murdoch children's research institute

Centre for Community Child Health

Mental Health in Primary Schools Pilot: 2022 Final Evaluation Report

Prepared for the Victorian Department of Education

May 2023

MHiPS
Mental Health in Primary Schools

THE UNIVERSITY OF MELBOURNE
Melbourne Graduate School of Education

The Centre for Community Child Health is a department of The Royal Children's Hospital and a research group of the Murdoch Children's Research Institute.

The Royal Children's Hospital Melbourne

Mental Health in Primary Schools: Final Evaluation Report 2022
Version 1.2

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The Department of Education are working in partnership with the Murdoch Children's Research Institute and the Melbourne Graduate School of Education to support Mental Health in Primary Schools. The MHWC model referred to in this resource was developed by the Centre for Community Child Health at the Murdoch Children's Research Institute and the Melbourne Graduate School of Education at the University of Melbourne.

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The Centre for Community Child Health acknowledges the Traditional Owners of the land on which we work and pay our respect to Elders past, present and emerging.

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Glossary

AToSS	Attitudes to School Survey
BAU	Business as Usual
CECV	Catholic Education Commission of Victoria
CoP	Community of Practice
DE	Department of Education Victoria
FTE	Full Time Equivalent
ISV	Independent Schools Victoria
ICSEA	Index of Community Socio-educational Advantage
MCRI	Murdoch Children's Research Institute
MGSE	Melbourne Graduate School of Education
MHiPS	Mental Health in Primary Schools pilot
MHWB	Mental Health and Wellbeing
MHWC	Mental Health and Wellbeing Coordinator
NWVR	North West Victoria Region
PD	Professional Development
POS	Parent Opinion Survey
SDQ	Strengths and Difficulties Questionnaire
SMH-SETS	Student Mental Health – Self-efficacy Teacher Survey
SWVR	South West Victoria Region

1.0 Executive summary

1.1 Introduction

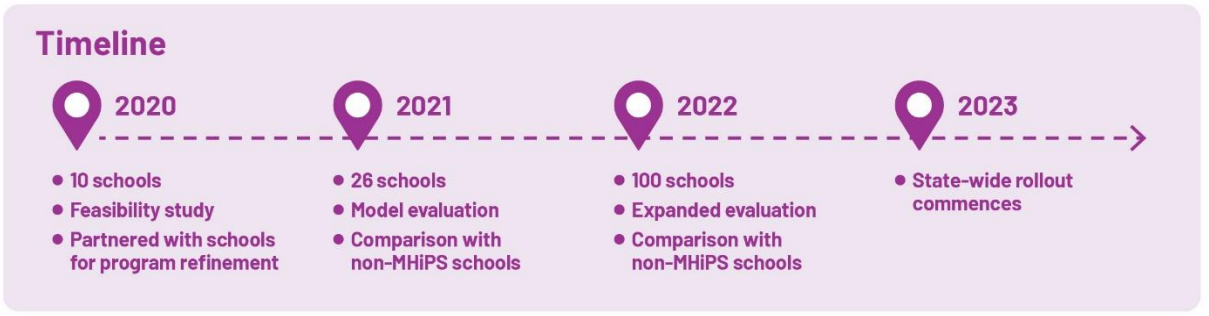
Over recent years we have seen an increasing and unsustainable rate of child mental health presentations to primary and tertiary mental health services (Hiscock et al., 2018). The Royal Commission into Victoria's Mental Health System (2021) and the Productivity Commission (Productivity Commission, 2020) identified education settings as a key place for supporting and promoting mental health and wellbeing. At the same time, they found that much of the burden to support students struggling with mental health challenges was falling on schools, school leaders, and educators.

In 2019, the Centre for Community Child Health at Murdoch Children's Research Institute (MCRI) and the Melbourne Graduate School of Education (MGSE), University of Melbourne conceptualised a model of school-based prevention and early intervention. The "Mental Health and Wellbeing Coordinator" (MHWC) model[1] involves a new role in primary schools accompanied by a training program that is designed to build the capacity of schools to be more effective in supporting student mental health and wellbeing.

In 2020, in partnership with the Victorian Department of Education (DE)[2] and with support from philanthropic donations to MCRI, a year-long co-design and consultation phase was conducted to ensure the conceptualised model addressed the needs of Victorian educators. Following overwhelmingly positive support from schools, leaders, educators, and other key stakeholders, the MHWC model was implemented and evaluated in a feasibility trial with 10 Victorian government schools in 2020 (2020 cohort). Referred to as the Mental Health in Primary Schools (MHiPS) pilot, the model was then further expanded to an additional 16 schools in 2021 (2021 cohort).

Following positive feedback on the model and preliminary evidence that the MHWC model increased the confidence of teachers to support student mental health, the Royal Commission into Victoria's Mental Health System (2021) encouraged the Victorian Government to expand the model further should it prove to be effective in larger evaluations. In response to this, the Government committed to a further expansion of the MHiPS pilot to an additional 74 schools in 2022 (2022 cohort). Thus 100 schools participated in the pilot in 2022, including evaluation of the implementation and impact of the MHWC model.

[1] © 2020 Murdoch Children's Research Institute and University of Melbourne.
[2] The title of Department of Education is used consistently throughout this report for clarity. However, the title was Department of Education and Training until 1 January 2023, at which point the title was changed to Department of Education.



The insights and recommendations from this report are based on data drawn from the three cohorts participating in the pilot. Report findings focus specifically on data collected from 2021-2022 as follows:

- MHWC and staff trainee training feedback surveys completed following participation in the training program, 2022.
- School staff surveys completed at multiple timepoints during 2021 and 2022.
- Parent surveys completed at multiple timepoints during 2021 and 2022.
- Selected classroom teacher surveys completed at multiple timepoints during 2021 and 2022.
- MHWC Job Analysis collected during Term 2, 2022.
- Focus groups completed with MHWCs and school staff in 2021 and 2022.
- DE Attitudes to Schools Survey (AToSS) data and Parenting Opinion Survey (POS) data based on the 10 original pilot schools (2020 cohort) in comparison to similar schools. The data used for this analysis was collected by DE from 2017-2021.

1.2 Key findings

Overall, there was overwhelming endorsement of the MHWC model by school staff. Data from school staff in the 2022 cohort at six months following program implementation indicate that the model had been well accepted within the school. Staff agreed that the MHWC model increased school and staff capacity to support student mental health and wellbeing, and the confidence to appropriately address mental health challenges as they arise ("mental health literacy").
Qualitative and quantitative data from the 2022 cohort also highlight positive impacts of the MHWC model on student mental health outcomes.
These findings are consistent with those from earlier stages of the pilot, indicating that the model's feasibility, acceptability and impact were maintained as the program scaled up to 100 schools.

1.2.1 Implementation of the MHWC model

(a) MHWC role

Key to the MHWC model is that the MHWC comes from an educator background; this is intended to facilitate the MHWC being embedded within the school, to give them important contextual information about child development and learning, and to maximise buy-in from the school. Survey data at six months follow up indicate 95% of school staff agreed it was important for the MHWC to have an education background, and both quantitative and qualitative data confirmed that the MHWC role had been accepted by existing staff.

Most MHWCs within the 2022 cohort were employed at FTE 0.6 or higher, and most (54.3%) filled another role in addition to the MHWC role. MHWCs largely completed tasks aligned to the scope and remit of their role as described in their position description. Findings from the 2022 job analysis indicated the majority of MHWC time (73.5%) was spent on role specific tasks, including whole school approaches to the prevention and promotion of mental health and wellbeing, supporting staff, meeting with staff and/or families, managing individual need, consulting with external services and participation in training or professional development.

With regards to time delivering activities related to the Multi-tiered System of Support, MHWCs spent most of their time (43.7%) working at the Tier 1 level of support – mental health promotion and prevention, including embedding training across the school, linking in with other wellbeing initiatives or whole school frameworks already in place (e.g. Respectful Relationships, School-wide Positive Behaviour Support). This was followed by time spent delivering Tier 2 activities (33.6%) – early intervention, including building the capability of teaching and education support staff to better identify and support students with mental health concerns in the classroom, and Tier 3 activities (22.7%) – intensive support, including creating clear referral pathways for students identified as requiring further assessment and intervention. Given the impact of the COVID-19 pandemic on staffing shortages, MHWCs were sometimes required to engage in classroom teacher roles (6.4% of their time).

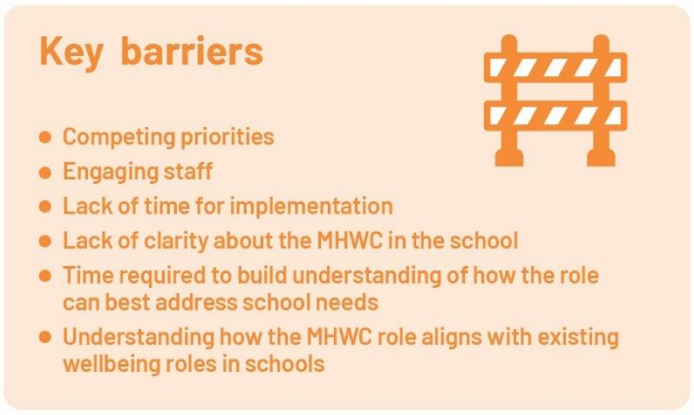
Implementation challenges

Despite the positive feedback on the MHWC model, there were several challenges to implementation. Limited time to implement the role was the main challenge identified by MHWCs and school leadership. At 10 months follow up, approximately half of all MHWCs from the 2022 cohort identified lack of time as the most significant barrier to making progress in their role and in improving outcomes for students/the school.

Among those with a role time fraction of 0.4FTE or 0.6FTE (smaller schools), time challenges primarily included insufficient time to undertake the role and/or conflicting demands of holding multiple roles within the school (including leadership roles and teaching roles). Among those with a role time fraction of 0.8FTE or 1.0FTE (larger schools), time challenges primarily related to insufficient time to undertake the role and/or a requirement to cover classes or undertake casual relief teaching responsibilities.

Lack of staff buy-in and lack of clarity around the MHWC role were also identified as significant barriers by approximately 10-15% of MHWCs. Qualitative data indicate that in some schools it had taken time (from one term to one year) for school staff and MHWCs to fully understand the role and establish how best to work within the role description and address the needs of the school. Findings indicate that role clarity was facilitated through leaders and staff attending the MHiPS core training, leadership support within the school context and by MHWCs running professional development (PD) for school staff early on in their role. Despite challenges experienced by a minority of MHWCs and schools around role clarity, survey data at 6 months follow up indicate 90.5% of MHWCs had a comprehensive understanding of their responsibilities as an MHWC and over three quarters of school staff perceived the MHWC role to be clear in comparison to other wellbeing roles.

The presence of existing wellbeing staff within the school was also noted as a barrier to role integration for a small number of MHWCs, particularly early on. In these cases, challenges included determining the new breakdown of roles for existing staff and the MHWC and managing tensions around introduction of a new wellbeing role into an existing team, including differing pay scales. However, MHWCs reported that this tension often dissipated over time, and was facilitated by school leadership being involved in role discussions. In addition, it should be noted that for most MHWCs (approximately 60%) other wellbeing staff were identified as being a source of support for their role.



A range of other challenges were noted, each of which was variously identified by a small minority of MHWCs, including lack of availability and/or access to external supports for students and families, lack of internal and/or external support for MHWC role, emotional load of the role and potential for burnout, and lack of teacher capacity to take on new ideas or responsibilities arising from the model.

Nevertheless, it should be emphasised that these documented challenges are in the context of the widespread acceptance and support of the new model and thus need to be kept in perspective; they are an important part of the learning about implementation, and relevant to upscaling of the model.

Enablers to role implementation

Findings related to integration of the MHWC role point to several important factors to maximise successful implementation of the MHWC model, including:

- leadership support for the role, including assistance with promoting, articulating and clarifying the role with consideration of role FTE and school context
- inclusion of staff trainees (school leadership and/or teachers) in the core training program to facilitate early implementation and integration of the role and build capacity and knowledge across the school
- delivery of MHWC-led Mental Health Literacy professional development session to school staff early following role commencement to facilitate integration of role within the school context and build staff capacity to identify and support students with mental health need
- ongoing professional development and role support through Communities of Practice and other MHWCs
- support from the DE-based regional MHiPS coordinator.

(b) Training program

Delivery of the training program was facilitated by Learning Leaders within the training team, and all core training modules (i.e., Mental Health Literacy, Building Capacity, Supporting Need and Community of Practice) were delivered online (via zoom). The introduction of the Learning Leader role in 2022 allowed for one-on-one support to MHWCs if required and closer proximity to MHWC learning as they embedded the role in their school.

Findings indicate the training program strongly supported the MHWC role. The majority of MHWCs agreed that each of the core modules gave clarity to their role (86.0 – 97.1%) and addressed the needs of their role (90.3 – 98.6%). In addition, MHWCs confirmed they had acquired knowledge (95.6 – 100%) and skills (94.3 – 98.6%) and could apply the learnings from their role (95.7% - 100%) to support a whole school approach to mental health and wellbeing and to support students with mental health and wellbeing needs.
Communities of Practice (CoP – for MHWCs in their first year) and Enriched Communities of Practice (ECoPs – for MHWCs post 1 year) are designed to deepen the learning from the first three modules via monthly sessions designed to connect MHWCs, allow the sharing of experiences and enable access to subject matter experts. MHWCs from the 2022 cohort identified all CoP sessions as being useful, with 'Challenging Behaviours' and 'Case Presentations rated 'most useful' (55.4% and 50.0% of respondents respectively).

MHWCs who attended the EcoPs also rated the modules highly, with 100% indicating agreement (21.1% moderately agree; 79.9% agree/strongly agree) that the module addressed the needs of their role. Specifically, MHWCs indicated that learnings from the ECoP would support their: engagement with external services; ability to incorporate trauma-informed practices among staff; engagement of staff in professional development on self-harm; and review of policies and processes around managing challenging behaviours and external referrals. Further evaluation of this module will be undertaken as part of the statewide expansion of MHiPS.

Findings indicate the training program also strongly supported staff trainee participants. Survey data from staff trainees indicated agreement that the various modules of the training program had increased their understanding of the MHWC role within their school context (96.7% - 98.7%) and increased their knowledge and skills about developing a whole school approach to mental health and wellbeing and supporting students with mental health and wellbeing needs (94.5% - 100%).

Challenges

Schools continued to be impacted by COVID-19 throughout 2022 with ongoing staff absences and shortages. As a result, some MHWCs and staff were unable to fully participate in the training program due to a need to provide teaching backfill within their school. To account for this, all sessions were recorded and posted to the online learning platform, Canvas. In addition, some schools had not hired MHWCs at the time of training commencement; this was addressed by the training team running individual support sessions for the schools and MHWCs who started later in Term 1 or 2.

Content development

As in previous years of the pilot, updates and adaptations were made to the training content in response to MHWC feedback and an ongoing continuous quality improvement schedule. The

overarching changes in 2022 focused on ease of navigation and usability of the learning management system, redevelopment of key tools to improve user experience, additional interactive content including a series of health professional videos to improve understanding of different disciplines and their role in supporting young people with mental health concerns and their interaction with the MHWC role, and developing additional pre-work content to allow for deeper exploration of learning concepts. Furthermore, feedback from training participants led to development of the training program as follows:

- Increased practical resources, templates, and specific actionable steps that MHWCs could draw from.
- Increased peer support discussions with other MHWCs, facilitated through check-in sessions and Communities of Practice (CoP).
- Additional training on school refusal and student mental health issues, including self-harm and suicide risk, facilitated through the CoP program.
- Additional information on engaging and working with external mental health services, facilitated by Psychologists and Social Workers.
- A new session delivered in a webinar style on Challenging Behaviours.

Feedback from MHWCs in alternative settings and sectors, including specialist and language schools and Catholic schools, indicated the training program was beneficial and generally aligned with their school context. However, some adjustment to content was suggested within some modules to further contextualise to these settings.

In addition to content development, the 2022 training program included the development of a Knowledge, Skills and Attitudes Capability Framework (KSA framework) for the MHWC role. The aim of the framework is to guide the MHiPS project, both for individuals and as a whole in terms of professional development and understanding the KSAs needed to be successful in the role. The statewide expansion of MHiPS will include evaluation of MHWC's knowledge, skills and attitudes based on the KSA framework.

The KSA framework built on the original framework developed in the early stages of the pilot but was codesigned with input from the entire MHWC group for 2022. Further development of the framework was supported through a working group, comprising Learning Leaders, Regional Coordinators and MHWCs. This codesign process was used to ensure the framework is:

- representative of all MHWCs
- a 'living' document providing opportunity for individuals to contribute to the development of fellow community members.

1.2.2 Impact of the MHWC model

As detailed in the MHiPS Program Logic (Smith, R. et al, 2022), the MHWC model is aimed at having short to medium term impacts at the teacher and school level, including increased confidence among classroom teachers and school staff to support student mental health and wellbeing, increased support for classroom teachers to manage student mental health need, a reduction in stigma around child mental health in school staff, increased engagement with service providers, and increased prioritisation of mental health and wellbeing. Parent and student outcomes are identified as longer-

term impacts, including increased parent mental health literacy, a reduction in stigma and an improvement in student mental health and wellbeing outcomes. Key findings are thus reported according to this theory of change.

(a) Classroom teacher capacity to support student mental health and wellbeing

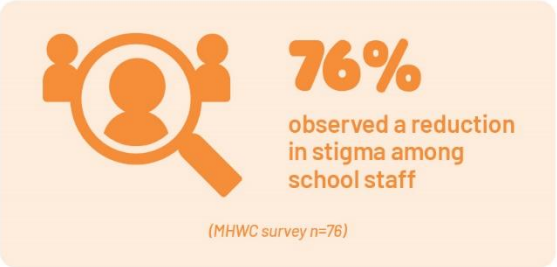
Findings indicate the MHWC model increased classroom teacher confidence to support student mental health and wellbeing at six months, ten months, 18 months, and 24 months post-MHWC introduction. Comparison with matched 'Business as Usual' schools indicated that confidence increased at ten months follow up in both MHWC (0.44 of a standard score, known as a standard deviation [SD]) and BAU schools (0.31 SD), however, at 18 months follow up, teacher confidence levels continued to increase in MHWC schools (a further 0.13 SD) but declined in BAU schools (a decrease of –0.02 SD). These findings suggest favourable longer-term effects of the MHWC model on teacher confidence. However, findings need to be interpreted in light of lower response rates at follow up (i.e., less than half of class teacher respondents completed follow up at 10 months (2022 cohort) and 18 months (2021 cohort)). Further data collection over a longer time frame will assist in strengthening these initial findings.

The MHWC-delivered Mental Health Literacy professional development session was considered particularly effective at building staff capacity to support student mental health and wellbeing. Survey data at six months follow up indicated that 71.1 % of classroom teachers attended the session, and of those, 94.8% confirmed it had increased their ability to identify and support students with mental health concerns. The positive impact on classroom teachers' confidence was further reflected in survey data from all staff with 89.5% confirming the model had increased teacher confidence to support student mental health and wellbeing.

Findings indicate that classroom teachers are being well supported by MHWCs in managing student mental health and wellbeing. Survey data from classroom teachers at ten months follow up indicate that 93.0% had recently (past month) received support from the MHWC, with 67.4% indicating they had received a lot or a great deal of support.

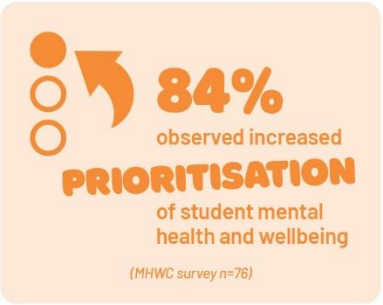
Qualitative feedback from classroom teachers identified a range of positive outcomes as a result of the MHWC presence. For example, teachers reported that MHWCs provided individual students with extended conversation times and contributed to a positive school culture and calming presence across the school community. Teachers also identified the support of MHWCs in various situations such as responding to teachers' concerns, facilitating family-school meetings, workshopping

classroom issues with students, and facilitating open discussions on mental health and wellbeing between students, staff and parents.



Findings based on teacher self-report and MHWC-report indicate a reduction in stigmatising attitudes toward child mental health among classroom teachers. Survey responses from MHWCs at ten months follow up indicated approximately three quarters had observed a reduction in stigma among school staff. Observations included increased frequency and openness of discussions related to mental health and wellbeing and more informed and empathetic language and approaches used to discuss and address student mental health issues. Teacher-reported data at 18 months follow up indicated stigmatising attitudes had reduced significantly in MHWC schools as compared to BAU schools, suggesting favourable longer-term effects of the model on reducing stigma among teachers.

