Final Report
Ed-LinQ Renewal Project

Revision history			
Date	**Version.**	**Author**	**Description of revision**
09/09/16	v0.1	Sophie Morson, Ed-LinQ Renewal Project Officer	Initial Draft
12/09/16	V0.2	Sophie Morson	Feedback from Judi Krause (Divisional Director, CYMHS, CHQ HHS) integrated to ensure clarity in the Executive Summary and deliverables section
10/10/16	V0.3	Sophie Morson in discussion with Judi Krause and Madonna Gassman (A/Program Manager, Specialist teams, CYMHS, CHQ CHHS)	Integration of feedback from the Queensland Mental Health Commission (received 26/09/16) regarding suggested wording, and changes to recommendations particularly relating to state governance, workforce development and program expansion.
04/04/17	V0.4	Sophie Morson in discussion with Judi Krause and Madonna Gassman (A/Program Manager, Specialist teams, CYMHS, CHQ CHHS)	Integration of final feedback from the Queensland Mental Health Commission and the Department of Education and Training (received 23/03/17 and 03/04/17 respectively to ensure accurate representation of departmental processes

Final Report, Ed-LinQ Renewal Project

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Executive Summary

The Ed-LinQ initiative was established under the Queensland Plan for Mental Health 2007-2017 to improve linkages and service integration between the education, primary care and mental health sectors for earlier detection and treatment of mental illness amongst school-aged children and young people. An independent evaluation found it yielded significant benefits for schools, Child and Youth Mental Health Services (CYMHS) and education-health partnerships (Mendoza et al, 2014). However, a number of factors at the program, policy, governance and workforce levels were found to limit the potential impact of the Ed-LinQ initiative. The Queensland Mental Health Commission (QMHC) funded the Children's Health Queensland (CHQ) Hospital and Health Service (HHS) to undertake the project between October 2015 and September 2016 with the following objectives:

1. Articulate the core elements of the Framework regarding strategic partnerships, enhancing capacity and provision of clinical guidance and develop recommended templates to measure and report the related activities for each;
2. Develop a proposed renewed Ed-LinQ model incorporating the above core elements as well as contemporary resources and influences;
3. Develop a proposed sustainable statewide model of professional development;
4. Develop a proposed suite of documents to help inform operationalisation of the model at the HHS level;
5. Develop proposed documents to guide operationalisation of Ed-LinQ at the statewide level;
6. Identify proposed resource requirements and likely collaborative processes for expansion of the Ed-LinQ initiative.
7. Ensure that the development of a performance monitoring framework to inform strategic activities is highlighted for further development following this time-limited project; and
8. Ensure that tailoring of Ed-LinQ resources to meet the needs of vulnerable groups to inform strategic activities is highlighted for further development beyond the duration of this time-limited project.

The project was implemented in close collaboration with key stakeholders including representatives from the education sector and HHSs engaged through a range of mechanisms. These comprised a cross-departmental Oversight Committee made up of senior representation from QMHC, CYMHS CHQ HHS, the Department of Education and Training (DET) and the Mental Health, Alcohol and Other Drugs Branch (MHAODB); a cross-sectoral Reference Group; a project working party; a forum attended by 66 stakeholders from across the state; discussions with HHSs; and individual consultations. The proposed Ed-LinQ model was designed to be contextualised within a shared understanding of school focused mental health promotion, mental illness prevention and early intervention; robust enough to withstand policy and funding changes; and sufficiently broad to encompass emerging issues that fit within a continuum approach to student well-being.

A draft model was circulated to all HHSs in August 2016. Representatives from 12 HHSs attended a consultation session in September 2016 and responded positively regarding the model's potential to enhance service delivery through the provision of school-based consultation-liaison, enhancing capacity and fostering strategic partnerships. Feedback by the Executive/Clinical Directors of HHS mental health services occurred largely through the nominated representatives following requests for input by all HHSs in the above processes. Once the model is endorsed by HHSs further consultation with education stakeholders is required to help articulate their cross-sectoral commitment to the achievement of Ed-LinQ's vision.

The Ed-LinQ Renewal Project identified a number of recommendations that fall within the following broad themes to enhance the early detection and collaborative care of mental health problems amongst children and young people in Queensland:

Statewide governance

Health and education stakeholders confirmed that a range of statewide functions are essential to ensuring effectiveness of the proposed model and that this statewide leadership would be most effective if embedded within a HHS. CHQ HHS, within their dedicated statewide remit, would be best-placed to lead the state program: In the short-term, priorities for implementation of the proposed model include:

- Development of a statewide implementation plan;
- Development of an evaluation and reporting framework, which is likely to include service-level agreements with HHS;
- Development of a communication strategy;
- Development of a statewide workforce development plan;
- Establishment and support of statewide strategic cross-sectoral governance and formalised collaborative agreements; and
- Modifications to the Consumer Integrated Mental Health Application to include fields for individual schools, school-based support staff and education sector type.

It is proposed that an important statewide function is the oversight and management of any future Ed-LinQ enhancements. Criteria have been developed to guide assessment of HHS suitability and capacity to implement the proposed model and therefore determine allocation of additional program resources as they become available.

Workforce development

The project outlined areas that will need to be considered in generating a robust, sustainable, cross-sectoral Ed-LinQ workforce development strategy. This includes retention of the content and face-to-face delivery of the current Ed-LinQ cross-sectoral workforce development program, and enhanced collaborative delivery by participants of the supplementary resources to equip school personnel with knowledge and skills relevant to their role. It is recommended that the state Ed-LinQ program undertake planning to ensure ongoing sustainability of the Ed-LinQ cross-sectoral workforce development program as an integral component of Ed-LinQ's workforce development strategy.

HHS Implementation

The project identified a number of core elements that are proposed for adoption by HHSs to strengthen the effectiveness and impact of early detection and collaborative care. These elements are focused on formalising and supporting a joint planned approach between health and education stakeholders to determine their early detection and collaborative care priorities and development of an agreed response to most effectively meet the needs of their local community. Statewide consistency will be enhanced through HHS recruitment of future Ed-LinQ Coordinators referencing standardised content regarding their role and requirements in implementing the proposed model. HHSs will also utilise the governance templates developed by the project in jointly developing, implementing and reviewing their annual Ed-LinQ work plan. This will include strategies to address the needs of vulnerable groups in their geographical area to enhance equity of program reach.

Application of the Ed-LinQ model to early childhood settings

CYMHS CHQ HHS noted the potential impact that application of a comparable model for early childhood settings could have in interrupting developmental trajectories into future mental illness. It is therefore recommended that there is future consideration of implementing a model for early detection and collaborative care amongst children prior to their commencement at primary school.

The Ed-LinQ Renewal Project represents an exciting opportunity to better address the needs of Queensland students experiencing mental health problems, and improve their future prospects in life. It is recommended that the QMHC consider the project findings to progress implementation of the proposed Ed-LinQ model through the Department of Health and DET.

Abbreviations

Acronym	Full name
AEDC	Australian Early Development Census
ATODS	Alcohol, Tobacco and Other Drugs Service
AMYOS	Assertive Mobile Youth Outreach Service
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and linguistically diverse
DET	Department of Education and Training
CHQ	Children's Health Queensland
CYMHS	Child and Youth Mental Health Service
HHS	Hospital and Health Service
ISQ	Independent Schools Queensland
MHAODB	Mental Health, Alcohol and Other Drugs Branch
MHPPMPEI	Mental health promotion, prevention and early intervention
PHN	Primary Health Network
QCEC	Queensland Catholic Education Centre
QCMHL	Queensland Centre for Mental Health Learning
QCPIMH	Queensland Centre for Perinatal and Infant Mental Health
QMHC	Queensland Mental Health Commission
SBYHN	School-Based Youth Health Nurse
SDE	School of Distance Education
SMHILE	School Mental Health International Leadership Exchange
SMHRCCG	School Mental Health Regional Care Coordination Group
UNCRC	United National Convention on the Rights of the Child

1 Project Description

1.1 Introduction

The Ed-LinQ initiative (Ed-LinQ) was established under the *Queensland Plan for Mental Health 2007-2017* (Queensland Government, 2008) to improve linkages and service integration between the education, primary care and mental health sectors for earlier detection and treatment of mental illness affecting school-aged children and young people. Within Hospital and Health Services (HHSs), 12 Ed-LinQ Coordinator positions work across these sectors by:

- facilitating a strategic approach for collaboration and integration between the sectors; and
- enabling improved access to mental health consultation, assessment, information and training opportunities.

A 2014 independent evaluation by ConNetcia funded by the Queensland Mental Health Commission (QMHC) reported many positive and highly-valued aspects of Ed-LinQ, with benefits identified for schools, health and mental health services and school-health partnerships (Mendoza et al., 2014). However, the evaluation report identified that the positive impact attributable to Ed-LinQ is not evident to the same extent in all HHSs with an Ed-LinQ program. Reviews of the overall initiative and Ed-LinQ cross-sectoral workforce development program noted specific factors at the program, policy, governance and workforce levels inhibiting the impact of Ed-LinQ that require action. In addition, the framework underpinning Ed-LinQ was established nearly a decade ago, and so was due for a review to consider and integrate contemporary themes and resources. The Ed-LinQ resource allocation has furthermore not been enhanced since initial establishment, and is not necessarily sufficient to meet current demands. Five HHSs are not funded for an Ed-LinQ program, and the state coordinator position was discontinued in 2012.

A workshop coordinated by the QMHC in March 2015 on integrating early intervention for the mental health of children and young people, identified a need to review the future directions of the Ed-LinQ program, its scope and model of implementation. This included in those locations where Ed-LinQ currently operates, as well as considering the appropriate model for areas not currently serviced by the program.

On the basis of their specialist paediatric focus and statewide remit, Children's Health Queensland (CHQ) Hospital and Health Service (HHS) was funded by QMHC to undertake the Ed-LinQ Renewal project. The project was delivered within the broader context of a number of state and national initiatives, including:

- The Queensland Department of Education and Training's (DET) Every Student Succeeding - State School Strategy 2017-2021;
- DET's development of their expanded Learning and Well-being Framework;
- An independent review of DET's education policy for students with a disability;
- The Department of Health's development of a statewide children's health service plan;
- Development and/or release of the QMHC's Action Plans relating to Suicide Prevention; Mental Health Promotion, Prevention and Early Intervention; Alcohol and Other Drugs; Rural and Remote Mental Health and Well-being; and Aboriginal and Torres Strait Islander Social and Emotional Well-Being;
- The Queensland Parliamentary Commission of Inquiry into closure of the Barrett Adolescent Centre, and the subsequent recommendations for service enhancement;
- Development of the Queensland Mental Health, Alcohol and Other Drugs Connecting Care to Recovery Plan 2016-2021;
- Development of the Queensland Government's Youth Strategy;
- Staged implementation of the National Disability Insurance Scheme from 1 July, 2016;

- Nationally Consistent Collection of Data on School Students with a Disability, which will determine how many students with a disability are enrolled in Australian schools; where these students are located; and the broad level of reasonable educational adjustment provided to assist them participate in schooling on the same basis as other students. Data has been collected nationally since 2015 and will help schools meet their existing obligations under the Disability Discrimination Act (1992) and Disability Standards for Education (2005), both of which recognise mental illness as a form of disability;
- Development of the (draft) National Mental Health Services Planning Framework;
- Current national mental health reform arising from recommendations into the National Mental Health Commission's 2014 *Review of Mental Health Programmes and Services.* This includes the federal government's commitment to "a single integrated end to end school based mental health programme which will support promotion and prevention activity and help to build resilience skills" (Commonwealth of Australia, 2015, p.15); and the central role of Primary Health Networks (PHNs) in commissioning headspace services for 12-25 year olds experiencing mild to moderate mental health problems; and
- Development of the Fifth National Mental Health and Suicide Prevention Plan.

The project also aligns with the *National Standards for Mental Health Services* (Commonwealth of Australia, 2010), *Advancing Health 2026* (Queensland Government, 2016) and the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* (QMHC, 2014).

1.2 Objectives

The overall objective of the Ed-LinQ Renewal Project is to develop a clear, consistent model of school-mental health collaboration at the state, regional and service levels. A renewed model will provide Ed-LinQ Coordinators, their managers and stakeholders practical guidance as part of an integrated system response for the timely identification of – and appropriate support for – Queensland primary and secondary school students experiencing mental health problems.

The project had a number of specific objectives:

1. Articulate the core elements of the Framework regarding strategic partnerships, enhancing capacity and provision of clinical guidance, and develop recommended templates to measure and report the related activities for each;
2. Develop a proposed renewed Ed-LinQ model incorporating the above core elements as well as contemporary resources and influences;
3. Develop a proposed sustainable statewide model of professional development;
4. Develop a proposed suite of documents to help inform operationalisation of the model at the HHS level;
5. Develop proposed documents to guide operationalisation of Ed-LinQ at the statewide level;
6. Identify proposed resource requirements and likely collaborative processes for expansion[1] of the Ed-LinQ initiative.
7. Ensure that the development of a performance monitoring framework to inform strategic activities is highlighted for further development following this time-limited project; and
8. Ensure that tailoring of Ed-LinQ resources to meet the needs of vulnerable groups to inform strategic activities is highlighted for further development beyond the duration of this time-limited project.

[1] In the context of this project, expansion relates to issues of equity and refers to (a) access to an Ed-LinQ program for those HHSs that are not currently resourced for one; or (b) expansion of reach (geographically and/or to vulnerable populations) to enhance the benefits of the renewed model for those 12 HHS already resourced for an Ed-LinQ program.

2 Background

2.1 Prevalence and impact of mental health problems amongst children and young people

Most children and young people in Australia experience good mental health and well-being, but a significant proportion will struggle. Data from the Australian Early Development Census (AEDC) has found that 22 percent of children nationally are rated by teachers in their first year of school as vulnerable on at least one of five developmental domains, which places them at risk of a range of future adverse outcomes. This level of vulnerability is higher amongst those in very remote areas and children from an indigenous background. In Queensland, 26 percent experience difficulties in one or more AEDC domain (Commonwealth of Australia, 2016). The most recent national snapshot of mental illness in children and young people estimated that 13.9 percent of the 4-17 year olds surveyed had experienced at least one mental illness in the previous twelve months, with comorbidity common across conditions (Lawrence et al., 2015). Of this group, 59.8 percent experienced a mild disorder, 25.4 percent experienced a moderate disorder and 14.7 percent experienced a severe disorder. Adolescents 12-17 years were three times more likely to experience a severe disorder than those aged 4-11 years, although only 60 percent of parents appear to have detected a self-reported major depressive disorder in their adolescent (Lawrence et el., 2015). Vulnerable groups of children and young people – including those living in rural or remote areas – may experience heightened risk of mental illness, and so may need tailored strategies designed to detect and respond to signs of emerging mental health problems (Royal Australian and New Zealand College of Psychiatrists, 2010).

