



Evaluation of the Ed-LinQ Initiative  
for the  
Queensland Mental Health Commission

October 2014



## Preface

In February 2014, ConNetica was contracted by the Queensland Mental Health Commission (QMHC) to undertake a review of the Queensland Ed-LinQ Initiative.

The purpose of the project was to develop and implement a framework to evaluate the Ed-LinQ Initiative, including reviewing the associated evidence. This project was conducted from mid-February until late August 2014.

The key research activities that were completed throughout the duration of this project included:

- In-depth face-to-face and telephone interviews with Ed-LinQ Coordinators, Child & Youth Mental Health Service (CYMHS) Directors, Evaluation Working Group (EWG) members, and other national and international experts in child and youth mental health and school-based programs.
- Focus Groups with school personnel and Department of Education Training and Employment staff
- Impact surveys of schools and CYMHS personnel
- Reviews of CYMHS Ed-LinQ local area data and documentation
- Review of the relevant areas of peer-reviewed and grey literature.

This final report details the qualitative and quantitative findings, including proposals to inform current and future policy directions and program initiatives in Queensland.

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### Suggested Citation

Mendoza J, Wands M, Salvador-Carulla L, Hackett M, Najlepszy L & Fernandez A (2014). *Evaluation of the Queensland Ed-LinQ Initiative: a school-community mental health initiative*. Report for the Queensland Mental Health Commission, Brisbane.

## Acknowledgements

The comprehensive nature of the data collected would not have been possible without the active support and commitment provided by:

Dr Simone Caynes, Queensland Mental Health Commission

The Evaluation Working Group members: John Percy, (Queensland Catholic Education Commission), Trish Brady (Independent Schools Association), Judi Krause (Child and Youth Mental Health Service), Dr John Dungan, (Research Services Strategic Policy and Portfolio Relations DETE), Brett O'Connor (Child Safety DETE), Lindy Fentiman (CHECK-Up), Karen Rockett (Mental Health Alcohol and Other Drugs Branch DoH), and Anthony Hillin and Rob McAlpine, NSW Institute of Psychiatry.

The ConNetica team wishes to acknowledge and thank the Queensland Ed-LinQ Coordinators and the many other individuals who contributed to the report within CYMHS, DETE and associated services.

## Abbreviations

Acronym	Meaning
ABS	Australian Bureau of Statistics
ATAPS	Access to Applied Psychological Therapies
CAMHS	Child and Adolescent Mental Health Services (Victoria or NSW)
CBT	Cognitive Behavioural Therapy
COAG	Council of Australian Governments
CYMHS	Child and Youth Mental Health Services
DALYs	Disability-adjusted life-years
DETE	Department of Education, Training and Employment
DoH	Department of Health, Queensland
EDs	Emergency Departments
EWG	Evaluation Working Group
GPO	General Practice Queensland (now CheckUp)
HHS	Health and Hospital Services
ICT	Information and Communication Technologies
ISA	Independent Schools Association
LSE	London School of Economics
MHPPEI	Mental Health Promotion Prevention and Early Intervention
MOU	Memorandum of Understanding
NAPLAN	National Assessment Program – Literacy and Numeracy
NAPMH	National Action Plan for Mental Health
NSSH	non-suicidal self harm
ODD/CD	Oppositional defiant disorder or Conduct Disorder
PCPs	Primary Care Providers
PHOs	Primary Health Organisations
QAS	Queensland Ambulance Service
QCEC	Queensland Catholic Education Commission
QMHC	Queensland Mental Health Commission
QPS	Queensland Police Service
SBHN	School based health nurse
SEL	Social and Emotional Learning (programs)
YAWCRC	Young and Well Cooperative Research Centre

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# Executive Summary

## Introduction

In February 2014, ConNetica was contracted by Queensland Mental Health Commission to undertake an evaluation of the Queensland Ed-LinQ Initiative. The purpose of the project was to develop and implement a framework to evaluate the Ed-LinQ Initiative, including reviewing the associated evidence.

The objectives of the evaluation project were:

- To review available evidence and practice relating to Health-Education collaborations for the early detection and intervention of mental disorders in children and young people.
- To measure the effectiveness of the Queensland Ed-LinQ Initiative against program aims and objectives, as well as benchmarks of effective models and practice.
- The provision of advice regarding current and future directions for the Ed-LinQ initiative and related strategic policy and program initiatives.

In addition, the Commission expressed the desire to use the findings of the evaluation to strengthen the evidence base regarding effective models and strategies for early intervention for children and young people with mental health problems.

This project was conducted in the period from late February to the early September 2014. Given procedures relating to data collection in schools and the inclusion of an additional survey, the final date for this project was extended from 30 June to 5 September 2014.

This final report provides:

- An overview of the Ed-LinQ initiative
- An overview of the evaluation project and the project methodology
- The review of available evidence and practice relating to health and education system collaborations
- The findings of the qualitative and quantitative research, and
- Current and future directions for the Ed-LinQ Initiative.

## Approach

This evaluation took an iterative and formative approach to enable the project evaluation team to consult with the QMHC Project Manager and the Evaluation Working Group (EWG) to reflect on the findings as the project developed and take appropriate agreed actions to adjust or 'pivot' if necessary. A preliminary evaluation



plan was presented to and later endorsed by the QMHC Project Management and the EWG.

Data was collected throughout the project from the Ed-LinQ Coordinators, Child and Youth Mental Health Service (CYMHS) staff, the EWG members, school personnel, national and international thought leaders in child and youth mental health, and other stakeholders via face-to-face interviews, phone interviews, focus groups and on line surveys. A total of 339 individuals have contributed to the data in this report.

## Background

The Ed-LinQ Initiative is a statewide initiative funded through the Queensland Plan for Mental Health (2007-2017) and administered by Department of Health. Ed-LinQ works strategically at a state and district level to improve linkages between the education sector, the primary care sector and the mental health sector. It aims to support these sectors to work collaboratively in order to enhance the early detection and treatment of mental illness affecting school-aged children and young people.

The Ed-LinQ Framework for Action was released in 2010 and was designed to provide a context for Ed-LinQ within the mental health and education sectors and to guide statewide and district governance. The initiative was led by the central policy unit of Queensland Health and developed in partnership with government, independent and catholic schools systems and the peak body for general practice, GPQ.

## Findings

The findings from the qualitative and quantitative research are complimentary and highlight the positive and highly valued impact of the Ed-LinQ Initiative for a significant number of schools across Queensland. However, that positive impact has been limited to some and not all CYMHS districts. The impact has been greatest in areas where schools have 'brought-in' to the Ed-LinQ Initiative recognising the need to partner with CYMHS rather than 'off-load' mental health issues to CYMHS or have limited engagement.

In these areas on the available evidence the Ed-LinQ Initiative has gone a long way to realising the stated objectives of Ed-LinQ – namely forming strategic partnerships, building capacity, and providing clinical guidance. Schools where Ed-LinQ has had a high impact have reported improved referral pathways and access to specialist support, cross agency communication, enhanced workforce capability, more comprehensive school mental health promotion and prevention, better selection and use of available resources and a greater capacity to address the mental health needs of students. There is some evidence to suggest that Ed-LinQ has enhanced young people's mental health, teachers' well being and that it has had a culture change effect on CYMHS.

However, these positive impacts are confined to too few regions and too few schools. This is in a sense unsurprising given the level of resourcing of Ed-LinQ, the lack of statewide infrastructure to support the initiative, the high level of need in schools and the relatively short period since Ed-LinQ's inception.

From the review of the literature and the consultations with national and international thought leaders ten key points relating to health-education collaborations on the early detection and intervention of mental disorders in children and young people are evident. These are listed below.

***Mental health programs for school age children are cost effective***

- Mental health promotion, illness prevention and early intervention in the school aged years is cost effective and has the potential to yield life long benefits across the lifespan, and overcome the potential for life-long disabling effects of unidentified and untreated illness.

***Senior leadership is key to effective cross-sector collaboration***

- *Collaboration starts at the top.* Authority for collaborative cross-sector initiatives involving health, education and community, like Ed-LinQ, needs to come from government and heads of agencies and be reinforced in actions and accountability. Alignment with the strategic priorities of government is beneficial.

***Whole of school approaches are more effective***

- *Whole of school approaches are more effective than single mode programs.*
- Whole-of-school approaches should include a balance between universal and targeted approaches and include early intervention programs for students with existing mental health problems.

***Joint planning and service integration underpins effective outcomes***

- Initiatives and programs must be:
  - Jointly planned and integrated at all points of planning and delivery.
  - Well articulated and marketed
  - Adequately resourced and sustained for the medium to long term to be effective.

***Programs need to be evidenced based***

- School based programming need to reflect the evidence and be part of an integrated whole of school strategy.
- School curriculums must include social and emotional learning.
- Social and emotional learning (SEL) programs must be embedded in curriculums.
- SEL programs that are universal in scope and target every student can prevent and/or ameliorate emotional distress and problem behaviours and enhance mental health, social, emotional and educational outcomes.

***Framework for collaborative actions are important***

- For collaboration to occur at the local school-community health service level, a comprehensive strategy sustained over time is necessary to achieve high rates of implementation and change.
- A sophisticated change strategy is required with the necessary 'hard' and 'soft' infrastructure to gain buy-in, provide sufficient guidance, build capacity and sustain engagement. Both the SEAL/TaMHS (UK) and PBIS (US) programs offer sounds models to emulate.

***The use of online material needs to be increased***

- Information technology including social media, offers a new platform for collaboration, program delivery and engagement with young people.
- The same challenges of coordinating traditional services are presenting with this new operating environment.
- Service integration between the digital and 'real' service environments has to be a goal in the coming five years.

***Effective leadership is critical to success***

- Leadership at state and local levels is critical to success.
- Leadership needs to demonstrate an active commitment to work in a collaborative way and lead reform.

***Measurement is essential to informed practice***

- What gets measured gets done.
- Data that has a focus on the end user (in this context children and young people) and outcomes and that is available on a timely basis for local and state level decision making.
- As in other areas of education like literacy and numeracy, data for improving the mental health and wellbeing of children and young people begins with knowing the status of their mental health and planning accordingly.

**Ed-LinQ initiative – current status and future actions**

Given the constraints of the available data due to inconsistent data collection methods and the inability of the system to capture all Ed-LinQ activities, the evaluation has confirmed that the Ed-LinQ initiative has demonstrated positive impacts in relation to:

- Forming strategic partnerships
- Building capacity, and
- Providing clinical guidance.

To sustain and increase in the short to medium and long term requires a series of integrated actions. These actions must occur at the policy, governance, partnership, and workforce resource and infrastructure levels.

A number of critical actions are required in the short term in regard to strengthening/securing/protecting Ed-LinQ. These are listed below.

**Policy:**

- Renewal of Ed-LinQ Framework that reviews the intent, functions, role and context and aligns with evidence about school focused Mental Health Promotion Prevention and Early Intervention (MHPPEI)
- This should maintain the primary Ed-LinQ initiative as an early intervention strategy with focus on its three main areas: strategic partnership, clinical consultation and capacity building but addresses the organisational, partnership, workforce and other factors that are diminishing impact and return
- Address the factors impeding clear and consistent metrics and data collection
- Establish standards for needs assessment, program planning and review
- Address role clarity of the Ed-LinQ coordinators but also of other key positions and services
- Integrating the Ed-LinQ Coordinator role into CYMHS Teams across the state
- Greater focus on engaging relevant primary care and community services
- Address the appropriate mix and timing of evidence based approaches (i.e. Integrated School Based Mental Health Interventions) based on the framework and the approved programs and interventions for schools
- Customising responses for priority groups (i.e. establishment of an Indigenous Ed-LinQ Initiative to address the specific needs of schools with higher numbers of Indigenous students)
- Integration with school based drug and alcohol initiatives

**Collaboration and Partnership**

- MOU developed and signed
- Set consistent template for governance arrangements at state and HHS levels so required cross sector leadership and engagement for collaboration and integration occurs
- Interagency Collaborations – based on mental health service mapping at regional (HHS) levels with agreed service pathways

**Governance Arrangements**

- State, regional and local school levels with defined roles, responsibilities and accountabilities
- Re-establish the Ed-LinQ state wide meeting group to provide leadership, initiative-wide accountability, priority setting, resource sharing, identification of best practice and strategic change projects

**Workforce**

- Commitment to the full establishment of ED-LinQ Coordinators is required
- Investigating opportunities to enhance the establishment through a joint education and health budget bid given the inadequacies of the allocation, the potential return on investment across sectors etc
- Commitment to continuing the cross sectoral workforce development program and investigation of sustainability of the model (i.e. Strategic Workforce Force Mental Health Capability Framework)

### **Infrastructure**

- Review of necessary infrastructure to support a cross agency initiative (e.g. web platform)
- Re-establish the Ed-LinQ state wide meeting group to provide leadership, initiative-wide accountability, priority setting, resource sharing, identification of best practice and strategic change projects
- Establishment of statewide Ed-LinQ Coordinators network to provide the opportunity to share resources, identify best practice and undertake joint strategic research or pilots
- Build capacity for quality and accurate data and information in regard to mental health needs of young people, service capacity and capability, improved data collection, analysis and reporting to ensure that services target those schools in most need, best practice is identified and the impact of initiatives is understood and quantified to inform future priorities and actions
- A school 'Readiness Assessment Tool' for Ed-LinQ Coordinators and regional leaders for assessing the readiness for change and engagement by schools

## **Longer term initiatives to secure better well being and mental health outcomes for young Queenslanders**

The findings from this review strongly reinforce the long term need to plan and implement a systemic and holistic approach to enhancing the mental health and wellbeing of young Queenslanders (0-18 years) to ensure that positive and sustained improvements are attained. This is a longer-term recommendation but based on the evidence is an imperative for consideration and action. The Ed-LinQ initiative would be one component of this systemic approach.

This systemic approach is built on five pillars: Leadership, Strategy, Governance, Infrastructure and Accountability.

### **Leadership**

- Establish and maintain strong leadership commitment to collaborative action for MHPPEI for school aged and the development of a dedicated strategy, resourcing and reporting on associated initiatives
- State Best Practice Professional Circle of Practice - Ed-LinQ Coordinators and relevant experts to ensure best practice guides and advice are available to all schools

### **Strategy**

- Integrated School Mental Health Program Framework for all schools – integrated universal, selected and targeted mental health and wellbeing programs with a 'gatekeeper' process to ensure all programs or interventions are appropriate from an evidence perspective
- Integrated School Based Mental Health Interventions – based on the framework and the approved programs and interventions for schools

- The mental health professional development needs of roles from a range of sectors that contribute to the mental health and well being of young people

**Governance**

- Governance Arrangements - at the – state, regional and local school levels with defined roles, responsibilities and accountabilities
- Interagency Collaborations – based on mental health service mapping at regional (HHS) levels with agreed service pathways

**Infrastructure**

- Queensland Young Persons Mental Health Annual Check-up – 0-18 years. An annual or biennial survey of the mental health and wellbeing of children and young people across Queensland to establish and monitor health status and enable planned interventions within a state wide plan – The Mentally Healthy Young Queenslanders Strategy.
- A supporting infrastructure – a web-based platform for all stakeholders (including teachers, service providers, students and parents), data collection systems and a marketing and promotion package for state wide and local level promotion of school mental health and wellbeing and the Ed-LinQ Initiative

**Accountability**

- Clearly defined roles and responsibilities and metric to monitor performance and identify outcomes and impact of various activities.

## Introduction

This section of the Report provides an overview of the evaluation project and the methodology used.

### Overview of project stages.

#### ***Stage 1 – Define***

The key activities that were completed in Stage 1 included:

- In-depth face-to-face and telephone interviews with Ed-LinQ Coordinators
- A review of the documentation supporting the establishment and implementation of the Ed-LinQ Initiative
- A review of the relevant areas of peer-reviewed and grey literature, and
- A facilitated workshop with the Queensland Mental Health Commission (QMHC) and the Evaluation Working Group (EWG).

#### ***Stage 2 – Evaluation Planning and Development***

The key activities that were completed in Stage 2 included:

- Implementation of project communication
- Continuation of the literature review and document analysis
- Development of all data collection tools, and
- Application for and resolution of ethics approval for schools.

#### ***Stage 3 – Data Collection***

The key research activities that were completed in Stage 3 included:

- In-depth face-to-face and telephone interviews with CYMHS Directors, EWG members, and other national and international experts in child and youth mental health and school-based programs
- Focus Groups with school principals, guidance officers and welfare support staff and regional office staff
- Impact surveys of schools and CYMHS and other stakeholders, and
- Reviews of CYMHS Ed-LinQ local area data and documentation.

#### ***Stage 4 Communication and Reporting***

This stage has focused on strategic and detailed analysis of the data and consideration of other relevant national and state policy and program initiatives relevant to the future of Ed-LinQ and the preparation of the draft report for the EWG and QMHC.

## Project Governance

A project reference group, known as the Evaluation Working Group (EWG), made up of representatives from the three education sectors (government, independent and catholic), CYMHS, Queensland Health, primary care and the QMHC was formed at the commencement of the project. The EWG met on three occasions and was regularly updated by the project team and QMHC throughout the evaluation. EWG members also assisted with the distribution of surveys and advising on protocols with schools. A copy of the Terms of Reference is included at Appendix 1.



# Methodology

## Introduction

### Framework for Evaluation

A planned approach to evaluate the impact and efficacy of the Ed-LinQ Initiative was developed in conjunction with the Framework for Action. A program logic model was used to develop the evaluation work. It is shown below in Figure 1.

Figure 1: Program Logic Evaluation Framework for Ed-LinQ

Strategic Focus Area	Strategic Partnerships	Enhancing Capacity	Clinical Guidance
	↓	↓	↓
Key State Actions	Collaborative development & evaluation of effective statewide formalised & strategic cross- sectoral partnerships & governance	Development & evaluation of culturally relevant, evidence based workforce development strategy for Ed-LinQ workforce & education sector workforce	Collaborative development & evaluation of Ed-LinQ clinical guidance model; child & youth mental health information source for education sector
Key District Actions	Collaborative development & evaluation of effective local formalised & strategic cross-sectoral partnerships & governance	Coordination, support & evaluation of targeted, culturally relevant, evidence based professional development activities & resources for stakeholders	Development, maintenance & evaluation of clinical referral pathways; provision of consultant liaison to education sector staff
Short Term Outcomes	Improved communication & shared commitment to Ed-LinQ vision	Improved access to evidence based child & youth mental health training & resources	Increased understanding of stakeholder resources & capacity; increased access to consultant liaison; increased coordination of services across sectors
Medium Term Outcomes	Strong & effective partnerships between sectors & stakeholders	Improved understanding of child & youth mental illness across sectors	Strong & coordinated clinical pathways in use within education sector; supported by consultant liaison; increased focus on mental health in education sector policy
Long Term	Seamless communication,	Early detection of emerging mental	Timely, accessible early intervention for

Outcomes	collaboration & integration across sectors	disorders in Queensland students	emerging child & youth mental illness; strong cross-sectoral commitment to supporting child & youth mental health
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The policy framework for the Ed-LinQ Initiative is consistent with supporting these broad outcomes for students.

## Literature Review

An extensive review of the literature was initiated at the commencement of the project principally to inform the response to:

- To review available evidence and practice relating to Health-Education collaborations for the early detection and intervention of mental disorders in children and young people, and
- The provision of advice regarding current and future directions for the Ed-LinQ initiative and related strategic policy and program initiatives.

The early literature review work also assisted in framing the questions and issues for the indepth interviews and later the surveys of schools and CYMHS staff and other service providers of mental health and related services. The review in the early stages included a focus on the policy and program documentation supporting the establishment and implementation of Ed-LinQ.

While there are hundreds of peer-reviewed publications on school based mental health and substance abuse programs, there remains a lack of rigorous evaluation and longitudinal measures, not just in Australia but globally. A number of systematic reviews and a rapid evidence review were included in the analysis.

### **Key Words used for searching:**

School mental health programs; child and adolescent mental health problems; promotion, prevention, early intervention; collaborative models for school health programs; student wellbeing; referral pathways; evaluation; professional development; workforce development.

### **Search sites:**

PubMed and PubMed Central: [www.pubmed.gov](http://www.pubmed.gov); Cochrane database: [www.cochrane.org](http://www.cochrane.org); Highwire press: <http://highwire.stanford.edu>; Open Medicine: [www.openmedicine.ca](http://www.openmedicine.ca); PLoS Medicine: <http://medicine.plosjournals.org>

Citation lists from the studies and reviews retrieved were also hand-searched for further studies. Previous recent literature reviews conducted by the authors on service integration, collaboration and collective action were also reviewed.

A range of government agency sites as well as peak bodies and significant school mental health research institutions from within Australia and overseas have also been searched. Extensive grey literature has been included in the review. Unpublished policy and planning

documents from Queensland Health have also been reviewed but are not listed in the literature review.

### ***Process for Inclusion***

From the initial searches, titles of papers relevant to the project objectives were highlighted and abstracts (N=438) obtained. One member of the team then reviewed all selected abstracts, selected articles based on a five point scale of relevance and coded each article according to a preliminary set of key themes and issues: data type; location of publication; school level/location; and type of service model. A second reviewer (LN) also reviewed and coded articles. Both reviewers then reviewed and summarised all included literature – a total of 141 peer-reviewed publications, grey literature and other publications. This does not include Queensland Health and local Ed-LinQ Coordinators' documentation.

The list of key themes and issues was expanded during the review. The final list of key themes and issues from the literature is as follows:

- Integrated or Collaborative Population health data – selected prevalence and service capacity for children and young adults in Queensland.
- General mental health services for children and young adults
- Clinical and Community Service Models for children and young adults
- General School Mental Health Policy, Plans & Programs
- School Mental Health Promotion & Prevention Programs
- School-based mental health services (Early identification and Intervention)
- Integrated or Collaborative Mental Health Service Programs or models
- Workforce Development Programs or models
- Economic case for investment
- Partnerships in schools, communities and health.

Benchmarks or performance data was not identified as a separate theme but a number of articles and publications addressed these issues.

## **Ed-LinQ Documentation Review**

An examination of the policy documentation for the development, approval and implementation of the Ed-LinQ Initiative was undertaken by the project team. This included documents dating back to 2007 on the scoping and planning of the project within the context of the Queensland Mental Health Strategy and Plan.

It included:

- Draft discussion and planning documents
- Implementation plans

- Evaluation frameworks and templates
- Reports from Forums and the cross-sector workforce development forums, and
- Newsletters from Ed-LinQ Coordinators.

In several Districts (including Ipswich, Gold Coast, Sunshine Coast, Mackay and Metro North) an analysis of available documentation provided by the Ed-LinQ Coordinator was also undertaken.

## Indepth Interviews

Face-to-face or telephone interviews were conducted with a range of interviewees throughout the project. Interviews were conducted by one member of the project team. Detailed notes were taken and word-processed. The majority of interviews were also recorded.

Initial indepth interviews were held with the Ed-LinQ Coordinators. These interviews ranged between 70 and 120 minutes. These interviews focused on the Ed-LinQ Coordinator role, local governance arrangements, model of service delivery or school engagement, local documentation (e.g. referral pathways), data, related initiatives, CYMHS and HHS support, and workforce development and future improvements to the initiative.

A number of Coordinators were able to share documentation and data from their region. This data were analysed by members of the project team.

Interviews, most often face-to-face, were conducted with EWG members and national and international leaders in child and youth mental health (called 'Thought leaders' in this report). For EWG members the interviews focused on many of the same issues as for the Ed-LinQ Coordinators but included matters relating to their broader roles.

The interviews with 'Thought leaders' focused on their areas of expertise in school based mental health, child and youth mental health services, integrated models and the emergence of Internet and social media services for young people.

All interviews were analysed to identify key themes by project team members. A full list of interviewees is included in Appendix 2.

## Focus Group Discussions

Four focus groups sessions were conducted following the completion of a comprehensive DETE ethics approval process. Two meetings were also conducted or observed. These were conducted in areas known to have a high level of Ed-LinQ activity, namely Sunshine Coast, Gold Coast and Mackay.

The focus groups involved principals from primary and secondary schools or colleges, guidance officers, other student welfare school staff and regional office staff. The total number of focus group participants was 36. All three school sectors were represented in three of the four focus groups. The discussions were structured around exploring the impact of the Ed-LinQ Initiative on schools in the region, the local governance structures, the partnership building processes and any evidence of success.

Approval for inviting participation in the focus groups for school personnel followed ethics clearance from DETE.

## Online Survey Data

Two surveys were developed targeting schools and CYMHS staff and other mental health and health service providers. The survey for schools and supporting documentation (participant information, consent forms etc.) were submitted to DETE for approval.

The online schools survey was developed by the project team based on the literature, the document analysis and on the results from the initial interviews with CYMHS Ed-LinQ Coordinators, national and international thought leaders and the EWG. A copy of the final survey is included as Appendix 3.

Following ethics approval from DETE, email invitations were sent to all Queensland public schools. As per DETE requirements, these emails were sent to school principals. A total of 1,272 public schools were sent the invitation to participate in the survey. Two follow-up reminder emails were sent approximately three and seven weeks following the initial invitation. A copy of the email, survey and the supporting documentation are contained in Appendix 4.

Mail Chimp, electronic mail software, was used to support distribution of the online schools survey and enhance response rates with all government schools. Mail Chimp enabled the research team to identify schools that had not opened and/or clicked on the link to the survey and target the reminder notices. The engagement of Queensland government schools is shown in Figure 2 below. This facility could not be used with Independent and Catholic schools due to the devolved distribution systems.

Figure 2: Ed-LinQ Schools Survey - Qld Government Schools Engagement

	Initial Invitation 3/6/2014	1 <sup>st</sup> Reminder 26/6/2014	2 <sup>nd</sup> Reminder 24/7/2014	Overall
Emails sent to primary schools	1005	931	801	
Number opened	83 (8%)	120 (12.8%)	49 (6%)	252 (25%)
Emails sent to secondary schools	267	220	195	
Number opened	47 (17.6%)	25 (11%)	17 9%	89 (33%)
Total emails sent	1272	1151	996	
Number opened	130 (10%)	145 (12.6%)	66 (6%)	341 (26.8%)

The same information was forwarded to the Queensland Catholic Education Commission and the Independent Schools Association for distribution through their distinct systems to school principals. A total of 186 independent Schools were sent the invitational emails and survey. All independent schools were sent reminder notices at approximately the same dates as government schools. In the case of the catholic schools, the invitational email and related information were sent to the five Queensland Dioceses who in turn were asked to distribute to all 269 catholic schools across the state. The project team had no way of verifying if all catholic schools received the email invitation.

A second online survey was developed targeting CYMHS staff and other mental health and health service providers. CYMHS District/HHS directors distributed this as a single email distribution list was not available due to organisational changes. Therefore it is not possible to determine a response rate to the survey invitation..

Quantitative data analysis was undertaken using STATA SE 12 software. A descriptive analysis of the responses was performed. In addition, the project team analysed the impact of Ed-LinQ on schools and the CYMHSs and other mental health and health service providers. Schools and CYMHS were classified into two broad groups: 1) those where Ed-LinQ had a low impact/low implementation, and 2) those where Ed-LinQ had a high impact/high implementation. The responses between those with high and low impact/implementation were then compared.

## Background

This section provides an overview of the Ed-LinQ Initiative and the policy context during the period since its inception to the present.

### About the Queensland Ed-LinQ Initiative

The Ed-LinQ Initiative is a statewide initiative funded through the Queensland Plan for Mental Health (2007-2017) and administered by Queensland Health. Ed-LinQ works strategically at a state and district level to improve linkages between the education sector, the primary care sector and the mental health sector. It aims to support these sectors to work collaboratively in order to enhance the early detection and treatment of mental illness affecting school-aged children and young people.

The Ed-LinQ Framework for Action<sup>1</sup> was released in 2010. It was designed to provide an overall framework providing a context for Ed-LinQ within the mental health and education sectors and to guide statewide and district governance. The initiative was lead by the central policy unit of Queensland Health and developed in partnership with government, independent and catholic schools systems and the peak body for general practice at the time, GPQ. The structure and function of Ed-LinQ was set out as shown in Figure 3 below.