(b) School capacity to support student mental health and wellbeing



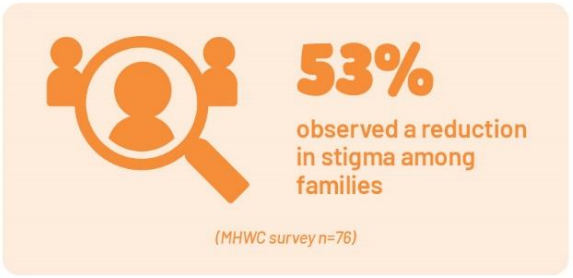
Qualitative and quantitative data indicate the MHWC model has led to an increase in school capacity to support student mental health and wellbeing, including increased prioritisation of student mental health and wellbeing across the school and an increased likelihood of student mental health needs being met within the classroom at 10 months follow up relative to BAU comparison schools.

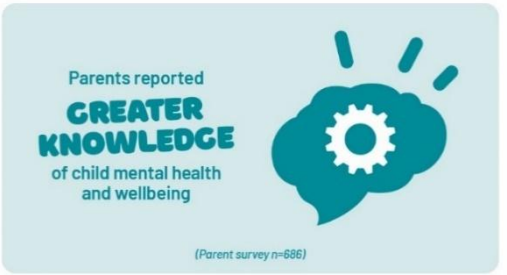
Qualitative feedback indicates the MHWC model has helped schools to build social emotional learning approaches across the school, increase conversations about student mental health and wellbeing, enable earlier support and intervention for students showing signs of mental health and wellbeing concerns and increase protective factors across the school (i.e., visibility of good role models).

Data from staff surveys and focus groups indicate that school engagement with mental health and wellbeing services – both internal and external – has improved for some schools over time but continues to be an ongoing challenge for others due to limited access to and/or availability of services.

(c) Parent/family mental health literacy and engagement

Parent survey data indicate an increase in parent mental health literacy (knowledge, help-seeking skills and confidence) at 10 months and 18 months follow up. While both intervention and control schools showed an improvement in parent knowledge around child mental health and wellbeing at 18 months follow up, parents from MHiPS schools, on average, showed a statistically significant 0.20 standard score higher than that of comparison schools. For example, at baseline 9.6% of parents in MHiPS schools indicated that '*Primary school aged children don't get depression'* and 20.8% indicated '*Persistent sadness and frequent crying is normal in children*', however, at 18-months follow up this decreased to 2.4% and 11.0% respectively.





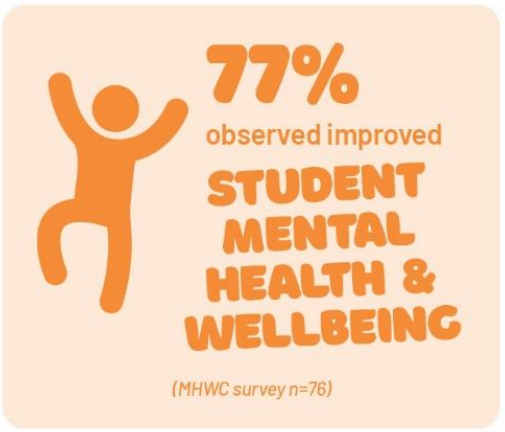
Qualitative feedback from MHWCs indicate the MHWC model has generated increased engagement between parents and the school. For example, MHWCs report providing information and resources promoting student mental health and wellbeing to parents via communication channels within the school, and that this was received positively. MHWCs also indicated that through the use of classroom observations, they have been able to facilitate conversations between teachers and parents where there are concerns relating to a particular child. The majority of MHWCs surveyed (53.0%) reported observing a reduction in stigma regarding child mental health among families, and qualitative feedback references families being more open to conversations about child mental health.

(d) Student mental health and wellbeing

As set out in the 2022 Monitoring and evaluation framework (Smith et al, 2022) student level impacts including improved mental, social and academic outcomes, are regarded as long-term outcomes (2+ years post intervention). Nevertheless, quantitative and qualitative data suggest both short- and longer-term effects of the MHWC model on student outcomes.

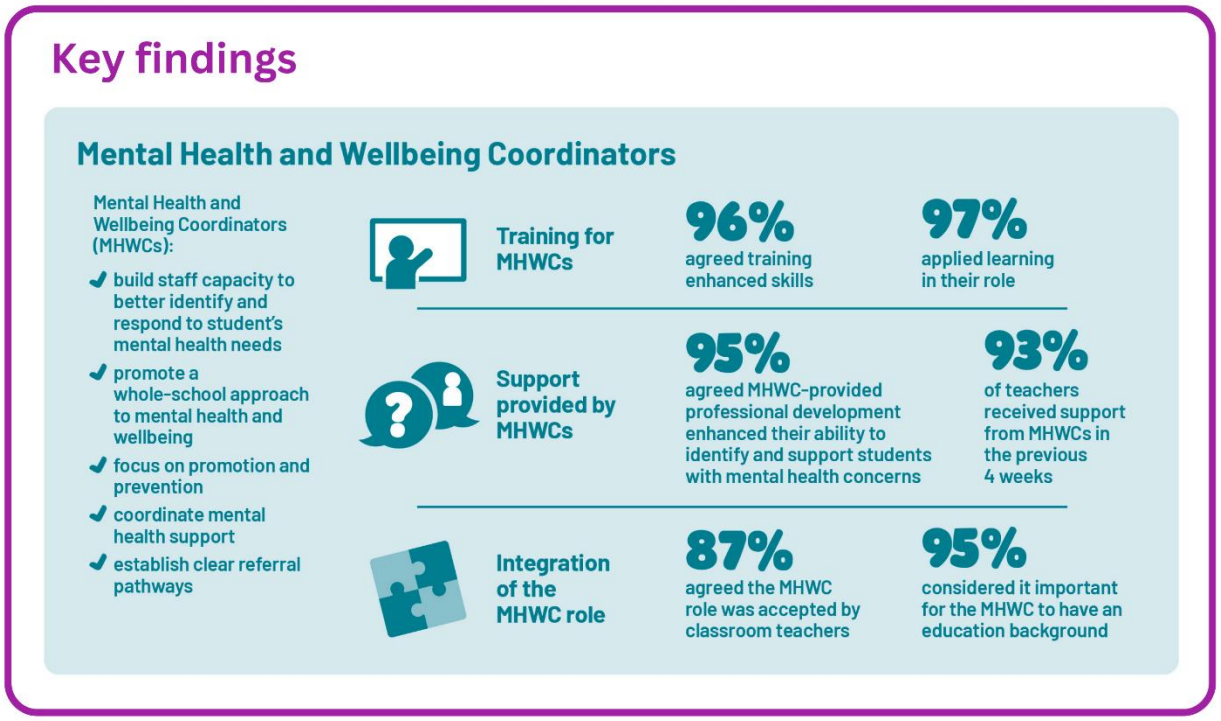
Parent survey data from the 2022 cohort indicate an improvement in student mental health (i.e., a reduction in the SDQ 'total difficulties score') at 10 months follow up, with an average decrease in total difficulties of 2.21 and 2.18 points for intervention and control schools, respectively. However, the difference between schools was not statistically meaningful. At 18 months follow up, findings based on unadjusted analysis indicate strong evidence for improvement from baseline compared with BAU comparison schools, with a significant decrease of 1.19 points in total difficulties. In addition, findings at 24 months post program commencement based on trend analysis with the 2020 cohort indicate evidence of improvement from the initial timepoint, with a significant 0.6 decrease in total difficulties.

Although these findings are potentially favourable of longer-term effects of the MHWC model on student mental health, they should be considered in light of lower response rates at follow up. In line with the program logic, further analysis based on data collection over a longer time frame and with a higher response rate will enable stronger conclusions to be drawn.

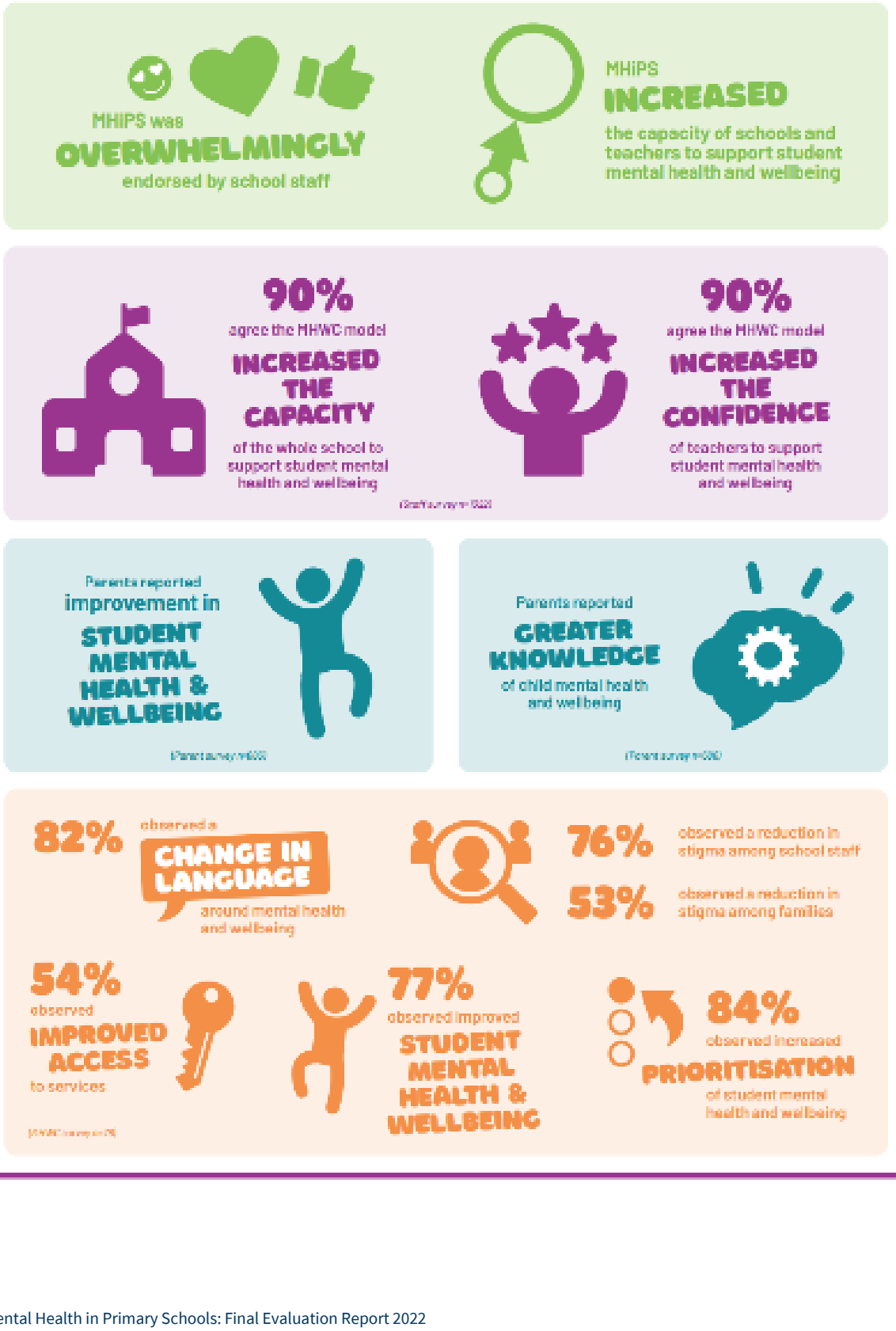


MHWC feedback at 10 months follow up indicated over three quarters (77%) had observed a positive impact on student mental health and wellbeing since commencing in their role. Observations primarily related to an increase in student help-seeking around mental health, an increase in implementation of coping strategies among students, and an increased willingness of students to discuss their mental health and wellbeing.

Qualitative data also suggest the MHWC model is having a positive impact on students through improved social and emotional wellbeing and improved in-school support for student mental health and wellbeing needs. This includes more open communication between staff and students regarding mental health and wellbeing, access to more supports at school and improved peer relationships.



Key findings



1.2.4 Limitations

The following limitations should be considered when interpreting findings from the MHiPS pilot evaluation:

- Disrupted implementation: Implementation of the pilot throughout 2020-2022 coincided with the COVID-19 pandemic during which the operation of schools was significantly impacted, thus affecting both implementation and evaluation of the MHWC model. For example, the need for schools to operate in a remote learning environment had an impact on the timely recruitment of MHWCs and limited implementation of the role, while staff shortages required some MHWCs to take on classroom teaching responsibilities limiting their capacity to undertake the MHWC role. Communication with schools was also impacted throughout this period thus impacting data collection activities and timelines.
- Limited generalisability: School recruitment into the pilot was based on school willingness to engage in the program. Schools that participated may not have been representative of all schools (e.g. greater readiness), potentially limiting generalisability of the evaluation results.
- Lack of diversity: The majority of schools that participated in the pilot (97%) were mainstream primary school settings, potentially limiting the applicability of the program to diverse school and student populations.
- Limited response rates at follow up: Low participant response rates at follow up, particularly school staff participants, potentially limited interpretation of findings on the long-term effectiveness of the program.
- Changes in broader mental health reform in school context: A significant increase in the focus on and funding of mental health and wellbeing in schools during the pilot period potentially makes it more difficult to isolate and attribute changes specifically due to MHiPS.
- Limited direct student voice: With the exception of the AToSS, all measures of student impact were indirect measures collected via parent or teacher report.

1.3 Key recommendations

1.3.1 State-wide implementation

Modifications to the training program and role scope which were introduced in 2022 strongly support implementation of the MHWC model. Based on the data presented in this report, the following recommendations are made:

(a) MHWC role

1. Findings from the evaluation indicate the majority of MHWC time is engaged in role-specific tasks aligned with the position description. **It is recommended that no change be made to the role description for MHWCs as it appropriately captures the aims and focus of the role.**
2. Pressure on time to engage in the full scope of the MHWC role is the most consistently reported barrier to successful implementation of the role. Given the constraints of allocating

the MHWC role FTE based on school size **it is recommended that (a) school leaders work closely with MHWCs to clarify role scope with consideration of FTE and ensure there is minimal diversion to non-MHWC activities and (b) DE continue to provide support to schools to identify other funding sources to support with program implementation and recruitment of MHWC (e.g. through the MH Fund menu, or the Student Wellbeing Boost[3]).**

3. Findings from the evaluation indicate the MHWC-delivered professional development activity from the Mental Health Literacy module is an essential component of the role in terms of role integration and building school staff capacity to support student mental health and wellbeing. **It is recommended the MHWC-delivered professional development component of the Mental Health Literacy training program continue to be a required deliverable for the role with expansion to other modules such as Supporting Need and Building Capacity.**

(b) Training / Communities of Practice program

4. Findings indicate the MHWC training program strongly supports the MHWC role, including the core modules and the ongoing Communities of Practice which is providing ongoing benefit to MHWCs at two years post commencement. **It is recommended:**
   - **staff trainees continue to be included in the initial core training sessions, to facilitate capacity building and integration of the role within the school context**
   - **the Communities of Practice continue as an essential component of the MHWC training program for at least two years**
   - **the training program continue to implement a continuous improvement cycle to ensure a tailored and responsive offering for schools**
   - **consideration be given to the need to contextualise to specialist and language schools and to other sectors (CECV and ISV) and DE to work with the training and evaluation teams around the scope of this work.**

5. The Learning Leader role facilitates both quality training delivery and ongoing learning support through the Communities of Practice and the provision of drop-in sessions. Initial feedback indicates the drop-in sessions are particularly subscribed early in the role (i.e., Terms 1 and 2) for MHWCs to check in on role focus and develop individual development plans. **It is recommended that monitoring and evaluation of the drop-in sessions be included in the early stages of the statewide roll out.**

(c) School leadership

6. Findings indicate that school leadership support is critical for supporting successful role integration, implementation, and providing ongoing role support. In particular, school leadership was identified as having a critical role in promoting the role within the school and

[3] Refer to : https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/BudgetReviewOctober202223/FundingSchoolsStudentWellbeing

providing role clarity with consideration of MHWC time fraction and school context. **It is recommended that additional support be provided to school leadership through a semi-regular 'opt-in' Community of Practice for this stakeholder group. This CoP could be facilitated by MGSE Training leadership) and include guided discussion regarding implementation barriers and enablers, clarification of MHWC role scope and advice regarding implementation best practices.** This leadership CoP could complement the existing support structures for leadership staff in schools such as the Induction session and planning activities and access/attendance at core training modules.

1.3.2 Further evaluation

Further evaluation is critical to inform long-term sustainability and impact of the MHWC model – particularly as it is rolled out across the State. **It is recommended that ongoing evaluation be prioritised, and specifically address:**

(a) Impact

7. **Long-term impact/maintenance of gains of the MHWC model on schools, teachers, parents and students.** This should include exploration of the Victorian Department of Education (DE) AToSS and POS data, teacher reported mental health literacy data, and data collection from 2021 and 2022 cohort parent and staff participants across a longer time period and with the aim of higher response rates.

8. **Insight into the factors that contribute to greater impact on student, teacher and school outcomes.** For example, what correlation is there, if any, between factors such as school size, MHWC FTE allocation and time available to undertake the role, school location, school sector, school type (i.e., EAL, specialist), mode of training delivery, school readiness and access to mental health support services on student mental health, and teacher confidence/capacity and school capability to support student mental health? This evaluation should include case study exploration for in-depth analysis of these factors.

9. **Implementing strategies to increase long-term follow up response rates and/or consider further data collection or analysis to strengthen and improve accuracy of findings.** This may include (a) review of future engagement with research participants (e.g., use of alternative platforms that provide value feedback to schools; development of an enhanced communications strategy in partnership with DE); and (b) review of analytical methods, e.g., use of meta-analysis, pooled analysis, etc. It is recommended MCRI work closely with DE Performance and Evaluation Division to prioritise relevant strategies.

10. **School-level evaluation and reporting.** It is recommended that consideration be given to provision of school-level feedback on evaluation findings to enable a cycle of review and planning for the model based on school-level data. This information to schools could also assist their annual planning process for the Wellbeing components indicated in FISO 2.0. This is currently outside the scope of the planned MHiPS state-wide evaluation.

(b) MHWC model

11. **Informing ongoing modifications to the model (training program and role) to maximise acceptability and successful outcomes**.

(c) Implementation

12. **Insight into the factors that affect successful implementation of the MHWC model** (relating to acceptability and feasibility). For example, what correlation is there, if any, between factors such as school size, MHWC FTE allocation and time available to undertake the role, school location, school sector, school type (i.e., EAL, specialist), mode of training delivery, school readiness and amount of engagement with mental health support services on how acceptable and feasible the MHWC model is within schools. This evaluation should include case study exploration for in-depth analysis of these factors.

13. **Further data collection and evaluation within the Catholic and Independent schools sectors**; in particular understanding differences, similarities, benefits and/or lessons to learn from pastoral care roles as compared with the MHWC role. Findings will assist in understanding how the Training Program can be adapted to further meet Catholic Education Commission of Victoria (CECV) and Independent Schools Victoria (ISV) requirements in light of future expansion.

(d) Operational considerations

14. **Time limitations for data collection, analysis and reporting.** Given the scope of the statewide expansion it is recommended the evaluation team work closely with the DE to continually review evaluation priorities and timelines.

2.0 Introduction

2.1 Background to the MHiPS Program

In recent years there has been increasing policy attention, at a state and national level, paid to child mental health. Both the National Productivity Commission (Productivity Commission, 2020) and the Royal Commission into Victoria's Mental Health System (2021) made detailed recommendations for child mental health. In addition, the National Children's Mental Health and Wellbeing Strategy (Australian Government National Mental Health Commission, 2021) detailed a comprehensive road map to guide investment over the next 5-10 years. This increased attention on child mental health is timely and follows reports of worrying increases in mental health concerns in schools and increased presentations of children with mental health issues to paediatricians and hospital emergency departments. The Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Lawrence et al., 2016) found that the impact of mental health disorders on children's education includes absenteeism, impaired functioning at school, and poorer academic performance compared to peers without mental health concerns. Left unaddressed, mental health challenges in childhood are related to increased risk of substance abuse, unemployment and suicidality (Patel et al., 2007).