Mental illness in childhood and adolescence can have a significant and long-lasting impact on a young person's developmental pathways into adulthood, and in some cases across generations. Without appropriate and timely intervention, it may interrupt their normal developmental experiences and therefore place a child or young person at greater risk of a wide range of adverse biopsychosocial outcomes. These include poor physical health, impaired social relationships, lower well-being, impaired functioning and greater adversity, including well into adulthood (e.g., Chen et al., 2006). They may also engage in risky behaviour such as self-injury, a non-fatal suicide attempt or death by suicide.

Mental illness can also contribute to educational disadvantage. A reciprocal relationship has been found between school connectedness and mental health (e.g., Schochet, Dadds, Ham & Montague, 2006), including in the transition to secondary school (Lester, Waters & Cross, 2013). Children and young people experiencing a mental illness are also less likely to reach their academic potential across a range of subjects and report a greater dislike of school (Lawrence et al, 2015), as well as engage in school refusal and/or truancy. Mental health problems may contribute to disengagement from school (Bowman, McKinstry & McGorry, 2016), which in turn contributes to potential long-term disadvantage including ongoing mental illness (Lansford, Dodge, Petit & Bates, 2016).

It has been estimated that 50 percent of adult mental illness starts before the age of 14, and 75 percent by the age of 25 years (Kessler, et al., 2007). In addition, mental disorders disproportionately account for the largest burden of disease in Australian young people relative to other age groups (Begg, et al., 2007). These figures have led Insel and Fenton (2005) to characterise mental disorders as the chronic diseases of the young. A 'downward developmental trend' has been noted, such that disorders appear to be starting at younger ages (Zubrick, Silburn, Barton & Blair, 2000). Anecdotally, there has also been increasing complexity and acuity of mental health problems noted over time. It is predicted that the next twenty years will bring many new and emerging challenges to the mental health of young Australians (Vic Health & CSIRO, 2015). However, young people may fail to access effective services for a range of reasons including stigma and embarrassment, poor mental health literacy and a preference for self-reliance (Gulliver, Griffiths & Christensen, 2010).

Beside the toll it exacts on individuals and their loved ones, mental illness is financially very costly to society. In 2013-14, more than eight billion dollars was estimated to have been spent directly on mental health-related services in Australia (Australian Institute of Health and Welfare, 2015). This represents 5.17 percent of the total federal health budget, despite mental illness contributing to 13 percent of the burden of disease in Australia in 2003 (Begg, et al., 2007). Mental illness also imposes financial strain on multiple other sectors (including education, justice and child protection).

No other health condition matches mental ill-health in the combined extent of prevalence, persistence and breadth of impact (Campion, Bhui & Bhugra, 2012). With limited financial resources available, these factors together highlight both the need for effective mental health promotion, mental illness prevention and early intervention (MHPMIPEI), and greater focus on responsive, effective and integrated care for mental disorders in children and young people. It is estimated that between one-quarter to one-half of adult mental illness may be preventable through appropriate intervention in childhood and adolescence (Kim-Cohen et al., 2003). Effective support and interventions during childhood and adolescence therefore provides the best opportunity to reduce the lifetime burden of mental illness on individuals and families, as well as the associated long-term social and economic costs. There is also considerable evidence and guidance for effective interventions during these life stages (Fonaghy et al, 2015). Intersectoral collaboration is especially warranted to address the various domains of a person's life affected by severe and persistent mental illness (Diminic et al, 2015).

2.2 School as an important setting for the early detection and management of student mental health problems

Lawrence, et al. (2015) found that 17 percent of the 4-17 year old Australians surveyed had used services for emotional or behavioural problems in the previous year. This included 11.5 percent who had accessed school support, and 14.8 percent who had used health services (primarily general practitioners). Parents advised that nearly 25 percent of children using health services had been referred by their school. Service utilisation of any kind increased to 56 percent in the last 12 months amongst those with mental disorders. Specialist child and adolescent mental health services were seen by 3.3 percent of those with mental disorders, compared with two fifths (40.2 percent) who had used school services in the previous year.

The Queensland profile of the Mission Australia Youth Survey (Cave, Fildes, Luckett and Wearing, 2015) indicated that one-third of the 15-19 year old respondents would approach their teacher or school counsellor for help with important issues, compared with nine percent who would turn to a community agency. Coping with stress was their top issue of concern, followed by school or study problems. One in ten respondents saw physical or mental health problems as barriers to the achievement of their study/work goals after school.

These findings validate the importance of schools in identifying and managing mental health problems. Article 29 of the United Nations Convention on the Rights of the Child has stated that "the education of the child shall be directed to the development of the child's personality, talents and mental and physical abilities to their fullest potential" (UNCRC, 1989). This is reflected through inclusion of personal and social capabilities in the national curriculum. Contemporary evidence highlights the strong and reciprocal relationship between academic and mental health outcomes (Sudo, Gormley, DuPaul & Anderson-Butcher, 2014). Mental health problems are therefore a clear impediment to optimal learning, the core business of the education sector.

> "Easier access to assessment for mental health issues, more support for those with anxiety illness in a classroom environment, more support in general from teachers and in educating other students on these matters"
>
> Recommendations from a female, 16 years, Queensland in the 2013 Mission Australia Youth Survey, cited in Ivancic et al, (2014), p. 11

Australian students spend nearly 11,000 hours at primary and lower secondary school alone (Organisation for Economic Cooperation and Development, 2014), and so schools represents an important potential setting for a range of

health interventions. Addressing mental health problems through awareness and early intervention in schools has been identified as a priority by young people, families, policy makers and researchers (e.g., Atkins, Hoagwood, Kutash & Seidman, 2011; Ivancic, Perrens, Fildes, Perry & Christensen, 2014; Mental Health Coordinating Council, 2014). There is also growing awareness of the adverse outcomes associated with traditional behavioural interventions. For example, suspensions have been found to independently increase the likelihood of adverse outcomes including antisocial behaviour (Hemphill et al, 2009), academic underperformance (Noltmeyer, Ward & McLoughlin, 2015) and contact with the youth justice system (Fabelo et al., 2011). It has been suggested schools develop connections between their behaviour management and mental health programs to focus on addressing underlying student needs (Anello et al, 2016).

However, schools may experience a number of barriers to acting upon this holistic view. A study of NSW teachers found that while there was clear acknowledgment of the impact of biopsychosocial factors on a student's learning and behaviour, they reported a wide variability in their knowledge, confidence and skills regarding how to manage this in a classroom setting. The majority of respondents identified that mental health was an area of significant concern for their school, especially in rural areas where teachers noted the need for greater community awareness and stigma reduction. Many expressed an urgency and frustration in their need for "additional support, including the need for more training, school counsellors, time, funding, resources, coordinated approaches between all services, parental involvement and better processes to help with student mental health problems. Teachers highlighted that they needed training 'to recognise the signs and symptoms of mental health problems' and that they were 'just expected to cope and find resources in the community'" (Graham, Phelps, Maddison & Fitzgerald, 2011, p. 489). Similarly, a national survey of 600 principals and teachers found that nearly all of them considered mental health to be as important as academic achievement. However, 22 percent did not believe it was their responsibility to address the mental health of students, 47 percent thought they did not have time to dedicate to achieving positive mental health outcomes and only 35 percent reported their school provided staff training to support student mental health (beyondblue, 2015). The high rates of teacher attrition in Australia, especially amongst new graduates, has been attributed in part to unrealistic pre-service expectations regarding the reality of classroom demands, including supporting students with complex needs (Bryer & Signorini, 2011; Mason & Poyatos Matas, 2015).

It has been recommended that the implementation and scale-up of school-based practices to support student well-being be intentional, explicit and systematic (Short, 2016). Weare (2015) suggests schools consider a range of strategies to address student mental health problems including early identification and intervention; professional learning regarding risk and resilience; developing supportive policies; connecting appropriately with approaches to behaviour management; implementing targeted responses; and identifying specialist pathways for support and referral. Enhancing school-based mental health capacity may be particularly important given projected population growth. By 2020 there is estimated to be a 24 percent increase in Queensland primary school students (an additional 106, 320 individuals) from 2010 (Australian Bureau of Statistics, 2013), and therefore an increase in secondary school students over the subsequent years.

2.3 Addressing child and youth mental health problems in Queensland

In Queensland, a number of key strategies are aimed at addressing mental health problems in school-aged populations. This includes service provision by non-government organisations, private practitioners and – increasingly – a wide range of online resources. Within school settings, support is provided through the employment of on-site specialist staff such as guidance officers/school counsellors, School-Based Youth Health Nurses (SBYHNs) and youth support coordinators. Although the availability and scope of their position varies according to education sector, they all have an important role to play in the early detection and

management of individual students with mental health problems. This may include an assessment of those identified as needing support, individual care (including advocacy for curriculum adjustment where required) and/or referral to an external service for those students with more entrenched difficulties. Specialist staff may also be in the position to contribute to the development of a whole-school approach to addressing mental health (problems), including building the capacity of teaching and leadership personnel as outlined above. However, specialist staff themselves may need more support to meet these aims. For example, mental health issues emerged as the most frequently requested topic in a 2014 training needs assessment of SBYHNs across Queensland, with a similar trend noted in the statewide SBYHN survey currently underway (Clekovic, personal correspondence, 05/09/16). While such needs may be progressed within a sector at a state and/or regional level, education support staff may benefit from additional cross-sectoral mental health input to build school and sector capacity to detect and manage student mental health problems.

CYMHS is a free public health service that provides primarily tertiary mental health care to children and young people aged 0-18 years (and their families) who are at risk of, or experiencing, severe and/or complex mental health problems. In 2013/14, CYMHS received $112 million funding, representing 10.25 percent of the state's total mental health budget. Service delivery spans the continuum of care from specialist prevention through to outpatient treatment, day programs, outreach support, residential care and treatment in child/adolescent inpatient units. As noted in Figure 1, there are a total of 42 community or remote CYMHS clinics in operation throughout Queensland.

There is considerable variability in CYMHS service delivery across Queensland. For example, Western Queensland PHN spans exactly the geographical area covered by the North, Central and South West HHSs, and experiences considerable challenges to the delivery of health services in this area:

> "The region covers more than half the State's land mass although it has only 1.5% of the population or approximately 72,000 people, the lowest compared to other PHNs….The remoteness and sparse population is associated with large travel distances between the region's 44 towns and villages. The people living in WQPHN face a unique set of challenges in maintaining and accessing good health care with poor regional public transport, limited patient and family accommodation and telecommunication constraints. In addition, after the NT PHN the Western Queensland catchment has the highest Aboriginal and Torres Strait islander population (19% of the total) with high socio-economic deprivation – factors that together mean high health risk factors and poor health outcomes compared with the Australian and state norms…..HHSs and other regional primary care service providers experience considerable difficulty in recruitment and retention of staff. Patients often experience fragmented, poorly coordinated and unreliable primary and community services". (Western Queensland PHN Strategic Plan 2016-2020, p.2).

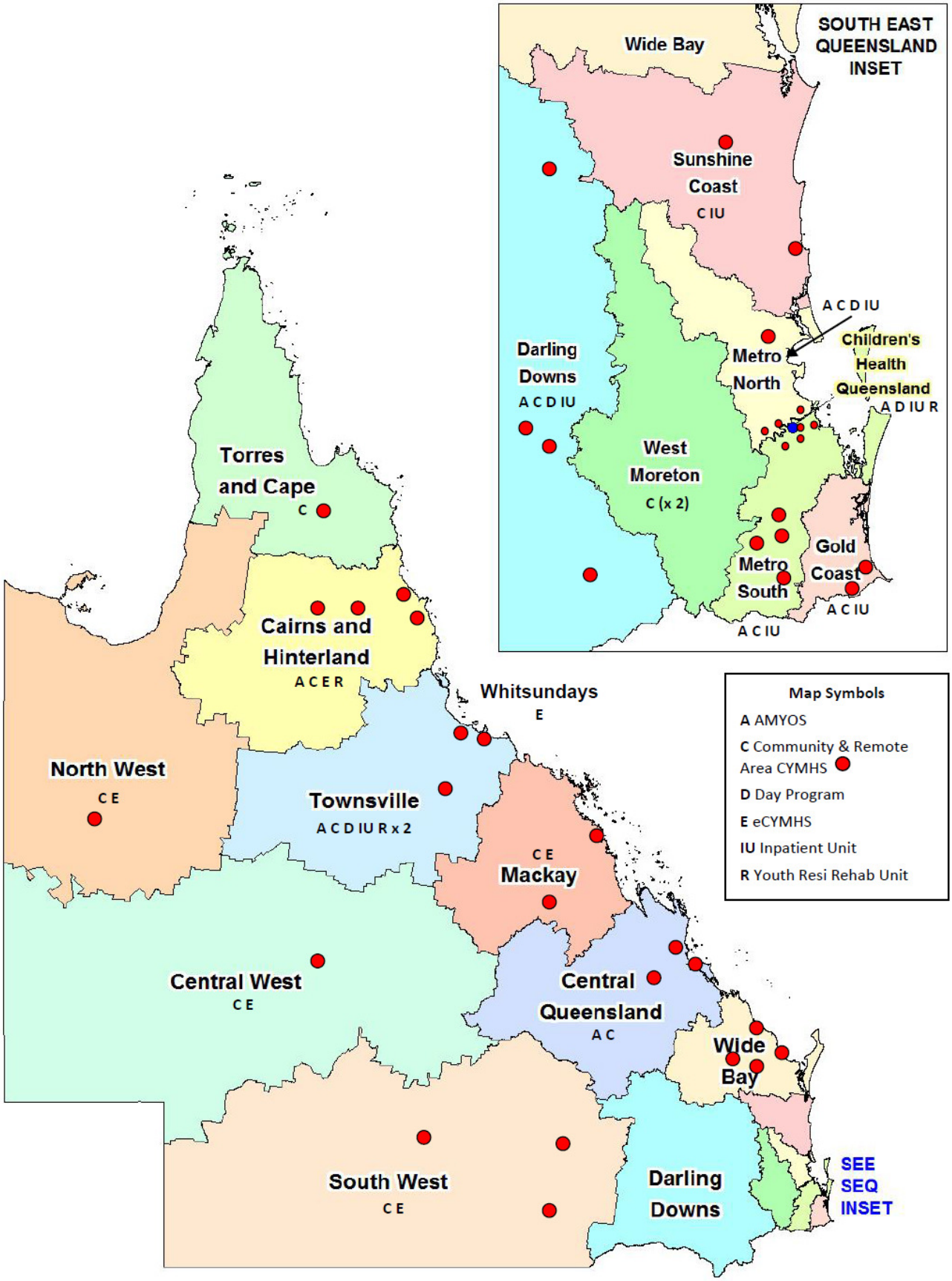
Despite the greater level of need for effective, integrated health care, service delivery may therefore be impacted by the wider sociocultural environment of life in rural and remote settings that warrant their own specific strategies (e.g., World Health Organisation, 2010). CYMHS service provision in these HHSs often occurs in the context of integrated mental health teams, where the Team Leader oversees service delivery across the age spectrum with a core small group of designated clinicians taking on child and youth cases. To provide rural and remote clinicians with additional support, CHQ CYMHS offers a telepsychiatry service known as eCYMHS. This involves the use of videoconference and teleconference technology to link mental health practitioners and their clients in nine rural and remote areas of Queensland with specialist CHQ CYMHS psychiatry and allied health expertise (see Figure 1 for the coverage provided by eCYMHS). Services include case review discussions, direct clinical assessment and treatment planning, and professional development as well as multiple annual outreach visits. eCYMHS also provide consultation, liaison and education to local primary health and education service providers to build local community capacity to support young people with complex mental health needs. Staff perceived eCYMHS as a valuable mechanism for improving skills (87 percent), enhancing their decision-making (87 percent) and obtaining

timely advice (94 percent). Clinicians reported feeling more comfortable seeing young people without the need for a face-to-face psychiatric assessment, with case consultations increasing from 444 in 2008/9 to 1010 in 2010/2011. By 2012, a total of 3982 eCYMHS consultations had been conducted (Wood, Stathis, Smith & Krause, 2012).

