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FINAL REPORT FOR THE OVERARCHING EVALUATION OF THE NATIONAL SUPPORT FOR CHILD AND YOUTH MENTAL HEALTH PROGRAM

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Smith SS[1], Salom C[1], Edmed S[1], Marrington S[1], Mamun AA[1], Huda MM[1], Potia A[1], Thorpe K[1], Cross D[2], & Runions K[2] (2021). Final Report for the Overarching Evaluation of the National Support for Child and Youth Mental Health Program. Institute for Social Science Research (ISSR), The University of Queensland.

1. Institute for Social Science Research (ISSR), The University of Queensland.

2. Telethon Kids Institute (TKI), The University of Western Australia

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Glossary

Term	Definition
Action Team Leader	An individual staff member within a service or school who coordinates the implementation of a whole of learning community approach to Be You. The Action Team Leader is also the primary contact for the Be You consultant who has been assigned to the service or school.
Be You consultants	The frontline staff employed by headspace and Early Childhood Australia (ECA) providing implementation support for Be You to registered services and schools.
Be You initiative	An initiative delivered by Beyond Blue in partnership with ECA and headspace, funded under the National Support for Child & Youth Mental Health Program (the Program).
Early learning service	Centre-based care such as long day care, preschool or kindergarten.
Educators	Staff (including guidance counsellors, wellbeing officers and others in roles who support children and young people in learning settings) working in an early learning service or school.
Emerging Minds consultants	A workforce group within the National Workforce Centre for Child Mental Health (NWC) working to support organisations, practitioners, peak bodies and other networks to promote the NWC and support workforce development of professionals to promote child mental health.
Emerging Minds initiative	An initiative to deliver the NWC, funded under the Program. The initiative is commonly known as 'Emerging Minds' by users, so this name is used by the Overarching Evaluation.
Individual evaluations	The separate evaluations of Be You and Emerging Minds.
Initiative	The preferred term for the individual schemes funded under the Program (Be You and Emerging Minds).
Practitioners	Clinical and non-clinical health, social and community professionals who work with children, adults or both in either public or private settings, in the Australian health and human services sectors (i.e. target users of Emerging Minds).
The Program	The National Support for Child & Youth Mental Health Program, which provided grants for workforce and education activities to build capabilities aligned with the Program's objectives.

Acronyms

Acronym	Full name
AARC	Average Annual Rate of Change
AARR	Average Annual Rate of Reduction
AIFS	Australian Institute of Family Studies
ABS	Australian Bureau of Statistics
AEDC	Australian Early Development Census
ANZSCO	Australian and New Zealand Standard Classification of Occupations
CALD	Culturally and Linguistically Diverse
CPD	Continuing Professional Development
CATS	Childhood to Adolescence Transition Study
CRM	Customer Relationship Management
CQI	Continuous Quality Improvement
DID	Difference in Difference technique
ECA	Early Childhood Australia
ELS	Early Learning Service
GST	Goods and Services Tax
HREC	Human Research Ethics Committee
IQR	Interquartile Range
ISSR	Institute for Social Science Research
KPI	Key Program Informant
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning
LSAC	The Longitudinal Study of Australian Children
LSAY	The Longitudinal Surveys of Australian Youth
LSIC	Longitudinal Study of Indigenous Children
MHE-NMDS	Mental Health Establishments National Minimum Data Set
NEI	National Education Initiative
NGO	Non-Government Organisation
NSW-CDS	NSW-Child Development Study
NWC	National Workforce Centre for Child Mental Health
PRC	Parenting Research Centre
SDQ	Strengths and Difficulties Questionnaire
SEIFA	Socio-Economic Indexes for Areas
SEHQ	School Entrant Health Questionnaire
UQ	The University of Queensland
VAS	Visual Analogue Scale
VSHAWS	Victorian Student Health and Wellbeing Survey
WA-HWSS	WA Health and Wellbeing Surveillance System

Executive summary

Background

The National Support for Child and Youth Mental Health Program (the Program) aims to improve mental health outcomes for children and young people, commencing with the early years and going through to adolescence, by providing targeted grants for workforce and education activities that will build capabilities aligned to the Program objectives.

The key objectives of the Program are to:

- build resilience and protective factors in children and young people, and the relationships that support them, to help promote a mentally healthy life
- improve the effectiveness of early intervention services and encourage help-seeking in children and young people at risk of experiencing mental health difficulties
- build and promote the evidence base for people that work with children, young people and their families around mental health promotion, illness prevention and early intervention strategies
- provide postvention services to support students in secondary schools to manage the distress caused by suicide and to reduce the risk of suicide clusters in their peer group.

The Program was initiated in response to the 2014 Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services report (the Contributing Lives Review). There are two initiatives that comprise the Program: the National Education Initiative (NEI) and the National Workforce Support in Child Mental Health initiative. Funding was made available from 2016–17 to 2020–21 to Beyond Blue to lead the NEI (now known as Be You) and to Emerging Minds to lead the National Workforce Centre for Child Mental Health (henceforth referred to as Emerging Minds).

The Be You initiative is targeted at Educators working in an early learning service (ELS) or school, including guidance counsellors, wellbeing officers and others in roles who support children and young people in learning settings. The initiative was designed with the expectation that facilitating capability development and practice change in Educators will result in them taking a more active role in supporting the mental health and resilience of children and young people and in providing effective responses to suicide (including postvention) when needed.

The Emerging Minds initiative is targeted at Practitioners, including clinical and non-clinical health, social and community professionals who work with children or adults, in either public or private settings, in the Australian health and human services sectors. The initiative was designed with the expectation that facilitating practice change and capability development in clinical and non-clinical Practitioners will result in a more effective approach to identifying and responding to mental health risks and issues. This, in turn, will contribute to improved mental health outcomes for children aged 0–12 years and the families, communities and organisations that support them.

In 2018, the Institute for Social Science Research (ISSR) at The University of Queensland (UQ), with subcontractors Telethon Kids Institute, was engaged by the Commonwealth Department of Health (the Department) to develop an Evaluation Framework and deliver an Overarching Evaluation of the Program. Another requirement of the project was a costed plan for a future longitudinal research study on national promotion, prevention, early intervention and postvention mental health programs for children and young people. The costed plan for a future longitudinal research study is reported elsewhere. This report presents the findings of the Overarching Evaluation, which covers the early phase of the Program's implementation period from November 2017 to October 2020. This period included the major unprecedented events of the severe bushfires and the COVID-19 pandemic. These events not only impacted on the Program delivery and data collection for the Overarching Evaluation, but also had a major impact on children and families and the services available to support them.

Overarching Evaluation

Scope

The Evaluation Framework for the Overarching Evaluation of the National Support for Child and Youth Mental Health Program (accepted by the Department on 28/5/2019) included the Program Logic and Theory of Change (see Appendix A), and defined the key Evaluation Questions, indicators (see Appendix B) and data sources that are reported below. This Evaluation Framework was co-designed with input from the Department of Health and the Scientific Advisory Group. The Program Logic included feedback from early consultation with Be You and Emerging Minds and incorporated the Program Logics developed for the individual initiative-level evaluations.

This Overarching Evaluation aimed to assess the appropriateness, effectiveness and cost-effectiveness of the Program and to identify opportunities to strengthen or improve it in order to meet its intended objectives. It addressed the following agreed key Evaluation Questions:

- How well has the Program been implemented?
- How appropriate is the Program design to deliver the intended outcomes?
- How effective is the Program in achieving its intended outcomes?
- How cost-effective is the Program?
- Were there any unintended outcomes or consequences associated with the Program?

The findings, described below under each key Evaluation Question, were used to inform the recommendations for the Program and initiatives. The initiatives have since been funded for an additional two years (i.e. from 2021–22).

Methods

This Overarching Evaluation used a suite of complementary qualitative and quantitative research activities to address the Evaluation Questions. The main research methods used included:

- design and administration of the National Support Network Survey: a national survey of Educators and Practitioners as the key target audiences for Be You and Emerging Minds, respectively
- an Integrated Data Analysis: a secondary analysis of multiple existing datasets appropriate to child and youth mental health
- a Value for Money assessment, including estimates of funding inputs from the Commonwealth Government and alternative scenarios generated from qualitative survey and interview data
- Community Case Studies: interviews and focus groups conducted with key stakeholder groups in four communities in Queensland and Western Australia, including Educators, Practitioners (clinical and non-clinical), and parents/carers of young people
- document analysis of evaluation reports from the two Program initiatives: Be You and Emerging Minds
- Key Program Informant Interviews with Be You and Emerging Minds staff.

Limitations

The findings presented in this report need to be interpreted with respect to the stated limitations and assumptions of the analyses. The widespread implementation of the Program across Australia, and lack of well-defined exposures to the Program, meant that it was not possible to establish an appropriate counterfactual (e.g. a comparison group not exposed to the Program). This limits the attribution of any observed changes in outcomes to the Program.

The Program is only one of many programs and initiatives that the Commonwealth and State Governments are implementing to support the mental health and wellbeing of children and young people. The complex environment of policies and frameworks intended to support the mental health and wellbeing of children and young people also presented challenges for attributing change to the Program.

The Program Logic articulates potential for change occurring at the individual user level (i.e. Educators and Practitioners), as well as for children, young people, their families and the community. Change beyond the individual user level takes time. The eventual translation to benefit for children, young people and their families, and longer term benefits to community and other social supports, are depicted as intermediate (emerging evidence from 2–3 years post-implementation) and long-term outcomes (up to 5 years) of the Program in the

Overarching Evaluation Program Logic. As such, it is likely too early to see a substantial impact of the Program on these critical intermediate and long-term outcomes.

Substantial work and development by the initiatives has occurred since the end of the evaluation period in 2020. The findings reported in this evaluation represent a snapshot in time during the early implementation phase of the Program. The level of change in response to the Program observed by the Overarching Evaluation at the individual user level (i.e. user satisfaction, awareness, knowledge and confidence), described in the key findings below, is consistent with the stage of maturation predicted by the Program Logic (see Appendix A).

Key successes

- The Program's delivery organisations have worked to rapidly meet and exceed ambitious recruitment targets for their respective initiatives.
- The initiatives' designs, philosophies and content development are evidence-informed.
- The initiatives have shown themselves to be responsive to evaluation findings.
- The majority of users reported that the quality of the professional development of both initiatives was excellent.
- As intended, Educators exposed to the Be You initiative improved their professional capability across a range of short-term outcomes compared with those not exposed.
- Both initiatives were responsive and adaptive to rapidly changing external context.

Key findings

How well has the Program been implemented?

Successful implementation of the Program was assessed in terms of the extent to which it was implemented as expected, the way implementation varied across different contexts, whether it reached the intended participants, and its integration and alignment with existing services. The Overarching Evaluation also examined the extent to which the two initiatives worked effectively with reference groups and each other to meet Program objectives, and the extent to which the initiatives adopted evaluation and robust outcome measurement as key drivers of continuous quality improvement.

Findings

- The evaluation period was marked by a period of unprecedented change (severe bushfires and global COVID-19 pandemic). These events affected the organisations delivering the initiatives, their staff, and the education and workplace environments targeted by the Program. The Program initiatives had not yet reached a steady state of operation in which to focus on engaging with schools, ELSs or other organisations to fully embed their respective frameworks.
- **The Program was largely implemented as expected by Beyond Blue and Emerging Minds.** However, the initiatives reported delayed timeframes for some aspects of implementation and an unexpectedly intense early user recruitment period. The discrepancy between initial planned timelines and the timing of actual implementation suggests that both initiatives underestimated the time required for start-up.
- The organisations collaborated well with their respective reference groups during the development phase and across the very early implementation period of the Program. However, there was evidence of a lack of ongoing, planned coordination between the initiatives, especially during the early-mid implementation phase (2019 to early 2020). There were promising signs toward the end of the evaluation period that the initiatives were again progressing towards cooperation as a cohesive Program.
- The two initiatives demonstrated responsiveness to individual evaluation findings, and both have adopted a continuous improvement framework to optimise their efficiency and effectiveness over time. Although there have been sequential evaluations of each individual initiative, the focus of these evaluations was process-oriented and weighted heavily toward reporting activities rather than outcomes. A common set of agreed, robust and consistent outcome indicators that could be used to monitor the intended benefits and impacts of the Program were not identified, although this was not required of the initiatives by the Department.
- The organisations leading the implementation and delivery of the Program's initiatives took different approaches to addressing different contexts in their implementation. Be You focused on consultants contextualising existing generic materials to different contexts, whereas Emerging Minds moved away from the development of generic materials toward sector-specific pathways and content.

- Based on available organisation-level postcode data, almost all geographic regions nationally, as categorised by the Australian Bureau of Statistics' Australian Statistical Geography Standard (SA2 and SA3), were exposed to the Program in some way (i.e. at least one registered organisation from that geographic location) between November 2017 and September 2020. SA2s represent communities that have a population range or 3,000 to 25,000 persons; SA3s reflect regional areas that have a population range of 30,000 to 130,000 persons. **This finding suggests very broad geographical coverage of the Program.**
- **The initiatives have been effective at recruitment of users.** There were 10,595 organisations registered to Be You between October 2018 and September 2020: 62% of organisations were classified as schools, and 37% were early learning centres. Be You had a total of 119,307 registered individual users as at September 2020. Emerging Minds engaged with 691 organisations in the period between November 2017 and August 2020. Emerging Minds had a total of 39,233 total individual e-learning registrations as at May 2020.
- A range of user types have engaged with the Program, consistent with (and sometimes exceeding) the original intentions of the Program. There are a range of additional community stakeholders whose roles in young people's mental health suggest they may also benefit from connection to Be You and Emerging Minds.
- A range of individual, organisational and structural-level factors were identified as enablers and barriers of implementation. Enablers of implementation included interaction with consultants and encouragement from workplace leadership. The most frequently reported barrier to implementing the learnings of the Program from an individual user perspective was a lack of time and workload pressures. Although mechanisms exist within both initiatives to promote whole-of-organisation uptake and engagement, such structural uptake and engagement is not widespread.

How appropriate is the Program design to deliver the intended outcomes?

The appropriateness of the Program's design was assessed in terms of the extent to which:

- the Program's two initiatives address the needs of the community
- the initiatives are evidence-based and enhance the evidence base to support children and young people's mental health
- the initiatives meet the needs of their target audience (i.e. Educators and clinical and non-clinical Practitioners and services who work with children).

Findings

- **Users perceived broad utility and appropriateness of resources of the initiatives for general needs**, but the range of resources to address children and young people with high and complex needs is limited.
- **The design of the content of each of the initiatives was adequately informed by current evidence.** Emerging Minds demonstrated a particular strength in making an evidence-based philosophy central to its ways of working. The initiatives demonstrated some progress toward enhancing the evidence base supporting their work, but there was limited evidence for an effective evidence dissemination strategy for both initiatives, or for a whole-of-Program strategy led by the Department.
- 43–45% of users who used the Program reported agreeing or strongly agreeing that the initiatives were *appropriate* to address the needs of the range of the children, young people and families with whom they interact in their workplaces. These diverse cohorts included Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds, people with disability, and people who identify as Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning (LGBTIQ).
- The majority of users reported being satisfied or strongly satisfied with the initiatives.
- The extent to which Be You met users' needs in terms of being a 'one stop shop' for resources and support was low: only 29% of Be You users agreed or strongly agreed that all their needs were met by the initiative.
- **The majority of users reported improving their practice in relation to child and youth mental health** (59% of Be You users and 69% of Emerging Minds users reported having *improved* or *somewhat improved* the way they work with students/children because of the initiative).
- The Overarching Evaluation found that the Program's reach to Educators and Practitioners may not be equitable where internet access, technology infrastructure and other facilities required to support Program delivery are not readily available.

How effective is the Program in achieving its intended outcomes?

We assessed the Program's effectiveness in building Educators' and Practitioners' capabilities aligned with the Program objectives by comparing Educators and Practitioners exposed to the Be You and Emerging Minds initiatives, respectively, to those who were unexposed to the initiatives on: awareness of and access to evidence about child and youth mental health; awareness and knowledge of processes to refer children, young people and their families to early intervention services or external supports available to support their mental health; confidence to recognise and respond to mental health risks in ways that are consistent with contemporary evidence; and knowledge of suicide postvention supports and depth of understanding about responding to suicide trauma (for Educators only). The extent to which these outcomes might lead to intermediate and long-term benefits for children, families and communities were examined using an analysis of baseline and short-term trends across a number of contemporary indicators of child and youth mental health outcomes, as well as interrogating the effectiveness of the Program on those indicators, where available data made that possible.

Findings

- Educators exposed to the Be You initiative were significantly more likely to be aware of evidence-based practice, value evidence, agree that access to evidence improves their practice, and engage in evidence-based practice. Practitioners (i.e. target users of Emerging Minds) self-reported being frequent, confident and competent users of evidence overall, regardless of their exposure to the Emerging Minds initiative.
- There was evidence that Educators exposed to the Be You initiative reported significantly greater understanding of the processes involved in referring children and families to external mental health supports, as well as greater confidence in connecting with, utilising and, where appropriate, referring children and young people to external mental health supports, compared to Educators not exposed to the initiative. There was high agreement and endorsement that Practitioners understood their role in referring children and families to external services for mental health support, regardless of their exposure to the Emerging Minds initiative.
- Educators exposed to the Be You initiative reported significantly greater confidence in their ability to identify children and youth at risk of experiencing mental health challenges, increased willingness to have conversations with children and families about mental health, a greater understanding of the mental health challenges facing children and young people, and greater understanding of when it may be appropriate to refer children and young people for specialist support. Practitioners reported high agreement and endorsement of each of these dimensions of mental health literacy, regardless of their exposure to the Emerging Minds initiative.
- There was mixed evidence for whole-of-setting changes of policy, procedure and practice consistent with the development of a mentally healthy culture and broader mental health literacy. There was high overall agreement that schools had policies and procedures that support mentally healthy learning communities, regardless of exposure to the Program, although Educators exposed to the Be You initiative were more likely to agree that their school has a culture that supports and promotes mental health. Practitioners reported high agreement that policies, procedures and cultures in their work settings support mental health, regardless of their exposure to the Emerging Minds initiative.
- Suicide postvention support was provided by Be You following critical incidents and in communities at high risk of suicide contagion. Educators who had used Be You were significantly more likely to agree that suicide postvention was a part of their role, that they had the knowledge and confidence to respond appropriately to a death by suicide in the school community, and that they had the knowledge and confidence to identify and communicate appropriately with young people who may be impacted or at increased risk of suicide contagion after a death by suicide. Educators exposed to the Be You initiative were also significantly more likely to report that their school had a suicide postvention plan in place compared to Educators not exposed to the initiative.
- Intermediate and long-term outcomes of the Program could not be robustly captured within the evaluation timeframe. This is consistent with the expected timelines for change in outcomes and impacts depicted in the Overarching Evaluation Program Logic (see Appendix A, accepted by the Department on 8/5/19). As such, longer term monitoring of these indicators is required, particularly with respect to the effects of the Program on specific child and youth outcomes. The findings of the Overarching Evaluation's Integrated Data Analysis provide benchmarks for outcomes to be assessed for when post-implementation data become available, and when intermediate and long-term outcomes of impact on children, families and the community are reasonably expected to be detectable.

How cost-effective is the Program in improving Educators' and Practitioners' capabilities aligned with the Program's objectives?

Findings

- Be You and Emerging Minds users overwhelmingly responded that using the Program was much less costly for professional learning than other equivalent activities or tools available for them to use.
- Substantial opportunity costs of *time* were identified for Educators engaging with the Be You initiative.
- **The Be You initiative benefits from economies of scale for delivery.** Increased uptake, and in turn increased engagement with the initiative, will likely see a reduction of delivery costs per user, which would represent increasing value for money over time.
- Conducting a cost analysis on the Emerging Minds initiative was not possible due to a lack of module-level costing data and specific registration figures by profession.

Were there any unintended outcomes or consequences associated with the Program?

Findings

- There was no evidence of counterproductive consequences of the Program at this stage of implementation. Based on available data, the Program did not have any effects contrary to those intended.
- The baseline level of knowledge and confidence among Practitioners surveyed was high regardless of whether they had engaged with Emerging Minds. These indicators may not have been appropriate to detect an effect of the Program for some of these professional groups. This finding may also reflect adoption by users seeking updates or reinforcement of their learning (e.g. continuing professional development) rather than adoption by users with low baseline levels of knowledge in the areas of infants' and children's mental health.
- Despite the original conceptualisation of Educators being excluded from the scope of the Emerging Minds initiative, there was unexpected crossover between the initiatives (i.e. Educators used the Emerging Minds initiative and Educators used both initiatives at the same time. Practitioners did not report using Be You).

Conclusions

The Program is still in a relatively early phase of implementation (2–3 years since launch dates). Although experiencing some initial delays and timeline challenges, the Program's delivery organisations have worked to rapidly meet and exceed ambitious recruitment targets for their respective initiatives and have shown themselves to be responsive to evaluation findings. The level of change in response to the Program observed by the Overarching Evaluation is consistent with the expected stage of maturation predicted by the Program Logic.

A range of early indicators are consistent with the Program's intent to build capability in Educators and Practitioners to support the mental health and wellbeing of children and young people. The Evaluation Team notes, however, the extent to which benefits for children and young people could be assessed and attributed to the Program was limited by practical constraints around the timely availability of relevant and appropriate data and the lack of an appropriate counterfactual (due to the universal roll out of the Program). The continuing and developing rollout of complex and interacting Program components, content and activities, overlaid by the impacts of major unprecedented events in the severe 2019–2020 bushfires and the COVID-19 pandemic, presented additional challenges in making attributions to the Program.

The Overarching Evaluation was conducted in the context of substantial social, health and mental health challenges for the community across 2019–2021 (see the Program timeline, Figure 1.2). These unprecedented events influenced the underlying mental health needs of children and young people, and increased recognition of the importance of mental health by stakeholders and Governments. A steady state of Program operation was not reached during the evaluation timeframe, but uptake of the Program's initiatives was strong and increased over time. The acceleration of uptake for both initiatives following the COVID-19 related Public Health Orders that restricted movement and gatherings reflected an increased reliance on online information/training platforms, which the Program was well placed to meet.

The success of the Program is premised on a range of assumptions, including that broader mental health systems and services have maintained or improved their capacity to address referrals and interactions from Educators and Practitioners. Improving knowledge, awareness and confidence of Educators and Practitioners to refer children and young people to appropriate supports is only one component of improving access to early

intervention services for children and young people at risk of, or experiencing, mental health difficulties. Building this capability does not directly address issues with accessing services (e.g. availability, timeliness, location, affordability) or fill service gaps. This Overarching Evaluation highlighted perceptions from Educators and Practitioners of gaps in the service environment to which they could refer children and families. Addressing such gaps is beyond the scope of this Program, but it is an area that warrants attention by policy makers so that children's and young people's mental health needs can be appropriately addressed once identified.

The Program is one of many programs and services delivered by Government to support the mental health and wellbeing of Australians. The Australian Government and all State and Territory Governments share responsibility for mental health policy and the provision of support services and programs. The Commonwealth and States are currently funding and implementing a range of strategies to address mental health needs. This includes a number of initiatives in the 2021–2022 Federal Budget that are intended to support the mental health and wellbeing of children and young people. These initiatives may complement the work of the Program in delivering positive mental health outcomes for children and young people. The interactions of these provisions with the Program could be considered in future evaluations.

Beyond Blue and Emerging Minds have demonstrated appropriate organisational capability and capacity to lead the delivery of their respective initiatives. However, the large-scale roll out of the Program meant that the initial design was for broad application, consistent with the requirements of the Grant agreements. Opportunities to improve tailoring for regional-level or individual needs may improve specific outcomes. To optimise the impact of the Program, an emphasis on large-scale organisational change to improve resourcing and support in Educators' and Practitioners' work contexts is needed.

The next step for the Program's two initiatives is to work to embed frameworks within systems, and to monitor the outcomes and impacts of the Program at the child and family level. Further work is needed to assess the longer-term impact of professional learning more directly on Educator and Practitioner competencies, and then to assess the intended downstream benefits to children, families, school communities and the broader community. We acknowledge that building capability takes time and the potential impacts of the Program on children, young people, their families and the community are yet to be fully realised.

Opportunities for future development of the Program

Table 1 presents a summary of the key recommendations of the evaluation. These recommendations are framed as opportunities for future development of the Program. Some of these recommendations are presented as considerations for the Department, even though they are not solely the responsibility of, or within the control of, the Commonwealth. In these instances, the Department may wish to consider whether there are levers within its control to influence change.