All three reports – the Victorian Royal Commission, the Productivity Commission, and the National Strategy – suggested that schools were an ideal platform to address mental health issues in children. However, there are a number of recognised barriers facing schools aiming to adequately support student mental health (Australian Education Union, 2019). Many schools report feeling overburdened with the increasing numbers of children with behavioural and emotional issues, and teachers report feeling uncertain about accurately identifying and supporting these children. Obtaining timely support from fragmented community services is further compounded by access and equity issues, with long waiting lists and services with narrow eligibility requirements.

In 2020 the Centre for Community Child Health at the Murdoch Children's Research Institute (MCRI) partnered with the Melbourne Graduate School of Education (MGSE) at the University of Melbourne to conceptualise an initiative to build the capacity of schools to address child mental health issues. In partnership with the Department of Education and Training Victoria (DE), in early 2020 an extensive exploratory phase was undertaken which included:

- consultation with domestic and international experts regarding current attempts at supporting child mental health in an education context
- a needs analysis where the views of Victorian educators on barriers and enablers to support student mental health were canvassed via survey and focus groups
- co-design sessions with staff from 10 pilot primary schools to obtain feedback on a draft Mental Health and Wellbeing Coordinator (MHWC) model and plans that had been developed for implementation.

These activities were crucial to ensuring key stakeholders were engaged, and their feedback incorporated to shape the pilot and help the MHWC model embed seamlessly into the existing school system.

Participating pilot schools received funding from DE to employ a MHWC to implement a whole-school approach to mental health and wellbeing, and to build the capacity of primary school staff to identify and respond to student mental health issues. The MHWC, a qualified teacher, took up their role following participation in a comprehensive training program; they also received ongoing support and professional development through a structured Community of Practice process. The role and the training program combine to form the "MHWC model".

Known as the Mental Health in Primary Schools (MHiPS) Pilot, implementation and evaluation of the MHWC model was initiated in the 2020 school year in 10 Victorian government schools. A detailed report on the design and findings from the initial 2020 pilot can be found in Primary School Mental Health Pilot 2020: Final Report, Centre for Community Child Health, Murdoch Children's Research Institute (2021).

In 2021, funding from the Victorian Government and the Ian Potter Foundation enabled expansion of the MHiPS pilot to an additional 16 schools (see Darling, et al., 2021). The Final Report from the Royal Commission into Victoria's Mental Health System (2021) recommended that the MHWC model be expanded further should it prove to be effective. The Victorian Government committed to a further expansion of the pilot to 100 schools in 2022.

This is the Final Evaluation Report for the 2022 expansion of the pilot prepared for DE by the Mental Health in Primary Schools team at MCRI and MGSE.

2.1.1 The MHWC model

The MHWC model comprises the introduction of a new resource into primary schools, the MHWC, who undertakes the role alongside an accompanying 2-year training and Community of Practice (CoP) program.

(a) The MHWC role

The MHWC is employed and funded a full-time equivalency (FTE; outlined below). To be recruited for the role, the MHWC requires a teaching qualification and registration with the Victorian Institute of Teaching. The MHWC receives evidence-based training around supporting the mental health needs of primary school students. The role of the MHWC is to build the capability of the whole school regarding student mental health and wellbeing (identification, promotion and prevention). Specifically, the MHWC role includes the following:

- Embedding evidence-based training and professional development (Tier 1 practices & frameworks) across the school and building the capability of teaching and education support staff to better identify and support students with mental health issues.
- Contributing substantially to the school's wellbeing team.

- Supporting the referral pathway for students identified as requiring further assessment and intervention within the school or to external community-based services (the MHWC role is not intended to provide 1:1 counselling support to students).
- Working proactively with regional staff (i.e., psychologists, speech and language therapists, social workers), school wellbeing and leadership teams, and other health professionals (community-based psychologists, paediatricians, GPs, other allied health) to engage appropriate mental health support such as assessment, counselling, classroom-based adjustments.
- Connecting wellbeing initiatives across the school and supports implementation of whole school approaches to mental health and wellbeing, including the social and emotional learning curriculum.

MHWC FTE allocation is determined based on number of student enrolments at each school. An additional loading is provided for MHWCs working in regional and rural schools.

The rationale for using a qualified teacher in the role is based on three key factors: the nature of the required support, resourcing needs in schools, and achieving strong implementation of the model. Each of these are detailed further below.

1. Nature of required support

An educational background for the MHWC creates a context for early identification of emerging concerns and allows for direct and immediate classroom-based adjustments and school-based support. It recognises that not all students with mental health concerns need intensive individualised support and that some children benefit from school and classroom-based adjustments or from support systems already established within the school or local community. Further, many children with mental health concerns also struggle with learning, so having someone with an educational background facilitates attendance to both mental health and learning needs.

A key factor identified in the original codesign phase, and the training delivery phase was that parents are often concerned about stigma, and thus highly resistant to discussions about mental health issues in their child. The MHWC provides non-clinical support in the school. The approach promoted through the training uses common, non-confrontational language to reduce stigma in conversations with school staff, students, and parents/carers, encouraging them to be open in sharing children's behavioural and emotional concerns with educators.

2. Resourcing needs in schools

Psychologists and other Student Support Services staff and Health, Wellbeing and Inclusion Workforces (HWIW) are currently under pressure due to the rise in mental health concerns as a result of the stressors associated with COVID-19. This demand on services means that assistance to students can be significantly delayed. Similarly, psychologists working in community settings have long waiting lists and there are equity related accessibility issues (i.e., high out of pocket costs, geographical location/travel time to access services). Schools in rural areas have lower access to mental health and wellbeing support for students, including particular challenges in accessing

Student Support Service (SSS) staff. Implementing an education-based role to support school staff will increase accessibility to student support.

3. Achieving strong implementation

Qualitative feedback from the initial stage of the pilot (noted in section 1.3 below) suggests that an experienced educator in this role maximises engagement and adoption by the school as the MHWC brings a teaching background and therefore 'lived experience' of the issues and concerns of teachers in the classroom. In addition, components of care for students identified as needing additional mental health support require daily implementation (e.g., behaviour support plans) and it is not feasible for an allied health professional to monitor this type of support activity on a regular basis.

A key aspect of the MHWC role is to broaden and strengthen linkages between families, the school and community services. The MHWC role is intended to provide a central point of contact for school staff and additional support options within DE and the community. Preliminary results from the initial stage of the pilot suggest that having a skilled education professional to support mental health and coordinate care reduces the burden on teachers attempting to manage mental health problems without adequate training, and with limited time capacity to connect with support outside the school.

2.1.2 The MHWC training program

The MHiPS training program for the 2022 expanded pilot spanned two years, as follows:

Year 1:

The training program for MHWCs in their first year consisted of four core modules – Mental Health Literacy, Building Capacity, Supporting Need, and Communities of Practice – and provided targeted content, tools, and resources to enable successful implementation of the MHWC role within schools.
The instructional design and delivery methods were based around a participant centred, problem-solving approach that preferences teaching the 'doing' of the role over 'telling' participants what they need to know. This method draws on the learner's existing knowledge and experiences to support contextual adaptation and differentiated learning. The training was also couched in a collaborative framework where self and peer evaluative and reflective practice is embedded both during and post-training. This approach develops and builds professional judgment and reasoning skills.

Induction: a preparatory module covering information about the MHiPS project and the MHWC role. This module was designed for school leadership and the MHWC to provide operational information regarding the training program, research activities and guided reflection on the implementation of the Mental Health and Wellbeing Coordinator role in each school. This session was delivered by the DE, MGSE & MCRI teams.

Core Training Modules encompassed the three training modules in which the MHWC engaged to build their own capacity to fulfil their role, and to establish plans to implement changes within their schools and the Community of Practice module The core training modules included:

Core Module 1: Mental Health Literacy was a fully online asynchronous learning module, 2-3 hours of self-paced learning, focused on foundational knowledge about child development, child mental health and wellbeing, with the aim of increasing child mental health literacy. In addition to the self-paced learning for MHWCs, a Community of Practice was conducted to support the follow-up development of a Professional Development session for staff at their school to engage and develop mental health literacy across the school.

Core Module 2: Building Capacity was aimed at building whole school capacity in mental health and wellbeing and comprised both online self-paced learning and synchronous seminars. Beginning with 3 hours of self-paced online learning, MHWCs and school staff were introduced to the concept and definitions of a whole school approach to mental health and wellbeing. A 4-hour seminar with the MHiPS training team followed. In this seminar, MHWCs assessed the wellbeing profile of their school, created a mental health and wellbeing plan and used evidence regarding programs and approaches to inform their decision-making as part of the cycle of inquiry that supports their plan. In 2023 and beyond, this module will also facilitate the planning of a Professional Development session for school staff led by the MHWC.

Core Module 3: Supporting Need began with 2-3 hours of self-paced online learning where participants were introduced to the role of the school in promoting student wellbeing. This pre-work was followed by 4 hours of online seminar learning with the MHiPS Training Team covering identification of mental health and wellbeing concerns, basic screening and assessment processes, and how to support colleagues in the classroom, manage referrals and work with parents and families. In 2023 and beyond, this module will also facilitate the planning of a Professional Development session for school staff led by the MHWC.

Core Module 4: Communities of Practice (CoP) was designed to deepen the learning from the first three modules, with sessions held monthly throughout the year. CoPs provided a space where MHWCs could connect, share experiences, access experts in mental health and wellbeing, and strengthen professional knowledge and networks. Delivery included both MHWC and MGSE-led sessions, with example content including case presentations, relationship skills, and self-care. MHWCs were also encouraged to commence their own local Community of Practice, holding these on the weeks when they did not have a scheduled MGSE-led CoP.

For all modules, learning was supported with readings, discussion boards, additional resources, and tools to support the MHWC role via the University of Melbourne's Learning Management System (LMS) Canvas. Weekly drop-in sessions were also offered to MHWCs as a forum to ask questions about the implementation and functioning of their role as well as their learning pathway. Evidence from 2022 suggests that attendance at drop-in sessions was high at the start of the year and then decreased as the year progressed. While the reasons for this decline were not canvassed directly, it is hypothesised that MHWCs required less frequent support as their confidence and

knowledge grew from time spent in the role. Responses to drop-in sessions will be evaluated more comprehensively as part of the statewide expansion.

Each school was encouraged to have three people attend core modules 2 and 3 – the MHWC, one Leadership, and one teaching staff (supported by CRT funding from DE). Schools could send additional team members along to training (e.g., wellbeing staff), however, the program only accommodated a maximum of four per school.

Year 2:

Expansion of the pilot in 2022 saw the introduction of the second year of the training program. MHWCs who were in the second year of the pilot attended MGSE-led Enriched Communities of Practice (ECoP) and continued meeting in their local MHWC CoPs. EcoPs focussed on further developing the MHWCs' knowledge and confidence as they enriched their learning and consolidated their role in the school. Topics included working with external services, trauma-informed practice and self-harm. Learning Leaders based at MGSE attended local MHWC CoPs to support case presentations (three per year). In addition to the CoPs, fortnightly drop-in sessions provided a frequent point for MHWCs to access their Learning Leader for support.

Knowledge, Skills and Attitudes Capability Framework

During a whole cohort Community of Practice in mid-2022, a Knowledge, Skills and Attitudes Capability Framework (KSA framework) for the MHWC role was developed. The aim of the framework is to guide the MHiPS project, both for individuals and as a whole in terms of professional development and understanding the KSAs needed to be successful in the role.

- The KSA framework built on the original framework developed in the early stages of the project but was codesigned with input from the entire MHWC group for 2022. Subsequent to this CoP, a working group comprising Learning Leaders, Regional Coordinators and MHWCs further developed the framework (see Appendix A) which was presented at the End of Year conference in November 2022. This codesign process was used to ensure the framework is: representative of all MHWCs
- a 'living' document that provides opportunity for individuals to contribute to the development of fellow community members.

2.2 Background to the evaluation

DE funded the Murdoch Children's Research Institute (MCRI) to conduct an evaluation of the expansion of the Mental Health in Primary Schools (MHiPS) Pilot in 2022. The pilot expanded to 100 schools in 2022, including 10 schools which commenced the program in 2020 (2020 cohort), 16 schools which commenced in 2021 (2021 cohort) and 74 schools which commenced in 2022 (2022 cohort).

The purpose of the 2022 MHiPS Pilot evaluation was to assess (a) implementation of the program in 2022 and (b) the short and longer-term impact of the program. Findings from the evaluation will

assist in informing the continued implementation and state-wide expansion of the MHiPS program from 2023.

2.2.1 Objectives and key evaluation questions

Table 1 lists the key evaluation questions which guided data collection and analysis, and their alignment to the evaluation objectives. Findings in this report are structured around these objectives. Relevant measures used to assess each outcome are detailed in the 2022 MHiPS Monitoring and Evaluation Framework (Smith, R., et al, 2022).

Table 1: Key evaluation questions and alignment with evaluation objectives

Implementation
1. Implementation of the MHWC model in 2022, including:
• does the training program increase skills, knowledge and confidence to implement or support the MHWC role; does it provide adequate resources / training materials?
• what are the barriers and enablers to application of the learning from the training program within the school?
• to what extent have MHWCs been able to carry out the responsibilities of the role, as defined by the position description, including: implementation of mental health and wellbeing support structures; engagement with regional DE staff (e.g., SSS) and engagement with other mental health professionals.
• have referrals to mental health services increased/decreased/stayed the same?
• what are the barriers and enablers to implementation of the model and integration of the MHWC role within the school? How have these issues been addressed?
• how does implementation differ in the following settings: rural/regional schools; schools with high proportions of CALD students (EAL schools) or students with a disability (special development schools)?
• is the 2022 expanded model feasible to implement; acceptable to school staff; appropriate to address student mental health and wellbeing needs?
Impact
2. Does the MHWC model lead to change in classroom teachers' capacity to support student mental health and wellbeing, including:
• confidence to support student mental health and wellbeing?
• perceived levels of support to manage student mental health and wellbeing?
• mental health literacy?
• attitudes towards child mental health?
3. Does the MHWC model lead to change in the capacity of non-teaching staff to support student mental health and wellbeing, including:
• mental health literacy?
• perceived levels of support to manage student mental health and wellbeing?

- attitudes towards child mental health?

4. Does the MHWC model lead to change in school-level outcomes, including:
• capacity to address and support student mental health and wellbeing?
• level of prioritisation of mental health and wellbeing?
• level of unmet mental health and wellbeing need within school classrooms?
• engagement with DE-based and externally based mental health and wellbeing service providers?
5. Does the MHWC model lead to change in parent-level outcomes, including:
• mental health literacy (knowledge and skills)?
• attitudes toward child mental health?
• levels of engagement with teachers, school and external MH services?
6. Does the MHWC model lead to change in student-level outcomes, including:
• mental health and wellbeing?
• levels of mental health and wellbeing support?
• levels of engagement with teachers and school?
• levels of engagement with mental health services?

2.3 Evaluation Methods

2.3.1 Approach

The 2022 MHiPS evaluation used a multi-method (qualitative and quantitative data), multi-site and multi-informant (MHWCs, school leaders, teachers, education support staff, parents/carers) design. The evaluation included data collected and analysed from three cohorts as described below:

- 2020 cohort: 10 schools commencing the MHiPS program in mid-2020. Evaluation included (a) analysis of trends over time starting 6 months post pilot commencement and follow up 16 months and 24 months post pilot commencement; (b) descriptive analysis of MHWC feedback on the Enriched CoP program; (c) analysis of qualitative focus group data; and (d) preliminary analysis using data collected through the DE Attitudes to School Survey (AToSS) and Parenting Opinion Survey (POS).
- 2021 cohort: 16 schools commencing the MHiPS program in 2021. Evaluation included (a) comparison with 21 matched "Business as Usual" (BAU) schools at 10 months and 18 months post pilot commencement; (b) descriptive analysis of MHWC feedback on the Enriched CoPs program; and (c) analysis of qualitative focus group data.
- 2022 cohort: 74 schools commencing the MHiPS program in 2022. Evaluation included (a) comparison with 35 matched BAU schools at 10 months post pilot commencement; (b) descriptive analysis of survey data, including training feedback and staff survey at 6- and 10 months post pilot commencement; (c) MHWC job analysis data; and (d) qualitative focus group data.

An overview of the methods, participants and data collection timepoints is detailed below.

2.3.2 School recruitment

The 100 primary schools delivering the MHWC model were identified by the Victorian Department of Education and Training (DE) from the North West Victoria Region (NSVR) – North-East Melbourne, Mallee, Hume Moreland and Loddon Campaspe areas – and South West Victoria Region (SWVR) – Barwon, Wimmera South West, Central Highlands, Brimbank Melton and Western Melbourne areas. Schools were recruited by DE based on mental health need (through consultation with regional stakeholders and Incident Reporting Information System [IRIS] data), readiness (ensuring schools have the capacity and willingness to participate) and context diversity (including metropolitan, regional and rural contexts, and those impacted to different degrees by COVID-19). In addition, two Specialist Schools and one English as an Additional Language (EAL) school were included among the schools recruited in 2022.

The 56 BAU schools were recruited by invitation from MCRI sent to selected primary schools in the NWVR and SWVR. BAU schools were matched with intervention schools on socio-demographic characteristics (i.e., ICSEA), school size (i.e., number of enrolments) and location (i.e., metropolitan/regional/rural).

Data from an additional 45 schools was included in a preliminary evaluation based on the DE AToSS and POS; these schools were identified using a 'similar school' methodology matched to the original 10 pilot schools. This is further detailed in Section 3.2.4 (d). Table 2 details the rural/regional and metropolitan breakdown for schools in each cohort.

Table 2: School location by rural/regional or metropolitan area

	2020 Cohort	2021 Cohort		2022 Cohort	
	Intervention Schools n=10	Intervention Schools n=16	BAU Schools n=21	Intervention Schools n=72	BAU Schools n=35
School Geographic Area, n (%)					
Metropolitan	5 (50.0)	7 (43.8)	10 (47.6)	41 (56.9)	20 (57.1)
Regional/Rural	5 (50.0)	9 (56.3)	11 (52.4)	31 (43.1)	15 (42.9)

2.3.3 Participants

Participants in the 2022 MHiPS pilot evaluation included the following:

Mental Health and Wellbeing Coordinators: At least one educator for each participating school took up the role of MHWC. Newly appointed MHWCs from 2022 cohort schools participated in the core training and were invited to complete baseline and follow up surveys, training feedback surveys, and participate in focus groups. A total of 72 MHWCs from the 2022 cohort completed the training feedback survey. MHWCs from 2020 and 2021 cohort schools participated in the Enriched Communities of Practice (ECoP) training program, and were invited to complete ECoP feedback

surveys, a follow up survey and participate in focus groups. A total of 21 MHWCs from across the 2020 and 2021 cohorts completed ECoP feedback surveys.

Staff trainees: Up to three staff trainees from each of the 74 x 2022 cohort intervention schools participated in the training. Participants were invited to provide training feedback via online survey. A total of 92 staff trainees completed training feedback surveys.

School staff: School staff, including school leaders, teachers, wellbeing staff and education support staff were invited to complete baseline and follow up surveys.

- For the 2020 cohort, 92 staff from intervention schools completed the initial SMH-SETS survey (6 months post pilot commencement); of these 58.7% completed follow up at 16 months and 37.0% completed follow up at 24 months.
- For the 2021 cohort, 440 staff from intervention schools and 381 staff from control schools participated in the baseline survey; of these, 58.2% (intervention) and 53.8% (control) completed follow up at 10 months, and 45.2% (intervention) and 33.3% (control) completed follow up at 18 months.
- For the 2022 cohort, 1,956 staff from intervention and 654 staff from control schools participated in the baseline survey; of these 52.3% (intervention) and 47.7% (control) completed the follow up at 10 months.

Additionally, leadership staff and classroom teachers from intervention schools across all three cohorts were invited to participate in focus groups.

Parents/Carers: Parents/carers of students who were in Years 2 and 4 when the school commenced the MHiPS program were invited to complete baseline and follow up surveys. The total number of parents participating at each wave of data collection for each cohort is detailed below:

- For the 2020 cohort, 241 parents from intervention schools completed the initial parent-report Strengths and Difficulties Questionnaire (SDQ) (6 months post pilot commencement). Data was provided for 252 students, with 79.0% completing follow up at 16 months and 75.0% completing follow up at 24 months.
- For the 2021 cohort, 385 parents from intervention schools and 301 parents from control schools participated in the baseline survey. Of these 96.1% (intervention) and 98.0% (control) completed the SDQ at baseline; 72.5% (intervention) and 74.1% (control) completed the SDQ follow up at 10 months follow up; and 34.1% (intervention) and 35.6% (control) completed the SDQ at 18 months follow up.
- For the 2022 cohort, 2279 parents from intervention schools provided data for 2240 students, and 961 parents from control schools provided data for 947 students in the baseline survey; 63.8% (intervention) and 69.5% (control) parents completed the follow up at 10 months.