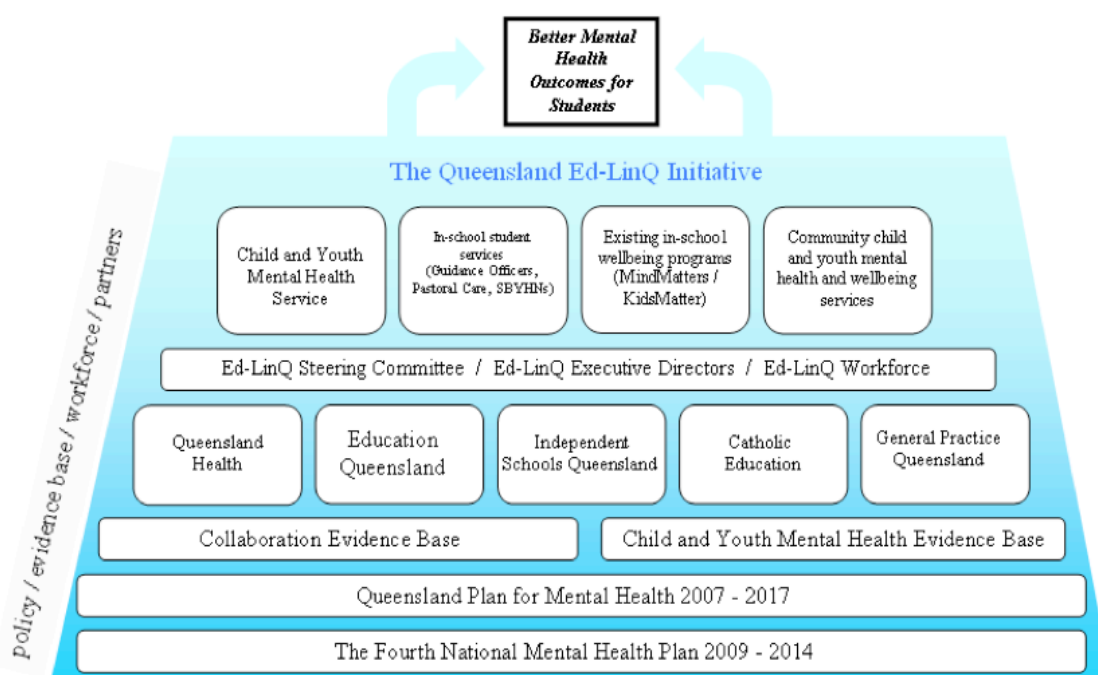


Figure 3: The Ed-LinQ Structure and Function

The Framework document emphasizes the importance of good mental health for children and young people to succeed in education and learning. It includes data to support the 'collaborative' approach which lies 'at the core of the Ed-LinQ Initiative' and the need for early detection and intervention.

<sup>1</sup> The Queensland Centre for Mental Health Promotion, Prevention and Early Intervention (2010). *The Queensland Ed-LinQ initiative: A framework for action*. Mental Health Alcohol and Other Drugs Directorate, Queensland Health.

Ed-LinQ is not a program or specific intervention as such, but a framework for collaborative action. It builds on existing resources within the mental health, primary care and education sectors, enhancing their capacity to respond to mental illness in students by improving and formalising the interface between the sectors.

Ed-LinQ was implemented in 12 regions across Queensland from 2009-2010.

*"The Queensland Ed-LinQ initiative enhances the capacity within sectors by providing a strategic interface between sectors, which adds value to the current service system without replicating existing services"<sup>2</sup>.*

## Key Ed-LinQ assumptions

Four key assumptions were identified in the Framework and foundation documentation of Ed-LinQ, namely that:

- Mental health prevention and early intervention for emerging mental illness will improve the resilience and mental health of students, which in turn improves educational outcomes.
- Improved collaboration between schools and mental health agencies will promote early identification and prevention of mental illness.
- The authority and resources made available to districts, services and practitioners by the Ed-LinQ initiative will support the Ed-LinQ vision.
- Cross-sectorial commitment to the Ed-LinQ initiative will be maintained.

## Strategic Focus

Three strategic focus areas for the Ed-LinQ Initiative at state and district levels are:

- **Strategic partnerships** - the development of collaborative interdepartmental and interagency relationships at a state and HHS level. At the state level, this includes planning and governance mechanisms and the development of an interagency memorandum of understanding. At a HHS level, this includes the development of protocols and mechanisms, which facilitate interagency and interdepartmental coordination and collaboration.
- **Enhancing capacity** - refers to processes that increase the knowledge, skills and understanding of stakeholders regarding mental health and mental illness in children and young people. At the state level, this will include the development and implementation of joint workforce development strategies for the mental health, education and primary care sector personnel. At the HHS level, this includes the coordination of and support for mental health professional development activities for education and primary care stakeholders.
- **Clinical guidance** - enhancing the care system through the provision of mental health consultation services; the development of clear, comprehensive referral

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<sup>2</sup> Ibid, pg 5.



pathways; and shared care models. At the state level, this includes the development of consultation liaison protocols to guide the practice of district Ed-LinQ Coordinators, as well as the development of child and youth mental health and mental illness information for distribution to state-level education sector stakeholders. At the HHS level, clinical guidance involves attendance at relevant district meetings where student mental health and mental illness is discussed, as well as the development, distribution and support of continually updated referral pathways for students identified as experiencing a mental illness.

## The Role of Education

It is worth restating in the context of this evaluation, the role of education in Australian society. In its broadest terms, education is the provision of formal or informal instruction to develop skills and to acquire knowledge, understanding, values and attitudes that will allow students to operate effectively in society and to succeed in life in personal, social and economic terms<sup>3</sup>.

An effective school education system supports student development across a range of skill areas<sup>4</sup>. It contributes to:

**Academic attainment** – based on the acquisition of academic skills and qualifications that demonstrate individual ability and provide a platform for further education, vocational training and employment

**Vocational preparation** – based on the identification of vocational interests and skills that prepare individuals for employment

**Social skills** – based on the development of behavioural management, communication and interpersonal skills that allow individuals to interact with other people and to build friendships and personal relationships

**Engagement as a citizen** – based on an understanding of individual rights and responsibilities, social institutions and values

**Emotional and spiritual wellbeing** – based on the development of a sense of personal and cultural identity and self-worth

**Physical health** – based on an understanding of how to manage personal and family health, maintain a healthy environment and access available services to meet health needs.

As in the health sector, there has been intense level of national and state reforms to the education sector. The development of the national curriculum, the introduction of

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<sup>3</sup> Council for the Australian Federation (2007). *The Future of Schooling in Australia*. Federalist Paper 2.

<sup>4</sup> Doyle L and Hill R (2012) *Our Children Our Future – Achieving Improved Primary and Secondary Education Outcomes for Indigenous Students*. A report published by AMP Foundation, Effective Philanthropy and Social Ventures Australia.

the NAPLAN testing program in 2008, the National Secondary Schools Computer Program (i.e. digital education revolution), the 'Building the Education Revolution' infrastructure program, the Independent Public Schools Program, funding formulae changes, the Gonski Review, the 'Great skills. Real opportunities' program reforming the interface between secondary schools and further education, and changes to school structures (i.e. extension of the state colleges and the 'Flying Start' program affecting the transition from primary to secondary school).

The extent of and contiguous nature of the reforms is important in the context of the education sector and its capacity to maintain a focus on initiatives like Ed-LinQ.

A national survey of over 2,000 school principals in late 2011, showed that three of the top sources of stress for them were the volume of work, the lack of time to focus on teaching and learning and managing government initiatives. The mental health of students was also in the top third of the 19 major sources of stress and concern for secondary principals<sup>5</sup>.

## The Health Policy Context

Ed-LinQ was introduced during a period of unprecedented investment by all Australian Governments in mental health services under the Council of Australian Government's National Action Plan for Mental Health 2006-11. During this period, an estimated additional \$8 billion was committed to mental health services by all governments<sup>6</sup>. The Queensland Government investment grew by \$983.3m over the five years of the NAPMH. However Queensland's growth in investment in promotion, prevention and early intervention was the lowest of any jurisdiction at just 1.7% with the combined average of all jurisdictions at 10.2%.

The Queensland Plan for Mental Health (2007-2017) was framed in the context of the what could be termed the 'COAG intervention' by the Prime Minister, Premiers and Chief Ministers with a focus on both collaboration and investment in prevention and early intervention.

The development of the Fourth National Mental Health Plan (2009-14) also reflected the shift in policy thinking to whole-of-government planning, collaboration, service integration and prevention and early intervention.

With the election of the Rudd Labor Government in late 2007, an ambitious agenda for health and hospital reform was developed. The reform agenda was informed by

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<sup>5</sup> Riley, P (2013) *The Australian Principal Health and Wellbeing Survey: Final Report*. Faculty of Education, Monash University, Clayton, Victoria

<sup>6</sup> Rosenberg S, Mendoza J and Russell L (2012) *Well meant or well spent? Accountability for \$8 billion of mental health reform*. MJA, 196; 3: 159-161.

the National Health and Hospital Reform Commission<sup>7</sup>. However it was almost two years after the Commission's report was handed to the Federal Government that Prime Minister Gillard was able to negotiate a National Health Reform Agreement in early 2011<sup>8</sup>.

A number of these reforms have relevance to the operational context of the Ed-LinQ Initiative, in particular the establishment of Medicare Locals for planning and coordination of primary health care, and the establishment of Local Hospital Boards (known as Health and Hospital Services in Queensland).

The development of Medicare Locals has provided a stronger organisational structure for primary care. This is most notable in areas where private practitioners are poorly distributed or completely absent.

The establishment of HHS has seen devolution of responsibility to the Boards of the HHS and a reduction in state-wide roles from Queensland Health. For the Ed-LinQ initiative, this saw the three state-wide roles gradually removed from 2012.

The announcement by the Abbott Government to replace the 61 Medicare Locals across Australia with an unspecified but significantly fewer number of new entities, Primary Health Organisations. The new PHOs will commence operation in July 2015. It is unclear as to how PHOs will relate to or align with HHS for care planning and service integration work. There can be little doubt that the effect of this change will be further disruption to nascent health reform and will diminish the capacity of the 'players' to focus on clients and service outcomes.

## The Prevalence and Etiology of Mental Health Problems in Children and Young People

### Prevalence

It is now well established that the substantial proportion of mental health problems in adults originate early in life and that the impact can be lifelong<sup>9</sup>. In Australia surveys indicate that between 14-18% of children and young people (4-16 years) will experience clinically significant mental health problems in any 12-month period. This equates to nearly 700,000 individuals<sup>10</sup>.

In the years 16-24, the incidence of mental health problems increases with nearly one in three young women and one in four young men experiencing a clinically significant

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<sup>7</sup> National Health and Hospitals Reform Commission (2009) *A healthier future for all Australians: final report*. Canberra: Commonwealth of Australia.

<sup>8</sup> Mendoza J, Rosenberg S and Russell L (2014). *Budget 2014: Policy Briefing Papers*. ConNetica, Caloundra.

<sup>9</sup> Kessler RC, Angermeyer M, Anthony JC et al (2007). *Lifetime prevalence and age of onset distributions of mental disorders in the World Health Organisation's World health Health Survey Initiative*. *World Psychiatry*; 6: 168-176.

<sup>10</sup> Whiteford HA, Buckingham WJ, Harris MG, Burgess PM, Pirkis JE, Barendregt JJ & Hall WD (2014). *Estimating treatment rates for mental disorders in Australia*. *Aus Health Review*, 38:80-85.

mental health problem<sup>11</sup>. More recently, a national Computer Assisted Telephone Interview (CATI) survey of 700 males (16-24 years) found 1) 1 in 5 young men report thinking about killing themselves in last 12 months and 2) Young men do not seek help & many young men are not using services until they reach crisis point<sup>12</sup>.

In Queensland, a recent report provided estimates of prevalence rates for children and young people with mild, moderate and severe mental disorders in 2011-12. For children 0-14 years the prevalence rate was 15.4% (or 138,623 persons) – 8.8% mild, 4.4% moderate and 2.2% severe. For those young people aged 15-24 the overall prevalence rate was estimated at 19.8% - 10.9% mild, 5.6% moderate and 3.4% severe. No estimates on treatment rates or service access for children and young adults are provided<sup>13</sup>.

There is some evidence to support the case that anxiety disorders and non-suicidal self-harm (NSSH) among Australian children and young adults are increasing but more data is needed. A recent New Zealand study of secondary school students however, showed a slight decline in aspects of self-reported mental health problems between 2007 and 2012. The authors of the study make the point that more ongoing monitoring and provision of evidence based interventions that prevent mental ill health and promote psychological wellbeing are required<sup>14</sup>.

## Impact of Mental Health Problems in children and young adults

Recent evidence compiled by the World Health Organization (WHO) indicates that 'by the year 2020, childhood neuropsychiatric disorders will rise by over 50% internationally to become one of the five most common causes of morbidity, mortality and disability among children'<sup>15 16</sup>. For young people neuropsychiatric disorders are a leading cause of disability accounting for 15-30% of the disability-adjusted life-years (DALYs) lost during the first 30 years of life<sup>17</sup>.

<sup>11</sup> Australian Institute of Health and Welfare (2011). *Young Australians: their health and wellbeing 2011*. Canberra.

<sup>12</sup> Burns, JM, Davenport, TA, Christensen, H, Luscombe, GM, Mendoza, JA, Bresnan, A, Blanchard, ME & Hickie, IB (2013). *Game On: Exploring the Impact of Technologies on Young Men's Mental Health and Wellbeing. Findings from the first Young and Well National Survey*. Young and Well Cooperative Research Centre, Melbourne.

<sup>13</sup> Diminic S, Harris M, Sinclair D, Carstensen G & Degenhardt L (2013) *Estimating the community prevalence and treatment rates for mental and substance use disorders in Queensland: Report to the Qld. Mental Health Commission*. Brisbane.

<sup>14</sup> Fleming TM, Clark T, Denny S et al (2014). *Stability and change in the mental health and wellbeing of New Zealand secondary school students 2007-2012: results from the national adolescent health surveys*. ANZ J of Psychiatry; 48 (5) 472-480.

<sup>15</sup> National Institute for Mental Health (2002)

<sup>16</sup> Gore FM, Bloem PJ et al (2011). *Global burden of disease in young people aged 10-24 years: a systematic analysis*. Lancet 377:2093-2102.

<sup>17</sup> Kieling C et al (2011). *Child and adolescent mental health worldwide: evidence for action*. The Lancet, 378; 9801 1515-1525.

Prevention and early intervention in childhood and early adulthood already offer the opportunity to avoid later mental health problems and improve personal wellbeing and productivity<sup>18</sup>.

In Australia, mental health problems in children and young adults represents a major public health issue and are leading cause of disability for males and females 10-14 years and the leading cause of death for males and females 18-24 years.

Childhood and adolescence are key developmental periods during which severe mental illness emerges, and social exclusion and disability may evolve. Half of all lifetime mental disorders start by 14 years of age and three quarters by 24 years of age<sup>19</sup>. The onset of mental health problems in young people is associated with high rates of enduring disability, including educational failure, impaired or unstable employment, and poor family and social functioning. The impact of any mental health problem at this stage of life can be profound with substantial disruptive effects on these important developmental processes, which can result in major long-term impairments for the individual<sup>20 21</sup>.

The effects of mental illnesses on children and young adults are substantial with the individuals' social, emotional and academic or vocational functioning affected. If left untreated, the affects of common mental illnesses can continue to adulthood with further occupational, economic and personal difficulties arising.

Children who are mentally healthy are better able to:

- Learn
- Experience stronger relationships with teachers, family members and peers
- Negotiate challenges including the transition into adolescence and then adulthood
- Achieve long-term education and career goals, and
- Enjoy a better quality of life. When early signs of difficulty are not addressed; mental health problems can potentially become more serious and possibly extend into mental disorders. For those experiencing mental disorders, early intervention and a more supportive environment can lead to better mental health outcomes later in life.

Evidence now shows that treatment delay contributes significantly to poor outcomes for young people who develop schizophrenia and the spectrum of non-affective

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<sup>18</sup> Ibid, pg 1516.

<sup>19</sup> Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. 2005. *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication*. Arch Gen Psychiatry; 62: 593–602.

<sup>20</sup> Masten AS, Burt KB, Roisman GI, Obradovic J, Long JD, Tellegen A. 2004. *Resources and resilience in the transition to adulthood: continuity and change*. Dev Psychopathol; 16: 1071–94.

<sup>21</sup> McGorry P. 2005. *Every me and every you': responding to the hidden challenge of mental illness in Australia*. Australas Psychiatry; 13: 3–15.

psychoses<sup>22</sup>. The 'critical theory hypothesis' that social disability develops in the prodromal stage and that during the early phase of illness development is where long-term disability and severity trajectories are formed<sup>23</sup>. In practical terms this means that the inability to obtain or retain employment are often early indicators of serious mental health problems.

## Access to Services

A growing body of evidence now indicates that the opportunities for preventing mental ill health are greatest when focused on children and young people and that early intervention strategies can be effective in preventing or delaying the onset of these disorders, and certainly alleviating the 'collateral damage' to the individuals' social, educational and vocational functioning and family dynamics<sup>24 25</sup>.

This is then, the key period for focusing preventative efforts and evidence based interventions. Yet in Australia until recently there have been few large-scale initiatives to significantly increase the access to and quality of care for children and young people. Indeed, there remain no national large-scale efforts focused on children 0-12 years.

For children in Australia only a minority with clinical levels of symptoms receive professional services<sup>26</sup>. These range from just 2% to 25% in the peer-reviewed literature.

Both traditional primary care (largely General Practitioner) and community mental health teams have shown low engagement with young people therefore rendering them ineffective in delivering evidence-based interventions for young people developing mental illnesses<sup>27 28</sup>. However, new service models such as headspace and digital-platform based services such as Reachout.com are improving access rates for young people aged 12-25 years<sup>29 30</sup>.

Estimates for the treatment rates for children and young people in Queensland have not been published but estimates of the rates of access in Victoria completed for the

<sup>22</sup> Marshall N, Lewis S, Lockwood A, Drake R, Jones P, Croudace T. 2005. *Association between duration of untreated psychosis and outcome in cohorts of first episode patients: a systematic review*. Arch Gen Psychiatry; 62: 975–83.

<sup>23</sup> Birchwood M, Todd P, Jackson C. 1998. *Early intervention in psychosis. The critical period hypothesis*. Br J Psychiatry; 172: s53–9.

<sup>24</sup> National Advisory Council on Mental Health (2011). *Models of collaborative care for children and youth (0-25 years): Final Report*. Canberra: Commonwealth Department of Health Ageing.

<sup>25</sup> Institute of Medicine (2009). *Preventing Mental, Emotional and Behavioural Disorders Among Young People: Progress and Possibilities*. Washington DC.

<sup>26</sup> AIHW (2002). *Australia's children: their health and wellbeing 2002*. AIHW: Cat No. PHE 36, Canberra

<sup>27</sup> Rickwood DJ, Deane FP & Wilson CJ (2007) *When and how do young people seek professional help for mental health problems*. Med J Aust, 187 (7 Supp): S35-39.

<sup>28</sup> Craig T, Garety P, Power P et al. 2004. *The Lambeth Early Onset (LEO) Team: randomised controlled trial of the effectiveness of specialised care for early psychosis*. BMJ; 329: 1067–9.

<sup>29</sup> Rickwood DJ, Telford NR, Parker AG, Tanti CJ & McGorry PD (2014). *Headspace – Australia's innovation in youth mental health: who are the clients and why are they presenting?* MJA 200(2), online 13/01/14, pp 1-4.

<sup>30</sup> Burns, JM, Davenport, TA, et al 2013.

Premier's office in 2006 showed that Child and Adolescent Mental Health Services saw fewer than 30% of the estimated number of high risk children in any one year and almost none of the children deemed low or moderate risk<sup>31</sup>.

## Pathways to child and adult mental illness

The search for new pathways to young adult and adult psychiatric illness has shifted focus in recent years from simplistic models of genetic predetermination. A growing body of evidence finds that childhood trauma and adversity establishes vulnerability to mental disorders in a non-specific but powerful way<sup>32</sup>. Psychosis in young adults has also been found to be associated with a history of child sexual abuse<sup>33</sup>.

The mechanisms by which such environmental factors (such as abuse and neglect) interact with genetic predispositions to cause critical changes in development of the adult brain are only just starting to be elaborated. Further, it is increasingly likely that some of these changes not only affect the individual with the illness but may also lead to basic changes in their genetic structure that may then be passed onto future generations by traditional genetic or novel epigenetic mechanisms. One example of this complex interaction is the relation between childhood trauma, cannabis consumption and the development of psychosis<sup>34</sup>.

While most childhood-onset anxiety and depression are transient or self-limiting disorders, and typically occur in the context of family and social difficulties, a significant subset are due to a range of other genetic and brain developmental difficulties. More severe or more disabling conditions may occur in up to 5 percent of primary school aged-children. The latter conditions are more likely to become chronic and disabling and result in significant difficulties with attendance at pre-school and primary school. Some specific conditions, such as obsessive-compulsive disorder are particularly disabling and are often associated with other neurological conditions such as Tourette's syndrome.

For children, the strongest predictor of future mental health problems is the current level of mental health problems they are experiencing<sup>35</sup>. Childhood experiences of trauma, neglect and abuse are also highly correlated with the development of mental

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<sup>31</sup> Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: the next wave of reform*. Prepared for the Dept. of Premier and Cabinet, Melb.

<sup>32</sup> McLaughlin K, Greif Green J, Gruber MJ, Sampson NA, Zaslavsky AM, and Kessler RC (2010) Childhood adversities and adult psychopathology in the National Comorbidity Survey Replication (NCS-R) II: Associations with persistence of DSM-IV disorders. *Arch Gen Psychiatry*; 67(2): 124–132

<sup>33</sup> Janssen I, Krabbendam L, Bak M, Hanssen M, Vollebergh W, de Graaf R, van Os J. Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatr Scand*. 2004 Jan;109(1):38-45.

<sup>34</sup> Houston JE, Murphy J, Shelvin M & Adamson G. (2011). *Cannabis use and psychosis: revisiting the role of childhood trauma*. *Psy Medicine*; 41 (11) 2339-2348.

<sup>35</sup> Hill L, Cole J, Lochman J et al (2004) *Effectiveness of early screening for externalising problems: issues of screening and utility*. *J Consulting & Clinical Psy*. 72: 809-820



illness in late childhood and early adulthood. It is therefore of great concern that rates of child abuse and neglect are rising rapidly<sup>36 37</sup>.

Equally concerning are the reports on bullying and cyber-bullying and its affects on mental health. Recent research shows bullied boys have significantly higher rates of depression and anxiety and lower self-esteem. Rates of self-harm were four times higher among boys who have been bullied<sup>38</sup>.

The Victorian Office of the Child Safety Commissioner<sup>39</sup> summarized the effects of abuse and neglect on learning and development as shown in the following table.

The experiences of childhood, adolescence, adulthood and old age present unavoidable points of change in our lives. These transitions can create vulnerability and stress, as can decisions about relationships, work and family, as well as 'crisis points' such as the death of a loved one. Equally, such changes and events present great opportunities for learning and growth<sup>40</sup>.

"To prosper and flourish in a rapidly changing world, we must make the most of all our resources – both mental and material..."<sup>26</sup>

Figure 4: Impacts on academic performance and social functioning

Impacts on academic performance	Impacts on social relationships
Reduced cognitive capacity	Need for control (causing conflict with teachers & other students)
Sleep disturbance (causing poor concentration)	Attachment difficulties (making attachment to school problematic)
Difficulties with memory (making learning harder)	Poor peer relationships (making school an unpleasant experience)
Language delays (reducing capacity for listening, understanding & expressing)	Unstable living situation (reducing learning and capacity to engage with a new school)

<sup>36</sup> AIFS (2013) *Child abuse and neglect statistics*. Update May 2013. Canberra.

<sup>37</sup> AIHW (2014). *Child protection Australia: 2012-13*. AIHW, Canberra.

<sup>38</sup> McMahon EM, Reulbach U, Keeley H, Perry IJ & Arensman E. (2010). *Bullying victimisation, self harm and associated factors in Irish adolescent boys*. *Social science & medicine*, 71(7), 1300-1307.

<sup>39</sup> Child Safety Commissioner (2007). *Calmer classrooms: a guide to working with traumatised children*. Victorian Government, Melb.

<sup>40</sup> Office of the UK Chief Scientist (2008) *The mental wealth of nations*. *Nature*, 455, 23 October.



## Literature Review

### Clinical and Community Service Models for children and young adults

It is not the focus of this review to examine in any comprehensive way, the developments in clinical and community service models for children and young people in mental health. A comprehensive review of models of collaborative care for children and youth (0-25 years) was commissioned by the National Advisory Council on Mental Health in 2010 and prepared by ORYGEN Youth Health Research Centre<sup>41</sup>. These provide a detailed review of the mental health needs and interventions available for children and young people across three developmental stages: early childhood (0-5 years); middle childhood (6-12 years); and youth (12-25 years).

Since then further studies in Australia have focused on clinical staging models for severe mood disorders and psychosis in youth<sup>42</sup> and integrated early interventions for high prevalence disorders (known as the 'Optymise' program developed by Brain and Mind Research Institute, University of Sydney).

### Models of School Mental Health

#### **School Mental Health Promotion**

There were already by 2005, over 1,000 school-based interventions focusing on health and mental health promotion and several systematic reviews and meta-analyses that show a clear benefit of such programs for mental wellbeing, illness prevention and academic success<sup>43 44</sup>.

The Institute of Medicine (2009) identified that the promotion of competence, self-esteem, mastery and social inclusion can serve as a foundation for both prevention and treatment of mental, emotional and behavioural disorders. When students become less connected to school there is a negative impact on their academic performance, behavior, and emotional and mental health. A lack of social competencies (i.e. empathy, decision making and conflict resolution skills) contributes to an increase in multiple risk taking behaviours.

A meta-analysis of school based social and emotional learning (SEL) programs found that effective mastery of social-emotional competencies is associated with greater

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<sup>41</sup> NACMH (2011). *Models of collaborative care for children and youth (0-25 years): Final Report*.

<sup>42</sup> McGorry PD, Purcell R, Hickie IB et al (2007). *Clinical staging: a heuristic model for psychiatry and youth mental health*. Med J Aust ,187(7 Supp): S40-42.

<sup>43</sup> Weisz J R, Sandler IN, Durlak JA, et al. (2005) *Promoting and protecting youth mental health through evidence-based prevention and treatment*. American Psychologist 2005;60:628-48.

<sup>44</sup> Institute of Medicine (2009) *Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities*. Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults. Washington, DC: The National Academies Press; 2009.

wellbeing and improved school performance<sup>45</sup>. The report is a meta-analysis of 213 school based K-12 SEL programs impacting on 270,034 students where evidenced based whole school SEL activities were (a) systematically taught in developmentally, contextually and culturally appropriate ways and (b) supported students to apply SEL skills to preventing specific problem behaviours (i.e. substance abuse, bullying etc.).

The SEL instruction used a SAFE model (Sequential, Active, Focused, Explicit). Outcomes identified increased competencies in emotional recognition, attitudes towards self and others, positive social behaviours, stress management, empathy, problem solving and decision making, a positive impact on problem behaviours including emotional distress, and an 11% increase in academic achievement. Increased student involvement and connection occurred through increased contribution to activities, the establishment of safe, caring learning environments, increased peer and family connections and improved classroom management and teaching practices.

Weare and Hind completed a systematic review of school mental health promotion and prevention programs 2011<sup>46</sup>. Known as the European Union Dataprev project the review included parenting, schools, the workplace and older people<sup>47</sup>. The schools component reviewed 52 systematic and meta-analyses and developed a set of general principles to guide school based mental health promotion and prevention. Most of the reviews (46) in this study were universal in scope in that they targeted all children in any particular age or setting including those with no 'problems'. Fourteen of these reviews included targeted interventions and six of the reviews were solely focused on targeted or 'indicated' interventions for children with or showing signs of mental health problems, violence or aggression and emotional and behavioural problems.

The interventions identified by the reviews had a wide range of beneficial effects on children, families and communities and on a range of mental health, social, emotional and educational outcomes.

The effect sizes associated with most interventions were generally small to moderate in statistical terms, but large in terms of real-world impacts. The impact on higher risk children was generally consistently higher than those interventions for children with milder problems.

The effects associated with interventions were variable and their effectiveness could not always be relied on. Weare and Nind found that most interventions only worked

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<sup>45</sup> Durlak, J A, Weissberg, R P, Dymnicki, A B, Taylor, R D, Schellinger, K B (2011). *The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions*. Child Dev't, 82(1): 405–432.