CYMHS differs from adult mental health services in a number of significant ways. It is in a prime position to interrupt developmental trajectories so that mental health problems don't become more entrenched, chronic and entwined with a child's emerging identity. In addition, CYMHS recognises that children and young people often receive mental health services within a family context, rather than in isolation. Wherever possible, families are therefore actively engaged to complement and sustain treatment gains. The nature of work with children and young people involves longer assessments, as well as the engagement of more individuals and services. It has been suggested that adopting a systems approach in this way requires up to a three-fold commitment in resources compared with the support provided to adults (Parker, et al., 2002, p. 5).

Amongst the national standards of contemporary service provision, mental health services are required to work in partnership with their community to promote mental health and address prevention of mental health problems and/or mental illness, and to facilitate coordinated and integrated services (Commonwealth of Australia, 2010) This provides a very clear mandate for CYMHS to strategically collaborate with the education sector and community stakeholders to enhance the provision of school-based mental health care. Building capacity in this way creates a more positive experience for children and young people through the provision of timely, effective care in the natural setting of their school. It also reduces the demand on clinical services (including potentially adult mental health services) through a reduction in acute presentations as well ensures more efficient use of limited CYMHS resources to accept and collaboratively support children and young people who do need this level of specialist recovery-oriented treatment. Along with cross-sectoral service commitment to addressing student mental health problems, CYMHS reorientation to enhance school-based early detection and collaborative care represents a significant return on investment for the well-being and academic success of young Queenslanders.

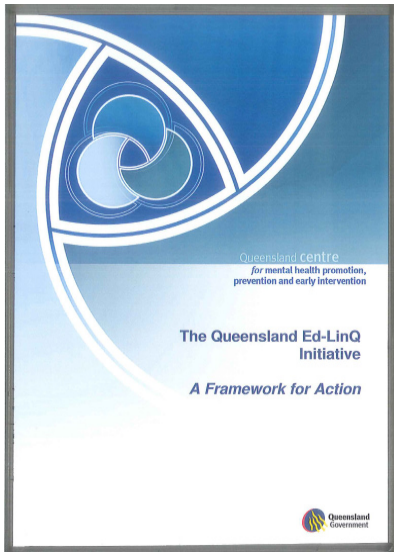
Figure 1. Map of CYMHS Service Provision across Queensland



2.4 The Ed-LinQ Initiative

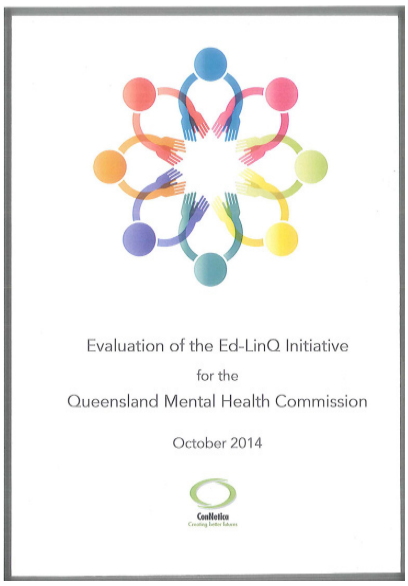
The Ed-LinQ initiative (Ed-LinQ) was established under the Queensland Plan for Mental Health 2007-2017 (Queensland Government, 2008) to improve linkages and service integration between the education, primary care and mental health sectors for earlier detection and treatment of mental illness amongst school-aged children and young people. It was inspired in part by NSW School Link, established in 1999 as a partnership between state health and education departments. An evaluation of NSW School Link found it contributed to enhanced school knowledge and management of student mental health issues, delivery of mental health programs and development of related policies and curriculum. School counsellors and CYMHS workers also noted improved quality of referrals, service access, coordinated care and clinical practice as a result of School Link support (Maloney & Walter, 2005). Ed-LinQ was governed through the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention (QCMHPPEI), which was managed by the Department of Health's Mental Health Directorate (now known as the MHAODB).

The Plan was divided in the phases 2007 – 2011 and 2012-2017, with Ed-LinQ resourcing in the first phase allocated towards a state Coordinator, a budget for workforce development and one full-time equivalent (FTE) Ed-LinQ Coordinator each of for 12 Health districts. Ed-LinQ Coordinators are clinicians based in CYMHS whose role is to locally implement the Ed-LinQ Framework for Action (QCHMHPPEI, 2010). The Framework articulated a vision for Ed-LinQ, to be achieved through the three focus areas of strategic partnerships, building capacity and clinical guidance. State governance was provided via a state Ed-LinQ Reference group comprising senior representatives from the health and education sectors, as well as a group comprising the Executive/Clinical Directors of those districts with an Ed-LinQ Coordinator. The Queensland Transcultural Mental Health Centre (QTMHC) also received temporary funding for a 0.5FTE Ed-LinQ Coordinator to enhance school-based early intervention and collaborative mental health care for students from a culturally and linguistically-diverse (CALD) background.



It had been intended that the second phase of the Queensland Plan for Mental Health would include development of an Ed-LinQ model of service and an evaluation and reporting framework, as well as consideration of the need for programs in the remaining five districts. However, resource allocation for the second phase was halted with devolution of service responsibility to the local level with establishment of Hospital and Health Services (HHSs) in July 2012. The role of the MHAODB changed to that of a systems manager of mental health service delivery across Queensland. This led to dismantling of the QCMHPPEI, and therefore loss of the state Ed-LinQ Coordinator position in providing support to Coordinators and monitoring HHSs accountability for allocated Ed-LinQ resources. Individual Ed-LinQ Coordinators continued to implement the Ed-LinQ Framework under the guidance of their HHS.

The QMHC was established in July 2013 to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system. Its vision for achieving this goal is articulated in the Queensland Mental Health, Alcohol and Drug Strategic Plan 2014-19. The Plan is based on the four pillars of better service, better MHPMIPEI initiatives, better collaboration and engagement and better transparency.



In 2014, an independent evaluation of Ed-LinQ by ConNetica funded by QMHC identified many positive and highly-valued aspects of the initiative (Mendoza et al., 2014). Benefits for schools included earlier identification of students requiring mental health services; embedding of mental health into the curriculum; greater parental involvement; improved staff well-being; a more strategic and integrated approach to the selection and utilisation of mental health services and programs; and greater staff capability to manage students with complex needs. Benefits for CYMHS included clearer referral processes; easier access to mental health services; reduced crisis interventions; and improved parental satisfaction and engagement with CYMHS. Benefits for local collaboration included improved CYMHS utilisation; enhanced understanding of service policies and procedures; and timely problem-solving to improve services access and outcomes. The evaluation made a number of recommendations to enhance and embed these benefits, as summarised in Appendix A.

Under its MHMIPPEI commitment, the QMHC has since 2013 taken on the role initiated by the MHAODB in 2011 of funding delivery of two-day cross-sectoral Ed-LinQ workshops to HHSs. These are facilitated by two trainers involved in the development and delivery of workshop content through their former role with the NSW Institute of Psychiatry, in which they were engaged to deliver training as part of the NSW School-Link initiative. The majority (96 percent) of cross-sectoral participants attending NSW School-Link training between 2000 and 2006 reported it had enhanced their clinical practice. Factors contributing to this improvement were attributed to the training's currency of evidence-based research, useful ways of conceptualising approaches to mental health and opportunities to learn and rehearse new assessment and intervention strategies. A significant correlation ($r = -.20$; $p = .01$) was found between the number of courses attended and the effect of training on practice, suggesting that greater attendance enhanced self-reported clinical skills. Most (85 percent) reported enhanced interagency collaboration as a result of the training, and two-thirds of school counsellors indicated effectively retaining the care of students they would have previously referred to other services (McAlpine, Hillin & Montage, 2008).

The Queensland workshops are conducted by the same trainers involved in roll-out of the NSW School-Link workshops, and are coordinated by HHS Ed-LinQ Coordinators. In some HHSs demand has exceeded capacity amongst interested and eligible stakeholders, with cross-sectoral representation encouraged to facilitate networking during and after the workshops. In their most recent contract with the QMHC, in 2015-16 the NSW-based trainers were funded to deliver 18 workshops which for the first time included those HHSs without an Ed-LinQ Coordinator. The funding also incorporates planning and coordination functions including liaison with Ed-LinQ Coordinators (or in the case of HHSs without an Ed-LinQ program, key education and CYMHS personnel) to support workshop delivery as well as chairing a quarterly teleconference with Ed-LinQ Coordinators across the state.

Commensurate with previous years, the 11 workshops delivered in 2015-16 to HHSs on their choice of topic (childhood anxiety, adolescent non-suicidal self-injury, mood disorders or diversity) have yielded much positive feedback by participants. (Hillin, 2016), with a sample of qualitative comments provided below. Evaluation data across all four topics suggested that participants found the workshops to be of high quality and relevant to their clinical work, and provided an important opportunity to meet and better understand the role of other service providers. Two-thirds of participants from the education sector (and half from the mental health sector) expressed interest in delivering a "cascade" resource designed by the facilitators to convey key workshop messages via a brief presentation appropriate for teaching and school leadership staff. However, there has been comparatively less uptake (and no evaluation data provided from cascade participants), with suggested impediments including competing demands of other aspects of their role; limited time for teacher professional development and differing prioritisation by school executive staff on addressing mental health

problems. See Appendix B for a summary of the recommendations arising from the most recent evaluation of the Ed-LinQ cross-sectoral workforce development program. QMHC has committed to funding its delivery until December 2017 but beyond that the future of the program is uncertain.

A sample of the qualitative feedback from the 2015-16 Ed-LinQ cross-sectoral workforce development program

An excellent workshop. Lots of practical ideas as well as the theory. Very worthwhile and felt as though the two days were very productive. Thanks!
- Guidance Officer, Metro North HHS, (Anxiety workshop)

Best cultural training I have ever been to, and I've been to a few! Very good practical applications.
- Psychologist, Youth Justice, Central Queensland HHS (Diversity workshop)

Overall a wonderful training experience. Really appreciated the presenter's knowledge and shared clinical experience.
- Occupational therapist, CYMHS, Cairns HHS (Mood disorders workshop)

A great networking opportunity
- Guidance officer, Townsville HHS (Mood disorders workshop)

Great interventions. User friendly. Lots of interest in courses from my peers and good feedback during year with outcomes from students after training. CYMHS are a very useful and collaborative organisation with our school - have assisted with training through Ed-LinQ.
- Guidance officer, CHQ HHS (NSSI workshop)

To inform development of its MHPMIPEI Action Plan, in March 2015 the QMHC convened a one-day stakeholder forum to discuss effective approaches for schools and health services to collaboratively understand, detect and intervene early in mental health problems and disorders affecting children and young people. The forum was attended by 60 cross-sectoral stakeholders from across Queensland, who engaged in a rich and far-reaching discussion on the topic. As a result of the forum, the QMHC identified an ongoing need to review the future directions of the Ed-LinQ program, its scope and model of implementation. This included in those locations where Ed-LinQ currently operates, as well as considering the appropriate model for areas not currently serviced by the program. It was considered important that the renewed Ed-LinQ model be contextualised within a shared understanding of school-focused mental health promotion, mental illness prevention and early intervention; robust enough to withstand policy and funding changes; and sufficiently broad to encompass emerging issues that fit within a continuum approach to student well-being.

CHQ HHS was funded by QMHC to undertake the Ed-LinQ Renewal Project to progress these aims. CHQ is the only HHS in Queensland focussing exclusively on the needs of 0-18 year olds, and with a statewide remit. The scope and deliverables of the project were outlined in a service level agreement signed by the QMHC and CHQ HHS in August 2015, with a variation to the agreement endorsed in April 2016 to enable extension of the project from the original completion date of 30th June 2016. The project was funded 12 October 2015 to 30 September 2016, and was resourced by one 0.8FTE project Officer employed by CYMHS, CHQ HHS.

Delivery of the project was associated with funding instalments from the QMHC, and underpinned by a project plan drafted October 2015 – February 2016 (see Appendix C). It was implemented through regular project meetings and/or discussions between QMHC and CYMHS CHQ HHS, and via the consultation processes outlined below.

3 Project Consultation

The following mechanisms were used to actively engage stakeholders in implementing the project:

3.1 Oversight Committee

The Ed-LinQ Renewal Project Oversight Committee comprised senior management from QMHC, MHAOD, DET and CYMHS, CHQ HHS. It complemented the functions of the project's Reference Group by:

- Ensuring alignment of project outputs and recommendations with relevant departmental planning processes and priorities;
- Facilitating cross-departmental communication and strategic planning; and
- Fostering respective departmental support and approval of project recommendations.

See Appendix D for the Ed-LinQ Renewal Project Oversight Committee Terms of Reference.

The group met in March, May, June, July and August 2016 for up to two hours duration, with the CYMHS CHQ HHS Divisional Director attending the final three meetings. Attendees provided specific input into the draft model at – and, in some cases, between - the meetings in May, July and August 2016, and reviewed the preliminary project recommendations at the August meeting. Members also provided contextual information about relevant departmental initiatives as summarised below.

DET's Learning and Wellbeing Framework (DET, 2012) acknowledges that optimising wellbeing within the school context requires a whole-school approach, and covers practices in four domains: learning environment; curriculum and pedagogy; policies and procedures; and partnerships. In early 2016 DET implemented a new departmental initiative with the employment of one mental health coach for each of its seven regions (and one in central office). Their role is to strengthen the capacity of Queensland state schools by providing a key point of contact for support and advice to principals, school leaders and regional staff about student mental health and wellbeing. This ensures that student mental health and wellbeing is promoted and supported effectively and efficiently, and students and families receive appropriate levels of support when they require it. DET is currently developing a much more detailed version of its Framework to integrate the strategies relating to a number of new departmental initiatives (including mental health coaches). The expanded Framework will support schools in developing their own individual learning and well-being plan to consider and address local impediments to academic success.