Appendix B details survey baseline characteristics of participants across all three cohorts and Appendix C details characteristics of focus group participants.

2.3.4 Data collection activities and timeline

Error! Reference source not found.3 summarises the data collection activities for each participant type and the relevant outcomes assessed by each.

Table 3: Data collection activities

Data collection	Participants / Cohort	OUTCOMES				
		Implementation	School Staff	School	Parents / Carers	Students
Staff survey	MHWCs Staff in participating MHiPS and BAU schools	X	X	X	X	X
Training feedback surveys	MHWCs Staff trainees	X				
Focus Groups	MHWCs Leadership / teachers	X	X	X	X	X
MHWC Job Analysis	MHWCs	X				
Parent Survey	Parents in participating MHiPS and BAU schools				X	X

For details of the data collection timepoints reflected in this report and their alignment with program implementation (excluding AToSS and POS data collection), see Appendix D. Timepoints indicate the commencement of data collection for that timepoint.

2.3.5 Methods of analysis

Methods of analysis used in the 2022 MHiPS pilot evaluation included the following:

Participant surveys

Staff, parent, and teacher-reported data collected at schools implementing the MHWC model was compared with data from BAU schools using a quasi-experimental (non-randomised) approach to determine whether any outcomes in schools implementing the MHWC model differed from similar schools without the model. This analysis involved 16 intervention and 21 control schools from the 2021 cohort followed up at 10 months and 18 months, and 74 intervention and 35 control schools from the 2022 cohort followed up at 10 months. BAU schools were matched to intervention schools on socio-economic status (Index of Community Socio-Educational Advantage [ICSEA]), location (metropolitan, regional, rural) and number of student enrolments.

Analysis of long-term follow up staff and parent data from the 2020 cohort of schools was based on analysis of trends over time on two key outcomes: teacher confidence to support student mental health and wellbeing (as measured by the Student Mental Health Self-Efficacy Teacher Survey (SMH-SETS) (Brann et al., 2021) and student mental health (as measured by the parent-reported SDQ (Goodman et al., 2000)) up until 24 months post-school commencement in the pilot, using repeated mixed models, including school and individual random effects.

Data relevant only to the intervention arm of the study drawn from staff surveys, parent surveys and training feedback surveys was analysed using descriptive methods to determine frequencies, means and standard deviations as relevant for categorical or continuous data. Open-ended text data was analysed using thematic text analysis.

Participant characteristics were summarised using descriptive statistics, reported with frequencies and percentages to describe the sample population (refer to **Error! Reference source not found.**).

Focus groups

Qualitative data was analysed with NVivo software using a structured and systematic process incorporating pre-determined categories informed by the key evaluation questions (KEQs) and stakeholder discussions. Additional categories emerging from the data were also considered. Analysis comprised both descriptive analysis: categorising broadly according to KEQs using a deductive approach; and thematic analysis: further analysis to code into themes, specific ideas, concepts or points developed inductively from the data.

MHWC job analysis

As part of understanding the implementation of the MHWC role within each school, MHWCs were asked to complete the job analysis tool. This tool required the MHWC to provide a brief description of daily tasks at 30-minute intervals over two separate weeks during Term 2, 2022. For each 30-minute interval, MHWCs were asked to record a description of the activity completed. Across the two weeks of data collection, job analysis tools were received from 83 MHWCs spanning 3498 hours. Data from 19 participants were excluded from the total sample as the total information provided was less than 50% of the FTE or the data provided was of poor quality. This reduced the total information-collection span to 3269 hours. Activity task codes classified as not working/school break were also excluded from the data. Following the exclusion of participants and recorded time not working in the MHWC role, total data analysed was based on 64 MHWCs spanning 2913 working hours.

MHWC job analysis data was analysed using descriptive methods to determine frequencies, percentage of time allocated, means and standard deviations for each coded work category to understand the scope and profile of the MHWC role. Data was collected via a custom-built tool using RedCap hosted at the University of Melbourne and analysed using Excel and SPSS where necessary.

2.4 Research approval and ethics

The study received ethics approval through the Human Research Ethics Committee (HREC) at The Royal Children's Hospital (# 65924) and approval through DE's Research in Schools and Early Childhood Settings (RISEC) process (2020_004332).

2.5 Limitations

Findings regarding impact of the MHiPS program should be interpreted in light of the following limitations:

- Findings are based on implementation of the MHiPS model throughout 2020-2022. During this period of time the operation of schools was significantly impacted due to the Victorian community's experience of COVID-19. During 2020 and 2021, schools experienced extended periods of remote and flexible learning and in the first half of 2022 schools experienced extensive staff shortages as a result of COVID-19 cases. These circumstances effected both implementation and evaluation of the MHIPS program, as follows:
  - MHWCs (along with all school staff) were required to work from home over an extended period in 2021 in many schools and most MHWCs (over 90%) had been required to take on classroom teaching responsibilities as a result of staff shortages in 2022 (see section 3.1.2 (d)), limiting their capacity to undertake their MHWC role.
  - Recruitment of MHWCs was delayed in some schools, potentially reducing impact of the model.
  - Communication with schools was limited throughout this period, impacting data collection activities and timelines.
  - Response rates at follow up were lower than at baseline, particularly for school staff participants (i.e., less than 50%). This may potentially limit interpretation of some long-term findings; however, the follow-up response rates are still within an acceptable range.

- The broader context of mental health reform within Victoria during this period has resulted in a significant increase in (a) focus on mental health and wellbeing in schools; (b) access to funding; and (c) number of mental health related programs being offered or introduced to schools (e.g., through the Schools Mental Health Fund Menu) throughout 2022, making the impact of MHiPS on outcomes difficult to isolate and attribute.

- There were specific limitations with regards to the evaluation of student impact based on analysis of the DE AToSS data and POS data. At the time of analysis, the most recent data available for these surveys was from 2021. Based on the timing of this data collection (Term 2 each year), only data relevant to the original 10 pilot schools who had commenced the program mid-2020 could be included in the analysis. Therefore, findings primarily reflect a short window of implementation during the original 6-month feasibility pilot (see section 3.2.4 (e)).

In addition, the following limitations are noted:

- Limited generalisability: School recruitment into the pilot was based on school willingness to engage in the program. Schools that participated may not have been representative of all schools (e.g. greater readiness), potentially limiting generalisability of the evaluation results.
- Lack of diversity: The majority of schools that participated in the pilot (97%) were mainstream primary school settings, potentially limiting the applicability of the program to diverse school and student populations. In addition, there was limited

scope to sufficiently engage EAL families in the evaluation. A wide range of factors need to be addressed when engaging EAL families in mental health research, which were beyond the scope of this evaluation.

- Limited direct student voice: With the exception of the AToSS, all measures of student impact were indirect measures collected via parent or teacher report.
- Reporting timeframes limited the extent to which the data could be analysed and considered – for example, analysis and consideration of DE collected AToSS and POS data (as described earlier) and further analysis and consideration of the MCRI-collected data.

3.0 Findings and analyses

3.1 Implementation of the MHiPS program

Findings detailed in this section relate to implementation of the MHiPS program.

3.1.1 Training program

Findings on the 2022 training program are based on all MHWCs and staff trainees from the 2022 cohort who participated in the core training modules (Mental Health Literacy, Building Capacity, Supporting Need and Communities of Practice) and all MHWCs from the 2020 and 2021 cohorts who participated in the Enriched Communities of Practice (ECoP) module (see Appendix E). Findings indicate the training program strongly supports the MHWC role.

(a) MHWC feedback (2022 cohort)

A total of 80 MHWCs commenced their role during Term 1, 2022. From this group, 72 (90%) completed the training feedback surveys. Table 4 details the proportion of respondents who agreed (somewhat agreed, agreed, strongly agreed) with each item, for each training module. Results indicate the training program strongly supported the MHWC role.

Table 4: MHWC agreement (somewhat agree/agree/strongly agree) with training feedback items for each module.

	Core Training Modules				
	Mental Health Literacy (n=72)	**Building Capacity (n=70)**	**Supporting Need (n=69)**	**Term 1 CoP (n=69)**	**Term 2 & 3 CoP (n=69)**
Gave clarity to my role	86.0%	92.8%	97.1%	N/A	N/A
Addressed the needs of my role	90.3%	91.3%	98.6%	94.3%	97.2%
Gained knowledge about supporting a whole school approach / students with MHWB needs	100%	95.6%	97.2%	95.7%	95.6%
Gained skills about supporting a whole school approach / supporting students with MHWB needs	97.2%	94.3%	98.6%	95.7%	95.6%
Increased confidence to undertake my role	95.8%	91.5%	97.1%	92.8%	95.6%
Can apply learning from the program to my role	100%	98.6%	N/A	95.7%	95.6%

MHWCs from the 2022 cohort were asked to identify the CoP sessions that were most useful to their role as MHWC in the school (MHWCs could choose more than one response). Responses from

MHWCs confirmed that all sessions were useful. Sessions identified as 'most useful' were 'Challenging Behaviours' (55.4% of respondents); 'Case Presentations' (50.0% of respondents); 'Cultural Safety and Understanding' (39.2% of respondents); 'Introduction to Case Presentations' (39.2% of respondents); 'Self Care' (37.8% of respondents); and 'Relationships Skills' (37.8% of respondents).

MHWCs provided examples of how they would immediately apply the learning from the core training program within their school. Responses covered the following key areas:

- Deliver PD to their school.
- Reach out to other MHWCs to learn and collaborate.
- Review of consent and privacy practices.
- Review of referral processes and documentation.

At the conclusion of the initial core training program, MHWCs from the 2022 cohort were asked to identify the main barriers and enablers to applying their learning within their school. Responses highlighted early challenges with role implementation: 47.8% of respondents indicated holding multiple roles within the school was the main barrier to application of learning and 30.4% identified lack of time as the main barrier. The main factors identified as facilitating early implementation included leadership support (85.5% of respondents) and staff support (66.7% of respondents).

As part of the Term 1 training feedback, MHWCs made suggestions about additional content they would like included in the training program to support their role. Based on MHWC responses, content was tailored for the Community of Practice program including provision of the following:

- Practical resources, templates, and actionable steps that MHWCs could draw from.
- Peer support discussions with other MHWCs via the Communities of Practice.
- Sessions on school refusal and student mental health issues, including self-harm and suicide risk.
- Information on engaging and working with external mental health services.

(b) Staff trainee feedback (2022 cohort)

A total of 180 staff trainees accompanied their school's new MHWC to the core training modules (Mental Health Literacy, Building Capacity, Supporting Need) in Term 1, 2022. Staff members who attended training were primarily classroom teachers (37.8%), principals or assistant principals (26.1%) or other wellbeing staff (12.8%). From this group of trainees, 92 (51.1%) completed the training feedback survey. Results detailed in Table 5 indicate the training program strongly supported the trainee in both (a) understanding and facilitating the role of the MHWC and (b) building knowledge and skills about developing a whole school approach to mental health and wellbeing and supporting students with mental health and wellbeing needs.

Table 5: Proportion staff trainees who agreed (somewhat agree/agree/strongly agree) with each item for each core training module.

	Mental Health Literacy (n=92)	Building Capacity (n=92)	Supporting Need (n=77)
Was relevant to my role at my school	97.8%	97.8%	98.7%
Helped me to understand the role of the MHWC in our school	N/A	96.7%	98.7%
Allowed me to contribute to the learning activities using experience from my role at my school	97.8%	97.8%	100%
Gained knowledge about child MHWB / supporting students with MHWB needs / developing a whole school approach to MHWB	95.6%	97.8%	97.4%
Gained skills to support students with MHWB needs / support a whole school approach to MHWB	94.5%	97.8%	100%
Increased confidence to undertake my role	91.3%	96.7%	96.1%
Can apply learning from the program to my role	95.6%	96.7%	98.7%

Staff trainees were asked what initial actions they would take to apply their learning from the training within their school context. Responses highlighted ways in which staff trainees could support the work of their MHWC and facilitate role integration, including:

- work with MWHC to share knowledge learnt with staff (through training)
- determine the needs of our school and the direction we need to take to build capacity
- work on developing appropriate resources for the school (e.g. update mental health plan, referral pathways, implementing care pathways policy or wellbeing referral form)
- review local referral services to utilise.

Qualitative data from MHWCs and staff trainees was consistent with findings from the feedback survey and confirmed strong support for the training program, as the following examples illustrate.

> *So, I do think the training's great, and I think when you start the role, it's really important that everyone knows that, really, the first or second term, it's a lot about the training and knowledge and learning. (MHWCs Group Interview #12, 2022 cohort)*

> *I thought the training in first term was really, really good, …leadership support, having time and, and given the resources to really do the training properly. I thought the training in first term was excellent. (MHWC Group Interview #8, 2022 cohort)*

Findings also indicate the core training modules, including Communities of Practice, supported MHWCs with regards to role clarification. Quantitative data at 6 months post program commencement indicated most MHWCs had a good understanding of their role with 90.5% confirming they had a comprehensive understanding of their responsibilities as a MHWC, and

89.4% confirming they had a comprehensive understanding about which aspects of the role on which to focus given their FTE allocation.

(c) MHWC feedback (2020 & 2021 cohort)

MHWCs who commenced their role in either 2020 or 2021 participated in the ECoPs throughout 2022. From this group, 19 (73.1%) MHWCs completed the Term 1 ECoP feedback survey and 21 MHWCs (80.7%) completed the Term 2 & 3 ECoP feedback surveys. The ECoP program was endorsed by all MHWCs; **Error! Reference source not found.**6 details the proportion of respondents who *moderately agreed* or *agreed strongly agreed* with each item for the ECoP feedback survey.

Table 6: Proportion MHWCs who moderately agree or agree/strongly agree with ECoP feedback items for each module.

Items	Term 1 ECoP (n=19)		Term 2 & 3 ECoP (n=21)	
	Moderately Agree	Agree / Strongly agree	Moderately Agree	Agree / Strongly agree
Addressed the needs of my role	21.1%	79.9%	4.8%	95.3%
Gained knowledge about supporting a whole school approach / students with MHWB needs	10.5%	89.5%	4.8%	95.3%
Gained skills about supporting a whole school approach / supporting students with MHWB needs	26.3%	73.7%	4.8%	95.3%
Increased confidence to undertake my role	15.8%	84.2%	4.8%	95.3%
Can apply learning from the program to my role	5.3%	94.7%	4.8%	95.3%

All ECoP sessions were identified as useful to the MHWCs in their role. The sessions identified as 'most useful' were 'Challenging Behaviours' (76.2% of respondents); 'Self-Harm' (61.9% of respondents); 'Trauma Informed Practices' (61.9% of respondents); and 'Working with External Services' (57.1% of respondents).

MHWCs provided examples of how they would immediately apply the learning from the ECoP within their role. Responses broadly related to the following:

- Increased engagement with external services; organisation of presentations and provision of additional support.
- Incorporation of trauma-informed practices among staff; professional learning and discussions regarding self-harm.
- Review of referral processes and documentation.
- Review of resources and documents regarding managing challenging behaviours.

MHWCs from the 2020/2021 cohorts were asked to identify the main barriers and enablers to application of the learning from the ECoP to their role. 'Lack of Time' (71.4%) and 'Multiple Roles within the School' (33.3%) were identified as the main barriers to application of learning, while 71.4% indicated 'Leadership Support' and 'Staff Support' (61.9%) as the main enablers.

A total of 11 MHWCs from the 2020/2021 cohorts participated in the focus groups conducted in Term 3, 2022. The interviewees noted there had been some changes over time, typically positive, with expansion of their role as relationships and trust were built. ECoPs were viewed positively; continuing MHWCs felt they could really develop their role and focus and discuss specific target areas of the role.

> *I really have liked that we have been able to have a bit of voice in the training that we're undertaking as we've gone on in our Enriched CoPs this year, because we've been able to target specific areas that are areas of need or concern at our school. (MHWCs Group Interview #1, 2020 & 2021 cohort)*

MHWCs from the 2020/2021 cohorts valued the opportunity to continue learning, especially from each other and having a sense of community in the role.

> *I think that the COPs that we do in the small groups are brilliant because it's our network and each one of our schools is really different, and I love understanding that and the flexibility in how that role's modified in that space. (MHWCs Group Interview #1, 2020 & 2021 cohort)*

3.1.2 Implementation of the role

Findings from analysis of survey and qualitative data indicate that MHWCs have been able to carry out the responsibilities of the role as intended and with a particular focus on Tier 1 prevention and promotion activities, including implementation of a range of mental health and wellbeing support structures. Strong engagement with regional and other mental health professionals was reported by around half of all MHWCs (2022 cohort) at 6 months follow up, but almost one in five noted *no* or *poor* engagement at this timepoint (see Appendix F). At 10 months follow up, findings suggest an improvement in engagement with services (see Appendix G).

(a) Job analysis

Results from the MHWC job analysis in Term 2 indicated the majority of MHWC time was spent on role specific tasks (73.5%), which included:

- whole school approaches/implementing and evaluating evidence-based prevention/promotion programs (17.3%)
- meeting with staff members and provision of staff support (13.7%)
- additional training or professional development (9.3%)
- MHiPS pilot activities (e.g., attending MHiPS or local CoP; completing job analysis tool) %) (8.8%)
- direct school-based support to children (8.8%)
- meeting with parents and/or combined parents and staff (5.1%)
- consultation with external services (3.5%)

- other: including classroom observations, record keeping, planning student supports, teacher wellbeing, and self-care (7.0%).

Unspecified or non-role-specific tasks (26.5%) included:

- general school duties (10.8%)
- administrative tasks (9.3%)
- classroom teaching due to COVID-19 and staff shortages (6.4%).

Job analysis data related specifically to the Multi-tiered System of Support indicated most time (43.7%) was spent on Tier 1 support activities: providing universal support for all members of the school community, followed by 33.6% on Tier 2 support activities: providing targeted support for students identified as being at risk, and 22.7% on Tier 3 support activities: providing intensive and individualised support. Further detail and results from the job analysis are detailed in Appendix H.

At 6 months follow up, MHWCs from the 2022 cohort were asked about how much of their time was spent implementing each of the various mental health and wellbeing support structures as described in the position description. Findings indicate that more than half (55.5%) of MHWC respondents spent a lot or most of their time promoting whole school approaches to prevention and promotion of mental health and wellbeing in students, staff and families. Table 7 summarises the proportion of MHWCs (n=81) who indicated *a lot* or *most* of their time for each relevant activity.

Table 7: Proportion of MHWCs who indicated 'a lot' or 'most' of their time for each core activity as per role description.

Core activities	**'A lot' or 'Most' of my time (n=81)**
Promoting a whole school approach to the prevention and promotion of mental health and wellbeing in students, staff and families.	55.5%
Supporting teachers and school staff embed mental health strategies, interventions and programs to identify and support students with mental health concerns.	38.3%
Supporting teachers and school staff to build their mental health literacy to identify and support students with mental health concerns.	29.7%
Supporting their school to create internal and external referral pathways for students identified as requiring further assessment and intervention.	34.6%
Coordinating individualised support for children with mental health and wellbeing concerns.	35.8%
Providing individualised support for children with mental health and wellbeing concerns.	38.3%
Providing small group support for children with mental health and wellbeing concerns.	13.0%
Engaging in activities unrelated to their role as MHWC.	18.9%

(b) MHWC-led PD sessions.

MHWCs from all cohorts reported that running staff PD sessions as part of their role had helped to increase teachers' awareness of mental health and wellbeing as well as how to recognise struggles and how to act to support students. This increased understanding in teachers has reportedly facilitated helpful conversations within the school community, including with parents.

> *Continuing to build that mental health literacy, I think that's been a big part. That's the parent, that's the staff, that's the students as well, opening up that conversation, helping teachers understand what it looks like when a student's struggling, how we can support them, helping parents understand where they can go for help. (MHWCs Group Interview #1, 2020 & 2021 cohorts)*

> *I have done a lot of PD with staff, it has been one of my big parts of the role. About raising awareness of mental health, but also explicitly looking at what that looks like in school-aged children and how we can assist them in the classroom. What can teachers do? So really taking it down and upskilling those teachers and giving them the confidence to support these students in the classroom. (MHWC Group Interview #8, 2022 cohort)*

One interviewee from the Teacher Group similarly reported a shift in thinking in their school to becoming more aware of student mental health and wellbeing over time.

