ANZSOG CASE PROGRAM

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From pilot to policy: the Mental Health in Primary Schools (MHiPS) Initiative

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Summary

In 2019, Murdoch Children's Research Institute (MCRI), launched a 10-school pilot to test the Mental Health in Primary Schools (MHiPS) Initiative in select Victorian schools. Developed in consultation with sector stakeholders, the initiative's goal was to increase the capacity of teachers and schools to recognise and respond to primary school students experiencing mental health challenges – an issue that had been largely overlooked in that age group. This would be achieved via the introduction of Mental Health and Wellbeing Leaders (MHWLs) who would provide support to classroom teachers while addressing the broader needs of the school community. Promising results from the initial rollout saw the pilot expanded to 26, then 100 schools across two regions. The pilot evaluation found that educators at MHiPS schools felt more confident in dealing with mental health concerns and observed improved student mental health and wellbeing. Similar observations were also made by parents. Findings from the 2022 final pilot evaluation led to the Victorian Government committing to the introduction of the initiative in all state and low-fee Catholic and independent primary schools by 2026. The Victorian Government allocated $200 million over four years (and $93.7 million ongoing) to the MHiPS rollout across ~1800 schools. This formed part of the largest single investment in student mental health in Australia to date.

ANZSOG case development statement

This case draws on interviews conducted by the author with persons involved in the development and implementation of the MHiPS Initiative. Their comments, which may have been edited for brevity and/or clarity, are included with their permission. The author gratefully acknowledges their participation in the creation of this case.

Introduction

2019: Professor Frank Oberklaid of the Murdoch Children's Research Institute (MCRI) joined Ian Potter Foundation CEO Craig Connelly for a meeting with Victorian Deputy Premier James Merlino. They were there to discuss a potential initiative designed to improve the mental health of primary school aged children. The initiative, called Mental Health in Primary Schools (MHiPS), was developed by the MCRI in consultation with sector stakeholders and had already been granted a provisional $500,000 by the Foundation to fund a pilot study. After previous positive discussions, Connelly decided it was time to lay out their three requests:

1. To match the Ian Potter Foundation's $500,000 grant,
2. To facilitate a 10-school pilot study, and if successful,
3. To extend the pilot to 100 schools.

The then Deputy Premier, who was also Minister for Education, gave them the answer they'd been hoping for. They had no idea just how timely that initiative would turn out to be.

The kids are not alright: children's mental health and the policy agenda

Over decades as a paediatric specialist and researcher, Professor Oberklaid and his colleagues had witnessed child mental health struggle on the fringes of the policy agenda. Adolescent mental health was making progress policywise, receiving increased attention (and resourcing) during the past decade. Although mental health conditions commonly manifest from adolescence onwards, almost 35% of adults with mental health conditions experienced the onset of symptoms prior to age 14 (Solmi et al., 2021). Yet, the mental health of children (i.e. between ages 5 and 13) was often glossed over or bundled together with adolescent health, even though they involve notable and distinct challenges.

Early childhood development is monitored periodically through Victoria's maternal-child health service to check that children are adequately cared for and meeting expected milestones up to age 4. Yet the years between toddler and teen are also a time of major change cognitively, emotionally and socially. Children's peer relationships become much more significant, their independence grows, and they start on the path towards puberty. Early childhood issues may dissipate or become entrenched, while new difficulties can emerge. The steady encroachment of technology and social media into children's lives has also introduced, intensified or accelerated problems such as body image issues and cyber-bullying. Oberklaid termed child mental health the 'elephant in the room' and after taking up his position at Murdoch Children's Research Institute (MCRI) , resolved to do something about it.

A 2015 Australian Government survey of more than 76,000 children found that 16.5% of boys and 10.6% of girls aged 4-11 years had experienced mental ill-health in the past 12 months (Lawrence et al., 2015, p.26). Children in low-income households, experiencing family dysfunction or living in rural areas were more likely to experience mental ill-health than those who were not (Lawrence, et al., pp.26-29). From 2008-2015, the number of children presenting to Victorian emergency departments with symptoms of mental ill-health rose by 6.5% annually (Hiscock et al., 2018). Children who experienced mental ill-health were also more likely to have difficulties as adults (Mulraney et al., 2021). The outcomes associated with long-term mental ill-health are often serious, negatively impacting many aspects of functioning and quality of life (Australian Institute of Health and Welfare, 2025).

It was also likely that many emotional/psychological difficulties in children went unrecognised. The Royal Children's Hospital (RCH) in Melbourne found that nearly a third of parents were often overwhelmed by their child's conduct (Royal Children's Hospital, 2018). RCH research also found that only 35% of parents were confident that they could spot the signs of a mental health problem in their children. Erroneous beliefs about child mental health were common. For example, 1/3 of parents were unaware primary school aged children could experience depression and that persistent sadness was not normal (Royal Children's Hospital, 2017). Another concerning finding was that 44% of parents were unsure where to go if their child was having social, emotional or behavioural difficulties (Royal Children's Hospital, 2017).