<sup>46</sup> Weare K & Nind M (2011). *Mental health promotion and Problem Prevention in Schools: What Does the Evidence Say?* Health Promotion International 26 (S1)

<sup>47</sup> Weare K & Nind M (2011). *Promoting mental health of children and adolescents through schools and school based interventions*. Three of the Dataprev Project. School of Education, University of Southampton, UK.

sometimes, some did not work at all and some were considerably more effective than average in some circumstances. As is now generally accepted in complex health promotion interventions, 'context is everything'<sup>48</sup>.

The characteristics of more effective interventions included:

- Teaching skills, focusing on positive mental health;
- Using whole school approaches that balance universal and targeted approaches – that is there is a need for both to make the most significant impact;
- Starting early with the youngest children and continuing with older ones;
- Using specialist clinically trained staff at the start of an intervention, but engaging school leaders for interventions to be sustainable;
- Parents and communities can add strength and depth to school programs;
- Operating for a lengthy period of time and
- Embedding work within a multi-modal/whole-school approach which included such features as changes to the curriculum including teaching skills and linking with academic learning, improving school ethos, teacher education, liaison with parents, parenting education, community involvement and coordinated work with outside agencies.

Importantly the reviews showed that interventions were only effective if they were completely and accurately implemented – that is with a high degree of fidelity. This is particularly the case in relation to whole-school interventions, which could be ineffective if not implemented with clarity, intensity and fidelity.

## School Based Mental Health Service Models

Unlike North America, models of school-based mental health early identification and Intervention are a relatively recent development in Australia<sup>49</sup>. In the US and Canada, professionally trained clinical staff have been undertaking early identification (assessment and screening) and early intervention programs for students with behavioural, social, emotional and psychiatric problems since the 1980s<sup>50</sup>.

The 2003 report of the President's New Freedom Commission on Mental Health identified school-based mental health services as a means to improving access to services for children with mental and emotional problems. Federal funding has supported the development of these services through the Mental Health in Schools

<sup>48</sup> Bate P (2014). *Context is everything*. In Perspectives on Context: a selection of essays considering the role of context in successful quality improvement. The health Foundation, London, UK.

<sup>49</sup> These are often termed 'indicated' interventions – that is services targeting children with the greatest need for support which may include intensive services such as one-on-one therapy

<sup>50</sup> Knitzer, J., & Cooper, J. (2006). *Beyond integration: Challenges for children's mental health*. Health Affairs, 25(3), 670-679.

program. Despite those efforts, mental health services in US schools remain marginalised and highly fragmented<sup>51</sup>.

In Australia, school-based programs for children and young adults with a clinical mental health need have been limited. Special needs schools have traditionally provided interventions for children with developmental and neurological learning problems (epilepsy, autism and so on). Few mainstream schools have been settings for indicated type programs.

Two recent examples of such programs have been the "Got It" program trial in NSW and the Schools-Early Action Program (CASEA) in Victoria.

CASEA is an early intervention program which aims to prevent the development of severe behavioural disturbance i.e. conduct disorder, in young children prep-Grade 3<sup>52</sup> which began in 2006. Based at schools, the program targets specific children and includes parents and teachers, who learn new ways of relating and dealing with daily challenges. The program addresses current issues with behaviour management to prevent any deterioration of behaviour in vulnerable students and promote health and wellbeing.

The early initiative ran until 2010. It was a collaboration between Child and Adolescent Mental Health Services (CAMHS) and government schools, and emphasised the role of parent-child interaction factors with child and school focused interventions. The program was framed on evidence that shows that high-risk children can be identified by the time they complete kindergarten.

CASEA developed into a larger pilot program involving the Royal Children's Hospital, CAMHS Service & Schools Early Action Program. It involved a whole school, multi-level, multidisciplinary approach to address emerging ODD/CD in 40 schools over a 4-year period (2007–2010).

Oppositional defiant disorder (ODD) or conduct disorder (CD) occurs when children's disruptive and antisocial behaviours start to interfere with their academic, emotional and/or social development. Significant reductions in both parent- and teacher-reported internalising and externalising symptoms were noted. Parent, teacher and child feedback was very positive.

Getting on Track in Time (Got It!) is a new school-based mental health intervention developed from the CASEA project in Victoria. In 2010-11 at three pilot sites, a model of care and an evaluation framework were developed and implemented. It is managed within the School-Link program. Got It! Involves clinicians working with school welfare

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<sup>51</sup> Adelman HS & Taylor L (2010) *Mental Health in Schools: engaging learners, preventing problems and improving schools*. Sage Publications

<sup>52</sup> State Government Victoria (2006) CAMHS and Schools-Early Action Program (CASEA).

staff to identify and target children who are experiencing mental health, social or behavioural problems and involves them and their parents in a term long small group program. An evaluation has been completed but is not yet available.

## Comprehensive or Integrated/Collaborative Models of School Mental Health

This review has identified a number of models of integrated or collaborative school-community mental health.

A number of integrated models of mental health care have developed in Australia, NZ, Ireland, and the US and elsewhere in response to the poor engagement by traditional services with young people. Most of these models have similar features. Involvement with schools in these models is inconsistent with the emphasis on integrated primary and specialist mental health, substance use and physical health needs of young people.

The exception in this group of child and youth friendly models in terms of school integration is the Milwaukee Wraparound One Child One Plan model<sup>53</sup>. This and other integrated community models for children and young people are summarised in Appendix 7.

Domitrovich and colleagues argue for integrated models of prevention to address the barriers and systematic difficulties with the uptake and impact of school-based services described in the previous section. They defined integrated models as “the fusing of independent strategies into one enhanced, coherent intervention or strategy”<sup>54</sup>.

These authors distinguish between two types of integration. “Horizontal” integration involves the combination of two or more interventions within the same risk level: universal, selected or indicated. “Vertical” integration combines interventions across two or more levels. They highlight the integration of the PATHS curriculum (a social and emotional learning program) and the PAX classroom management program. Both of these are universal interventions.

Another high quality comprehensive school mental health program is the *Positive Behavioral Interventions and Supports* (PBIS) model<sup>55</sup>. PBIS is a three-tiered, whole-school strategy that aims to prevent mental health and disruptive behaviours and enhance the schools climate by creating and sustaining primary (universal school-

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<sup>53</sup> Wraparound Milwaukee – *one child, one plan* (USA) Accessed 4 April, 2014 <http://wraparoundmke.com>

<sup>54</sup> Domitrovich CE, Bradshaw CP, Greenberg MT, Embry D, Poduska JP and Jalongo NS (2010) *Integrated models of school-based prevention: Logic and theory*. *Psychology in the Schools* 47(1) 71–88

<sup>55</sup> Bradshaw CP, Pas ET, Bloom J, Barrett S, Hershfeldt P, Alexander A, McKenna M, Chafin A & Leaf P (2012) *A state-wide partnership to promote safe and supportive schools: the PBIS Maryland Initiative*. *Adm Policy Ment Health*; 39(4):225-37

wide), secondary (selective) and tertiary (indicated) systems of support. PBIS is a statewide initiative that was formed and led through a partnership between the Maryland State Department of Education, Sheppard Pratt Health System, and Johns Hopkins University, which focused on implementing evidence-based practices and conducting prevention research in Maryland public schools. Sound governance and accountability through continuous data collection and reporting have underpinned this ten-year collaboration. Key elements identified by the researchers in the creation and sustaining of this initiative have been:

- Shared understanding and acceptance of the importance of the issues
- State-wide multi-agency PBIS State Leadership Team with nested level of support down to school PBIS Teams
- Adequate 'systems and infrastructure' for marketing and program dissemination
- Continuous communication prior to during and after adoption of the program
- Community based participatory research to enrich the partnership – learning by reflecting in a sense
- Genuine equality of partnership – authentic, long-term relationship between the partnering agencies
- Data collection and analysis to determine impacts and adjust interventions supported with adequate infrastructure – a state-wide data system to monitor and evaluate PBIS
- Cross-professional training and technical assistance
- Rapid response to needs and coordinating the provision of services
- Local change champions and use of key opinion leaders, and
- Capacity for adjusting and expanded programs at the school level.

PBIS must start with schools 'buying in' rather than a mandatory approach. A measure of the success of the approach in marketing the program is that in the 10 years since inception (from 2000-10), half of Maryland's 1,465 public schools have implemented PBIS.

Of particular note to this Review, is a recently completed 'rapid review' of school-based intervention programs and shared care collaborative models in NSW<sup>56</sup>. The rapid review focused on programs that aim to prevent mental disorders and those that provide early help to children and young people experiencing a mental disorder.

The authors looked at the onset of mental health disorders and the available, evidence-based programs or interventions that could be applied in school settings.

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<sup>56</sup> Christensen H, Calear A, Tait R, Gosling J, Griffiths K & Murray K (2011). *School-based intervention programs and shared care collaborative models targeting the prevention of or early intervention in child and adolescent mental health problems: a rapid review*. Sax Institute for the NSW Dept of Health, Sydney

The review identifies specific programs that have shown evidence of effectiveness and recommends programs for different mental health disorders. Figure 3 shows the onset and timing of interventions and the different programs for various disorders are summarised in Appendix 8.

The NSW School-Link initiative, introduced in 1999, is presently being reviewed and a new strategy and Action Plan has been developed for approval by government<sup>57</sup>. The findings of the review and the recommendations for the next phase of School Link align with the findings of the Ed-LinQ review.

In recent years the FRIENDS and Got It! Programs have been added to School-Link to create a more integrated approach to school mental health. FRIENDS is a well researched Australian 'universal' school mental health promotion program<sup>58</sup>. FRIENDS includes "Fun FRIENDS (for children 4-7 years), FRIENDS for Life (8-11 years), My FRIENDS (for 12-15 years) and Adult Resilience (for young people 16-18 years). The provision of additional resources and professional development for teachers to support the state-wide rollout of FRIENDS is also underway.

### Notable International Programs - SEAL Program UK

The *Social and Emotional Aspects of Learning for Secondary Schools (Primary and Secondary) (SEAL)* in the UK takes a whole-school approach to promoting social and emotional learning that aims, when fully implemented, to involve all members of the school and focuses on all aspects of school life, including school plans, strategies, policies, teaching and learning, behavior support and staff development to support social and emotional learning. It is a collaborative model that brings community capacity in mental health into school environments.

The program uses a broad five-level categorisation of social and emotional aspects of learning: self-awareness, managing feelings, motivation, empathy and social skills. These skills also contribute to a more positive school climate and promote staff effectiveness and well-being.

*Primary and Secondary SEAL* effectively links with other national school-based initiatives and is supported by key reference documents such as the National Institute for Clinical Excellence's guidelines for primary and secondary schools. The SEAL program was devised by the Department for Children, Schools and Families and initially piloted in 60 schools in 2006, and has been available to all schools since 2011.

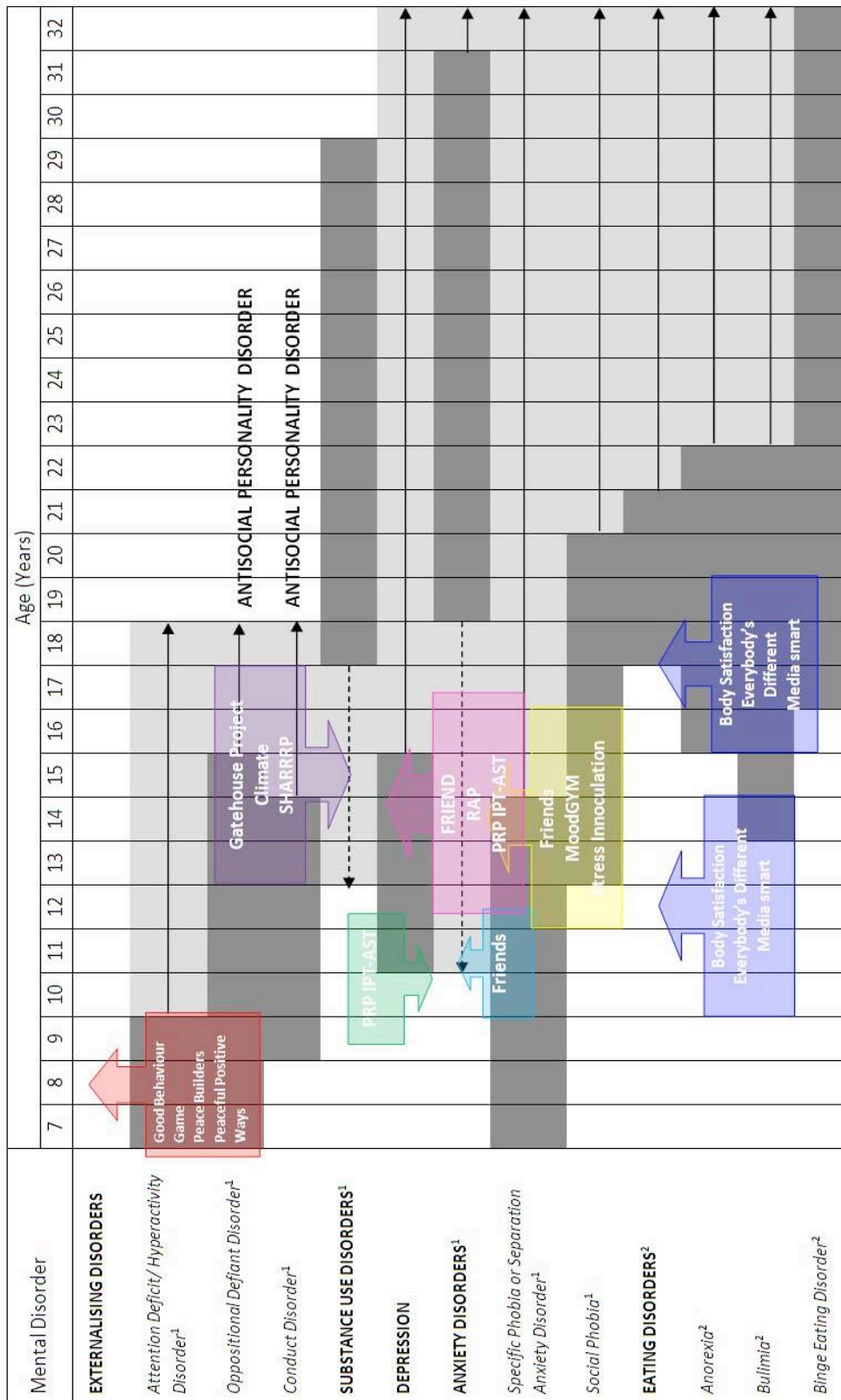
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<sup>57</sup> The document is not available until approval by NSW Government.

<sup>58</sup> Barrett, PM, Farrell, LJ, Ollendick TH & Dadds M (2006) *Long-Term Outcomes of an Australian Universal Prevention Trial of Anxiety and Depression Symptoms in Children and Youth: An Evaluation of the Friends Program*. J. of Clinical Child & Adolescent Psychology, 35: 3, 403 — 411



Figure 5: Optimal Points of Delivery and recommended programs (Christensen et al)



Consultation shows that not all schools implemented the program in England, nor did those that did implement all aspects of the program. Those schools that did implement the program on a whole-school, universal basis had a positive influence on school ethos, student



experience, absenteeism and school attainment. Key drivers of the positive results were school engagement through the ability to provide scope for local variation, leadership engagement, good use of data, staff development and mentoring and attention to detail in implementation<sup>59</sup>.

The results of this study highlight the role of school ethos in systematically connecting whole-school practices relating to SEAL with key indicators of school success. The following framework (in Figure 4) shows the structure of SEAL.

The next stage of development in school mental health in the UK, building on the success of SEAL is the "Targeted Mental Health in Schools" (TaMHS) project again funded by the Dept for Children, Schools & Families. Its aim is to transform the way that mental health support is delivered to children aged 5-13, to improve their mental wellbeing and tackle problems more quickly. There are 25 *pathfinders*, each of which are being funded to develop and deliver an innovative model of mental health support. This model is made up of 2 key elements:

**Strategic integration** – all agencies involved in the delivery of child & adolescent mental health services (schools, local authority services, PCTs, other health trusts, the voluntary sector) working together strategically & operationally to deliver flexible, responsive & effective early intervention mental health services for children & young people.

**Evidence-informed practice** – interventions for children & families at risk of & experiencing mental health problems, which are planned according to local need & grounded in our increasing knowledge of 'what works'.

This '3-waves' intervention model will be familiar to schools from the national literacy & numeracy strategies. The range of interventions proposed is centred upon the Social & Emotional Aspects of Learning (SEAL) program; and is aligned with the recommendations of National Institute of Clinical Excellence (NICE) on promoting social and emotional wellbeing in primary schools<sup>60</sup>.

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<sup>59</sup> Bannerjee R, Weare K, Farr W (2014). *Working with Social and Emotional Aspects of Learning (SEAL) Associations with school ethos, public social experiences, attendance and attainment*. British Ed Research Journal, 40, 718-742

<sup>60</sup> National Institute for Health and Clinical Excellence (2008) *Social and Emotional Wellbeing in Primary Education*. NICE Public Health Guidance No. 12.

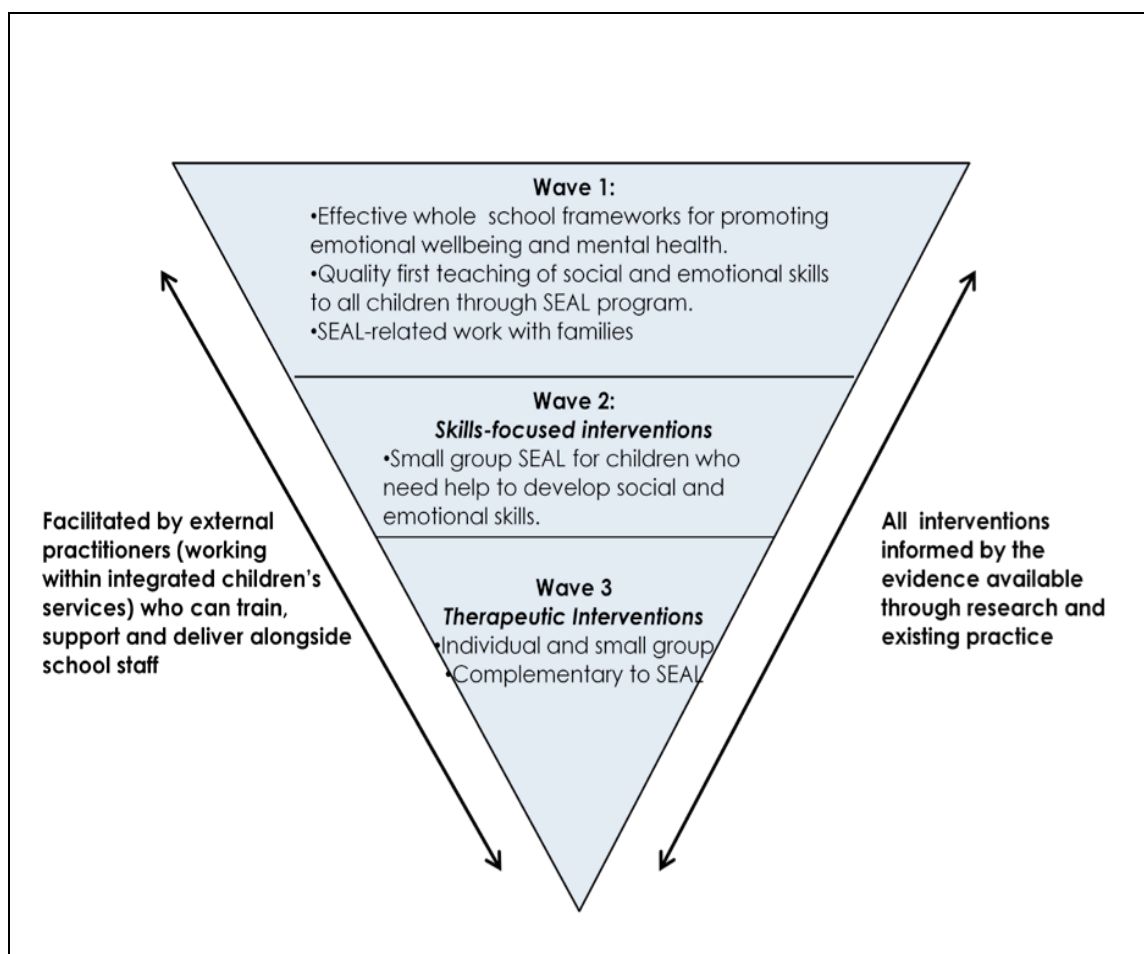


Figure 6: SEAL Model – social, emotional aspects of learning

## Suicide Prevention Programs

While not related solely to school settings, Robinson and colleagues completed a systematic review of suicide prevention for young people in 2011<sup>61</sup>. They found that the evidence regarding effective interventions for adolescents and young adult with suicide attempt, deliberate self-harm or suicidal ideation extremely limited. They reviewed only programs from clinical settings – EDs, hospital inpatient, community mental health and CAMHS services. No programs involving gatekeeper training were included. While there were significant limitations in the studies reviewed (sample size in particular) the authors concluded that CBT shows some promise, but further investigation is required in order to determine its ability to reduce suicide risk amongst young people presenting to clinical services.

Katz and colleagues undertook a systemic review of school-based suicide prevention programs in 2013<sup>62</sup>. All of the studies reviewed (16) were focused on North American settings. Few programs have been evaluated for their effectiveness in reducing

<sup>61</sup> Robinson J, Hetrick S, Martin C (2011) *Preventing suicide in young people: systematic review*. ANZ J of Psychiatry; 45, 3-26

<sup>62</sup> Katz C, Bolton SL, Katz LY, Isaak C, Tilston-Jones T, Sareen J, & Swampy Cree Suicide Prevention Team (2013). A systematic review of school-based suicide prevention programs. *Depression and Anxiety* 30:1030–1045

suicide attempts. Most studies evaluated the programs' abilities to improve students' & school staffs' knowledge & attitudes toward suicide.

*Signs of Suicide* and the *Good Behavior Game* were the only programs found to reduce suicide attempts. Several other programs were found to reduce suicidal ideation, improve general life skills, and change gatekeeper behaviors. There are few evidence-based, school-based suicide prevention programs, a combination of which may be effective. The authors note that it would be useful to evaluate the effectiveness of general mental health promotion programs on the outcome of suicide.

## Information Technology

Almost all young people are now daily users of social media. The rapid development of social media and digital platforms for entertainment are generally viewed negatively in the Australian community for the risks these environments pose for children and young people. These risks include vulnerability of children and young people to cyber-bullying and 'predators', exposure to inappropriate and disturbing content, and the impact of the time spent on social media on their health and wellbeing.

These are justifiable concerns for parents and educators and schools now routinely include safe Internet and social media use for students at all ages.

The national Computer Assisted Telephone Interview (CATI) survey of 700 males (16-24 years) referred to earlier found that technology presents an unprecedented opportunity to work directly with young men to create new ways of engagement, new service models of care, and greater empowerment for young men in their management of stress and life pressure<sup>63</sup>.

Several studies have established the efficacy of Internet programs and social media communications solutions for improving the mental health and wellbeing of young people, including several school based programs<sup>64 65 66</sup>.

One large Australian study looked at the use of the MoodGYM program, an Internet based CBT program, by adolescents in school and non-specific settings. The study compared adherence rates for 1,000 secondary school students and more than 7,000

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<sup>63</sup> Burns J, Davenport T, et al 2013

<sup>64</sup> O'Kearney R, Kang K, Christensen H, & Griffiths K (2009). *A controlled trial of a school-based internet program for reducing depressive symptoms in adolescent girls*. *Depression and Anxiety* 26:65–72 (2009)

<sup>65</sup> Robinson J, Hetrick S, Cox G, Bendall S, Yung A & Pirkis J (2014). *The safety and acceptability of delivering an online intervention to secondary school students at risk of suicide: findings from a pilot study*. *Early Intervention in Psychiatry*. Published online 31 March 2014

<sup>66</sup> Teesson M, Newton N, Slade T, et al (2014) *The CLIMATE Schools Combined Study: A Cluster Randomised controlled trial of a universal internet-based prevention program for youth substance misuse, depression and anxiety*. *BMC Psychiatry*; 14 (32).

adolescents who accessed the MoodGYM program over an open access URL over a 5-week period<sup>67</sup>.

In terms of program completion, there was an almost 10-fold higher rate of completion for the school based sample. The school settings provided in class opportunity to undertake the program and teacher encouragement, support and guidance.

While the school-based trials are encouraging, clearly more research is needed to establish the value of these interventions and how best to integrate them with school based prevention and early intervention efforts.

There is also a growing recognition of the value of using digital technologies to facilitate and enhance inter-agency communication and collaboration<sup>68</sup> and professional development.

In August 2013 the then Federal Opposition now Abbott Government, announced a \$5 million investment under which the Young and Well Cooperative Research Centre (YAWCRC) will deliver a project to fundamentally reshape the system of care and embed technology in Australia's youth mental health services. This project is called *Synergy*.

"Synergy is an e-mental health ecosystem of complimentary Young and Well CRC products, certified apps and web based interventions, running on an underpinning set of standards, interfaces and technologies<sup>69</sup>."

This mix of online support and underpinning technology is called the Synergy Ecosystem. Synergy is not a personalised electronic health record, nor an e-mental health portal like MindHealthConnect, developed in 2012.

The 'Synergy Ecosystem' enables technologies to interact and be used by young people to manage their wellbeing and mental health. Synergy positions the young person as owning, controlling and sharing their data. This data is not clinical data but rather is information collected by digital technologies that can enhance wellbeing and, if needed facilitate clinical care and engagement with clinical services, both online and offline.

Clearly the development of this digital platform will have significant implications for the integration of all mental health services for young people, not just those in the virtual domains.

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<sup>67</sup> Neil A, Batterham P, Christensen H, Bennett K & Griffiths K (2009) *Predictors of adherence to a CBT Website in school and community settings*. J Med Internet Res, 11(1)

<sup>68</sup> Bradley-Klug KL, Jeffries-DeLoatch KL, St. John Walsh A, Bateman LP, Nadeau J, Powers DJ & Cunningham J (2013) *School psychologists' perceptions of primary care partnerships: Implications for building the collaborative bridge*, Ad. In School Mental Health Promotion, 6:1, 51-67.

<sup>69</sup> See Appendix 9 for an in-confidence brief on Synergy

A summary of Synergy and another specific mental health online program (Mindstar) with relevance to the future of Ed-LinQ are included in Appendices 9 and 10.

## Partnerships and Collaboration

There is now an extensive literature on community models of collaborative or integrated health and social care and models of integrated human services in other settings such as disability, employment and housing<sup>70 71 72</sup>. In mental health, there is growing body of evidence that suggests collaborative and coordinated care delivers the better quality services and outcomes for individuals and families<sup>73</sup>, particularly for those with multiple and complex needs<sup>74</sup>.

There is considerable ambiguity in the literature on the terms care coordination, service integration and care collaboration. In this review, we have viewed 'collaboration' as the necessary action/s of service leaders and providers to achieve service integration and care coordination and a particular form of working together characterized by a shared purpose, authority, control, resources and accountability<sup>75</sup>.

Adapting one view of coordinated care as a core function of team-based primary and community care to a broader community context a definition of care coordination might be as follows<sup>76</sup>:

Care coordination delivers systematic, responsive and supportive care to people with multiple and complex care needs and includes:

- Coordination and management of a range of health and social care services for an individual client and family to create a comprehensive and continuous experience;
- Coordination of providers to encourage team work and shared knowledge; and
- Coordination of service delivery organisations to create an integrated network.

Care coordination needs to operate at the level of service delivery with the person, at the level of teams, whether they be intra agency, interagency or inter-sectorial and at broader service system level.

The aim of care coordination is to ensure the delivery of systematic, responsive and supportive services to a person with complex and multiple needs. Care co-ordination

<sup>70</sup> King, G & Meyer, K (2006). *Service integration and coordination: a framework of approaches for the delivery of coordinated care to children with disabilities and their families*. Child: Care, Health and Development, 32: 4.

<sup>71</sup> Imison C, Naylor C, Goodwin N, Buck D, Curry N, Addicott R, Zollinger-Read P. (2011) *Transforming our health care system: Ten priorities for commissioners*. London: The Kings Fund.

<sup>72</sup> Malinkowski T & Adams P (2009). *Shared care models: a high level literature review*. J of Cancer Institute, NSW vol 1.