> *I think we've been more aware as staff to be doing more regular check-ins. Having seen the mental health continuum, of having that in mindset of, 'I wonder how these kids are doing', or 'Maybe that's been going on for longer than I might have noticed in the past', so being able to do more of those check-ins. It's also, I think, probably led to more awareness of and making note of when there has been any incidents or things like that to be able to track how we're actually doing. (Teachers Group Interview #9, 2022 cohort)*

(c) MHWC engagement with internal and external mental health support services

Findings from survey data at 6 months follow up indicate less than half of MHWCs had good engagement with external mental health support services (e.g. GPs, speech therapists, child protection, youth justice system, charities) and just over half had good engagement with DE areas/units providing mental health support (e.g. Student Support Services, School Nurse, Board Certified Behaviour Analyst, Senior Wellbeing and Engagement Officer) (see Appendix F) In addition, almost 1 in 5 reported their engagement with these services was 'poor' or 'none'. Details below:

- 40.7% rated their engagement with local agencies as 'good' or 'excellent'; 33.3% rated their engagement as 'fair'; and 19.7% rated their engagement as 'poor' or 'none'.
- 50.6% rated their engagement with DE areas/units as 'good' or 'excellent'; 27.2% rated their engagement as 'fair'; and 18.5% rated their engagement as 'poor' or 'none'.

Findings from the staff survey at 10 months follow up indicate school engagement with local agencies and DE areas/units did improve following introduction of the MHWC model, and this was also reflected in MHWC feedback (see Section 3.2.2 (d).

(d) Role time fraction details

The following information summarises quantitative data related to the allocated time fraction for the MHWC role including findings on additional competing factors which may have impacted implementation of the role.

MHWC time fraction and other factors were reported at 6 months follow up (see Appendix F). Findings from 81 MHWCs who commenced their role in 2022 indicated:

- 28.1% were employed at 0.4-0.5 FTE; 32.4% at 0.6-0.7 FTE; and 39.5% at 0.8-1.0 FTE
- 38.2% had worked more than their allocated FTE in their role in the preceding 4 weeks
- 54.3% held multiple roles within the school; other roles included classroom teacher (27.3%); specialist teacher (20.5%); principal or assistant principal (9.1%); or other (43.2%) (including disability inclusion officer; leading teacher, wellbeing leader)
- 91.4% indicated they had been required to take up classroom teaching responsibilities as a result of staff shortages; 74.1% indicated they had spent up to 2 weeks in total across the year, 9.9% a total of 3-4 weeks, and 7.4% more than 4 weeks in teaching responsibilities.

In addition, at 6 months follow up (Term 3) 20.4% of school staff respondents indicated there had not been an MHWC consistently employed in their school as follows: 1.0% indicated not at all; 1.1% indicated less than a term; and 18.3% indicated 1-2 terms.

3.1.3 Feasibility, Acceptability, Appropriateness

Survey findings from school staff (2022 cohort) and MHWC focus groups indicate the MHWC role integrated well with existing school staff and structures, and that the model was seen as feasible, acceptable and appropriate (see Appendices F and G).

Survey data from school staff (2022 cohort) at 6 months follow up indicate more than three quarters (77.0%) reported the MHWC role to be somewhat clear or very clear in comparison to other wellbeing roles; 16.7% reported the role of the MHWC was somewhat unclear (see Appendix F). Findings also indicate the role had integrated well as follows:

- 89.1% confirmed (moderately agree / agree / strongly agree) the MHWC role had been accepted by existing wellbeing staff
- 91.0% confirmed the MHWC role had been accepted by leadership
- 89.8% confirmed the MHWC role had been accepted by classroom teachers
- 85.9% confirmed the MHWC role had merged well with existing school wellbeing structures
- 95.7% confirmed the education background of the MHWC (i.e. teaching qualification) was important given their understanding of the role. Specifically, 69.2% rated the education background of the MHWC as very important; 26.5% rated it as somewhat important.

Survey data at 10 months follow up indicate school staff perceive the MHWC model as acceptable, appropriate, and feasible (see Appendix G). In particular, 91.3% of MHWCs indicated they liked the model, 88.2% indicated it was a good match for their school and 81.0% indicated it had been implementable. Classroom teacher respondents also confirmed they liked the model (74.9%) and

that it had been a good match for their school (77.0%). Table 8 details the acceptability, appropriateness and feasibility by respondent role.

Table 8: Proportion of respondents agreeing (completely agree/agree) with each item.

Item	MHWC		Classroom teacher		Other staff	
	N	n (%)	N	n (%)	N	n (%)
I like the Mental Health & Wellbeing Coordinator model.	80	73 (91.3%)	391	293 (74.9%)	347	253 (72.9%)
The Mental Health & Wellbeing Coordinator model has been a good match for my school.	76	67 (88.2%)	391	301 (77.0%)	346	258 (74.6%)
The Mental Health & Wellbeing Coordinator model has been implementable.	79	64 (81.0%)	391	290 (74.2%)	346	257 (74.3%)

Feedback from the MHWC group interviews from both cohorts indicate that the model has been well received within schools and has been useful in supporting staff to meet the mental health and wellbeing needs of students.

> *I think the role has meant that there's somebody there for staff to go to at an earlier point. So, you've been able to nip some of those early things in the bud and put in some supports, so it doesn't escalate. Whereas before, because the people power wasn't there, that problem has probably got bigger than they needed to, before we put supports in. (MHWCs Group Interview #2, 2020 & 2021 cohorts)*

> *… I think [leadership] attitudes around how we work with families and stuff has sort of evolved, which is awesome. Initially their view was no, we don't have anything to do with, say, community referrals or external services, this is where we stop, but that's changed. So, I have a role in that, they have a role in that too. So, yeah, they're supportive of it, they see a lot of value in it. (MHWCs Group Interview #1, 2020 & 2021 cohort)*

Feedback from teachers and school leaders was similarly supportive of the MHWC model.

> *But from what I've seen over the last year and a half, the person in the role, she does a great job with those students who need that extra bit of care and support. … I've seen leaps and bounds, what the students were like, some of them that she has worked with, what they were like to what they are like now, and it's just unbelievable. (Teacher Interview #3, 2020 cohort, Metro school)*

> *Overall, I love the role and what it's brought to the school. We've been looking for this opportunity within our own budgets all the time in the last few years but now we've got that opportunity with the funding. (School Leaders Group Interview #11, 2022 cohort)*

3.1.4 Barriers and enablers to implementation

(a) Barriers to implementation

MHWC survey data at 10 months follow up identified the "most significant barriers to making progress and improving outcomes". Lack of time was the most commonly reported barrier to making progress, indicated by approximately 45% of MHWCs. 'Lack of time' incorporated insufficient time fraction for the role, competing priorities, holding multiple roles, and having to cover classes due to teacher shortages. Specific examples included:

- *time restraints due to time fraction*
- *lack of time within my current school setting*
- *ensuring that my 1.0 role stays as close to 1.0 as possible*
- *time, being taken away from the job to CRT or cover classes*
- *time being taken up to address the needs the school has that are outside of my role as MHWC (e.g. supporting need of individual students that I am hired to do on my other 2 days which bleeds into my other days)*
- *time - 2 days a week are not enough*
- *not being in the role fulltime / being the first point of call if a CRT [casual relief teacher] cannot be found and used for PP [professional practice] day release*
- *the amount of work*
- *teacher shortage and covering classes*
- *having an Assistant Principal role as well.*

The second most reported barriers related to staff attitudes, whole school buy-in and role clarity (reported by approximately 13-14% of MHWCs). Comments indicated that some MHWCs had struggled to have their role accepted by other staff and some MHWCs mentioned this included dealing with stigma around child mental health. Comments related to role clarity indicate that a lack of understanding about the role created difficulty, particularly where there was a pre-existing wellbeing team. Specific examples included:

- *staff not wanting assistance with students; they want to fix things themselves.*
- *stigma/staff reluctance*
- *stigma with mental health and competing priorities within the school*
- *having all staff on board with understanding the process and willing to meet you halfway*
- *profound confusion between my role and other wellbeing staff*
- *the fact that MHWC are not funded as Leading Teachers and automatically part of the Leadership Team*
- *finding where the MHWC fits in with our very establish wellbeing and sub-school leader system without over stepping*
- *lack of clarity in terms of the role description (this was a barrier earlier but that is becoming less so with time).*

Other barriers variously reported by a small minority of MHWCs included school-specific factors, limited access to services, lack of leadership support, insufficient training/skills and parent buy-in.

Focus group data collected in Term 3, 2022 was generally consistent with survey data. MHWCs from both regional and metropolitan schools discussed how the time fraction allocated to their school restricted their level of impact in the role and also had an impact on their own wellbeing. Key themes related to the challenges that were due to the part-time nature of the role and the level of mental health need in some schools.

> *But it's a bit tricky finding the time in some ways because I'm only here two days a week because it's a small school, that's the capacity for our role. (MHWC Group Interview #10, 2022 cohort)*

> *My [mental health] has regressed slightly, unfortunately, just purely because of numbers. I was in the role 5 days a week last year, and then we lost a few numbers, so I was put down to 4 days a week, and then we lost teachers, so I was put down to 3 days a week and now 2 days a week in the classroom. So purely from that point of view, last year I was able to do a lot more work in the classrooms, where I just can't get around to those classrooms now. So, it's much more about the PD and the tier three stuff, as opposed to doing any small groups or doing any modelling. So, it's a bit frustrating, but that's how our school's gone. (MHWCs Group Interview #2, 2020 & 2021 cohort)*

> *…when we're trying to do a full-time role in part-time hours as well as pick up the other part of the job that we're doing…we need to be careful about our own mental health…because the need is extreme and growing by the day but we just physically don't have the hours. (MHWC, regional, 2022 cohort)*

Feedback from a school leader in the 2022 cohort indicated their school's need extended beyond the level of allocated FTE, and that they had tried to find funds elsewhere to compensate and maximise the impact of their MHWC.

> *I think one of the challenges too, is how you measure the need in each school. …. I was funded for 0.4 but I've actually put in equity funding to make it a larger role of 0.6 and even then, it is still a challenge to ensure the program has impact at that level. (School Leaders Group Interview #11, 2022 cohort)*

Feedback regarding role integration and role clarity highlighted challenges associated with implementing the role where there was an existing wellbeing team.

> *I feel that our wellbeing team was well established and because we weren't sure what my role was, I had to just sort of float and I think being a teacher for so long, didn't want to overstep. …They didn't want me to necessarily change what was already in place, but they were happy for me to bring something else to the school which has been really great. (MHWC Group Interview #12, 2022 cohort)*

(b) Enablers to implementation

At 10 months follow up, MHWCs from the 2022 cohort were asked to identify from where or from whom they obtained support in their role within the school context. MHWC responses indicated leadership as the most commonly reported source of support (90.8%), followed by wellbeing staff

(57.9%), teachers (26.3%) and 'other' staff (e.g., psychologist, school chaplain, etc) (4.0%). The most commonly reported sources of support external to the school were Communities of Practice/ other MHWCs (84.9%), followed by DE regional staff/regional MHiPS coordinator (17.8%), external mental health services (16.4%), training team/learning staff (6.8%), and other (e.g., Melbourne Archdiocese Catholic Schools) (4.1%).

Focus group data collected in Term 3, 2022 was consistent with survey data. Enablers identified included school leadership support, Communities of Practice and DE regional coordinators. For example:

> *I think probably leadership support is a major factor, I know there are some MHWCs where that leadership support is not as great and they've, for example had to do a lot of time in the classroom [due to teacher shortages] and they've really been pulled off their MHWC role. So, I think leadership support is, is huge, and they need to value the role. (MHWCs Group Interview #8, 2022 cohort)*

> *I think that the CoPs that we do in the small groups are brilliant because it's our network and each one of our schools is really different, and I love understanding that and the flexibility in how that role's modified in that space. (MHWCs Group Interview #1, 2020 & 2021 cohort)*

> *My big enabler was the regional coordinator, [they were] instrumental in coming in and assisting me when I was having communication breakdowns with my leadership. Even though they were very supportive, it was just a case of getting on the same page I suppose; and [the coordinator] came in and really assisted with the conversation and helped us to set some school-wide goals that made it a lot better for me and a lot better for the school. (MHWCs Group Interview #8, 2022 cohort)*

3.1.5 MHiPS model in rural and regional schools

Focus groups were conducted with 25 MHWCs, 13 school leaders, 9 teachers and 2 wellbeing staff from rural and regional schools in Term 2 and Term 4, 2021. Common feedback regarding integration of the role was similar to that of metro schools in that the MHWC role requires ongoing support from leadership, the education background of MHWCs enhances buy-in and having an internally appointed MHWC offers advantage.

> *I think it really does help to have a practicing classroom teacher…it's that real organic way of understanding how complex classrooms are and [that] wellbeing is one aspect of what we do but we're also there to teach the curriculum…. (Teacher, regional)*

MHWCs from rural schools expressed concern that working part-time was insufficient to meet the level of need within the school and that they often feel a great deal of pressure to fulfill all the requirements of the role despite limited hours.

> *…when we're trying to do a full-time role in part-time hours as well as pick up the other part of the job that we're doing…we need to be careful about our own mental health…because the*

need is extreme and growing by the day, but we just physically don't have the hours. (MHWC, regional)

…even if there's only 70 children in the school, there's 45 kids that come up as at risk…and we've got 40-something that are diagnosed with autism. (MHWC, rural)

Feedback also indicated that the high level of need and lack of alternate resources has meant MHWCs frequently have one-on-one sessions with students in order to help meet their support needs.

… we might say that the MHWC role doesn't do one to one… but the reality, and particularly in regional and rural schools, is if something goes wrong, if a crisis happens, the MHWC can't say well actually I'm about building capacity of teachers…I'm not going to do that… (Principal, regional)

It's another person who can offer another perspective and one-on-ones, [which] due to time and 53 other kids in the classroom, we can't necessarily offer in some schools in that moment of need… (Teacher, regional)

Many participants claimed that some form of professional supervision is both warranted and necessary for the role given MHWCs are often navigating and holding very complex psycho-social concerns, exacerbated by systemic service shortages in rural and regional areas.

I would support it because I don't think we can say the MHWC role is going to be clearly defined around building capacity without having some sort of counselling role. (Principal, rural)

3.1.6 MHiPS model in specialist schools and language schools

The 2022 expansion of the pilot included two specialist schools and one language school. Two focus groups were carried out in June 2022 comprising three MHWCs and five participants in leadership/wellbeing roles from specialist and language schools. The key challenges and learnings as reported within these focus groups were as follows:

Key challenges:

- Ensuring families, school staff and mental health services understand that the role is not intended as a clinical position thus differentiating it from the mental health practitioner role in secondary schools.
- Forging a relationship between MHWCs and families in specialist and language schools given the classroom teachers' strong rapport with families in these schools.

Key learnings:

- Successful and timely integration of the role requires the invested support and trust of leadership and a willingness to align the MHWC role with a school's Annual Implementation Plan (AIP) and Social Emotional Learning (SEL) curriculum.
- MHWCs' familiarity with classroom dynamics and students' needs has enhanced buy-in for the role among teaching staff.

- Upskilling the mental health literacy of teachers has enhanced their compassion and support for students with behavioural issues and strengthened their whole-school approach to wellbeing.

Participants were positive about the training overall, and particularly the mental health literacy module which they believed benefited all participants, regardless of school type. Some participants felt that the Supporting Need and Building Capacity modules needed to be modified to suit the unique needs of their students.

(a) Feedback from specialist schools

Unique to specialist schools are the number of school-employed allied health staff. Defining how the MHWC role integrated with these roles was a key objective in these schools. Feedback indicated that improving mental health literacy within the school was seen as an important aspect of their role.

> *…previously teachers would probably just have passed kids on to [the wellbeing officer] …[now] they're receiving training and language around mental health…this is all of our responsibility…. (MHWC, specialist school)*

> *…when we talk about mental health, I make it really clear that it's not [MHWC]'s job. This is everyone's role…it really is about embedding a better understanding of mental health and wellbeing in the teaching and learning…. (Leadership, specialist school)*

Interviewees reported similar enabling factors to those from mainstream schools, including that the role required the invested support of leadership whilst also maintaining some autonomy, having an MHWC with an education background enhanced educator buy-in and that internally appointed MHWCs offered advantages. Participants agreed that leadership's understanding of the role and their support, confidence and trust in the appointed MHWC was vital for successful implementation of the role.

> *I've been fortunate that [leadership] is very supportive – we've got a team approach going. (MHWC, specialist school)*

> *…we've got a staff member with a lot of credibility and a lot of capacity, and so there's trust there that something will evolve…. (Leadership, specialist school)*

> *I look at [MHWC]'s role pretty similar[ly] to a learning specialist, except her expertise is around the promotion and understanding of mental health and wellbeing. (Leadership, specialist school)*

An education background was perceived as enhancing buy-in from teachers, both for the MHWC role itself and for elevating the importance given to student wellbeing overall.

> *…being a teacher, that's really significant, because it symbolises to other teachers that everybody has a role to play in this space - you don't need to be a psychologist or a social worker…. (Leadership, specialist school)*

MHWCs asserted that they were playing an active role in reducing the strain on teachers to manage student behavioural issues in their classrooms.

> *…it's opened up that dialogue for teachers to reach out…rather than going "oh this is just what a student does…", going "oh no there might be another cause - what can we do to help support them?" …people are…beginning to understand why we're seeing these behaviours and what we can do to support them. (MHWC, specialist school)*

3.1.7 MHiPS model in Catholic schools

Through a group interview with four Catholic school MHWCs from the 2022 cohort, gaps in knowledge and Catholic Education Commission of Victoria Ltd (CECV) specific concerns were raised. Feedback from Catholic school MHWCs indicated the training helped reduce stigma and opened dialogue around mental health and provided a process and framework for identifying and planning a response to mental health and wellbeing needs. Suggestions for additional content mirrored feedback from government school MHWCs including more information about trauma-informed approaches.

When asked if all aspects of the training were relevant to Catholic schools, MHWCs identified the differences in funding, especially the lack of Mental Health Menu and Fund. They found these discussions in the CoPs isolating. They also raised concerns about the scheduling for the training falling on specific days which often fell on common days (e.g., Feast Days, Holy Days of Obligation, Easter, Advent etc.). The Catholic school MHWCs thought that the CoPs were a great source of support and inspiration, and the drop-in sessions were useful.

3.2 Impact of the MHiPS program

Findings in this section are reported according to the theory of change outlined in the program logic (Smith, et al., 2022). Findings related to shorter-term outcomes at the teacher and school level are reported first. Parent and student outcomes are theorised to follow initial impact at the teacher and school level and thus identified as longer-term.

3.2.1 Classroom teacher capacity to support student mental health and wellbeing

(a) Confidence to support students' mental health and wellbeing

At the 18-month follow-up, the majority of MHWC respondents (94.9%) and classroom teachers (87.9%) from the 2020 and 2021 intervention schools (n = 26) reported that the MHWC model had increased the confidence of classroom teachers to support student mental health and wellbeing

needs (see Appendix I). These results mirror the same level of agreement at the 6-month follow up (see Interim Report, January 2022).

The 2022 cohort (n = 76 intervention schools) reported similar levels of agreement in the same period of six months since the introduction of the MHWC model, with the majority of MHWC respondents (94.9%) reporting that the MHWC model had increased classroom teachers' confidence to support student mental health and wellbeing. The majority of classroom teachers (87.9%), leadership (90.5%) and other school staff (89.9%) also agreed the model had increased classroom teachers' confidence to support student mental health and wellbeing (see **Error! Reference source not found.**).