Yet getting assistance for children wasn't necessarily easy. Public waiting lists for specialist assessment or treatment were frequently 12 months or longer. Obtaining a private appointment might be quicker but could involve prohibitive fees or onerous travel. The MCRI identified 147 different types of programs and services related to child mental health in Victoria, making it a confusing and fragmented system (Oberklaid, 2022). Many programs or services had strict eligibility thresholds, e.g., were limited to children with an already diagnosed condition or the most urgent/severe cases. They also tended to be concentrated in metropolitan areas. Services were often not well integrated and even professionals had difficulties knowing where to refer families.

The situation, in part, reflected the fragmented responsibility for mental health policy and service delivery within, and between, different levels of government. However, the need for comprehensive change had become clearer. Over recent decades, a growing body of research across multiple disciplines pointed to the impact of a child's environment and experiences on development, mental health and adult outcomes, as well as the value of prevention, early intervention and coordinated responses (Productivity Commission, 2020, pp.89-99;209-213). Meanwhile, mounting concern about the functioning and capacity of mental health systems had prompted multiple inquiries. In late 2018, the Victorian Government announced it would hold a Royal Commission into the mental health system in Victoria. This coincided with the Federal Government directing the Productivity Commission to investigate how improving the nation's mental health could boost economic participation and growth. Both were set to explore the ways in which governments could better support and promote child mental health.

As Co-Group Leader of Child Health Policy, Equity and Translation at the Murdoch Children's Research Institute, Oberklaid was well placed to help. Previously Foundation Director of the Centre for Community Child Health at Melbourne's Royal Children's Hospital, Oberklaid also had extensive experience on numerous government committees, expert panels and advisory boards He had also been Chair of the Victorian Children's Council for over 12 years, advising the Premier and Ministers on child health policies and services. He was interested in developing a child mental health initiative that was community-based and preventative rather than individually targeted and reactive. It was also important for it to be needs-led rather than reliant on formal diagnoses, or siloed into a specific professional area.

In 2018, Oberklaid and Dr. Simone Darling, a senior project officer, obtained a small philanthropic grant to begin exploring some ideas. Primary schools quickly emerged as a good venue for intervention. Encompassing ages 5-12, primary school is a universal platform,' Oberklaid explained, 'It's non-stigmatizing: almost every child goes to school. But the biggest attraction of all is that we have teachers observing these kids, six hours a day, five days a week, 40 weeks a year, in the playground, in the classroom and so on.'

However, they also realised that any initiative involving schools would require an in-depth understanding of the educational environment and the cooperation of many different stakeholders to have any hope of success. Australian schools had been used to deliver a variety of wellbeing programs to their students for many years but with varying results. Consistency of application, staff confidence and commitment, program clarity, resourcing and appropriate evaluation had all been identified as influencing factors (Productivity Commission, 2020, pp.228-229). So began a lengthy process of consultation and collaboration.

Model building

'We spent literally a year meeting people, listening to people, looking at the international literature, looking at what was happening overseas - *and then* started to conceptualise a model,' Oberklaid recalled. He and the MCRI team convened talks with the Victorian Principals' Association, the Victorian Department of Education and the Victorian branch of Australian Education Union to share ideas and gauge interest. Key to developing the plan was conducting a needs analysis.

The MCRI team partnered with the University of Melbourne's Faculty of Education, conducting multiple focus groups and surveying more than 1000 primary school leaders, teachers, health and wellbeing staff, and allied health support staff from schools across metropolitan, rural and regional Victoria. MCRI's goal was to determine the obstacles or difficulties they faced identifying and addressing mental health concerns, as well as supporting children with recognised problems. The research team also wanted frontline perspectives on what they thought they needed to promote better child mental health overall.

Looking at educators specifically, the research suggested that they appreciated the importance of student mental health but often felt ill equipped to deal with problems effectively. This was due to several factors, most notably, inadequate training, resources and time. Although teachers had some grounding in child mental health, they felt the

heavy demands of their role precluded much additional training. Moreover, many students had complex psychosocial needs that far exceeded the kind of help they could reasonably provide. ‘One of the key things that came out of these conversations,’ noted Melbourne University’s Dr Georgia Dawson, ‘was how much schools were holding, particularly out in areas where families are struggling and where there’s lots of family violence. These people who'd gone into teaching were acting as counsellors and social workers.’

Anne-Maree Kliman made similar observations. Then head of the Victorian Principals Association, she participated in multiple consultations. ‘Teachers learn how to educate children,’ Kliman said, ‘They don't learn how to apply clinical therapy.’ She thought that it was important to be able to give teachers some initial strategies to build their toolkit in knowing what to look for when identifying problems. Yet it was also important for them to know when to refer concerns on or have a higher level conversations about a child. Skye Wimpole, Manager of Mental Health Policies and Programs at the Victorian Department of Education, meanwhile noted that ‘over-pathologising’ could also be a problem. Schools at a loss to deal with struggling students would sometimes ‘just refer them straight to a psychologist. And that wasn't always the right approach.’ Even when external help was needed, schools didn’t necessarily know who to contact or where to direct families, she remarked.