Table 1 Summary of key recommendations of the Overarching Evaluation

	Context	Recommendations for future development of the Program	Timeframe
Structure of the Program	Further collaboration between Be You and Emerging Minds should continue to identify areas of crossover and alignment, build on strengths and capitalise on efficiencies.	The Department to facilitate increased collaboration between Beyond Blue and Emerging Minds to: • better coordinate their approaches to monitoring Program outcomes • strengthen information-sharing processes • build mechanisms to foster ongoing synthesis of evidence and sharing of evidence • avoid duplication of effort and redundancy of content • explore opportunities for "collective impact" • explore opportunities to bridge connections between Educators and Practitioners.	Short term
Evaluation	As the Program matures, increased focus should be given to moving from process and activity-based reporting to outcome-based reporting. Agreed, robust, consistent outcome measures of change in Educator and Practitioner capability are needed. Additionally, agreed, robust, consistent outcome measures of social and emotional wellbeing in children and young people are needed to monitor the overall benefits and impacts of the Program.	The Department to: • align the requirements of the individual initiatives' evaluation imperatives to move toward an outcomes-focused approach • reduce activity reporting burden on initiatives • work with Be You and Emerging Minds to continue to support a continuous quality improvement approach • work with Emerging Minds to build its capability and capacity in data analytics. Emerging Minds may require further funding, consultation, and support to do this work • conduct future outcome- and impact-focused evaluations consistent with the Program Logic and with built-in continuous feedback mechanisms to ensure that initiatives remain responsive to the original scope and objectives of the Program.	Medium term
Implementation by context and need	There are opportunities to improve targeting of initiatives to better tailor information, resources, programs, and servicing to Educators and Practitioners working with higher-needs or diverse groups of children	The Department to consider: • reducing emphasis on recruitment targets and set targets for the level of engagement within participating settings.	Medium term

	Context	Recommendations for future development of the Program	Timeframe
	and young people. Although there is some evidence that the initiatives, particularly Emerging Minds, are making progress to address these issues with new learning pathways/content, further progress is required to address these unmet needs.	• expanding the scope for the Program to increase its reach to key community groups who interact with children and young people. The Department to work with Be You and Emerging Minds to consider the following (which may require further funding and support): • Attention should be paid to local school and community context: explore ways to leverage local knowledge and use data to inform regional level planning for consultant activities. • The Program should make progress toward making resources and services for each initiative more relevant for diverse user and beneficiary groups in the next funding period. • The Program should consider additional professional learning and resources to support users who work with higher needs or special groups of children and young people. The Department to: • continue to work with the initiatives to address the structural barriers to implementation of the Program reported by users • consider the emerging recognition of the need for appropriate mental health services for early childhood (1–5 years) • consider the role of the Program in meeting the needs of young people (+12) who have disengaged or been excluded from education.	
Program alignment & integration	The success of the Program is premised on a range of assumptions, including that broader mental health systems and services have maintained or improved their capacity to address referrals and interactions from Educators and Practitioners. Improving knowledge, awareness and confidence of Educators and Practitioners to refer children and young people to appropriate supports is only one component of improving access to	The Department to: • consider tracking external mental health service capacity and any other changes in context that might bear on the utility of the Program. Specifically, monitoring the capacity to meet increasing demand for services as Program users become more confident to refer, and monitoring the breadth of available services to ensure that the specific needs of children across a range of ages and mental health problems are met	Long term

	Context	Recommendations for future development of the Program	Timeframe
	early intervention services for children and young people at risk of, or experiencing, mental health difficulties. Building this capacity does not directly address issues with accessing services (availability, timeliness, location, affordability) or fill service gaps. These barriers to access were frequently reported by Educators and Practitioners as preventing them from being able to support child and youth mental health. Although schools may be an effective gateway to the broader mental healthcare system, system-level accessibility issues are not addressed by the Program.	• consider the alignment between clinical capacity in current support systems and potential changes in referrals to these because of the Program. • identify and remove barriers to accessing mental health services and supports • ensure targeted activities of the initiatives retain alignment with the longer-term objectives of the Program.	
Whole-of-setting engagement	Individual Educators and Practitioners reported a range of barriers to supporting child and youth family health. School/organisational structural and leadership support of initiatives can address many of the common barriers that individual Educators and Practitioners report facing (e.g. lack of time, competing priorities, role confusion). A whole-of-school/service and organisation approach empowers individual users to utilise external supports and services. Whole school/organisation "buy in" promotes a consistency of approach to child and youth mental health and wellbeing within the setting.	The Department to: • consider clarifying the policy intent of the Program to emphasise whole-of-setting changes • identify enablers and barriers to whole-school/whole-organisation uptake • leverage positive drivers of engagement, for example professional accreditation or continuing professional development (CPD) recognition • collect rigorous data on school/organisation-level of engagement, accountability, activity and outcomes.	Medium term
Equity of access	Issues of inequity of access were found related to digital access to online environments, especially in regional and remote areas.	The Department to consider barriers to equity of access to the Program and the potential utility of supplementary face-to-face services aligned with the Program.	Long term
Blended delivery model	The predominantly online mode of delivery allows for scalability and sustainability of the Program. However, the blended model of	The Department to review funding to ensure initiatives have sufficient resources (e.g. consultant workforce) to support the blended delivery	Short term

	Context	Recommendations for future development of the Program	Timeframe
	delivery (website platform with consultant support) is appropriate to deepen engagement and address the needs of users who have needs that cannot be sufficiently met by online resources or who have alternative learning preferences. The use of consultants in some form is needed, particularly at important points of engagement with schools and organisations (e.g. early in engagement or after critical incidents). Awareness of and satisfaction with the current blended delivery model was mixed.	model as increasing numbers of early learning settings, schools and organisations to engage with the Program. The Department to work with Be You and Emerging Minds to: • promote benefits of online access • promote role and functionality of consultants • ensure there is sufficient capacity for consultant support targeted at areas of higher need.	
Evidence base	The design of the Program's initiatives was mostly informed by the evidence, but there was limited documentation for an effectively evidenced implementation and dissemination strategy for both initiatives, or for a whole-of-Program strategy.	The Department to work with Be You and Emerging Minds to: • continue to foster a "culture of evidence", including diversity of evidence types (i.e. considering clinical/Practitioner knowledge, lived experience) • continue to consider and build in "evaluability" for any new initiative developments • develop overt Program level strategy for evidence dissemination • follow recommendations from implementation science for further roll-out and scale-up.	Medium term
Data issues and information gaps	This Overarching Evaluation was limited by the lack of reliable and valid data about the geographical reach of the initiatives, which limited the types of analyses that could be completed, and the extent that we could describe the reach of the Program and attribute change to the Program.	The Department to: • explore opportunities to encourage embedded data collection on wellbeing outcomes for children and young people in all jurisdictions and learning settings, including early learning services. These data would need to be nationally consistent to inform ongoing evaluation of the Program and other wellbeing programs delivered in learning settings. This is consistent with the Productivity Commission's recommendation to "collect nationally consistent data on student wellbeing and use it to report on progress against the outcomes in the national	Short term

	Context	Recommendations for future development of the Program	Timeframe
		agreement, inform policy planning and improve schools' implementation of a social and emotional wellbeing curriculum" • improve data collection by Emerging Minds, Beyond Blue and their delivery partners to support Program-level evaluation, for example, accurate demographic and geographical data, identification of Practitioner roles by ANZSCO identifier codes, and valid data on level of engagement/exposure to the Program (i.e. participation of individuals in modules, module completions, assessment of module learning) • build in evaluability for any future iterations of the Program to enable stronger assertions of causal attribution (e.g. use of regional pilot trials with a well-defined control group) • improve alignment between evaluation types and Program activities for any future initiatives to ensure that implementation is appropriate (process evaluation) and outcomes meet the expectations of the Program (outcome or impact evaluation).	

Introduction

This report presents the findings of the Overarching Evaluation of the National Support for Child and Youth Mental Health Program.

In 2014, the National Mental Health Commission conducted a national review of mental health programs and services. The report, *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services* (the Contributing Lives Review), highlighted the lifetime benefits of investing in the mental health and wellbeing of children and young people, particularly by addressing critical service gaps for very young children (aged between 0–12 years). In recognition of the importance of this population group, the review called for the identification of the mental health and wellbeing needs of children and young people as a national priority for mental health networks, and emphasised the importance of prevention, mental fitness, and early intervention for this population group.

In the area of child and youth mental health, the Contributing Lives Review found that there were opportunities to reduce duplication of programs and increase the coordination of services in child and youth mental health. According to the Contributing Lives Review, this duplication of programs and uncoordinated approach arose over time because of a lack of clarity in the roles and responsibilities of programs and initiatives, or because of a lack of clear strategic direction. The Contributing Lives Review suggested that opportunities to consolidate outcomes and increase productivity across the system could be achieved by:

- improving the targeting and integration of services
- reducing duplication and uncoordinated implementation

In its response to the Contributing Lives Review, the Commonwealth Government initiated the National Support for Child and Youth Mental Health Program (the Program), with the aim of enabling key actors in the community that regularly interact with Australian children and young people to function as prompts and facilitators in promoting positive mental health and wellbeing for children and youth. Funding of up to $133.3 million (GST exclusive) from 2016–17 to 2020–21 was initially made available for the Program.

The aims of the Program were to build a more efficient, integrated, and sustainable mental health system, and to promote improved targeting of effort, resources, and outcomes for the mental health consumer with a focus on:

- building resilience skills and protective factors in children and young people to help promote a mentally healthy life
- enhancing and promoting the evidence base that informs mental health promotion, illness prevention and early intervention strategies for children and young people
- improving access to, and effectiveness of, early intervention services for children and young people at risk of, or experiencing, mental health difficulties
- providing suicide postvention services to support students in secondary schools to minimise the distress caused to students and reduce the risk of suicide clusters in peer groups.

These overarching objectives were to be addressed by activities in two Program schemes: The National Education initiative (for Educators to support children aged 0–18 years) and the National Workforce Centre for Child Mental Health (NWC – for Practitioners to support families and children aged 0–12 years. Beyond Blue and Emerging Minds were successful in becoming the providers for these respective national initiatives.

The two initiatives of the Program were among a range of initial activities of the Commonwealth Government's response to the Contributing Lives Review, with the aim of contributing to the broader goal of strengthening children and young people's mental health and wellbeing.

In broad terms, the initiatives seek to facilitate practice change and capability development in Educators (National Education Initiative, now known as Be You) and health, social and community professionals (NWC) so that these key actors in the community would take a more active role in supporting the mental health and resilience of children and young people and a more effective approach to identifying and responding to mental health risks and issues, and would effectively respond to suicide, including postvention when needed.

Be You is led by Beyond Blue, with delivery partners Early Childhood Australia and headspace National Youth Mental Health Foundation (headspace). Be You was designed to integrate and build on five existing federally

funded initiatives (Response Ability, KidsMatter Early Childhood, KidsMatter Primary, MindMatters and headspace School Support) into a single national "end-to-end" education-based program. In brief, Be You is a pre-service and in-service education model focused on the education and training of Educators (including pre-service Educators) for child and youth mental health promotion, prevention and early intervention in early childhood services and schools. Be You also designs and delivers suicide postvention services. Be You is primarily an online platform that is supported by over 70 Be You consultants from Early Childhood Australia and headspace. Be You provides continuous professional development, resources, evidence-based programs, and referral pathways to give Educators the skills and strategies needed to encourage positive mental health, and to identify and address mental health early in children and young people from birth to 18 years.

The National Workforce Centre for Child Mental Health is led by Emerging Minds with a range of delivery partners. The Emerging Minds initiative designs, promotes and delivers training and information for health, social or community professionals who work with children and their families to promote mentally healthy behaviour and relationships in children. The aim of the initiative is to support these professionals to engage in best practice to identify, assess and support infants and children 0–12 years at high risk for mental health issues.

The activities of both initiatives are expected to be designed, delivered, and continuously improved in line with available evidence.

The Overarching Evaluation background

The Commonwealth Department of Health (the Department) sought an Overarching Evaluation of the Program, together with a costed plan for a future longitudinal research study on national promotion, prevention, early intervention and postvention mental health programs for children and young people. The Institute for Social Science Research (ISSR) at The University of Queensland (UQ), in collaboration with experts from the Telethon Kids Institute (the Subcontractor), was engaged by the Department to conduct the Overarching Evaluation of the Program, including developing an Evaluation Framework.

The Evaluation was termed an "Overarching Evaluation" because each of the initiatives had ongoing evaluation activities underway at that time, and have since engaged in further evaluations. The relevant reporting period considered for analysis in the Overarching Evaluation began from the date that the initiatives were funded (April 2017). It was originally agreed that the Overarching Evaluation would consider data up until 31 July 2020. However, delays in receiving the final datasets from Beyond Blue and Emerging Minds meant that the Overarching Evaluation considered data on Program implementation up to 30 September 2020 for Beyond Blue (Be You) and 25 August 2020 for Emerging Minds.

Purpose of the Overarching Evaluation

Although Be You and Emerging Minds have commissioned their own individual evaluations, the Overarching Evaluation was sought to provide a comprehensive assessment of how the two initiatives contribute to achieving the desired outcomes of the Program.

The purpose of the Overarching Evaluation was to analyse the extent to which both the workforce and education initiatives contribute to achieving the aim and objectives of the Program. The Overarching Evaluation aimed to:

- assess the appropriateness of the Program
- assess the effectiveness of the Program
- assess the cost-effectiveness of the Program
- identify opportunities to strengthen or improve the Program in order to meet its intended objectives.

The scope of the Overarching Evaluation was agreed with the Department, and the in-scope aspects specified in the Evaluation Project Plan are:

- analysis of the appropriateness, effectiveness, and cost-effectiveness of the Program
- analysis and consolidation of findings from the individual evaluations (the Overarching Evaluation should build on, but not duplicate, the results of the individual evaluations)
- analysis of findings from publicly available evaluations of the programs being integrated into the education initiative

- consideration of any other relevant programs or services on the early intervention continuum as they relate to the Program (e.g. referral pathways, shared care approaches)

Out of scope aspects of the Overarching Evaluation are:

- analysis of other initiatives delivered by Beyond Blue and Emerging Minds and their partner organisations outside of the Program
- analysis of the effectiveness or appropriateness of other programs and services on the child and youth mental health supports continuum (except in terms of their intersections with the Program)

Structure of this report

This report outlines the evaluation design and methodology, data analysis conducted, conclusions drawn and recommendations for the Program resulting from the Overarching Evaluation of the Program. The report is structured into eight chapters to provide an overview of the evaluation approach and the external context of the period that the Program was implemented and delivered (Chapter 1); a description of the evaluation methodology and an overview of the objectives of the core and supplementary evaluation activities (Chapter 2); and a synthesis of the findings against the key Evaluation Questions (Chapter 3). Chapters 4–7 present the detailed methodology, findings, conclusions, and limitations of the four key evaluation activities: The National Support Network Survey, Integrated Data Analysis, Value for Money assessment, and Community Case Studies. Finally, the overall conclusions and recommendations are outlined in Chapter 8.

A number of key supplementary items are provided as appendices for reference, including:

- a snapshot of the Overarching Program Logic and Theory of Change for the Program
- a simplified version of the Indicator Matrix used to guide analysis of evaluation data
- detailed findings from the Key Program Informant Interviews
- supplementary analyses for the National Support Network Survey
- supplementary analyses for the Integrated Data Analysis
- supplementary content for the Value for Money assessment

This report follows on from and draws upon the following documents provided to the Department over the course of this Overarching Evaluation (described briefly in Table 2).

Table 2 Documents provided to Department of Health during the Overarching Evaluation

Document name	Purpose	Date accepted by DOH
Project Plan and Risk Management Plan	To provide detailed project planning and clear scoping of the project deliverables. This document specified the tasks and inputs of activities, including dependencies between tasks and timelines for completion of each element, a governance framework, budget and resourcing framework, and a risk management plan.	10 September 2018
Evaluation Framework	To present the Overarching Program Logic and Theory of Change, and outline the approach to evaluating the Program, including a description of evaluation methodology, indicators and procedures for data collection. This document also included an extensive data audit identifying all published and grey data sources describing surveys of child and youth mental health in Australia.	28 May 2019
Interim Report 1	To update the Department on key progress, including research methodology and data collection methods.	25 July 2019
Interim Report 2	To update the Department on key progress, including data collection activities and emerging findings.	20 August 2020

Document name	Purpose	Date accepted by DOH
Progress Reports 1–4	To update the Department on progress and key findings to date and challenges of the Overarching Evaluation.	4 March 2019 (1), 26 November 2019 (2), 20 March 2020 (3), 26 November 2020 (4)
Workplans		
National Support Network Survey Work Plan	To provide a background on the purpose of the survey, detail the methodology, including recruitment approach, and outline an Ethics strategy.	25 July 2019
Community Case Studies Work Plan	To provide a background on the purpose of the Community Case Studies, define the case study sites, detail the methodology, including recruitment approach, and outline an ethics strategy.	25 July 2019, revision accepted September 2019
Integrated Data Analysis Work Plan	To provide background to the analysis approach, detail the methodology of the Integrated Data Analysis, define the data needs for the activity, and outline an ethics strategy.	23 January 2020
Value for Money Work Plan	To review the literature on health economic evaluations, define the data needs for the activity, detail the proposed methodology, and outline an ethics strategy.	July 2019, revision accepted 2 March 2020
Program Considerations Brief	To provide preliminary reflections on the challenges and opportunities for the initiatives. The considerations were provided to the Department of Health to assist in improving the targeting and management of the Program.	1 April 2021

1. Overarching Evaluation approach and context

This chapter of the report outlines our approach to the evaluation, including a description of the underlying principles, and development of the Program Logic and Indicator Matrix used to inform the evaluation. This chapter concludes with a discussion of the external context of the environment that the Program and the Overarching Evaluation were conducted in.

1.1 Evaluation approach

The Overarching Evaluation used a Logical Framework approach; this was informed by a Program Logic and Theory of Change, which depict the ways that the Beyond Blue National Education Initiative (Be You) and the National Workforce Centre for Child Mental Health (NWC – Emerging Minds) initiative are intended to work in the larger scale to achieve the aims of the National Support for Child and Youth Mental Health Program (the Program). The Overarching Evaluation Program Logic was developed by The University of Queensland Evaluation Team, in collaboration with the Australian Government Department of Health and its Evaluation Centre of Excellence, and with inputs from Beyond Blue and Emerging Minds. This Program Logic and the development process are presented in Appendix A. Using the Program Logic, the Department of Health and the Evaluation Team (with input from the Scientific Advisory Group) agreed on the Overarching Evaluation Questions and developed an Indicator Framework to monitor the performance of the Program against specified criteria.

1.2 Overarching Evaluation Framework and questions

The Evaluation Framework was also co-developed with representatives from the Commonwealth Department of Health, which endorsed the final Evaluation Framework on 28 May 2019. In addition to seeking input from Beyond Blue and Emerging Minds, the Overarching Evaluation Team established an expert advisory panel,

known as the Scientific Advisory Group, comprising senior researchers with high-level expertise in child and youth mental health, economic analysis, longitudinal research, and evaluation. This group was convened periodically across the evaluation period to provide advice on the design and conduct of the evaluation and to review and advise on interpretation of findings (see Figure 1.1 below for more detail).

MEMBERS OF THE SCIENTIFIC ADVISORY GROUP
Professor Rosa Alati, Curtin University (social determinants of maternal and child health)
Professor Justin Kenardy, UQ Faculty of Health and Behavioural Sciences (suicide and trauma)
Associate Professor Richard Brown, UQ School of Economics (economic analysis)
Professor Mark Western, UQ ISSR (evaluation science and longitudinal design)
Professor Steve Zubrick, Telethon Kids Institute (child and youth mental health)

Notes. ISSR = Institute for Social Science Research. UQ = The University of Queensland

Figure 1.1 Members of the Scientific Advisory Group

The Overarching Evaluation Questions were based on those included in the Request for Quotation (23 April 2018) and Official Order but were further refined through a consultative process that included input from all the key stakeholders named above. From this process, the key Overarching Evaluation Questions emerged:

1. How well has the Program been implemented?
2. How appropriate is the Program design to deliver the intended outcomes?
3. How effective is the Program in achieving its intended outcomes?
4. How cost-effective is the Program?
5. Were there any unintended outcomes or consequences associated with the Program?

The relationship between the Overarching Evaluation Program Logic and the Evaluation Questions is depicted in the Indicator Matrix, presented in Appendix B.

As shown in the Program Logic (see Appendix A), intermediate and long-term outcomes/impacts were not assessed in this Overarching Evaluation due to the evaluation period covering only the early implementation phase of the Program. In discussion with key stakeholders from Be You and Emerging Minds, the timeframe in which intermediate level outcomes and long-term outcomes/impacts were expected to be achieved was 3–5+ years. This timeframe is consistent with commentary from the Productivity Commission's report (2020), which emphasised that some of the benefits expected from reforms that improve the social and emotional wellbeing of families with young children or young Australians (e.g. quality of life and income opportunities) may not be evident for many years into the future. However, we demonstrate progress towards early outcomes on some indicators in this evaluation by examining trends in our integrated data analysis activity.

1.3 Principles underpinning the evaluation design

The approach taken to the design of the Evaluation Framework was informed by the following key principles:

- Collaborative approach: The Evaluation Team worked closely with The Department, Beyond Blue and Emerging Minds in a collaborative, participative, and supportive fashion to encourage commitment and build capacity for translation of results.
- Overarching perspective: The Evaluation Framework leveraged value from the individual evaluations of the component initiatives to avoid duplication of effort. However, this evaluation has an overarching perspective that focused on processes related to the operation of the initiatives, which inform the high-level indicators of the Program. The Overarching Evaluation was not designed to compare the two initiatives, rather to assess how the activities of the component initiatives and the changes they achieved contributed to the high-level indicators of change that the Program was designed to achieve.
- Leveraging existing data: The Evaluation Framework recognised the potential benefits of leveraging existing data appropriate for analyses relevant to some of the evaluation indicators.

- High-quality data: To make appropriate conclusions about the Program's effectiveness, only high-quality data (assessed using contemporary data quality rating approaches, including the ABS Data Quality Framework (2009) were considered appropriate or sufficient for evaluating change and making recommendations.
- Where there was a lack of high-quality data (or data were unavailable), indicators were estimated or augmented by data (quantitative and qualitative) from other activities.

1.4 Evaluation context

This Overarching Evaluation has taken place at a time where substantial contextual change has had an impact on the mental health of Australians. These externalities include the 2019–2020 bushfires and the COVID-19 pandemic. Figure 1.2 presents a timeline showing the phases of the Program and its component initiatives, including timeframes for the setup, launch and reporting periods. These timelines are overlaid with the time periods during which the community was impacted by the intense 2019–2020 bushfire event and by the (ongoing) COVID-19 pandemic. Finally, the timelines associated with the UQ Overarching Evaluation activities are depicted relative to the timeline of the Program to demonstrate the data reporting periods covered by the Overarching Evaluation.

1.4.1 Bushfires

Although bushfires are a common natural disaster in Australia, the 2019–2020 fire season was particularly long and devastating. Bushfires can be frightening for many people, including children and young people not in direct danger, and create direct disruption to communities. Our informal observation of the social media accounts of Beyond Blue (Be You) and Emerging Minds during this time indicated that both initiatives targeted some specific content to this issue. The Department provided additional funding of $8 million to Beyond Blue, and its Be You partners, Early Childhood Australia and headspace National, to work with affected schools and early learning services and provide additional information and training for Educators, parents and carers. The Department provided further description of the activities undertaken (and future activities commissioned) by Beyond Blue in communication dated 3 March 2020.

Briefing notes obtained from Be You noted that The Bushfire Response Program was established to deliver targeted mental health support to early learning services and schools affected by bushfires across Australia. This support included the deployment of Contact Liaison Officers, who tailored support to the needs of individual learning communities and supported the development of a recovery plan; trauma support and guidance in the form of events (using Emerging Minds Community Trauma Toolkit as a basis for training); and community support service mapping in the local area. The Bushfire Response Program project team at Be You is undertaking ongoing monitoring and review activities for this work.

Although Emerging Minds received no additional funding, it was observed by the Evaluation Team that the initiative shifted its focus during this period to respond to additional demands on its support and resources related to the bushfires, and worked with Be You to support its work in this area. Although an evaluation of this work is out of the scope of the Overarching Evaluation, some data relevant to this work was captured in the Key Program Informant Interviews when examining the effectiveness of the initiatives in delivering the Program in different (and unexpected) contexts.

Impact on data collection and findings

The timing of the 2019–2020 bushfires coincided with the data collection period of the National Support Network Survey. Although it is difficult to quantify the effect of the bushfires on recruitment efforts, it is highly likely that this event impacted the capacity of schools, clinics, teachers, and Practitioners in affected areas to distribute and complete the questionnaire. This may have had a particular impact on recruitment of participants via Education Queensland facilities due to the research approval for this jurisdiction only being granted in early 2020. Finally, when interpreting the data, the Evaluation Team considers the bushfires as a confounding historical event when reporting survey and case study data. This means it is likely that the bushfire events may have impacted on participants' responses to the survey and interview questions in ways that were not anticipated by the design of these activities. Participants' responses reflect a single point in time that were very likely impacted by changing national and international conversations and awareness of children's and young people's mental health and

wellbeing, and heightened impacts of family and community-level trauma from these bushfires, which may have impacted findings.

1.4.2 COVID-19

The COVID-19 pandemic poses significant mental health and wellbeing challenges for children, young people and those who work with these groups, as well as practical challenges in the provision of support to these groups. These challenges were compounded by the ongoing impacts of the (then) recent bushfires and longer-term impacts of the extended drought. The health and economic impacts of COVID-19, as well as disruption to the daily life and routines of families due to public health control measures, increased risk factors and decreased protective factors (e.g. availability of usual social supports) for short- and long-term impacts on mental health and wellbeing for children, young people, families and the community. As such, the National Mental Health and Wellbeing Pandemic Response Plan (National Plan; Australian Government 2020) called for early intervention to mitigate downstream mental health impacts due to the COVID-19 pandemic. The National Plan recognised that children and young people face unique impacts from COVID-19, including disengagement from education; disconnection from school-provided social assistance and support; disconnection from clinical services to address existing or emerging mental health issues; delays in social development; disruption to schooling during critical transition points; and an increased risk of abuse and neglect.

The Overarching Evaluation was not able to directly consider the extent to which the initiatives were agile in responding to the needs of the community within the context of the COVID-19 pandemic, with the exception of some data gathered during the Key Program Informant Interviews, which was collected to provide context for the following Overarching Evaluation subquestions:

- Question 1b) To what extent has implementations varied across different contexts?
- Question 2a) To what extent does the design of the Program address the needs in the community?

Impact of COVID-19 on data collection and findings

COVID-19 resulted in several challenges for the Overarching Evaluation, including the limited uptake of participation in research activities, delays in timely access to secondary data, and the requirements for variation to data collection methods. These impacts were documented in the second Interim Report.

Understanding whether the mode of Program delivery facilitated uptake during the COVID-19 restriction period is beyond the scope of the Overarching Evaluation.

1.4.3 Pilbara suicide cluster

In response to suicide events in Western Australia, the Federal Government committed funding for suicide prevention programs to target Indigenous youth. Beyond Blue was awarded a grant of $2.32 million to fund a mental health education program in the Western Australian Kimberley and Pilbara regions from March 2019 to February 2021.

The Pilbara–Kimberley project was designed as an extension of Be You to be a place-based mental health education program. The program was developed in partnership with Aboriginal and Torres Strait Islander communities to incorporate concepts of cultural wellbeing and mental health for Aboriginal communities in the Kimberley and Pilbara. This extension of the Be You project was out of scope for the Overarching Evaluation. A separate evaluation has been undertaken by the Menzies School of Health Research.

1.5 Policy context

The Program sits within a broad and complex policy environment. The responsibility for mental health policy and the provision of programs and support for the mental health and wellbeing of Australians is shared between the federal and state and territory levels of government. The Australian Government has responsibilities for funding primary care and out of hospital specialised care through the Medicare Benefits Schedule, and also funds a range of services for people living with mental health difficulties. The State and Territory governments are responsible for the funding and provision of state and territory public specialised mental health services and associated psychosocial support services.

Intergovernmental efforts to improve the mental health and wellbeing outcomes of Australians have a long history. The Australian Government and State and Territory Governments, via the National Mental Health

Strategy, have worked to develop mental health programs and services, and to better coordinate services to address the mental health concerns of Australians. These efforts to improve mental health and wellbeing outcomes have been subject to a range of past reviews, including the 2014 National Review of Mental Health Programmes and Services conducted by the National Mental Health Commission (NMHC 2014a) and more recently the Productivity Commission's Mental Health inquiry (2020).

In addition to ongoing strategies, of which the Program is part, all levels of governments have been responding specifically to the mental health impacts of the 2019-20 bushfires and COVID-19 pandemic with various funding support to support the mental health and wellbeing of Australians affected by these events.

The Australian Institute of Health and Welfare (AIHW, 2021) documents the recent national developments in mental health policies and strategies. Specifically, in the recent 2021-22 Federal Budget, the Australian Government announced a $2.3 billion investment in the National Mental Health and Suicide Prevention Plan, responding to recommendations from the Productivity Commission's Inquiry Report on Mental Health and advice from the National Suicide Prevention Advisor. Also within the 2021-22 Budget are a number of initiatives announced that intend to support the mental health and wellbeing of children and young people, and may complement the work of the National Support for Child and Youth Mental Health Program to deliver positive mental health outcomes for children and young people. An additional $117 million investment in this budget will fund establishment of a comprehensive evidence base to support real time monitoring and data collection for mental health and suicide prevention systems, with the intent to enable services to be delivered to those who need them, and to improve mental health outcomes for Australians.

These investments and reforms in mental health across all jurisdictions interact with the efforts of the Program and are likely to affect the way in which the Program is implemented or the way in which its outcomes develop. They may address some of the additional needs identified by stakeholders during the Evaluation. They are however outside the sphere of influence of the Program itself, and beyond the scope of this Evaluation. The existence of broader policy context is recognised as an external factor in the Program Logic (See Appendix A).

1.6 Note on data reporting periods

Secondary data were obtained from the individual evaluations and integrated data analysis activities where relevant to the period beginning with the initiative launch dates and ending on 31 July 2020. When the Overarching Evaluation compared the periods of 'before the Program' and 'after the Program', the April 2017 funding disbursement date was used to indicate the initiation of the Program. The primary data for the Overarching Evaluation were mostly gathered before the pandemic restrictions were enacted in Australia, with some data collected during the height of COVID-19 restrictions. As a result of this, data from the post-peak COVID-19 lockdown era are limited. As such, no direct observations could be made about the impact of COVID-19 on the appropriateness or effectiveness of the Program in addressing the needs of the community.