The *MHAODB* launched the Connecting Care to Recovery Plan 2016-21 (Queensland Health, 2016) to provide strategic direction regarding public health service delivery that is pending Queensland Government approval. It will be the successor to the Queensland Plan for Mental Health 2007-17, and accompanied by a corresponding resource plan. The MHAODB is also currently developing a mental health workforce strategy to guide HHSs in implementing Service Plan priorities. At the time of the project's conclusion in September 2016, it was anticipated that the Plan would include an enhanced recurrent Ed-LinQ resource allocation to complement the funding it already provides for Ed-LinQ Coordinators through service level agreements with HHSs.

The Ed-LinQ Renewal project is included as a strategy in the Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015-17 (QMHC, 2015) and the Queensland Rural and Remote Mental Health and Wellbeing Action Plan 2016-2018 (QMHC, 2016). All five QMHC action plans include a commitment from DET, with QMHC support recently provided to mental health coaches to access training in facilitating Wheel of Well-Being workshops and the Mental Well-being Impact Assessment.

3.2 Reference Group

The Ed-LinQ Renewal Project Reference Group comprised 18 key stakeholders from the health and education sectors who served the following functions:

- Providing input into the project plan regarding the identification of – and progress towards – key deliverables in meeting the stated aims of the project;
- Providing advice and leverage regarding communication and consultation processes, progression of emerging challenges and themes and options for meeting preliminary project recommendations;
- Ensuring alignment of project processes and outcomes with strategic initiatives and activities; and
- Providing a forum for a review of the final report prior to wider distribution.

Representation from HHSs was sought via an expression of interest circulated in November 2015 to the line managers of all Ed-LinQ Coordinators, as well as mental health service managers of those HHSs without an Ed-LinQ program. The initial intention had been to limit this to attendance by two HHSs, but given the interest expressed by four HHSs all respondents were accepted. They comprised Central Queensland, Darling Downs, Sunshine Coast and Metro North HHSs (as well as CHQ HHS as the project lead).

To enable comparable representation from DET as a key stakeholder, a similar expression of interest was circulated through their central office inviting representation by a Senior Guidance Officer from four of their seven regions. The following DET regions were represented at the meeting: Far North, South-West, Central and South-East Queensland. This was complemented by attendance of senior staff from Independent Schools Queensland (ISQ) and the Queensland Catholic Education Commission (QCEC), with other stakeholders identified in discussion with the QMHC.

See Appendix E for the Reference Group Terms of Reference.

The group as a whole met on the following dates with an average of 14 members in attendance: December 2015; February 2016; April 2016; May 2016; and August 2016 (when the above photo was taken). Attendees were engaged in discussions to help shape the project plan, cross-sectoral forum and proposed Ed-LinQ model.

In addition, a smaller group of members was convened for a one-off meeting in February 2016 to provide input on contemporary influences and initiatives of relevance to the project. A sub-group of the Reference Group (comprising representatives from the QMHC, MHAODB and CYMHS, CHQ HHS, as well as all four of the participating Ed-LinQ line managers) was convened during the Reference group meeting scheduled for June 2016. They were joined by the State Ed-LinQ Workforce Development Coordinator to contribute to a more focused discussion to ensure the model met HHS needs in implementing the Ed-LinQ program.

3.3 Working Party

The Reference Group meeting in June 2016 identified the need to review the model in more detail, resulting in the formation of a project working party (for which no Terms of Reference were generated given time limitations). This comprised representation from the QMHC, MHAODB and Sunshine Coast CYMHS as an HHS with a well-embedded Ed-LinQ model, as well as the Ed-LinQ Renewal Project Officer. Meetings of up to three hours duration were held in June, July (twice) and August 2016, with part of the latter meeting also attended by the Acting Program Manager, Specialist Teams, CYMHS CHQ HHS. Discussion was devoted to a review of the Ed-LinQ framework, program and core activities, and consideration of likely indicators and

measures. The model was developed in an iterative process, with the Project Officer integrating feedback between meetings for endorsement or further refinement by the group. Discussion also helped articulate the responsibilities, knowledge, skills and attributes of Ed-LinQ Coordinators as change agents, as well as criteria by which to gauge an HHS's capacity to implement the proposed model.

3.4 Cross-sectoral forum

A cross-sectoral forum was held in March 2016 to seek stakeholder input into the project by:

- Engaging participants in application of the existing Ed-LinQ Framework to test its currency; and
- Identifying additional priorities and strategies to integrate into the renewed Ed-LinQ model.

A strong focus on co-design was adopted throughout planning and delivery of the forum. In February 2016, a request was circulated to members of the project Reference Group as well as Ed-LinQ Coordinators and their line managers seeking real-world scenarios for use during the forum. These formed the basis of table discussions grouped by geographical location for the duration of the forum. Participants were sent reading materials prior to the forum to enhance their understanding of the Ed-LinQ initiative. Experiences in accessing school-based support for mental health problems was also sought from CHQ CYMHS consumers and carers (see Appendix F). A written summary of this feedback was provided on the day to inform forum discussions, and was emailed to attendees after the event to inform their practice. They were also sent all presentation slides and the contact details of consenting delegates to facilitate ongoing networking.

The 66 forum participants were drawn from the three education sectors as well as community-based mental health services. Service managers and providers from school regions and HHSs attended, as did representatives of statewide policy and planning bodies and Queensland Coordinators of the headspace national programs. Amongst the group were seven of the new mental health coaches from the Department of Education and Training (DET), 10 senior guidance and student support officers, four Primary Health Networks, 10 HHS Ed-LinQ Coordinators and an additional 11 CYMHS representatives. In total, 12 HHSs were represented at the forum, with the project providing funding to support attendance by six HHSs.

The forum commenced with an introduction to the policy context from the perspectives of the QMHC and DET. Scenario-based workshops were conducted using pre-prepared prompts, with participants given the opportunity to provide feedback to the larger group at the end of each session. See Appendix G for a program of the day.

Stakeholder discussion endorsed retention of the existing three focus areas of the original Ed-LinQ Framework, with key themes for integrated service responses including robust and respectful collaboration; clear governance processes; cross-sectoral investment; high-quality workforce development; access to a web-based resource; and embedding Ed-LinQ activities into service planning and delivery to ensure greater accountability and ownership of the initiative. Principles by which these responses ideally occur included adopting a continuum of responsibility across sectors; addressing issues systemically; developing a shared understanding of mutual goals; respectful collaboration across professional boundaries; modified options that are flexible and differentiated; and consideration of diversity. It was recommended that a common system be developed to consistently collect data. Throughout the forum, participants highlighted the following three themes as critical to Ed-LinQ's ongoing success: greater clarity of its scope and functions; improved communication and marketing; and strong leadership support.

There was considerable energy and enthusiasm demonstrated by participants, who engaged in robust discussions with colleagues during the forum. As noted in the evaluation summary in Appendix H, attendees strongly endorsed the approach adopted including the opportunity to network. Suggestions for enhancements reinforced the themes raised during the day and informed development of the proposed model.

3.5 Consultation with HHSs

Ed-LinQ Coordinators were strategically engaged to provide input into the project. The Project Officer attended the Coordinator teleconference in October 2015 to obtain an update regarding their work, and to introduce the project. At the subsequent teleconference in February 2016, the Project Officer sought specific feedback about local implementation of the Ed-LinQ initiative including current issues, useful resources and areas for improvement. Questions regarding these areas were emailed out to all Coordinators and their line managers to obtain any additional feedback, including from those who had been unable to attend the teleconference. It was noted that while Coordinators were implementing valuable initiatives, there was a wide variability in consultation processes, strategic planning, evaluation measures and reporting requirements. There also appeared to be limited awareness of - or engagement with - schools in their local area that are implementing the KidsMatter/Mindmatters framework, and minimal inclusion of service user representatives on HHS Reference Groups.

The Project Officer attended a further teleconference in August 2016 to update Coordinators on the project, and provide additional information prior to the upcoming HHS consultation session (see below). During this meeting Ed-LinQ Coordinators identified the need to better engage with and support Schools of Distance Education (SDE) in their region given the higher likelihood of mental health problems and the largely online model of service delivery adopted through necessity by these schools to engage, educate and support participating students. It was noted that a number of SDEs had experienced significant increases in enrolments in recent years. Feedback from CHQ Ed-LinQ Coordinators identified their recent engagement with the Brisbane SDE (which supports more than 4000 students) to deliver brief mental health literacy sessions to its 200-strong staff had been well-received.

All Coordinators and their line managers were invited to attend the cross-sectoral forum, with those Coordinators in attendance profiled here. Coordinators were also encouraged to attend a two-hour gathering the day before the forum to raise any issues and clarify underlying assumptions. This meeting was attended in person by seven Coordinators (and one via videoconference), and was facilitated by the Project Officer. Participants noted appreciation for the opportunity to gather as a group, highlighted the benefits of protecting their role from future scope creep and expressed relief at receiving greater clarity, direction and support for local implementation of their program.

Ed-LinQ Coordinators and their line managers (as well as the service managers of those HHSs without an Ed-LinQ program) were invited to submit feedback on the draft Ed-LinQ framework (section 1 of the renewed model) in May 2015. They were also circulated the draft model in August 2016, with a 90 minute meeting held in September 2016 to provide a forum for questions, discussion and suggestions. It was attended in person or via videoconference by a total of 27 people, representing all but four HHSs (Sunshine Coast, South-West, North-West and Mackay). Participant roles included Ed-LinQ Coordinators, CYMHS Team Leaders and/or the Executive/Clinical Director (or their nominated delegate) of an HHS's mental health

service (which in some cases included an integrated drug and alcohol service). The model was generally very well-received and generated considerable interest, optimism and in-principle support by those in attendance. Participants expressed curiosity about implementation processes following the project, and identified that a number of factors (including sufficient human resources of CYMHS clinics, a travel budget and/or service accountability) may need to be considered to ensure effective implementation. The only suggested change to the model itself was offering Ed-LinQ support to build the internal capacity of schools to help them meet the required criteria to access CYMHS consultation-liaison at student support meetings. An amendment was made to the Terms of Reference of the School Mental Health Regional Care Coordination Group (SMHRCCG) to reflect this suggestion. Feedback received via email from an Ed-LinQ Coordinator immediately following the meeting stated that "it was noted how much work you had put in to this [the model] and its impact as it will be so useful for Ed LinQ coordinators" (personal correspondence, 01/09/16). All HHSs were also circulated a template on which to provide written feedback if they were not able to attend this consultation session, although none took up this opportunity.

3.6 Engagement with HHS Mental Health Service Directors

The mental health service managers of all five HHSs without an Ed-LinQ program were invited to attend the cross-sectoral forum to help inform development of the model, and sent a copy of Section 1 (Framework) of the draft model in May 2016 to review. The invitation to provide feedback on the proposed model at the consultation session in September 2016 was extended to the mental health service managers of all HHSs (see Appendix I). It had been intended that the final draft model would be tabled for the monthly statewide HHS Mental Health Service Clinical/Executive Director meeting in September, 2016. However, as this meeting was cancelled it was not possible to have it noted for HHS endorsement prior to the project's completion as had been planned.

3.7 Individual review of specialist expertise

3.7.1 Education sector

In 2015 there were a total of 1725 schools in Queensland, supporting an estimated 793,545 students across a wide variety of settings (Australian Bureau of Statistics, 2015). Meetings held during the project with staff from each of the three education sectors identified a number of potential opportunities and/or challenges:

The majority of students attend one of Queensland's 1234 state schools. Key strategies driving reform under the *DET Strategic Plan 2015-19* include *Advancing Education: Every Student Succeeding* and DET's commitment to the whole-of-government response to *Early Action: Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015-2017* and the *Queensland Suicide Prevention Action Plan 2015 -2017.* The Project Officer had the opportunity to view DET's Mental Health Hub of Capability, which was launched in December 2015 to enhance staff promotion of student well-being and help support students with mental health problems. In March 2016 the Project Officer provided an overview of CYMHS and the Ed-LinQ initiative at the orientation session of the new mental health coaches.

A total of 299 schools are administered by the QCEC across five regional dioceses. This includes the 12 schools and three outreach sites managed by Edmund Rice Australia's Flexible Learning Network. Unlike DET, Catholic schools include 'social emotional impairment' as a category for student verification. QCEC has also employed a number of officers to help enhance uptake and implementation of KidsMatter and Mindmatters. The Association of Counsellors of Catholic Secondary Schools in Queensland hold an annual conference, which in 2016 focused on youth mental health.

ISQ operates differently from the other two education sectors in that it is not a system but a peak body representing the interests of a very diverse range of 192 member schools. ISQ has been advocating since

the inception of Ed-LinQ for the development of a web-based platform to facilitate access to information to help enhance the mental health outcomes of students.

3.7.2. KidsMatter/Mindmatters mental health promotion frameworks

The Project Officer attended three meetings of the KidsMatter/Mindmatters State Reference Group (in October 2015, February 2016 and July 2016). This enabled a reciprocal exchange of information, with attendees expressing optimism regarding project deliverables. Discussion also highlighted potential changes arising from impending national mental health reform, and profiled state strategies to enhance parental engagement in education. Queensland's KidsMatter Early Childhood Project Officer expressed an interest in considering project findings to inform educational settings for the younger years. The Acting State Coordinator furthermore noted the opportunities for more consistent engagement of the Ed-LinQ initiative amongst schools completing the component on supporting students experiencing mental health problems. The Project Officer attended local delivery of a KidsMatter training session on this topic, with discussions suggesting it would prove a useful forum to actively promote the Ed-LinQ program to participating schools.

3.7.3 Statewide Ed-LinQ Workforce Development Coordinator

Discussions were held in person or via telephone with the Statewide Ed-LinQ Workforce Development Coordinator in October 2015 and February and August 2016. These covered observations of the initiative to date, including the needs of HHSs without an Ed-LinQ Coordinator as well as the skills required of Ed-LinQ Coordinators in facilitating systems change. The Coordinator also contributed to the one-off project meeting on contemporary influences in February 2016, attended the cross-sectoral forum in March, contributed to the Reference Group discussion in June 2016 and provided feedback on the draft model in June and September 2016. The Project Officer furthermore attended the Ed-LinQ teleconferences in October 2015, February 2016 and August 2016 to obtain an update on the Ed-LinQ cross-sectoral workforce development program.

3.7.4 Dovetail

Dovetail holds a unique role in their extensive knowledge of youth service delivery in Queensland, with their entire focus on enhancing the youth drug and alcohol capacity of service providers from a range of sectors. This includes through stakeholder engagement with their website resource. Discussion with Dovetail staff noted that the majority of their queries in 2015-16 were from schools, and related to "requests for AOD education materials" and "concerns/issues regarding a specific young person". Dovetail advised they are in preliminary discussions with DET and the MHAODB to develop a policy toolkit to support schools in responding to drug and alcohol issues.