<sup>73</sup> Butler M, et al (2011). *Does integrated care improve treatment for depression? A systematic review*. J of Ambulatory Care Management; 34(2), 113-125.

<sup>74</sup> Schapp W (2006). *The C's in Community Mental Health*. Admin & Policy in Mental Health & Mental Health Services Research; 33 (6): 737-739.

<sup>75</sup> Nous Group (2013) *Collaboration blueprint*. Prepared for the NSW Public Service Commission.

<sup>76</sup> Ehrlich, CE, Kendall, E, Muenchberger, H & Armstrong, K (2009). *Coordinated care: what does it really mean?* Journal of Health & Social Care in the Community, 17(6).

is important in ensuring that providers in different parts of the health and social care system work in a joined-up way and enable clients to be cared for in the most appropriate setting.

### ***Core requirements of service and care coordination***

It is clear from the review of the literature that service and care coordination do not occur without an understanding that no one organisation or program can meet all of a person's needs and without a commitment to collaborate at the key levels of:

- Individual provider/practitioner
- Intra-agency
- Interagency
- Cross sector, and
- System wide.

There are a number of common elements or features in effective service integration from the literature. These are described in the Table 3<sup>77</sup>.

### Strategies for service coordination in school settings

Although schools are powerful agencies for social influence, including changing community health, they are limited by time and resources and, in a sense, compete with the social and environment determinants of health active in the broader community. It is only through integrated, community-school health initiatives that schools can have a positive influence on the health and wellbeing of their students and the broader community. This need for service integration in relation to health issues has long been recognised<sup>78</sup>. Similarly the strategies and mechanisms for achieving health and education service integration have been well established<sup>79 80</sup>. These include:

- School wide or whole-of-school approaches
- Integrated family and school approaches
- Teacher training - pre and in-service
- Physical space
- Providing time to collaborate

<sup>77</sup> The table is based on an unpublished literature review by ConNetica for the Dept of Education, Employment and Workplace Relations, (2013) *Evaluation of the Goodna Family Centred Employment Program*.

<sup>78</sup> Coonan W, Owen N & Mendoza J (1990) *Australia: Perspectives in school health*. Int. J of School Health; 60(7), 301-307.

<sup>79</sup> Mellin EA, Anderson-Butcher D & Bronstein L (2011) *Strengthening Inter-professional Team Collaboration: Potential Roles for School Mental Health Professionals*, *Advances in School Mental Health Promotion*, 4:2, 51-60,

<sup>80</sup> Mellin EA, Bronstein LR, Anderson-Butcher D et al (2010) *Measuring interprofessional collaboration in expanded school mental health: model refinement and scale development*. J of Interprofessional care; 24(5) 514-523

- Positive relationships between collaborators, and
- Training specialists to link systems of care.

In the US, specific tools to assist schools build capacities for collaboration in five key areas have been developed focusing on<sup>81</sup>:

- Planning
- Collaboration and stakeholder involvement
- Cultural competence
- Quality improvement, and
- Surveillance.

These are available at:

<http://csmh.umaryland.edu/Resources/smhcapacitybuilding/tools.pdf>.

Barriers to collaboration<sup>82 83</sup>

The barriers to collaboration and developing integrated care, in general, from the literature include:

- Funding processes and time periods– e.g. competitive tendering and short term funding can erode collaboration.
- Technology – different systems and requirements
- Inadequate time due to existing workloads
- Client confidentiality
- Culture and leadership issues
- Career advancement and promotion may be more linked to evidence of leadership rather than partnership working
- Workforce competencies – that is the knowledge and experience with working with other professionals and organisations.

In relation to school-community collaboration on mental health the key barriers from the literature include:

- Different perceptions and concepts of health, mental health and health promotion and prevention in the health and education sectors
- Administrative pressures

<sup>81</sup> National Assembly on School-based Health Care. *Assessment Tools for School Mental Health Capacity Building*. Available at [info@nasbhc.org](mailto:info@nasbhc.org)

<sup>82</sup> Young I, St Ledger L & Blanchard C (2012) *Monitoring And Assessing Progress In Health Promoting Schools: Issues For Policy Makers To Consider*. International Union for Health Promotion and Education, Saint-Denis Cedex, France.

<sup>83</sup> Whiteford H & McKeon G (2012). *System level intersectoral linkages between the Mental Health and Non-Clinical Support sectors*. Prepared for Commonwealth Dept of Health and Ageing, Canberra.

- Financial pressures/under-resourcing
- Curriculum pressures
- Conceptual and linguistic differences
- Differences in expectations
- Role restrictions and perceptions
- Absence of coordination structures and mechanisms
- Privacy and confidentiality
- Lack of care continuity in health systems, and
- Poor information management.

## Economic case for investment

While there is a body of evidence surrounding the cost effectiveness of early intervention programs for young people and to a lesser extent children<sup>84</sup>, there is almost a complete lack of robust economic evaluations of the impact of school mental health related programs.

In 2009 the London School of Economics (LSE) undertook an analysis of the cost-benefits of school-based social and emotional learning (SEL) programs to prevent conduct problems in childhood and school-based interventions to reduce bullying<sup>85</sup>.

In the absence of robust studies on the impact of SEL programs on conduct problems, modeling done by the LSE that was based on effective programs showed a strong case that school-based SEL programs provide substantial costs savings for the public sector in crime and health related impacts.

In relation to bullying, high-fidelity programs in schools show good results with reductions in bullying behaviours of over 20%. The cost of the program was estimated at £15.50 per student per year and savings (based on robust modeling) of £1,080 per student. So even if repeated every year, the cost benefit ratio is in excess of 1:5.

More broadly, Nobel Laureate James Heckman and colleagues has set out a compelling case for investment in services for disadvantaged young children as opposed to investments in services later in early adulthood as a 'best buy' for public and community resources. Heckman points to an abundance of evidence that

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<sup>84</sup> Access Economics (2009). *The economic impact of youth mental illness and the cost of effectiveness of early intervention*. Report for ORYGEN Youth Research Centre, Melb.

<sup>85</sup> Knapp M et al (2009) Mental health promotion and mental illness prevention: The economic case'. Eds Knapp M, McDaid D & Parsonage ML. Department of Health, London



investing in high quality early childhood interventions fosters abilities, 'attacks inequality at the source' and can boost economy prosperity<sup>86</sup>.

Figure 7: Common elements in effective collaboration for care coordination

<b>Governance arrangements</b>	Clearly articulate roles and responsibilities, terms of reference, selection of stakeholders and metrics for monitoring performance. Ensure policy frameworks are broad and flexible enough to enable devolution of service planning & delivery to local or regional level
<b>Leadership</b>	Organisational leadership demonstrated through an active commitment to work in a coordinated & cooperative way with others; breakdown service silos; lead reform efforts
<b>A long-term commitment of resources</b>	A minimum commitment of three years, with preference for five years or more to bring about sustainable changes
<b>A client focus</b>	The experience of service and support of the client is central to sound policy development & service delivery.
<b>A focus on outcomes</b>	A balance of short & long term results and clear overall outcome with timely reporting
<b>Shared knowledge</b>	An open, common set of resources & knowledge and sustained focus on practice development
<b>Communication</b>	The effective, efficient, timely & synchronised communication of information between practitioners, service providers & policy makers
<b>Facilitate</b>	Government agencies and national bodies moving from controlling and directing to the role of facilitating and enabling
<b>Leverage, Augment, complement and supplement</b>	Policy makers need to collaborate with service deliverers and the community sector to leverage investment of resources and augment, complement and supplement existing programs and services to deliver the policy objectives
<b>Integrated networks and</b>	Plan and cooperatively build integrated networks – in assessment, planning and reporting, human resources,

<sup>86</sup> Heckman, JJ (2013). *The case for investing in disadvantaged young children*. In Big Ideas for Children: Investing in our Nation's Future. University of Chicago.

<b>systems</b>	learning and development, ICT systems etc. Integrated and comprehensive assessments of need - holistic health, social and risk assessments
<b>Local capacity and ownership</b>	Engaging the local leaders across sectors (business, community and government)
<b>Partnership and reciprocity</b>	The recognition that complex social issues require genuine cross-sectorial partnerships – within and beyond government – and a shared responsibility in the outcomes
<b>Provision of incentives</b>	New incentives such as rewards, recognition or autonomy or funding can all be used to stimulate change/improvement

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## Workforce and Workforce Development

The literature on workforce and workforce development included guidelines and procedures from various Australian state education authorities, government research on the schools workforce, peer-reviewed publications and the Ed-LinQ workforce development reports.

A key issue in this section of the literature related to the role of the various professionals supporting child and youth mental health and wellbeing.

### **Workforce – Roles in Mental Health**

A recent Productivity Commission report on the Schools Workforce<sup>87</sup> examined “issues impacting on the workforces in the early childhood development, schooling and vocational education and training sectors, including the supply of and demand for these workforces, and provide advice on workforce planning, development and structure in the short, medium and long-term”. The report was to inform considerations by the Council of Australian Government’s on national productivity and within this context, examine and make recommendation on the “most appropriate mix of skills and knowledge required to deliver on the outcomes in the COAG national framework”.

The Productivity Commission report recommends greater ‘innovation in the composition of the school workforce to improve student outcomes’ and ‘reducing the adverse effects of individual, economic and social factors on student outcomes’<sup>88</sup>. The report recognises that schools and school workforce policies need to be supported by ‘broader policy actions to help tackle the sources of educational advantage’. Therefore, initiatives that target health, family and community-related barriers to the learning outcomes of disadvantaged students have important roles to play in promoting equality of educational opportunity.

The report makes no mention of mental health and only one reference to mental illness regarding an ‘expanded involvement of health workers and school counselors in early detection and support for students with mental illness’ – and this a reference to submissions from QCEC and Victorian School Nurses<sup>89</sup>.

#### Education Professionals

The core role of all education professionals (i.e. teachers, teacher assistants, leaders and principals) is to maximise the potential of every child or student. Quality teachers and education professionals create an environment where all students are expected to learn successfully through working with their peers and other school workers, recognise the diverse ways that students learn, challenge them by setting high expectations, provide them with continuous feedback and bring to the classroom a deep knowledge of the subject matter<sup>90</sup>.

Principals have primary responsibility for setting their school’s culture and with the other members of the school leadership group; they provide the foundation for

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<sup>87</sup> Productivity Commission 2012, *Schools Workforce, Research Report*, Canberra.

<sup>88</sup> Ibid, pg 33-35

<sup>89</sup> Ibid, pg 213

<sup>90</sup> McMasters G (2007) quoted in *Schools Workforce, Research Report 2012*, pg 9

excellence in student outcomes. This includes teaching and learning direction, support to school staff, efficient resource management, and positive relationships with students, parents, the local community and education authorities<sup>91</sup>.

With one in eight children and up to one in four adolescents experiencing a mental health problem, school professionals serve a critical role in first identifying learning and social problems, identifying mental health problems, assessing the impact of these conditions on learning and development and adapting the learning environment to address the educational and psychological needs of students.

They must also know when and where to referral students for assessment and support, both within and beyond the school boundary.

The non-teaching workforce has expanded in Australian schools in recent years – most notable has been the services of health professionals (such as school nurses and child psychologists) as well as counsellors and student welfare coordinators (who may at times also be teachers).

### **School Nurses**

The role of school nurses in Australia is poorly defined with minimal literature assessing the role. The *National School Nursing Professional Practice Standards* confirm, “The role varies with the education sector, age group/s, setting, program objectives and stakeholder expectations”<sup>92</sup>.

There is general agreement in the literature regarding the complex scope of school nurses work. The *National School Nursing Professional Practice Standards* indicate school nursing involves primary health care, cultural competence, early detection and early intervention, health promotion, prevention, health education, chronic condition management, environmental health and safety, emergency/crisis management, first aid, sports health, health counselling, service delivery and resource management.

The *National School Nursing Professional Practice Standards* indicate there is often limited policy support in the education system for the work of the school nurse. The Government of South Australia has published a *Student Mental Health and Wellbeing* document, which makes reference to school-based counsellors and regional support staff rather than nurses<sup>93</sup>.

The Queensland Government *Supporting Students’ Mental Health and Wellbeing* procedure indicates non-Education Queensland staff, including school-based youth health nurses, support students’ mental health and social and emotional wellbeing in a variety of ways. However there is no other specific mention in this procedure on the role of nurses<sup>94</sup>. Queensland Government has developed a school nurse practice model providing guidelines and direction for nurses in the delivery of clinical focused nursing services in schools. The model makes no reference to mental health<sup>95</sup>.

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<sup>91</sup> Ibid, pg 20.

<sup>92</sup> National School Nursing Professional Practice Standards (2012)

<sup>93</sup> Government of South Australia Student Mental Health and Wellbeing

<sup>94</sup> Queensland Government (2014) Supporting Students’ Mental Health and Wellbeing Procedure

<sup>95</sup> Queensland Government (2013) The Role of the Education Queensland Registered Nurse – A Practice Model

A KPMG review of the Victorian secondary school nursing program identified nurses emanate from diverse professional backgrounds, a small component (7.8%) from mental health. The review found that in Victoria nurses undertake regular assessments of young people, particularly in relation to sexual health, mental health and general health issues. The most predominant student clinical issues identified by nurses included (in order of frequency) mental health, sexual health and family issues. The review also found that mental health promotion occurs in schools to a lesser degree than either drug and alcohol or sexual health programs, despite this being identified as a key priority area for students by both secondary school nurses and school stakeholders<sup>96</sup>.

Queensland nurses referred numerous students to mental health services during the school nurse program implementation. The increased burden on these services resulted in additional mental health education being provided for nurses. Nurses developed the necessary skills and became more comfortable ceasing referral of students too quickly<sup>97</sup>.

In contrast to the Victorian and Queensland experience, very few NSW students access the school nurse for mental health, sexual or drug and alcohol advice. Rather approximately 70% of a nurse's working day is reportedly spent on clinical activities<sup>98</sup>.

A Western Australian study highlighted the complexity and demanding aspect of the high school nurse, practicing in an area that requires the application of advanced knowledge and skills<sup>99</sup>.

The Australian Government Productivity Commission *Schools Workforce* report highlighted "those performing specialised support roles (such as child psychologists and school nurses) must possess relevant qualifications — typically a three-year degree or diploma<sup>100</sup>. The report makes no mention of mental health. KPMG recommended in their *Victorian Review of the secondary school nursing program*, that a skills audit be undertaken and mandatory training/professional development in adolescent health, adolescent mental health and health promotion be undertaken within first year of school nurse employment.

A USA study highlights similar findings to the Victorian and Queensland-based literature with 31% of students 'primary' presenting issue being mental health concerns. School nurses reported limited comfort in mental health intervention and desire for additional mental health training. Findings from the study support the case for an increased role of school health nurses in mental health and the urgency of establishing training for school nurses on mental health competencies<sup>101</sup>.

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<sup>96</sup> KPMG (2009) Department of Education and Early Childhood Development: Review of the Secondary School Nursing Program Final Report – Executive Summary.

<sup>97</sup> Barnes M, Courtney MD, Pratt J, Walsh AM (2004) School-Based Youth Health Nurses: Roles, Responsibilities, Challenges and Rewards

<sup>98</sup> Moses K, Keneally J, Bibby H, Chiang F, Robards, Bennett D (2008) Beyond Band-aids: Understanding the role of school nurses in NSW – Summary Report

<sup>99</sup> Downie J, Chapman R, Orb A, Juliff D (2002) The Everyday Realities of the Multi-Dimensional Role of the High School Community Nurse

<sup>100</sup> Australian Government Productivity Commission (2012) *Schools Workforce -Research Report*

<sup>101</sup> Stephan SH & Connors EH (2013). School nurses' perceived prevalence and competence to address student mental health problems. Ad. In *School Mental Health Promotion*, 6(3), 174-188.

In the UK, The Schizophrenia Commission also noted the potential for school health nurses in delivering mental health prevention and early intervention initiatives<sup>102</sup>.

### **Primary Care Providers**

Primary health care providers (PCPs) and school professionals have complementary roles in providing services for children and adolescents with mental health needs. PCPs have major role in identifying and screening for mental health conditions, educating and supporting families, assessing the need for and prescribing medication and coordinating care<sup>103, 104</sup>.

Few programs or initiatives have targeted developing the capacity of primary care providers to work with schools in relation to the mental health needs of students. Twenty-four schools and six Divisions of General Practice participated in the MindMatters Plus GP trials in 2003-2005<sup>105</sup>. While the program improved the referral pathways to primary care, it was not seen by stakeholders as improving the access to care nor did it enable GPs to have a presence in schools.

As highlighted earlier in the discussion on access to mental health care, young people particularly those 14-24 years, are low users of GP and psychology services in Australia. Recent research here and overseas points to the need for mental health services for young people to focus on promoting independence, autonomy, employment, low stigma and the avoidance of overly medicalising problems<sup>106 107</sup>. The development of the headspace program across Australia has seen the provision of integrated, youth friendly mental health and substance abuse services with General Practice and an improvement in access to earlier care.

The Queensland Primary Mental Health Care Strategy, a sub-ordinate document to the Queensland Mental Health Plan 2007-2017, provided a framework to support collaboration and service integration between public mental health services (hospital, community, adult and CYMHS services) and PCPs. While there is no specific reference to Ed-LinQ or indeed school sectors, there is a clear intent to enhance prevention and early intervention services and linkages of programs.

It is not possible to determine what, if any effect the QPMHC Strategy had on the capacity of primary health care providers to support and collaborate with schools on mental health issues.

<sup>102</sup> The Schizophrenia Commission (2012). *The Abandoned Illness: A report by the Schizophrenia Commission*. Available at [www.rethink.org](http://www.rethink.org)

<sup>103</sup> Power TJ et al (2013). Coordinating mental health care across primary care and schools: ADHD as a case example.

<sup>104</sup> WHO (2001).

<sup>105</sup> Lewis V, Marsh G, Redfern J, and Bakacs L. (2005). *Evaluation of MindMatters Plus and MindMatters Plus GP: Final Report*. For Aust Professional Association Professional Development Council (APAPDC). Dept of Health & Ageing

<sup>106</sup> Plaistow J, Masson K, Koch D, Wilson J, Stark R, Jones P, Lennox B. (2014). *Young people's views of UK mental health services*. *Early Intervention in Psychiatry*; 8 (1): 12–23.

<sup>107</sup> NACMH (2011). *Models of collaborative care for children and youth (0-25 years): Final Report*. Canberra: Commonwealth Department of Health Ageing.

## Literature Review - Summary

The ten key points from this review of the literature relating to health-education programs, collaborations, workforce development and the early detection and intervention of mental disorders for children and young people are:

1. The need to have effective school and community promotion, prevention and early intervention programs addressing mental health and wellbeing of children is clear given the potential for life-long disabling effects of unidentified and untreated illness.
2. Collaboration starts at the top. Authority for collaborative cross-sector initiatives involving health, education and community, like Ed-LinQ, needs to come from government and heads of agencies and be reinforced in actions and accountability. Alignment with the strategic priorities of government is beneficial.
3. Whole of school approaches are more effective than single mode programs. Whole of school approaches should include a balance between universal and targeted approaches and may need to consider early intervention programs for students with existing mental health problems.
4. Initiatives and programs to be effective must be well planned, integrated, well articulated and marketed, adequately resourced and sustained for the medium to long term to be effective.
5. Optimal points of delivery of evidence based programs are now available and should be part of an integrated whole of school strategy.
6. Curriculums must provide for social and emotional learning (SEL) programs that are universal in scope and target every student can prevent and/or ameliorate emotional distress and problem behaviours and enhance mental health, social, emotional and educational outcomes.
7. For collaboration to occur at the local school-community health service level, a comprehensive strategy sustained over time is necessary to achieve high rates of implementation and change. A sophisticated change strategy is required with the necessary hard and soft infrastructure to gain buy-in, provide sufficient guidance, build capacity and sustain engagement. Both the SEAL/TaMHS (UK) and PBIS (US) programs offer sound models to emulate.
8. Information technology including social media, offers a new platform for collaboration, program delivery and engagement with young people. The same challenges of coordinating traditional services are presenting with this new operating environment. Service integration between the digital and 'real' service environments has to be a goal in the coming five years.
9. Leadership at state and local levels to demonstrate an active commitment to work in a collaborative way and lead reform is critical to success.

10. What gets measured gets done. Data that has a focus on the end user (in this context children and young people) and outcomes and that is available on a timely basis for local and state level decision making. As in other areas of education like literacy and numeracy, data for improving the mental health and wellbeing of children and young people begins with knowing the status of their mental health and planning accordingly.



## Documentation Review

### Policy and Planning Documentation

The analysis of the Ed-LinQ policy and planning documents pointed to a number of clear policy intentions. At a strategic level the Ed-LinQ Initiative had a 'Framework for Action', which intended to provide a consistent statewide approach and a basis for collaborative interdepartmental and interagency relationships at a state level. This includes planning and governance mechanisms and the development of an interagency memorandum of understanding.

In terms of enhancing capacity, at the strategic level this includes the development and implementation of joint workforce development strategies for the mental health, education and primary care sector personnel. For clinical guidance at the state level, this included the development of consultation liaison protocols to guide the practice of district Ed-LinQ Coordinators, as well as the development of child and youth mental health and mental illness information for distribution to state-level education sector stakeholders.

Finally, at the strategic level there was a strong commitment in the policy documentation to continuous improvement and adoption of best practice in child and youth mental health. This was to be supported through the implementation of formative and summative evaluation processes.

At a more operational level, the Ed-LinQ documentation provided more detail on these strategic intentions, namely that:

- The Framework for Action provided guidance to mental health, primary health care and education staff involved in the Ed-LinQ initiative.
- The Framework aimed to inform the stakeholders at state and District levels.
- At the school level, Ed-LinQ aimed to improve the knowledge and skills of school staff in identifying at risk students, access to information and resources and the referral or service pathways.
- Related to this, was the intention of developing and deploying shared care models and clear and consistent referral pathways at a district level, based on the resource/service mix available.
- A key intention of the initiative is to identify core resources in each sector (i.e. mental health, primary health care and education) and (then) provide the 'strategic interface' that adds value to existing services and avoiding duplication.
- At the HHS level, in relation to clinical guidance the intention was to involve attendance at relevant district meetings where student mental health and mental

illness is discussed, as well as the development, distribution and support of continually updated referral pathways for students identified as experiencing a mental illness.

- To provide a clear governance structure for the initiative to enable effective cross-sectoral consultation and collaboration including joint planning and review.
- Related to the governance structures, Ed-LinQ aimed to establish Memorandums of Understanding between the key agencies at the state-wide level and at district level, see the establishment of protocols and other mechanisms for effective coordination and collaboration.
- At a District level, it was intended that local governance structures be established to enable tailoring of Ed-LinQ to the District's needs.
- Ed-LinQ sought to improve partnerships and communications between State Mental Health Services (CYMHS) and schools.
- In relation to the workforce, Ed-LinQ sought to coordinate and provide support for mental health professional development activities for education and primary care stakeholders.
- Related to workforce, there was a clear intention to "improve the baseline knowledge of mental health issues, such as awareness of and access to programs like Youth Mental Health First Aid".

Each of these policy intentions was assessed in the evaluation.

Clearly, the Ed-LinQ policy framework attempted to balance the need for a consistent statewide approach with a degree of fidelity recognising the different levels of service capacity and community needs across the twelve Districts. To what extent Ed-LinQ Coordinators have been able to engage stakeholders at the District level will be a key factor in assessing the program's impact.

### Documentation from Ed-LinQ Coordinators.

A review of the available documentation from several Ed-LinQ districts was undertaken. The focus of this element of the evaluation was on process and impact data. The districts were Ipswich, Sunshine Coast, Gold Coast, Mackay and Metro North. This is summarised in Appendix 11.

The documentation received informed the evaluators in key areas including governance, operating processes, reference to government requirements, feedback received from schools and consumers and program outputs. Some provided an analysis of issues and barriers they were experiencing.

Governance is supported through establishment of Management Groups, regular meetings, Joint Partnership Agreements, Memorandums of Understanding, and a clear understanding for the need for collaboration, communication, role definition and timely and effective service provision. Clear processes, in particular relating to referral

management were seen as crucial, with several regions providing these processes to ConNetica as evidence.

Evidence was provided of the standard Queensland Ed-LinQ program documentation that formed the basis for all operations. Implementation plans, reporting and strategic planning was referenced back to the Government's overarching requirements and target areas.

The feedback collected by Ed-LinQ Coordinators from schools and collaborators was overwhelmingly positive. The need for the services being offered by Ed-LinQ was supported, with many mentioning the increasing incidence and complexity of children with mental health problems, often involving families, and how the Ed-LinQ initiative helped give them skills and confidence to meet those needs, in concert with the individual expertise of facilitator and the CYMHS staff. Accessibility was seen as key to good outcomes.

Of note was the feedback from schools, where professional development opportunities, access to expertise and the timeliness of services being mentioned in many environments.

It is interesting to note that the feedback generally indicates that the outcomes required in the areas of Strategic Partnerships, Enhancing Capacity and Clinical Guidance are being improved by the program.

One region indicated that 486 meetings were held in a school term. These were CYMHS related, possible mental health related and non-mental health related such as staff development and advice. If extrapolated to a full school year this equals over 1,800 meetings and interactions.

## Ed-LinQ Workforce Development Program

The evaluation team was provided with two reports on the Ed-LinQ cross-sectoral workforce development undertaken in 2011 and 2012<sup>108 109</sup>. A third report covering 2013 could not be included in the review.

In 2011, training was offered over two consecutive days in Mackay, Rockhampton and Gold Coast. A total of 110 participants attended the programs with just over 45% from Queensland Health, 35% from education sectors and the remainder from youth sector and NGOs. The results from the workshops was generally very positive in terms of satisfaction, participant learning and confidence and the advancement of cross-

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<sup>108</sup> Qld Centre for Mental Health Promotion, Prevention and Early Intervention. *The Ed-LinQ cross-sectoral workforce development pilot May-August 2011. Final Report*

<sup>109</sup> Qld Centre for Mental Health Promotion, Prevention and Early Intervention. *The Ed-LinQ cross-sectoral workforce development workshops March-June 2012. Non-suicidal self-harm. Final Report*

sectoral relationships. On the last point, at one of the sites, only a handful of CYMHS staff participated which compromised this objective.

In the 2012 programs, eleven 2-day programs were conducted in nine locations across the state with 312 attendees. A third of the attendees were from mental health services. Again results were positive for self-reported changes in knowledge and confidence and improved cross-sectoral relationships. These short reports on the cross-sectoral training and the results from the indepth interviews, highlight that the Ed-LinQ Initiative is a provider of quality training in child and youth mental health to the stakeholder groups and that participants found the training programs provided the opportunity to increase skill and establish networks with a cross sector of agencies.

## Qualitative Data

### Focus Group Findings

The following qualitative data is based on the outcomes of four face-to-face focus groups, one service collaboration meeting and one joint CYMHS and school welfare meeting that was observed by a member of the evaluation team. This data was collected during June 2014 in Mackay, Gold Coast and Sunshine Coast. These regions were targeted by the evaluation team based on the earlier interviews, which indicated high levels of engagement with schools. These interactions, the focus groups and meetings, involved a cross section of service providers including primary health workers, guidance officers, chaplains, school based health nurses, school principals and CYMHS team members. A total of 36 participants attended the four focus groups and meetings, which were approximately of one hour in duration.