1.7 Timelines

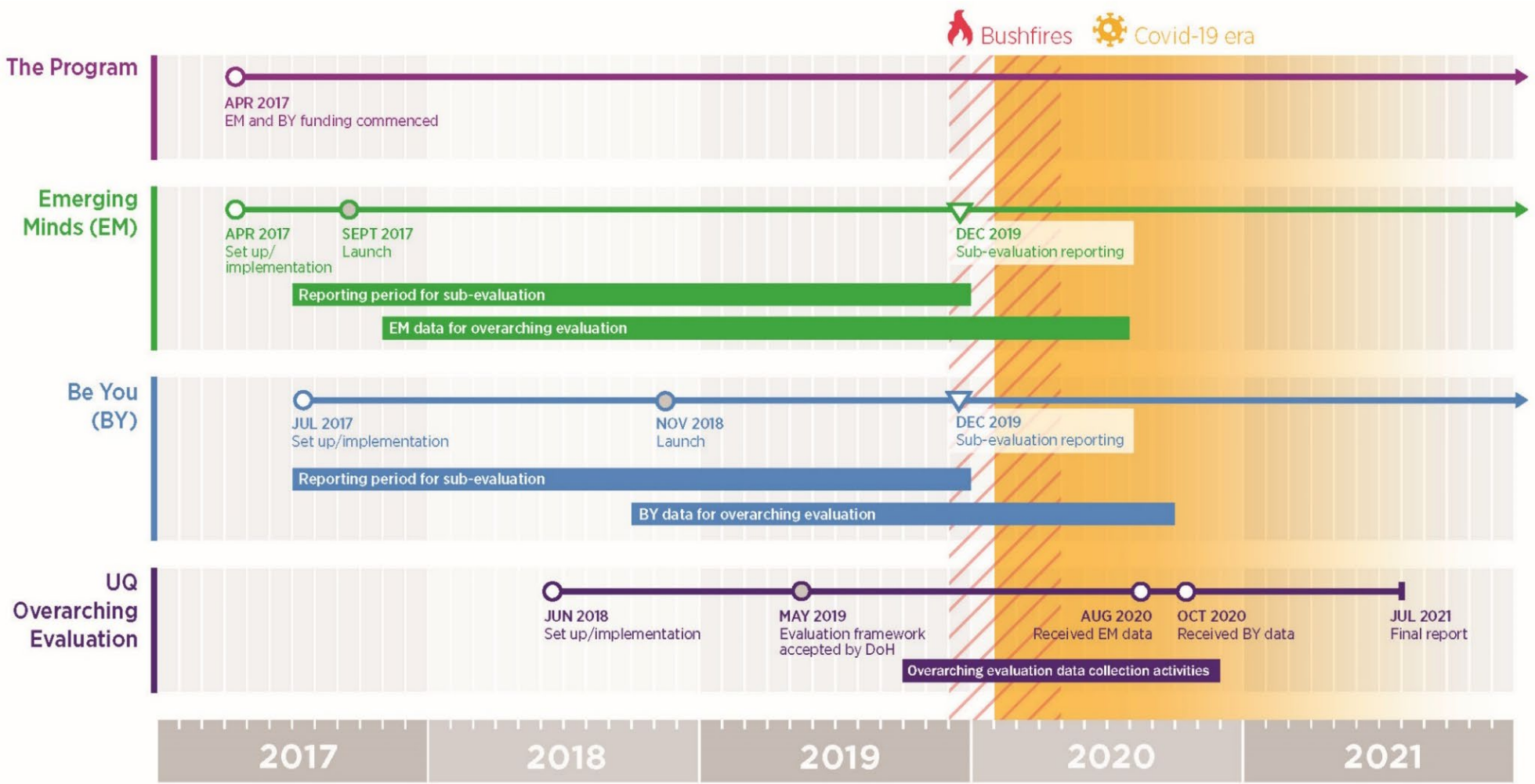


Figure 1.2 Timeline of the Overarching Evaluation

2. Evaluation methodology

This chapter of the final report provides a summary of the data sources and methods of the Overarching Evaluation. This chapter also provides information about ethics approval processes and evaluation limitations.

2.1 Evaluation challenges

- The Program sits within a complex environment of government policies and frameworks, making it difficult to attribute changes in outcomes to the Program specifically without an appropriate counterfactual alternative to the Program for comparison.
- The widespread implementation of the Program across Australia, and lack of well-defined exposures to the Program, meant that it was not possible to establish a robust counterfactual.
- The Program Logic articulates change occurring at the individual user level (i.e. Educators and Practitioners) as well as for children, young people, their families and the community. Change beyond the individual user level takes time, with the Program Logic anticipating intermediate and long-term impacts occurring after the evaluation period.

2.2 Evaluation activities

A multi-method research design was developed to address the key Evaluation Questions. A range of activities was used to capture the depth and breadth of Program activity, including:

- National Support Network Survey
- Integrated Data Analysis
- Value for Money assessment
- Community Case Studies
- Systematic Analysis of Initiative Documentation
- Key Program Informant Interviews.

2.3 Core Evaluation activities

2.3.1 National Support Network Survey

The National Support Network Survey was designed to gain insights into the state of mental health capabilities, confidence and experiences of Educators and Practitioners who work with children, young people and their families.

The surveys identified recognition and exposure to Program activities, and ascertained the effects of the Program on a range of dimensions aligned with the Overarching Evaluation Indicator Matrix, including:

- beliefs and attitudes toward the mental health of children and young people
- awareness of, and access to, evidence about child and youth mental health
- awareness and knowledge of processes to refer children, young people or their families to early intervention services or external supports available to support child and youth mental health
- confidence to recognise and respond to mental health risks in ways that are consistent with contemporary evidence
- knowledge of suicide postvention supports and depth of understanding about responding to suicide trauma.

The design of the survey incorporated a between-groups methodology. This methodology was used to enable:

- a comparison between Educators who had been exposed to the Be You initiative and those who had not been exposed to the Be You initiative
- a comparison between Practitioners who had been exposed to the Emerging Minds initiative and those who had not been exposed to the Emerging Minds initiative.

For some questions, retrospective or ‘12 months ago’ data were collected to inform estimates of change (pre-intervention to post-intervention) attributed to the Program by the participants. For these questions, a difference-in-difference (DID) technique was used. The DID approach calculates the effect of an intervention (i.e. the Program initiatives, either Be You or Emerging Minds) on selected outcomes. The analysis compares the average change-over-time in the outcome variable for the exposed group to the average change-over-time for the control/comparison group.

The survey also elicited direct insights from Users (i.e. those exposed to the Be You and Emerging Minds initiatives) on their perceptions of the appropriateness and effectiveness of the Program. Qualitative reports were collected from participants to understand their views about enablers and barriers related to supporting child and youth mental health, as well as the enablers and barriers of the initiatives' implementation. These data were coded, and themes were reported based on the frequency with which they were reported by participants.

2.3.2 Integrated Data Analysis

The objective of the Integrated Data Analysis was to use, where appropriate and feasible, existing data sources relevant to the mental health and wellbeing of Australian children and young people to develop indicators for measuring and monitoring national mental health outcomes relevant to the implementation of the Program.

Specific objectives were:

- to assess the appropriateness of the Program by estimating the match between Program implementation areas and geographic and demographic identifiers of need for mental health supports
- to assess the baseline and future trend of the planned mental health related indicators (outputs and outcomes) in the Evaluation Framework, as well as the effectiveness of the Program against those indicators where possible, from existing data sources.

Two different types of data source were used in this integrated analysis of the Program: existing data from contemporary longitudinal studies and from repeated cross-sectional surveys in Australia that have collected child and youth mental health related data; and data from the organisations implementing the Program (Beyond Blue (Be You) and Emerging Minds) related to the geographical reach of activities funded under the Program for the period from funding disbursement until 31 July 2020. Data from the implementing organisations were used to identify the geographic and demographic coverage and intensity of the Program activities. The existing data sources were used to understand the level, baseline trend and geographic extent of the mental health outcomes of Australian children and young people based on the planned evaluation indicators.

2.3.3 Value for Money assessment

The objective of the Value for Money assessment was to help decision-makers assess whether the costs of the initiatives are reasonable and justified in comparison to the expected benefits of the Program. This type of analysis assesses the Program's efficiency and effectiveness at producing economically beneficial outcomes and is based on initial investment and ongoing costs. In order to conduct an efficient Value for Money assessment, we identified indicators in two categories: the direct and indirect costs of the Program; and the benefits achieved from the implementation of the Program. These two indicators formed the foundations of the Value for Money assessment. A key challenge in conducting the Value for Money assessment was the lack of a robust counterfactual or control group against which we could compare the costs and benefits of the Be You and Emerging Minds initiatives of the Program. In the absence of a well-defined control group, the costs were instead compared to 'next best' alternatives. This method compared the costs of the Be You and Emerging Minds initiatives to their respective alternatives using the costs that would have been incurred in the absence of these initiatives.

2.3.4 Community Case Studies

The purpose of the Community Case Studies was to explore the reach and influence of the Program in local contexts among community Practitioners and Educators, and parents/carers. The objective was to elicit community views about the implementation, influence and potential benefits of the Program in context rather than asking directive questions about the experiences, uptake and impact of the specific initiatives, which is addressed in other evaluation activities (e.g. the National Support Network Survey). The Community Case Studies enabled a 'deep dive' into the experiences of children's and young people's support networks in local communities of interest, thereby identifying and illustrating practical enablers and barriers to Program effectiveness. Particular attention was paid to relational issues such as service integration, contextual risks and community capacity to respond effectively. The Case Studies provided rich narratives about the impact of the Program on local community dynamics in supporting service delivery, elicited a deeper understanding about the Program's impacts on family dynamics, and considered the impact of Program delivery and activities in different community contexts.

The Case Studies were conducted in four communities, two in Queensland and two in Western Australia. In each state, one urban/suburban site and one rural/remote site was selected. We identified respondents and conducted focus group interviews that aimed to generate visual representations of community assets, mental health concerns, and directions for improvement and change. We used a combination of semi-structured dialogue and visual artefacts to encourage respondents to systematically identify the local climate for mental health, community connections and specific challenges. We overlaid this knowledge with consideration of how Program activities in the community had contributed to identified strengths and barriers. The data collected were both visual artefacts and recorded conversations from focus groups. Visual artefacts were analysed for emerging themes, and for consistency or differences between settings and participants. Transcriptions were analysed in two distinct ways: via inductive analysis and via deductive analysis.

2.4 Supplementary activities

2.4.1 Document Review

This evaluation included a desktop analysis of relevant documents from the Program initiatives at two time points: first, to inform the development of the Overarching Evaluation Framework, and second, to extract relevant secondary qualitative and quantitative data against the predefined evaluation indicators to supplement the Overarching Evaluation's primary data collection activities.

Documents relating to discussions that arose in the monthly initiative stakeholder meetings were provided to the UQ Evaluation Team by the Department of Health or sourced directly from Beyond Blue and Emerging Minds.

We first undertook a focused review of the individual evaluation specifications for the Program initiatives (e.g. evaluation frameworks and interim reports) to inform the Overarching Evaluation Framework and Indicator Matrix. From this work, potential secondary qualitative and quantitative data from the individual evaluations were identified as potentially relevant to the Overarching Evaluation indicators, to avoid duplication of evaluative activities.

Subsequently, a structured desktop analysis of relevant documentation was conducted. The individual evaluations were the primary documents that provided context for the Overarching Evaluation. We reviewed the qualitative and quantitative data for the individual evaluations that were delivered by the Parenting Research Centre, the Australian Institute of Family Studies and Deloitte Access Economics. Supporting documents were also examined where relevant. The types of documents included in these analyses included evaluation frameworks, evaluation reports, progress reports, final reports, financial reports and other documents (e.g. presentation slides). These documents provided data relevant to a number of Overarching Evaluation indicators and provided other indices of impact, delivery costs, information around service network reach and future capacities.

The document analysis involved importing documents into qualitative data analysis software (NVivo), scanning relevant documentation and data from the individual evaluations and organisation documentation, and coding relevant information to selected evaluation indicators. This work provided contextual analysis of qualitative and secondary data from the individual evaluations to produce insights into how the Program activities have addressed key objectives. The relevant data from the individual initiative evaluations were then extracted and synthesised according to each indicator. The detailed findings of this work are available on request. It is important to note that the conclusions drawn from these findings are subject to the completeness, accuracy and availability of the source documentation.

2.4.2 Key Program Informants Interviews

To address gaps in data sources, two semi-structured interviews were conducted with selected representatives from Beyond Blue National Education Initiative (Be You) and Emerging Minds NWC – Mr Tim Moran, Head of Education at Beyond Blue, and Mr Brad Morgan, Director of the NWC. The interviews were designed to address questions of Program implementation and appropriateness of Program design. The broad questions were provided to the interviewees in advance so that they could seek key input from other team members as needed before the interview (see Appendix C). The interviews were conducted by UQ evaluation specialist, Dr Caroline Salom, in November 2020. Data from these two qualitative interviews were recorded with permission and transcribed. The interviews were analysed manually for emerging themes and responses to key issues. These interviews provided relevant context and perspective to facilitate the synthesis of other evaluation activity

findings. A summary of the key points extracted from the interview transcripts against the relevant indicators (including quotes where relevant) is provided in Appendix C.

2.5 Data sources for the evaluation

The evaluation draws on quantitative and qualitative data from a range of primary and secondary sources. Some of these data were drawn from the individual initiatives that collected usage information and primary data from their own individual evaluations. Other data were collected specifically for this Overarching Evaluation. Table 2.1 provides a summary of these data sources to describe whether the data were primary or secondary, and the timeframe covered.

Table 2.1 Summary of evaluation data sources

Name	Description	Dates covered
Surveys of Educators who were either users or non-users of the Be You initiative	Primary data collected for the Overarching Evaluation	Survey open between 20 September 2019 and 21 May 2020
Surveys of Practitioners who were either users or non-users of the Emerging Minds initiative	Primary data collected for the Overarching Evaluation	As above
Community Case Studies: focus groups and interviews	Primary data collected for the Overarching Evaluation	QLD sites: Mt Isa: 28–30 October 2019 South Brisbane/Logan: 27 April – 15 May 2020 WA sites: Cockburn: 6 & 19 December 2019; 6–7 February 2020 Albany: 30–31 January 2020
National and regional existing data sources	Secondary data used in the Integrated Data analysis	Refer to Table 5.2 in the Integrated Data Analysis chapter
Be You data for Overarching Evaluation	Administrative data collected by Beyond Blue from Be You users and used in the integrated data analysis and Value For Money activity	Data collected October 2018 to September 2020
Emerging Minds data for Overarching Evaluation	Administrative data collected by Emerging Minds from Emerging Minds users and used in the integrated data analysis and Value For Money activity	Data collected November 2017 to August 2020
Initiative Documentation	Secondary qualitative data	Various documents/reports received during the period 2019 and 2020
Interviews with key Program informants	Primary data collected for the Overarching Evaluation	Interviews conducted between 22 March 2020 and 9 April 2020

2.6 Evaluation ethics

Ethics approval was obtained from The University of Queensland's Human Research Ethics Committee (approval numbers: #2019001536 [National Support Network Survey], #2019001538 [Community Case Studies], #2020000170 [Integrated Data Analysis]). Additional research approvals and permissions were obtained from relevant State Education Departments, non-Government schools and early learning services, and the Catholic Diocese. These approvals are described in Appendix D.

2.7 Evaluation synthesis and analysis

After the data collection period for the evaluation activities, a series of workshops was held to synthesise findings, reach a consensus on evaluation indicators and generate recommendations. These workshops were held over two weeks in March 2021, with the Evaluation Team meeting to triangulate and synthesise the data from each activity. Following this work, the Evaluation Team generated draft recommendations for consideration.

2.8 Limitations of the evaluation

To address methodological limitations of individual evaluation activities, the Overarching Evaluation design collected a range of data (qualitative and quantitative), including primary data collections, to ensure triangulation of results and adequate coverage of the information needed to address the Evaluation Questions.

Attribution: Existing data sources utilised in the evaluation have limitations that impact on attribution of any observed effects to the Program. We encountered data gaps and inadequate and inappropriate data, which impacted our ability to assess some indicators. Other limitations included: many of the identified data sources could not be analysed at the school or individual level to facilitate comparisons between Program users and non-users; data were often collected at the state level, rather than nationally, with some states (e.g. NSW and Victoria) over-represented; some data sources were subject to selection bias due to convenience sampling; there were indicators that were better suited to longer term measurement and may not be sufficiently sensitive to detect change over shorter time periods; data sources rarely provided adequate age-range coverage (e.g. prominent cohort studies such as the Longitudinal Study of Australian Children (LSAC) are currently collecting data on older teens); the interval between data collection varies, as such, data sources with lengthy data collection intervals were better suited to identify long-term trends; and the timing constraints of the Overarching Evaluation may have impacted data availability and access. These limitations were assessed for each data source using the data quality framework (see Evaluation Framework document).

Generalisability: Only some data sources included a participant sample that was representative, or designed to be representative, of the broader population (e.g. LSAC). The National Support Network Survey and Community Case Studies were not designed to elicit a representative sample, in acknowledgement of feasibility, but to provide informed snapshots for the evaluation. In the National Support Network Survey, the Overarching Evaluation has sampled from both users and non-users of the Program, which addressed in part the selection bias in the individual evaluations' data collection that used the initiative platforms to distribute surveys to users only. The Overarching Evaluation's approach of sampling broadly from potential Program users has the benefit of being able to interrogate Program effects on Educators or Practitioners across a spectrum of exposure to the Program.

Design: Although randomised control trials (RCTs) are considered gold standard in terms of evidence and determining causality, due to the timing of the Overarching Evaluation and implementation approach, and ethical and other concerns associated with withholding of supports, this design could not be adopted. The National Support Network Survey and Community Case Studies provide single point in time estimates of Program effects. As such, the Overarching Evaluation cannot describe trends over varying stages of the Program's implementation. However, the National Support Network Survey used a retrospective pre-post design to estimate change over time that could be attributed to the Program. The bespoke nature of the survey allowed the Overarching Evaluation to directly assess questions of attribution.

3. Synthesis of Overarching Evaluation findings

The purpose of this Chapter is to summarise the broad findings of the Overarching Evaluation as they relate to each of the Key Evaluation Questions. The results on which this draws, with full methodological detail, are presented in the Activity Chapters (Chapters 4-7) or in the appendices for the supplementary activities.

In this Chapter, we provide a high-level summary for each of the Key Evaluation Questions, representing a summary assessment of the available data and the extent to which they support the indicators of that question.

These summaries and conclusions were derived following a series of collaborative workshops, which were held over two weeks in March 2021 and attended by all members of the Evaluation Team. The purpose of the workshops was to triangulate and synthesise the findings from each activity.

We report a brief synthesis of the findings against each Evaluation Question followed by a table that summarises the overall findings.

3.1 Overarching Evaluation Question 1

How well has the Program been implemented?

Successful implementation of the Program was assessed in terms of the extent to which it was implemented as expected, the way implementation varied across different contexts, whether it reached the intended participants, and its integration and alignment with existing services. The Evaluation Team also examined the extent to which the two initiatives worked effectively with reference groups and each other to meet Program objectives, and the extent to which the initiatives adopted evaluation and robust outcome measurement as key drivers of continuous quality improvement.

This section draws on data from document analyses, Community Case Studies, the National Support Network Survey, the Integrated Data Analysis, the Value for Money assessment and Key Program Informant Interviews (KPI interviews).

Subquestion a: To what extent has the Program been implemented as expected?

Issues of scope, scale and timeliness, adherence to plans, collaboration (within/between) and complementarity, continuous evaluation/evidence incorporation

The Document Review and the Integrated Data Analysis show that the Program has been largely implemented as expected with regard to scope and scale, with both initiatives reporting significant growth over time in the number of registrants and users, the volume of available content, and the initiatives' geographic reach. However, timeliness was a challenge: the ramp-up time taken to develop both content and delivery systems, and then to recruit users, was longer than expected for both initiatives. Analysis of the KPI interviews suggested that the approaches taken by each initiative had their own advantages: Emerging Minds was quick to make early content available to users, but then needed time to broaden the scope of its offerings to meet a range of requirements. Similarly, its delivery systems took time to develop and come online. In contrast, Be You significantly delayed its launch to allow for delivery structures to be in place and greater initial content development but is still developing its monitoring systems. Despite these significant delays, some planned activities were still to be addressed by 31 December 2019, including:

- incorporating Be You into tertiary institutions for pre-service education for teachers and early childhood staff
- redevelopment of pre-existing KidsMatter and MindMatters resources and development of other content
- development of the Program's Directory Database
- Quality Integrity Framework (ensuring fidelity of processes and practices).

Both initiatives significantly exceeded their original expectations for the time needed to realise full implementation (including staff recruitment), and initially diverted implementation resources (e.g. consultants) into development and recruitment (see KPI interviews). This resulted in opportunistic engagement of potential registrants by consultants, rather than strategic and in-depth guidance on how to access, adapt and implement the resources available through the two initiatives (Emerging Minds Evaluation Report 2018, Be You Final Implementation Evaluation Report 2020).

Early collaboration with reference groups was extensive (as per Document Review), with benefits including early buy-in, increased awareness raising and uptake, and the incorporation of subject matter expertise in the design and development of resources (Be You Formative Evaluation, Emerging Minds 2019 Evaluation). The ways that the initiatives worked with their reference groups developed over time: Be You streamlined some processes to improve decision making efficiency, and Emerging Minds adapted its ways of working with reference groups to improve delivery. The breadth of collaboration with reference group was appropriate to meet the jurisdictional challenges of the Program and the needs of a range of stakeholders. This level of engagement was not sustained at a systemic level across the delivery period due to recommendations arising from Be You's individual formative evaluation, and some Be You engagement groups reported feeling underutilised (Be You Final Implementation Evaluation). Emerging Minds reported ongoing consultation with subject matter experts in resource delivery, although this was often ad hoc rather than systematic (KPI interviews). Collaboration between the initiatives also lapsed somewhat after initial stages of implementation, consistent with the level of facilitation provided by the Department over that period. The 2020 Emerging Minds evaluation recommended that Emerging Minds and Be You work together on opportunities for a combined targeted strategy to build change in both Educators and referral and treatment pathways. The initiatives have shown signs in the last six months of returning to a more collaborative state to address issues of complementarity (KPI interviews).

Both initiatives have engaged with multiple phases of evaluation and appear to be incorporating learnings from the evaluations via continuous improvement cycles (as per Document Review, KPI interviews), with Emerging Minds demonstrating a strong commitment to Continuous Quality Improvement. Be You has developed a Monitoring, Evaluation, Reporting and Learning Framework (unsighted) to facilitate this. Data collection and monitoring systems for both initiatives intended to track resource use, and analyse user profiles and user needs, are still being developed. These systems are required for accurate and nuanced understanding of audiences, requirements and patterns of utilisation (Integrated Data Analysis) but are yet to achieve maturity.

Subquestion b: To what extent has implementations varied across different contexts?

Adaptation according to participant type, support to tailor resources, implementation

Subquestion c: To what extent has the Program reached the intended participants?

Geographic reach, proportion of disadvantage, coverage/provision designed to be equitable, needs-driven; participant numbers increase over time across groups

Nationally, 69% of Australian schools were registered with Be You as at 30 June 2020 (Be You monthly report June 2020). The high proportion of regional and remote participating schools (42.1%) relative to the number of students serviced by these schools (i.e. 2018 ABS data show that 29% of Australian students attend schools in regional or remote areas) demonstrates a concentration of effort in typically harder to reach areas. Data for Early Learning Services were less detailed but indicated good uptake by these services. The proportion of participating schools by sector approximated the breakdown of Government, Catholic and Independent schools in Australia (i.e. 70%, 18%, and 12%, respectively). Corresponding data for Emerging Minds (Emerging Minds Evaluation Report 2020) were less available, but registration information showed users to be based in all states and territories, with the distribution of uptake in each region approximating population sizes. The majority of engaged organisations were initially based in SA, VIC and NSW, but this broadened over time. Individual users may have been more widely distributed, with Practitioner backgrounds including psychology and occupational therapy, social work and early childhood education. Inner-regional users (e.g. areas such as Cairns, Logan and the Barossa Valley) were somewhat over-represented in the registrants.

Although both initiatives showed strong recruitment in regional and remote areas and smaller populated states, they are likely to be less accessible in some of these areas due to internet connectivity and other potential barriers to access, as identified in the Be You Final Implementation Evaluation and mentioned by some participants in the Community Case Studies.

Three-quarters of schools registered with Be You fell within the medium Index of Community Socio-Educational Advantage (ICSEA) range, with only 10% in lower and 15% in higher ranges, as at 31 July 2019 (Be You Final Implementation Evaluation Report). Forty per cent of these schools reported a medium-high proportion of students with CALD backgrounds. Data regarding the socio-demographic reach of Emerging Minds were not available to determine reach into higher risk populations.

Data from the early implementation evaluations of both initiatives suggest that the early focus of activity was on recruitment of users, with a universal approach to implementation, rather than tailoring resources to meet specific school or population requirements (as per Document Review, KPI interviews). Later activities (see Community Case Studies) noted the efforts of consultants to assist schools in choosing resources to meet their specific or local needs, but others (see National Support Network Survey) suggested a strong need for more adaptation for specific populations, like Aboriginal and Torres Strait Islanders, young people from CALD backgrounds or those with diverse gender or sexual identities. Adjunct activities such as the Pilbara and Kimberley Project and Bushfire Response Program show developing potential to address these issues. Despite this limitation, there is evidence that engaged Educators and a range of other Practitioners have implemented learnings from Be You and Emerging Minds in their practice.

Subquestion d: To what extent is the Program aligned/integrated with existing services?

Reduced duplication of offerings, specific roles for two components, links with mental health services, improvements in practice

Each initiative reported extensive review of existing resources to identify points of duplication (as per Document Review), but as noted above, are in the process of developing collaborative review pathways to reduce duplication between the initiatives. Be You registrants are predominantly Educators, but Emerging Minds registration data show that Educators (school and ELS) access Emerging Minds resources as well as those available via Be You; this suggests a need to ensure complementarity between the two initiatives.

The objectives of the Program are aligned with improving integration with existing services (e.g. by improving confidence and understanding of referral pathways), but do not address the barriers to accessing health services or gaps in service coverage. The National Support Network Survey showed that the majority of the Educators found Be You beneficial in terms of improving their understanding of policies and practices within and beyond school settings for referral to mental health services. Emerging Minds users also reported an increase in understanding and capacity to use external referral pathways. However, Educators and Practitioners noted limitations in the scope and range of services available for children and parents, particularly for complex cases and especially in rural/remote areas (see National Support Network Survey, Community Case Studies, Document Review).

Subquestion e: What are the implementation lessons?

Enablers and barriers; what does the "perfect storm" look like?

A range of enablers and barriers were observed across different components of the evaluation (see National Support Network Survey, Community Case Studies, Value for Money analyses). Some content barriers emerged: text length and density were noted as limiting, with a preference expressed for video, interactive and simplified material. Limitations in the initial Emerging Minds material in addressing specific workforce and practice contexts was also noted.

One of the greatest and most commonly cited barriers for both Emerging Minds and Be You users was time: time in schedules to address mental health as a priority need, time in the day to learn, and time to consider practice change and implement learnings. Extra learning presented a significant opportunity cost to users, although e-learning and the free online platforms did present efficiencies in delivery and attendance costs for organisations (see Value for Money analyses).

The free online platforms provide an advantage for participants (demonstrated by heightened use during COVID-19 restrictions) but can also prove restrictive where access is limited by internet infrastructure or computer access outside of the school/work environment (see National Support Network Survey, Community Case Studies).

As demonstrated by one particular setting (see Spotlight Case Study), an optimal environment for engagement, learning and implementation included high levels of awareness of the resources available, including the roles of the consultants to guide resource selection, adaptation for context and implementation. One critical factor was the presence of dedicated leadership within a facility to recognise the role of Educators and Practitioners in addressing child mental health needs, then to structure, support and champion both learning opportunities and

implementation or incorporation into organisational and individual practice. Table 3.1 below summarises the overall findings for each indicator of Overarching Evaluation Question 1.