3.7.5 Office for Youth

The Project Officer was sought out by the Manager of the Queensland Government's Office for Youth to provide an overview of CYMHS, Ed-LinQ and the Renewal Project in the context of the Office's development of the new Youth Strategy. The Strategy has been based on consultation in early 2016 with young people across Queensland, but has yet to be released.

3.7.6 MHAODB

As well as seeking their input via the Oversight Committee, Reference Group and working party, a meeting was held with the MHAODB regarding alignment of the proposed model with the (draft) National Mental Health Services Planning Framework. Additional discussion with the MHAODB provided background information regarding the development of the mental health workforce strategy to support implementation of the impending Services Plan 2016-21.

3.7.7 NSW School-Link

The Project Officer reviewed the NSW School-Link Strategy and Action Plan 2014 -17 (NSW Ministry of Health, 2015), which includes explicit reference to supporting mental health recovery through the provision of holistic care. Discussion with the state Coordinator in February 2016 suggested that a transition from the face-to-face cross-sectoral workforce development program outlined above to online training had seen very little stakeholder uptake. A teleconference was held between the QMHC, CYMHS CHQ HHS and NSW School-Link in May 2016 to develop further understanding of their work. NSW generously shared a number of resources including their data collection tool, which was reviewed in development of the renewed Ed-LinQ model

3.7.8 Ballarat Health Services CYMHS Redesign Project

A brief scope of national policy identified Victoria's Mental Health Reform Strategy 2009-2019 (Victorian Department of Human Services, 2009) as being of particular relevance to the Ed-LinQ Renewal Project. Its CYMHS Redesign Demonstration Project saw Ballarat Health Services undergo an internal transformation to enhance mental health service delivery for young people aged 0-25 years across the 48,000 km2 of the Grampian region. It was driven by stakeholder feedback as well as internal audits that indicated the region was characterised by 'a fragmented and silo-driven patchwork of services that were not well connected' (Victorian Department of Health and Human Services, 2015, p.53). The project was overseen by a consortium of 16 services, including the Department of Education and Early Childhood Development. Considerable effort in establishing respectful and collaborative partnerships helped address pre-existing service barriers and silos. Open communication and maintaining a client focus also reduced the resistance expressed by some CYMHS staff.

One of the project's nine redesign strategies comprised re-orientating CYMHS to deliver secondary consultations to enhance stakeholder access to timely mental health expertise. It was associated with a range of phased actions, including the development of a consultation model, staff training, stakeholder communication and embedding this service enhancement into routine clinical care. It was complemented by the redesign strategy of implementing a workforce development program, which has been delivered to over 890 individuals across 34 organisations. Data from 2010–11 and 2013–14 indicate total referrals, assessments and treatments to the service increased by 38 per cent, 64 per cent and 61 per cent respectively. Anecdotal evidence also suggested greater success in attracting and recruiting staff due to the appeal of having a role with integrated functions across the continuum of care (Victorian Department of Health and Human Services, 2015).

Redesign strategies have now been fully embedded into CYMHS service delivery. Ballarat Health Service's successful implementation of the project moreover received a Minister's Award for an 'Outstanding achievement by an individual or a team in mental healthcare' at the 2013 Victorian Public Healthcare Awards.

3.7.9 Specialist input provided by CYMHS CHQ HHS

Project consultation was also held with the following CHQ CYMHS representatives to access their expertise:

3.7.9.1 *Consumer Carer Consultant:* This staff member provided valuable input throughout the project to ensure the perspectives of children, young people and parents/carers were considered. Although the model did not lend itself to the inclusion of all suggestions, they would be a valuable addition to inform program implementation. The Consumer Carer Consultant supported broader strategies to better inform school communities on how to identify and support student mental health problems.

3.7.9.2 *Members of the Youth Advisory Group:* Two former CYMHS consumers (females in their late teens) highlighted the importance of teachers observing changes in student behaviour, providing

discrete support and seeking specialist help when needed, but noted this would require more staff training. Both highlighted the need for improved early intervention given the apparent increase in issues such as anxiety, bullying and poor body image.

3.7.9.3 *Queensland Centre for Perinatal and Infant Mental Health (QCPIMH):* Centre staff shared their experience regarding specialist statewide capacity-building, including communication of key messages via engaging visual tools, collaborative generation of a model of workforce development, strategies for addressing turnover of skilled trainers and use of a website to equitably scale-up stakeholder access to relevant knowledge and skills. QCPIMH also strongly recommended application of the Ed-LinQ model to early childhood settings to enhance early detection and collaborative care of mental health problems amongst young children.

3.7.9.4 *eCYMHS:* The Coordinator of eCYMHS provided additional context for the needs of HHSs without an Ed-LinQ program (excluding Wide Bay HHS), and provided feedback that helped shape the criteria developed to gauge the capacity of HHSs to implement the renewed Ed-LinQ model (see Section 5.6.2.1).

3.7.9.5 *Project Manager, Adolescent Mental Health Extended Treatment Initiative:* Feedback was sought on CHQ's strategic oversight in embedding Assertive Mobile Youth Outreach Service (AMYOS) in nine CYMHS sites across Queensland, and the role of readiness factors such as a critical mass of CYMHS staff and the identified need for more responsive service delivery.

3.7.9.6 *Research staff:* Two staff with specialist skills in research and evaluation reviewed a draft of the proposed model in August 2016. At their suggestion the initial measures were simplified, and an existing tool used to gauge stakeholder satisfaction was reviewed.

3.7.10 Workshop attendance: Partnering and collaboration in complex systems

The Project Officer attended this one-day workshop in March 2016 to enhance implementation of the project. Highlights included review of a range of partnering strategies relevant and applicable at different levels and stages of collaboration; consideration of the principles of equity, transparency and mutual benefit; recognition of stakeholder narratives to seek common ground; balancing the learning, creating and doing processes over time; and discussion of tools and resources to foster collaboration. Workshop resources were shared with Reference Group members, and informed development of the Ed-LinQ Renewal model.

3.7.11 National mental health reform conference

In May-June 2016, the Project Officer also had the opportunity to attend a two-day conference on impending national mental reform. Presentations on stepped care, data collection, organisational change and upscaling impact through the use of technology were particularly useful in informing implementation of the project. The Project Officer actively sought out other Queensland delegates, including representatives from Mental Illness Fellowship and five of the state's PHNs. A manager from the Central Queensland, Wide Bay and Sunshine Coast PHN expressed considerable interest in Ed-LinQ, and advocated for a program in Wide Bay HHS. Slides from all conference presentations were shared with the QMHC.

3.7.12 Brief review of the literature

The project offered a limited opportunity to investigate the contemporary evidence base regarding school-based early detection and collaborative care. Of note was the recent emergence of the School Mental Health International Leadership Exchange (SMHILE; see Weist, Short, McDaniel & Bode, 2015) as a source of expertise. The list of articles located during the project is included in Appendix J. At the project's conclusion, electronic copies of all articles were circulated to members of the Reference Group, Ed-LinQ Coordinators and their line managers and the mental health service managers of the five HHS without an Ed-LinQ program.

4 Project Expenditure

Delivery of the project was aligned to instalments specified in the contract, as summarised below:

Project Item	Amount	Due Date	Status as at 30/09/16
Start-up costs	$25,000	November 2015	Paid
Project Plan	$50,000	February 2016	Paid
Initial progress report	$20,000	April 2016	Paid
Second progress report	$20,000	June 2016	Paid
Draft final project plan	$35,000	August 2016	Pending
Total			**$150,000**

Listed below is a summary of costs directly accrued over the course of the project:

Project Item	Specifications	Amount
Project Officer salary	0.8FTE HP5.2 Project Officer for the period 12 October 2015 to 30 September, 2016, including on-costs	$107,189.22
Ed-LinQ Cross-Sectoral Forum: 17 March, 2016	Venue hire and catering	$4,848.59
	Travel reimbursement for the following HHSs: • Cairns and Hinterland • Central Queensland • Central West • Mackay • Townsville • Wide Bay	$5,083.35
Complexability workshop	One-day registration	$385.00
National Mental Health Reform Conference: 31 May – 1 June, Sydney	Costs included registration, flights, accommodation, meal allowance, incidentals and taxi vouchers	$2,332.61
TOTAL		**$119,838.77**

CYMHS CHQ HHS covered additional costs associated with the project including the following:

- Administrative support provided in minuting Reference Group discussions.
- Support provided by the Program Manager, Specialist Teams in:
  - Line management of the Project Officer;
  - Attendance at project meetings with QMHC;
  - Preparing for and chairing all Ed-LinQ Reference Group meetings;
  - Preparing for and facilitating the Ed-LinQ cross-sectoral forum in March 2016;
  - Attending Oversight Committee meetings; and
  - Chairing the HHS consultation session in September 2016.
- Attendance by the Divisional Director at preliminary project discussions, three Oversight Committee meetings and review of documentation prior to submission to QMHC.
- Costs of all project photocopying and printing.
- Costs associated with facility rent, utilities and equipment.

It is estimated that cost of the above activities would approach the project balance of $30,000.

5 Project Deliverables

Achievement towards each of the project deliverables is outlined below with any recommendations made. These recommendations are summarised in full in Section 6.

5.1 Articulate the core elements of the Framework regarding strategic partnerships, enhancing capacity and provision of clinical guidance, and develop recommended templates to measure and report the related activities for each

Discussion at the cross-sectoral forum in March 2016 confirmed the relevance of these key areas identified in the original Ed-LinQ Framework for Action (QCMHPPEI, 2010). However, working party discussion generated the revised name of "provision of school-based consultation liaison" for the latter area to enhance engagement with mental health expertise. The three areas were also reordered within the model to highlight school-based consultation liaison as an incentive for schools to access Ed-LinQ support.

Considerable working party discussion was devoted to the generation of core Ed-LinQ activities at the state and HHS levels. It was intended that clear articulation of the "what" of the program would enhance consistency across the state, with the local "how" of implementation to be determined by individual HHSs according to their need and capacity. Underpinning the generation of all activities was adoption of a joint planned approach to program delivery. Ed-LinQ Reference Groups at the HHS level are responsible for developing, implementing and reviewing an annual program and SMHRCCG plan integrating all program activities in alignment with the state program. There is also a focus on monitoring and reporting activities to ensure accountability to - and integrity of - the proposed model. Given the need to develop a number of critical state program elements (including workforce development and communication strategies and an evaluation and monitoring framework), these are currently considered both an activity and an output. Longer-term, they will represent inputs to support ongoing HHS implementation.

It had been intended that the program would include specific reference to relevant education sector activities to reflect their commitment to achieving Ed-LinQ's vision. A similar approach had been taken in generation of the NSW School-Link Strategy and Action Plan (NSW Ministry for Health, 2015). Timing of the development of DET's expanded Learning and Well-Being Framework did not align with generation of the Ed-LinQ model, and so this could not be considered during the project. However, it remains important to integrate contributions of the education sector to articulate this shared commitment to the early detection and collaborative care of Queensland students experiencing mental health problems. This may over time include cross-sectoral funding for collaborative activities undertaken through the Ed-LinQ program at the state and/or regional level, and a focus on supporting SDEs to address the unique mental health needs of their school communities.

> RECOMMENDATION 1: State Ed-LinQ program to engage the education sector to ensure integration of student well-being and support priorities and directions into the proposed Ed-LinQ model.

Program activities were reviewed as part of a broader consultation about the draft Ed-LinQ model with the Reference Group, Oversight Committee, HHSs and the Statewide Ed-LinQ Workforce Development Coordinator, with feedback from these consultations integrated throughout. Program activities are summarised in Table 2 of Appendix K, the proposed Ed-LinQ model.

5.2 Develop a proposed renewed Ed-LinQ model incorporating the above core elements as well as contemporary resources and influences

It was intended that the proposed Ed-LinQ model be contextualised within a shared understanding of school-focused mental health promotion, mental illness prevention and early intervention; robust enough to withstand policy and funding changes; and sufficiently broad to encompass emerging issues that fit within a continuum approach to student well-being. As noted above, it was developed in an iterative process of co-design with key stakeholders. The Framework (Section 1 of the model) was generated and disseminated first to provide a strong foundation by articulating Ed-LinQ's rationale, vision, aim, key focus areas and guiding principles. The Program (Section 2) provided more detail specifically regarding the levels at which the model operates, stakeholder roles and responsibilities, critical success factors, potential risks to effective implementation, the program logic and core Ed-LinQ activities at the state and regional (HHS) levels. It was also agreed at the final working party and Oversight Committee meetings that delivery of the program would include explicit reference to recovery-oriented care as a means of holistically supporting students with existing mental illness. The model's strategic focus on early intervention and responsive access to specialist services is commensurate with the stepped care approach endorsed by the current mental health reform agenda (Commonwealth of Australia, 2015).

One of the key messages of the model is that the Ed-LinQ initiative is a whole-of-service response rather than the sole responsibility of the Ed-LinQ Coordinator. Coordinators therefore hold a very important role in helping embed the Ed-LinQ program as a core function of CYMHS service delivery. The consultation session with HHSs in September 2016 was an important forum for reviewing the proposed model and considering implications for service reorientation where required. Participants expressed optimism at the opportunities it afforded, although due to time restrictions executive endorsement by all HHSs could not be sought during the project.

Strong consensus amongst key stakeholders during the project consistently identified the need for state leadership of the proposed Ed-LinQ model. This includes the development and management of HHS Ed-LinQ reporting and monitoring systems required to ensure integrity of – and fidelity to – the model, including alignment with statewide priorities. Stakeholders supported the statewide leadership to be embedded within a HHS with a strong commitment to the Ed-LinQ program, and which would further support stakeholder engagement and maximise program impact following conclusion of the Ed-LinQ project. CHQ as the only HHS with a statewide remit – as well as a specialist paediatric focus – would be ideally placed to take on this coordination role. This aligns with the statewide model recently implemented for the Assertive Mobile Youth Outreach Service (AMYOS) which CHQ CYMHS leads.

This will include obtaining appropriate endorsement through the relevant channels to ensure that CHQ CYMHS is organisationally supported to implement the proposed state model and further seek the endorsement of the Executive/Clinical Directors of HHS mental health services.

RECOMMENDATION 2: CHQ to establish and lead a statewide leadership model to implement the Ed-LinQ program

Project discussion identified the need to ensure a clear and consistent communication strategy to help "brand" the Ed-LinQ initiative, and enhance recognition, interest, comprehension and commitment from stakeholders at all levels across a range of sectors. A number of contributors to the project identified the benefits of a designated website as a central reference point to increase equity of access to Ed-LinQ resources.

