in. And it does not have to be forever either – a year or two can help.

Moira DEEMING: Is it legally different, though? That is what I am asking.

Stefan GRUENERT: Yes.

Moira DEEMING: Can you explain to me the legal difference between the reporting and consent standards for someone like you coming into a school and for me as a teacher – if, for example, I was a teacher.

Stefan GRUENERT: Well, our staff members do not have to share the content of what the students are telling them about unless there is a risk of harm or safety. If you are working as a staff member in the school, there are different expectations and legal responsibilities around sharing, even to build up themes and things if you are not sharing everything.

Moira DEEMING: Is that to do with the mature minor status? Like, how is that actually legal? Is that through declaring them as a mature minor?

Stefan GRUENERT: There is that element, and I think where we have found our work program best works is at about year 10. You need to do more education and stuff earlier, but this is when these behavioural issues start emerging. And so absolutely we can treat each young person under that category.

Moira DEEMING: Okay, great. This is a question for anyone who might like to answer.

Petra STAIGER: Can I just add something to that, Moira?

Moira DEEMING: Yes, of course.

Petra STAIGER: I think that was really critical, from the conversations I was having, because with some of the young people, they just would not raise vaping, cannabis use or anything. Even if there were coexisting – which there would be – mental health issues, they would not raise the drug and alcohol issues, so you have got kids in there who are not raising very significant things.

Stefan GRUENERT: With teachers, you mean, Petra?

Susan SAWYER: They would not raise it with teachers or school wellbeing coordinators.

Petra STAIGER: Sorry, they would not raise it with the teachers or the wellbeing team.

Moira DEEMING: Unless there was that guarantee that it would not get back to Mum and Dad.

Petra STAIGER: Yes, but they would raise it with the AOD clinician. They used to test them, the clinicians would tell me. They would say something and see if the world fell down or not. Obviously, if there were any safety concerns – but when the relationship was built, they did start to be able to share that information with teachers. There was one example of a boy who ended up having to – because he was not coming to school for four or five months, most of the time because he was looking after siblings because his father was in and out of

rehab, so he was asleep and all sorts of things. Once the boy was connecting to the AOD clinician, who was able to provide the infrastructure and supports around that family, that information was then shared with the teachers: 'Actually, he's not falling asleep. This is what happened, and blah, blah, blah.' I think just that trust needs to build up with young kids. They are just not going to raise these issues unless they feel confidentiality. Sorry, I just wanted to add that.

Moira DEEMING: No, that is all right; I am just on a time limit.

Petra STAIGER: I know you are.

Moira DEEMING: Fantastic, thank you. It sounds like a complete redesign of what schools are – that it is almost like a health hub or a one-stop shop for basically a whole bunch of things that kids might need, not necessarily with your program but with the whole delivery of all these services. I have concerns about this from only one perspective, and it is to do with the transferral of basically parental power of attorney, with medical issues and things like that, from them to the kids through a mature minor status and then the parents not knowing what is going on with their children. I had a parent of a 14-year-old child who went to see a doctor in school, but that child did not even know her own medical history properly because she was 14. The mother was just extremely distressed that her child was sent into a room with an adult alone when she might have been able to consent as a mature minor but really did not even know her own medical history. I do think there is going to be a rising issue of mistrust around these kinds of things. They sound very good to me. I can see that you all care about children very much. I can see that. I think there is a real hurdle that is going to come up with parents worrying that they are being cut out of important things, really important things that could hurt their children.

Susan SAWYER: Moira, can I just reassure you that there are no differences in the implementation of the mature minor Act for kids who are seen in the Doctors in Secondary Schools program or in alcohol and drug programs to what would otherwise be seen in general practice, and so the policy –

Moira DEEMING: The issue raised is that they can do it within school time so that their parents would never know that they had been to see a doctor, so that there would be no missing time in their day.

Susan SAWYER: Which would be the same if that child was to choose to see the GP who might sit across the road from the school as well.

Moira DEEMING: Yes.

Susan SAWYER: There is absolutely no difference.

Moira DEEMING: It is about the trust between parents and schools as to working in partnership with them or undermining them. So what I heard today is that you really care about kids, and I can see that, and you did talk about parents and families a little bit. I have a problem with the transferral of parental rights in consent for medical care without their knowledge. I think if that happens, they need to know about it – that is my standard. I just think that is going to be a hurdle. What do you suggest? Because I think these programs sound great. You understand my concern, though, right? They sound great – having met you, I would trust you – but if it was someone that you do not know and something was happening and something was going on with your baby, your children, you want to know what is going on, you want to support them, you want to make sure that nothing goes wrong, that they have given the right information to a medical carer.