Table 3.1 Indicator summaries for Overarching Evaluation Question 1

Subquestion	Indicator	Summary
a. To what extent has the Program been implemented as expected?	1. The extent that the Program is implemented as it was prescribed (adherence to implementation plans and protocols) by Beyond Blue and Emerging Minds and consultants	The Program has been largely implemented in line with the expectations of Beyond Blue and Emerging Minds, with caveats for delayed timeframes for the start of the Program, content development and internal capacity development. Be You experienced a more intense recruitment phase than originally expected. In the early implementation phase, Be You and Emerging Minds consultants reported misalignment between their work role and the role description due to an unexpected emphasis on recruitment activities.
	2. Extent that the initiatives collaborated with each other and with reference groups during the development and across delivery of the Program	The evidence for this indicator is mixed. There is evidence of breadth of engagement with consumer groups by the initiatives. For Be You, their highly consultative approach resulted in some inefficiency in decision making processes during the development phase, though this has since been addressed. The extent of collaboration between the initiatives has varied over time. There was a lack of evidence of ongoing, planned coordination between the initiatives, especially in delivery. However, we note evidence of renewed collaboration.
	3. The extent to which initiatives have adopted continuous evaluation (including robust, consistent outcome measurement) at the ground level and responded to generated evidence (i.e. have an implementation cycle), if prescribed	There is partial progress toward meeting this indicator for both initiatives. There is clear evidence that the initiatives are undertaking and responding to evaluations. Both initiatives have adopted a continuous improvement framework. However, the focus of evaluations has been process-oriented and weighted heavily toward reporting activity rather than outcomes. There was no evidence of agreed, robust consistent outcome indicators that could be used to monitor the overall benefits and impacts of the Program.
b. To what extent has implementation varied across different contexts?	1. The extent to which Beyond Blue and Emerging Minds delivered their initiatives to different contexts (e.g. different population groups, geography, service types)	This indicator has been met.
	2. The extent to which users (Educators and Practitioners) working in different contexts used the Program to change their practice	There is partial progress toward meeting this indicator for both Be You and Emerging Minds. There is scope to improve meaningful engagement and increase focus on practice change components of the Program.
c. To what extent has the Program reached the intended participants?	1. The proportion of disadvantaged (i.e. high risk) areas reached by the Program	The evidence for this indicator is mixed. Further progress is required to improve targeting of the Program on the basis of need.
	2. Extent to which users and stakeholders agree that the service coverage/provision is	There are opportunities to improve targeting of initiatives to better tailor information, resources, programs and servicing to Educators and Practitioners working with higher needs or diverse groups of children and young people. There were also issues of inequity found related to digital access to

Subquestion	Indicator	Summary
	designed to be equitable, needs-driven	online environments, especially in regional and remote areas. Although there is some evidence that the initiatives, particularly Emerging Minds, is making progress to address these issues with new learning pathways/content, further progress is required to address issues of equity within the Program.
	3. Extent of geographical reach of each initiative	This indicator has been met. There is an acceptable breadth of coverage in geographical terms based on the registration and engagement data provided to the Overarching Evaluation Team, although further progress is required to improve the quality of data collected to understand the geographic reach of the Program at a finer resolution.
	4. Number of users and proportion (if denominator available) by role type reflect the potential pool of people who interact with children	This indicator has been met. However, there are opportunities to broaden the original scope of users targeted by the Program to address needs identified in the community.
	5. Extent that the number of users and registrations (i.e. schools/ELS) of each initiative aligns with targets and increases over time	This indicator has been met.
d. To what extent is the Program aligned/integrated with existing services?	1. Extent of the Program's overlap (e.g. age range, location, delivery environment) with State programs targeting child and youth mental health	Insufficient data to make an assessment.
	2. The degree to which Educators and Practitioners report feeling confident in their ability to connect with, utilise and, where appropriate, refer children and young people to mental health supports compared to no Program	This indicator has been met.
	3. The degree to which Educators and Practitioners report changes to ways of working with, or referring on to, other mental health settings, compared to no Program	There is some evidence that Educators report changes to ways of working with, or referring on to, other mental health settings, compared to no Program. Practitioners report high confidence and knowledge in relation to working with, or referring on to, other mental health settings, regardless of exposure to the Program. However, there are system-level structural issues that the Program does not address, with barriers reported for availability of clear pathways for local, affordable and timely support services.
e. What are the implementation lessons?	1. Reported enablers and barriers of implementation identified by users, consultants, and Beyond Blue and Emerging Minds	A range of enablers and barriers of implementation were reported by users and Beyond Blue and Emerging Minds. The extent to which the Program is oriented to leverage enablers and address potential barriers is discussed further in the report.

3.2 Overarching Evaluation Question 2

How appropriate is the Program design to deliver the intended outcomes?

This section of the report explores the appropriateness of the Program design to deliver the intended Program outcomes. The appropriateness of the Program's design was assessed in terms of the extent to which the Program's initiatives, Be You and Emerging Minds, address the needs of the community, the extent to which the Program is evidence-based, and the extent to which the Program meets the needs of its target audience (i.e. Educators and clinical and non-clinical Practitioners and services who work with children). Each of these subquestions were informed by indicators.

A variety of data sources were used to investigate the Program's appropriateness, including qualitative data from the Community Case Studies, the National Support Network Survey and the Document Review, and qualitative data from the KPI interviews.

Subquestion a: To what extent does the design of the Program address the needs in the community?

Satisfaction that resources address child and youth mental health needs

To assess the extent that the Program was designed to deliver the intended outcomes of the Program, the National Support Network Survey asked respondents to rate the degree to which they agreed that the range of resources (e.g. modules, programs, webinars, fact sheets) met their needs to address child and youth mental health needs. The National Support Network Survey found that the majority of users agreed or strongly agreed that the online resources on the Be You (60%) and Emerging Minds (59%) platforms helped them to support children and young people's mental health needs.

There was limited evidence from the Community Case Studies to allow for assessment of whether the initiative resources helped users to support child and youth mental health due to limited overall uptake of the Program in the communities examined. However, a Spotlight Case Study of an early learning setting suggested that the Educators found the resources helpful, but not unique. Areas of unmet need identified in the Community Case Studies was a lack of specific information for users to connect with other professional services (referral points) and evidence-based information to support the mental health and wellbeing of infants and very young children.

We also considered the findings from the individual evaluations as relevant to this question. Analysis of the individual evaluation findings highlighted a range of unmet needs with the range of resources for both initiatives, with suggestions for more advanced and context-specific content. Overall, there was evidence that users perceived broad utility and appropriateness of resources for general needs, but the range of resources to address children and young people with high and complex needs was limited.

Ongoing monitoring of user perceptions of the utility of the Program's resources will be needed to ensure that the Program remains responsive to user needs to support children and young people's mental health (we note that Be You has a focus group of Educators, known as "Education Voices", who could be used for this purpose). We recommend that Be You and Emerging Minds continue to develop additional resources to support Educators and Practitioners working with children and young people who have high and complex needs. There is also an emerging need to better understand the mental health and wellbeing of infants and young children. We suggest co-development of resources by the Program's initiatives and emerging external services to support the needs of very young children.

Satisfaction with online mode of access

Results from the National Support Network Survey found that the extent to which Educators and Practitioners prefer website-delivered professional learning compared to other ways of learning varied among target users. Only 24% of Educators agreed or strongly agreed that they prefer website-delivered professional learning compared to other ways of learning. The remaining participants either had no clear preference, or preferred alternative modes of delivery (e.g. face-to-face). Roughly equal proportions of Practitioners reported a preference for website-delivered professional learning, alternative modes of learning, or no strong preference one way or the other.

Discussions with Practitioners and Educators in the Community Case Studies offered mixed evidence for the support of the online delivery of professional training programs. Although there were few discussions around the

Program's initiatives specifically due to low levels of exposure, interviewees offered views on online delivery of programs more broadly, which were split. Those who supported online delivery of professional training programs suggested that online programs are easy to attend, self-paced, flexible and without unnecessary social interactions. Those who preferred face-to-face learning modalities suggested that online training lacks interactive and skills-practice components, is hard to access without internet or appropriate technology, and may be less stimulating and engaging. Some Practitioners noted that the opportunity to build networks with other people/services was missing from online learning opportunities. Many interviewees, especially those residing in rural and remote areas, found it difficult to learn online because of their limited access to reliable internet. Others noted a lack of time or learning space after hours to engage with self-directed learning. Some others also preferred face-to-face delivery of training as they found youth mental health training better with in-person mentoring and skill practising. Information provision (theory learning) and skills practice (implementation of learning) are different processes. An online modality may be more appropriate for theory learning than implementation of learning.

Findings from the Document Review for Be You on the appropriateness of the online portal was mixed. Some Educators reported that the online platform enabled them to have free and ready access to content and materials. However, the issue around internet connection was again raised by users in regional and remote areas, highlighting that the online mode of Program access acted as a barrier to meeting some users' needs. The Document Review highlighted that participants in the Emerging Minds evaluation had mixed feelings about the platform and e-learning. Participants shared similar reflections regarding online learning throughout the evaluations. Many valued the flexibility of online learning as it made professional development accessible to those with time and resource limitations, as well as those in rural areas. However, some participants did not enjoy online learning as they did not find the format accessible due to a distaste for e-learning or the complexity of the platform. Furthermore, participants suggested complementing the modules with supervision to improve engagement and asked for some formal recognition of completion to prevent e-learning procrastination.

Data from multiple sources concurred that user satisfaction with the primarily online mode of delivery of the Program was mixed. There were indications of issues of appropriateness with the mode of Program access to meet user preferences, and where equity of access was impacted due to unreliable internet in rural and remote areas. Overall, findings from the Overarching Evaluation activities suggest that users have needs and preferences that extend beyond digital resources. Online resources alone are not the solution to improving Educator and Practitioner capacity to support the mental health and wellbeing of children and young people. Although digital resources do not meet all user needs, the online platform is a critical component for scalability and sustainability of the Program. The Overarching Evaluation Team also acknowledges the important complementary role of the consultants in the Program.

Satisfaction with consultants

There was limited evidence available to assess user satisfaction with the consultants, suggesting low interaction with consultants in the group of users surveyed and interviewed for the Overarching Evaluation activities. The number of Emerging Minds users who rated their satisfaction with the Emerging Minds consultants in the survey was too small to draw reliable conclusions. However, we note that this low engagement may reflect the different approach to engagement taken by Emerging Minds consultants, which was more likely occur at the organisational level rather than individual user level (e.g. e-learning registrants).

Of the Be You users who responded to the consultant item, 30% either agreed or strongly agreed that the Be You consultants helped them to support the child and youth mental health needs of their early learning service or school.

Qualitative feedback from the survey indicated that the most frequently cited enabler of implementation for Be You users (i.e. applying the Be You learnings to their practice) was an interaction with the consultants. However, when consultant availability was limited or the interaction was negative, this was cited as a barrier to implementation.

In interviews with Practitioners and Educators for the Community Case Studies, a number of Educators who reported having "found" Be You "by accident", rather than as part of structured learning approach, were not aware of the consultant role. Those who had engaged with consultants (refer to the Spotlight Case Study) reported finding consultants helpful and effective.

The Document Review noted that the support from Be You consultants was highly valued by action team leaders given the important role they played in supporting Be You implementation and adaptation. This satisfaction differed between ELSs and schools, with Be You users from ELSs tending to have higher satisfaction with consultants compared to users from schools. Action team leaders from ELSs reported that the support they received from consultants was highly aligned with their expectations, while action team leaders from schools reported much lower alignment with their expectations. The Document Review for Emerging Minds indicated that organisations had highly variable and individualised pathways of interactions with consultants (e.g. targeted brief engagements, place-based engagements, and "implementation/quality improvement activities"). Further monitoring of organisations and users' perceptions of these interactions is needed.

Although data were limited, there was mixed evidence found for user satisfaction with the role of the consultants in supporting child and youth mental health. Findings may reflect dissonance between the original intention for consultants and their actual focus on recruitment in the early implementation phase, which may have come to the detriment of support to users. The evaluation found indications of low uptake and awareness of this feature of the Program by users. This finding may also reflect low engagement with consultants by users not in an action team leader or a leadership position within a school or organisation. Given the number of ELSs and schools signed up for Be You and Emerging Minds, the level of consultant support per learning setting/organisation may not be sufficient to sustain delivery.

Subquestion b: To what extent is the Program evidence-based?

We examined the extent to which the design of each of the initiatives was informed by the evidence base by reviewing documents provided by the Department of Health, Beyond Blue and Emerging Minds, as well as analysing the qualitative data from the KPI interviews.

Consideration of the evidence base in the design of the initiatives

We first considered the extent to which the initiatives considered implementation science in planning the way in which their respective initiatives were implemented. The Document Review indicated that a broad range of evidence was drawn upon during the development of the Be You initiative, with an emphasis on KidsMatter and MindMatters initiative frameworks because of alignment in objectives with Be You and the Australian Government directive. However, there was limited evidence that implementation science was used in the planning stages in the areas of system change or large-scale organisational change in education settings.

There was evidence that Emerging Minds drew on implementation science theory in its design. KPI interviews revealed that Emerging Minds looked to the implementation science literature in the planning of the initiative. According to the Emerging Minds informant, Emerging Minds drew on the available research evidence in the planning stage by using a systematic and thorough process, but that the available evidence to draw from was limited in some areas. Non-traditional evidence has also informed the initiative, including the lived experience of families and Practitioner expertise.

Supporting an evidence-based philosophy

We did not sight any policy documents consistent with supporting an evidence-based philosophy for either of the initiatives. However, the KPIs made statements that were consistent with support for an evidence-based philosophy. The Deloitte Access Economics formative evaluation found that staff perceived that drawing on an appropriate evidence base was vital for the initiative. The Be You website emphasises its "evidence informed approach" to equipping Educators to support the mental health and wellbeing of children and young people. The Emerging Minds website lists the "diffusion of evidence into practice" as one of the three key components of the initiative.

Consideration of the evidence base in content development

There was greater evidence of the consideration of the evidence base with regard to the content generated by the initiatives. Findings from the KPI interviews with Be You indicated that it has a heavy reliance on subject matter experts external to Beyond Blue to assess evidence when developing content. Be You also considers the evidence generated through its feedback, evaluation, website analytics, advisory groups and expert channels.

We noted the development of a range of evidence-based resources within Be You, including published literature reviews and fact sheets. Although not delivered within the 1 June 2017 to 31 December 2019 reporting period,

the redevelopment of the Program's Directory involved developing a purpose-built evidence-based assessment criterion so that users can understand the quality of evidence supporting the programs listed in the Directory. This activity indicates the prioritisation of evidence when selecting programs/interventions for inclusion on the website and demonstrates the use of clear decision rules about the use of evidence. An assessment of the appropriateness of these decision rules was outside the scope of the evaluation.

Emerging Minds demonstrated a particular strength in making an evidence-based philosophy central in its ways of working. Evidence appears to be a core value of the Emerging Minds initiative, with established processes for developing content using "three pillars of evidence": reviewing the research, the views of Practitioners, and the views of those with lived experience. Emerging Minds has taken an iterative approach through initiative design and delivery, with ongoing review and iterative change in response to new or generated evidence.

Overall, the findings suggest that the Program is mostly guided by the evidence. Opportunities for improvement may be found through the prioritisation and incorporation of implementation science for whole-school and systems change with Be You. We recommend that the initiatives continue to foster a culture of evidence, including the consideration of a diversity of evidence types (e.g. clinical/Practitioner knowledge, lived experience). We suggest that the initiatives build mechanisms to foster ongoing synthesis of evidence and sharing of evidence generated by the initiatives.

Subquestion c: How well is the Program viewed by participants?

To understand how well the Program is viewed by users we drew on results from the National Support Network Survey, the Community Case Studies and the Document Review.

Satisfaction with the Be You initiative broadly, and for the quality of professional development specifically, was assessed in the National Support Network Survey. In the survey, 57% of Be You users who responded (31% neutral; 12% disagree or strongly disagree) and 57% of Emerging Minds users (30% neutral; 13% disagree or strongly disagree) agreed or strongly agreed that they were satisfied overall with the initiative. The quality of the professional development for the initiatives was rated from poor to excellent by users. Of those responding, 58% of Be You users reported that they found the professional development as excellent (31% neutral; 11% poor), and 62% of Emerging Minds users reported that they found the professional development to be excellent (29% neutral; 10% poor).

Despite these generally positive user satisfaction ratings, the extent to which the initiatives met the users' needs in terms of being a "one stop shop" for resources and support was low: only a small proportion of Be You users (29%) and Emerging Minds users (17%) agreed that all their needs were met by the respective initiatives. Most users of each of the initiatives (58% of Be You users and 80% of Emerging Minds users) agreed or strongly agreed that they needed to use additional resources to those provided by the initiatives to support child and youth mental health within their work setting. This finding contradicts the intention of Be You to be a "single, national end-to-end education-based program".

There was overall limited uptake of the Program by participants from the Community Case Studies, which may reflect the early stage of implementation of the Program, selection bias, or the small number of participants included in this activity. A handful of users reported the initiatives as useful in terms of providing knowledge and information, and generally rated the Be You platform as easy to navigate and user-friendly. However, these users noted that it did not provide opportunities or specific information for its users to connect with other professional services (referral points). Participants from the Community Case Studies suggested a limited need for developing another online platform, suggesting that numerous platforms offering collated general mental health information are already available. The range of additional sources noted by participants included some with a significant evidence base, but others that were less well credentialled. Interviewees suggested that a platform that provides guidance around navigating between different resources to better support youth mental health might be more useful. Guidance regarding the evidence base for such resources may also be helpful.

Overall, there was mixed evidence to support the degree of user satisfaction to access sufficient resources and services to meet their needs within the Program.

Conclusions

There was mixed evidence that the Program design was appropriate to deliver the intended outcomes. User perceptions of limitations to the range of resources available, issues with equity of access to the Program and user perceptions of gaps in Program coverage suggest that further progress is required to ensure that the Program is suitable for a broad range of needs of users and to reflect the needs of the community. As discussed throughout this report, to optimise the impact of the Program, emphasis on large-scale organisational change (in addition to the building of individual capacity) is needed to scaffold the achievements at individual level and support more sustained change. A continuing consideration of Program implementation to support system level change is needed. Table 3.2 below summarises the overall findings for each indicator of Overarching Evaluation Question 2.

Table 3.2 Indicator summaries for Overarching Evaluation Question 2

Subquestion	Indicator	Assessment
a. To what extent does the design of the Program address the needs in the community?	1. The degree to which users agree that the range of resources (e.g. modules, programs, webinars, fact sheets) meets their needs to address child and youth mental health needs	There was mixed evidence for this indicator. There was evidence that users perceive broad utility and appropriateness of resources for general needs, but the range of resources to address children and young people with high and complex needs is limited.
	2. The degree to which users agree that the primary mode of Program access (i.e. online portal) meets their needs to address child and youth mental health need.	There was mixed evidence for this indicator. There was evidence for broad utility and appropriateness for the mode of Program access for many users, but it does not address issues of equity of access. The evidence suggest that the needs of the community extend beyond digital resources.
	3. The degree to which users agree that the activities of the consultants meet their needs to address child and youth mental health needs	Only a small proportion of Be You users agreed that the activities of the consultants met their needs. Findings may reflect dissonance between original intention for consultants and their actual focus on recruitment in the early implementation phase, which may have come to the detriment of support to users. There was limited evidence available to assess user satisfaction with the Emerging Minds consultants, suggesting low interaction with consultants in this group of users.
	4. The degree to which users prefer self-directed/online learning used in the Program versus alternative learning modalities not utilised in the Program	There was mixed evidence for this indicator. There is a need to promote value and benefits of online learning to users who do not prefer this modality.
	5. The above indicators disaggregated by users working with diverse and at-risk groups	Insufficient data to make an assessment.
b. To what extent is the Program evidence-based?	1. The extent to which the design of each of the initiatives is informed by the evidence base	The Emerging Minds initiative is strongly informed by the evidence base. There is mixed evidence for this indicator for the Be You initiative. The evidence base for large-scale systems/organisational change based on implementation science was unclear in the initiative's design.
	2. Initiatives have policy document/statements	There was some evidence that the initiatives have statements consistent with or supporting an evidence-based philosophy.

Subquestion	Indicator	Assessment
	consistent with or supporting an evidence-based philosophy	Emerging Minds demonstrates a particular strength in making an evidence-based philosophy central in their ways of working
	3. The extent to which initiatives consider evidence when selecting information and programs/interventions and activities (e.g. initiatives have clear decision rules about use of evidence)	This indicator has been met.
c. How well is the Program viewed by participants?	1. Reported degree of user satisfaction with access to sufficient resources and services to meet their needs within the Program (i.e. users don't need to go elsewhere to access information) compared to no Program	There is mixed evidence for this indicator. Overall, the majority of users agreed or strongly agreed that they were satisfied with the initiatives and that the quality of the professional development was excellent. However, only a small proportion of users agreed that the initiatives provided them with everything they needed to support the mental health of children and young people. This finding contradicts the intention of Be You to be a "single, national end-to-end education-based program".

3.3 Overarching Evaluation Question 3

How well has the Program achieved its outcome?

This section of the report addresses the effectiveness of the initiatives in achieving the intended Program outcomes. The findings reported in this section represent a snapshot in time during the early implementation phase of the Program.

The effectiveness of the Program was assessed in terms of the extent to which the Program has established an evidence base for mental health promotion, prevention and early intervention; informed mental health policy and programs in schools/support organisations; improved access by children and young people to mental health services; improved mental health and wellbeing for children, young people and their families; reduced the risk of suicide clusters; and improved mental health literacy. Some of the indicators relating to improved mental health and wellbeing for children, young people and their families are represented as intermediate and long-term outcomes of the Program (as depicted in the Overarching Evaluation Program Logic, Appendix A). Although some findings are presented at the child and family level in this section, it is likely too early to see a significant impact of the Program on these indicators. Additionally, the evaluation design and complex policy and framework environment to support the mental health and wellbeing of children and young people present challenges for attributing change to the Program on these outcomes.

Data from each of the evaluation activities were used to inform the assessment of effectiveness, including data from the Community Case Studies where relevant, the National Support Network Survey, Integrated Data Analysis and Document Review, and from the KPI interviews.

Subquestion a: To what extent has the Program established an evidence base for mental health promotion, prevention and early intervention?

The National Support Network Survey asked respondents direct questions about their use of evidence, and about changes in use of evidence associated with exposure to the Program. Educators exposed to the Be You initiative were more likely to be aware of evidence-based practice, more likely to value evidence, more likely to agree that access to evidence improves their practice, and more likely to engage in evidence-based practice. Practitioners reported being frequent, confident and competent users of evidence overall, regardless of their exposure to the Emerging Minds initiative.

KPI interviews provided limited evidence for an effective evidence dissemination strategy for both initiatives, or for a whole-of-Program strategy. Be You has started to develop an explicit knowledge dissemination strategy,

but the primary current use of new evidence is for its internal purposes. Emerging Minds demonstrated some progress toward meeting this indicator through its focus on policy submissions. Both initiatives would benefit from articulating a more overt strategy for evidence dissemination.

Overall, there was mixed evidence for the extent to which the Program has established an evidence base for mental health promotion, prevention and early intervention.

Subquestion b: To what extent has the evidence base informed mental health policy and programs in schools/support organisations?

The National Support Network Survey asked respondents direct questions about the extent to which evidence has informed policy and programs in their settings. There was high overall agreement that schools had policies and procedures that support mentally healthy learning communities, regardless of exposure to the Program, although Educators exposed to the Be You initiative were more likely to agree that their school has a culture that supports and promotes mental health. These Educators were also more likely to report that their schools had referral processes in place for students experiencing mental health challenges, and that their workplace worked well with external services to support students' mental health. Practitioners reported high agreement that policies, procedures and cultures in their work settings support mental health, regardless of their exposure to the Emerging Minds initiative. Likewise, the presence of referral procedures and satisfaction with external services did not vary with exposure to this initiative.

Findings from our Document Review suggest that the Be You framework and training materials work to support mentally healthy school cultures, and that the learning community approach has been effectively implemented by a number of ELSs and schools. There may be limited awareness among Educators that this resource is available, alongside the individual professional development tools. The Document Review related to the Emerging Minds initiative identified many organisational and systemic barriers that worked to prevent organizations from implementing better child mental health policies, despite the willingness of individual Practitioners. This can be seen in data around the profile of engagements, with ~15% of engaged organisations in active implementation collaborations with Emerging Minds consultants in 2019, and a smaller proportion that were working to effect organisational-level change.

Overall, there was evidence that Be You users more strongly agreed that their school has a culture that supports and promotes mental health compared to Educators who had not been exposed to the Program. However, there was otherwise limited evidence that workplaces had implemented policies and programs to support/reinforce a mentally healthy culture because of exposure to the Program.

Subquestion c: To what extent has the Program improved mental health literacy?

The National Support Network Survey asked respondents direct questions about the extent to which the Program has improved mental health literacy in their settings. Educators exposed to the Be You initiative reported greater confidence in their ability to identify children and youth at risk of experiencing mental health challenges, increased willingness to have conversations with children and families about mental health, a greater understanding of the mental health challenges facing children and young people, and greater understanding of when it may be appropriate to refer children and young people for specialist support. Practitioners reported high agreement and endorsement of each of these dimensions of mental health literacy regardless of their exposure to the Emerging Minds initiative. For example, there was near universal willingness to have conversations with children and their families about mental health, consistent with the workplace settings and roles of these Practitioners. These findings may be explained by the composition of participants in the Emerging Minds survey, who were mostly from mental health focused professional backgrounds and likely had better mental health literacy than Practitioners from non-mental health professional backgrounds due to their studies, training and CPD requirements.

These "high-baseline" findings were reflected in the Community Case Studies, where (in the absence of exposure to the Program), Practitioners generally reported higher levels of confidence than Educators to identify and respond to young people's mental health problems.

These findings were broadly consistent with those identified in the Document Review. For example, a user reflection survey found that 70% of Educators in ELSs reported that the Be You resources had improved their capacity to identify and respond to children and young people's mental health issues within learning settings.

Educators in ELSs also reported increased confidence in raising the topic of mental health with children and their families. This benefit was less clear for school-level Educators, with only 43% reporting improvement in capacity and 49% reporting improvement in confidence in responding to mental health concerns of children and young people. A similar pattern in findings was reported for improved understanding of processes, policies and practices associated with referral to mental health services both within and outside of their education environments, with greater benefits from Be You reported by ELS Educators.

For Emerging Minds, data extracted from the Document Review confirms that Practitioners typically have well-developed awareness and understanding of the importance of child and youth mental health practice, but that e-learning participation was still associated with improved knowledge, confidence and competence in relation to mental health and children. There was consistent evidence that engagement with Emerging Minds improved awareness of child mental health. Although Practitioners reported an overall lack of confidence in navigating conversations about mental health with parents and carers, they also reported that engagement with Emerging Minds had improved this confidence. Other data suggest variability in understanding, confidence and capacity across different Practitioner groups. In some cases, this pointed to specific needs in education and training on particular (advanced) topics, for example, around intergenerational trauma.

Overall, evidence against specific indicators supported a benefit from the Program for mental health literacy among Educators and Practitioners. It appears likely that many Practitioners had already achieved an overall greater level of knowledge, confidence and competency around mental health of children and young people (e.g. high overall endorsements in survey responses and other data) than Educators, consistent with their professional training, work roles and settings. Educators reported significant benefits from their interactions with the Be You initiative, although this benefit might be greatest in the early learning sectors. This evidence is limited to Educators and Practitioners. The impact of the Program on mental health literacy among children and young people, their families, and within the broader community was not determined.

Subquestion d: To what extent has the Program improved access by (target group) children and young people to mental health services?