5.3 Develop a proposed sustainable statewide model of professional development

The Ed-LinQ cross-sectoral workforce development program involves a learning needs assessment process of participating health and educational personnel. However, a broader need exists to be clear about what is required to equip and support members of the broader school community - including teachers as well as health personnel - to undertake their roles in early detection and support. This would then inform the generation, alignment and implementation of an Ed-LinQ workforce development strategy at the state and HHS levels.

Review of the workforce development framework developed by QCPIMH proved informative in generating a range of considerations regarding a sustainable Ed-LinQ workforce development strategy. Generation of the strategy will be used to systematise training within Queensland to examine what is already available and where gaps may be, but will not be used as a competency tool to assess the skills and abilities of individual service providers. Cross-sectoral generation – and, if required, resourcing - of a state Ed-LinQ workforce development strategy will inform the development of counterpart strategies at the HHS levels through discussion with strategic partners, including at Ed-LinQ Reference Groups and incorporation in collaboration agreements and annual work plans. Strategies at the state and HHS levels will include clear guidance regarding the evaluation of individual activities as well as the impact of the strategy overall.

The Ed-LinQ workforce development strategy will:

- Define the target workforce groups, content areas and levels of training. These levels are likely to fall across a continuum that acknowledges the role of Ed-LinQ in the broader spectrum of MHPMIPEI and integrated care, and incorporates the following areas:
    - Awareness/health promotion/prevention (for delivery by stakeholder groups such as the KidsMatter/Mindmatters frameworks);
    - Basic skills/screening/identification (targeted at groups such as teacher
    - Intermediate skills; and Advanced assessment and intervention modules, such as those currently offered by the Ed-LinQ cross-sectoral workforce development program.
- Provide guidelines on the core competencies of identified workforce groups in relation to their role in the early detection and/or collaborative care of mental health problems amongst young people in school settings.
- Provide a framework to support the identification of learning and development needs of each identified workforce group of relevance to the Ed-LinQ initiative.
- Provide structure and support to the delivery of evidence-based learning and development activities for identified workforce groups. This will include utilisation of existing infrastructure such as the Queensland Centre for Mental Health Learning (QCMHL), the Mental Health Online Professional Development and DET's Mental Health Hub of Capability. Any activities provided will ideally be free/low-cost, accessible, practical, engaging and able to be tailored to a range of individual settings and needs. The QCPIMH's model of workforce development includes a well-resourced web-based platform to enable stakeholder access to resources, including video-recorded information sessions on relevant content delivered by sector experts. A similar approach has been adopted by Dovetail in the use of its website to enhance youth drug and alcohol capacity in Queensland. Longer-term, the Ed-LinQ initiative may wish to consider developing such a portal to enhance stakeholder access to program resources, including learning and development activities.
- Inform organisations currently providing or developing professional development courses for their identified workforce groups to help embed and enhance evidence-based early detection and collaborative care in ongoing practice, including input into the development of sector orientation courses.

- Promote best practice across Queensland for early detection and collaborative care of student mental health problems, informed by ethical evidence-based practice, available clinical practice guidelines and key policy documents.

RECOMMENDATION 4: State Ed-LinQ program to generate and implement a cross-sectoral workforce development strategy to inform the generation and implementation of counterpart strategies at the HHS level.

A significant element of the strategy is the Ed-LinQ cross-sectoral workforce development program funded initially through the QCMHPPEI and most recently the QMHC. A review of the latest evaluation report (Hillin, 2016) suggested its face-to-face cross-sectoral delivery enabled important opportunities to network, identify and clarify misunderstandings regarding systems of care and enhance commitment to ongoing collaboration. When combined with the reportedly poor uptake of the online training developed by NSW School-Link, it is recommended that delivery of this activity remain face-to-face to enhance the partnership function vital to the success of HHS Ed-LinQ programs.

Despite the interest shown by workshop participants, only a small proportion of attendees appear to have delivered the cascade training to their sector. This limits wider access to its key messages, and therefore the potential impact on school settings. The proposed Ed-LinQ model at the state and HHS levels should therefore actively pursue strategies to promote, implement and evaluate cross-sectoral delivery and evaluation of the cascade resource. This would require accountability through Ed-LinQ Reference Groups and collaboration agreements, and inclusion in annual Ed-LinQ work plans.

RECOMMENDATION 5: State Ed-LinQ program to retain the content and delivery format of the Ed-LinQ cross-sectoral workforce development program, and enhance cross-sectoral commitment for collaborative delivery and evaluation of the cascade resource to school settings.

Longevity of the current delivery of the Ed-LinQ cross-sectoral workforce development program also needs to be reviewed. Recommendations to ensure ongoing stakeholder access to the program are provided in a staged manner, as outlined below.

Short-term:

- Ensuring the workforce component of the Ed-LinQ model aligns with the Mental Health Workforce Development Strategy currently under development through the MHAODB, which will ideally include a focus on stakeholder education to encompass cross-sectoral capacity building.
- With funding for the workshop development program only available through the QMHC until December 2017, interim funding may need to be sourced to ensure its continuity while sustainable options are being explored.
- The state Ed-LinQ program undertake planning for ongoing sustainability of the Ed-LinQ cross-sectoral workforce development program. A cost-benefits analysis of potential options is considered in Table 1.

Option 4 (i.e. delivery by SGOs[2] and senior CYMHS staff) appears to be the most advantageous and sustainable model based on this preliminary analysis. If this option is to be implemented it will require robust

[2] Discussion with SGOs confirmed that the delivery of professional development is consistent with their current role. However, the recent recruitment of additional Guidance Officers in state schools does not appear to have been matched by a corresponding increase in SGO allocations to oversee their practice. If

cross-sectoral commitment and governance, including progression at the state and HHS levels via Ed-LinQ Reference groups and inclusion in Ed-LinQ collaboration agreements between the Department of Health and DET. This will help address potential challenges to effective and sustainable implementation, including the four identified in Table 1.

Medium-term:

- The state Ed-LinQ program resource and trial the preferred option of delivery. A formal evaluation would include feedback from current trainers and facilitators as well as immediate and follow-up feedback (including implementation outcomes) from workshop participants and attendees of the cascade training. A review of this option may be enhanced through involvement of an external party such as the Queensland Centre for Mental Health Learning and/or an academic institution.

Longer-term:

- The state Ed-LinQ program consider outcomes from the trial to review, disseminate and embed the final model into sustainable service delivery, including via ongoing Ed-LinQ collaboration agreements.
- HHSs to consider local resourcing requirements for the approved model, and if not within their existing budget consider exploring other options including seeking supplementary funding support from local stakeholders and/or the state Ed-LinQ program.

RECOMMENDATION 6: State Ed-LinQ program to undertake planning to ensure ongoing sustainability of the Ed-LinQ cross-sectoral workforce development program.

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delivery of the Ed-LinQ workforce development sessions is to be added to their workload, DET may need to consider additional SGO allocation to regions to ensure it does not place an unrealistic demand on their role.

Table 1. Cost-Benefit Analysis of Options to Deliver a Sustainable Model of Workforce Development

Option	Cost	Benefit
1. Retention of the current model	• Cost of delivery, including travel from NSW to deliver the workshops; • Trainers not local to the area to help tailor planning and delivery; • Investment of the program in only two trainers, and therefore limited scope should one/both exit the current model; and • Limited ability to help oversee local delivery of the cascade resource.	• Credibility of the trainers and training content; • Consistency of delivery throughout history of the Ed-LinQ initiative, and across multiple sites; and • Trainers not aligned with one particular sector.
2. Delivery of the current content (through Department of Health access) via a tender process	• Cost of salaries as well as travel costs; • Trainers not local to the area to help tailor planning and delivery; • Investment of the program in only a small number of trainers, and therefore limited longevity with staff turnover; • Lack of history with the Ed-LinQ initiative if current trainers are unsuccessful; • Trainers may represent only one sector; • Limited integration with the broader Ed-LinQ initiative; and • Limited ability to help oversee local delivery of the cascade resource	• Credibility of the training content; • Consistency of delivery across multiple sites; • Transparency in allocation of the tender; and • Likelihood of applications from Brisbane-based stakeholders, which would reduce travels costs for workshops in south-east Queensland.
3. MHAODB employment of two trainers to deliver the model based on current Department of Health access to the content	• Salaries and travel costs; • Trainers not local to the area to help tailor planning and delivery; • Investment of the program in only two trainers, and therefore limited scope should one/both exit the current model; • Lack of stakeholder familiarity with the trainers; • Trainers represent only one sector; and • Limited ability to help oversee local delivery of the cascade resource.	• Credibility of the training content; • Consistency of delivery across multiple sites; and • Strong linkages with the MHAODB in implementation of the Ed-LinQ program
4. Current trainers train identified facilitators (most likely 2-3 senior Guidance Officers and 2-3 senior CYMHS clinicians) in each HHS to deliver the training by one representative from each sector, and provide medium-term support and supervision	• Approval processes required to identify and support potential local facilitators; • Cost of implementing a train-the-trainer program and follow-up support; • Potential variability in quality of delivery across Queensland; and • Turnover of trained staff.	• Credibility of the training content; • Trainers represent the two main sectors (education and mental health) involved in the Ed-LinQ program; • Trainers have their own local and sector knowledge to help tailor planning and delivery; • Strong linkage to the local Ed-LinQ initiative, including ability to help oversee delivery of the cascade resource; • Training sufficient facilitators per HHS would help minimise the impact of turnover; • Possibility of delivering a greater number and range of workshops per year; • Support offered through the existing trainers while incoming trainers orient to delivery of the workshops; • Opportunity for Statewide Coordinator and other sector staff (including QCMHL trainers) to be introduced to the train-the-trainer model so that they can longer-term run this program for incoming facilitators.

5.4 Develop a proposed suite of documents to help inform operationalisation of the model at the HHS level

The proposed Ed-LinQ model in Appendix K includes an Action Implementation Guide (Appendix B) that includes the following three documents considered by the project working group as critical in supporting HHSs in their implementation of the model: a Terms of Reference for the HHS Ed-LinQ Reference Group; a template for the HHS Ed-LinQ work plan; and a Terms of Reference for the SMHRCCG. These were disseminated for discussion at the HHS consultation session on 1 September 2016, and feedback on the latter integrated as noted above. Monitoring HHS utilisation of these – and future - documents will be undertaken by the state Ed-LinQ program in its implementation of the model.

5.5 Develop proposed documents to guide operationalisation of Ed-LinQ at the statewide level

A review of core Ed-LinQ activities at the state level (see Appendix K, Table 2, column 3) provides guidance for implementation of the state Ed-LinQ program. Effective delivery is based on a strong foundation of cross-sectoral commitment leveraged through governance mechanisms including the state Ed-LinQ Reference Group (complemented by an HHS mental health service Clinical/Executive Director Ed-LinQ meeting) to jointly develop and undertake an annual state Ed-LinQ action plan. This commitment will also be articulated in a state Ed-LinQ collaboration agreement/s, which will inform the generation of related agreements at the HHS level.

It is anticipated that key short-term strategies of the state Ed-LinQ program will include:

- Re-establishing the state Ed-LinQ Reference Group and HHS mental health service Clinical/Executive Director Ed-LinQ Groups;
- Engaging HHSs;
- Developing a communication strategy as outlined in Recommendation 3;
- Overseeing development of an evaluation and reporting framework as outlined in Recommendation 12 below; and
- Commencing development of a collaboration agreement/s at the state level to inform program implementation at the state and local levels.

Strong consensus across the sector over the course of the project identified that recruitment of a state Ed-LinQ Coordinator was considered central to effective delivery and monitoring the state Ed-LinQ program. The state Ed-LinQ Coordinator needs to maintain strategic liaison with HHS Ed-LinQ programs to ensure alignment with the state program. Given the agency to lead the state Ed-LinQ program has yet to be selected, it was agreed that generation of a role description for a State Coordinator was beyond the scope of the project. Project discussions suggested the role description will need to reflect advanced skills in leadership, change management, stakeholder negotiation, monitoring service accountability and strategic oversight. It may be appropriate over time to consider the introduction of a state Coordinator responsible for implementation of the model in primary and secondary schools given the differing developmental needs and support structures available in each.

RECOMMENDATION 7: State Ed-LinQ program to develop a plan to implement the proposed Ed-LinQ model.

Project discussions reinforced the value of including the following stakeholders in the state Ed-LinQ Reference Group:

Dovetail's credibility, extensive networks, vast knowledge of youth service delivery across Queensland, regular contact with the education sector, current development of a policy toolkit for schools and demonstrated experience in innovative capacity building make it a valuable partner for the renewed Ed-LinQ model. In addition, at a policy level the independent review of the Ed-LinQ recommended "integration with school-based drug and alcohol initiatives" (Mendoza et al., 2014, page 12). Given the reciprocal relationship between mental health and substance use problems in young people and strategic directions regarding integrated service delivery for those with dual diagnosis (Queensland Health, 2011), the state Ed-LinQ program would benefit considerably from input by Dovetail.

P&Cs (Parents and Citizens') Qld and the *Federation of P&F (Parents and Friends) Associations of Catholic Schools in Queensland* play an important role in facilitating the reciprocal support and communication between parent and carers and their respective education sector in striving for the shared goal of improved student and school outcomes[3]. A representative from both bodies attend the state KidsMatter/Mindmatters Reference Group, where over the course of the project they were noted to make important contributions about parental engagement in education and the role of families in fostering mental health and identifying and supporting students with mental health problems. Both agencies were invited to the cross-sectoral forum in March 2016, with a representative from the Federations of P&F Associations in attendance. Given the important role families can play in partnering with schools to access help for their child and yet the apparent gap in parental mental health literacy to enhance early intervention (Lawrence et al., 2015), these bodies may represent a previously untapped resource to both inform and be informed by the state Ed-LinQ Reference Group. Doing so may also assist advocacy within their respective sector to better engage and inform parents and carers as an important source of early detection and collaborative care. Regional representatives may also be considered for inclusion on HHS Reference Groups.

Consumer and carer representatives bring the reality of lived experience to enhance service improvement. The CHQ CYMHS Consumer Carer Consultant and Youth Advisory Group members interviewed during the project clearly articulated the protective role of education, opportunities for early intervention by schools and the need for consultation in delivering collaborative care. Inclusion of CYMHS consumer and carer experiences in the cross-sectoral Ed-LinQ forum generated positive anecdotal feedback both on the day and following the forum. With the renewed model's inclusion of enhancing recovery-oriented care, representatives of those accessing CYMHS assistance would be in an important position to inform implementation of the model. Selection, remuneration and support of an appropriate representative/s on the state Ed-LinQ Reference Group would need to be undertaken in line with existing policies for consumer/carer input, including at the regional levels if this were considered by HHSs.

RECOMMENDATION 8: State Ed-LinQ program to consider representation of the following stakeholders in the state Ed-LinQ Reference Group: Dovetail, P&Cs Qld, the Federation of P&F Associations of Catholic Schools in Queensland and an appropriately recruited and supported CYMHS consumer/carer.