The educators surveyed observed the impact of the school environment when it came to student mental health, especially a school culture that prioritised mental well-being and took a whole-of-school approach. School leadership was particularly important, as was engagement with the broader school community. However, the factors that impeded families from getting help for their children – social, economic, cultural and personal – also impeded their capacity to work with schools on mental health issues. Experienced educators noted that the difficulties confronting families seemed greater than ever.

All Victorian primary schools ran mental health programs for the student body. Social and Emotional Learning (SEL) had been part of the Victorian Curriculum since 2017 and aimed to teach students emotional regulation, awareness, relationship, and decision-making skills. Most schools also had access to some kind of individual mental health support, such as a school psychologist or counsellor. However, schools differed markedly in terms of what was on offer and for whom. Some services or programs were reserved for students experiencing problems, others were more broad-based, for example, education sessions to build emotional awareness and resilience. Funding sources also varied. Some programs/services were fully or partially funded by the Victorian Department of Education; others were supported using school’s own funds or relied on fundraising. As a result, access could be patchy.

Compounding these issues was the difficulty in finding enough personnel to fill counselling and allied health roles within schools. Turnover was high and educators were often left frustrated by poor communication, coordination and continuity of care. School psychologists and those in similar roles were also limited in the number of children they could work with and were often separate from the rest of the school community. There were similar issues with external providers including workforce shortages. Along with the detrimental effects of delays on children experiencing mental ill-health, there were the impacts on fellow students and teachers as they struggled to manage disruptions, absences and divided attention.

What teachers wanted, Dawson found, was, ‘a dedicated resource, someone whose sole focus was on student mental health and well-being. Someone that could build relationships with community services and get students seen. And someone who could come into the classroom and help teachers who were overwhelmed.’ From the consultations, Oberklaid and Darling concluded that schools needed a new, on-site role. This person would not be a clinician, nor work with children in a therapeutic capacity, but would support teachers dealing with students having difficulties. They would liaise with families and health care providers where needed but also attend to the mental wellbeing of the broader school community.

It was vital, noted Anne-Maree Kliman, that this person had classroom experience and understood the schools they worked in. However, ‘What we didn't really want to see was another program that we had to put teachers through,’ she said. ‘What we wanted was a quality educator who becomes a champion and point of reference for this work at the school. Someone to help to support families, students and teachers, as needs arise, or to direct them to where they can get the relevant support. We also wanted ongoing support for the teacher to ensure that they're constantly upskilled, and able to transfer that knowledge into the school environment.’

The Mental Health Wellbeing Leader (MHWL)

As the project team spoke to stakeholders and assessed the data, a model started to crystallise. The initiative, called Mental Health in Primary Schools (MHiPS), would create a new position for schools called the Mental Health and

Wellbeing Leader (MHWL).[1] MCRI, Melbourne University's Faculty of Education and stakeholders agreed that MHWLs should be qualified teachers but not be replicating the work of a Student Support Services officer or psychologist. Instead, the MHWL would work at the school and teacher level on a number of functions:

- Analysing the school to determine areas of concern in relation to mental health
- Assessing the capacity of staff to identify and support students with mental health issues
- Sourcing and embedding evidence-based training across the school to build staff capability and confidence in dealing with student mental health
- Identifying referral pathways for students who need further assessment or intervention from either internal or external providers
- Developing and implementing whole-of-school approaches to mental health and wellbeing
- Consulting and coordinating with colleagues, local area schools and health professionals to triage cases, share resources and identify emerging needs
- Engaging with ongoing professional development and peer support.

MHWL training

Once they had an idea of what was required, MCRI partnered with Melbourne University's Faculty of Education who designed and delivered a training program. Drawing on the needs analysis and consultations, Associate Professor Jon Quach and Dr Georgia Dawson led the design of the initiative and emphasised a problem-solving approach. Every school was different and MWHLs, they observed, might be working anywhere from small schools in tight-knit rural communities to metropolitan schools with 1000+ pupils and highly diverse needs. As such, they focused on equipping participants with the skills to perform the role rather than try to prepare them for every possible scenario.

Dawson, Quach and colleagues created a course of four core modules: Mental Health Literacy, Building Capacity, Supporting Need and Learning Communities. The first module was designed to further educate participants on child mental health and wellbeing. The second taught MHWLs how to assess the needs of their particular school, use evidence to select different programs or strategies for implementation, and create mental health and wellbeing plans. Evaluating impact was also addressed. The third module looked at ways of identifying mental health and wellbeing concerns, the use of screening and assessment tools, supporting colleagues, managing referrals and dealing with parents, caregivers and families. After training, MHWLs would be enrolled in the fourth module: MHiPS Learning Communities – monthly sessions which enabled further education, peer learning, information sharing, and mutual support.