### Range of activities undertaken by Ed-LinQ Coordinators.

The range of activities and functions undertaken or coordinated by the Ed-LinQ Coordinators in Mackay, Gold Coast and the Sunshine Coast included:

- Professional development sessions that were tailored to the unique needs of individual pre, primary and secondary schools and groups of schools on a range of topics including identifying the signs and symptoms of mental illnesses, strategies to improve well being, referral pathways to the CYMHS team and or other appropriate services, suicide ideation, suicide postvention, available mental health resources – online and hard copy
- Workforce capability workshops professional development opportunities conducted by Anthony Hillin, (Ed-LinQ Statewide Training Coordinator) that were attended by a cross section of community service and allied health providers and school personnel
- Regular newsletters outlining tips and strategies on a range of mental health related topics, available resources and services
- Regular meetings with schools that were attended by student welfare staff (guidance officers, counsellors, chaplains and school based nurses), principals and deputy principals to discuss relevant contextual issues impacting the mental health and well being of school students and the school community in general, available and relevant services and resources, specific needs and progress of students needing and or currently accessing support and early intervention strategies to best enable preventative outcomes

*Our Ed-LinQ Coordinator plays a pivotal role in bringing all relevant staff and services together. This has really improved the quality of mental health services we are offering to students.*

- Joint case management meetings with CYMHS team members, school welfare staff (guidance officers, chaplains and school based health nurses) and the students' parents to discuss suitable interventions and support mechanisms at home and in the school
- Ed-LinQ Coordinator and other CYMHS team members being available to assist staff to debrief after serious and disturbing experiences relating to students' mental health issues in the school, including suicide postvention. This was seen as a very positive contribution to school staff's health and well-being.
- Improved working relationships between CYMHS and the SBHN in relation to the provision of mental health services, which was identified as a very positive contribution to students' health and well being as their competencies expanded and enhanced the range of services that could be offered to schools, students and parents. Their involvement especially enhanced the provision of prevention and early intervention services.
- Regular meetings with representatives from clusters of schools, usually attended by guidance officers and principals or deputy principals to discuss broad mental health and well being needs of the cluster, strategic workforce development needs, referral pathways, service needs and strategies to secure required services
- Regular meetings with groups of guidance officers to discuss broad mental health and well being needs of the region, workforce development needs, service needs and strategies to secure required services and referral pathways
- Initiation of regular meetings between CYMHS team members and their allocated school to discuss whole of school mental health and well being contextual issues, service and resource needs generally and specific student needs and associated case management progress
- Facilitation of parent information evenings on a range of mental health related topics
- Providing opportunities for schools to collaborate with needed services by identifying school needs and suggesting appropriate service referrals
- Advocating for regions to have access to various school based mental health programs such as KidsMatter in the Mackay region
- Documentation of service referral pathways, and
- A link between the CYMHS teams and schools, which enhanced the flow of two way communication, mutual understanding of needs and service offerings and streamlined service referrals.

*The newsletters that are distributed by the Ed-LinQ Coordinator are very informative and keeps us (school) up to date with the latest resources, research, and evidence.*

## Increasing need for mental health services

It was reported that the incidence of students presenting with mental health issues, especially anxiety and trauma related concerns was significantly increasing in schools.

There was agreement that the Ed-LinQ Coordinators had played a key role in improving the early identification, prevention and provision of clinical mental health services to students. There was significant and unanimous support for this role to be continued as schools were not confident in their capacity nor competency to meet the current and growing need for mental health services for young people in schools. One focus group participant shared that the positive mental health outcomes for students in the school were also positive for their local community as a whole.

Four principals attending one focus group discussion were in agreement that '**Ed-LinQ is an essential service** given the increasing prevalence and complexity of mental health problems in schools'.

### Local governance arrangements and engagement of Ed-LinQ services

These varied in the three areas and their structure directly reflected the needs, context and school support for the provision of Ed-LinQ related services.

Structures included formal and scheduled interagency meetings with guidance officers, principals, CYMHS and other youth mental health providers who meet to discuss the health and well being issues of young people in their region/cluster, strategies and services to best meet these needs such as streamlined referral pathways, alternative CYMHS service offerings and professional development requirements. This approach was most noticeable on the Sunshine Coast and Gold Coast. Clusters have been adopted in those large geographical regions such as the Gold Coast so that specific needs of areas are identified and addressed.

In those regions where support for Ed-LinQ is not universal across the region, the Ed-LinQ Coordinator has used their initiative to establish groups of like-minded individuals who valued the provision of Ed-LinQ services and agreed to work collaboratively to improve the provision of mental health services to young people. In this case, regional guidance officers meet as a collective group and regular meetings are scheduled with a range of service providers.

All Ed-LinQ Coordinators who were based in the regions where the focus groups were conducted reported directly to the CYMHS Team Leader and it was unanimously supported that the Ed-LinQ role needed to be embedded within the CYMHS team to provide schools with a streamlined and integrated access to a range of mental health services that met varying levels of needs.

In relation to formal Memorandums of Understanding (MOUs) between Education and Health Departments, there was a misconception that the Education Department had not signed the required paper work. In reality, the Education Department had signed the relevant documentation, however Queensland Health's signing coincided with the

establishment of the Hospital and Health Services (HHS) and that the magnitude of other activities during this structural change meant that MOU had not been seen as a priority and therefore not completed. In the absence of this formal MOU, focus group participants reported that they decided to “just get on with business, regardless” and therefore created structures that best suited the context of their region.

## Enabling a planned approach to mental health in schools

A consistent benefit attributed to the Ed-LinQ Coordinator was their ability to provide advice to schools on strategic and integrated approaches to the utilisation of a range of mental health services and programs so that specific school needs were best met and required outcomes were more sustainable. Schools reported often feeling bombarded, overwhelmed and not adequately informed to make appropriate decisions about which mental health programs to deliver in their school. They agreed that the Ed-LinQ Coordinator could play a key role in assisting the schools to make these program selections.

*I find the networking meetings provide the opportunity to discuss the needs of our local area. This is very valuable as we have particular needs that need to be addressed*

## Improved Service Collaboration and Integration

There was unanimous agreement that the Ed-LinQ Coordinator had facilitated improved working relationships between schools, CYMHS and other relevant services. This improved collaboration has resulted in the following outcomes:

- Increased contact between service providers via workforce development programs and joint case management, which enhanced trust and credibility between services. Strengthening of professional working relationships due to a better understanding of available services, scope of service provision and operating context.
- Improved access to and utilisation of CYMHS services as a result of CYMHS case managers being assigned to and undertaking scheduled monthly meetings in schools to discuss students' needs and associated case management and, when required, meet with parents and students to provide clinical services.
- Discussion on school contextual issues that are impacting health and well being outcomes for students and staff, identification of resource needs and or share relevant resources.
- Ed-LinQ Coordinators sharing updates on current or potential case management requirements with CYMHS team members, which enhanced case management interventions and awareness of potential needs.

*Knowing what I (CYMHS team member) have just learnt about the context of the school and the principal's willingness to address mental health issues, we can now offer a range of services. I was not aware that school staff knew so little about our services and mental health issues.*



- Better understanding of other services' policies and procedures especially in relation to confidentiality and associated sharing of client information.
- Improved utilisation of CYMHS services and working relationships between members of the CYMHS team and schools as a result of cross sector networking and professional development opportunities.
- CYMHS staff better understanding the way in which a school's contextual issues, such as the influence of a principal's support for mental health services were impacting the health and well being of students and teachers and resulting commitment to various intervention strategies.
- Interagency delivery of a range of professional development programs such as Youth Mental Health First Aid, which further strengthens and demonstrates the benefits of service collaboration.
- Increased willingness amongst services to assist one another to overcome barriers to accessing/utilising mental health services for young people.
- Timely resolution of misunderstandings between services and shared problem solving to increase appropriate referrals and improve service access and outcomes.
- The Ed-LinQ Coordinator had improved the working relationship between the school based health nurse (SBHN) and the CYMHS team. This improved the range and quality of integrated services offered to young people in schools.
- In Mackay, the Ed-LinQ Coordinator was a key reason for the roll out of Kids Matter and Mind Matters in the region. The Ed-LinQ Coordinator knew that the program had the potential to address many of the region's needs and that the initial plan was to not offer the program to Mackay. As a result of her input and advocacy the program was offered to the Mackay Region.

*We (CYMHS) are often prepared for the cases before the referral comes, as the Ed-LinQ Coordinator routinely shares the outcomes of school meetings and needs of particular students.*

*CYMHS involvement has lifted the collective capability of Guidance Officers*

## Improved service referral processes

There was unanimous agreement that the referral processes to CYMHS was more efficient. Schools, as a result of the work undertaken by the Ed-LinQ Coordinator were clearer about what cases to refer and how to refer to CYMHS, which reduced the number of incorrect referrals and associated wasted effort, time and frustration. It was reported that the reduction in incorrect referrals also assisted with reducing the waiting time to access a CYMHS appointment in some locations, as the CYMHS teams did not waste time reviewing and rejecting

*As a result of our Ed-LinQ Coordinators relationships with the schools, our CYMHS team now has more Indigenous students accessing CYMHS services,*

inappropriate referrals.

Some parents were reported to have commented to the school guidance officer that they were impressed that they did not need to wait too long to get an appointment for their child. Another improvement in the referral process related to the Ed-LinQ Coordinators knowledge of various referrals, which enabled them to provide the CYMHS team with more background information about various students even before the referral had been received. In some instances this ensured that those students who needed to be seen immediately were “fast tracked” to an appointment and the CYMHS team members were better informed about the needs and context of the young person accessing their service.

Another positive comment attributable to the referral process being better understood and agreed was the provision of consistent services and school staff being able to confidently and correctly outline to students and their parents the referral process and activities that would be undertaken during case management.

### Reduced crisis interventions

It was reported by CYMHS team members that their case management practices have become less crisis and reactive focused due to improved referral processes and schools’ ability to provide students with appropriate early intervention support. These outcomes were directly attributed to the role of the Ed-LinQ Coordinators who had provided opportunities for schools to develop their staff’s expertise in a range of mental health issues and better knowledge of when and how to refer to CYMHS. These outcomes were positively viewed, as they often resulted in young people not experiencing severe mental health problems.

### Reduced incidence of hospitalisation due to early intervention and prevention

In Mackay it was reported that the earlier identification of students with anorexia and provision of intervention/prevention strategies had resulted in a noticeable reduction in hospitalisation and length of hospital stays for these young people. This outcome was directly attributed to the role of the Ed-LinQ Coordinator and her ability to ensure that these students received timely access to services to minimise the severity of their condition and that schools were better informed about what signs to look for to determine if referrals to CYMHS were needed. Members of the CYMHS team noted that this outcome had resulted in reduced health costs and associated emotional grief for all affected stakeholders. This outcome was directly attributed to the work undertaken by the Ed-LinQ Coordinator.

*Our region has reduced hospitalisations relating to anorexia. This would not have occurred without the work undertaken by the Ed-LinQ Coordinator.*

## Embedding mental health in the curriculum

It was noted that in those schools where significant effort had been applied to improving the mental health literacy of school staff and the proactive management of young people's mental health there was **an increased ability to embed mental health in the curriculum**. This embedding reduced the likely severity of young people's emerging mental health issues as they were identified sooner and early intervention strategies were applied. The role of the Ed-LinQ Coordinator in enabling these outcomes was critical as it was reported that they were the enablers of the professional development, ongoing timely advice to schools on student needs and improved relationships between schools, CYMHS and other services.

## Parental Involvement

In many schools, parents were identified as a critical element in the provision of holistic mental health services to young people. They were always invited to participate in the management of their children's mental health plans. The relationship building between the parents, school and CYMHS that resulted helped to build mutual trust, enable open and ongoing communication to monitor their children's well being and offer appropriate support as needed. One principal noted that once parents were better informed and confident in their ability to assist their children they would only contact CYMHS when they knew more expert support was needed. This knowledge and confidence boosted the parents' willingness to play an active role in their children's recovery, which significantly improved and sustained positive outcomes.

*When the parents participate in the case management meetings with the school, Ed-LinQ coordinator, CYMHS and the school the outcomes for the students are much better.*

## Improved students and teachers health and well-being

As a result of mental health professional development delivered by the Ed-LinQ Coordinator, teachers were more confident and competent to identify students' needs in relation to mental health and to appropriately intervene. Principals, guidance officers and teachers did not feel burdened to provide mental health services but rather took solace in knowing that available services could be accessed and how they could positively contribute to the health and well being of their students. This knowledge improved teachers' well being as it reduced their anxiety around mental health issues, as they felt better prepared and confident in knowing what to do and were clear on the boundaries of their role in relation to mental health and what other services they could access if clinical or more indepth support was required.

## Need for increased use of online media

There was recognition that there needed to be more information relating to the availability of online mental health services especially for males who are more reluctant to attend face-to-face services. It was preferable to see these services as a part of an integrated mental health service delivery framework and suite of available products.

## Personal attributes of the Ed-LinQ Coordinators

There was unanimous support that those individuals in the Ed-LinQ Coordinator roles needed to demonstrate excellent interpersonal and technical skills. The role required effective use of influencing skills to establish and maintain mutual trusting relationships, build and maintain networks, time management and organisational skills and initiative to identify needs and develop tailored interventions. Professional qualifications in education and psychology provided first hand experience in the work context of schools and CYMHS and helped to build the Ed-LinQ Coordinators credibility with the schools and agencies. In some situations, such as suicide postvention, the school has directly requested the expertise of the Ed-LinQ Coordinator as this person had an existing relationship with the school that is credible and mutually respected.

*We have confidence in our Ed-LinQ Coordinators ability and support and as a consequence we are more willing to address students' mental health needs in the school.*

## Interview Findings

A total of 32 interviews, with 39 individuals, were conducted with a cross section of stakeholders. These included all Ed-LinQ Coordinators, CYMHS Directors and team leaders, other CYMHS staff, a SBHN, a school principal, national and international thought leaders on mental health, the Ed-LinQ workforce development providers, individuals from programs similar to Ed-LinQ, and members of the Ed-LinQ Evaluation Steering Committee. These face to face and phone interviews were completed on a one to one basis and were generally of a half hour in duration. They were conducted during March – June 2014. The following information provides a summary of the key findings that arose during the interviews.

*The Ed-LinQ position is a fundamental element of the CYMHS team. We see this role as critical to improving working relationships between schools and CYMHS and improving referral pathways and increased early intervention.*

## Ed-LinQ Coordinators - overview

The length of time in the Ed-LinQ Coordinator role varied from 5 years to less than 12 months. Some Ed-LinQ Coordinators initially were employed in the CYMHS team as clinicians and transitioned to the Ed-LinQ Coordinator position when the role was created in 2010. Those that had a strong connection with the CYMHS team prior to the creation of the Ed-LinQ Coordinator role noted that their existing relationships helped them to gain support for the functions and for them to build strong working relationships between this role and the clinicians. One Ed-LinQ Coordinator shared that in their region there was not strong support for the new position and that this was

the driving force behind their collection of data to demonstrate activities, cross sector support and outcomes for the role.

The professional backgrounds of the Ed-LinQ Coordinators included nursing, psychology, social work, youth work and teaching. Some Ed-LinQ Coordinators had limited knowledge of mental health prior to commencing the role. The reporting relationships for Ed-LinQ Coordinators varied across the state. Some reported directly to the CYMHS team leader, while others were not included in the CYMHS team. Those whose reporting relationship was the outside CYMHS reported that it was difficult to enhance working relationships between CYMHS and schools.

Those Ed-LinQ Coordinators whose role was seen as an essential element and function of the CYMHS team were far more successful in arranging regular meetings between CYMHS staff and schools, involving CYMHS more closely in joint case management planning and improving the referral process between CYMHS and schools. Some Ed-LinQ Coordinators reported that frequent change in the person holding the CYMHS team leader role had resulted in a lack of consistent and clear direction in relation to the key deliverables relating to her role as each team leader had different expectations. There was strong agreement amongst Ed-LinQ Coordinators that they wanted more clarity around their role, especially in relation to services offered to schools, contribution to clinical services and data collection and reporting.

*Clearer and consistent governance structures would greatly enhance the Ed-LinQ role's strategic and state wide contribution to the health and well being of young Queenslanders.*

## Ed-LinQ Key Stakeholders

Ed-LinQ Coordinators identified the following roles and organisations as key stakeholders with whom they regularly met to improve the provision of mental health services to young people, improve cross agency collaboration and referral pathways:

- CYMHS team members
- Providers of ATAPS services for children
- Medicare Local (previously Divisions of GPs)
- Headspace
- Local GPs, psychologists and psychiatrists
- School principals, deputy principals and school welfare staff including guidance officers, counsellors, chaplains and school based health nurses, parents
- MindMatters and KidsMatter providers
- Representatives from Catholic and Independent schools

- Anthony Hillin and Rob McAlpine - the Ed-LinQ Statewide Training Coordinators who delivered the state wide Ed-LinQ workforce capability program
- Youth Support workers
- Residential Care workers, and
- Foster Care workers.

## Governance Arrangements

Varying governance arrangements were identified across the state. The support of local schools and the CYMHS leadership played a key part in the governance structure. In some regions where formal structures had once existed, these were discontinued when there was a change in government and resulting structural changes. Many of these governance frameworks have not been reconvened. Individuals included in governance structures included principals and guidance officers/counselors from State, Catholic and Independent Schools, representatives from flexible learning centres, school based health nurses, key service providers such as headspace and Medicare Locals and CYMHS team leaders and or Clinical Directors from Queensland Health.

In some regions it was reported that the Ed-LinQ Coordinator had jointly developed their Ed-LinQ Strategic Plan with input from members of their governance group. This involvement maximised the members' willingness to support and promote various initiatives. In the North Queensland Education Office, a new role had been created which focused on building capacity in mental health in the area. The Ed-LinQ Coordinator was meeting with this person fortnightly to discuss strategic training needs and solutions, collaborative partnership arrangements and other business. The Ed-LinQ Coordinator viewed this new role very favorably.

Many Ed-LinQ Coordinators and other stakeholders reported a need to have consistent governance arrangements so that key deliverables and roles were clearly articulated and individuals could be held accountable for their defined role and resulting contribution to young people's mental health and well-being.

Some Ed-LinQ Coordinators reported difficulties that they had experienced as a result of personnel changes in the CYMHS Team Leadership. This had resulted in different demands being placed upon the Coordinators in relation to the services they offered, and reporting requirements and varying levels of support for the Ed-LinQ role. One Ed-LinQ Coordinator reported that they had not had a CYMHS Team Leader since November 2013 which meant that she had no one with whom to discuss cases, problem solve or debrief. This lack of support made it difficult for the Ed-LinQ role to have maximum strategic impact and broader cross sector support in the region.

Lack of mandate to engage Ed-LinQ services and evidence based programs

There was a concern that principals now had more autonomy in relation to which services they allowed in their schools and that in one school this had negatively impacted their willingness to engage Ed-LinQ services. It was shared that one school had a significant number of students who were being excluded due to reported behavior problems yet no mental health interventions were sought. Converse to this lack of support for Ed-LinQ, another school principal who previously had not wanted to engage Ed-LinQ was now much more interested as he realised that the evidence linked improved mental health outcomes to improved teacher well being and morale and student academic performance.

Another concern was expressed over the lack of formal processes to vet mental health programs that are adopted in schools. Some principals and other school personnel reported that they felt overwhelmed by the breadth of mental health services being offered to schools and that they are not suitably skilled to evaluate the appropriateness of various programs to include in their school. It was noted that the Ed-LinQ Coordinator could assist with this vetting and identification of how the various programs could be included to address various school and individual student needs.

### Range of Training programs provided by Ed-LinQ Coordinators

Ed-LinQ Coordinators provided schools with access to a range of professional development opportunities to schools, parents and services within their broader community. Topics covered included:

- Anxiety and depression
- Bullying
- Youth Mental Health First Aid
- How the brain develops
- Trauma and attachment theory
- Understanding challenging behaviour
- Suicide prevention and post suicide support strategies
- Self help programs – on line and face to face programs
- Resilience, and
- Building self esteem.

*Regular in-services for staff and parent programs was critical to embedding mental health issues in the curriculum.*

*Our staff are more willing and able to address students' mental health issues. They know what to do and are clear about their role and to whom else they can refer if more in depth assistance is required. This has improved our teachers' self being.*

Many Ed-LinQ providers worked with other agencies and or guidance officers to deliver these programs. This shared facilitation provided stakeholders with access to



cost effective professional development, training times that suited participants and further demonstrated the value of cross sector collaboration. Some Ed-LinQ Coordinators shared that it would be advantageous to have a mechanism to meet and share their programs with one another so as to minimise duplication of effort and develop shared best practice programs on a range of topics.

## Embedding mental health into everyday school practice

One regionally located school principal reported that the Ed-LinQ Coordinator's availability to deliver evidence based mental health related in-services programs to her teachers and students' parents minimised associated costs, such as travel and time away from school. This same school reported that they ensured that the in-services were provided regularly so that the concepts and strategies remained fresh in the minds of the teachers and as a consequence the teachers were more willing and able to apply the strategies to everyday teaching.

This regularity of professional development and focus on applying the strategies resulted in the school embedding a range of mental health initiatives with a focus on prevention and early identification in their school's curriculum and policies. This school was adamant that thanks to the Ed-LinQ Coordinators role, they had **reduced the prevalence and severity of mental health issues experienced by their students and improved the well being of their staff**

as the anguish associated with teaching students with mental illnesses had been reduced. In addition, **teachers were more willing to address students' mental health issues** as they were clear on the boundaries of their role in relation to mental health, they knew that they could rely upon the Ed-LinQ Coordinator to provide assistance if required and that if access to a clinician was required that the support of the CYMHS team would be forthcoming. The senior administrative staff from this school were adamant that, with the support of the Ed-LinQ Coordinator and the associated services, their **students' well being and learning and academic performance had improved**.

*We need more clarity in our role so that we can all focus on the same key deliverables and our stakeholders know what they can expect from all of us.*

It was noted by Catholic Schools that much of their work in the area of mental health and well being was incorporated into their personal development curriculum. It was also noted that in these schools that there was an expectation that mental health programs were to be part of an overarching and integrated curriculum framework and it was for this reason that the KidsMatter and MindMatters Programs were adopted.



## Ambiguity in relation to Ed-LinQ Coordinators' Role

With the change in state government and the reduction in state government preventative services, limited funds and loss of CYMHS staff, many Ed-LinQ Coordinators found that they were required to undertake clinical activities such as intake and case management. Time devoted to these tasks ranged from 0-50% of their role.

While the Ed-LinQ Coordinators understood the need to fulfill these roles there was a strong consensus that it did take them away from delivering key Ed-LinQ functions relating to professional development, improved interagency work and referral pathways and therefore limited the effectiveness of the role in enabling systemic change. This involvement in clinical related services also created some tension between schools and Ed-LinQ Coordinators, as some schools had an expectation that all Coordinators with whom they worked would provide clinical related services, which was not the case. It must be noted that some Ed-LinQ Coordinators valued being able to practice clinical related skills as they believed that this helped them to be more effective in their role as they maintained currency in their clinical expertise and professional registration and boosted their credibility with the CYMHS team members.

## Service Referral Pathways

Across the state there were different approaches to referrals including phone contact, faxing/emailing referral documents and online solutions. There was strong agreement; especially in those regions where there was a close working relationship between CYMHS staff and the Ed-LinQ Coordinator that service pathways between schools and CYMHS were more streamlined and better understood by key stakeholders. This had resulted in reduced time being wasted on making incorrect referrals and CYMHS staff needing to assess these referrals that were inappropriate. It was often reported that schools were now undertaking initiatives that facilitated preventative mental health outcomes and/or early intervention strategies with the support of the Ed-LinQ Coordinator and other relevant services, which reduced the need for schools to refer such cases to the CYMHS team. In some regions, the increased presence of the CYMHS staff in the schools resulting from monthly scheduled meetings to discuss school and individual students' needs and progress with various cases, improved working relationships and mutual trust between CYMHS and schools.

All Ed-LinQ Coordinators reported that the referral pathways had been documented.

*We have no effective way to objectively measure young Queenslanders mental health needs. We need to collect base line data to determine the impact of our initiatives.*

## Breadth of service provision

There was no consistent approach to service delivery across the state. In some regions, Ed-LinQ Coordinators focused on providing services to those schools that had the most referrals to the local CYMHS team. This approach was dependent upon schools making referrals to the CYMHS team. In other regions Ed-LinQ was a reactive service that was dependent upon schools approaching the Ed-LinQ Coordinator to provide services or the Ed-LinQ Coordinator approaching schools to offer services that were subsequently utilised.

These approaches highlighted the lack of baseline data that is available in relation to the health and well being of young Queenslanders. As a consequence the ability to target those schools in most need of mental health services is limited. It was reported that in Rockhampton, since the Ed-LinQ Coordinator's role has not been filled for a significant length of time, there is very limited access to prevention and early intervention services in this region. While subjectively it was reported that there are significantly unmet needs there is no data to quantify this need. Some Ed-LinQ Coordinators reported that they have so many schools to cover in their region that in the absence of any obligations to use the services provided by Ed-LinQ resulted in them work with only those that are interested. One region used a School Readiness Tool to determine if the school is suitable and therefore best placed to effectively benefit from the Ed-LinQ services.

*We have no consistent approach to data collection and the system cannot capture Ed-LinQ functions. This is a major problem that we need to address.*

## Data collection

Due to the lack of consistent data collection and the inability of the Consumer Integrated Health Application (CIMHA), the statewide mental health data system to capture non clinical work completed by the Ed-LinQ Coordinators such as school meetings, interventions, networking and professional development, it is very difficult to provide quantitative measures of performance. The Sunshine Coast Ed-LinQ Coordinator has been able to make some adjustments to the CIMHA system to better capture data about her work however there is still no data on specific services offered to individual schools and the alignment of CYMHS clients with their schools and the role of the Ed-LinQ Coordinator in the referral process.

Ed-LinQ Coordinators do have data relating to workshop attendance, feedback on programs and anecdotal feedback on the positive impact that their role has had on the mental health and well being of the young people and their teachers in their region. The positive outcome for teachers was reported as being due to them feeling more confident in their ability to identify students' mental health needs and available services to whom to refer students if comprehensive interventions were required.

Some Ed-LinQ Coordinators reported that they had written very lengthy reports in relation to their activities, however these were never analysed by more senior staff. There was unanimous agreement amongst the Ed-LinQ Coordinators that the data collection system needed to be improved and that metric requirements, associated business rules and reporting requirements agreed and applied consistently across the state. It was suggested that the reports needed to be tabled at District Level (HHS) and used to inform future mental health strategies and resource allocations.

## The role of the School Based Health Nurse (SBHN)

School and CYMHS team members viewed the inclusion of School Based Health Nurses in the provision of school based mental health services very favorably. This was especially due to their nursing skills, which, in some instances, were enhanced by formal mental health qualifications to assist with early identification. There were examples of the SBHN working closely with the CYMHS team to ensure that school activities aligned with and supported clinical case management initiatives. The SBHN was often approached by students for support, as students were more confident that their needs and discussions would be kept confidential, as the role was not employed by the Department of Education.

*The School Based Health Nurse plays a really important role in the provision of mental health services to young people in schools.*

## Providing services in large geographical areas

It was reported by Ed-LinQ Coordinators that in regional areas, the time they needed to spend traveling to schools reduced the time they had available for direct service delivery. Opportunities to use technology, such as Skype or other online mental health products were seen as positive ways to minimise the negative impact of distance.

*The workforce capability program has greatly improved interagency networking and interagency provision of services.*

## Ed-LinQ Cross Sectoral Workforce Development Program

### **NSW Institute of Psychiatry Workforce Capability Program**

There was strong support for this program, which is a cross sectoral workforce development program. The program targets education, health and other workers who have a core role in providing services to school aged children. The programs seek to develop both knowledge and expertise in mental health and provide the opportunity to establish and strengthen collaborative partnerships. Both outcomes were achieved and the collaboration resulted in understanding of one another's services and ways of continuing to work together to improve the mental health of young people in their area. It was reported by one Ed-LinQ Coordinator that it was now commonplace for

individuals from different organisations to sit together at these sessions, as participants better knew one another and had formed professional working relationships. While one region had chosen not to deliver this program as they already provided services in their area with access to similar professional development opportunities, the majority of other HHS regions were fully committed to the continuation of the program.

## Factors impacting the role and overall provision of mental health services to young people

The uncertainty of the ongoing role of the Ed-LinQ Coordinator has been very difficult for individuals in this position. Some expressed concern about a lack of support for their role and a frustration with the need to continually justify their position. School based guidance officers and chaplains are now experiencing similar uncertainty which impeded the provision of strategic, long term school based mental health and well being programs. Other contextual factors impeding mental health services for young people include reduced NGO mental health services due to state government budget cuts, lack of clarity around the state government's provision of preventative services, changes in CYMHS leadership positions, reduced administration support in schools and increasing expectations on schools to deliver a broad range of services

*The provision of mental health services has been negatively impacted by structural changes, budget cuts and uncertainty in future tenure.*

## Lack of state wide Ed-LinQ Framework

There was unanimous support for the re-establishment of a statewide Ed-LinQ Coordination Group. The key role of this group would be the opportunity for Ed-LinQ Coordinators to network, share resources, identify best practice, agree on reporting and system requirements and jointly work on strategic initiatives. Without this group there is a concern that much duplication of effort occurs as resources are not shared and that Ed-LinQ services are focused on meeting everyday needs and not addressing emerging strategic needs, which would assist Ed-LinQ Coordinators to continue to develop and expand their professional expertise and benefit to schools.