Included in Appendix A of the proposed model (Appendix K) is an overview of the responsibilities of an Ed-LinQ Coordinator in helping implement the model, which were included for comment in the HHS consultation session in September 2016. Along with knowledge, attributes and skills required of Ed-LinQ Coordinators that emerged through project discussions, these responsibilities are reflected in the content recommended to assist HHSs in future recruitment of Ed-LinQ coordinators (see Appendix L). Project discussions identified

[3] There is no equivalent overarching body for ISQ.

the advantages of input by the State Coordinator in the selection of new Ed-LinQ Coordinators to enhance consistent implementation of the program across Queensland. Ed-LinQ Coordinators will benefit from ongoing professional development to maintain and enhance their specialised knowledge and skills as change agents. This could be coordinated by the state Ed-LinQ Coordinator in discussion with CYMHS managers and informed by training needs analyses for inclusion at the HHS level in the annual Professional Development Plans of individual Coordinators. Forums for discussing and addressing common professional development needs include quarterly teleconferences and/or an annual state Ed-LinQ forum.

RECOMMENDATION 9: State Ed-LinQ program to consider the proposed content for inclusion in HHS role descriptions in recruiting to future Ed-LinQ Coordinator positions.

5.6 Identify proposed resource requirements and likely collaborative processes for expansion of the Ed-LinQ initiative.

Given the breadth of this section, it is broken into three parts:

5.6.1 Allocation of any additional resourcing to the Ed-LinQ program

Additional enhancements for the Ed-LinQ program in the Connecting Care to Recovery Plan 2016 -2021 would represent an important foundation for expansion of the Ed-LinQ program. Statewide consultation undertaken during the project identified strong cross-sectoral consensus for the following priorities to progress implementation of the proposed model:

- Recruitment of a state Ed-LinQ Coordinator to help implement the state Ed-LinQ program;
- Development of a communication strategy;
- Development of an Ed-LinQ evaluation and reporting framework; and
- Funding to support delivery of the Ed-LinQ cross-sectoral workforce development program, as outlined in Recommendation 6.

Consideration for expansion of the Ed-LinQ program to HHSs would also be made based on demonstration of their capacity to implement the proposed model, and identification of their need for expansion. These two factors are considered in more detail below.

RECOMMENDATION 10: State Ed-LinQ program to consider any future budgetary allocations for the Ed-LinQ program to address the following priorities: recruitment of a state Ed-LinQ Coordinator; development of a marketing and communication strategy; development of an Ed-LinQ evaluation and reporting framework; support for ongoing access to the Ed-LinQ cross-sectoral workforce development program; and expansion of the Ed-LinQ program to those HHS with demonstrated capacity to implement the proposed model and a clear need for expansion.

5.6.2 Additional enhancements to expand access to the Ed-LinQ program

Enhancing the early detection and collaborative care of student mental health problems in school settings as outlined by the renewed Ed-LinQ model may not be as simple as allocation of funds for a/another Coordinator/s per HHS. In rural and remote areas, there may be challenges to the recruitment and retention of CYMHS staff at an HP3 level, let alone the HP4 level required of an Ed-LinQ Coordinator as a senior CYMHS clinician. With so few specialist CYMHS positions, in the event of a vacancy there may also be the very real risk of an Ed-LinQ Coordinator appointed to these HHSs being asked to take on a clinical caseload in response to service demand. Cape and Torres HHS has the additional challenge of being spread across multiple island sites without any CYMHS service provision, but instead being supported via an outreach

model by the Remote CYMHS team based in Cairns. Allocation of an Ed-LinQ Coordinator to rural and remote HHSs may therefore not have access to a critical mass of population or service infrastructure to sufficiently support or make the best use of this specialist role. Enhancements will therefore be considered based on service capacity and need to support an expanded Ed-LinQ program.

Effective implementation of the proposed Ed-LinQ model requires of all HHSs a whole-of-service response in adopting the functions of the Ed-LinQ program, and so is not necessarily reliant on the resource allocation for an Ed-LinQ Coordinator to achieve this. HHSs may believe that they are insufficiently resourced to implement the renewed Ed-LinQ model as intended. It was not considered appropriate or possible for the project to approach HHSs to ascertain their capacity and need for Ed-LinQ expansion, and therefore make costed recommendations for additional resources required for this expansion. However, the following two-step process is proposed to guide HHSs wishing to introduce an Ed-LinQ program or expand the reach of their existing program. Interested HHSs would be invited to submit an application via a call for expressions of interest circulated when additional funding is available for Ed-LinQ expansion, and would be required to demonstrate their capacity and need to implement an expanded Ed-LinQ program as outlined below.

5.6.2.1 HHS demonstration of capacity to implement the renewed model

Interested HHSs would first need to meet a clear set of minimum criteria to reflect their capacity for service (re)orientation to early detection and collaborative care of students with mental health problems. Reference to the literature on organisational transformation during the project identified four factors considered critical in assessing readiness for change: organisational climate that facilitates change; current attitudes and efforts towards prevention; commitment to change; and capacity to implement change (Castaneda et al, 2012).

Further project discussion generated a range of related criteria against which HHSs (including those currently without an Ed-LinQ program) would be gauged to ascertain their capacity to implement the Ed-LinQ renewed model. These were strongly endorsed by HHS representation at the project working party. Achievement of capacity criteria (summarised in Table 2) would form the prerequisite for demonstrating the need for additional resourcing.

In considering the mental health needs of children and young people, it has been identified that “mentoring and support, and development of innovative ways to meet needs of rural populations – e.g. telepsychiatry, secondments, better use of information and communication technology – are essential to allow sufficient focus on prevention and early intervention” (Royal Australian and New Zealand College of Psychiatrists, 2010, p.6). HHSs without an Ed-LinQ program may only have the capacity to implement the proposed model with application of such innovation, possibly supplemented through additional funding. Project discussions identified several options that could be considered by HHSs currently without an Ed-LinQ program to enhance their capacity to implement the proposed model without reliance on their own Ed-LinQ Coordinator:

- recruitment of an additional CYMHS clinician/s to enhance team adoption of the model;
- budget for workforce development to upskill existing clinicians in the required skill set;
- additional equipment or an enhanced travel budget to undertake program activities;
- adaptation of a model such as eCYMHS to school settings; and/or
- a funded partnership with an HHS/cluster with an existing Ed-LinQ program (ideally one with shared educational and/or PHN regions) to provide mentoring, training and/or service delivery to assist the intending HHS implement its Ed-LinQ program. This may require demonstration of service capacity by the partner HHS via a service level agreement (including demonstration of their own service capacity to take on this role, and accountability for any additional funding provided for such a support role).

Table 2. Criteria against which to gauge HHS capacity to implement the renewed Ed-LinQ model

Organisational climate that facilitates change

- Strong supportive leadership for the renewed Ed-LinQ model from the CYMHS Team Leader and HHS mental health service management staff
- Engaged CYMHS staff who are receptive to expanding their current scope of practice
- Robust processes for effective governance, planning, communication, accountability and policy and workforce development
- Robust processes for exploring, feeding back and embedding change processes into service delivery

Current attitudes and efforts towards prevention

- Demonstrated history of CYMHS partnerships and delivery of integrated care with other sectors
- In integrated mental health services, acknowledgment of the (potential) value of CYMHS in the provision of early intervention and tertiary prevention
- Demonstrated interest in and experience by CYMHS in the delivery of effective early intervention and collaborative care e.g. through ACHS feedback on compliance with related National Mental Health Standards
- Strong interest from local education partners to collaboratively achieve the Ed-LinQ vision

Commitment to change

- Awareness of mechanisms for addressing the needs of vulnerable groups in the local setting
- Regional cross-sectoral acknowledgment of the prevalence and impact of child and youth mental problems, and the need to implement systemic reform
- Demonstrated experience of CYMHS compliance with accountability measures for service enhancement
- Demonstrated experience in CYMHS data collection, monitoring and reporting via CIMHA

Capacity to implement change

- Critical mass of population to provide a robust support system in which to embed and implement Ed-LinQ resources via:
  (1) sufficiently large and stable health team with a range of experience to promote career progression through mentoring and supervision;

  (2) number and centralisation of schools;

  (3) number of schools with sufficient support structures/networks; and

  (4) density of available support services.

- Identification of the ideal location for expanded Ed-LinQ resources, including clarity of line reporting and ease of embedding the program into service delivery
- Infrastructure to address challenges provided by geographical distances between stakeholders e.g., access to cars, travel budget, access to technology to facilitate communication
- In the case of those HHSs with an existing Ed-LinQ program, evidence of service (re)orientation to implement the renewed Ed-LinQ model to enable at least minimum compliance with the Ed-LinQ evaluation and reporting framework with program reach only limited by insufficient resources.

5.6.2.2 Demonstration of HHS need to access additional resources to implement the renewed Ed-LinQ model

Seeking additional support to introduce/expand their Ed-LinQ program would require quantification of local demand via a range of data that may include - but is not limited to - the following factors. Access to such data would be facilitated by strong HHS partnerships with stakeholder services including their education providers and local PHN/s.

Population profile:

- Current and projected population, including proportion of children and young people;
- Socio-economic and cultural background of residents; and
- Degree of remoteness.

Health profile:

- Availability and accessibility of local face-to-face support services;
- Rates of health service utilisation, including profiles of referrals by schools to services such as headspace or CYMHS;
- Prevalence of suicide attempts/completion, including presentations to local emergency departments and contacts to headspace school support.

Educational profile:

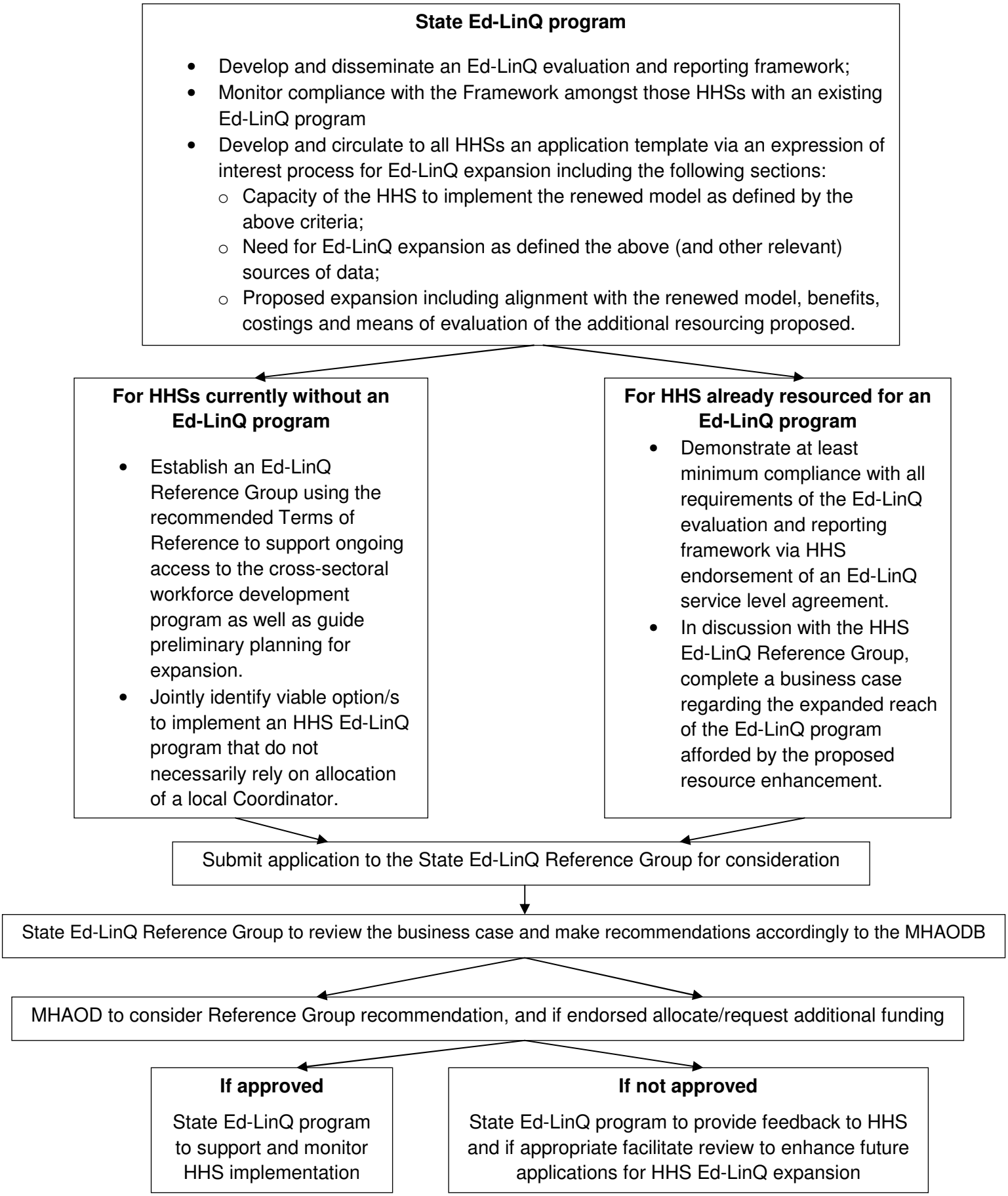
- Current and projected student enrolments;
- Number and type of schools implementing the KidsMatter and/or Mindmatters frameworks, in particular those who have progressed to the component regarding supporting students with mental health problems;
- Numbers and types of schools in the HHS, including the following as settings likely to experience greater mental health needs and/or need for enhanced staff support to manage these:
  - Special schools;
  - Boarding schools;
  - Schools of Distance Education; and
  - Alternative education sites.
- Profile of schools in the HHS according to their Index of Community Socio-Educational Advantage (ICSEA), a sale that is calculated nationally for each school and available on the My School website.
- Proportion of schools in the HHS reporting the proportion of children with one (and more) domains of vulnerability as measured by the AEDC;
- Profile of schools in their HHS regarding attendance, behavioural incidents, suspensions, exclusion and level of achievement towards identified learning targets; and
- Needs analysis of the local education sector/schools/school-based disciplines to identify ongoing gaps that enhancement of the regional Ed-LinQ program could help address.

5.6.2.3 Processes for expansion of the Ed-LinQ program

Future expansion of the proposed Ed-LinQ model needs to be carefully considered, and conducted transparently and equitably. It is recommended that the processes outlined in Figure 2 be undertaken to facilitate this opportunity amongst interested HHSs.

RECOMMENDATION 11: State Ed-LinQ program to consider the expansion process proposed by the Ed-LinQ Renewal Project for endorsement and implementation.