Now that MCRI had a clear vision of what was needed and an education partner in the University of Melbourne, it was time to test their idea with a pilot. Conducting a trial large enough to gather meaningful data would invariably require government support but MCRI wasn't about to approach with an outstretched hand alone.

The Ian Potter Foundation

While the MHiPS proposal coalesced, Oberklaid engaged in talks with the Ian Potter Foundation, a philanthropic organisation with an interest in areas such as health and early childhood development. An initial grant application, as the concept was still being formulated, was unsuccessful but after some refinement of the proposal, then CEO Craig Connelly saw promise in the project. He recalled some initial skepticism about using educators rather than psychologists as MHWLs. However, Oberklaid and the MCRI team's reasoning and expertise proved persuasive (Centre for Community Child Health, 2024). The Ian Potter Foundation Board offered an initial $500,000 grant to support a pilot program, with a view to the government matching it. Both Connelly and Oberklaid understood that early government support was vital for the project to have its best chance but that approaching decision-makers with philanthropic backing reduced the risk for government partners.

Normally, Connelly explained, such proposals would first go through central ministries such as the Department of Premier and Cabinet or Treasury. This gave them the best chance of prevailing in Cabinet deliberations. Fortunately, they were dealing with the then Deputy Premier James Merlino, who was also Minister for Education[2]. 'Government sees a lot of good ideas but they always have to make the tough decisions around what to choose,' said Connelly. However, he noted the MCRI case was aided greatly by having robust research behind it and a respected advocate in Oberklaid.

[1] Originally termed the Mental Health and Wellbeing Coordinator.
[2] James Merlino also became Minister for Mental Health in September 2020.

Following positive discussions with Merlino's Chief of Staff, the proposal for an initial 10-school pilot, with a possible expansion to 100, was put to the Deputy Premier and accepted. MCRI would now be working under the auspices of the Department of Education with its logistical support. Justin McDonnell had been in the Wellbeing Health and Engagement Division at the Victorian Education Department since 2016, as a Director then Executive Director. He had seen substantial inroads made when it came to mental health in secondary schools and had been looking for opportunities to make similar progress at the primary school level. McDonnell had also noticed that mental health at school had become a concern for the public. He and his Education Department colleagues would be responsible for organising the pilot on the ground: enlisting schools, recruiting MHWL teachers and providing head office support for participants.

'It was a really different model,' noted Wimpole, '[but] felt like it was a really accessible model for us to implement in the way that teachers are working in schools already. And this was doing two things: it was building their capacity to respond to mental health concerns in young people, but also their capacity to build their skills in implementing social and emotional learning throughout their teaching.'

Launching the pilot

Victorian primary schools varied considerably in terms of size, location and demographics, from one-classroom, mixed-grade rural schools to large suburban schools exceeding 1000 students. Approximately 1800 schools (~1200 government run) had primary-aged students, including combined primary-secondary schools and special schools catering for students with particular educational needs (Department of Education Victoria, 2021).

MHWLs would be teachers with classroom experience and funded according to the size of the school. For example, some schools would have a full-time MHWL while smaller schools would have the role funded on a part-time basis. Initially, it would be to the equivalent of at least 2 days per week. In the case of part-time MHWLs, a teacher or assistant principal might split classroom and MHWL duties or a full-time MHWL might divide their time across multiple schools.

The initial stage of the pilot was to test the overall feasibility of the MHiPS model. For this, Victorian Department of Education selected 10 schools in its north-western region which took in parts of suburban Melbourne, regional centres such as Bendigo and remote areas including the Mallee. The invited schools (5 metropolitan and 5 rural/regional) reflected different demographics. Evaluation, noted Rachel Smith, MHiPS Research Manager, was built into the model from the very outset. To begin with, teachers were surveyed to gauge their mental health literacy, attitudes towards mental health and confidence in addressing mental health problems. They were also asked about their schools' approach to mental health and wellbeing, as well as the behaviour and likely mental health needs of their students. At the same time, parents and carers completed questionnaires about their mental health literacy and their children's mental wellbeing. These measures would be revisited periodically to assess changes. MCRI researchers also gathered data on the use of school-based and external mental health services.

At the beginning of 2020, Melbourne University's Faculty of Education had just welcomed its first cohort of MHWLs for training when COVID-19 broke out. The MHIPs team had to pivot quickly into a fully online learning program. Over time, this became a hybrid experience incorporating asynchronous online elements along with in-person seminars. Remote-area and rural participants attended virtually. Researchers then followed up with MHWLs as they took on their new roles.