The findings reported in this evaluation represent a snapshot in time during the early implementation phase of the Program. The level of change in response to the Program observed by the Overarching Evaluation at the individual user level (i.e. user satisfaction, awareness, knowledge and confidence) is consistent with the expected stage of maturation predicted by the Program Logic. Change beyond the individual user level (i.e. for children, young people, their families and the community) takes time, with the Program Logic anticipating such changes likely occurring after the evaluation period.

The National Support Network Survey asked respondents about the extent to which they understood their role in referring children, young people and their families to external mental health supports. Educators exposed to the Be You initiative were more likely to endorse that they understood their role in referring children, young people and their families to external services for mental health support compared to those not exposed to the initiative. There was high agreement and endorsement that Practitioners understood their role in referring children and families to external services for mental health support, regardless of their exposure to the Emerging Minds initiative.

Findings from the individual evaluation of Be You, reported in our Document Review, suggest that the majority of Educators in school settings did not agree that Be You improved their understanding of the internal and external referral processes (although the majority of Educators in an ELS setting did agree or strongly agree that Be You improved their understanding of these processes).

Findings from the individual evaluation of Emerging Minds suggested that users reported that e-learnings helped in them having a better understanding of the referral pathways available to them and how to use them; however, Practitioners still reported limited availability of appropriate service referral pathways for children and families in certain circumstances, such as children with substance abuse issues, or those in rural areas. Although addressing such gaps is beyond the scope of this Program, the success of the Program is premised on a range of assumptions, including that broader mental health systems and services have maintained or improved their capacity to address referrals and interactions from Educators and Practitioners.

These findings indicate that there is mixed evidence that the Program is building confidence and knowledge in the processes involved in referring children, young people and families to external supports. These knowledge and confidence indicators are important preconditions of learning settings and service organisations/Practitioners being effective gateways for children, young people and families to access external mental health supports, but they do not address many of the system-level barriers to improving access to support services that are outside of the scope of the Program, such as availability of services with respect to wait-times, travel distance, affordability and service coverage.

Subquestion e: To what extent has the Program improved mental health and wellbeing for children, young people and their families?

The Integrated Data Analysis activity was used to assess the impact of the Program on improving mental health and wellbeing for children, young people and their families. As described in Chapter 5, assessment of this impact was limited by practical constraints around the timely availability of relevant and appropriate data (including data from restricted sources relating to child and youth suicide, and potentially informative data from ongoing studies and surveys with content relevant to mental health and wellbeing of children and young people). Some of this information is expected to be released in late 2021 and onwards, providing the potential for later analysis of change in outcomes associated with the Program implementation period (Chapter 5).

The Program's implementation is within the very early stages (two–three years since the launch of the initiatives). As described in the Program Logic documents for each of the individual initiatives, and the overarching Program Logic developed to guide this evaluation, this reflects an early stage in eventual translation to benefit for children, young people and their families, and longer term benefits to community and other social supports. As such, it is likely to be too early to see a significant impact of the Program on these critical intermediate and long-term outcomes.

Subquestion f: To what extent has the Program reduced the risk of suicide clusters?

The National Support Network Survey asked respondents (to the Be You survey only) direct questions about the extent to which they agree that suicide postvention is part of their role, the extent to which they have the knowledge and confidence to respond appropriately post-suicide to reduce the risk of suicide contagion, and whether their school had a suicide postvention plan in place. Educators exposed to the initiative were more likely to agree that suicide postvention was a part of their role than were those not exposed to the initiative. Educators exposed to the Be You initiative also reported higher agreement than those not exposed to the initiative to having the knowledge and confidence to respond appropriately to a death by suicide in the school community, and the knowledge and confidence to identify and communicate appropriately with young people who may be impacted or at increased risk of suicide contagion after a death by suicide. Educators exposed to the Be You initiative were also more likely to report that their school had a suicide postvention in place compared to Educators not exposed to the initiative.

Findings from our Document Review suggest that Be You is active in providing suicide postvention support in response to critical events, as well as supporting communities experiencing a potential suicide contagion risk.

Overall, there is evidence that Be You is providing suicide postvention services to support Educators and schools to respond appropriately in the event of a suicide in the school community. The extent to which this support is reducing the distress caused to students and reducing the risk of suicide clusters in peer groups could not be determined due to limitations with access to data within the evaluation period.

Conclusions

There was evidence that the Program has achieved partial progress toward achieving its intended outcomes. The evidence of this progress has primarily been observed at the individual Educator and Practitioner level, focusing on capability development. There is emerging evidence of implementation of best practice by individual Educators and Practitioners, but limited evidence that whole-of-setting engagement is taking place, and that interactions with the community are taking effect. At this time, there is limited evidence for impact on mental health and wellbeing outcomes for children, young people and their families. This level of change takes time. As stated in the Program Logic, longer term outcomes or sector-wide impacts may not be evident within three years of Program operations, and may require longer term monitoring (e.g. up to five years, or through longitudinal research beyond the timeframe of the evaluation) to be assessed. The Overarching Evaluation Team has had a

range of interactions with Beyond Blue and Emerging Minds team members, and we have noted that they have prioritized early-stage activities consistent with the Program Logic. For example, Beyond Blue has emphasised to the Evaluation Team that the child and youth outcomes examined by the Overarching Evaluation represent outcomes that are beyond the expected scope of impact for Be You. Although the Evaluation Team acknowledges that the Program is one part of a range of measures funded by the Commonwealth and state and territory levels of government to improve child and youth mental health outcomes, the purpose of the Program should be kept in mind, and the Theory of Change that guided it should remain up front and conspicuous – it should continue to guide the approach and activities of the initiatives. Table 3.3 below summarises the overall findings for each indicator of Overarching Evaluation Question 3.

Table 3.3 Indicator summaries for Overarching Evaluation Question 3

Subquestion	Indicator	Assessment
a. To what extent has the Program established an evidence base for mental health promotion, prevention and early intervention?	1. There is evidence of a dissemination strategy for evidence generated by the initiatives	There was limited evidence of an effective dissemination strategy for both initiatives. Emerging Minds demonstrated some progress toward meeting this indicator through its focus on policy submissions. Both initiatives would benefit from articulating an overt strategy for evidence dissemination.
	2. The extent to which users report being better (e.g. more frequent, more confident, more competent) users of evidence compared to no Program	There is some evidence that users exposed to the Be You initiative reported being better users of evidence compared to those not exposed to the Be You initiative. Emerging Minds users reported being frequent, confident and competent users of evidence, regardless of exposure to the initiative, indicating that support to improve evidence-based practice may not be an area of high need in the workforce.
b. To what extent has the evidence base informed mental health policy and programs in schools/support organisations?	1. Extent to which users report that their ELS, school or organisation has implemented policies and programs to support/reinforce a mentally healthy culture based on the contents of the Program	There was some evidence that Be You users more strongly agreed that their school has a culture that supports and promotes mental health compared to Educators who had not been exposed to the Program. However, there was otherwise limited evidence that Be You and Emerging Minds users agreed that their workplaces had implemented *policies* and programs to support/reinforce a mentally healthy culture based on the contents of the Program compared to no Program.
c. To what extent has the Program improved mental health literacy?	1. Degree to which users feel confident identifying children and youth at risk of experiencing mental health conditions compared to no Program	This indicator has been met. There was a potential ceiling effect for Emerging Minds users' data.
	2. Users report an increased willingness to have conversations about mental health with children, young people and families, compared to no Program	This indicator has been met. There was a potential ceiling effect for Emerging Minds users' data.
	3. Users report an understanding of the different mental health challenges facing children and youth compared to no Program	This indicator has been met. There was a potential ceiling effect for Emerging Minds users' data.

Subquestion	Indicator	Assessment
	4. Users report an improved understanding of when it is *appropriate* to refer children and young people for specialist support compared to no Program	This indicator has been met. There was a potential ceiling effect for Emerging Minds users' data.
d. To what extent has the Program improved access by (target group) children and young people to mental health services?	1. The extent that users report an improved understanding, awareness and availability of appropriate service referral pathways compared to no Program	This indicator has been met. There was a potential ceiling effect for Emerging Minds users' data.
e. To what extent has the Program improved mental health and wellbeing for children, young people and their families?	1. Child and youth wellbeing related indicators	Too early to tell. This level of change takes time. As stated in the Program Logic, longer term outcomes or sector-wide impacts may not be evident within three years of Program operations, and may require longer term monitoring (e.g. up to five years, or through longitudinal research beyond the timeframe of the evaluation) to be assessed.
f. To what extent has the Program reduced the risk of suicide clusters?	1. Uptake of suicide postvention support compared to no Program	There is evidence that Be You suicide postvention support is being provided to learning communities that have experienced a critical event (suicide, attempted suicide, suicide-related behaviours) or are at a potential suicide contagion risk. Educators exposed to the Be You initiative are more likely to have a suicide postvention plan in place at their school compared to Educators not exposed to the initiative.
	2. Number of registrations via suicide postvention as a proportion of school-aged suicides	Insufficient data to make an assessment.
	3. The degree to which teachers agree that suicide postvention is part of their role	This indicator has been met. There is evidence that exposure to the Be You initiative is associated with a greater extent of agreement that suicide postvention is part of their role.
	4. The extent to which teachers are confident that they can respond appropriately post-suicide and reduce risk of suicide exposure and contagion	This indicator has been met. Overall, awareness and confidence to respond appropriately post-suicide and reduce risk of suicide exposure and contagion is higher in Educators exposed to the Be You initiative than in those not exposed to the Be You initiative.
	5. Student psychological distress scores post-suicide within the school community is reduced	Insufficient data to make an assessment.
	6. Rate of suicide clusters for children and youth	Insufficient data to make an assessment.

3.4 Overarching Evaluation Question 4

How cost-effective is the Program?

Subquestion a: How efficiently have Program resources been used?

Findings from our Document Review suggest that there was a degree of uncertainty among Be You team members regarding efficient deployment of resources during the design and implementation phases. Inefficiencies were observed in the areas of content development delays, stakeholder engagement, communication across internal groups and between delivery partners, and in decision making processes. However, Beyond Blue was highly responsive to these early issues, and subsequently implemented strategies to address them.

For Emerging Minds, the Document Review revealed that due to the Program contract finalisation being delayed, the initiative experienced early inefficiencies associated with tight timeframes. The individual evaluation of Emerging Minds noted that there was limited time to develop organisational structures and operational processes prior to the start of the initiative. These factors had a notable impact on the time it took to organise sufficient skilled staffing for the initiative. For example, in 2019, the Emerging Minds individual evaluation noted that achieving the aims of the initiative was challenging due to the greater than anticipated time it took to onboard staff.

Emerging Minds has demonstrated evidence of attending to issues of efficiency by implementing strategies to promote workforce sustainability. The Document Review revealed that these strategies were actioned by consultants responsible for implementing strategies for sustainability promotion, included running workshops and "train-the-trainer" sessions.

The KPI interviews with Emerging Minds revealed that efficiency has increased over time, with the perception that content development by Emerging Minds is "prolific". It was noted that some efficiencies were realised by Emerging Minds taking advantage of prior development work and existing audiences and contacts.

The extent that Program efficiencies can be achieved over time were also examined in the Value for Money assessment (see Chapter 6). The Be You initiative demonstrated economies of scale for delivery with increasing uptake by Education professionals. The analysis showed that costs per user are likely to decrease significantly as user uptake and engagement in the initiative increase. Be You will demonstrate greater value for money as more users sign up and utilise its resources. Be You has already demonstrated strong success in recruiting users to the initiative, meaning that economies of scale (reduced cost per user) are being realised. Emerging Minds also demonstrated increased registrations over time. Although there was insufficient data to undertake a formal Value for Money assessment for Emerging Minds, it is expected that a similar pattern of results would be found, based on the commonalities of the initiative designs.

Overall, findings suggest that efficiency in delivery is increasing over time due to the responsiveness of the organisations to evaluation, an increasingly adept workforce and economies of scale.

Subquestion b: What are the (additional) costs associated with the Program?

The iterative development of information and resources will likely be needed to address ongoing and changing mental health needs in the community. The development of these new or revised resources will attract additional costs over time.

In the KPI interviews, Program informants were asked whether they had incurred any additional costs from a financial or resourcing perspective. The response to this question by the KPIs indicated that Beyond Blue was able to develop and implement Be You within its approved budget (with an underspend). The Emerging Minds informant reported that there were no significant additional expenses incurred by the organisation at the current scale, but held the view that the Program would ideally need an ongoing investment over years, as there are opportunities that could be expanded or developed more deeply. For example, Emerging Minds has identified ways to expand the scope of its work (e.g. via increased engagement with Aboriginal and Torres Strait Islander organisations) that cannot be resourced within the current initiative budget. The Beyond Blue informant noted that the website and digital platforms/infrastructure will need ongoing investment over time to promote the sustainability and scalability of the initiative, and to overcome workforce limitations.

One of the aims of the Program was to address the Contributing Lives Review's finding that there were multiple initiatives promoting social and emotional health and wellbeing for children and young people across education settings. It was recommended that these initiatives be integrated into one single national education-based program. These initiatives included Response Ability, KidsMatter Early Childhood, KidsMatter Primary, MindMatters and headspace School Support. When comparing the average spending per year on the five initiatives to the average per year costs of Be You, the additional costs of Be You were found to be negligible – the costs of the Be You initiative per year are relatively similar to the combined costs per year of the five programs that have since been integrated into the Be You initiative. Taken together with findings of increasing uptake of Be You by Educators, this finding suggests that there are overall efficiencies in this aspect of the design and approach of the Program.

Based on the Overarching Evaluation activities, the availability of time to complete the learning activities associated with the Program has been consistently identified as a barrier to accessing and applying learnings of the Program from the user perspective (see Survey Chapter, Community Case Studies, Document Review). This finding was also evident in the higher opportunity costs of time calculated for the Value for Money assessment. Opportunity costs are the costs of forgoing another activity in order to participate in the Program. For example, when Educators spend time engaged in mental health training, they forego time they would otherwise spend teaching or preparing classwork. Even though opportunity costs are not direct monetary expenses, they are key costs incurred by participants and employers in return for their involvement in a training activity. For Be You, the opportunity cost of time was the highest component of all indirect costs for the initiative. There was insufficient data to determine the opportunity costs associated with the Emerging Minds initiative, but it is likely that a similar pattern of results would be found. Consistent with these findings, the Document Review also revealed that Educators and action team leaders reported the largest cost being the time spent on the Be You initiative, which could be used for other activities (i.e. the opportunity cost of time). Review of Emerging Minds documents also indicated that time and resource availability was consistently noted as a barrier to implementing child mental health initiatives.

Overall, the organisations and users reported few additional costs of the Program. The opportunity cost of time is consistently high, and likely requires further acknowledgement and amelioration so that users and organisations are more likely to fully utilise the Program.

Subquestion c: How do user costs compare to no Program?

Findings from the National Support Network Survey (see Chapter 6, Value for Money assessment) indicate that most participants exposed to Be You reported that the initiative was less or much less costly to use for their professional learning when compared to other activities or tools currently available. At the same time, most participants exposed to Be You reported that, in the absence of the initiative, it would cost a similar amount or be much more costly to obtain information needed to support students'/children's mental health if Be You was not available to them.

The results from the National Support Network Survey for Emerging Minds revealed that, compared to other activities, users overwhelmingly responded that using Emerging Minds was less costly. If Emerging Minds was not available, the majority of Emerging Minds users acknowledged that the costs to obtain resources and information that they need to support child and youth mental health would likely be high.

Most Be You users perceived that the initiative was time neutral compared with similar alternatives that they may use to support child and youth mental health (i.e. it is not more time intensive or less time intensive than other available online programs). Additionally, most users agreed that using Be You information and resources was an efficient use of their time, compared to sourcing relevant information themselves from other sources if Be You was not available. This finding indicates that the Be You initiative facilitates the streamlining of the learning and research process for Educators.

Most Emerging Minds users perceived that the initiative took much less time or less time compared to other activities or tools used for continuing professional learning, and that it would take more time or more much more time to source the relevant information from other sources to support children's mental health.

Overall, these findings provide positive indications that the Program is cost-effective, when compared to no Program, from the perspective of the user.

Conclusions

Overall, potential cost inefficiencies were associated with the start-up and early implementation phase of the Program, but both initiatives acted quickly to address these inefficiencies. Available data were consistent with an overall cost-comparability between initiatives funded prior to the Program, and the activities of the Program. Increased efficiency, consistent with "economies of scale", were indicated by strong early adoption of Program initiatives by Educators and Practitioners, and by consistent growth in uptake and engagement. The costs to participants of the Program were not greater than the costs associated with alternative sources of information and education, and typically less costly. The indirect costs to the participants and their organisations of time (i.e. the time required to engage with the Program), an opportunity cost, was high, and remains a perceived or actual barrier to stronger engagement with the Program.

Table 3.4 below summarises the overall findings for each indicator of Overarching Evaluation Question 4.

Table 3.4 Indicator summaries for Overarching Evaluation Question 4

Sub question	Indicator	Assessment
a. How efficiently have Program resources been used?	1. The extent that the Program is implemented efficiently with respect to time, costs, and resources used	Overall, potential cost inefficiencies were associated with the start-up and early implementation phase of the Program, but both initiatives acted quickly to address these inefficiencies. Available data are consistent with an overall cost-comparability between initiatives funded prior to the Program, and the activities of the Program.
	2. The extent the Program efficiency varies across different contexts	There were insufficient data to make an assessment for this indicator.
	3. The extent that Program efficiencies are achieved over time (i.e. set-up costs reduce over time, operational costs associated with outcome attainment do not increase over time)	The Be You initiative demonstrated economies of scale with increasing uptake by Education professionals. There were insufficient data to make an assessment for Emerging Minds, but it is expected that a similar pattern of results would be found based on the commonalities of initiative design.
b. What are the additional costs of the Program?	1. Users, Emerging Minds and Beyond Blue report additional costs are identified as being associated with the Program	Time was the most frequently cited barrier by Educators and Practitioners to engaging with and implementing learnings from the Program. The opportunity cost of time was the highest component of all other costs incurred by Educators. Although there were insufficient data to conduct a formal analysis, it is expected that a similar result would be found for Practitioners using Emerging Minds. No additional costs of the Program were identified by Emerging Minds or Beyond Blue.
c. How do user costs compare to no Program?	1. Users report changes to costs associated with capability development in supporting child and youth mental health	The financial costs to participants of the Program were not perceived to be greater than the financial costs associated with alternative sources of information and education, and typically less costly. The costs of time to participants of the Program were also not perceived to be greater than the costs of time associated with obtaining alternative sources of information.

3.5 Overarching Evaluation Question 5

Were there any unintended outcomes or consequences associated with the Program?

Subquestion a: What were the unintended outcomes/consequences?

To understand whether there were any unintended consequences associated with the Program, either positive or negative, we considered whether any of the knowledge and confidence indicators changed in a direction that was not expected by the Program Logic. We also directly asked Program users to identify unexpected consequences (positive or negative) that they experienced during the Program's implementation. For this Evaluation Question, we primarily drew on the National Support Network Survey and the Community Case Studies activities.

We did not identify any consistent unintended consequences of the Program. Based on available data, users' capacity to support the mental health of children and young people did not decrease. We did observe a null effect for user knowledge and confidence outcomes for users of the Emerging Minds initiative. There may have been a range of methodological reasons for this effect, such as the ceiling effect, social desirability bias, and a relatively small number of participants in the exposed group (see Limitations section of the Survey chapter). However, there are also policy mechanisms that may explain these findings. The survey provides an estimate of Program effects at a single point in time during the early phase of implementation. Additionally, the baseline level of knowledge and confidence among Practitioners was high, regardless of whether they had engaged with Emerging Minds or not. A higher baseline level of knowledge, confidence and practice in relation to child mental health in some professional groups was also identified in the individual evaluation of Emerging Minds (e.g. higher baseline knowledge in mental health focused professions, as compared to nurses and teachers). The individual evaluation noted that this high baseline of knowledge at registration is expected for the mental health focused professions given the likelihood that they have already received training in this area. The findings from the Overarching Evaluation may indicate that broad mental health literacy and knowledge about the use of evidence-based practice may not be key areas of need to be addressed by the Emerging Minds initiative. We note that the Emerging Minds initiative has already begun to respond to these professional differences in baseline knowledge through the introduction of profession-specific "learning pathways". The development of learning opportunities that address the mental health needs of specific population groups could be another appropriate area of specific future effort for Emerging Minds. It may be important for future evaluations to test Practitioners' competence, or to look for benefit in downstream outcomes for children.

The Overarching Evaluation Team also observed a crossover effect, with some Educators using Emerging Minds only (i.e. instead of Be You), or using both initiatives at the same time (see Spotlight Case Study). This engagement was unanticipated in the design of the Program. In the 2018 Process and Outcomes Evaluation for Emerging Minds, it was stated: "The education sector is excluded from this project. It is covered by a separately-funded project, the National Education Initiative, led by Beyond Blue, headspace and Early Childhood Australia." Despite this, early childhood Educators and teachers were in the top three registrant groups for Emerging Minds, and this group was also represented in the Overarching Evaluation activities examining the Emerging Minds initiative. This uptake by Educators is an unanticipated consequence that has implications for the appropriateness of the Program design in terms of potential areas of duplication. However, this finding also highlights the opportunity for the initiatives to collaborate on areas of alignment to have a collective impact, a strategy that the Emerging Minds individual evaluation has already articulated.

When we asked Program users to identify unexpected outcomes that came out of their interactions with the Be You and Emerging Minds initiatives (either positive or negative), we received very few responses. Of those responses received, users primarily framed their response around their impression of the initiative (positive or negative) relative to their expectations. For example, users reported they found the resources "useful", or that the content was more basic than expected. For several users, they stated that it was simply too early to tell if anything unexpected was to come from their interactions with the initiative. Unintended consequences did not emerge as a consistent theme in the Community Case Studies.

An unexpected increase in users registering for Emerging Minds e-learning and e-learning completions was observed following the COVID-19 related restrictions. Be You experienced a second spike in registered users around this period also, and a spike in website and resource use was also observed following an email about the availability of coronavirus resources. It is likely that COVID-19 restrictions drove up interest in online learning

modalities to respond to increased need for mental health support in the community, as face-to-face opportunities ceased to be feasible. This finding highlighted the utility of this primarily online modality where it was deemed acceptable, or available, but also reveals potential issues of equity where it was not.

Conclusions

Overall, we found very little evidence of unintended outcomes associated with the Program, and specifically, no reports of negative impacts on knowledge, confidence and capacity to support the mental health and wellbeing of children and young people. The overall high (but potentially variable) level of baseline knowledge reported by users of Emerging Minds is consistent with the education and training backgrounds of some of the groups targeted by the initiative. A more tailored approach has subsequently been adopted by Emerging Minds. The outcomes of this change might be assessed against competency (rather than knowledge), or against higher level knowledge benchmarks. The uptake of the resources and supports provided by the Emerging Minds initiative by Educators suggests that these resources also have value for this group. This was not an initial aim of the Program but may provide a point of focus on the potential overlap and synergies between the two initiatives. Table 3.5 below summarises the overall findings for each indicator of Overarching Evaluation Question 5.

Table 3.5 Indicator summaries for Overarching Evaluation Question 5

Sub question	Indicator	Assessment
What are the unintended outcomes/ consequences?	1. User knowledge and confidence indicators do not improve compared to no Program	Emerging Minds users' knowledge and confidence outcomes, as assessed by the National Support Network Survey, did not show improvement compared to Practitioners not exposed to the initiative. We observed a high baseline on knowledge and confidence indicators from survey data for Emerging Minds users. Although there may be methodological explanations, it is also possible that some of these knowledge and confidence indicators should not be key target areas for the Emerging Minds initiative.
	2. Target users identify consequences (positive or negative) of the implementation of the Program	A limited range of consequences (positive of negative) of implementation were reported by target users.

4. National Support Network Survey

4.1 Background and purpose

The National Support Network Survey was designed to gain insights into the state of mental health capabilities, confidence and experiences of Educators and Practitioners who work with children, young people and their families.

The surveys identified exposure to Program activities and ascertained effects of the Program on the following dimensions:

- beliefs and attitudes toward child and youth mental health
- awareness of, and access to, evidence about child and youth mental health
- awareness and knowledge of processes to refer children, young people and their families to early intervention services or external supports available to support child and youth mental health
- confidence to recognise and respond to mental health risks in ways that are consistent with contemporary evidence
- knowledge of suicide postvention supports and depth of understanding about responding to suicide trauma.

The survey also elicited direct insights from initiative users (i.e. those exposed to the Be You and Emerging Minds initiatives) on their perceptions of the appropriateness and effectiveness of the Program.

4.2 Design

The survey design was cross-sectional and incorporated a between-groups methodology This methodology was used to enable:

1. a comparison between Educators who had been exposed to the Be You initiative and those who had not been exposed to the Be You initiative
2. a comparison between Practitioners who had been exposed to the Emerging Minds initiative and Practitioners who had not been exposed to the Emerging Minds initiatives.

The surveys were not designed to compare the initiatives to each other.

The surveys also included a retrospective pre-post design to estimate change over time that could be attributed to the Program. Select questions were designed to elicit an estimate of pre-intervention state for those who had and did not have access to the Program (e.g. How confident are you in addressing mental health issues in students now compared to a year ago?).

4.3 Instruments

To account for the differences between the initiatives, two surveys were developed:

1. a survey suitable for Be You's target users (including alternative forms for control participants and exposed participants)
2. a survey suitable for Emerging Minds' target users (including alternative forms for control participants and exposed participants).

Within these surveys, a series of questions were asked about participants' awareness, access and use of the initiatives to redirect participants to the appropriate alternative forms of the surveys. These questions were used to allocate participants to either a "control" or an "exposed" group, based on predefined criteria (see below). Appendix E also outlines these questions and the criteria used to allocate participants to the appropriate survey form.

The alternative forms for exposed participants in both surveys included an additional set of questions that related to exposed users' satisfaction with the initiatives.

Although the questions were largely consistent between the Be You and Emerging Minds surveys, items were customised to reflect the differences in target users and beneficiaries between the two initiatives.

To address the Evaluation Questions, the survey largely used purpose-developed items to capture the nuances of the Program and differences in the populations surveyed, and to improve attribution of effects to the Program. These purpose-developed items were informed by the Overarching Evaluation Indicator Matrix (see Evaluation Framework). Where possible, survey items were informed by the broader literature on the assessment of Educator confidence, self-efficacy and capability in supporting children and young people's mental health (Ekornes, 2015; Linden & Stuart, 2019; Reinke et al., 2011); nursing research on the assessment of evidence-based practice (Upton & Upton, 2006); and previous evaluations (e.g. Deloitte Access Economics' Be You Implementation and Early Outcome Evaluation Report; KidsMatter Primary Evaluation Final Report, 2009).

Visual Analogue Scales (VAS) were applied to explicit questions or statements (except for validated scales, where the original response formats were retained). A VAS uses a linear response format that can potentially range from 0 (e.g. Strongly disagree) to 100 (e.g. Strongly agree).

Qualitative data were also collected using the survey in the form of free-text responses to five open-ended questions.

Both the Educator and Practitioner surveys covered the following broad constructs:

- personal demographic and workplace details
- awareness and involvement in mental health initiatives for children
- extent of involvement in the Be You or Emerging Minds initiative, if applicable
- user perceptions of the initiatives (e.g. extent that the initiatives meet their needs, how well the initiative is viewed by users, enablers and barriers to implementation, unexpected consequences), if applicable
- knowledge about external mental health services
- confidence to connect and use external mental health services
- confidence in abilities to address child and youth mental health challenges
- confidence to have conversations with children and families about child and youth mental health needs
- abilities to help children learn and seek help for mental health issues
- perceptions of workplace culture and practices regarding mental health
- application of evidence-based practice regarding mental health
- alternative approaches to obtaining information and professional learning to support child and youth mental health
- enablers and barriers to supporting child and youth mental health
- perceptions of factors that influence child and youth mental health.