Table 9: Percentage of agreement by role: Classroom teacher confidence to support student mental health & wellbeing needs: 2022 cohort

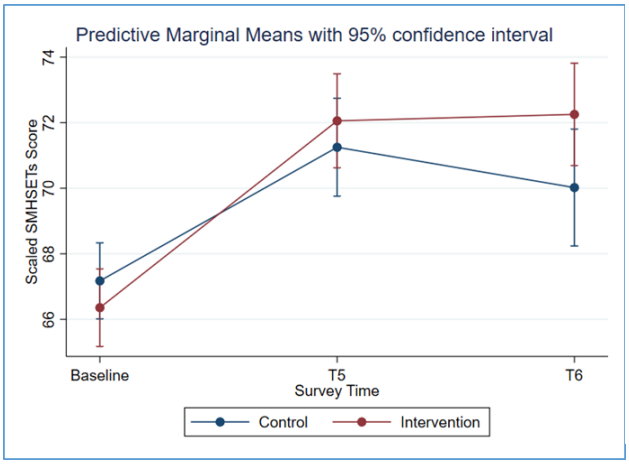
	Strongly disagree (%)	Disagree (%)	Moderately disagree (%)	Moderately agree (%)	Agree (%)	Strongly agree (%)
MHWC (n = 79)	0.0	0.0	5.1	48.1	39.2	7.6
Classroom Teachers (n = 685)	2.3	4.5	5.3	41.8	36.5	9.6
Leadership (n = 158)	1.9	2.5	5.1	29.1	46.8	14.6
Other staff (n = 410)	1.5	3.7	4.9	31.5	46.6	12.0

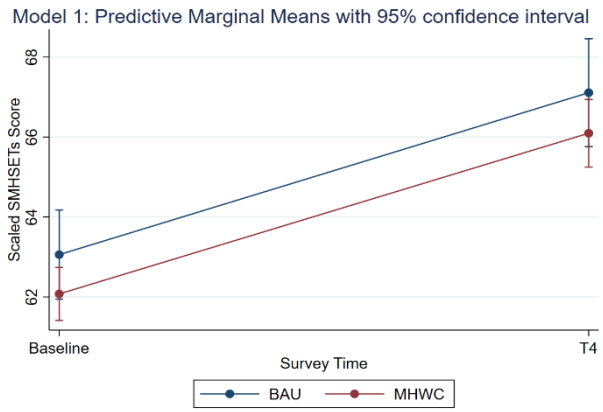
Note. n = 1,332 responses, 72 missing responses. Data from the 2022 cohort (n = 74 schools): 6-month follow-up. Classroom teacher responses include leading teachers with classes; Leadership responses include principals/assistant principals/leading teachers without classes; Other staff responses include wellbeing staff, education support staff, specialist teachers, and other non-teaching school staff.

Quantitative data using the SMH-SETS measure (Brann et al., 2020) found that for the 2021 and 2022 cohorts, staff confidence in supporting student mental health increased in both intervention and control schools (see Appendix J). However, key differences exist in the data time points, with identified long-term effects of the MHWC model intervention.

Classroom teachers' confidence from intervention and BAU cohorts increased in 2021 and 2022 data. However, data from the 2021 cohort at time points between 10 months and 18 months indicate that classroom teachers' confidence in supporting student mental health remained constant in the intervention schools, while classroom teachers' confidence decreased in BAU schools (See Figure 1, Graph 1a; Intervention M = 5.70-5.90; BAU M = 4.08-2.85).

Figure 1: Scaled SMH-SETS score in classroom teachers by survey time: 2021 and 2022 cohorts





Graph 1a. 2021 Classroom teachers

Graph 1b. 2022 Classroom teachers

Note. School Mental Health Self-Efficacy Teacher Survey (SMH-SETS)
2021 Baseline = March 2021; T5 = 10 months from Baseline; T6 = 18 months from Baseline
2022 Baseline = March 2022; T4 =10 months from Baseline

In addition, trend analysis based on SMH-SETS data collected with the 2020 cohort indicate a significant increase in confidence at both 16 and 24 months follow up compared to time 1. On average, the SMH-SETS at 16 months follow up was 2.93 (95%CI 1.07-4.78, p=0.002) higher than time 1, and 24 months follow up 3.80 (95%CI 1.57-6.03, p=0.001) higher than time 1.

When discussing confidence in supporting students' mental health and wellbeing, feedback in focus groups was generally positive, and MHWCs provided perceived and actual support across the school communities. School leaders and MHWCs noted an increase in the prioritisation of student mental health and wellbeing, identifying increased teacher confidence, accountability, and MHWC-led professional development focused on student mental health and wellbeing.

> *… I think overall the impact has been our teachers are more confident in understanding it [child mental health], and I think wellbeing is taking much more of a focus. (MHWCs Group Interview #1, 2020 & 2021 cohorts).*

> *… I think we've had two PDs so far with staff, generally around building capacity …creating an awareness of particularly the mental health continuum and the BETLS (Behaviour Emotions Thoughts Learning and Social Relationships) tool and that these tools exist and how staff can actually go about using them. Just building that capacity and confidence for staff to know these things are out there, these are the things to reach out for and find, and then going from that to build the confidence for people to ask questions and to follow up from there. (Teachers Group Interview #9, 2022 cohort).*

Similarly, classroom teachers and MHWCs observed a change in students, where open communication about social and emotional wellbeing improved students' relationships with their learning, which in turns builds confidence in MHWC and classroom teachers.

… I have had positive feedback as well, … you get the teachers feedback that [the child] used this [strategy] today or I'm seeing a difference in terms of their willingness to learn. It's kind of a reassurance as well that it is being effective. (MHWCs Group Interview #10, 2022 cohort)

(b) Perceived support in managing student mental health

Findings indicate that classroom teachers are receiving support from MHWCs in managing student mental health and wellbeing in both the short and longer-term. Survey data from classroom teachers at 10 months follow up (2022 cohort) indicate that 93.0% had recently (past month) received support from the MHWC, with 67.4% indicating they had received a lot or a great deal of support (see Appendix G). At 18 months follow up, data from class teachers in the 2021 cohort indicate 93.7% had recently received support from the MHWC, with 73.3% indicating they had received a lot or a great deal of support (see Appendix I).

Qualitative feedback from classroom teachers in the 2022 cohort focus groups indicated that the presence of MHWCs broadly improved teachers' sense of support in addressing student mental health and wellbeing. The feedback highlighted the MHWCs availability to support teachers in working through their concerns, facilitating meetings with families, workshopping classroom issues with students, and enabling open discussions of mental health and wellbeing between students, staff and parents.

… I think it's nice that it's a bit of a weight off the teachers as well. It's someone that they can go to but it's not another thing that is solely a responsibility of teachers. So, when they have a concern, there's somebody specific that they can go to, somebody knowledgeable, someone they can go to for help that will take some of that load and help them navigate what the best thing to do is. Teachers' workloads are enormous, and I think they see somebody's actually putting some resources towards trying to relieve some of that load, which is good. (Teachers Group Interview #9, 2022 cohort)

[They are] a really good resource in terms of connecting and having those meetings with families, so that's been really valuable. (Teachers Group Interview #9, 2022 cohort).

One MHWC specifically mentioned that they have seen an improvement in teachers' capacity to manage problems within the classroom.

…they're not expecting me to come into their class and solve the problem, they've got a lot more agency over solving the problem and building their relationships with the students while I just develop the lesson. So, I think the building of capacity has been successful, which is really great. (MHWCs Group Interview #1, 2020 & 2021 cohorts)

(c) Mental health literacy (knowledge and skills)

Survey data at 6 months follow-up (2022 cohort) indicated almost three quarters of classroom teachers (71.1%) reported attending the Mental Health Literacy professional development session delivered by the MHWC (see Appendix F). Out of 487 classroom teachers from the 2022 cohort, a consensus of 94.8% of respondents agreed (Somewhat agree/Agree/Strongly agree) that the

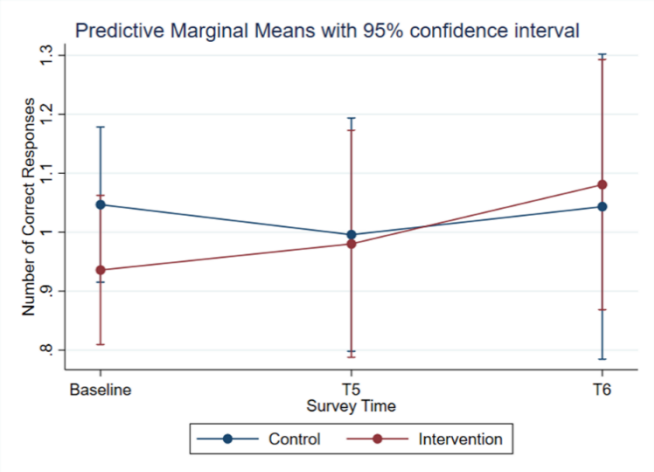
professional development on mental health literacy enhanced their ability to identify and support students with mental health concerns.

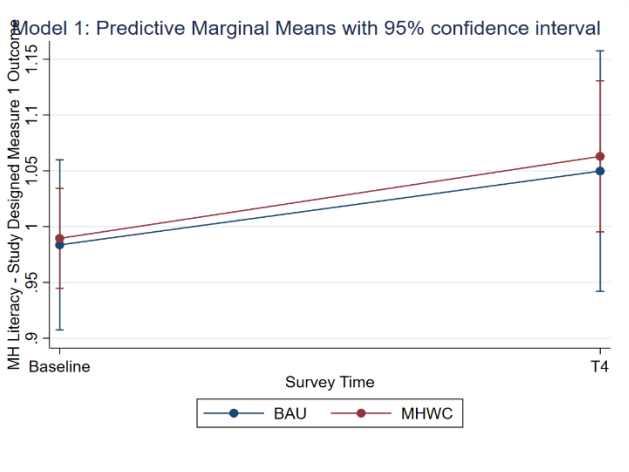
At 10 months follow up, MHWCs (2022) reported observing a range of impacts indicating improvement in teachers' child mental health knowledge and skills, including enhanced vocabulary, increased willingness to engage in conversation, demonstrated use of tools introduced through the MHWC model and an increase in identification and support of students with mental health need (see Appendix G). Observations included:

- *[I am receiving] requests from teachers for support implementing strategies within class.*
- *Teachers are very proactive in seeking support early for their students.*
- *Teachers are more aware of the signs to look for and understand that if the wellbeing of the child is not being met the impact that has on learning*
- *Teachers are able to more readily suggest strategies for students to use to help with their mental health and wellbeing.*

To further understand classroom teachers' general mental health literacy, responses to two questions relating to knowledge about child mental health were analysed, with scores based on correct answers. At 10 months follow up (2022 cohort), there was no significant change in scores relative to BAU schools (ES = 0.01, M = 0.01, CI = -0.13, 0.14, p = 0.916; see Figure 3b). However, data analysis based on the 2021 cohort found that classroom teachers' mental health literacy improved at the 18-month time point indicating an increase in results relative to the BAU schools (ES = 1.26, M = 1.10, CI = 0.80, 1.67, p = 0.429; see **Error! Reference source not found.**a). These findings suggest that while impact of the MHWC model may not be seen in the short-term, there is evidence of a longer-term increase in mental health literacy. However, due to low response rates at 18 months follow up, further data collection over a longer timeframe would assist in drawing conclusions about the unique impact of the MHWC model.

Figure 2: Mental health literacy (knowledge score in classroom teachers by survey time: 2021 and 2022 cohorts





Graph 2a. 2021 Classroom teachers	Graph 2b. 2022 Classroom teachers

Note. Change over time, Literacy Measure 1
2021 Baseline = March 2021; T5 = 10 months from Baseline; T6 = 18 months from Baseline
2022 Baseline = March 2022; T4 =10 months from Baseline

In addition, increased positive teachers' perceptions, knowledge and skills in managing and supporting student mental health was a common theme that emerged from the focus groups. Some insights include the following MHWC comments from the 2022 cohort:

> *… this year it seems teachers are much more aware from doing a lot of the PD, particularly at the start of the year around mental health literacy, they're identifying some of those students that are withdrawing, some of those students that might be okay sometimes, but they know because of family history they've got to keep an eye on them. So, I think that's been a really big turnaround for teachers, is they're really taking notice of that now. (MHWCs Group Interview #8, 2022 cohort)*

> *… It's definitely made a huge difference; I think it's just changed some staff's perspective in that it's not just being naughty or it's not just refusing to do work. If you look at a student as a whole and the risk factors and all that, there's other things that might be contributing to behaviour. And you know, if we can understand that, then we can better support. (MHWCs Group Interview #10, 2022 cohort)*

> *… I think that we as teachers and staff, in general, have a better understanding because of the programs we now know that are available to us. (Teacher Interview #3, 2020 cohort, Metro school)*

Teachers from the 2022 cohort also commonly reported adopting a shared vocabulary as a positive impact of the program, with teachers from one of the teacher group interviews specifically referencing how the introduction of the Mental Health Continuum has given staff a tool and enhanced skills to communicate about and monitor student wellbeing.

> *… There's been a few things that [the MHWC has] done, but one of the biggest is that [they've] introduced the Mental Health Continuum. So, we have that at the front of our classroom, and we model moving ourselves up and down the continuum through the day and talk with the students just to create a shared vocabulary around mental health and to demonstrate that our mental health goes up and down throughout the day depending on what happens. (Teachers Group Interview #9, 2022 cohort)*

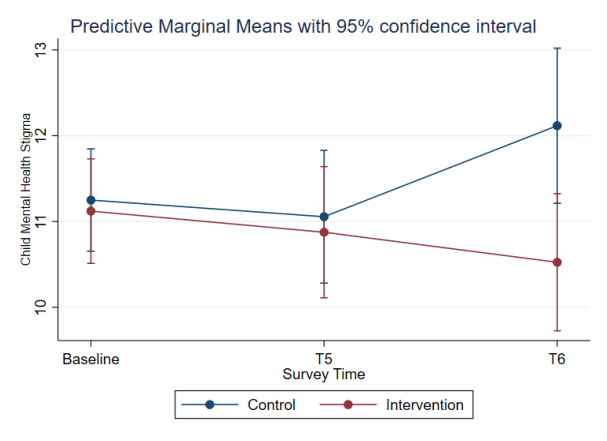
> *… I think we've been more aware as staff to be doing more regular check-ins. Having seen the Mental Health Continuum, of having that in mind of, 'I wonder how these kids are doing', or 'Maybe that's been going on for longer than I might have noticed in the past', so being able to do more of those check-ins. It's also, I think, probably led to more awareness of and making note of when there has been any incidents or things like that to be able to track how we're actually doing. (Teachers Group Interview #9, 2022 cohort)*

(d) Attitudes toward student mental health

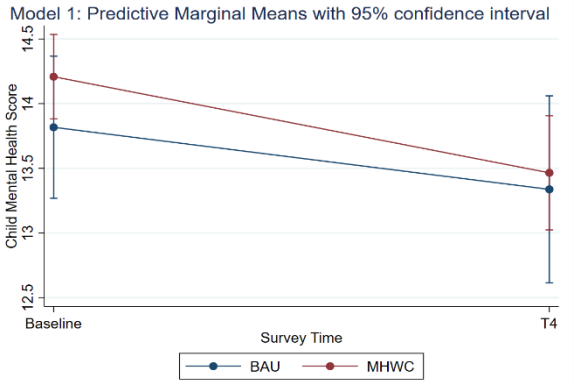
Findings indicate that the MHWC model has contributed to a reduction in stigmatising attitudes toward child mental health among classroom teachers. Results were based on both teacher self-report and MHWC-report data.

3 illustrates a downward trend in holding negative attitudes about student mental health based on teacher-report data. While there was no statistical difference demonstrated in the 2021 cohort at the 10-month time point (ES = -0.01, M = -0.05, CI = -1.01, 0.91, p = .915), there was a marked quantitative difference between the intervention and BAU arm at the 18-month time point (ES = -0.39, M = -1.46, CI = -2.54, -0.38, p = .008). The data suggests the MHWC model reduces negative attitudes towards student mental health. While small changes were detected in the 2022 cohort (ES = -0.06, M = -0.26, CI = -1.23, 0.11, p =.502), a larger effect in the 2021 data suggests teachers in the control arm were more likely to attach stigma to student mental health concerns compared to classroom teachers from schools implementing the MHWC model.

Figure 3: Classroom teachers mental health stigma over time



Graph 3a. 2021 Classroom teachers



Graph 3b. 2022 Classroom teachers

Note. Change in Child Mental Health Stigma reported in Classroom Teachers
2021 Baseline = Feb 2021; T5 = 10 months from Baseline; T6 = 18 months from Baseline
2022 Baseline = Feb 2022; T4 =10 months from Baseline

Survey data from MHWCs at 10 months follow up (2022 cohort) indicates the model is having an impact on reducing stigma around child mental health (see Appendix G). The majority of MHWCs (76.3%) noted they had observed a reduction in stigma around child mental health and wellbeing among school staff since commencing in their role. MHWCs indicated they had observed increased frequency and openness of discussions related to mental health and wellbeing, as well as a more informed and empathetic approach to addressing mental health issues in students. Observations included:

- *[I am] not hearing negative comments about children's mental health. Teachers appear more understanding.*
- *Teachers want to improve outcomes and are approaching quickly when identifying warning signs, [and are] open to trialling new ideas and strategies in the classroom.*

- *Teachers are more aware of the signs to look for and understand that if the wellbeing of the child is not being met the impact that has on learning.*
- *Teachers are having open conversations and are more confident in seeking help.*
- *I notice that people are starting to be more open minded and change the way they see behaviour and how they respond to the behaviour, e.g., an openness to discussing challenging behaviours and being curious to explore it with me the MHWC.*

3.2.2 School capacity to support student mental health and wellbeing

The impact of the MHIPS program on school capacity to support student mental health and wellbeing was evaluated by assessing (a) perceptions about overall school capacity to support student mental health and wellbeing, (b) prioritisation of student mental health and wellbeing across the school, (c) levels of unmet mental health need within the classroom, and (d) engagement with internal and external mental health service providers. Overall, findings to date indicate the MHWC model has led to an increase in school capacity to support student mental health and wellbeing, increased prioritisation of student mental health and wellbeing across the school and a reduction in level of unmet mental health need within the classroom relative to BAU comparison schools. However, school engagement with mental health and wellbeing services – both internal and external – is an ongoing challenge due to limited access to and/or availability of services.

(a) Perceptions of school capacity

Staff survey data at 6 months follow up indicate that 90.0% of school staff agreed (somewhat agree/agree /strongly agree) that the MHWC model had increased whole school capacity to support student mental health and wellbeing needs (see Appendix F).

Further insight into how the model is enhancing school capacity was provided through MHWC focus group feedback and survey feedback from MHWCs at 10 months follow up. Survey feedback indicated that 81.6% of MHWCs had observed a change in language around child mental health and wellbeing in their school, including enhanced vocabulary, increased willingness to engage in conversation around child mental health and wellbeing, demonstrated use of tools introduced through the MHWC model and increased focus on social and emotional learning (see Appendix G). Observations included:

- *[There is] use of language around [the] tiers of support*
- *We use the mental health continuum in every classroom, teachers use the language from it to discuss a child's mental health.*
- *Language used is that introduced through MHWC initiatives - e.g., SEL programs, MH literacy training, MH continuum.*
- *[There is an] increase in conversational engagement and willingness to discuss MHWB.*
- *Children are talking about their mental health as are our teachers.*
- *I notice that people are starting to be more open minded and change the way they see behaviour and how they respond to the behaviour.; e.g., an openness to discussing challenging behaviours and being curious to explore it with me the MHWC.*

Feedback from the MHWC group interviews indicated the model had enhanced school capacity, including through building social emotional learning approaches across the school, increasing conversations about student mental health and wellbeing, enabling earlier support and intervention for students showing signs of mental health and wellbeing concerns and increasing protective factors across the school.

> *My role, it's about building the social emotional learning approach for the whole school, but it's also about building the capacity of the staff through professional learning but also through the PLCs [Professional Learning Communities], because each year level has different cohorts, different needs, and so that's been really helpful and purposeful to be able to do that. (MHWC Group Interview #1, 2020 & 2021 cohort)*

> *So, I feel like I've gained a bit of momentum as the year's gone on and there are more conversations, generally, among kids and staff and I've been getting more buy-in in terms of staff meeting time and things like that. So, yes, the role's making a difference. (MHWCs Group Interview #12, 2022 cohort)*

> *I think the role has meant that there's somebody there for staff to go to at an earlier point. So, you've been able to nip some of those early things in the bud and put in some supports, so it doesn't escalate. Whereas before, because the people power wasn't there, problems probably got bigger than they needed to, before we put supports in. (MHWCs Group Interview #2, 2020 & 2021 cohorts)*

However, one school leader highlighted that the MHWC role had fit into a wider effort within their school to address the mental health and wellbeing needs of their students, and therefore noted that positive advances in these areas could not be exclusively credited to the MHWC model.