Good timing

Although COVID-19 complicated rollout of the MHiPS pilot, the impact was not entirely negative. The pandemic and ensuing lockdowns, including school closures, focused further attention on the importance of child mental health and its relationship to educational settings. While many children struggled with the lack of in-person contact, home-schooling also exposed issues that had flown under-the-radar for some students. Other developments also made the MCRI efforts very timely. In 2020, the Productivity Commission released its findings. Regarding the primary school years in particular, the Commission suggested that state and territory governments 'update the National School Reform Agreement, to include improvements in student wellbeing as one of its outcomes' (Productivity Commission, 2020, p.7). It recommended that governments, 'develop a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum' (Productivity Commission, 2020, p.8).

The Commission wanted to see schools and governments collect and report data on student emotional wellbeing and ensure that accredited, evidence-based social and emotional learning programs were part of teacher training and professional development. Social and emotional learning programs delivered to students also needed to be accredited and rigorously assessed for effectiveness. Furthermore: 'Each school principal should be accountable for the development and monitoring of wellbeing strategies, and progress against national targets,' (Productivity Commission, 2020, p.8).

The Victorian Government's Royal Commission into the state's mental health system reported next. To no one's great surprise, it found a fragmented, crisis-driven approach to mental health care. The wide-ranging inquiry recognised the role of 'everyday' settings (such as schools and workplaces) in mental health promotion and illness prevention. It also determined that primary and secondary schools had the highest unmet need for mental health support within the education system and that universal or whole-of-school approaches could achieve improvements to student social/emotional skills and wellbeing (State of Victoria, 2021, p.98).

The Royal Commission's final report recommended that the government fund evidence-based initiatives aimed at developing and supporting students' social and emotional wellbeing. It also wanted the government to develop a fund enabling schools (especially rural and regional schools) to select from a suite of approved programs according to their individual needs. The report mentioned the MHiPS pilot underway and noted that, 'should this pilot prove to be effective, the Commission encourages the Victorian Government to extend the pilot to more schools,' (State of Victoria, 2021, p.101).

In early 2020, Frank Oberklaid was also appointed co-chair of the working group tasked responsible for developing the 2021 National Children's Mental Health and Wellbeing Strategy for the Federal Government's National Mental Health Commission. It too identified educational settings as one of the key pillars in improving child mental health and recommended the introduction of wellbeing staff into all primary schools as a priority action (National Mental Health Commission, 2021, p.13).

Scaling up and rolling out

The pilot phase of the MHiPS initiative also involved in-depth focus group sessions with first ten schools, MHWLs and other stakeholders to assess how the project was unfolding and to integrate that feedback into the design of MHiPS going forward. MWHLS were asked about their training and how it equipped them for the new role as well as how they spent their time performing the role. This feedback was then used to refine the training modules. Schools and MWHLs responded positively to the model and saw it as something that could be feasibly integrated into existing school structures. One of the benefits of MHiPS that participants noted was the flexibility it allowed in terms of implementation. MHWLs were not obliged to select particular programs or address set priorities but were able to tailor plans to the school environment.

Given this, MCRI was able to move to the next stage, expanding the pilot to a total 26 schools in 2021. In this phase, MHiPS schools were matched with non-participating 'control' schools for comparison. Early findings suggested that the initiative was indeed increasing the confidence of teachers in supporting student mental health, so the Victorian Government and Ian Potter Foundation agreed to expand the pilot to the full 100 schools in 2022. The trial would now cover two Victorian school regions and would also include non-government Catholic schools. Fortunately, Wimpole recalled, the Catholic education sector was interested in the initiative and some Department of Education staff had experience working with the sector which helped the pilot's introduction.

By 2022, MCRI and the Melbourne University Faculty of Education completed their evaluation of the pilot which involved multiple surveys on MWHL training, school staff feedback, parent feedback and classroom teacher feedback at different timepoints, up to 2 years after the pilot's launch. The evaluation team also conducted MHWL and school staff focus groups and collected data from control schools. Although MCRI and partners were not expecting to see major changes to child mental health in the short term, they anticipated improvements to the capacity of teachers and schools to deal with mental health issues.

Overall, they found 'strong endorsement' of the MHWL model by MHWLs and school staff. Of the MHWLs surveyed, more than 95% reported that MHWL training had enhanced their skills and been applied in their role. MWHLs were particularly positive about the Learning Communities and the value of peer support. Feedback also guided the inclusion of additional content on topics such as school refusal and working with external service providers (Smith et al., 2023, p.12). Meanwhile, 87% of school staff reported that the MHWL role had been accepted by classroom teachers and 95% agreed it was important for the MHWL to have an education background (Smith et al., 2023, pp.17-18).