The Educator survey included additional questions on uptake and confidence with suicide postvention.

4.4 Participants

4.4.1 Inclusion criteria

- Australian Educators (including guidance counsellors and others in roles that support children and young people in learning settings) working in an ELS or school (i.e. target users of Be You)[1]
- Australian Practitioners (clinical and non-clinical) who work with children, adults or both in either public or private settings in the Australian health and human services sectors (i.e. target users of Emerging Minds).

These broad inclusion criteria meant that both users and non-users of the Program could be included in the sample to enable interrogation of Program effects.

[1] Pre-service educators were not included in Overarching Evaluation activities because the incorporation of Be You into tertiary institutions for pre-service education for teachers and early childhood staff was not the focus of this phase of implementation. Briefing information sighted for the Document Review indicate that pre-service project activities have been prioritised by Be You for the 2020–2021 Department of Health contract period.

4.5 Procedure

4.5.1 Sampling frame

The recruitment strategy for the National Support Network Survey was designed to include a range of Educators, other professionals in education, health workforce and other Practitioners involved in care or support of children and young people across sectors and location. Recruitment involved a top-down approach, with potential participants being approached via their Principal, Centre Director or Practice Manager etc., rather than direct approach to Educators and Practitioners through advertisement or other means. This approach was necessary and appropriate because of the respondents' institutional settings, and the direction we received from the Department and Jurisdictional Ethics Committees to not place undue burden on participants and organisations for the purpose of the Evaluation.

4.5.2 Educators

For Educators, a comprehensive list of schools and Government-run early learning services was obtained from:

- the website of each State and Territory Education Department (for Government schools)
- the website of each Diocese for which we had Ethics approval (for Catholic schools)
- the Independent Schools website in each State and Territory (for Independent schools).

We also conducted an online search of private providers of ELSs in each State and Territory.

From August 2019 to March 2020, a total of 3,695 educational sites (Early Learning Centres, Kindergartens, Preschools, Primary and Secondary schools) across Independent, Catholic and State sectors were contacted and invited to distribute the survey to their staff.

To recruit participants from Government schools and early childhood settings, State Departments of Education require projects to obtain "Research Approval". This Research Approval only provides researchers with the authority to approach school principals or early childhood site managers to invite them to participate in the research. Whether the principal or site manager agrees for their staff to participate is voluntary, and likewise, subsequent staff participation is also voluntary. This two-step approach process means that principals and site managers acted as "gatekeepers" for Educators to participate in the National Support Network Survey.

This approach impacted the survey in several ways. First, the time taken to obtain the research approval and then approach principals and site managers was lengthy and resource intensive. Details of the delays to the survey due to the research approval processes were also documented in Progress Report 2 (November 2019) and Progress Report 3 (March 2020). Second, the pool of teachers who could complete the survey was limited by principals and site managers who declined to have their school or early childhood setting participate in the research.

4.5.3 Practitioners

We sought out potential users of Emerging Minds using a systematic identification and approach process:

- We compiled a list of relevant large organisations, including hospitals, PHNs and State Child and Youth Mental Health Services, who we then approached to distribute the recruitment materials to their staff on our behalf.
- We contacted relevant professional associations to either distribute the link to their members on our behalf or provide a database of contact information for individual Practitioners.
- We conducted an online search of smaller clinics and practices, who we then approached to distribute the recruitment materials to their staff on our behalf.

In total, over 3000 survey links were emailed to individual Practitioners and Practitioner groups.

4.5.4 Coverage

All States and Territories in Australia were covered.

4.6 Ethics

Primary ethics approval for the National Support Network Survey was received from The University of Queensland Human Research Ethics Committee (HREC) as detailed in Table 4.1.

Table 4.1 Ethics approvals or the National Support Network Survey

HREC committee	Approval received	Approval number
University of Queensland Humanities and Social Sciences, Low & Negligible Risk Ethics Sub-Committee	15/07/2019	2019001536

4.6.1 Additional approvals in education settings

Applications to the various State and Catholic school jurisdictions were made for the survey to be conducted at educational institutions within these jurisdictions. These jurisdictional applications and approvals are detailed in Appendix D.

Prior to receipt of approvals from educational jurisdictions to approach schools, contact was made with Independent schools and Early Learning Centres. Independent schools did not have an additional approval process, so the research team sought permission at the individual school level.

4.6.2 Timing of ethics approvals and recruitment

The timeline in Table 4.2 shows the recruitment period for the National Support Network Survey. The recruitment period for this evaluation activity intersected with the 2019–2020 bushfires and the COVID-19 pandemic.

With the onset of the COVID-19 pandemic in March and April 2020, three school jurisdictions (State and a Catholic jurisdiction in Queensland and a Catholic jurisdiction in NSW) suspended their approvals to avoid additional demands on the schools within these jurisdictions during this time. The 2019–2020 bushfires and the COVID-19 pandemic also impacted on our ability to reach clinicians and Practitioners, as the focus of their work shifted due to demands for clinical assistance and the move to the provision of Telehealth platforms for the delivery of their services. As agreed with the Department, direct recruitment efforts were limited to reduce respondent burden at the start of the COVID-19 pandemic. It was then agreed to formally cease recruitment in mid-May 2020. Opportunities for further data collection were not possible within the remaining evaluation period.

Table 4.2 Timeline of survey data collection activities 2019–2020

Data collection activities/events	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	April 2020	May 2020
Ethical clearance received											
Jurisdictional approvals submitted											
Jurisdictional approvals received											
Recruiting Educators											
School holidays											
2019–2020 bushfires											
Recruiting Practitioners											
COVID-19 pandemic											
Survey rollout – surveys active											

Note. The red shading indicates periods where recruitment of participants was impacted or not possible.

4.7 Participant characteristics

The background characteristics of the Educators and Practitioners are presented in Table 4.3 and Table 4.4, respectively.

4.7.1 Educators

In total, 770 Educators responded to the Be You survey, Within the survey, participants were allocated to one of two conditions (i.e. the "exposed" or "control" group) using the Qualtrics Survey Software functionality based on their responses to a series of questions about their exposure to the respective initiative (see Appendix E for full redirection logic description).

Of the total respondents to the Be You survey, 215 participants were allocated to the exposed group and 441 participants were allocated to the control group. Following group allocation, 50 participants in the exposed group and 20 participants in the control group did not respond to any of the key outcome items. Thus, those 70 participants were excluded from the analysis. The final analytic sample of Educators for the Be You survey was 586 participants. Of these participants, 165 participants met criteria for inclusion in the exposed group, and 421 participants met criteria for the control group. Most participants were female (78%) and the mean age of the sample was 45 years. The median years of experience working within schools or services was 16 years (IQR: 8.00, 26.00). The professional background of Educators reflects the broad definition of Educator used in the Overarching Evaluation, which is teaching staff (74%) and others in roles in the ELS or school community who interact with and support children and young people (e.g. counsellors, psychologists, nurses; 26%). The proportion of early childhood Educators in this sample was low (2.4%), which reflects the difficulties encountered in accessing this sample using the gatekeeper method rather than direct approach to Educators through advertisement or other means.

Table 4.3 Characteristics of Educators who participated in the Be You survey

	Exposed % (n/N)	Control % (n/N)	Total % (n/N)
Sex			
Male	16.97(28/165)	23.10(97/420)	21.37(125/585)
Female	83.03(137/165)	76.19(320/420)	78.12(457/585)
Other	--	.71(3/420)	0.51(3/585)
Mean age (SD) [N]	45.04 (11.28) [161]	44.85(12.18) [414]	44.90(11.93) [575]
Types of profession			
Counsellor	3.64(6/165)	0.48(2/421)	1.37(8/586)
Early Childhood Worker	2.42(4/165)	1.66(7/421)	1.88(11/586)
Mental Health Nurse	--	0.24(1/421)	0.17(1/586)
Nurse and/or Midwife	1.21(2/165)	0.24(1/421)	0.51(3/586)
Psychologist	8.48(14/165)	1.19(5/421)	3.24(19/586)
Social Worker	3.03(5/165)	0.24(1/421)	1.02(6/586)
Teacher/Education	71.52(118/165)	86.7(365/421)	82.42(483/586)
Tertiary Student	--	0.24(1/421)	0.17(1/586)
Youth Worker	1.82(3/165)	1.19(5/421)	1.37(8/586)
Others	7.88(13/165)	7.84(33/421)	7.85(46/586)

	Exposed % (n/N)	Control % (n/N)	Total % (n/N)
Types of organisation			
Combined (e.g. Primary and Middle School)	13.94(23/165)	5.46(23/421)	7.85(46/586)
Early Learning Service	4.24(7/165)	1.66(7/421)	2.39(14/586)
Middle School	1.21(2/165)	0.95(4/421)	1.02(6/586)
Primary School	24.85(41/165)	25.89(109/421)	25.6(150/586)
Secondary School	52.12(86/165)	62.71(264/421)	59.73(350/586)
Special School	1.82(3/165)	1.9(8/421)	1.88(11/586)
Others	1.82(3/165)	1.43(6/421)	1.54(9/586)
School type/sector			
Catholic	41.14(65/158)	45.28(187/413)	44.13(252/571)
Government	55.7(88/158)	51.57(213/413)	52.71(301/571)
Independent	1.9(3/158)	3.15(13/413)	2.8(16/571)
Others	1.27(2/158)	--	0.35(2/571)
Work type			
Non-teaching Staff	37.18(58/156)	21.16(84/397)	25.68(142/553)
Teaching Staff	62.82(98/156)	78.84(313/397)	74.32(411/553)
Median (IQR) [N] duration of schoolwork experience (in year)	5.00 (3.00, 11.00) [156]	5.00 (2.00, 11.00) [411]	5 (2.00, 11.00) [567]
Median (IQR) [N] duration of total work experience (in year)	19.67(8.92, 28.00) [147]	15.21(7.13, 26.00) [400]	16.00(8.00, 26.00) [547]

Note. IQR = Interquartile range. N = Number of participants. SD = Standard Deviation.

4.7.2 Practitioners

In total, 383 Practitioners responded to the Emerging Minds survey. Within the survey, participants were allocated to one of two conditions (i.e. the “exposed” or “control” group) using the Qualtrics Survey Software functionality based on their responses to a series of questions about their exposure to the initiative (see Appendix E for full redirection logic description). Of the total respondents to the Emerging Minds survey, 97 participants were allocated to the exposed group and 192 participants were allocated to the control group. Following group allocation, 49 participants (32 from the exposed group and 17 from the control group) were excluded from the analysis as they did not respond to any of the key outcome items. The final analytic sample of Practitioners for the Emerging Minds survey was 240 participants. Of these participants, 65 met criteria for inclusion in the exposed group, and 175 participants met criteria for the control group. Most participants were female (79%) and the mean age of the sample was 45 years. The median years of experience working in the health or human services sector was 13 years (IQR: 7.75, 23). The professional background of Practitioners varied, with the largest background represented being psychologists (24%), followed by social workers (19%). There were also early childhood Educators and school teachers in this sample, which is consistent with the crossover effect of Educators using the Emerging Minds initiative only, or using both initiatives at the same time, which was observed in other Evaluation activities and in Program data reported by Emerging Minds.

Table 4.4 Characteristics of Practitioners who participated in the Emerging Minds survey

	Exposed % (n/N)	Control % (n/N)	Total % (n/N)
Sex			
Male	18.46(12/65)	19.43(34/175)	19.17(46/240)
Female	81.54(53/65)	78.29(137/175)	79.17(190/240)
Other	--	2.29(4/175)	1.67(4/240)
Mean age (SD) [N]	43.83 (11.55) [63]	44.94(12.48) [168]	44.64(12.22) [231]
Types of profession			
Consumer or Carer Consultant	--	0.57(1/174)	0.42(1/239)
Counsellor	10.77(7/65)	12.07(21/174)	11.72(28/239)
General Medical Practitioner	1.54(1/65)	2.87(5/174)	2.51(6/239)
Health Promotion Officer	--	1.72(3/174)	1.26(3/239)
Mental Health Nurse	3.08(2/65)	1.72(3/174)	2.09(5/239)
Nurse and/or Midwife	7.69(5/65)	2.3(4/174)	3.77(9/239)
Occupational Therapist	6.15(4/65)	4.02(7/174)	4.6(11/239)
Psychologist	18.46(12/65)	26.44(46/174)	24.27(58/239)
Social Worker	30.77(20/65)	14.37(25/174)	18.83(45/239)
Speech Pathologist	--	0.57(1/174)	0.42(1/239)
Teacher/Education	3.08(2/65)	17.24(30/174)	13.39(32/239)
Youth Worker	3.08(2/65)	4.6(8/174)	4.18(10/239)
Other	15.38(10/65)	11.49(20/174)	12.55(30/239)
Median (IQR) [N] duration of work experience (in year) in current workplace	4.33 (2.00, 7.67) [65]	3.92 (1.83, 8.41) [173]	4 (1.83, 8) [238]
Median (IQR) [N]duration of total work experience (in year)	13.00(8.00, 20.17) [65]	14.00(7.5, 23.00) [173]	13.00(7.75, 23.00) [238]

Note. IQR = Interquartile Range. N = Number of participants. SD = Standard Deviation.

4.8 Data analysis

A cross-sectional comparison of data collected after Program implementation was conducted between participants with and without access to or uptake of the Program as a dichotomous variable (i.e. Program users versus control group). Participants without access to or uptake of the Program in this case provided a “control” group for comparison of Program effects.

4.8.1 Group allocation

Be You. To allocate Educators to either the control or exposed group, a series of questions was asked to measure “exposure”. Participants were first asked if they had heard or participated in a range of Programs (including Be You, Emerging Minds, KidsMatter, MindMatters and others). If the participant did not spontaneously select Be You, they were then prompted with a specific question asking if they had heard about Be You. If they selected “No” to this question, they were allocated to the control group. If they selected “Yes”, they were asked a series of questions about their level of exposure. They were asked, “Have you browsed, read or downloaded any resources (e.g. fact sheets, tools) on the Be You website?”, and “Have you registered online

as an individual Educator or staff member for Be You?" If participants selected "Yes" to at least one of these questions, they were allocated to the exposed group. Participants who did not endorse engaging with Be You based on these questions (i.e. participants who selected "No" for both questions, or a combination of "No" and "Unsure", were allocated to the control condition.

***Emerging Minds*.** To allocate Practitioners to either the control or exposed group, a series of questions was asked to measure "exposure". Participants were first asked if they had heard about or participated in a range of Programs (including Be You, Emerging Minds, KidsMatter, MindMatters and others). If the participant did not spontaneously select Emerging Minds, they were then prompted with a specific question asking if they had heard about Emerging Minds. If they selected "No" to this question, they were allocated to the control group. If they selected "Yes", they were asked a series of questions about their level of exposure. They were asked, "Have you browsed, read or downloaded any resources (e.g. articles, podcasts, webinars, research papers, toolkits) on the Emerging Minds website?", and "Have you registered online for Emerging Minds eLearning courses?" If participants selected "Yes" to at least one of these questions, then they were allocated to the exposed group. Participants who did not endorse engaging with Emerging Minds based on these questions (i.e. participants who selected "No" for both questions, or a combination of "No" and "Unsure", were allocated to the control condition.

The full logic of this allocation procedure is detailed in Appendix E.

4.8.2 Statistical analysis

Descriptive analysis was first conducted to understand the characteristics of the Educators and Practitioners. For the between-groups analysis of participants' *current* perceptions of their knowledge and confidence in relation to child and youth mental health, we compared participants' median (Mdn) responses or proportions, depending on the measurement scale for the response variable. Comparisons between the exposed group and the control group were conducted using a simple quantile regression model. A binary logistic regression model was used to compare proportions, where relevant. Quantitative data from the survey were analysed with STATA.

Supplementary analyses: Difference-in-difference method

For some outcome indicators, retrospectively estimated pre-intervention data (exposed group) or "12 months ago" (control group) data were also collected. For these constructs, a difference-in-difference (DID) analysis approach was used to assess Program efficacy. The DID technique calculates the effect associated with an intervention (i.e. either Be You or Emerging Minds, depending on the survey) on selected outcomes. There were 8 outcome indicators examined in this way for the Emerging Minds survey, and 9 outcome indicators for the Be You survey (additional items relating to suicide postvention in learning communities were examined for Educators but not Practitioners because this was not in scope for Emerging Minds). The analysis compares the average change over time in the outcome variable for the exposed group to the average change over time for the control group.

The outcome indicators were assessed in two different scales in the efficacy analysis: numeric score that ranged from 0–100; and nominal scale with binary category (score >=80 vs <80). We used binary categories because of an observed clustering of scores around the mid-point (i.e. 50) of the response scale, which may have indicated a non-response or neutral rating.

A simple quantile regression model was first used to compare the median score between the exposed and control group at the two different time points (i.e. current time and "12 months ago/before the Program"). In contrast, a binary logistic regression model was used to compare the proportion of participation score >80 between the exposed and control groups.

Finally, to see the Program effect outcome indicators, we used the DID regression model. The DID estimate is a widely used statistical technique for pre-post intervention control design for efficacy analysis. In this approach, Program effect was measured as the DIDs in the median score (or proportion of score >80) of the outcome indicators. The estimate should be zero if there is no Program effect and negative if there is a reduction in the score or the proportion for the exposed participants compared to the control participants.

Technically, the regression model was the following structure to estimate the Program effect having adjusted by the difference in the score at the baseline (12 months ago):

Outcome = Intercept + a*Group + b*Time + c*Interaction + error

Where group is one if it is the exposed participants, and zero if it is the control participants; where time is one if recent time and zero if 12 months ago; and where interaction is one if the exposed group at the recent time. The c-coefficient will be considered as the estimate of the intervention effect. For the outcome of numeric score, the DID quantile regression model was used, whereas, for the binary outcome variables (score >80), the DID logistic regression model was used.

Using this method, there were no overall significant findings consistent with change attributable to participation in the initiatives, except for improvement of knowledge of referral pathways for Be You users. We present the results of the DID analyses in Appendix F.

4.8.3 Treatment of missing data

There were substantial missing values (~ 15%) on the outcome variables in the survey data. Therefore, the DID analysis was performed in both the available sample and the "missing value imputed" complete sample. We used the multiple imputation (MI) statistical technique to impute the missing value in our sample. In MI, the distribution of observed data is used to estimate a set of plausible values for missing data. The missing values are replaced by the estimated plausible values to create a "complete" dataset. Our outcome variables were continuous variables with a response range value between 0 to 100. Therefore, we used MI with the *"truncreg"* command in STATA to impute the missing outcome values, which fills in missing values of continuous variables with a restricted range (0 to 100) using a truncated regression imputation method. The imputation routine consisted of 1000 iterations to create 30 imputed datasets. Imputations were validated by comparing distributions of covariates before and after imputation. Efficacy estimates from the imputed sample were compared with the efficacy estimates with available case analysis. There were no significant changes in the estimates between the imputed sample and the available sample. Therefore, the efficacy estimates from the imputed sample were included in this report.

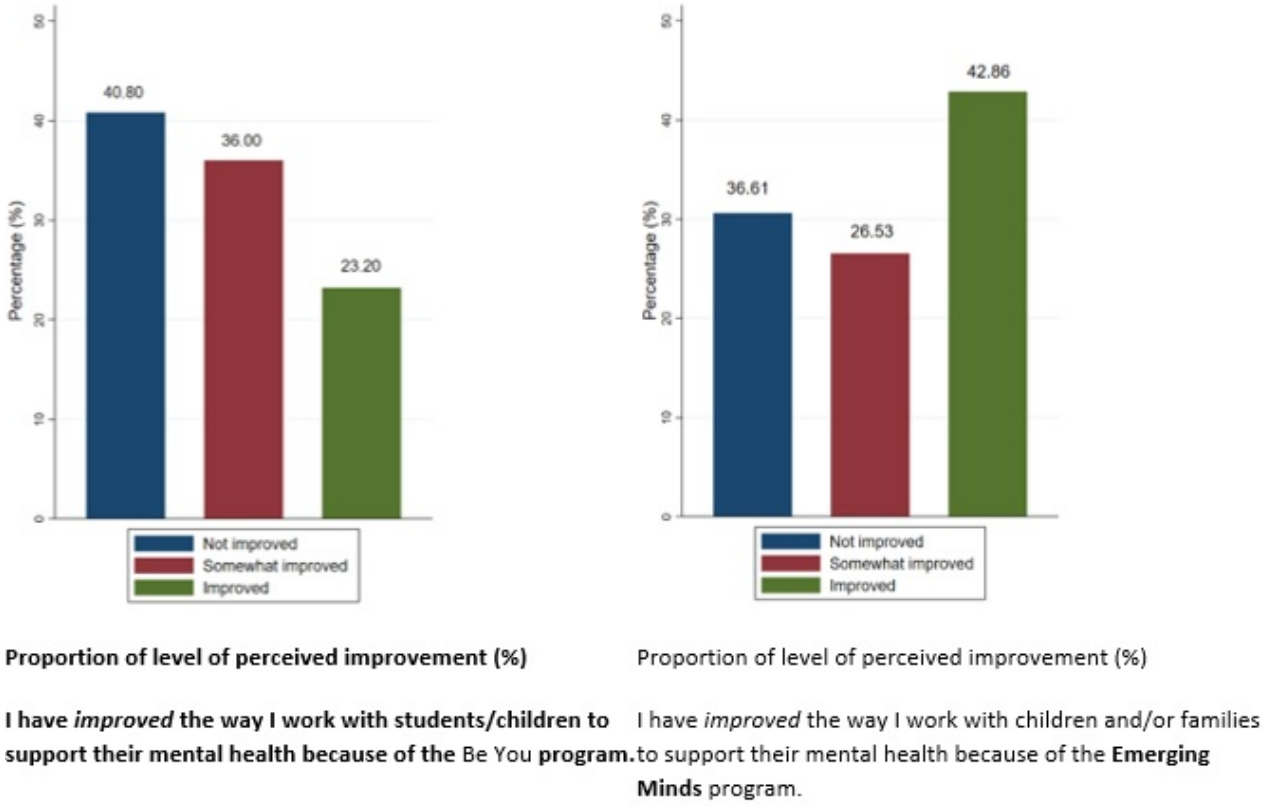
4.8.4 Coding of open-ended items

Qualitative data from the survey were coded and thematically analysed using NVivo qualitative data analysis software. Themes were reported based on the frequency with which they were mentioned by participants.

4.9 Results

Question 1, subquestion b, indicator 2: The extent to which users (Educators and Practitioners) working in different contexts used the Program to change their practice.

For this indicator, we drew on survey data with Educators and Practitioners who had been exposed to the initiatives. Participants were asked to respond on a VAS ranging from 0 (Not improved) to 100 (Improved). Figure 4.1, presented below, represents participants' scores on this scale that have been categorised into *Not improved* (0–40), *Somewhat improved* (>40–60) and *Improved* (>60–100).



Note. Responses were provided on a 100-point VAS ranging from 0 (Not improved) to 100 (Improved). Participant's responses were categorised into Not improved (0-40), Somewhat improved (>40-60), and Improved (>60-100).

Figure 4.1 Proportion of Educators and Practitioners who perceived that they had improved the way they work with children and families to support their mental health because of the Be You (left) and Emerging Minds (right) initiatives.

59% of Be You users self-reported that they had *Somewhat improved* or *Improved* the way they work with students/children because of the Be You initiative (41% *Not improved*): *Mdn* = 50 (IQR: 21, 60) [N=125].

69% of Emerging Minds users self-reported that they *Somewhat improved* or *Improved* the way they work with children and/or families to support their mental health because of the Emerging Minds initiative (31% *Not improved*): *Mdn* = 56 (IQR: 27, 75) [N = 49].

Overall, most of the Emerging Minds user sample reported that their practice in relation to child and youth mental health had *Somewhat improved* or *Improved* because of the Program. Approximately half of the sample of Be You users reported that they had *Somewhat improved* or *Improved* their practice because of the Program, indicating that there is some scope to improve meaningful engagement and increase focus on practice change components of the Be You initiative. However, it should be noted that the Be You initiative launched in November 2018 (approximately one year prior to survey data collection), and responses during this early stage of implementation may reflect the relatively high proportion of users reporting no practice change.

Question 1, subquestion c, indicator 2: Extent to which users and stakeholders agree that the service coverage/provision is designed to be equitable, needs-driven.

Educators and Practitioners who were exposed to the Be You or Emerging Minds initiatives were asked a set of items about the extent to which they agreed that the initiatives were appropriate for working with a diverse range of population groups. They were asked to respond on a VAS ranging from 0 (*Strongly disagree*) to 100 (*Strongly agree*). Participants' scores on this scale were then categorised into *Disagree* or *Strongly disagree* (0–40), *Neither agree nor disagree/Neutral* (>40–60) and *Agree* or *Strongly agree* (>60–100). Table 4.5 and Table 4.6 present the proportion of users who agreed or disagreed with these statements for Be You and Emerging Minds, respectively.

Table 4.5 Proportion of Be You users who agree or disagree that the Be You initiative is appropriate to meet the diverse needs of users working with different population groups

	Disagree or Strongly disagree % (n)	Neither agree nor disagree % (n)	Agree or Strongly agree % (n)
Be You meets the diverse needs of the children and young people who attend my Early Learning service or school; Mdn = 57(IQR = 50, 75) [N = 128]	14.84% (19)	42.19% (54)	42.97% (55)
Be You is appropriate for Aboriginal and Torres Strait Islander students/children; Mdn = 52(IQR = 50, 75) [N = 126]	13.49% (17)	46.03% (58)	40.48% (51)
Be You is appropriate for students/children from culturally and linguistically diverse backgrounds; Mdn = 52(IQR = 50, 77) [N = 123]	18.70% (23)	39.02% (48)	42.28% (52)
Be You is appropriate for students/children with a disability; Mdn = 52(IQR = 50, 80)[N = 126]	13.49% (17)	42.86% (54)	43.65% (55)
Be You is appropriate for students/children who identify as LGBTIQ; Mdn = 54(IQR = 50, 78) [N = 121]	16.53% (20)	39.7% (48)	43.80% (53)

Note: IQR = Interquartile range; LGBTIQ = Lesbian, Gay, Bisexual, Trans and Gender Diverse, Intersex and Questioning; Mdn = Median; N = number of respondents. Educators rated their level of agreement on a VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree). Participants' scores on this scale were then categorised into one of three categories: Disagree or Strongly disagree (0–40), Neither agree nor disagree/Neutral (>40–60) and Agree or Strongly agree (>60–100).

Overall, 43% of Be You users *Agree* or *Strongly agree* that Be You is appropriate to address the range of children and young people who they interact with in their ELS or school. When enquiring about specific groups of children with diverse needs, the proportion of users who *did not* agree that the Be You initiative was appropriate was highest for culturally and linguistically diverse children or young people (19%).

The proportion of users who *Agree* or *Strongly agree* that the content of Be You is appropriate for diverse groups of children and young people was lower than the figures reported in the Be You 2019 Implementation and Early Outcome Evaluation Report (approximately 66% agreement). There was no comparable data from the Emerging Minds individual evaluation for comparison.

For Emerging Minds users, 45% of users *Agree* or *Strongly agree* that the Emerging Minds initiative is appropriate to address the range of children and families who they interact with in their workplace. When enquiring about specific groups of children or families with diverse needs, the proportion of users who agreed or strongly agreed that the initiative was appropriate was highest for Aboriginal and Torres Strait Islander groups (40% *Agree* or *Strongly agree*; 10% *Disagree* or *Strongly disagree*).