## National and International Thought Leaders

Interviews were held with leaders in school mental health from Australia (NSW, Victoria, WA), US, Canada, Europe and the UK during the course of the evaluation.

In Australia, the general consensus among the interviewees was that the need for universal programs on social and emotional wellbeing, mental health and substance use was no longer questioned. Both the need for such programs (those with sound

evidence) and the evidence supporting there application is overwhelmingly clear notwithstanding the pressures on the school's curriculum.

A further general point of consensus was the need for school and community initiatives to link more closely. This is particularly relevant in the context of the national roll out of headspace centres and various online services for early identification and intervention.

The 'enhanced headspace' program funded by the Federal Government will see new specialist youth mental health service centres opening in 2016. The first Queensland enhanced headspace centre will be on the Gold Coast with a 'spoke' to Logan City.

Finally, the development of online services is changing the landscape rapidly in a number of ways:

- Access to services – anytime, anywhere and in total privacy if required. One result of this is that more males are obtaining information
- Increasing awareness through more online conversations about mental health issues which in turn creates more searching for more information and advice and engaging with services
- Increasing empowerment of the consumer – the Apps now available can help them 'self-regulate' sleep, exercise, mood, diet etc. and get immediate feedback, and
- Opening up many opportunities for service providers to link online and offline services.

Schools were largely seen as not operating in the online space. That is, risk assessment issues overrode the value of utilising and integrating online services and tools.

The developments in online mental health services in Australia are world leading.

In the US there are no formal mental health promotion programs at Federal or State Levels, it is described as an incomplete "patchwork" of mental health services. There are no distinct interagency programs between schools and other services that focus on early identification and intervention in the schools. This situation was described by a senior health academic as problematic as the referral out of the school system usually results in long waiting lists and increase cost due to the increasing severity of the mental illness as the illness is left unattended.

In the US the layers of governance around responsibility for young people's mental health are complicated and not integrated, which impedes access to services and confuses lines of accountability. It was identified that California has a comprehensive approach to mental health in schools and utilises a number of programs including Positive Behaviour Interventions and Supports (PBIS) developed in Maryland, the integration of Mental Health Evidence Based Practices, the school based

'Wraparound' model first developed in Milwaukee, and implementing the SAMHSA curriculum Eliminating Barriers to Education.

In the UK, there has been considerable focus on social and emotional learning in both primary and secondary schools. The SEAL program is now in more than half of all English schools. Selected and targeted interventions for students who are at higher risk or have a mental illness are now gaining traction. The SEAL model provides a clear framework for all schools and health care providers.

The National Institute of Clinical Excellence (NICE) has published and continues to update 'Public Health Guidelines' on social and emotional wellbeing in schools and this gives 'agency' and clear direction to the schools and other stakeholders on these issues.

In Canada, the Canadian Commission for Mental Health collaborated with the national departments for health and education to develop a national framework for school-based mental health services, known as 'Evergreen'<sup>110</sup>. Provincial governments and school authorities have now developed province-wide frameworks to guide local and district comprehensive and integrated school mental health initiatives. The literature related to Evergreen and the Nova Scotia Evergreen framework<sup>111</sup> were accessed in the literature review.

Similarly an Italian Mental Health Expert commended information relating to the European Unions approach to school mental health programs. The literature relating to these initiatives was accessed and included in the literature review.

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<sup>110</sup> The full title is "Evergreen: a child and youth mental health framework for Canada", July 2010.

<sup>111</sup> This is "Wellbeings: the Nova Scotia School Mental health Framework". May 2011.

## Conclusion - Qualitative Findings

The results from the interviews and focus groups are complimentary and highlight the positive and highly valued impact that the Ed-LinQ Coordinator role has had on the mental health of young people. The Ed-LinQ Coordinators undertake a range of activities that have improved referrals, cross agency support and workforce capability and reduced the severity of hospital stays resulting from mental illnesses. In those regions where there is strong CYMHS, school and cross sector support for the role, this positive impact is considerably greater. In addition to enhancing young people's mental health, teachers' well being has also been positively impacted and interagency collaboration has improved.

Key areas from the qualitative analysis that need to be addressed to consolidate and expand the value of the Ed-LinQ Initiative across the region relate to:

- Formalised governance arrangements at the state, region and local levels so that key stakeholders' roles and responsibilities, including those of senior education and health bureaucrats, principals, school welfare staff, Ed-LinQ Coordinators and support services roles are aligned, complimentary, articulated and accountabilities are understood
- A defined role for the Ed-LinQ Coordinator to ensure provision of consistent services across the state
- Improved data collection, analysis and reporting to ensure that services target those schools in most need, best practice is identified and the impact of initiatives is understood and quantified to inform future actions
- Strategic identification of workforce development needs so that programs directly relate to school context and needs in the short and long terms, as this will enhance continued early identification and prevention and embedding of mental health in school curriculums
- Publication of guidelines around standards that must be met by mental health programs that are wanting to be delivered in schools to ensure programs are suitable and aligned with other school curriculum initiatives, and
- Establishment of a state wide Ed-LinQ Coordinators network to provide Coordinators with the opportunity to share resources, identify best practice and undertake joint strategic research or pilots.

## Quantitative Data - Survey Results

### Survey 1 - Schools - Results

The project team contacted 1,272 schools directly and 269 Catholic and 186 Independent schools indirectly through the QCEC and ISA respectively. A total of 186 schools responded to the survey – this is just over 10% of the total number of schools in Queensland.

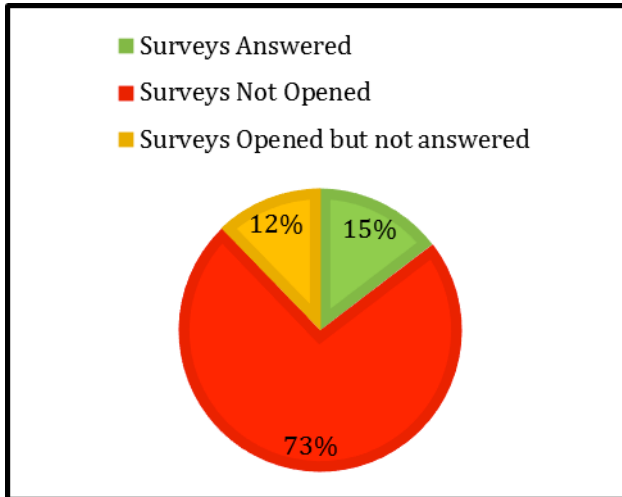


Figure 8: Responses from Qld Government Schools

The majority of the schools (66%) that answered the questionnaire were located in the area of **Brisbane and Moreton**, which includes the Gold and Sunshine Coasts. The next highest number of responses (10%) was received from Northern (based in Townsville). No responses were received from the **Central West Area**.

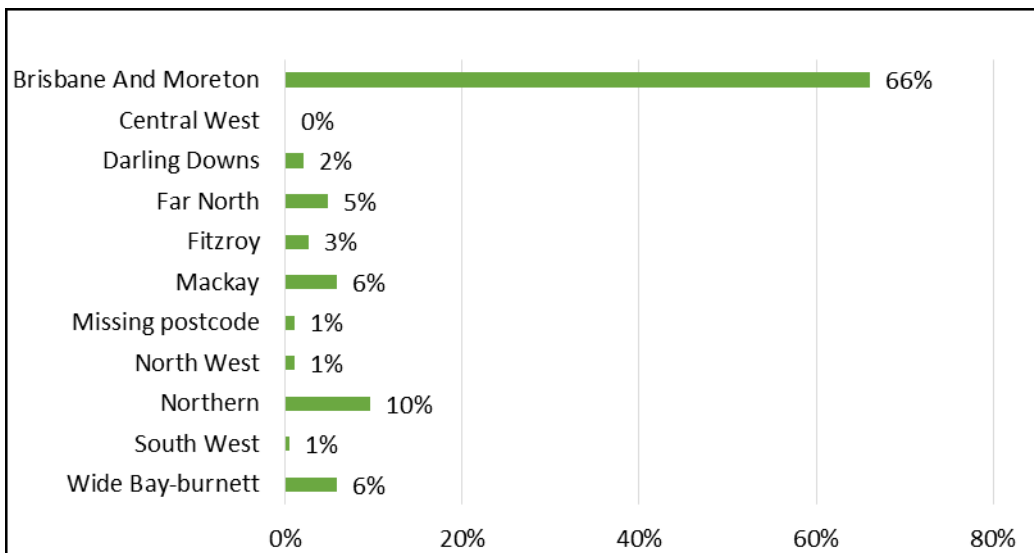


Figure 9: Distribution of responses to Ed-LinQ survey by region



- Most of the schools (60%) that answered the survey were from the Government sector. Approximately 70% of all schools in Queensland are government schools.

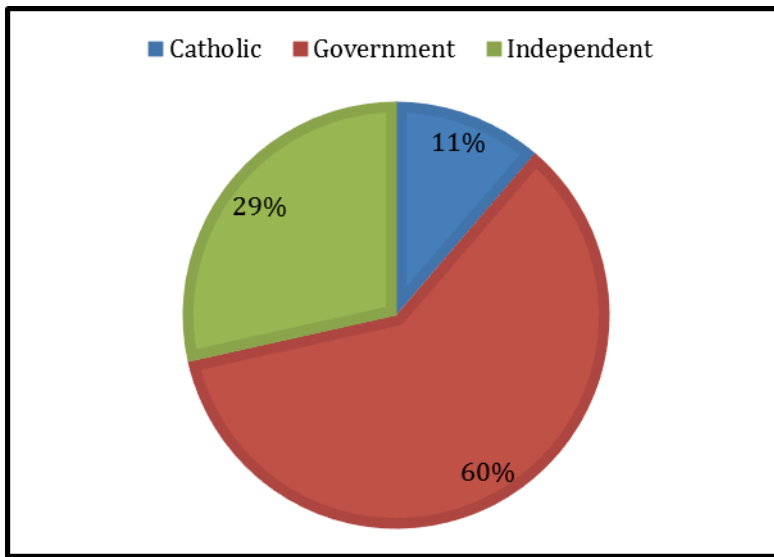


Figure 10: Ed-LinQ school responses by school sector

- The majority of the persons who completed the questionnaire were guidance officers/counsellors (47%), followed by Principals or Heads (33%). Teachers or learning support teachers made up just 4% of respondents.

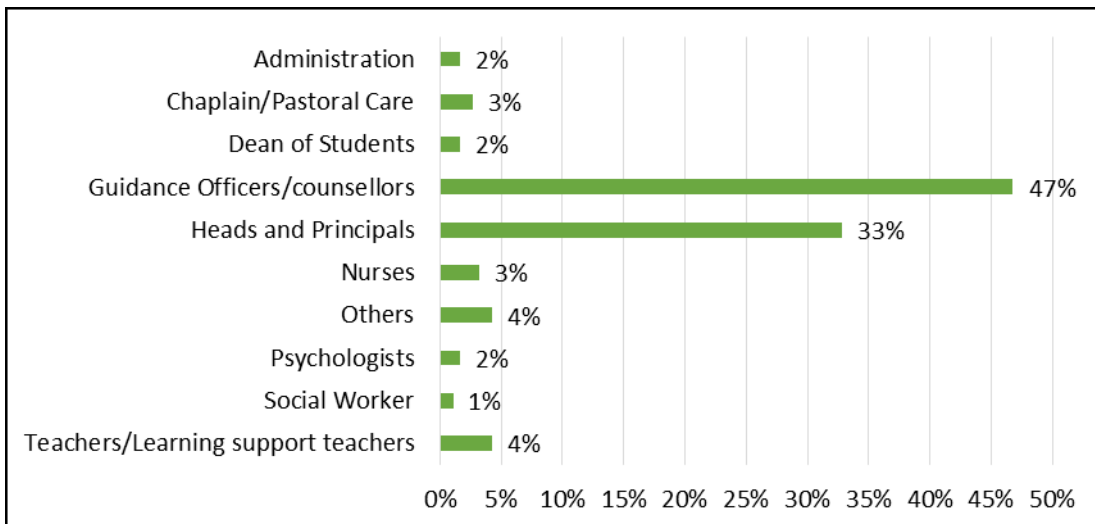


Figure 11: Ed-LinQ school survey - role responses

- It is estimated that the number of students attending schools that completed the online schools survey is 151,356<sup>112</sup>. The majority of the schools that completed the online

<sup>112</sup> It is possible that some of the students were double counted if people from the same school answered the survey. However, this is highly improbable. Although data was confidential, so we do not know the name of the school, we have information on the postcode where the school is located. When the postcode was the same, we compared the IP from where the survey was answered, the sector, the postcode and the telephone. Just in 4 cases there were doubts. So, the error will be lower than 0.5%.

schools survey (94%) covered students aged 10 to 14 years old. By contrast, 65% provided school services to the youngest age group (students 0-5 years).

	Responses	Percentage	Total Number of Students	Average Number
<b>0- 5 years old</b>	120	65%	10355	86
<b>6-9 years old</b>	128	69%	34539	270
<b>10-14 years olds</b>	174	94%	53483	307
<b>15-18 years old</b>	143	77%	52979	370

Figure 12: Estimated number of students in schools

### *What has been the impact of the Ed-LinQ Initiative at the schools?*

By combining a number of the survey questions, an assessment of the level of impact /implementation that the Ed-LinQ Initiative has been made. The level of impact or implementation was classified into six (6) sequential levels as shown in Table 5.

- According to the impact assessment scale, at least 63% of the schools were aware of the existence of the Ed-LinQ Initiative<sup>113</sup>. However, the level of implementation as measured by the online schools survey, was low, with just 28% providing services, interventions and/or technologies directly related to the objectives of Ed-LinQ.

<b>0</b>	<b>No impact</b>	Ed-LinQ has not impacted on the school (i.e. the school does not know about the project)
<b>1</b>	<b>Awareness</b>	Decision makers within the school are cognisant of the topic, have taken action to improve its knowledge on the topic and have received and provided feedback on the information delivered.
<b>2</b>	<b>Assimilation</b>	There is evidence that the school and specific decision makers within the organisation have incorporated the information into their own existing knowledge-base and organisational strategy (including training).
<b>3</b>	<b>Translation</b>	The school has transferred the new knowledge into policy action in legislation, plans, policy programs, regulatory norms, documentation and/or official indicators.
<b>4</b>	<b>Provision</b>	Care delivery, including services, interventions and/or technologies directly related to the new knowledge has been made available and it is used by the students.
<b>5</b>	<b>Monitoring</b>	The school has incorporated the new knowledge into its own assessment, surveillance and monitoring systems.

Figure 13: Sequential levels of the impact of Ed-LinQ

<sup>113</sup> Among the 186 schools that answered the survey, 49 said that they knew the program, but did not complete the survey. We have assumed that the level of impact at these schools were just of awareness.

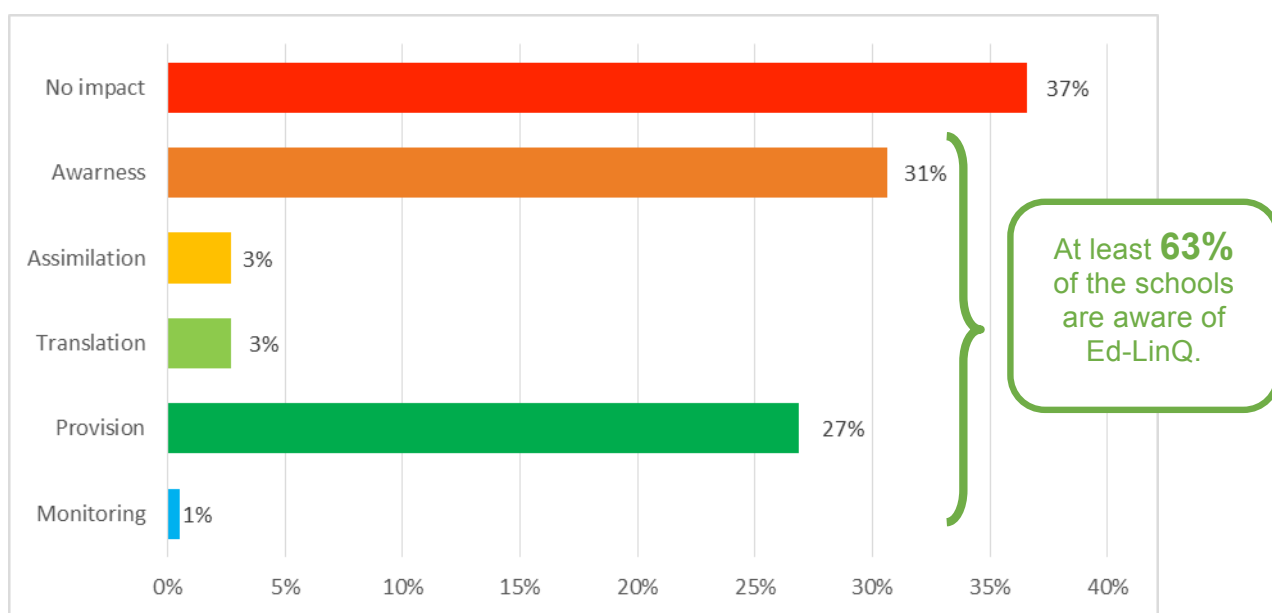


Figure 14: Impact of Ed-LinQ on Queensland schools

#### *Impact of Ed-LinQ in the Schools of Queensland (Geographic Distribution)<sup>114</sup>*

The research team geographically mapped the schools that responded to the online school survey in the Brisbane area and across Queensland. Each one of the schools that answered the survey was located by postcode (see Figures 11 and 12). The dots on each map represent the individual schools that responded to the online schools survey while the color reflects the level of impact reached by the Ed-LinQ Initiative. Where there is an area without any dots, this means that schools in this area did not respond to the survey or provide adequate data.

#### *What do we know about schools where Ed-LinQ has not had any impact?*

- Most of the schools that were not aware of Ed-LinQ were participating in other mental health initiatives (65%). Among them, more than two thirds indicated they would be keen to participate in more mental health related programs. It is also interesting to note that 63% of those schools that were not aware of the Ed-LinQ Initiative and that did not participate in other mental health initiatives, were willing to know more about other mental health programs. This highlights a significant opportunity to expand Ed-LinQ and other mental health programs in schools. It may also indicate a growing awareness of the need for responses to mental health issues for children and young people.

<sup>114</sup> Maps provided by Dr. Thomas Astell-Burt and Dr. Xiaoqi Feng, University of Western Sydney

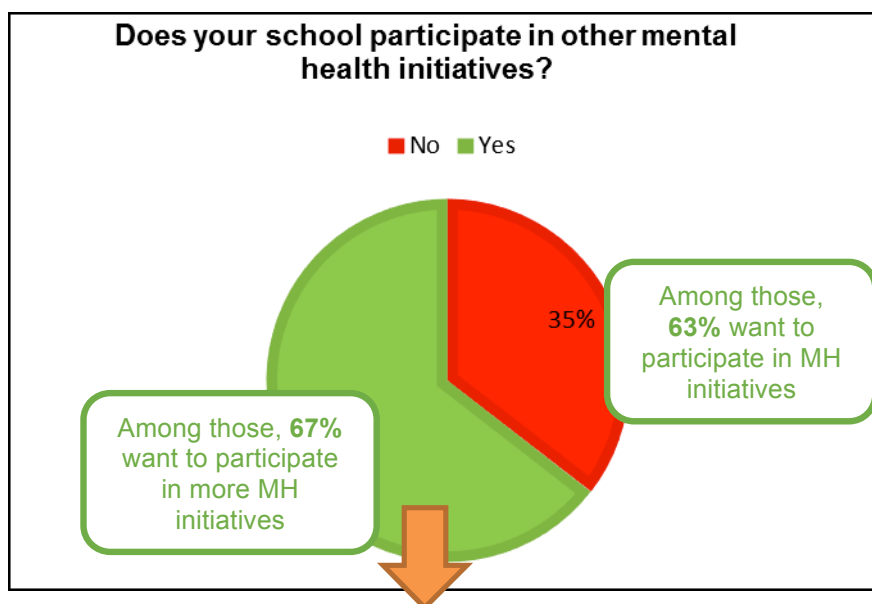


Figure 15: Other mental health initiatives in Qld schools

These schools are participating in the following programs: Awareness program:

- Beyondblue
- Bush Children's
- Dalby hospital family
- Carers link
- Healthy Minds
- ISQ Wellbeing Workshops
- KidsMatter
- Mindfulness
- Braveheart
- MindMatters
- Friends
- You can do it
- Peace Builders
- Positive Psychology program
- Reach Out Program
- Medicare Local Youth Mental Health
- Sunnykids
- Child Safety
- Resilience program
- Specific Programs delivered by school staff.

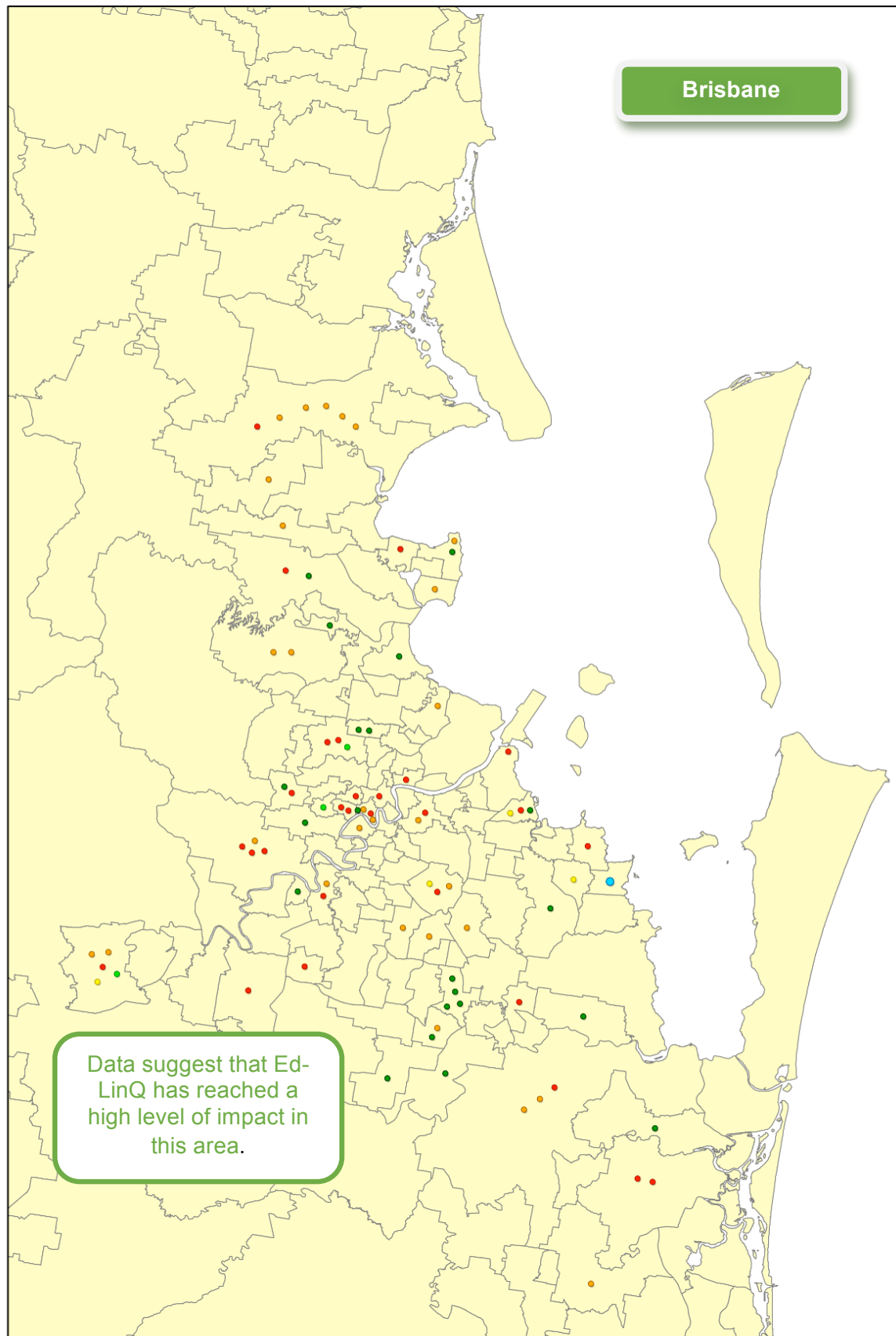


Figure 16: Brisbane region - impact of Ed-LinQ initiative

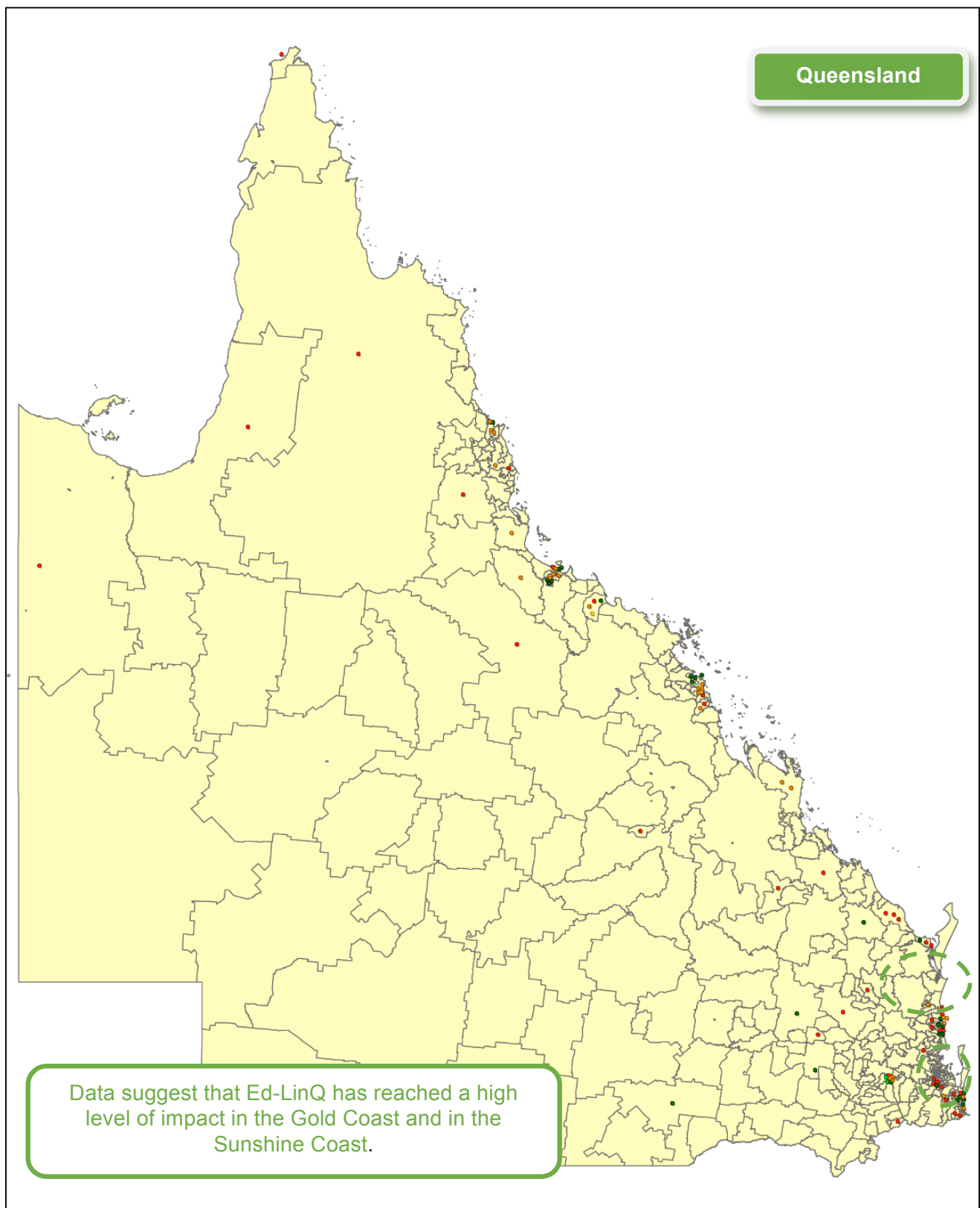


Figure 17: Queensland – impact of Ed-LinQ initiative on schools

### What do we know about the schools where Ed-LinQ has had an impact?<sup>115</sup>

#### General Description

In those schools that were at least aware of the existence of Ed-LinQ, which is in 63% of online survey respondents, we found that:

- **33%** of these schools actively disseminate information relating to Ed-LinQ (i.e. Ed-LinQ was presented at the school)
- **59%** were participating in other mental health initiatives
- **26%** would be and 58% were not sure if they would be willing to participate in more mental health related programs.
- The most common Ed-LinQ related activities that have occurred in schools were training of Students Welfare Staff, followed by defined referral pathways.