Critically, researchers found sustained increases in the confidence amongst classroom teachers in supporting student health and wellbeing at 6, 10, 18 and 24 months after the introduction of MHiPS. These improvements also exceeded those at control schools (Smith et al., 2023, p.13). Ninety-three percent of classroom teachers also indicated that they had received support from a MHWL in the past month, with two-thirds reporting that it had been substantial (Smith et al., 2023, pp.13). One tool developed by MCRI for use by MWHLs, classroom teachers and parents was the Children's Wellbeing Continuum. Using simple, non-clinical terms, it asked users to rate children from 'good' to 'overwhelmed' on 8 key domains such as emotions and behaviour. It gave educators, clinicians, and families a quick snapshot of how children were functioning, as well as common, non-stigmatizing language for discussing their wellbeing (Exhibit B).

Both qualitative and quantitative data suggested the MHWL model had also improved the ability of schools to meet students' mental health needs and students at MHiPS schools were more likely to have had mental health concerns addressed in the classroom. The MHiPS model was found to have increased mental health awareness across the school and fostered more social and emotional learning (Smith et al., 2023, pp.17-18). Over half of MHWLs reported a reduction in stigma around mental health issues amongst families (Smith et al., 2023, p.15). Seventy-seven percent of MHWLs also observed improvements in student mental health and wellbeing (Exhibit B). Responses from MWHLs during focus groups included:

> '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.'
>
> '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. '
>
> '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' (Smith et al., 2023, p.62).

Parental surveys found increased mental health literacy over time, and in comparison to non-intervention schools. Researchers also found evidence of increased engagement between parents and schools on mental health issues (Smith et al., 2023, pp.15-18). Parents reported improvements in student mental health over time and compared to non-intervention schools, although parents in the 'control' schools also reported improvements (Smith et al., 2023, p.16). While COVID had disrupted aspects of the pilot and likely impacted findings, the results were a promising indicator for the MHiPS team of the benefits the model could bring long term.

The main issue encountered by half of MWHLs was insufficient time to implement the role. Some staff experienced difficulties balancing part-time appointments with other responsibilities, while a small minority were unsure about how to perform the role or experienced a lack of staff buy-in (Smith et al., 2023, p.9). Getting engagement with external service providers could also prove challenging. However, strong leadership support and early involvement of school staff helped facilitate implementation (Smith et al., p.10).

Going statewide

In mid-2022, the MHiPS team got some very welcome news. The Victorian Government announced its intention to expand the Initiative to all government and low-fee Catholic and independent primary schools. The expansion would commence in 2023 with a view to completion by 2026. The Victorian Government committed $200 million to the rollout over the next four years which would see a MHWL employed in approximately 1800 primary schools across the state. This commitment was part of the Government's $600 million universal student mental health and wellbeing reforms, representing the largest ever single funding pledge for child mental health in Australia.

For project team members, it represented a rare opportunity to see research become government policy. Although the pressures of working with government and adapting to their reporting requirements was a challenge, Rachel Smith acknowledged. Anticipating requirements at the outset of a project was always difficult and changes were inevitable. That said, she noted that the support and goodwill of the Department of Education made the process much easier. MHiPS' rapid escalation also meant MCRI and Melbourne University had to move quickly to expand their own teams. 'When we went into it, we obviously had an end in mind, but we also didn't expect that it would go quite as big as it ended up going. We've also had to shift and change in terms of the relationships as the Initiative has scaled up,' Dawson recalled.

Another challenge was recruiting additional MWHLs. It wasn't difficult to find interested candidates. However, McDonnell noted, general teacher shortages exacerbated by the pandemic made it hard for schools to sacrifice classroom staff. This was particularly true for rural and regional areas, who typically had additional challenges in finding staff. For Wimpole, the wide range of school settings had produced had many different challenges but 'I think it's been a really interesting project to work through in terms of some of those questions,' she reflected 'and how you evolve something like this, so that you eventually can make it sustainable as well.'

Yet despite ongoing teacher shortages delaying rollout, creating the MWHL position had been key to MHiPS' success, Justin McDonnell reflected: 'Right from the start, I think the concept of a new role being a must was significant. One of the features of programs that have failed to scale is that they come with a training package but require existing staff to carve out time or be taken off other duties to implement them'.

The availability of internal and external service providers such as child psychologists, was also a persistent challenge, especially in more remote areas. However, MHWLs were assembling to devise local solutions noted Megan Keyes, Strategic Partnerships and Impact Manager for the MHiPS initiative. 'A nice success story that's come out of this is that schools have gotten together and said, "Okay, these are the students we are concerned about, how can we work together to triage them so that the person who needs the most help gets that help first?"' MWHLs were also good at sharing ideas and experiences that had worked for them with their peers.

Claire Tobin (then Acting Executive Director of Wellbeing Health and Engagement Division Health, at the Department of Education) described how they installed staff in their regional offices to help schools with MHiPS implementation. She also worked closely with MCRI and the University of Melbourne to continually refine the initiative: 'The evaluation running alongside [MHiPS] has meant that we've been able to iterate how the program is delivered, and make tweaks to the training, to the model, to the guidance. With each wave of the rollout, we've learned more about what's working or what's not, and then we've been able to adjust that approach for the next wave,' she said.