Table 4.6 Proportion of Emerging Minds users who agree or disagree that the Emerging Minds initiative is appropriate to meet the diverse needs of users working with different population groups

	Disagree or Strongly disagree % (n)	Neither agree nor disagree % (n)	Agree or Strongly agree % (n)
The Emerging Minds program meets the diverse needs of the children and young people who attend my workplace; Mdn = 55(IQR: 48, 77) [N = 51]	13.73% (7)	41.18% (21)	45.1% (23)
Emerging Minds is appropriate for Aboriginal and Torres Strait Islander children and/or families; Mdn = 50.5(IQR = 48, 74) [N = 50]	10% (5)	50% (25)	40% (20)

	Disagree or Strongly disagree % (n)	Neither agree nor disagree % (n)	Agree or Strongly agree % (n)
Emerging Minds is appropriate for Children and/or families from culturally and linguistically diverse backgrounds; Mdn = 50(IQR = 48, 70) [N = 51]	15.69% (8)	50.98% (26)	33.33% (17)
Emerging Minds is appropriate for Children and/or families with a disability; Mdn = 52(IQR = 47, 68) [N = 51]	17.65% (9)	47.06% (24)	35.29% (18)
Emerging Minds is appropriate for Children and/or families who identify as LGBTIQ Mdn = 54.5(IQR = 48, 72.5) [N = 52]	15.38% (8)	46.15% (24)	38.46% (20)

Note. IQR = Interquartile range; LGBTIQ = Lesbian, Gay, Bisexual, Trans and Gender Diverse, Intersex and Questioning; Mdn = Median; N = number of respondents. Practitioners rated their level of agreement on a VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree). Participants' scores on this scale were then categorised into one of three categories: Disagree or Strongly disagree (0–40), Neither agree nor disagree/Neutral (>40–60) and Agree or Strongly agree (>60–100).

Question 1, subquestion d, indicator 2: The degree to which Educators and Practitioners report feeling confident in their ability to connect with, utilise and, where appropriate, refer children and young people to mental health supports compared to no Program.

Question 1, subquestion d, indicator 3: The degree to which Educators and Practitioners report changes to ways of working with, or referring on to, other mental health settings, compared to no Program.

Question 3, subquestion c, indicator 4: Users report an improved understanding of when it is appropriate to refer children and young people for specialist support compared to no Program.

Question 3, subquestion d, indicator 1: The extent that users report an improved understanding, awareness and availability of appropriate service referral pathways compared to no Program.

For these indicators, we drew upon a range of survey questions about referral processes and procedures. First, participants were asked to rate their agreement about the extent to which they understood their role in referring children/families for mental health support.

Table 4.7 shows that the extent that Educators reported understanding their role in referring students was very high among users exposed to the Be You initiative (Mdn = 93), and significantly higher than compared to Educators who had not been exposed to the Be You initiative (Mdn 79).

Table 4.8 shows that there was no significant difference between Practitioners who were exposed to the Emerging Minds initiative (Mdn = 93) and those who were not (Mdn = 89) with regard to their agreement that they had a role in referring children and families to external services for mental health support. This lack of difference may be because there was high agreement that referring children and families to external mental health supports was understood as part of the Practitioner's role, regardless of group membership.

Table 4.7 Educators' perception of their role in referring students/children to external services for mental health support

	Control Mdn (IQR) [n]	Exposed Mdn (IQR) [n]	*D* (95% CI) SIG
I understand my role in referring students/children to external services for mental health support	79 (50, 92) [411]	93 (75, 100) [157]	14 (8.11, 19.89) <0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; n = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group. Educators rated their level of agreement on a VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree).

Table 4.8 Practitioners' perception of their role in referring children and families to external services for mental health support

	Control Mdn (IQR) [n]	Exposed Mdn (IQR) [n]	*D* (95% CI) SIG
I understand my role in referring children and/or families to external services for mental health support	93 (78, 100) [174]	89 (77, 100) [59]	-4 (-12.23, 4.23)) 0.339

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; n = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group. Practitioners rated their level of agreement on a VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree)

Educators and Practitioners were also asked a series of related questions about how confident they felt with knowing *when* and *how* to refer children and young people for external support, and then how to connect and work with these external supports. Participants were asked to respond on a VAS ranging from 0 (not at all confident) to 100 (very confident). The median item scores and the difference between the exposed and control groups are presented in Table 4.9 (Educators) and Table 4.10 (Practitioners). An aggregate score is also reported and depicted in Figure 4.2.

Overall, the degree to which Educators reported feeling confident in their ability to connect with, utilise and, where appropriate, refer children and young people to mental health supports was higher for those Educators who had been exposed to Be You (Average Mdn = 85) compared to Educators who had not been exposed to Be You (Average Mdn = 56).

The median confidence score for Practitioners was not significantly different for those Practitioners who were exposed to Emerging Minds (Average Mdn = 87) compared to those who were not (Average Mdn = 83). However, the median confidence score was consistently high for both groups.

These data suggest that Educators who have been exposed to the initiative have greater confidence in their ability to connect with, utilise and, where appropriate, refer children and young people to external mental health supports compared to no initiative. Although Practitioners exposed to the Emerging Minds initiative do not have greater confidence in their ability to work with external service supports compared to the control group, these data show that these Practitioners have consistently high confidence, regardless of exposure to the Program.

Table 4.9 Educators' knowledge of when and how to refer students/children to external services for mental health support

	Control Mdn (IQR) [n]	Exposed Mdn (IQR) [n]	*D* (95% CI) SIG
I know <u>when</u> to refer students/children to mental health services external to my workplace	61 (36, 85) [393]	88 (70, 100) [151]	27 (17.89, 36.11) <0.0001
I know <u>how</u> to refer students/children to mental health services external to my workplace	59 (29, 85) [377]	85.5 (65, 100) [150]	26 (17.38, 34.62) <0.0001
I know how to connect children and/or families with mental health services external to my workplace when needed	52 (26, 80) [373]	86 (60, 100) [151]	34 (26.48, 41.52) <0.0001
I know how to work with external services to support students/children with mental health needs	51.5 (28, 80) [360]	87 (56, 100) [149]	35 (28.48, 41.52) <0.0001
Average:	56 (30.5, 79) [396]	85 (61.75, 99.5) [151]	29 (21.02, 36.98) <0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; n = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group. Educators rated their level of agreement on a VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree).

Table 4.10 Practitioners' knowledge of when and how to refer children and/or families to external services for mental health support

	Control Mdn (IQR) [n]	Exposed Mdn (IQR) [n]	*D* (95% CI) SIG
I know <u>when</u> to refer a child and/or family to mental health services external to my workplace	89 (72, 100) [167]	87 (77, 100) [59]	-2 (-10.03, 6.03) 0.624
I know <u>how</u> to refer a child and/or family to mental health services external to my workplace	83 (56, 97) [166]	88 (70, 100) [59]	5 (-4.28, 14.28) 0.290
I know how to connect children and/or families with mental health services external to my workplace when needed	83 (60, 96) [165]	87 (78, 100) [59]	4 (-2.02, 10.02) 0.192
I know how to work with external services to support children and/or families with mental health needs	82.5 (60, 96) [166]	87 (73, 100) [59]	5 (-3.69, 13.69) 0.258
Average:	83 (60, 96) [165]	87 (78, 100) [59]	4 (-2.02, 10.02) 0.192

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; n = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group. Practitioners rated their level of agreement on a VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree).

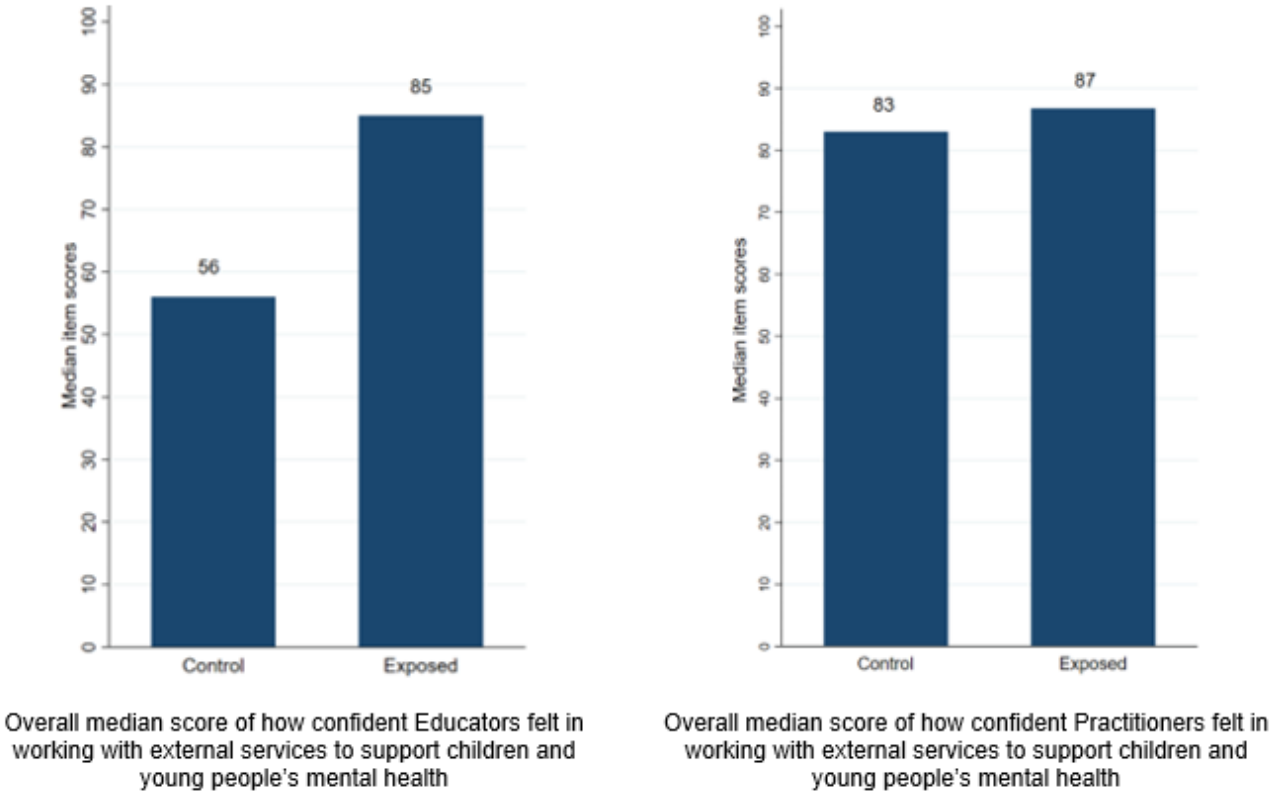


Figure 4.2 Comparison between control and exposed groups' median aggregate score for Educators' (left) and Practitioners' (right) knowledge of how and when to refer children/families to external services to support their mental health

Question 1, subquestion e, indicator 1: Reported enablers and barriers of implementation identified by users, consultants and Beyond Blue and Emerging Minds. (D1, D2, D3, D4)

Two open-ended questions were included in each of the surveys to elicit factors that enabled or impeded the implementation of the initiatives from the users' perspective. Open-ended questions were used to obtain unconstrained responses. These data were interrogated to identify common themes. An inductive analysis approach was used. These findings are reported below.

Participants in the control and exposed groups were asked what things help them or inhibit them from providing mental health support for students/children in their workplace. The responses from the control group and exposed group were first examined separately to determine if there were any substantive differences based on group membership. The top 3 enablers and barriers for each group (control and exposed) for each initiative (Be You and Emerging Minds) are reported in Table 4.11 and Table 4.12, respectively.

Table 4.11 Summary of the 3 most frequently cited enablers and barriers of supporting the mental health of children and young people, as reported by Educators, control and exposed groups

Top 3 enablers		**Top 3 barriers**	
Be You control group	Be You exposed group	Be You control group	Be You exposed group
Availability of internal specialised support	School and structural support	Not enough time/workload constraints	Not enough time/workload pressure
Structural and leadership help	School culture that supports and promotes mental health	Lack of knowledge and training	Parent, family or child support

Top 3 enablers		Top 3 barriers	
Collaboration with other staff	Awareness and availability of external supports	Parent, family or child support	Lack of funding and resources

Table 4.12 Summary of the 3 most frequently cited enablers and barriers of supporting the mental health of children and young people, as reported by Practitioners, control and exposed groups

Top 3 enablers		Top 3 barriers	
EM control group	EM exposed group	EM control group	EM exposed group
Availability of evidence-based information and programs	Availability of evidence-based information and resources	Not enough time/workload constraints	Barriers to access external services
Workplace structures and leadership support	Collaboration with colleagues	Lack of funding and resources	Lack of funding and Resources
Workplace culture that supports and promotes mental health	Workplace structures and leadership support	Barriers to access external services	Not enough time

Note. EM = Emerging Minds.

Given that the top 3 enablers and barriers for Educators and Practitioners did not vary substantially between the exposed and control groups, we report the full collated findings in detail for both Educators (see Table 4.13) and Practitioners (see Table 4.14) below.

Table 4.13 below presents the major recurring themes that were identified by all Educators (i.e. control and exposed groups collapsed) as being enablers or barriers to supporting the mental health and wellbeing of children and young people. These themes are presented in descending order from the most frequently reported to the least reported. Infrequently reported responses (i.e. fewer than four mentions by control or exposed groups) are not reported below.

Table 4.14 below presents the major recurring themes that were identified by all Practitioners (i.e. control and exposed groups collapsed) as being enablers or barriers to supporting the mental health and wellbeing of children and young people. These themes are presented in descending order from the most frequently reported to the least reported. Infrequently reported responses (i.e. fewer than four mentions by control or exposed groups) are not reported below.

A wide range of enablers and barriers to supporting child and youth mental health were identified. These enablers and barriers were identified at different levels of context: individual (e.g. Educator/Practitioner wellbeing, personal mindset and attitudes), school and workplace environment (e.g., structural and leadership support, school/organisation culture), external service system factors (e.g., awareness and availability of external services, funding and policy level support), parental and family factors (i.e., parent and family support or non-support), and the broader community (e.g., community attitudes, stigma). Themes about the school and workplace environment were raised consistently as both enablers and barriers of providing mental health. The most frequently mentioned barrier was a lack of time and workload pressure. Other school/ organisation factors commonly reported included structural and leadership support (or non-support), school/workplace culture, and availability (or non-availability) or internal specialised support (or lack thereof). These school and workplace environment level findings represent important barriers to address within the scope of the Program.

Table 4.13 Educators' Perceptions of the Enablers and Barriers to Supporting the Mental Health of Children and Young People

Enabler reported	Example quote	Barrier reported	Example quote
Availability of internal specialised support (41)	"There have been mental health specialists in all the schools I've worked in. Having had little such specialised training myself, I've called on the expertise of the specialists to either advise me or support the child directly." (Control group)	Not enough time/ workload pressure (88)	"Main inhibiting factor is huge workload and little time/staffing resource to meet mental health needs in the schools I work at." (Control group)
Structural and leadership support (33)	"Leadership are very supportive and have a wealth of knowledge as to whom to contact for further support." (Control group)	Lack of knowledge and training (41)	"I am inhibited as there are teachers who are targeted for these types of training due to their role in welfare within the school. As I do not currently hold a welfare role, I do not have access to any of this type of training and I have never been targeted." (Control group)
Workplace culture that supports or promotes mental health (20)	"Our school climate is good – teachers are pretty much universally of the view that this is a great place to work. We 'have each other's backs' and support each other." (Control group)	Lack of parent and family, or child support (34)	"Lack of parent support in two ways: 1) Parents not admitting there's a problem with their child's mental health, and 2) Parents using mental health as an excuse for their child to not attend school or complete work, rather than encouraging resilience and seeking help in order to improve the situation." (Control group)
Awareness and availability of external supports (16)		Lack of awareness or availability of external support (26)	"Changing government services. Hard to be sure about what is available……. lack of appointments to specialists available, long waiting lists for appointments." (Control group)
Professional development (15)	"Up to date training and information is helpful. My employer provides training in suicide prevention and youth mental health first aid training." (Control group)	Lack of funding and resources (23)	"Money allocation and time allocation." (Control group)
Collaboration with other staff (9)	"We have approachable staff to discuss any concerns. You need to remember to speak up with colleagues whenever you are concerned about a student and be persistent." (Control group)	Lack of perceived responsibility or clarity (by self or others) that work role requires it (18)	"I don't know enough or what my role is, I tend to hand ball it to senior staff who I hope will contact the social worker or appropriate people." (Control group)
Availability of	"Private services and websites extremely helpful."	Poor Educator	"My own mental health issues due to work/home

Enabler reported	Example quote	Barrier reported	Example quote
online resources (12)	(Control group)	wellbeing (13)	imbalances and the demands of the school." (Control group)
Personal mindset and attitudes toward mental health (8)	"Staff disposition: a willingness to want to connect with students despite the challenges." (Control group)	Culture and language barriers (12)	"I feel the school as a whole has neglected the importance of understanding that Aboriginal families are in need of a more cultural approach to mental health but in saying this, I know the school would be open in learning how this could be implemented into our workplace." (Control group)
Availability of evidence-based information and programs (6)	"… research, awareness, school programs like SPEAK UP! Stay ChatTY." (Control Group)	Class sizes too large (12)	"Big class sizes also inhibit how well you can know your class." (Control group)
Parent/family or child support (6)	"Parental acknowledgement and support." (Control group) "The students themselves being open to discuss mental health, particularly if it is a taboo subject at home." (Control group)	Personal mindset and attitudes (11)	"My core business as a teacher is to educate students to become literate and numerate. I don't believe I should have to add to this already very high workload to manage the mental health of students as well." (Control group)
		Lack of information (due to confidentiality issues or information sharing) to support individuals (10)	"Often teachers are unaware of issues that are occurring with their students outside of school. Sometimes Principals are informed but we may not be told due to confidentiality reasons." (Control group)
		Community attitudes to mental health (i.e. stigma) (10)	"Stigma about discussing mental health issues or seeking help." (Control group)
		Lack of availability of internal specialised support (8)	"There is a significant shortage of psychologists who can be placed in schools. The result is that a senior college of over 850–900 students only have access to a psych on average 2–3 days a week. This puts huge pressure on other staff supporting students' mental

Enabler reported	Example quote	Barrier reported	Example quote
			health and limits students' access to the expertise of a psych." (Control group)
		Curriculum crowding (8)	"Trying to teach a curriculum loaded subject does not allow for a teacher to take time to get to know his/her students and getting know their mental health issues." (Control group)
		Lack of structural and leadership support (7)	"Lack of responses from those in hierarchy when expressing concerns." (Control group)
		Lack of evidence-based information (6)	"… finding evidence-based resources." (Control group)
		Workplace culture that does not support or promote mental health (5)	"… a disengaged school community (working on this!)." (Control group)
		High and complex needs of children and students (5)	"The increase in the number of students with mental health challenges." (Control group)
		Discontinuity of contact with children (4)	"I am a relief teacher so am all over the place." (Control group)
		Geographical isolation (4)	"Living in a rural area there are few external support services." (Control group)

Note. Enablers and barriers are reported in descending order of most frequently reported to least frequently reported.

Table 4.14 Practitioners' perceptions of the enablers and barriers to supporting the mental health of children and their families

Enabler reported	Example quote	Barrier reported	Example quote
Availability of evidence-based information and programs (17)	"Access to good training and programs that are evidence-based and easily available." (Control group)	Not enough time/workload constraints (36)	"Have a large workload for the hours I work, and I often have to prioritise which means I am not always able to meet with children/their families or am not able to be as responsive as they need." (Control group)
Workplace structures and leadership support (16)	"Having a supportive workplace culture, colleagues and management willing to assist with professional knowledge and practice wisdom, regular professional supervision, services which make referrals easy and are willing to collaborate to meet the needs of the client." (Control group)	Lack of funding and resources (26)	"Workplace models of care – some service requirements are contrary to best practice for particular diagnostic groups. This is associated with funding levels, FTE and service priorities." (Control group)
Workplace culture that supports and promotes mental health (12)	"Things that help: support team and workplace culture." (Control group)	Barriers to access external services (26)	"Long referrals wait times for bulk-billing mental health Practitioners." (Control group)
Professional development (12)	"Access to resources, services and professional development." (Control group)	Geographical isolation (15)	"Availability of services in rural areas and consistency of services provided" (Control group)
Collaboration between services and agencies (10)	"Working cooperatively as part of a care team. For example, when a GP completes a very detailed referral and is willing to work alongside me to ensure that risk and any medication needs are managed. Or to work with CAMHS/CYMHS or a psychiatrist if required to ensure safety. Working alone with a child who has mental health concerns is only appropriate when risk is deemed low – this is becoming rarer." (Control group)	Parent/family support (14)	"Family issues can inhibit clinicians from providing support. For example, family member disagreeing or unwilling to support children with their therapeutic goals. Family custody or legal issues inhibited by parents attempting to triangulate clinicians." (Control group)
Collaboration with colleagues (10)	"Things that help – working in an environment with clinicians from a range of disciplines and expertise who are happy to share their knowledge. Very supportive work colleagues." (Control group)	Awareness and availability of external support (13)	"Referral pathways are sometimes limited." (Control group)

Enabler reported	Example quote	Barrier reported	Example quote
Parent/family support (7)	"Encouraging families to come in as opposed to individuals." (Control group)	Lack of continuity of care (10)	"Difficulty recruiting staff to meet the demand for services. Lack of options to refer families on to where they cannot afford private services and are not eligible for public/NGO services." Cessation of treatment when Better Access Medicare rebate annual allocation is used. Difficulty for families in accessing Psychoeducational or Developmental Assessment to assist with differential diagnosis and treatment planning - long waiting lists, not eligible, or cannot afford private services. Schools not supporting recommendations for supporting children's mental health in the school environment." (Control group)
		Lack of knowledge and training (9)	"The lack of knowledge about what services I can refer them to. Part of my role I cover basic mental health signs to look out for and to see school counsellor. We have a booklet about how kids respond to trauma that we give to all our patients but other than that that's about it. There doesn't seem to be a lot of education around mental health in kids in my workplace unless you work in that department or ward. I also lack the skills to start these conversations and keep them going and lack the skills to provide the support." (Control group)
Awareness and availability of external supports (7)	"Local skilled professionals are a help." (Control group)	Lack of collaboration between services and agencies (8)	"Lack of agency collaboration, particularly between govt services and NGO or not profit when a systemic approach is required." (Control group)

Enabler reported	Example quote	Barrier reported	Example quote
Availability of online resources (4)	"Help – CPD + colleagues + online availability." (Control group)	Community attitudes toward mental health and support (e.g. stigma) (7)	"A sad, but widespread community attitude and stigma working against child and adolescent mental health." (Control group)
Adequate funding and resources (4)	"Funded programs – assist low-income families to get care." (Control group)	Lack of evidence-based information or programs (6)	"Lack of access and readily available resources … lack of examples how to use the resources." (Control group)
Experience (4)	"20 years' experience working in a Child and Adolescent Mental Health Service has given me confidence, skills and knowledge to work with children and families. I then add 11 years' experience in private practice to support me to help children and families." (Control group)	Workplace structures and leadership support 5)	"The CAPA model hinders my ability to update my knowledge of recent research, trends or practices because I am allocated a particular number of new clients that I must attain – so opportunities for study don't happen and if you happen to fall ill or need to be home to look after your kids – you still have the same amount of clients allocated to you." (Control group)
Personal mindset and attitude (4)	"See people's diagnosis as something separate from them – it is not who they are in totality." (Control group)	Service gaps (5)	"Gaps in the system, not meeting all the criteria for some services, some services reluctant to accept referrals, organisational limitations (no outreach, no home visits)." (Control group)
		Lack of affordable or convenient professional development (5)	"Problem of lost income while attending CPD, I live in a regional area so the cost of attending CPD events." (Control group)

Enabler reported	Example quote	Barrier reported	Example quote
		Lack of role clarity (5)	"Unsuitable environment (adult clinical setting) and inappropriate models of care (insufficient opportunity to work independently with parents to ensure approach is consistent between home and therapy setting)." (Control group)
		High and complex needs of children (4)	"Large volume of needs – not being able to address the need due to large volume of clients, complexity of their problems." (Control group)
		Medicare session limitations (3)	"Even under Medicare there are the constraints of only 10 sessions which do not meet the needs of complex family dynamics of child mental health." (Exposed group)

Note. Enablers and barriers are reported in descending order of most frequently reported to least frequently reported.

Enablers and barriers of implementing the learnings from the initiatives as reported by users

Participants were also asked to identify any enablers or barriers that they experienced with their use of the Be You and Emerging Minds initiatives specifically. Only Educators and Practitioners who had been exposed to the initiatives were asked to respond to this question. Table 4.15 presents Be You users' perceptions of the enablers and barriers of implementing the learnings from Be You in descending order of most frequently reported to least frequently reported. Infrequently reported responses (i.e. fewer than two mentions) are not reported below. Table 4.16 presents Emerging Minds users' perceptions of the enablers and barriers of implementing the learnings from Emerging Minds, also in descending order. Due to the small sample size of Emerging Minds users, all responses are reported.

The number of participants who responded to this open-ended question was small, particularly for the Emerging Minds User survey. Enablers and barriers of initiative use were predominantly identified at the school/workplace level (e.g. time and workload pressure, school/organisation structural and leadership support, whole-school/organisation approach). Person-level factors such as personal mindset and attitude, personal preferences for specific materials and modality of delivery were also commonly identified. Additional enablers and barriers were identified at the intersection between the user and initiative. The most frequently cited enabler for Be You users was interactions with consultants. However, when consultant availability was limited or the interaction was negative, this was cited as a barrier to engagement.

Table 4.15 Enablers and barriers of implementation of the learnings from the Be You initiative, as reported by Educators exposed to Be You

Enablers reported	Example quote	Barriers reported	Example quote
Consultant support (8)	"The support staff from Be You that were allocated to our school were fantastic and made accessing their knowledge and expertise around the Program much easier."	Time/workload pressure (18)	"it has been difficult to find the time to familiarise myself more with the Be You resources".
School structural and leadership support (5)	"Admin support building it into staff meetings allowed more time."	Lack of desired content (5)	"It seemed hard to find resources to use for students, such as videos to show and online materials to directly use with students."
Helpful information (5)	"I like that the programs have a summary of cost, geographical area and learning goals which saves a lot of time researching this myself."	Personal attitudes towards mental health (3)	"Trying to get staff enthusiastic about PD on mental health."
Internal specialised support encourages use (2)	"Guidance Officer and Chaplain at school are very proactive and supportive of Be You. I was already a part of MindMatters."	Online modality (3)	"I enjoy a more face to face approach on learning."
Initiative promotion activities (2)	"Early Childhood Teachers' Association Annual Conference enabled me to have a good look at the website and what it offered, as well as the school."	School structural or leadership support (2)	"Barriers are definitely executive that are intimidated by what they don't understand and barriers of lack of community support and buy in…… Needs to be whole school for full effectiveness."
School culture supports and promotes mental health (1)	"Our school team is very committed and have worked collaboratively and successfully as a team to implement and support programs in the school."	Lack of consultant support (2)	"Yes, the local rep refused to come to our school because she 'didn't have time'. When I spoke to GOs from other schools they said they had the same response – that the local rep would only speak to groups of schools at once (even though their school has 3000 students). Communication is very poor."

Enablers reported	Example quote	Barriers reported	Example quote
		Unfavourable comparison to previous programs (2)	“KidsMatter had the whole package – surveys, data collection, audit tools and planning assistance.”
		School/service culture does not support mental health (1)	“Overall, I think the schools in general just shrug mental health off, and 'don’t' have time', or 'it's someone else’s job'.”
		Lack of community support (1)	“Lack of community support and buy in.”
		Lack of whole-school approach of emphasis (1)	“Encouraging staff to follow individual professional learning does not promote whole-school culture which as far as I am aware is the most successful way to embed new learning.”
		Lack of fit with curriculum (1)	“Just difficult to find where in the curriculum some sessions belong.”
		Lack of applicability to diverse age range (1)	“We tried to introduce KidsMatter to our school some years ago. Difficult in an F–12 setting, it fell by the wayside and I feel we still need something to have a consistent approach to teaching and helping students navigate their mental health.”