Figure 2. Proposed process for Ed-LinQ expansion contingent on available funding



5.7 Ensure that the development of a performance monitoring framework to inform strategic activities is highlighted for further development following this time-limited project

Ed-LinQ Coordinators have over a long period of time identified the need for greater clarity and consistency in recording and reporting their activities, including to reflect and protect the important early intervention function it serves. Given development of an evaluation and reporting framework is beyond the scope of the current project, Table 2 in Appendix K includes only a brief reference to indicators and measures to gauge the impact of program activities. It is therefore important to expand on these preliminary concepts to provide guidance to HHS Ed-LinQ programs regarding the ongoing delivery and reporting of their work, including accountability for existing and future allocation of Ed-LinQ resources in implementing the proposed model. This is likely to include the development and monitoring of service level agreements. In generating this framework, the state Ed-LinQ program would be well-placed to seek input from interstate stakeholders including NSW School-Link and Ballarat Health Services as well as the international expertise of SMHILE.

RECOMMENDATION 12: State Ed-LinQ program to develop an Ed-LinQ evaluation and monitoring framework in consultation with key stakeholders and the available evidence base.

It should be noted that project discussions yielded significant interest amongst Ed-LinQ Coordinators and CYMHS Team Leaders in being able to track the impact of program implementation through changes in school engagement. At present schools can only be reflected as a referring agent or third party under the general category of "education" on the Consumer Integrated Mental Health Application (CIMHA), the database used by public mental health services in Queensland. This means that trends in referrals and involvement in collaborative care by individual schools can only be accessed via a manual review of case notes, which is labour-intensive and therefore a disincentive for completion. The data collection system preceding CIMHA was pre-populated with individual schools within each district (now HHS). Adding this function to CIMHA as well as including the drop-down name of specific professions associated with school settings would enable monitoring trends in a range of areas including (but not limited to) the following domains:

- Uptake of consultation-liaison offered by the Ed-LinQ program;
- Patterns of referrals and engagement, including in response to critical events or natural disasters;
- Rates of appropriate/inappropriate referrals to CYMHS by schools;
- Trends in presenting problems referred by schools;
- Degree of school involvement in cases accepted to CYMHS; and/or
- Referral options offered for cases referred by schools that are not accepted by CYMHS.

Access to this data by school, education sector and/or school-based profession would facilitate more effective planning of service responses by CYMHS and other sectors as well as help gauge the impact of Ed-LinQ activities. It is anticipated that a full list of all Queensland schools could be imported from the MySchool website, with a function embedded within CIMHA to enable HHS Mental Health Information System Support Officers to collate school data by education sector. This source of data could then be referenced in the evaluation and reporting framework to be developed by the state Ed-LinQ program.

RECOMMENDATION 13: MHAODB to add and maintain the names of all individual schools (by sector) and school-based professions as referring agents and third parties to CIMHA to enhance Ed-LinQ program planning and evaluation.

It should also be noted that the current range of measures included in the proposed Ed-LinQ model reflects the collection of process data only. While findings from self-reports relating to NSW School-Link and Ed-LinQ suggest that access to early detection and collaborative care improves the quality of support offered to

students, it would make a more compelling case if this could be quantifiably demonstrated. Such an approach was attempted by Professor David Kavanagh in evaluating the impact of Dual Diagnosis Coordinators (DDCs), who are employed by Queensland's Department of Health to build the capacity of mental health and ATODS clinicians and systems to deliver integrated care for dual diagnosis issues (co-existing substance use and mental health problems) experienced by their consumers. His research suggested that over time, the clinical support given to case managers by DDCs who were provided with additional skills in dual diagnosis practice, organisational change and the provision of specialist consultation and supervision was associated with a greater proportion of dual diagnosis assessment and interventions (as evidenced by audits of consumer files) than by those case managers whose DDCs who did not receive this additional skills training (personal correspondence, Kavanagh, 06/09/16). Although a long-term, goal, the Ed-LinQ initiative could similarly partner with an academic institution/s to undertake research investigating the impact of early detection and collaborative care on both service providers and the students they support.

RECOMMENDATION 14: State Ed-LinQ program to give future consideration to evaluation of the Ed-LinQ program on the quality and impact of mental health care provided to students.

5.8 Ensure that tailoring of Ed-LinQ resources to meet the needs of vulnerable groups to inform strategic activities is highlighted for further development beyond the duration of this time-limited project.

As noted, some groups of children and young people are at greater risk of experiencing mental health problems. A guiding principle of the renewed Ed-LinQ model is that of equity both in terms of geographical reach (addressed in 5.6) and population groups. Through local knowledge of these groups including mapping their educational engagement and achievement, health status and service access, an HHS Reference Group is in a prime position to tailor the Ed-LinQ program to the needs of its community. This will include developing and aligning specific Ed-LinQ strategies targeting vulnerable groups with other regional resources and activities delivered within and between sectors, as well as those being implemented at the state and/or federal levels. The state Ed-LinQ program would equally benefit from the maintenance of strong links with bodies and strategies representing these groups, including where indicated their inclusion on the state Ed-LinQ Reference Group.

These should include - but are not limited to – the following groups and related strategies, as well any additional strategies prioritised in impending policy documents:

- *Culturally and linguistically diverse (CALD):* An MHPMIPEI program maintained by the Queensland Transcultural Mental Centre; Multicultural Mental Health Coordinators employed by HHSs to enhance the cultural capability of mental health services and the mental health capacity of community agencies supporting CALD populations.
- *Aboriginal and Torres Strait Islander (ATSI):* Closing the Gap strategies including addressing health and educational inequalities experienced by indigenous children and young people; implementation of recommendations arising from the ATSI Child and Youth Health Worker Forum held in March 2016.
- *Children and young people at risk of – or experiencing – abuse/neglect:* Strategic direction included in the Queensland Government's reforms regarding domestic and family violence and enhancing the child protection system. This includes nine Regional Child and Family Committees designed to target local priorities for implementing these reforms, and Evolve Interagency Services in their provision of therapeutic and behaviour support services for children and young people in care.
- *Children in contact with the Youth Justice system:* Strategies include development of the adolescent court liaison service; health and education services delivered to young people in detention' and

specialist consultation-liaison provided to stakeholders supporting young people with mental health needs and offending behaviours.

- *Children and young people with a disability:* Staged implementation of the NDIS, strategies recently introduced by DET including an Autism Hub and the employment of regional autism coaches.

Two vulnerable groups that do not currently appear to have a strong resourcing profile in the state policy landscape are children of parents with a mental illness and young people who identify as lesbian, gay, bisexual, transgender, intersex or questioning. Both groups are known to have significantly higher rates of a range of adverse outcomes including mental health problems, disengagement from education, a non-fatal suicide attempt and/or or death by suicide (e.g., Reupert & Maybery, 2016; Russell & Fish, 2016; Skerrett, Kolves & de Leo, 2016); and yet often go undetected by services. Ed-LinQ programs at the state and HHS levels would therefore also include a focus on these groups to ensure equity of service provision.

Given the breadth of issues involved in service responses to vulnerable groups, the state Ed-LinQ program may wish to consider creating an additional position/s to develop and implement Ed-LinQ strategies at a state level for such groups. This position/s would ideally be co-located with the State Ed-LinQ Coordinator and maintain strong links to the relevant sectors, and would attend the state Ed-LinQ Reference Group to contribute to its strategic planning and implementation. They could also offer a viable option for backfill/succession planning for the state Ed-LinQ Coordinator through their access to specialist knowledge of the state program.

RECOMMENDATION 15: State Ed-LinQ program to ensure alignment of the state and HHS Ed-LinQ programs with strategies targeting vulnerable groups, develop program-specific strategies where required and consider the creation of a state Ed-LinQ position/s focusing on these groups.

Although outside the scope of the project, CYMHS CHQ HHS acknowledges the considerable potential for application of the renewed Ed-LinQ model in educational settings prior to the commencement of primary school. Providing specialist support to kindergarten programs (including those delivered through long day care centres) via consultation-liaison, enhancing capacity and strategic partnerships would significantly enhance the early detection and collaborative care of three to five year olds experiencing mental health problems. This could help alleviate the presentation of children entering primary school with pre-existing emotional and/or behavioural difficulties (as evidenced by AEDC and school suspension data). Such an approach is consistent with the end-to-end continuum of school mental health care recommended by the federal government (Commonwealth of Australia, 2015), and reflects the strong and growing evidence base regarding health interventions as early in life as possible It is also very timely given the current expansion of kindergarten programs across Queensland (including in rural and remote areas) as part of DET's Flying Start reform. Development of the model would require collaborative input from Queensland stakeholders supporting the early childhood sector (such as DET, Creche & Kindergarten Association, Lady Gowrie Queensland, KidsMatter Early Childhood and CYMHS, including the QCPIMH). It may also warrant additional investment in CYMHS capacity to take on this function. Consideration of an equivalent model for early childhood could be informed by learnings from implementation of the renewed Ed-LinQ model - as well as a review of the evidence base in these settings – for development and embedding in service delivery via a staged manner. CYMHS CHQ HHS strongly recommends this approach as a significant return on investment in the mental health of Queensland's children.

RECOMMENDATION 16: State Ed-LinQ program to consider development and implementation of a similar model to support the early detection and collaborative care of mental health problems experienced by children in educational settings prior to their commencement at primary school.

6 Project Recommendations

Below is a summary of the recommendations in full made in Section 5:

1. State Ed-LinQ program to engage the education sector to ensure integration of student well-being and support priorities and directions into the proposed Ed-LinQ model.
2. CHQ to establish and lead a statewide leadership model to implement the Ed-LinQ program.
3. State Ed-LinQ program to develop an Ed-LinQ communication strategy to help inform and engage diverse target groups regarding implementation of the proposed model.
4. State Ed-LinQ program to generate and implement a cross-sectoral workforce development strategy to inform the generation and implementation of counterpart strategies at the HHS level.
5. State Ed-LinQ program to retain the content and delivery format of the Ed-LinQ cross-sectoral workforce development program, and enhance cross-sectoral commitment for collaborative delivery and evaluation of the cascade resource to school settings.
6. State Ed-LinQ program to undertake planning to ensure ongoing sustainability of the Ed-LinQ cross-sectoral workforce development program.
7. State Ed-LinQ program to develop a plan to implement the proposed Ed-LinQ model.
8. State Ed-LinQ program to consider representation of the following stakeholders in the state Ed-LinQ Reference Group: Dovetail, P&Cs Qld, the Federation of P&F Associations of Catholic Schools in Queensland and an appropriately recruited and supported CYMHS consumer/carer.
9. State Ed-LinQ program to consider the proposed content for inclusion in HHS role descriptions in recruiting to future Ed-LinQ Coordinator positions.
10. State Ed-LinQ program to consider any future budgetary allocations for the Ed-LinQ program to address the following priorities: recruitment of a state Ed-LinQ Coordinator; development of a communication strategy; development of an Ed-LinQ evaluation and reporting framework; support for ongoing access to the Ed-LinQ cross-sectoral workforce development program; and expansion of the Ed-LinQ program to those HHS with demonstrated capacity to implement the proposed model and a clear need for expansion.
11. State Ed-LinQ program to consider the expansion process proposed by the Ed-LinQ Renewal Project for endorsement and implementation.
12. State Ed-LinQ program to develop an Ed-LinQ evaluation and monitoring framework in consultation with key stakeholders and the available evidence base.
13. MHAODB to add and maintain the names of all individual schools (by sector) and school-based professions as referring agents and third parties to CIMHA to enhance Ed-LinQ program planning and evaluation.
14. State Ed-LinQ program to give future consideration to evaluation of the Ed-LinQ program on the quality and impact of mental health care provided to students.
15. State Ed-LinQ program to ensure alignment of the state and HHS Ed-LinQ programs with strategies targeting vulnerable groups, develop program-specific strategies where required and consider the creation of a state Ed-LinQ position/s focusing on these groups.
16. State Ed-LinQ program to consider development and implementation of a similar model to support the early detection and collaborative care of mental health problems experienced by children in educational settings prior to their commencement at primary school.

7 Project Conclusions

The QMHC funded CYMHS CHQ HHS to undertake the Ed-LinQ Renewal Project October 2015 to September 2016 inclusive to help enhance the benefits of early detection and collaborative care for children and young people in Queensland experiencing mental health problems. It was strongly informed by previous evaluations of the Ed-LinQ initiative, and undertaken in a time of unprecedented state and national reform that lends itself to greater service innovation and integration. The project adopted a very strong collaborative approach to governance and co-design through consultation with consumer and carer representatives, key service providers, policy makers and the contemporary evidence base. It was implemented within the designated resource allocation, addressed the eight stated objectives and successfully met key milestones throughout its 50 week timeframe.

> "Children are our future. Through well-conceived policy and planning, governments can promote the mental health of children, for the benefit of the child, the family, the community and society".
>
> *World Health Organisation, 2005, p. vii*

A key project deliverable comprised development of a model that was designed to be contextualised within a shared understanding of school focused MHPMIPEI; robust enough to withstand policy and funding changes; and sufficiently broad to encompass emerging issues that fit within a continuum approach to student well-being. The final proposed model articulated Ed-LinQ's rationale, aim, vision, key focus areas, principles, roles and responsibilities, critical success factors, potential risks, program logic, core activities at the state and HHS levels and preliminary program indicators and measures. It also included explicit reference to the enhancement of holistic care provided by the education and mental health sectors to students with existing mental illness to support their recovery. A key message of the model was adoption of the Ed-LinQ program as a core function of CYMHS settings across Queensland. Given the distribution of CYMHS teams across the state, this will greatly enhance the scope of work previously undertaken primarily by Ed-LinQ Coordinators. The model was well-received by HHS CYMHS representatives, although has yet to be endorsed by Executive/Clinical Directors of Queensland's public mental health services. It also requires additional input from the education stakeholders to reflect cross-sectoral commitment to its implementation, with a model of state leadership to be determined by the Department of Health.

The Ed-LinQ Renewal Project developed key documents to guide HHS implementation of the model, and content for inclusion in an HHS role description to aid the recruitment of future Ed-LinQ Coordinators. It articulated a process for expansion for HHSs with an Ed-LinQ program - as well as those without one – to enhance equity of program benefits, and outlined means of ensuring sustainability of the current workforce development program. Finally, the project provided suggestions for the consideration for any future budgetary allocations for the Ed-LinQ program, commentary on the development of an evaluation and reporting framework and guidance on the program's consideration of vulnerable groups. CHQ CYMHS recognises the potentially significant impact of applying a comparable model to early childhood settings, and strongly endorses such an opportunity to embed at an even younger age the timely early detection and collaborative care for mental health problems experienced by Queensland children.

The Ed-LinQ Renewal Project represents an exciting development in the history of school-based mental health service provision in Queensland. Successful implementation of the proposed model has the potential to make a significant difference to the lives of many vulnerable children and young people through strong cross-sectoral commitment to early detection and collaborative care.

It is recommended that the QMHC consider the findings of the Ed-LinQ Renewal Project to progress implementation of the proposed Ed-LinQ model through the Department of Health and DET under the statewide leadership of CHQ HHS.

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