> *It's more that all of the pieces of the puzzle in terms of wellbeing fit together as opposed to it being solely attributed to MHiPS. (School Leaders Group Interview #4, 2020 & 2021 cohorts, Metro school)*

(b) School prioritisation of student mental health and wellbeing

MHWC survey data at 10 months follow up indicated increased school prioritisation of student mental health and wellbeing. Survey feedback indicated that 83.8% of MHWCs had observed an increased prioritisation of student mental health and wellbeing in their school since commencing in their role. Observations included implementation of new structures and processes that include a greater focus on mental health and wellbeing; inclusion of student mental health and wellbeing in staff meeting agendas; scheduling of regular wellbeing sessions; increased professional development around mental health; inclusion in the school curriculum; inclusion in the annual implementation plan; and greater support from teachers and leadership.

Staff survey data at 10 months follow up indicated that the likelihood of identifying mental health and wellbeing as an 'essential' priority within the school had increased significantly in schools implementing the MHWC model (OR 1.82 (1.36,2.42)). However, this increase was not significantly

different from the increase in BAU schools. This finding is potentially not surprising given the current broader context of mental health reform within Victoria which has included a significant increase in focus on mental health and wellbeing in all schools.

Focus group feedback from MHWCs and School Leaders in both cohorts identified ways in which student mental health and wellbeing had been prioritised, including through increased accountability, increased teacher confidence in addressing mental health and wellbeing in the classroom and increased focus on mental health and wellbeing.

> *It made us accountable as a leadership team to ensure that we made provisions on the meeting schedule for [the MHWC] to be able to deliver that PL [Professional Learning]. … As a result of having the person in that position it made us accountable to make sure we made provision of time for that learning to happen. (School Leaders Group Interview #11, 2022 cohort)*

> *…so now it becomes a non-negotiable more than this is something that we would like to do. Wellbeing is now something that we need to do, and it needs to be in our programs and being taught in our classrooms. (MHWCs Group Interview #1, 2020 & 2021 cohorts)*

> *I think [the MHWC] driving the incorporation of wellbeing at the forefront of a lot of different things that we're doing in the school. (Teacher Interview #3, 2020 cohort, Metro school)*

> *But I think overall the impact has been our teachers are more confident in understanding it [child mental health], and I think wellbeing is taking much more of a focus. (MHWCs Group Interview #1, 2020 & 2021 cohorts)*

(c) Level of unmet mental health need in the classroom

Survey data from classroom teachers at 10 months follow up indicated student mental health need within the classroom increased substantially for both intervention and control schools. The low rates of identified mental health need at baseline likely reflects limited teacher knowledge about each student's needs at that timepoint (i.e., early Term 1).

However, the odds of classroom teachers reporting that students with mental health need are receiving sufficient support are higher in the intervention group over time compared to the control (OR 2.86 (1.79,4.56)). This suggests mental health need is more likely to be met in schools implementing the MHWC model.

Error! Reference source not found. summarises the proportion of students in each class identified with (a) mental health and wellbeing need and receiving insufficient support (i.e., not receiving any or not receiving enough) (b) mental health and wellbeing need and receiving sufficient support (i.e., receiving enough MHWB support), (c) no additional mental health and wellbeing need, and(d) the proportion about which the classroom teacher is unsure.

Table 10: Summary of mental health and wellbeing need within the classroom as reported by classroom teachers (2022 cohort)

	Baseline	10 months follow up

	Control (n=5,702)	Intervention (n=15,622)	Control (n=2,336)	Intervention (n=5,630)
MHWB need: receiving insufficient support	2.7%	4.7%	26.3%	27.7%
MHWB need: receiving sufficient support	2.9%	2.2%	14.3%	18.2%
No additional MHWB need	86.6%	80.7%	52.1%	45.5%
Unsure	7.8%	12.4%	7.4%	8.6%

Note: MHWB = Mental health and wellbeing

Feedback from the Term 3 focus groups with MHWCs, Leadership and Classroom teachers indicates the program is helping to address unmet student mental health and wellbeing need within the classroom by increased early identification and intervention with students and increased help-seeking from the students themselves.

> *The early intervention is happening a lot more now for students and we're seeing a lot more help-seeking behaviours from students as well, because they know that that help is there. (MHWCs Group Interview #8, 2022 cohort)*

> *We've got a lot more students now accessing help and getting that help before the problems get too bad as well. So, we're having a lot more of that early intervention happening. (MHWCs Group Interview #8, 2022 cohort)*

> *I think it's really helped to catch a lot of the kids that would normally fly under the radar, a lot of the ones that have high anxiety but are performing academically, or they're not a behavioural problem in the classroom. Academically, they're doing fine or well enough, and so they can easily get left off our welfare list, when we've got so many other emergencies and spot fires that are immediate, but they're no less important, and we know how much chronic anxiety over time leads to a whole host of mental health and physical health life-long problems. So, to be able to catch this and put things in place for these kids, it's so important. (Teachers Group Interview #9, 2022 cohort)*

> *So, when we have kids with high needs, I feel that I've become a bit of a stopgap at school for getting some strategies in just to get these kids through until they're able to be picked up by the external services. (MHWC Group Interview #1, 2020 & 2021 cohort)*

(d) Engagement with mental health and wellbeing service providers

Findings indicate improved engagement between schools and mental health and wellbeing service providers following implementation of the MHWC model. However, access to services remains a challenge for many schools.

Survey data from school staff (2022 cohort) indicate engagement with services improved following implementation of the model. At 10 months follow up 77.2% of school staff indicated 'good' or 'excellent' engagement between the school and local mental health agencies as compared to

baseline (52.8%), and 73.2% reported 'good' or 'excellent' engagement with DE (or CEO) support services as compared to baseline (53.8%). A similar increase in engagement was found across both intervention and control schools.

Despite an increase in engagement, access to services remains a challenge in many schools. At 10 months follow up, 54.1% of MHWCs reported improved access to services, however, this largely reflected improved knowledge of relevant services, clearer referral pathways and improved engagement. As noted by one MHWC: *… I think not so much improved access but improved knowledge around what services would be of use. I believe we still have work to do in this area.*

Focus group feedback from MHWCs and school staff during Term 3 confirmed engagement with internal DE mental health service providers (e.g., Student Support Services (SSS)) was strong in some schools but remained an ongoing challenge in others.

> *We have a really good SSS consultant that comes. [They have] actually just finished [up in the role], which is frustrating, but we met up with [them] once a fortnight, and [they are] a psychologist, and great to pick brains of and everything. (MHWCs Group Interview #2, 2020 & 2021 cohort)*

> *So, I guess in my role I've been working a lot with our SSS staff. We're very fortunate one of our SSS staff works on site with us so we can actually, you know, get in [their] ear all the time. (MHWCs Group Interview #8, 2022 cohort)*

> *I think engagement at the moment is very hard, everybody's just under pressure because of COVID. There's not enough SSS. There are not enough professionals out there. There's a waitlist for absolutely everything. …. It's taking a lot longer than it used to, and it's just the fact that everybody doesn't have the staff at the moment, SSS, [speech therapists], psychologists. (Teachers Group Interview #9, 2022 cohort)*

> *I think across the board, I know certainly in the region where my school is, there is a real workforce shortage in SSS. So, we've been having to do things better by ourselves because there's just not the workforce there. (School Leaders Group Interview #11, 2022 cohort)*

> *The waiting list is extensive, you wouldn't even bother to put a student on the waiting list with an SSSO for any counselling. We just refer them out to a GP for a mental health care plan or we try to get them to access any NDIS funding. Like it's pointless. (School Leaders Group Interview #4, 2020 & 2021 cohorts)*

Feedback from MHWCs indicated long waiting lists as one of the key challenges in terms of engagement with external services.

> *The biggest problem we have in terms of external services is there's just none that are accessible. The waitlists are 12 to 18 months for any service. It's just crazy. So, when we have kids with high needs, I feel that I've become a bit of a stopgap at school for getting some strategies in just to get these kids through until they're actually able to be picked up by the external services. So, that's probably where the difficulty lies at the moment. And I know they're*

putting lots of money into it, but we need it now, not in three years' time or five years' time. We need it now. (MHWC Group Interview #1, 2020 & 2021 cohort)

A small minority of MHWCs indicated they were not responsible for referrals in their school.

I'm finding that I'm not part of student support groups and I'm not talking to SSS staff or anything like that at this stage. So, I'm not really linking people in with external services. I'm more tier one, maybe a bit of tier two, tier three is not in my wheelhouse at the moment. (MHWC Group Interview #12, 2022 cohort)

I don't have the capacity to communicate with the SSS and the external services. That's a big blocker for me, because there's someone else in that role, and I'm not allowed to sit in on those meetings. (MHWC Group Interview #2, 2020 & 2021 cohort)

3.2.3 Parent impact

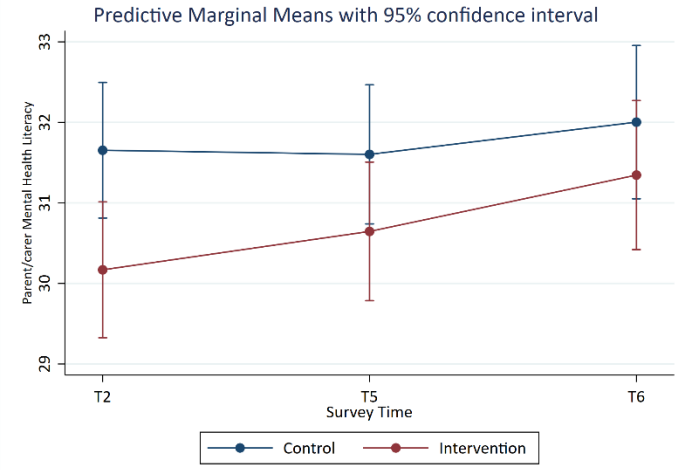
(a) Mental health literacy

The parent survey included a range of items aimed at assessing parent's mental health literacy as related to children. Three measures were included: (1) a 6-item measure of child mental health knowledge; (2) a 2-item measure of help seeking, and (3) a 1-item assessment of confidence in identifying child mental health concerns.

Findings from the comparative analysis based on parent survey responses from the 2021 and 2022 cohorts indicate significant improvement (0.20 standard score higher) in child mental health knowledge in intervention schools at 10 months and 18 months follow up compared to control (see Appendices H and I). For example, at baseline 9.6% of parents in MHiPS schools indicated that 'Primary school aged children don't get depression' and 20.8% indicated 'Persistent sadness and frequent crying is normal in children'; however, at 18-months follow up this decreased to 2.4% and 11.0% respectively.

Findings at 10 months were consistent across 2021 and 2022 cohorts. **Error! Reference source not found.**4 shows the improvement from baseline to 18 months follow up for parents in 2021 cohort intervention schools compared to control; this difference was statistically significant (ES = 0.20, M = 0.83 (0.05, 1.60), p = 0.036).

Figure 4: Parent mental health knowledge over time (2021 cohort)



Note. Change in Child Mental Health Knowledge reported in Parents/Carers
2021 Baseline (T2) = Feb 2021; T5 = 10 months from Baseline; T6 = 18 months from Baseline

Findings from the comparative analysis also showed that at 10 months follow up parents in the 2022 cohort were more likely to report confidence in help seeking (OR = 1.26 (1.08,1.48), p = 0.004) and recognising signs of mental health problems (OR = 1.27 (1.07,1.52), p = 0.007) as compared to baseline. However, there was no significant change in likelihood relative to BAU schools.

Consistent with survey findings, focus group feedback indicated increased parent knowledge about supporting their child and seeking help, but also highlighted challenges in some schools around building parent mental health literacy. Some insights include the following MHWC comments from the 2022 cohort:

> *Continuing to build that mental health literacy, I think that's been a big part. That's the parent, that's the staff, that's the students as well, opening up that conversation, helping teachers understand what it looks like when a student's struggling, how we can support them, helping parents understand where they can go for help. So, I think that's been a big aspect in our school, building that mental health literacy. Certainly, still room to grow. But that's been one big advancement, I think. (MHWCs Group Interview #1, 2020 & 2021 cohorts)*

> *We shared a lot of information around mental health and wellbeing particularly in lockdown, so I think the parents… some had commented that that was really helpful, and it was mainly around how they could support their kids, but support for them as well. So, I think that's been somewhat positive. A long way to go though, still. (MHWCs Group Interview #1, 2020 & 2021 cohorts)*

One MHWC from the 2020 & 2021 cohort highlighted that while connection with parents has generally been positive, at times the needs of parents in their school have been beyond the scope of the MHWC role.

> *The newsletters that I send out have had positive feedback from parents, because it's given them some literature and ideas in that sense. But, I have them rocking up at my door in tears*

and various things, thinking that I'm a counsellor, and it's like, well, I'm not a counsellor for kids, let alone for parents, so again, that's that role title, I think. But also, I think it's just desperation. It's somebody else that they can go to and it's a role, so it's like "Anybody, let me talk to someone, and someone might help me." (MHWC Group Interview #2, 2020 & 2021 cohorts)

Some MHWCs in the 2022 cohort noted that they have not been able to engage with parents much yet but are hoping to next year as their role progresses, with a focus to build mental health literacy.

If I'm in this role next year, I'll be trying to develop that mental health literacy in the parent community as well. It's going to be quite difficult with 70% of our parent cohort not speaking English, but that is what I would love to do next year, is extend this kind of conversation and this kind of awareness out into, you know, even newsletter articles and ideas, and maybe then we can have family events back at school and things. (MHWC Group Interview #8, 2022 cohort)

(b) Attitudes towards child mental health

Findings from the comparative analysis using data from the parent survey were inconsistent regarding a change in parent-reported stigmatising attitudes over time. Survey and focus group feedback indicated a reduction in stigma among families had been observed in some schools but not in others. Cultural background was identified as important in addressing attitudes about child mental health.

The parent survey included a 6-item self-report scale (Heflinger, et al., 2014) aimed at assessing parent attitudes toward child mental health. Findings from the comparative analysis indicate a significant reduction in stigmatising attitudes at 10 months follow up in the 2021 cohort relative to BAU schools (ES = -0.16, M = -0.67 (-1.16, -0.17), p = 0.009). However, this was not reflected at 18 months follow up (see Appendix I). The reduction in parent-reported stigma was not reflected in the 2022 cohort (see Appendix G).

Survey data at 10 months follow up indicated around half of all MHWCs (53.4%) had observed a reduction in stigma among families (see Appendix G). MHWCs noted an increase in support-seeking behaviour from parents as suggestive of a reduction in stigma relating to child mental health and wellbeing. Observations also frequently referenced more open communication between parents, students and staff and a greater willingness for parents to ask for and accept advice provided. However, observations also noted the model had a bigger impact on staff willingness to discuss mental health concerns as compared to parents and ongoing challenges in working with differing cultural perceptions of child mental health and wellbeing. Observations included:

- *More parents [are] open to discussions around mental health of their child and [are] seeking support, parents [are] looking for support to engage with counsellors or psychologists for their children where appropriate.*
- *Families are having more open dialogue with teachers and staff and are actively seeking support and advice.*
- *Families appear to be more onboard, however some are still hesitant to discuss it. Staff are better at bringing up mental health or wellbeing concerns using more appropriate language.*

- *Overall, most feedback was positive and indicated that discussions around mental health are generally becoming easier and more acceptable within school communities in response to the MHWC model.*

Focus group feedback highlighted the challenges in addressing stigma around child mental health based on cultural background:

> *And the fact that it's just part of the dialogue, really, is breaking down the stigma. Because you've still got gorgeous parents that just are terrified, and rightly so, because of their histories of what they learnt, so they don't want to talk about it. But if we're talking about it and their kids are talking about it and they're seeing… yeah, it's much more approachable. (MHWCs Group Interview #1, 2020 & 2021 cohorts)*

> *We've got a lot of cultures at our school and in many of them … it is frowned upon to have a mental health problem or even talk about it. So, it's going to be a big push next year, but there is going to be resistance from parents as well. (MHWCs Group Interview #8, 2022 cohort)*

(c) Engagement with teachers and school

Feedback from the Term 3 focus groups with MHWCs indicated increased engagement between parents and the school (via the MHWC). MHWCs reported providing information and resources promoting student mental health and wellbeing to parents via communication channels within the school, and that this was received positively. MHWCs also indicated that through the use of classroom observations, they have been able to facilitate conversations between teachers and parents where there are concerns relating to a particular child.

> *Promoting mental health and wellbeing through our Facebook page and fortnightly newsletters has been beneficial. I've had a bit of feedback from parents saying how they enjoy reading little tips about what they can try at home. And also, in terms of when a classroom teacher wants to talk to parents about an issue, I've been able to go in there to the classroom and do observations and make some notes and then talk to the teacher about things and really come up with some good information to come to the parents with. And not just the teacher trying to get across it, because there's a lot of things that the classroom teacher can't see so having somebody else observe them and then have a conversation afterwards reinforces for the teacher but then also supports the parents and what they're seeing as well. (MHWC Group Interview #10, 2022 cohort)*

3.2.4 Student impact

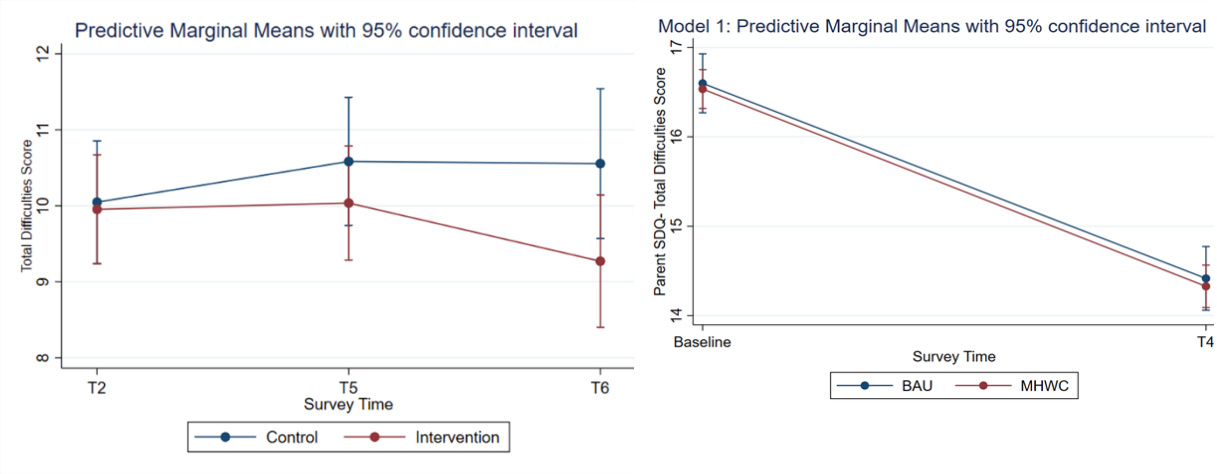
(a) Student Mental Health and Wellbeing

Findings from the mixed model analysis based on parent-reported survey data from the 2022 cohort using the standardised Strengths and Difficulties Questionnaire (SDQ) (Goodman, et al. 2000) indicate that at 10 months follow up the Total Difficulties Score had reduced significantly from baseline in both intervention (M=-2.21, 95% CI = -2.39- -2.02, p<0.001) and control schools (M=-

2.18, 95% CI = -2.46- -1.91, p<0.001) (see Appendix G). Data from the 2021 cohort showed no change at 10 months follow up in intervention schools (M=0.08 (-0.39-0.55), p=0.731) but a significant increase in total difficulties in control schools (M=0.54, 95% CI=-0.01-1.06, p=0.046) (see Appendix I).

However, at 18 months follow up, the Total Difficulties Score had reduced significantly from baseline in intervention schools (M=-0.68, 95% CI=-1.33- -0.04, p=0.038) and remained unchanged in control schools (M=0.51, 95% CI=-0.23-1.24, p=0.175) (see Appendix I). **Error! Reference source not found.**5 shows the decrease from baseline to 18 months follow up was greater for students in intervention schools compared to control, and this difference was statistically significant (M=-1.19, 95% CI=-2.17- -0.21, p=0.017). Findings from the trend analysis with the 2020 cohort data also indicate a reduction in the SDQ Total Difficulties Score at 24 months follow up. Mixed model analysis of the intervention schools showed a significant longer-term decrease in the Total Difficulties score (M=-0.60, 95% CI=-1.19--0.01, p=0.048), further supporting the findings based on the 2021 cohort.