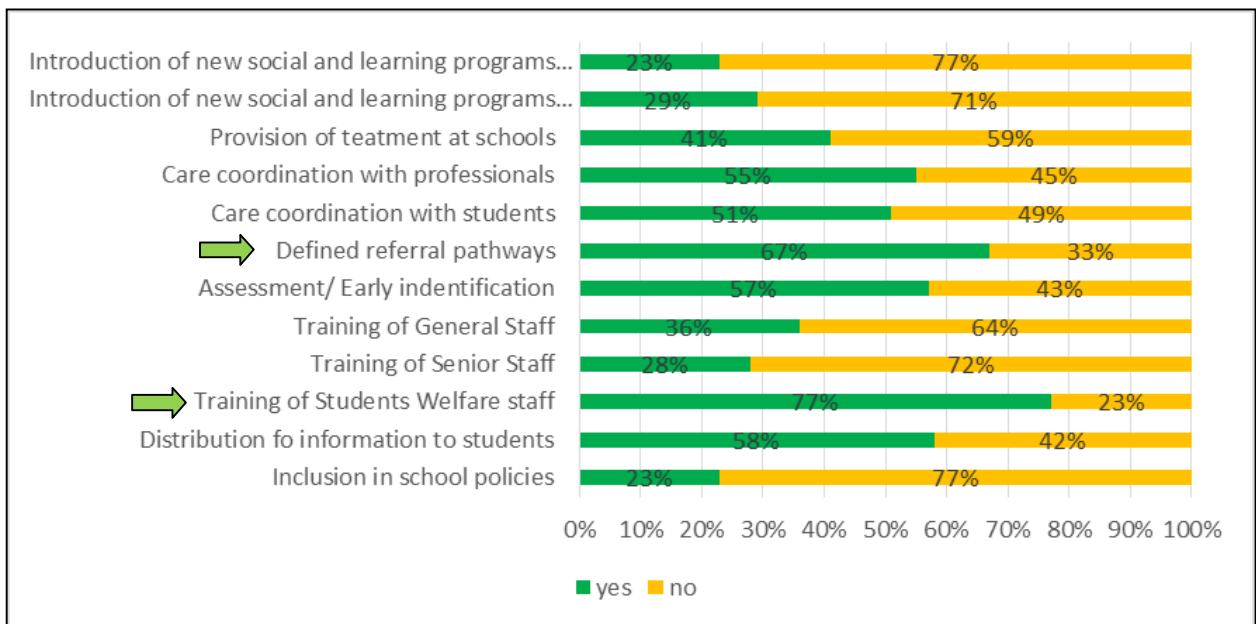


Figure 18: Ed-LinQ initiative related activities in schools

- With regard to **other** social and emotional wellbeing activities being undertaken at the school, the majority (62%) reported mandatory activities related to Pastoral care and/or Personal Development.

<sup>115</sup> We are using information of 69 schools with complete data (out of 118 where there has been an impact)

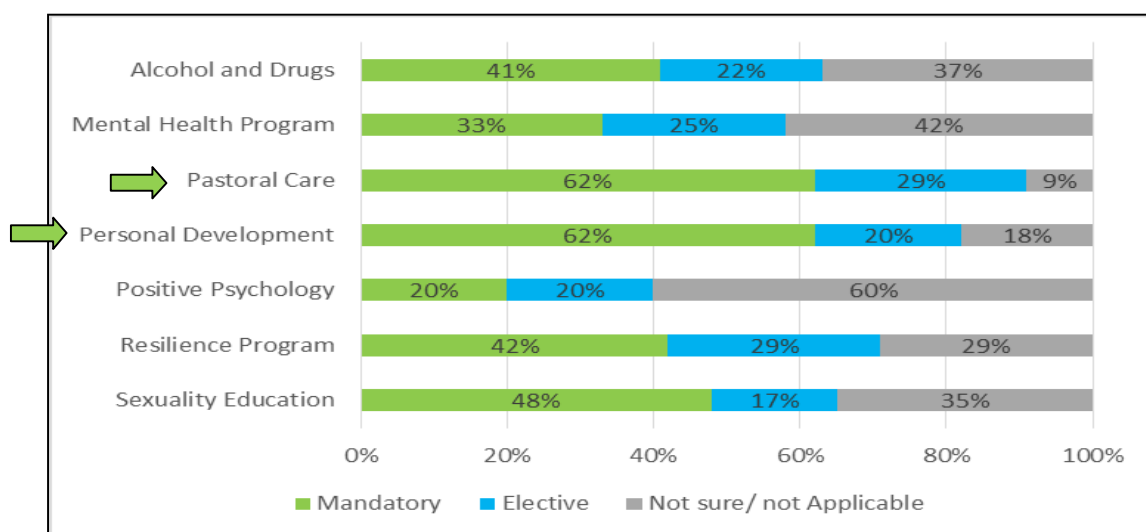


Figure 19: Social and emotional well being activities undertaken in schools

- The majority of the schools reported that **the participation of their school in the Ed-LinQ Initiative contributed** to improved students' access to mental health resources (64%). Student attendance and performance were reported to have improved in a quarter of the schools<sup>116</sup>. Directly relevant to the objectives of Ed-LinQ, was an increased capacity of staff to support students, reported in nearly 3 out of 4 schools (73%), and improved staff knowledge in 2 out of 3 schools (67%). Staff access to mental health resources was also reportedly improved in 68% of the schools.

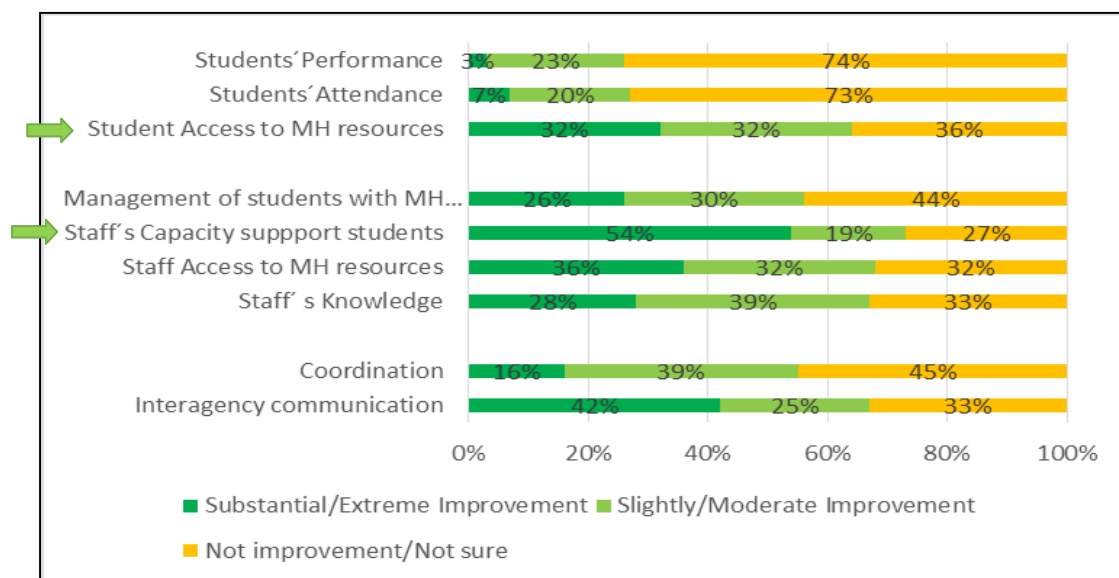


Figure 20: Impact of Ed-LinQ on students and staff outcomes

<sup>116</sup> See comment on relationship with low and high impact later in this section.



Finally, most of the schools (64%) were satisfied with Ed-LinQ Initiative. Only 11% were dissatisfied with this initiative.

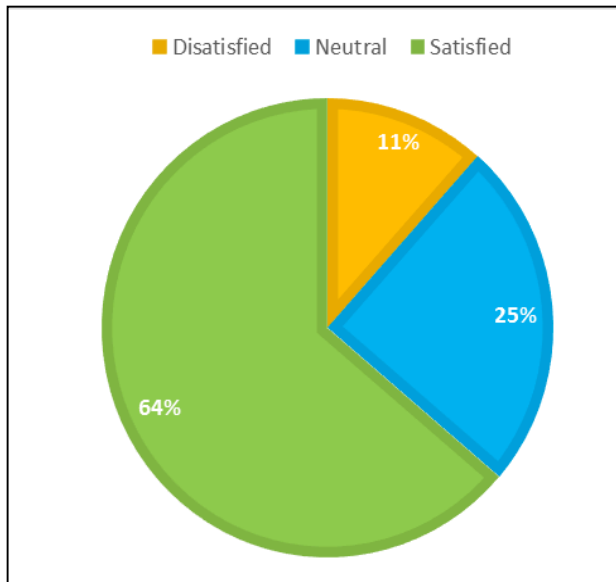


Figure 21: Overall school satisfaction with Ed-LinQ

### Comparison between schools with a Low and High impact /implementation of Ed-LinQ

In order to know what factors were associated to achieving a higher impact/implementation, the schools were separated into low impact/implementation (including impact levels 1,2 and 3 – awareness, assimilation and translation) and high impact/implementation (including levels 4 and 5, provision and monitoring).

The data suggested that:

- Active Dissemination (i.e. Ed-LinQ coordinators and/or staff going to schools) is statistically related to higher impact.

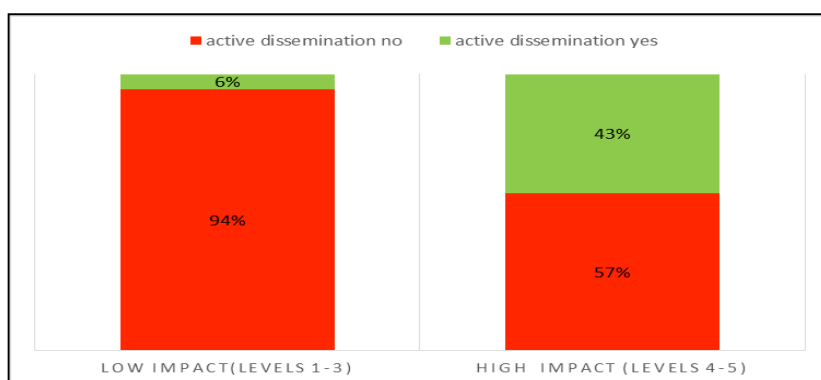


Figure 22: Impact on dissemination of information

- Those schools with a lower Ed-LinQ impact **participated in more mental health initiatives**, although this was not statistically significant. This suggests that those schools where Ed-LinQ had not reached a high level of impact/implementation could be overwhelmed or confused by the array of programs available. Alternatively, it could be that schools with a higher impact had integrated the different mental health initiatives available according to a better understanding of needs and alignment of programs.

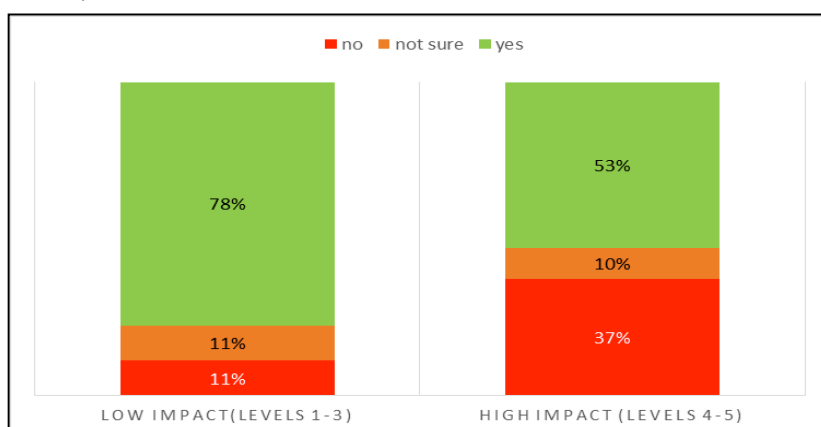


Figure 23: Participation in mental health initiatives

- Those schools with a higher impact/implementation of the Ed-LinQ Initiative perceived more improvement in the areas related **with coordination and interagency communication**, than those schools with a low impact/implementation of the Initiative<sup>117</sup>.
- Schools with a higher impact/implementation of Ed-LinQ also reported greater improvement in those areas related to knowledge staff and capacity to deal with students with mental health issues. These were 3 to 4 times higher than schools in the low impact group.

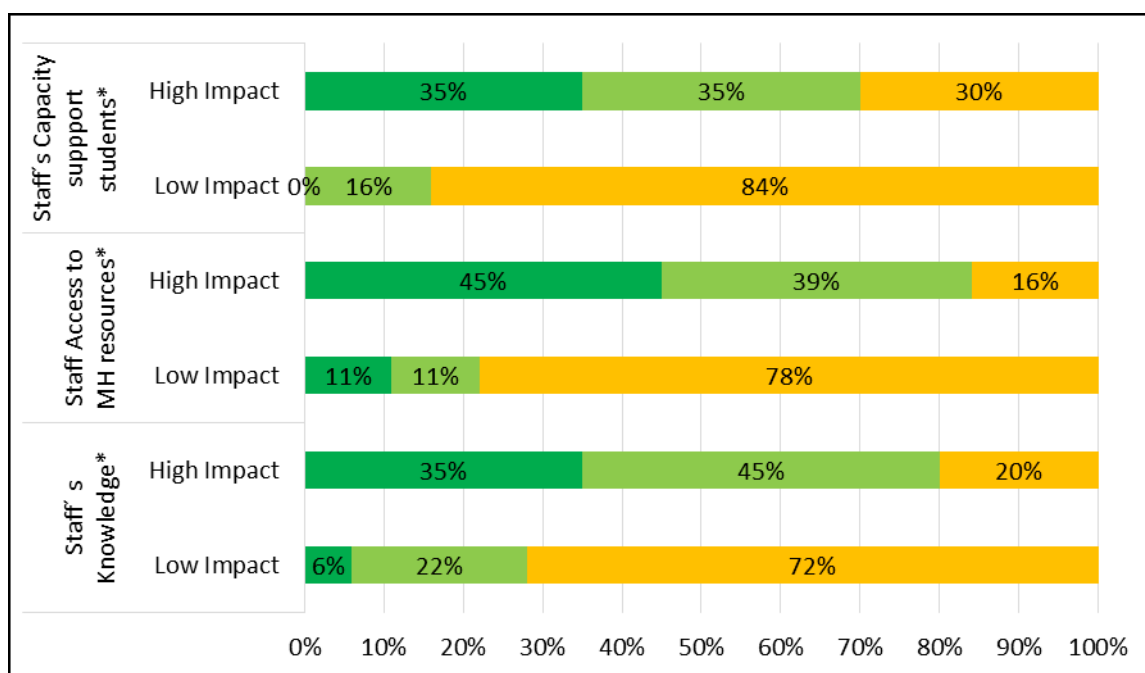


Figure 24: Impact of Ed-LinQ

- However, with regard to students' related outcomes, only an improvement in students' access to mental health resources was found. There were no differences between schools with low and high impact/implementation of Ed-LinQ in the perception that the program improved students' attendance and or performance.

<sup>117</sup>\* Statistically Significant

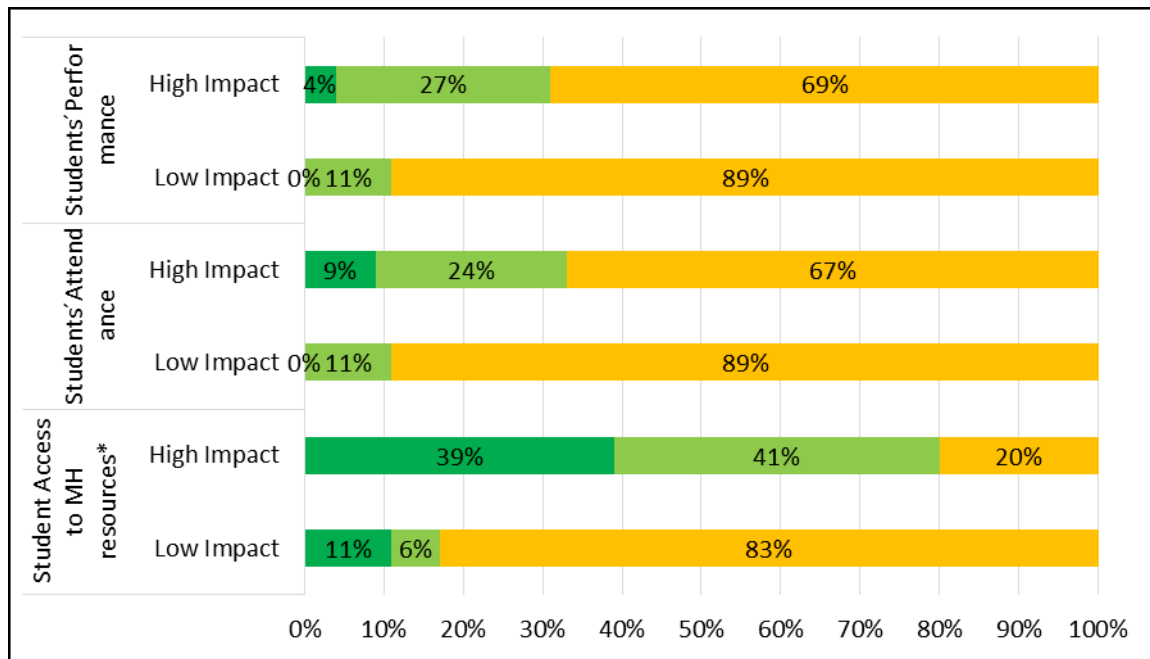


Figure 25: Impact of Ed-LinQ

- Satisfaction with Ed-LinQ was higher in the schools where Ed-LinQ had more impact, although this was not statistically significant

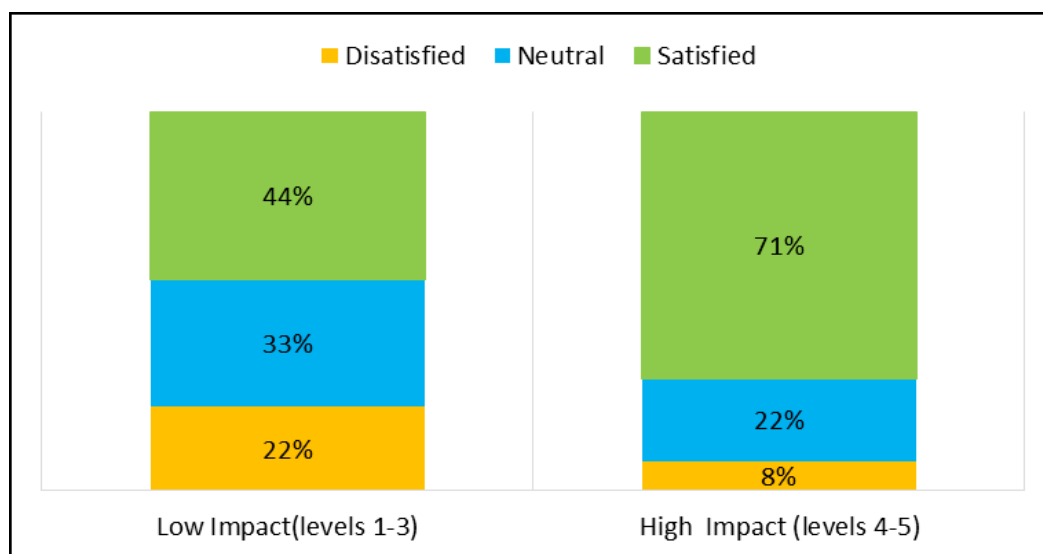


Figure 26: Satisfaction with Ed-LinQ

## Survey 2 – Child and Youth Mental Health Services - Results

A total of 78 professionals from CYMHS and other mental health and related services across Queensland answered the survey. The analysis was conducted with the 70 cases (90%) that had complete and valid data.

### General Description

- The majority of the responses came from Metro South (29%), Townsville (23%) and Children's Health Queensland Hospital (19%).

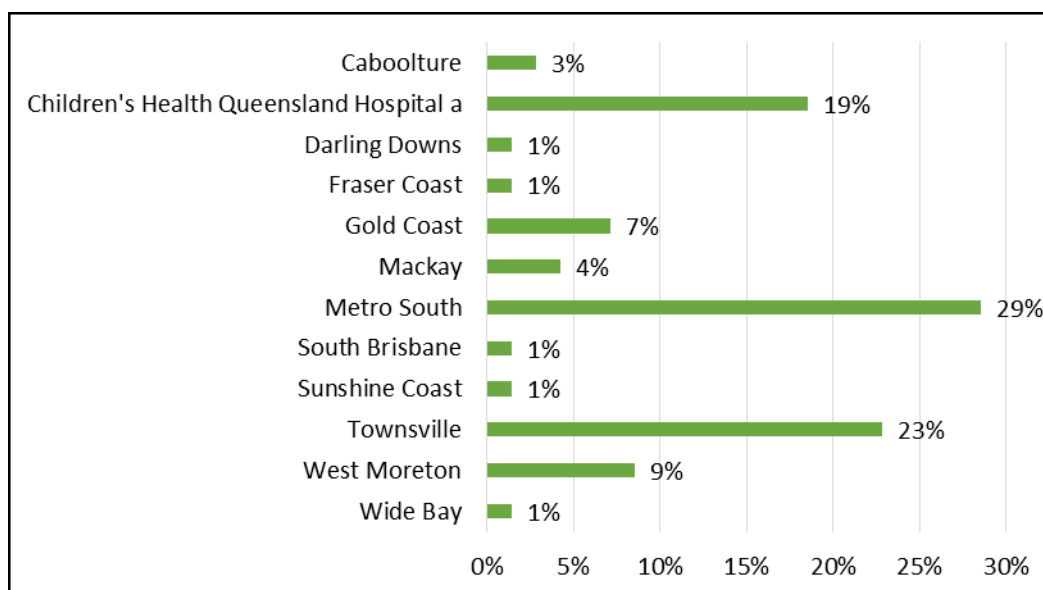


Figure 27: Distribution of CYMHS online survey respondents

- Most of the persons (88%) who answered the survey work for CYMHS, working as psychologists, psychiatrists, nurses, social workers and speech pathologists, or team leaders/directors.

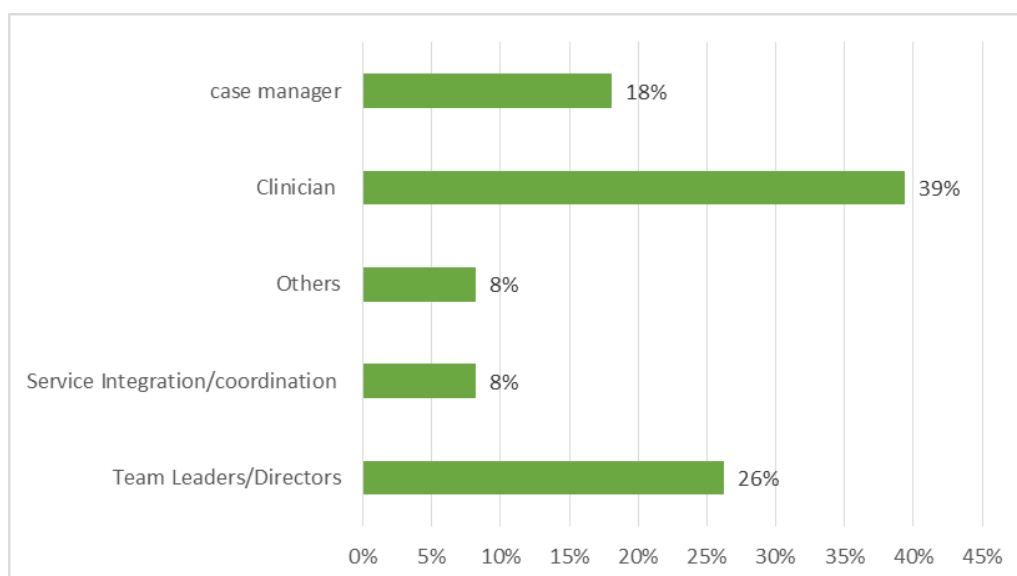


Figure 28: Roles of CYMHS survey respondents

- Persons who answered the survey were highly experienced; almost half of them (48%) had been working in CYMHS and other mental health and related services for more than 10 years with only 5% less than 12 months.

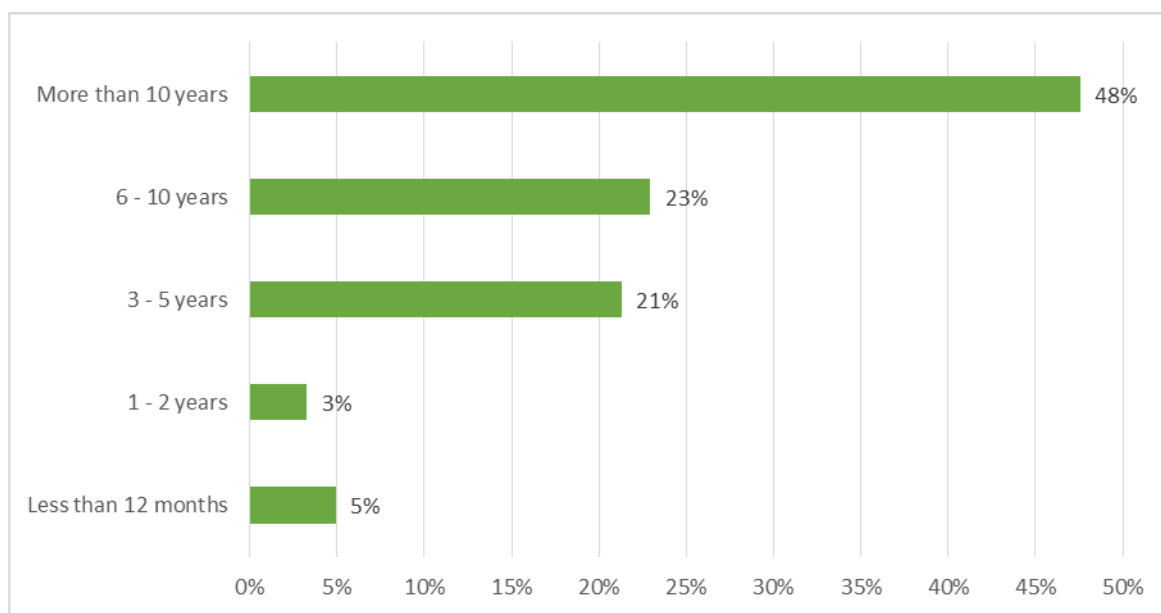


Figure 29: CYMHS staff – Number of years working in CYMHS

### ***Impact of the Ed-LinQ Initiative at CYMHS***

- The level of impact of the Ed-LinQ Initiative across CYMHS is greater than that found in the schools. Nearly 80% of the CYMHS staff are providing services related to Ed-LinQ. Only 13% did not know anything about the initiative<sup>118</sup>.