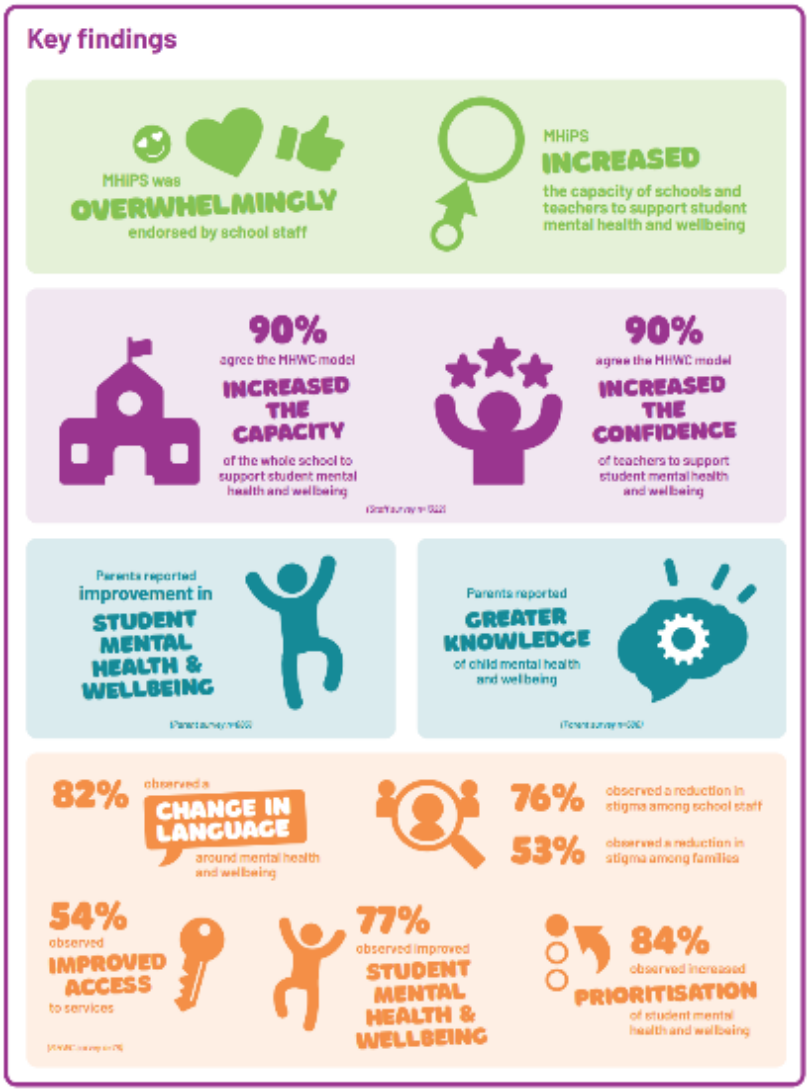
Despite different perspectives, different ways of working and successive changes of minister since 2022, the initiative was still thriving. This was something Tobin attributed to, 'continual investment to maintain trust and make sure everyone's on the same page,' particularly in the form of regular workshops and cross-sector meetings. Looking back at the MHiPS pilot, Tobin said, 'A real reflection from me has been the value of partnership and codesign. This would not be a successful program, if any one of the partners did this on their own…It has meant that we can each bring our strengths to the table and benefit from others'. She continued: 'It's also been quite challenging, that partnership approach. It means that government has to release some control. It takes a bit more time, and certainly a lot more effort, but I think for greater impact and outcomes.'