Stefan GRUENERT: It is a really important issue that I think every health and wellbeing professional grapples with, and often you are faced with the choice of: what is the least worst thing that we can do? Do we provide services and opportunities to people to get some sort of support or access or information in a setting that is accessible to them and that they want or do we set it up in a way where they often do not do that? I think every worker is encouraging the young person at particular points on most things, depending on their age, to share that information with their parents and integrate it as much as possible. So one of the benefits of our workers – because they are not school staff – is they can absolutely go and find that young person, they can go into the homes, have those conversations, work with the parents to work that through. That is critical to their work. Family are an amazing resource – you have got to bring them along on the journey.

Moira DEEMING: Most, of course.

Stefan GRUENERT: Most, yes. And there may be reasons there they are trying to hide or – you know, you want to understand those to make sure that it is not just, as you say, a way of undermining families and parents. So I think it is an important issue to grapple with, but I have seen the alternative, when those things are not available. It is not as if the parents have any idea often of what is going on and do not get the young people those services, and things usually get worse, in my experience.

Moira DEEMING: That is right. It is just –

Susan SAWYER: I would start from the perspective that most health professionals are also parents and are absolutely coming from the recognition of the parental perspective so can fully, fully appreciate that perspective. But as Stefan was saying, there is this additional opportunity that they have, in addition to what parents' opportunities are, to work with the young person. As you said, typically you are really working very hard to engage a young person to have discussions with their parents that typically do happen – it is just a matter of timing.

The CHAIR: Thank you. We are running short of time so a few quick questions just to finish it off in relation to your presentation today and just in relation to access to your program. You said that it might not be in school. How does the school access your program, and who actually initiates that? Is it the school or recommendations?

Stefan GRUENERT: At the moment there is no real access to our program. We have run it for multiple years. We have got a dribble of funding left to just keep a few elements going, but we certainly have been having conversations both at the Commonwealth level, with various MPs and the schools and the state education department, who have welcomed our submission to say, 'Look, how could we make this program available in more schools? What would it look like?' So from our perspective – and it is not even just Odyssey doing it; we feel like there should be some resources available for things like this whether as part of a menu or other things, particularly with drug and alcohol, schools could get some resources to be able to do these if they are a high-needs school. So at the moment there is no access.

The CHAIR: No access. So at the moment you said that you assist some schools and you said that you moved on.

Stefan GRUENERT: We have been in seven schools out in the west, mostly around Melton, Gisborne, Tarneit –

The CHAIR: Yes, I am just wondering: how did that come to be?

Stefan GRUENERT: How did that work?

The CHAIR: Yes.

Stefan GRUENERT: Well, they saw us working through a few community schools and a couple of schools with our youth workers working from a health perspective in the community and seeing more and more kids being referred from that and not showing up. We approached the schools and said, 'Hey, we can come in the school,' and we got some funding and a grant to do that with eight schools in the west. More principals have said, 'How do we get access to this?' And we are like, 'Sorry, we don't have any funding.'

Petra STAIGER: Because there is no funding.

Stefan GRUENERT: There are no resources.

The CHAIR: Just one more quick question in relation to, safety-wise, touching on Moira's point, information passed on to workers or whoever is there at the school, the safety aspect: at what stage is safety more crucial, and who decides to pass information on to another person or not pass it on? Who decides that?

Stefan GRUENERT: I think there are two conversations there. One is with the school to understand their expectations, and if you are doing a whole-school approach, you are also talking to the parents and making them aware of this. As you are setting this up in the school, you have really clear expectations and understandings of what you are going to be sharing in terms of themes and issues that come up, and then at what point is there risk to the child or anything that you are learning across that boundary. I think a lot of that

happens in the set-up, and then you have to trust the clinicians and the workers and the health professionals, as we do across the rest of the system, to be able to make those decisions.

The CHAIR: Basically it would rely on the person who listens to the information, the clinician or the worker, to decide if it passed that threshold of a safety concern and to pass on information. There is no-one checking that or monitoring that at all?

Stefan GRUENERT: Well, there are managers and supervision, absolutely, and there are case reviews. But often you are working in collaboration with child protection. Sometimes you work with a family and you discover there are multiple people already involved in this person's life, so you would try and bring the whole team together. Absolutely you have to have good clinical governance. No one individual is ever carrying these issues on their own.

The CHAIR: So it goes into the team information in relation to that person going to school, and there is a team overseeing that?

Stefan GRUENERT: Yes, and managers and supervisors, absolutely.

The CHAIR: I just want to know in relation to –

Stefan GRUENERT: It is really important, because we do not want any one individual carrying the load of a risk and making that call on their own. It has got to be a shared decision as part of a team.

The CHAIR: All right. I think time has run down. Thank you so much for coming in and for making yourselves available.

Witnesses withdrew.