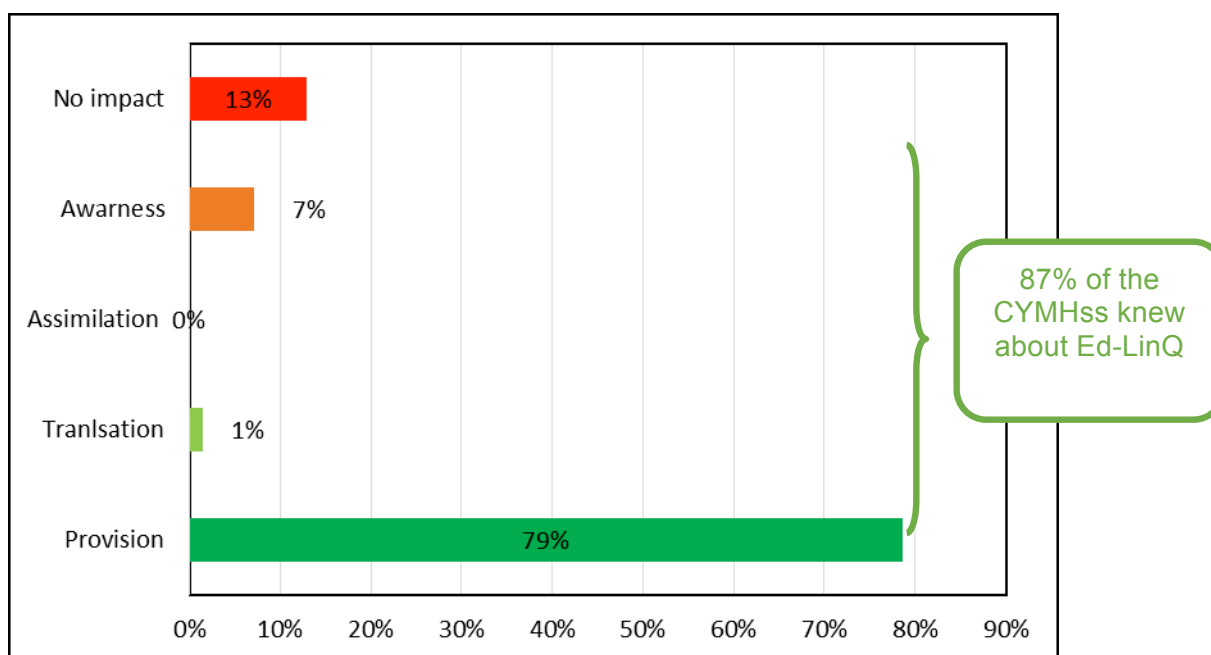


Figure 30: Overall impact of Ed-LinQ within CYMHS

<sup>118</sup> In the case of CYMHCs, as the level of impact reached by Ed-LinQ is very high, we are not able to make comparisons by different level of impact (we do not have enough data to do this).

***Experiences and views of the Ed-LinQ Initiative among those where Ed-LinQ has had an impact.***

- Most CYMHS personnel and other mental health and related services that answered the survey had good knowledge regarding the Ed-LinQ initiative. They knew and understood the role of the coordinator (79% agree or strongly agree), were aware of the objectives (75% agree or strongly agree) and have enough information about the Initiative (72% agree or strongly agree). They also thought that the Initiative was well supported by evidence (76% agree or strongly agree); and that the cost of Ed-LinQ is justified (68% agree or strongly agree).
- Areas of improvement have been identified regarding the documentation supporting Ed-LinQ, the process of consultation and the State-wide support. These are shown by the red arrows in Figure 26.
- Ed-LinQ was viewed by CYMHS and other mental health and related services staff as having facilitated better interactions with schools (82%). Schools were seen as important settings for CYMHS and an important partner for effective service delivery. Staff also felt Ed-LinQ aligns with CYMHS's priorities but that business plans, resource allocations and the systems to support Ed-LinQ could be areas for improvement.



Figure 31: Experience and views of respondents who have been impacted by Ed-LinQ



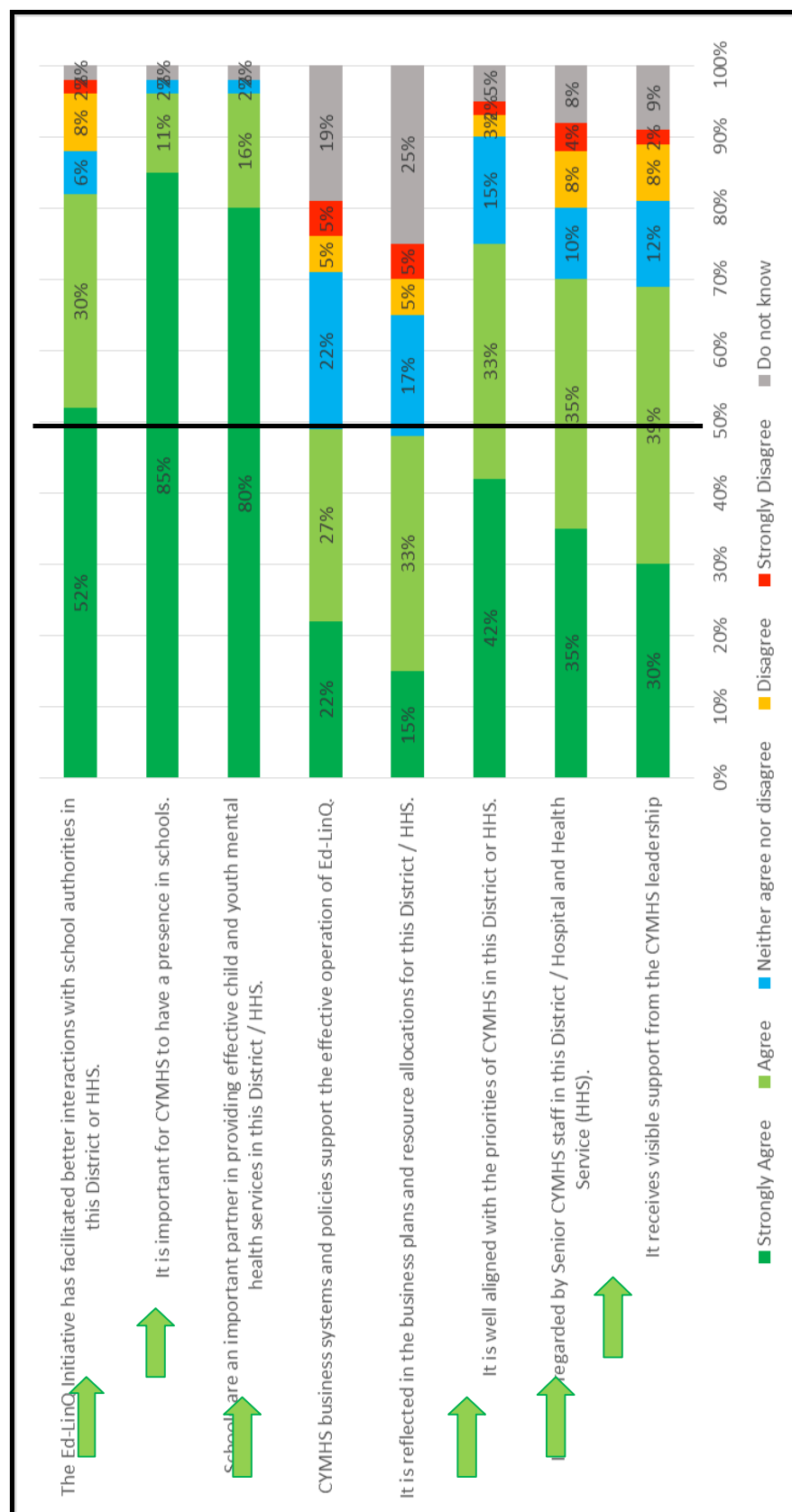


Figure 32: Experience and views of respondents who have been impacted by Ed-LinQ

- The **most common Ed-LinQ related initiative** that has occurred in the CYMHS was related to training to staff, followed by distribution of information to schools, case coordination with schools and defined referral pathways. This aligns with the information provided by schools.

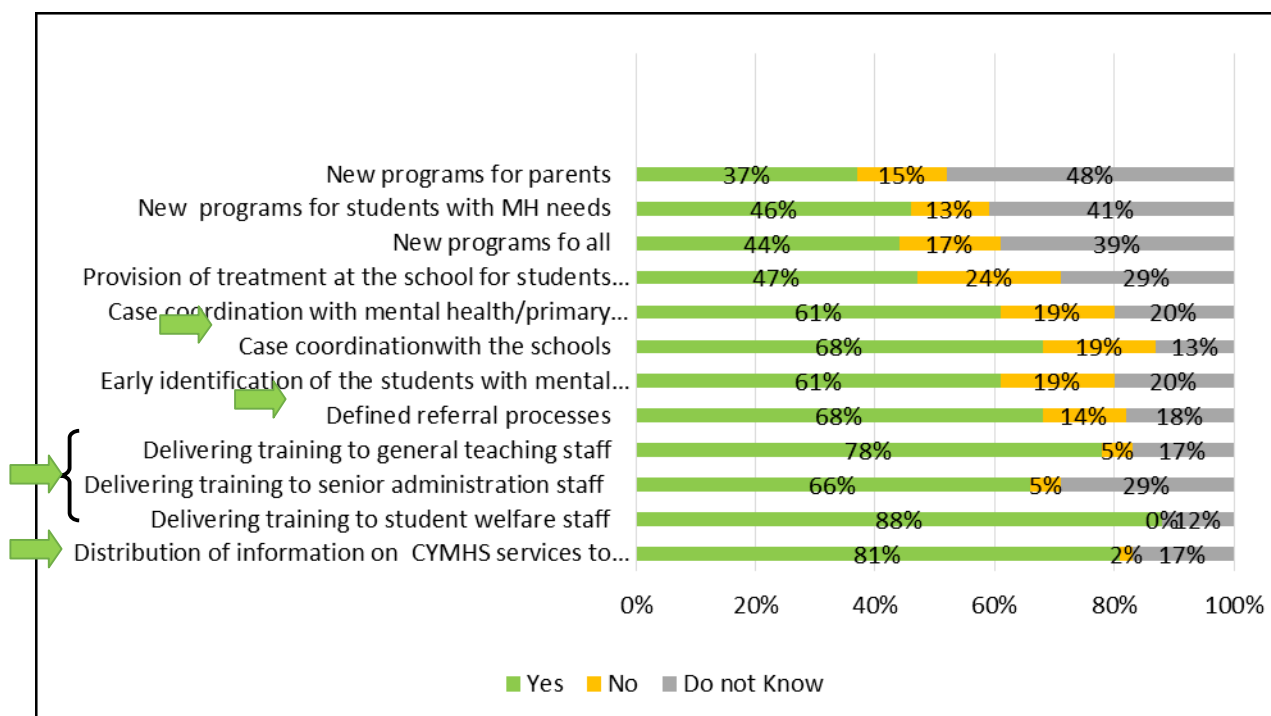


Figure 33: Most frequently reported Ed-LinQ related activities

- With regard the **objectives** of the program, most of the CYMHS professionals agreed that Ed-LinQ has helped to build a more collaborative approach (75%). They also agreed that it has increased the capacity of school staff to identify students in need (68%). This is very similar to the views provided by education professionals from schools survey.

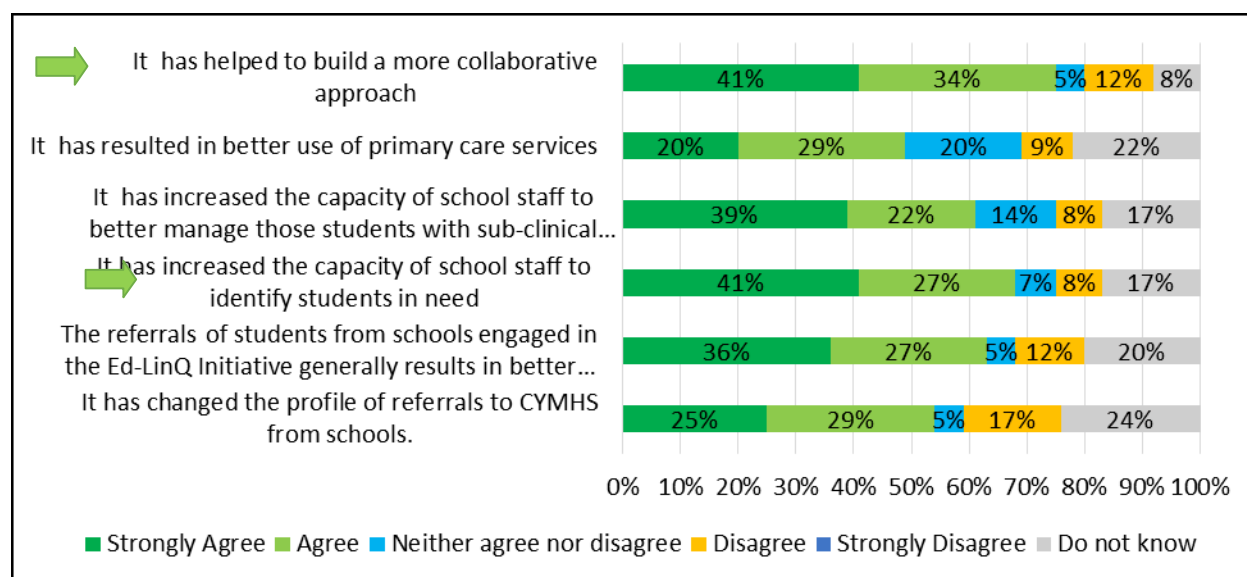


Figure 34: Impact of Ed-LinQ

The levels of **satisfaction** among CYMHS and other mental health and related services staff are very similar to those reported by schools, with almost two thirds being satisfied with the Ed-LinQ Initiative.

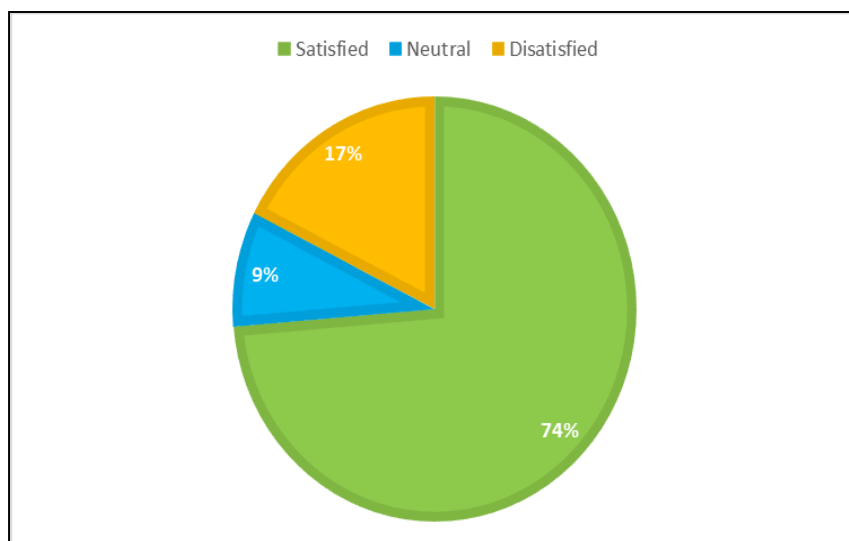


Figure 35: Satisfaction with Ed-LinQ

## Quantitative Finding Conclusion

These results demonstrate strong school and Child and Youth Mental Health Services providers support for the Ed-LinQ initiative and demonstrate that the objectives of the initiative in relation to service collaboration, workforce capacity building and improved services have been met. Those schools that have been impacted by Ed-LinQ the most report the greatest increase in the mental health knowledge of staff, staffs' capacity to deal with students' mental health issues, students' access to mental health information, interagency communication and service coordination. While in those schools where there has been a higher Ed-LinQ impact there is stronger support for the initiative, overall the majority of schools are supportive of more mental health related activities within their school.

There was strong support amongst Child and Youth Mental Health Services staff that it is important for CYMHS to have a strong relationship with schools and that schools play an important role in the provision of mental health services to young people. The results also showed strong agreement that the cost of Ed-LinQ is justified and supported by evidence and that the initiative has resulted in increased provision of training to student welfare staff and general school staff, distribution of information to schools about CYMHS services, case coordination with schools and defined referral pathways. This aligns with the information provided by schools.

## Summation of Evaluation Findings

The following details the summary of evidence arising from the qualitative and quantitative data in relation to Ed-LinQ's policy intentions. These findings confirm that the Ed-LinQ initiative, especially in those regions where the impact has been greatest has significantly improved strategic partnerships, built workforce capacity and enhanced clinical services.

Figure 36: Summary of evaluation findings in relation to Ed-LinQ policy intentions

Policy Intention	Summary Finding	Sources	SoF
<i>Strategic Policy Intentions</i>			
<b>'Framework for Action' (FfA) which intended to provide a consistent state-wide approach &amp; a basis collaborative inter/departmental &amp; agency relationships (state level). Included planning &amp; governance mechanisms &amp; the development of an interagency MoU.</b>	<p>The FfA provided initial support and guidance.</p> <p>FfA needed more ongoing reinforcement</p> <p>Key subordinate governance documents inc inter-dept MOU, not progressed or deployed impacted on Ed-LinQ</p> <p>Loss of state wide roles impacted on FfA</p> <p>Lack of accountability</p>	<p>. Interviews</p> <p>. Focus Groups</p> <p>. Documentation review</p>	4.5
<b>Enhancing capacity included: development &amp; implementation of joint workforce development strategies for the mental health, education &amp; primary care sector personnel.</b>	<p>Engagement of NSWIP has delivered high quality, consistent workforce development</p> <p>Engagement with PHC lowest of target groups</p> <p>Strategic approach to workforce not evident</p>	<p>. Workforce dev't reports</p> <p>. Focus Groups</p> <p>. Interviews</p> <p>. School survey</p> <p>. CYMHS survey</p>	4.5
<b>Clinical guidance included development of consultation liaison protocols to guide the practice of district Ed-LinQ Coordinators &amp; the development of child &amp; youth mental health &amp; mental illness information for distribution to state-level education sector stakeholders.</b>	<p>Limited evidence of state wide guidance was found – related to referral pathways</p> <p>Little evidence of high level guidance for schools on key issues for child and youth mental health.</p> <p>Local guidance developed in many districts</p>	<p>. Interviews</p> <p>. Focus Groups</p> <p>. Documentation review</p> <p>. CYMHS survey</p>	3.5
<b>A strong commitment to continuous improvement &amp; adoption of best practice in child &amp; youth mental health. Supported through the</b>	<p>Evaluation framework developed</p> <p>Reporting template developed</p> <p>CIMS unable to collect data on Ed-LinQ</p>	<p>. Interviews</p> <p>. Focus Groups</p> <p>. Documentation review</p>	3

implementation of formative & summative evaluation processes.	Evaluation framework not deployed		
HHS/School Level Policy Intentions			
The Framework for Action provided guidance to mental health, primary health care & education staff involved in Ed-LinQ	Varied across Districts. Where Ed-LinQ had strong governance, framework provided focus for CYMHS & education, not PHC	. Focus Groups . Interviews . School survey . CYMHS survey	4
The Framework aimed to inform the stakeholders at District levels.	Awareness within CYMHS high Awareness in education sectors varied Awareness in PHC poor	. Focus Groups . Interviews . School survey . CYMHS survey	4
For schools, Ed-LinQ aimed to improve knowledge & skills of school staff in identifying at risk students, access to information & resources & referral/service pathways.	Clear evidence from schools with high impact that Ed-LinQ has significantly improved capacity within school Too few schools have been impacted	. Focus Groups . Interviews . School survey . CYMHS survey . Workforce dev't reports . Documentation	4.5
Developing & deploying shared care models & clear & consistent referral pathways at a district level, based on resource/service mix available.	Clear evidence from schools with high impact that Ed-LinQ has significantly improved capacity within school Too few schools have been impacted	. Focus Groups . Interviews . School survey . CYMHS survey . Documentation review	3.5
To identify core resources in each sector (i.e. mental health, primary health care and education) & (then) provide the 'strategic interface' that adds value to existing services, avoiding duplication.	No clear evidence emerged of strategic mapping of resources. Districts undertook some resource identification and then integration	. Focus Groups . Interviews . School survey . CYMHS survey . Documentation review	4
In relation to clinical guidance: intention was to involve attendance at relevant district meetings where student mental health/illness is discussed, as well as development,	This was evident in districts with high levels of Ed-LinQ activity and school engagement	. Focus Groups . Interviews . School survey . CYMHS survey . Documentation review	3.5

distribution & support of continually updated referral pathways for students identified as experiencing a mental illness.			
To provide a clear governance structure for the initiative to enable effective cross-sectoral consultation & collaboration including joint planning & review.	<p>Governance was not linked to accountability in CYMHS nor schools. Commitment to Ed-LinQ was personal choice of decision makers in both key sectors.</p> <p>Changes to structures in primary care made it difficult for lead agencies.</p>	<ul style="list-style-type: none"> <li>. Focus Groups</li> <li>. Interviews</li> <li>. School survey</li> <li>. CYMHS survey</li> <li>. Documentation review</li> </ul>	4.5
Related to the governance structures, Ed-LinQ aimed to establish MoUs between the key agencies at district level, see the establishment of protocols & other mechanisms for effective coordination & collaboration.	<p>Little evidence of this occurring. In the absence of state level MOU there was a reluctance to develop local documents.</p>	<ul style="list-style-type: none"> <li>. Focus Groups</li> <li>. Interviews</li> <li>. School survey</li> <li>. CYMHS survey</li> <li>. Documentation review</li> </ul>	4
At a District level, it was intended that local governance structures be established to enable tailoring of Ed-LinQ to the District's needs.	<p>District level governance was only found in a few regions.</p> <p>Where it was operating, it did ensure tailoring to needs</p>	<ul style="list-style-type: none"> <li>. Focus Groups</li> <li>. Interviews</li> <li>. School survey</li> <li>. CYMHS survey</li> <li>. Documentation review</li> </ul>	4
Ed-LinQ sought to improve partnerships & communications between CYMHS & schools	<p>Clear evidence that in many Districts this was achieved. Ed-LinQ built bridges between the sectors</p>	<ul style="list-style-type: none"> <li>. Focus Groups</li> <li>. Interviews</li> <li>. School survey</li> <li>. CYMHS survey</li> </ul>	4
On the workforce, Ed-LinQ sought to coordinate and provide support for mental health professional development activities for education and primary care stakeholders.	<p>The cross-sector workforce dev't activity has delivered this where it has occurred</p> <p>Less evidence on this outcome with local workforce dev't activity</p>	<ul style="list-style-type: none"> <li>. Focus Groups</li> <li>. Interviews</li> <li>. School survey</li> <li>. CYMHS survey</li> <li>. Documentation review</li> <li>. Workforce dev't reports</li> </ul>	4
On workforce, there was a clear intention to	<p>Good evidence from those areas where Ed-LinQ has had</p>	<ul style="list-style-type: none"> <li>. Focus Groups</li> <li>. Interviews</li> </ul>	4

**"improve the baseline knowledge of mental health issues, such as awareness of and access to programs like Youth Mental Health First Aid".**

higher impact, that knowledge and awareness have improved.  
Schools with high impact more selective in MH program choices

. School survey  
. CYMHS survey

# Recommendations

## Short to Medium Term Recommendations

A number of critical actions are required in the short to medium term in regard to strengthening and sustaining Ed-LinQ. These actions can be grouped into five key categories:

- Policy
- Collaboration
- Governance
- Workforce capacity
- Infrastructure.

Specific actions within each category are detailed below.

### **Policy:**

- Renewal of Ed-LinQ Framework that reviews the intent, functions, role and context and aligns with evidence about school focused MHPPEI
- This should maintain the primary Ed-LinQ initiative as an early intervention strategy with focus on its three main areas: strategic partnership, clinical consultation and capacity building but addresses the organisational, partnership, workforce and other factors that are diminishing impact and return
- Address the factors impeding clear and consistent metrics and data collection
- Establish standards for needs assessment, program planning and review
- Address role clarity of the Ed-LinQ coordinators but also of other key positions and services
- Integrating the Ed-LinQ Coordinator role into CYMHS Teams across the state
- Greater focus on engaging relevant primary care and community services.
- Address the appropriate mix and timing of evidence based approaches i.e. Integrated School Based Mental Health Interventions – based on the framework and the approved programs and interventions for schools.
- Customising responses for priority groups i.e. establishment of an Indigenous Ed-LinQ Initiative to address the specific needs of schools with higher numbers of Indigenous students.
- Integration with school based drug and alcohol initiatives
- Specifies guidelines around standards that must be met by mental health programs that are wanting to be delivered in schools to ensure programs are suitable and aligned with other school curriculum initiatives

### **Collaboration**

- Operationalise MOUs between Education Department and Queensland Health /HHS
- Set consistent template for governance arrangements at state and HHS levels so required cross sector leadership and engagement for collaboration and integration occurs



- Interagency Collaborations – based on mental health service mapping at regional (HHS) levels with agreed service pathways.

### **Governance**

- Formalise and operationalise state wide, regional and local structures and functions that ensure alignment between the strategic intent and delivery of initiatives that underpin the cross sector young persons well being and mental health policy.
- Structures include:
  - Executive Level** - agency head level to develop cross sector strategic policy and drive and be accountable for initiatives in their respected agencies to improve well being and mental health outcomes for young persons. Key departments initially would include education and health.
  - State Coordinating Group** –establish and oversee initiatives that enable a multimodal school response to young persons' well being and mental health needs, integrated governance structures, selection and promotion of appropriate school based mental health programs, measurement and reporting
  - Ed-LinQ Coordinator Level** - state wide coordination of Ed-LinQ coordinators to facilitate ongoing provide leadership, initiative-wide accountability, priority setting, resource sharing, identification of best practice and strategic change projects
  - Local Geographical Level** - cross sector local geographical cluster groups to identify and address specific needs of local regions, establish and monitor agreed referral pathways, organise professional development, track and monitor performance
  - School Level** – integrated approach to embedding well being and mental health within the curriculum, professional development for school staff, and local community, oversee appropriate use of referral pathways, collaboration with relevant organisations and data collection.

### **Workforce capacity**

- Commitment to the full establishment of ED-LinQ Coordinators is required
- Investigating opportunities to enhance the establishment and sustainment of the Ed-LinQ role through a joint education and health budget bid given the inadequacies of the allocation and the potential return on investment across sectors
- Commitment to continuing the cross sectoral workforce development program and investigation of sustainability of the model i.e. Strategic Workforce Force Mental Health Capability Framework
- Build local capacity for cross agency to deliver professional development programs

### **Infrastructure**

- Review of necessary infrastructure to support a cross agency initiative e.g. web platform
- Re-establish the Ed-LinQ state wide meeting group to provide leadership, initiative-wide accountability, priority setting, resource sharing, identification of best practice and strategic change projects

- Establishment of statewide Ed-LinQ Coordinators network to provide the opportunity to share resources, identify best practice and undertake joint strategic research or pilots.
- Build capacity to enable collection and analysis of quality data and information in relation to mental health needs of young people and service capacity
- Improved and consistent data collection, analysis and reporting to ensure that services target those schools in most need, best practice is identified and the impact of initiatives is understood and quantified to inform future priorities and actions
- A school 'Readiness Assessment Tool' for Ed-LinQ Coordinators and regional leaders for assessing the readiness for change and engagement by schools

## Longer term recommendations.

The findings from this review strongly reinforce the need to plan and implement in the longer term a systemic and holistic approach to enhancing the mental health and wellbeing of young Queenslanders (0-18 years). The Ed-LinQ initiative would be one component of this systemic approach. The social and economic benefit of such an approach will involve and impact a larger cross section of sectors and service providers.

This systemic approach is built on five pillars: Leadership, Strategy, Governance, Infrastructure and Accountability. Key initiatives relating to each pillar are detailed below.

### **Leadership**

- Establish and maintain cross sector executive leadership commitment to collaborative action for MHPPEI for school aged and the development of a dedicated strategy, resourcing and reporting on associated initiatives.
- Establish a State Best Practice Professional Circle of Practice - Ed-LinQ Coordinators and relevant experts to ensure best practice guides and advice are available to all schools.

### **Strategy**

- Establish an integrated School Mental Health Program Framework for all schools – integrated universal, selected and targeted mental health and wellbeing programs with a 'gatekeeper' process to ensure all programs or interventions are appropriate from an evidence perspective.
- Deliver integrated school based mental health interventions – based on the framework and the approved programs and interventions for schools.
- Develop a strategic cross sectoral workforce development framework.

### **Governance**

- Consolidate governance arrangements at the state, regional and local school levels with defined roles, responsibilities and accountabilities.
- Comprehensive interagency collaborations that are based on mental health service mapping at regional (HHS) levels with agreed service pathways.

**Infrastructure**

- Conduct a Queensland Young Persons Mental Health Annual Check-up – 0-18 years. This survey of the mental health and wellbeing of children and young people across Queensland can be used to establish and monitor young person's health status and enable planned interventions within a state wide plan – The Mentally Healthy Young Queenslanders Strategy.
- Establish a web-based platform for all stakeholders (including teachers, service providers, students and parents).
- Review and enhance data collection systems to ensure robust collection and analysis of cross sector data relating to young persons' mental health and well being.
- Develop and implement a marketing and promotion package for state wide and local level promotion of school mental health and wellbeing and the Ed-LinQ Initiative.

**Accountability**

- Clearly defined roles and responsibilities and metric to monitor and assess performance cross sector performance.