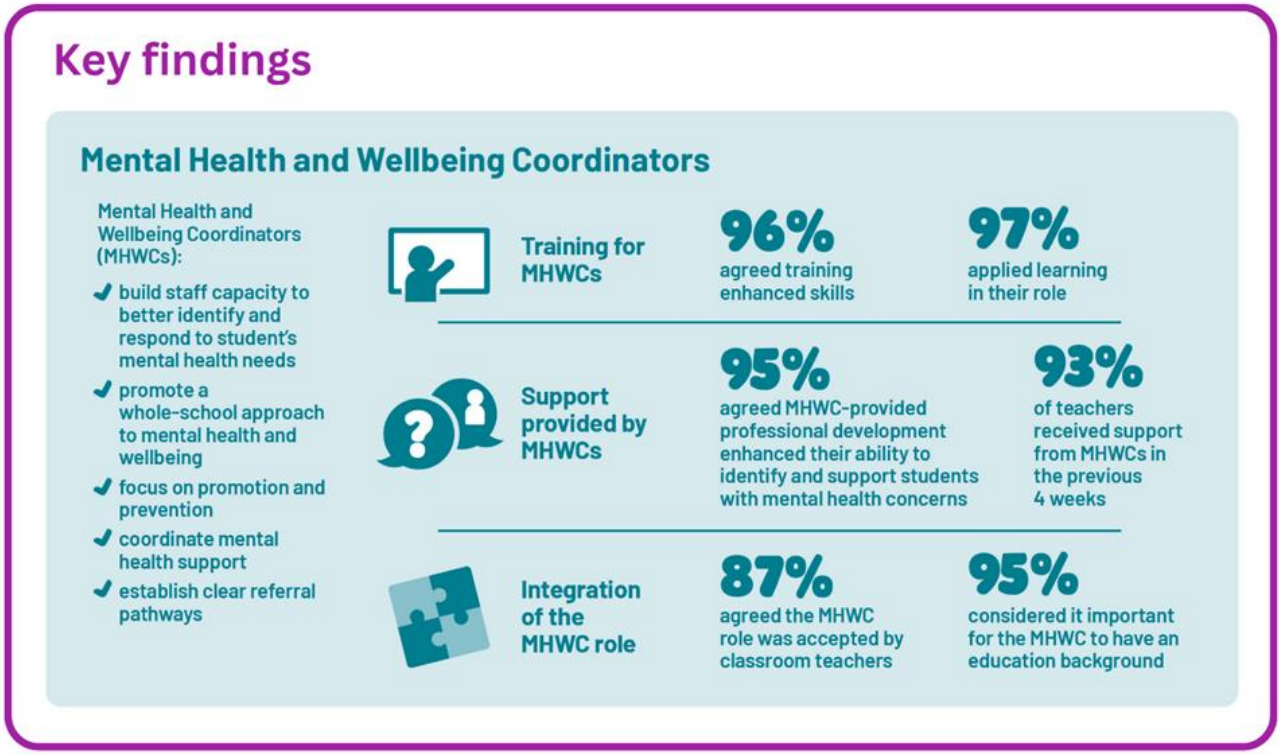
Meanwhile, one of the most gratifying aspects of MHiPS for Frank Oberklaid was hearing from participants how the model was changing the culture of schools such that mental health was no longer an 'add on' but a core part of operations. Added Keyes: 'I look at some of the qualitative comments that say, "Well, teachers are starting to understand that it's not just a behavioral problem. They're understanding that there's something more there." And because we've worked in this area for so long, it surprises me that some teachers still think, "Oh, it's just someone being naughty." There is still that misunderstanding out there but we're seeing that start to change.'

Emily Duff, a MWHL in Melbourne's outer western suburbs, noted that: 'The biggest [impact] now is that we are actually getting proactive in supporting students through mental health [challenges] rather than being reactive when it's too late. [Instead of] looking at the student as just a learner, it's more of a holistic approach.' She noted that in some cases health practitioners were able to come on site to work with children and that it allowed them to integrate the student's therapy goals into their individual education plans. She also observed that since MHiPS parents were more inclined to approach the school for help which improved the trust and rapport between staff and families (Centre for Community Child Health, 2024).

In terms of the future, Oberklaid and his MHiPS partners were looking to see how the MHiPS model might be implemented in other states and territories. Oberklaid and the MHiPS team understood the importance and value of a long lead in to build relationships and understand the situation well: 'This isn't an off-the-shelf product that we can just implement; context is everything, because every jurisdiction is doing things of their own. We made a decision early on that we weren't going to compete, and we weren't going to duplicate existing work'. He added, 'It's going to be different in every state and the training will look different in each local jurisdiction. So the codesign process is going to be very, very important.'

Exhibit A: MHiPS evaluation results





Alt text: Infographic displaying results from MHiPS evaluation

Source: Smith et al., 2023, pp.17-18.

Exhibit B: The Children's Wellbeing Continuum

The Children's Wellbeing Continuum

The Children's Wellbeing Continuum (the Continuum) can provide a snapshot of a child's social-emotional wellbeing at a point in time.

By helping to identify those children who are struggling and need support, the Continuum assists with prevention and early intervention efforts. It may also help to prevent the development of more serious problems that need treatment.

The Continuum is designed to reduce the stigma that often accompanies mental health issues, especially for parents, and facilitate them seeking help early when they see their child is not coping. It is not designed for use as a screening or diagnostic tool.

Using the Continuum

To use the Continuum, reflect on a child's wellbeing over the past four weeks using the table below.

	Good	Coping	Struggling	Overwhelmed
Emotions				
Behaviour				
Social relationships				
Thoughts				
Sleep				
Energy				
Routines, rhythms and rituals				
Learning				

Alt text: Graphic shows the 'Children's Wellbeing Continuum' starting with 'Good', to 'Coping', to 'Struggling' to 'Overwhelmed' developed to provide a snapshot of a child's social- emotional wellbeing at a point in time.

Source: The Centre for Community Child Health (2022), The Children's Wellbeing Continuum, The Murdoch Children's Research Institute and The Royal Children's Hospital. https://doi.org/10.25374/MCRI.2061946

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