Figure 5: Parent-reported Total Difficulties Score



Graph 5a. 2021 Cohort

Graph 5b. 2022 Cohort

Note. Change in SDQ Total Difficulties Score as reported by parents
2021 Baseline = Feb 2021; T5 = 10 months follow up; T6 = 18 months follow up
2022 Baseline = Feb 2022; T4 =10 months follow up

Survey data from MHWCs at 10 months follow up indicated 77.3% had observed an impact on student mental health and wellbeing since commencing in their role (see Appendix G). Observations primarily related to an increase in student help-seeking around mental health, an increase in implementation of coping strategies among students, and an increased willingness of students to discuss their mental health and wellbeing. Observations included:

- *Children have become much more comfortable in seeking help, which is the first step – and are actually sharing with peers how they have sought help and encouraging each other to do the same.*

- *Students [are] acknowledging their emotional needs and changes. Students [are] appreciating check in/out conducted by MHWC.*
- *Students involved in the wellbeing support groups have learned coping strategies to deal with their challenges in the playground and in the classroom. They have increased their self-awareness and triggers and subsequently improved their responses.*
- *Students who have experienced challenges with mental health have developed relationships with supporting staff and are more confident to seek support.*
- *Based on implementation in a cohort of [students learning about the] Zones of Regulation, students benefit from the knowledge and language developed.*

Feedback from the Term 3 focus groups with MHWCs and classroom teachers indicated that more open communication about social and emotional wellbeing and improved peer relationships among students were common observations as a result of MHWC involvement with students. These observations have also been linked to improvements in class participation and learning ability in some students, with specific examples included below.

> *I think the actual information given to the children has worked, because parents will come to me now, or they'll ring, and they'll say, "My child said you were talking about anxiety, and my child's anxious," those type of things. So, I think it's actually opened up a dialogue, which is really good. (MHWCs Group Interview #2, 2020 & 2021 cohorts)*

> *We've got some very introverted girls in our pod and some friendship group difficult dynamics between a few of those girls, and the ones that have been working with [the MHWC], we've just noticed that their confidence has grown in the classroom. So, we've noticed, with their learning in general, they're more open to putting their hand up or having their work shared, and their friendship skills, some of those problems that we were having at the start of the year have died down, so on the whole, there's been an improvement in their communication with each other and their ability to resolve some of those conflicts that were happening. (Teachers Group Interview #9, 2022 cohort)*

> *I have had positive feedback as well, so if you've worked with a student about okay, these are the strategies we're going to try when we need to regulate. Then you get the teachers feedback that oh they used this today or I'm seeing a difference in terms of their willingness to learn. It's kind of a reassurance as well that it is being effective. (MHWCs Group Interview #10, 2022 cohort)*

(b) Support for mental health and wellbeing

Feedback from the Term 3 focus groups with MHWCs, Leadership and Classroom teachers indicates the program is having an impact on in-school mental health and wellbeing support for students through the provision of individual support, small-group support, and support of teachers within the classroom. The MHWC role has provided an in-school staff member for students to have individual conversations about mental health and wellbeing and, in some schools, the role has been integral to establishing peer groups (e.g., lunchtime clubs) aimed at supporting student social and emotional wellbeing.

But from what I've seen over the last year and a half, the person in the role, she does a great job with those students who need that extra bit of care and support. With the school refuser for example, she has the ability to work with them and let the teacher get on with the other 20 plus students that they have. And I've seen leaps and bounds, what the students were like, some of them that she has worked with, what they were like to what they are like now, and it's just unbelievable. (Teacher Interview #3, 2020 cohort, Metro school)

[The MHWC] has been able to get to some of those students who it's not an emergency yet but they need social skills. Particularly with our Year 5s, [they have] a couple of girls' groups where they're lacking in some of those social skills, partly because of lockdowns, partly COVID and also this age group and cohort. Being able to then give the time and have those longer conversations that we can't do as teachers but that doesn't require a referral or more intensive mental health interventions, which has then improved their learning but also the cohesion of the pod as a whole. (Teachers Group Interview #9, 2022 cohort)

We've seen the usefulness for Tier 1 and Tier 2. It makes sense that they can support teachers with those students. Friendship issues, you know, we've started up lunchtime clubs. (School Leaders Group Interview #4, 2020 & 2021 cohorts)

So, I'm taking some social groups and stuff, that the class teachers haven't got space to. And I've been able to run lunchtime clubs and provide a space within our school that children can come to when they just need some regulation time. (MHWC Group Interview #2, 2020 & 2021 cohorts)

Because our school's got a therapy dog, you can see the impacts. The kids absolutely love [the MHWC] being around and the therapy dog. They're just so happy to see the dog, and their whole demeaner changes. Everyone has commented on how much calmer a lot of students are just around [the MHWC] and the dog, because [the MHWC] just brings that peace to them, I suppose, even on days when the dog isn't around. It's just [the MHWC] is such a calm influence on people. (Teachers Group Interview #9, 2022 cohort)

(c) Student engagement with teachers and school

Feedback from the Term 3 focus groups with MHWCs indicates improved engagement between teachers and students around mental health and wellbeing, citing the introduction of interventions that promote a shared language and provide strategies to help students when they are struggling with their mental health and wellbeing.

We did a fair few of the Tier 1 interventions, like the Zones of Regulation, through the school. Giving students a language around their emotions and how they're feeling, but also a language that teachers and students share in terms of how you are feeling, what do you need to do. And some strategies as well around what to do if we are in those poor mindsets or we're feeling dysregulated. Students are trying to take more and more responsibility for what they can do. Again, that's something that's been pretty positive. (MHWC Group Interview #2, 2020 & 2021 cohorts)

> *There's been a few things that [the MHWC has] done, but one of the biggest is that [they've] introduced the Mental Health Continuum. … so, in each of our year level pods, we have a Mental Health Continuum, an actual visual of it, and each of the teachers are a little mini Bitmoji. So, we have that at the front of our classroom, and we model moving ourselves up and down the continuum through the day and talk with the students just to create a shared vocabulary around mental health and to demonstrate that our mental health goes up and down throughout the day depending on what happens. (Teachers Group Interview #9, 2022 cohort)*

Improvements in students' class and teacher engagement was also a common theme discussed in relation to students having worked with the MHWC, however no interviews discussed impacts on attendance or academic outcomes.

> *Being able to give the time and have those longer conversations that we can't do as teachers but that doesn't require a referral or more intensive mental health interventions, which has then improved their learning but also the cohesion of the students as a whole. (Teachers Group Interview #4, 2022 cohort)*

> *We definitely have seen a difference in our senior students. I have really been working hard with the [Year] 4 to 6 teachers on developing our social emotional learning in the classrooms, and we've seen a big difference in the way that they are relating to each other, the way that they are treating staff when they come in. The kind of conversations we're having, like the restorative conversations after incidents are so much more in depth from the student's point of view. We're getting a much bigger awareness of themselves and other people around them. So that's been really positive. (MHWCs Group Interview #8, 2022 cohort)*

(d) Student engagement with mental health services

Feedback from the Term 3 focus groups with MHWCs indicate that increased teacher ability to recognise mental health concerns had led to an increase in internal referrals and early intervention. However, MHWCs reported ongoing difficulties with external referrals due to lack of available services and/or long waiting lists.

> *I would say we have had an increase [in referrals]. I don't know whether it's as much an increase to external services, but I know our internal referrals have definitely increased because of staff awareness of mental health concerns. I think before the pilot and all of this education about mental health, teachers felt like they had to hit specific criteria in order to put in a wellbeing referral. So, I think a lot of staff are now putting in more referrals more regularly, they'll say there's no big event that's happened, but I'm seeing this, this and this in the classroom, and all of those things are combining and [the student] is just not thriving, they're not doing as well as what I would expect or compared to how they have been doing. So, they'll put in a referral, and we've got a lot more students now accessing help and getting that help before the problems get too bad as well. So, we're having a lot more of that early intervention happening. (MHWC Group Interview #8, 2022 cohort)*

(e) Student outcomes based on the AToSS and POS

To assist in evaluating the impact of the MHiPS program, data collected on the AToSS and POS from the original 10 pilot schools was compared with data from 45 similar schools[4] from 2017 to 2021 (see Appendix K). The constructs which were included in the analysis included the following from the AToSS: Teacher Concern, School Connectedness, Advocate at School, Managing Bullying, Respect for Diversity, and Emotional Awareness and Regulation; and the following from the POS: Confidence and Resiliency skills, and Student Connectedness.

AToSS/POS data collection took place in 2021 in the pilot schools which had been implementing the MHiPS program for three school terms (Terms 3 and 4, 2020 and Term 1, 2021). This coincided with extended periods of remote and flexible learning as a result of the Victorian community's experience of COVID-19, and this had a significant impact on school operations and implementation of the program. Given this and the short timeframe for follow up, it was not expected there would be significant changes from pre-implementation to post-implementation or between pilot and comparator schools. Nevertheless, the analysis provided a valuable opportunity to consider how the data could be utilised for the scaled-up state-wide evaluation.

The analysis involved (a) comparing % endorsement on each construct between pilot and comparator schools from 2017-2021, and (b) analysing the differences between pilot and comparator schools' post-intervention (2021) controlling for baseline (2019).

Findings are detailed in Appendix K and summarised below:

- There was no statistically significant change over time in % endorsement across all schools for all constructs and no difference between pilot schools and comparator schools.
- Percentage endorsement tended to decrease in 2021 compared to 2019 for most constructs across all schools.
- The largest differences between the pilot and comparator schools at 2021 post intervention were for "Confidence and Resiliency Skills" (POS), 2.71% higher endorsement in pilot schools, and "Student Connectedness (POS), 0.71% higher endorsement in pilot schools.

[4] The comparator schools were matched to the pilot schools by DE using a similar school methodology to enable fair and meaningful comparisons between schools with similar characteristics. The method used to create the groups was 'statistical neighbour'. With four factors used in the model, the location of each school is represented in a four-dimensional 'statistical' space. For each school, the distance to each school in the state is calculated (within this four-dimensional 'statistical' space). The schools with the closest distance to the school, form the similar schools group. The matching characteristics included student family occupation and education (SFOE) index, school size, cultural diversity, and remoteness. DE provided the comparator AToSS/POS data deidentified, listed by a school number. The characteristics used for selection were not provided for the schools and couldn't be included in the analysis.

4.0 Conclusions

4.1 Conclusions

Findings in this report relate to evaluation of the implementation and impact of the MHWC model in 100 schools as part of the MHiPS pilot. Findings are primarily drawn from qualitative and descriptive quantitative data based on schools implementing the MHWC model in 2022. In addition, analysis of data based on comparison with BAU schools enabled conclusions to be drawn about the impact of the MHWC model at 10 months and 18 months over and above 'business as usual'. However, findings should be considered in light of a range of limitations impacting implementation and evaluation of the pilot, including COVID-19 impacts on schools, broader context of mental health reform within Victoria and lower than expected survey response rates.

Overall, findings from the 2022 MHiPS evaluation indicate strong endorsement of the MHWC model by school staff. Data from school staff in the 2022 cohort at six months following program implementation indicate that the model had been well accepted within the school. Staff agreed that the MHWC model increased school and staff capacity to support student mental health and wellbeing, and the confidence to appropriately address mental health challenges as they arise ("mental health literacy"). Qualitative data from the 2022 cohort also highlight positive impacts of the MHWC model on student mental health and wellbeing outcomes. These findings are consistent with those from earlier stages of the pilot involving fewer schools and indicate feasibility, acceptability and impact of the model were maintained as the program scaled up to 100 schools.

4.1.1 Implementation

Findings related to implementation focussed on both implementation of the MHWC role and the training program.

MHWC role

The MHWC role is undertaken by a person with an education qualification. This is intended to facilitate the MHWC being embedded within the school, ensuring important contextual information about child development and learning, and maximising buy-in from school. Findings indicate the majority (95%) of school staff agree the education background of the MHWC is important. Findings also confirmed that the MHWC role had been widely accepted by existing staff.

Most MHWCs within the 2022 cohort were employed at FTE 0.6 or higher, and many (54.3%) filled another role in addition to the MHWC role. MHWCs largely completed tasks aligned to the scope and remit of their role as described in their position description. Findings from the 2022 Job Analysis indicated the majority of MHWC time (73.5%) was spent on a wide range of role specific tasks, including (but not limited to): whole school approaches to the prevention and promotion of mental health and wellbeing, provision of direct school-based support to children, and participation in training or professional development. Given the impact of the COVID-19 pandemic

on staffing shortages, MHWCs were sometimes required to engage in classroom teacher roles (6.4% of their time).

Despite the positive feedback on the MHWC model, a range of challenges were identified with regards to implementation of the role. Limited time to implement the role was the main challenge identified by MHWCs and school leadership. At 10 months follow up, approximately half of all MHWCs from the 2022 cohort identified lack of time as the most significant barrier to making progress in their role and in improving outcomes for students/the school. Time challenges included insufficient time to undertake the role, requirement to undertake CRT relief work, and holding multiple roles within the school (including leadership roles and teaching roles). A range of other challenges were noted, each of which were variously identified by a small minority of MHWCs. These included lack of staff buy-in, lack of role clarity, lack of availability and/or access to external supports for students and families; lack of internal and/or external support for MHWC role; emotional load of the role and potential for burnout; lack of teacher capacity to take on new ideas or responsibilities arising from the model. Nevertheless, it should be emphasised that these documented challenges are in the context of the widespread acceptance and support of the new model.

Findings also pointed to several factors important to maximising successful implementation of the MHWC model, including: participation of staff trainees (school leadership and/or teachers) in the core training program to facilitate early implementation and integration of the role and build capacity and knowledge across the school; delivery of MHWC-led Mental Health Literacy professional development session to school staff early in role commencement to facilitate integration of role within the school context and build staff capacity to identify and support students with mental health need; leadership support for the role, including assistance with promoting, articulating and clarifying the role with consideration of role FTE and school context; ongoing professional development and role support through Communities of Practice and other MHWCs; and support from the DE-based regional coordinator.

Training program

Despite various challenges to implementation of the training program due to COVID-19 impacts in 2022, survey findings indicate the program strongly supported the MHWC role. A large majority (85-99%) of MHWCs agreed that the various components of the training program gave clarity to and addressed the needs of the MHWC role and resulted in acquisition of knowledge and skills to support a whole school approach to mental health and wellbeing and supporting students with mental health and wellbeing needs. In addition, MHWCs who had been in their role for 1+ years were unanimous in their endorsement of the newly introduced Enriched Communities of Practice program.

Findings indicate the training program also strongly supported staff trainee participants, i.e., those 2-3 staff per school who were invited to participate in core modules with the aim of facilitating integration of the MHWC role within the school. Feedback from staff trainees confirmed the various modules of the training program had increased their understanding of the MHWC role within their school context and increased their knowledge and skills about developing a whole school

approach to mental health and wellbeing and supporting students with mental health and wellbeing needs.

4.1.2 Impact

Findings related to impact of the MHWC model focussed on the short- and medium-term impacts as described in the Program Logic. At the teacher and school level, this included assessing confidence among classroom teachers and school staff to support student mental health and wellbeing, perceived support for classroom teachers to manage student mental health and wellbeing, stigma around child mental health, engagement with service providers, and prioritisation of mental health and wellbeing. At the parent level, this included assessing parent mental health literacy and stigma around child mental health and wellbeing and at the student level: student mental health and wellbeing outcomes.

Teacher outcomes

Findings indicate the MHWC model increased classroom teacher confidence to support student mental health and wellbeing at six months, ten months, 18 months, and 24 months post-MHWC introduction. Comparison with matched 'Business as Usual' (BAU) schools indicated that confidence increased at 10 months follow up in both MHWC and BAU schools, however, at 18 months follow up findings suggest that teacher confidence levels increased incrementally in MHWC schools but declined in BAU schools. These findings suggest favourable longer-term effects of the MHWC model on teacher confidence. However, further follow up over a longer time period would enable stronger conclusions to be drawn.

The MHWC-delivered Mental Health Literacy professional development session was considered particularly effective at building staff capacity to support student mental health and wellbeing. Survey data at 6 months follow up indicated almost three quarters (71%) of classroom teachers attended the session, and of those, almost all (95%) confirmed it had increased their ability to identify and support students with mental health concerns. The positive impact on classroom teachers' confidence was further reflected in survey responses from all school staff, with 90% confirming the model had increased teacher confidence to support student mental health and wellbeing.

Findings based on teacher self-report and MHWC-report indicate a reduction in stigmatising attitudes toward child mental health among classroom teachers. Survey responses from MHWCs at 10 months follow up indicated approximately three quarters had observed a reduction in stigma among school staff. Observations included increased frequency and openness of discussions related to mental health and wellbeing and more informed and empathetic approaches to addressing student mental health issues. Teacher-reported data at 18 months follow up indicated stigmatising attitudes had reduced significantly in MHWC schools as compared to BAU schools, suggesting favourable longer-term effects of the model on reducing stigma among teachers.

Findings indicate that classroom teachers are being supported by MHWCs in managing student mental health and wellbeing. Survey data from classroom teachers at 10 months follow up indicate

that a large majority (93%) had recently (past month) received support from the MHWC, with more than two thirds (67%) indicating they had received a lot or a great deal of support. Qualitative feedback from classroom teachers identified a range of positive outcomes as a result of the MHWC presence. For example, teachers reported that MHWCs provided individual students with extended conversation times and contributed to a positive school culture and calming presence across the school community. Teachers also identified the support of MHWCs in various situations such as responding to teachers' concerns, facilitating family-school meetings, workshopping classroom issues with students, and facilitating open discussions on mental health and wellbeing between students, staff and parents.

School outcomes

Findings indicate the MHWC model has led to an increase in school capacity to support student mental health and wellbeing, including increased prioritisation of student mental health and wellbeing across the school and an increased likelihood of student mental health need being met within the classroom at 10-month follow up relative to BAU comparison schools. Qualitative feedback indicates the MHWC model has helped schools to build social emotional learning approaches across the school, increase conversations about student mental health and wellbeing, enable earlier support and intervention for students showing signs of mental health and wellbeing concerns and increase protective factors across the school (i.e., visibility of good role models). However, findings related to engagement with mental health services are mixed. Staff survey data indicates that school engagement with internal and external mental health services has improved for some schools over time but continues to be an ongoing challenge for others due to limited access to and/or availability of services.

Providing school level reporting on findings is currently out of scope for the planned MHiPS statewide evaluation. However, consideration should be given to providing data to schools to enable a cycle of review and planning for the model. This information to schools could also assist their planning process for the Wellbeing components indicated in FISO 2.0.

Parent outcomes

Parent survey data indicate an increase in parent mental health literacy (knowledge, help-seeking skills and confidence) at 10 months and 18 months follow up. An increase in parent knowledge around child mental health and wellbeing was greater in intervention schools compared to BAU comparison schools at 18 months follow up. Qualitative feedback from MHWCs indicate the MHWC model has generated increased engagement between parents and the school. For example, provision of information and resources promoting student mental health and wellbeing to parents via communication channels within the school, and use of classroom observations which have facilitated conversations between teachers and parents where there are concerns relating to a particular child.

Student outcomes

The student level outcomes outlined in the MHiPS program logic, which include improved mental, social and academic outcomes, are identified as long-term (2+ years post intervention). Nevertheless, findings suggest the MHWC model is having an impact on some student mental health and wellbeing outcomes in the shorter term.

MHWC feedback at 10 months follow up indicated 77% had observed an impact on student mental health and wellbeing since commencing in their role. Observations primarily related to an increase in student help-seeking around mental health, an increase in implementation of coping strategies among students, and an increased willingness of students to discuss their mental health and wellbeing.

Qualitative data also suggest the MHWC model is having a positive impact on students through improved social and emotional wellbeing and improved in-school support for student mental health and wellbeing needs. This includes more open communication between staff and students regarding mental health and wellbeing, access to more supports at school and improved peer relationships.

Findings from comparative and trend analysis are potentially favourable of longer-term effects of the MHWC model on student mental health and wellbeing. At 18 months follow up, findings from the comparative analysis indicate a reduction in 'total difficulties' as measured by the SDQ relative to BAU schools, while at 24 months follow up, findings from the trend analysis indicate a significant reduction in 'total difficulties' from the initial timepoint. However, given limitations due to lower response rates at follow up, further follow up over a longer time frame would enable stronger conclusions to be drawn.

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Appendices

Appendix A: Knowledge, Skills and Attitudes Framework
Appendix B: Baseline characteristics of participants across all three cohorts (2020-2022)
Appendix C: Characteristics of focus group participants
Appendix D: Key data collection timepoints
Appendix E: 2022 Training Feedback Data
Appendix F: Staff Survey Data, 6 months follow up (2022 cohort)
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Appendix J: SMH-SETS Data and SDQ Data, 24 months follow up (2020 cohort)
Appendix K: Analysis of AToSS and POS data (2020 cohort)
Appendix L: Additional visual representation of key findings from 2023 MHiPS Induction presentation

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