Note. Enablers and barriers are reported in descending order of most frequently reported to least frequently reported

Table 4.16 Enablers and barriers of implementation of the learnings from the Emerging Minds initiative, as reported by Practitioners exposed to Emerging Minds

Enabler reported	Example quote	Barrier reported	Example quote
Leadership encouragement to engage (3)	"Manager encouraged completing this as part of induction."	Not enough time (3)	"Barriers are primarily time – I see a lot of great content on EM emails and have flagged them to review when I have time."
Time and resourcing allow access during work hours (2)	"Workplace recommendation and supporting of accessing resources during work hours when possible was very helpful and showed how valued these resources and knowledge is."	Lack of specificity to work type (2)	"Not really relevant to my practice – I am a solo practitioner and am not often in a position to refer children to other services."
Colleague support to engage with initiative	"Wellbeing Hub colleagues."	Lack of referral information (1)	"Not enough referral information relating directly to my work environment."
		Need for organisational support to Implement (1)	"Need systematic supports in your organisation to guide implementation of learning in practice."
		Website difficulties with navigation (1)	"Website can be difficult to navigate."

Note. Enablers and barriers are reported in descending order of most frequently reported to least frequently reported

Question 2, subquestion a, indicator 1: The degree to which users agree that the range of resources (e.g. modules, programs, webinars, factsheets) meets their needs to address child and youth mental health needs.

Educators and Practitioners who were exposed to the initiatives were asked to rate their agreement on a series of statements about their overall satisfaction with the initiatives, including the online components and professional learning. Participants responded to a VAS of 0 to 100. The anchor labels (e.g. *Strongly agree*, *Excellent*) varied depending on the statement. These results are presented in Table 4.17 and Table 4.18 for Be You and Emerging Minds, respectively.

Overall, there were low levels of dissatisfaction with each of the initiatives. Most users rated the quality of professional development and training as *Excellent*. The extent that the initiatives met the users' needs in terms of being a "one stop shop" for resources and support was low: a small proportion of Be You users (29%) and of Emerging Minds users (17%) agreed that all their needs were met by the respective initiatives. Most users of each of the initiatives (58% Be You users and 80% Emerging Minds users) agreed or strongly agreed that they needed to use additional resources than those provided by the initiatives to support child or youth mental health within their work setting. This finding indicates that there may be opportunities to expand resources and supports for the Be You initiative, which has the stated design intent to be "one single, national end-to-end education-based program" (see Be You website). Although there was no equivalent design intent for the Emerging Minds initiative, these results indicate that there is also scope to expand resources and support.

Table 4.17 Proportion of Be You users who agree or disagree that they are satisfied with the Be You initiative and its range of resources and professional development activities

	Disagree or Strongly disagree % (n)	Neither agree nor disagree % (n)	Agree or Strongly agree % (n)
I am satisfied <u>overall</u> with the Be You program; Mdn= 65(IQR: 50, 83) [N = 129]	11.63% (15)	31.01% (40)	57.36% (74)
Everything I need to support mental health of children and young people in my role is covered by Be You; Mdn= 50(IQR: 34, 71) [N = 123]	32.52% (40)	38.21% (47)	29.27% (36)
I need to use other resources in addition to those provided by Be You; Mdn= 74(IQR: 50, 86) [N = 127]	10.24% (13)	27.56% (35)	62.2% (79)
	Poor	Neither poor nor excellent	Excellent
The quality of the professional development for Be You; Mdn= 65(IQR: 50, 84) [N= 123][a]	11.38% (14)	30.89% (38)	57.72% (71)

Note. IQR = Interquartile range; Mdn = Median; N = number of respondents

Educators rated their level of agreement on a VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree). Participants' scores on this scale were then categorised into one of three categories: Disagree or Strongly disagree (0–40), Neither agree nor disagree/Neutral (>40–60) and Agree or Strongly agree (>60–100).

a Educators rated their level of agreement on a VAS ranging from 0 (Poor) to 100 (Excellent). Participants' scores on this scale were then categorised into one of three categories: Poor (0–40), Neither poor nor excellent/Neutral (>40–60), and Excellent (>60–100).

Table 4.18 Proportion of Practitioners who agree or disagree that they are satisfied with the Emerging Minds initiative and its range of resources and professional development activities

	Disagree or Strongly disagree % (n)	Neither agree nor disagree % (n)	Agree or Strongly agree % (n)
I am satisfied overall with the Emerging Minds program; Mdn= 64(IQR: 50, 81)[N = 53]	13.21% (7)	30.19% (16)	56.6% (30)
Everything I need to support the mental health of children and/or families in my role is covered by the Emerging Minds program; Mdn= 47(IQR: 25, 55) [N = 46]	34.78% (16)	47.83% (22)	17.39% (8)
I need to use other resources in addition to those provided by Emerging Minds; Mdn= 83(IQR: 68, 100) [N = 55]	3.64% (2)	16.36% (9)	80% (44)
	Poor	Neither poor nor excellent	Excellent
The quality of the training courses, webinars and/or podcasts by Emerging Minds: Mdn= 69(53, 80) [52] [a]	9.62% (5)	28.85% (15)	61.54% (32)

Note. IQR = Interquartile range; Mdn = Median; N = number of respondents

Practitioners rated their level of agreement on a VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree). Participants' scores on this scale were then categorised into one of three categories: Disagree or Strongly disagree (0–40), Neither agree nor disagree/Neutral (>40–60), and Agree or Strongly agree (>60–100).

a Practitioners rated their level of agreement on a VAS ranging from 0 (Poor) to 100 (Excellent). Participants' scores on this scale were then categorised into one of three categories: Poor (0–40), Neither poor nor excellent/Neutral (>40–60), and Excellent (>60–100).

Question 2, subquestion a, indicator 2: The degree to which users agree that the primary mode of Program access (i.e. online portal) meets their needs to address child and youth mental health needs.

Educators and Practitioners who had been exposed to Be You and Emerging Minds were asked the extent to which they agreed with a series of statements about their perceptions of the online components of the initiatives. Table 4.19 and Table 4.20 present users' perceptions of the Program's mode of access (i.e. online portal). Participants responded on a VAS ranging from 0 (*Strongly disagree*) to 100 (*Strongly agree*). A high proportion of Be You and Emerging Minds users agreed or strongly agreed that the online resources were useful, and easy and convenient to access. However, the extent to which the initiatives met the users' needs in terms of being a "one stop shop" for online resources was mixed. 43% of Educators and 45% of Practitioners exposed to the Program agreed or strongly agreed that the respective websites provided them with enough information.

Table 4.19 Proportion of Be You users who agree or disagree that the Be You website and online resources are easy to access and are sufficient to meet their needs

	Disagree or Strongly disagree % (n)	Neither agree nor disagree % (n)	Agree or Strongly agree % (n)
The Be You website provides me with enough information; Mdn = 55(IQR: 49, 73) [N = 131]	16.03% (21)	41.22% (54)	42.75% (56)
The online resources provided by Be You help me to support student/child mental health; Mdn = 65(IQR: 50, 79) [1 N = 25]	8.8% (11)	31.2% (39)	60% (75)

	Disagree or Strongly disagree % (n)	Neither agree nor disagree % (n)	Agree or Strongly agree % (n)
The online resources on the Be You website are easy and convenient to access; Mdn = 70.5(IQR: 50, 86) [N = 126]	11.9% (15)	23.81% (30)	64.29% (81)
Average; N=133	10.53% (14)	25.57% (38)	60.90% (81)

Note. IQR = Interquartile range; Mdn = Median; N = number of respondents

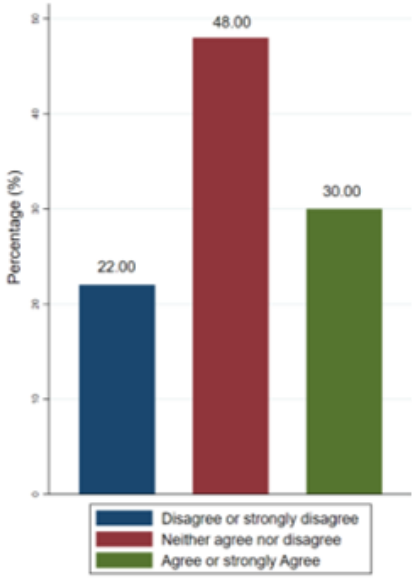
Table 4.20 Proportion of Emerging Minds users who agree or disagree that the Emerging Minds website and online resources are easy to access and are sufficient to meet their needs

	Disagree or Strongly disagree % (n)	Neither agree nor disagree % (n)	Agree or Strongly agree % (n)
The Emerging Minds website provides me with enough information; Mdn = 54(IQR: 40, 68) [N = 47]	27.66% (13)	27.66% (13)	44.68% (21)
The online resources provided by Emerging Minds help me to support children and/or families' mental health; Mdn = 65(IQR: 50, 81) [N = 51]	15.69% (8)	25.49% (13)	58.82% (30)
The online resources on the Emerging Minds website are easy and convenient to access; Mdn = 75.5(IQR: 57.5, 91) [N = 52]	3.85% (2)	26.92% (14)	69.23% (36)
Average; N=54	7.41% (4)	38.89% (21)	53.7% (29)

Note. IQR = Interquartile range; Mdn = Median; N = number of respondents

Question 2, subquestion a, indicator 3: The degree to which users agree that the activities of the consultants meet their needs to address child and youth mental health needs.

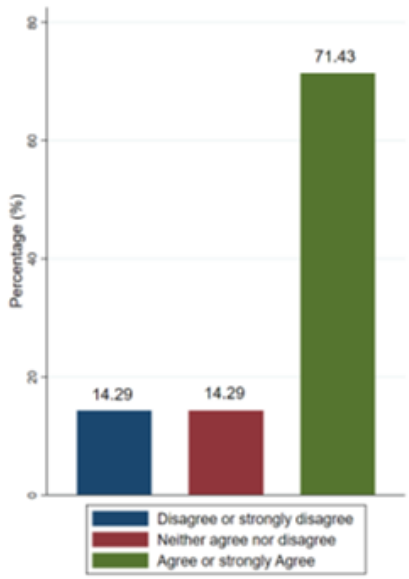
Participants were asked to rate the extent to which they agree or disagree that the activities of the consultants meet their needs on a VAS ranging from 0 (*Strongly disagree*) to 100 (*Strongly agree*). Participants' scores on this scale were then categorised into *Disagree* or *Strongly disagree* (0–40), *Neither agree nor disagree/Neutral* (>40–60) and *Agree* or *Strongly agree* (>60–100). Figure 4.3 shows that 30% (48% *Neither agree nor disagree; 22% Disagree)* of Be You users *Agree* or *Strongly Agree* that the Be You consultants helped them to support the mental health needs of children and young people. There were too few ratings from Emerging Minds users to reliably interpret the results as only users who had previously responded "Yes" to a question about whether they had worked with an Emerging Minds consultants were able to respond to this question.



Proportion·of·level·of·perceived·agreement·(%)

The **Be You** consultants help me to support the mental health needs of children and young people at my Early Learning Service or school

(Mdn = 50(IQR: 42.5, 74.5) [N =100])



Proportion·of·level·of·perceived·agreement·(%)

The **Emerging Minds** consultants help me to support the mental health needs of children and/or families

[Mdn = 70(IQR: 50, 80) [N =7])

Note. Responses were provided on a 100-point VAS ranging from 0 (Strongly Disagree) to 100 (Strongly Agree). Participants' responses were categorised into Disagree or Strongly disagree (0–40), Neither agree nor disagree/neutral (>40–60) and Agree or Strongly agree (>60–100).

Figure 4.3 Be You (left) and Emerging Minds (right) users' perceptions of satisfaction with the consultants in helping them to support children, young people and their families

Question 2, subquestion a, indicator 4: The degree to which users prefer self-directed/online learning used in the Program versus alternative learning modalities not utilised in the Program.

Participants were asked about the extent to which they preferred an online modality for learning compared to an alternative modality (face-to-face). Participants responded on a VAS, with responses that could potentially range from 0 (*Strongly disagree*) to 100 (*Strongly agree*). Table 4.21 (Be You) and Table 4.22 (Emerging Minds) show that there were no significant differences between control and exposed groups for either initiative on this item. Therefore, these groups were combined and we report the proportion of users who *Disagree* or *Strongly disagree*, *Neither agree nor disagree*, and *Agree* or *Strongly agree* with having a preference for website-delivered professional learning compared to other ways of learning, as depicted in Figure 4.4.

Table 4.21 Educators' preference for website-delivered professional learning compared to other modalities

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
I prefer website-delivered professional learning compared to other ways of learning (e.g. face-to-face)	48(28, 55) [378]	50(30.5, 72.5) [128]	2(-1.8, 5.8)/0.302

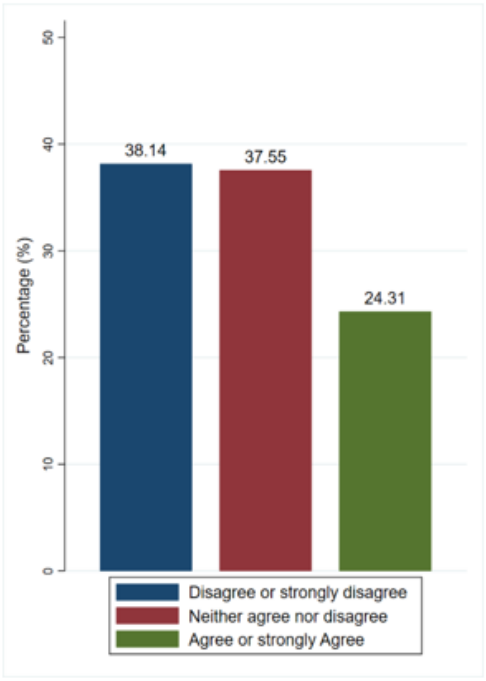
Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

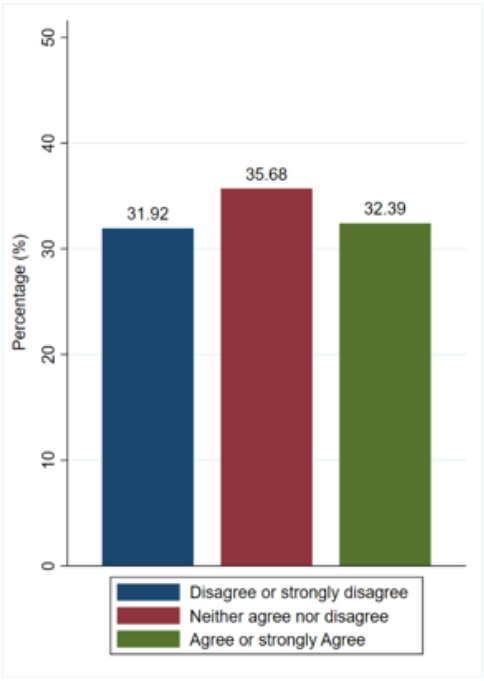
Table 4.22 Practitioners' preference for website-delivered professional learning compared to other modalities

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
I prefer website-delivered professional learning compared to other ways of learning (e.g. face-to-face)	50(35, 67) [161]	52.5(39, 78.5) [52]	4(-2.88, 10.88)/0.253

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

There was no significant overall difference in preference for online modality (versus alternative modality) between those exposed to the initiatives or the control groups. Only 24% of Educators *Agree* or *Strongly agree* that they prefer website-delivered professional learning compared to other ways of learning. The remaining participants either had no clear preference one way or the other, or preferred alternative modes of delivery (e.g. face-to-face). Roughly equal proportions of Practitioners report a preference for website-delivered professional learning, alternative modes or learning, or no strong preference one way or the other.





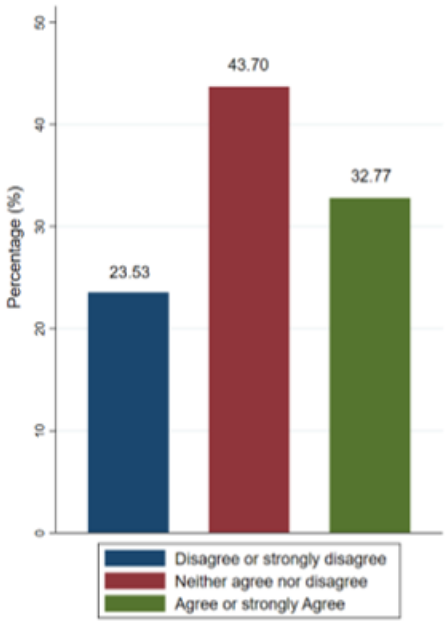
Note. Responses were provided on a 100-point VAS ranging from 0 (Strongly disagree) to 100 (Strongly agree). Participants' responses were categorised into Disagree or Strongly disagree (0–40), Neither agree nor disagree/neutral (>40–60) and Agree or Strongly agree (>60–100).

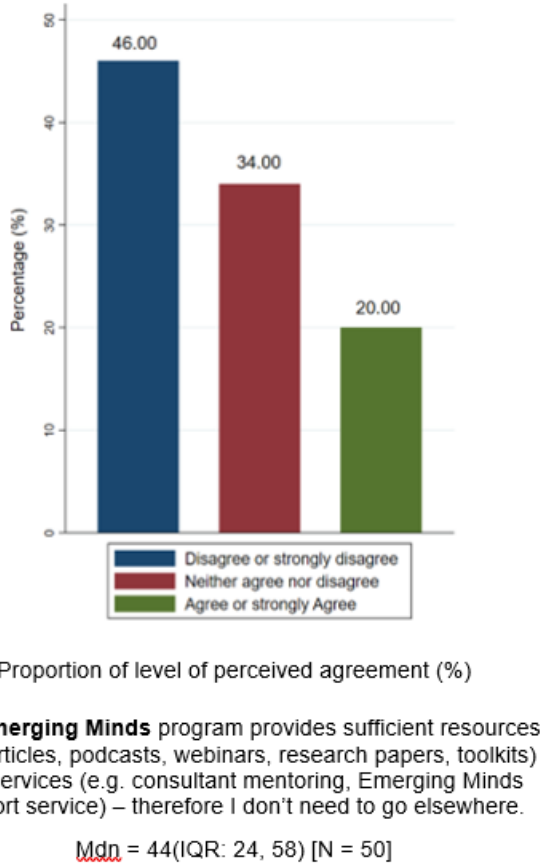
Figure 4.4 Proportion of Educators (left) and Practitioners (right) who preferred website-delivered professional learning compared to other ways of learning

Question 3, subquestion a, indicator 1: Reported degree of user satisfaction with access to sufficient resources and services to meet their needs within the Program (i.e. users don't need to go elsewhere to access information) compared to no Program.

Figure 4.5 depicts the proportions of Be You and Emerging Minds users who agreed or disagreed that the initiatives had sufficient resources and services to meet their needs. The extent that the initiatives met the users' needs in terms of being a "one stop shop" for resources and support was low: 33% of Educators exposed to the Be You initiative agreed or strongly agreed that they did not need to go elsewhere for information and support. 20% of Practitioners

agreed or strongly agreed that they did not need to go elsewhere for information and support. These data reflect an early stage of implementation of the Program, and it should be noted that the organisations have continued to develop a more extensive range of resources for the initiatives.





Note. Responses were provided on a 100-point VAS ranging from 0 (Strongly Disagree) to 100 (Strongly Agree). Participants' responses were categorised into Disagree or Strongly disagree (0–40), Neither agree nor disagree/neutral (>40–60), and Agree or Strongly agree (>60–100).

Figure 4.5 Be You users' (left) and Emerging Minds users' (right) perceptions of how sufficient the initiatives' resources were to meet their needs

Question 3, subquestion a, indicator 2: The extent to which users report being better (e.g. more frequent, more confident, more competent) users of evidence compared to no Program.

Participants were first asked whether they had heard the term "evidence-based" before. The proportion of Educators in both the control and exposed groups who had or had not heard this term before is depicted in Table 4.23.

Educators were then asked to consider their practice in relation to student/child mental health and think about how they have applied learnings from new evidence regarding mental health. These perceptions were rated on a VAS of 0 (*Strongly disagree*) to 100 (*Strongly agree*) for questions 1 and 2, and then on a VAS of 0 (*Never*) to 100 (*Very frequently*) for the remaining questions. Table 4.24 presents Educators' perceptions of evidence-based practice, and a comparison between the control group and exposed group.

Practitioners were first asked whether they had heard the term "evidence-based" before. The proportion of Practitioners in both the control and exposed groups who had or had not heard this term before is depicted in Table 4.25. Practitioners were then asked to consider their practice in relation to child mental health and think about how they have applied learnings from new evidence regarding mental health. These perceptions were rated on a VAS of 0 (*Strongly disagree*) to 100 (*Strongly agree*) for questions 1 and 2, and then on a VAS of 0 (*Never*) to 100 (*Very frequently*) for the remaining questions. Table 4.26 presents Practitioners' perceptions of evidence-based practice, and a comparison between the control group and exposed group.

Educators who were exposed to the Be You initiative were more likely to be aware of evidence-based practice than those who were not exposed to the initiative. Educators exposed to the Be You initiative had higher levels of agreement that evidence is important and improves their practice in relation to supporting child and youth mental health within their work setting. The frequency with which Educators engage in evidence-based practice is significantly higher for Educators who were exposed to the Be You initiative than Educators who were not exposed to the Program.

Practitioners, regardless of exposure to the Emerging Minds initiative, had universal awareness of evidence-based practice (Mdn = 100). Practitioners *Strongly agree* that evidence is important and improves their practice. The frequency with which Practitioners engage in evidence-based practice is high, regardless of group membership. There were no significant differences in the extent to which users report being better (e.g. more frequent, more confident, more competent) users of evidence compared to no Program.

These data suggest that the Be You initiative is associated with greater use of evidence-based practice by Educators in their approach to supporting the mental health of children and young people. The high level of awareness and use of evidence-based practice among Practitioners, regardless of exposure to the initiative, suggest that this is not an area of high need among this workforce.

Table 4.23 Comparison of the proportion of Educators who have heard the term "evidence-based practice" before by control and exposed groups

	Control % Yes (n/N)	Exposed % Yes (n/N)	*D* (95% CI) SIG
Have you heard of the term "evidence-based practice" before?	93.14(326/350)	97.26(142/146)	4.12(0.37-7.86)/ 0.031

Table 4.24 Educators' perceptions of the importance of evidence-based practice and frequency with which they have applied learnings from new evidence regarding mental health

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
It is important to keep up-to-date with new evidence	96(81, 100) [337]	100(90, 100) [142]	4(0.63, 7.37)/ 0.020
Learning from new evidence has improved my skills in mental health	80(58, 98) [323]	92(78.5, 100) [140]	12(5.63, 18.37)/ <0.0001
Do you critically appraise any literature/information or intervention programs you have discovered?	60(30, 79) [303]	79(54, 95) [134]	19(11.65, 26.35)/ <0.0001
Do you integrate the evidence you have found with your expertise?	69(50, 86) [307]	83(67, 96) [139]	14(7.23, 20.77)/ <0.0001
Do you evaluate the outcomes of your practice?	71.5(50, 88) [314]	83.5(63, 96) [138]	12(5.87, 18.13)/ <0.0001
Average of above 3 items:	65.67(62.14, 70) [321]	79(74.56, 83.33) [141]	13.33(7.31, 19.36)/<0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Table 4.25 Comparison of the proportion of practitioners who have heard the term "evidence-based practice" before by control and exposed groups

	Control % Yes (n/N)	Exposed % Yes (n/N)	*D* (95% CI) SIG
Have you heard of the term "evidence-based practice" before?	97.92(141)	100.00(141)	-2.08(-4.42, 1.00)/0.294

Table 4.26 Practitioners' perceptions of the importance of evidence-based practice and frequency with which they have applied learnings from new evidence regarding mental health

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
It is important to keep up-to-date with new evidence	100(91, 100) [142]	100(89.5, 100) [52]	0(-2.89, 2.89)/1.00
Learning from new evidence has improved my skills in mental health	98(85, 100) [141]	100(85, 100) [51]	2(-2.78, 6.78)/0.411
Do you critically appraise any literature/information or intervention programs you have discovered?	84(59, 100) [139]	83(68, 98) [50]	-2(-11.48, 7.48)/0.678
Do you integrate the evidence you have found with your expertise?	90(75, 100) [139]	84.5(74.5, 98.5) [52]	-6(-12.14, 0.14)/0.055
Do you evaluate the outcomes of your practice?	81(64, 97) [138]	81.5(64.5, 99.5) [52]	-1(-9.89, 7.89)/0.825
Average of above 3 items:	84.17(79.94, 88.06) [142]	81.83(76.27, 88.87) [52]	-2(-8.55, 4.55)/0.548

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Question 3, subquestion b, indicator 1: Extent to which users report that their Early Learning Service, school or organisation has implemented policies and programs to support/reinforce a mentally healthy culture based on the contents of the Program.

Educators were asked to rate their agreement with a series of statements about their workplace culture (see Table 4.27) and the extent to which their workplace works well with external services to support child and youth mental health (see Table 4.28). Educators responded on a VAS from 0 (*Strongly disagree*) to 100 (*Strongly agree*).

Practitioners were asked to rate their agreement with a series of statements about their workplace culture (see Table 4.29) and the extent to which their workplace works well with external services to support children's mental health (see Table 4.30). Practitioners responded on a VAS from 0 (*Strongly disagree*) to 100 (*Strongly agree*).

Educators who have been exposed to the Be You initiative reported significantly greater levels of agreement (Average Mdn = 83) that they work within a school or service that has a culture that supports and promotes mental health compared to Educators who have not been exposed to the Be You initiative (Average Mdn = 75). Educators who have been exposed to the Be You initiative also reported significantly higher levels of agreement (Average Mdn = 83) that their school or service works well with external services and families to support the mental health of children and young people, compared to Educators who have not been exposed to the Be You initiative (Average Mdn = 71).

There were no significant differences between Practitioners' perceptions of their workplaces' culture based on initiative exposure (Exposed Average Mdn = 84; Control Average Mdn = 83). Similarly, there was no significant difference between Practitioners' perceptions of the extent to which their workplace works with external services and families to support child and youth mental health based on initiative exposure (Exposed Average Mdn = 82; Control Average Mdn

= 78). There was a significant difference on one item, but in an unexpected direction: “My workplace communicates effectively with families of children experiencing mental health challenges” (Exposed Average Mdn = 84; Control Average Mdn = 91).

Participants who were exposed to the initiatives were asked to rate a statement about the extent to which their workplace encouraged them to participate in the initiative. Figure 4.6 shows that of those respondents who were exposed to the Program, 54.3% and 43.7% of Be You users and Emerging Minds users respectively agreed or strongly agreed that they were supported by their workplace leadership to participate in the initiatives. These data indicate that there is opportunity to improve the extent to which the initiatives work with schools, services and organisations to develop workplace leadership commitment.

Table 4.27 Educators’ perception of the extent to which their service/school has a culture that supports and promotes mental health

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
My workplace has policies and procedures that support a mentally healthy learning community	75(51, 90) [407]	80(60, 96) [152]	5(-0.97, 10.97)/0.101
Mental health is important to our broader school/learning community	99(82, 100) [352]	100(91, 100) [143]	1(-2.28, 4.28)/0.549
Our broader school/learning community supports and promotes mental health	75(55, 89) [352]	81(64, 95) [137]	6(0.5, 11.5)/0.033
My school has a strong community of learning around mental health	68(50, 85) [345]	80(66, 94) [137]	12(4.33, 19.67)/ 0.002
Average:	75.38(73.75, 78) [418]	82.5(78.41, 86.59) [159]	7.25(3.04, 11.46)/0.001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Table 4.28 Educators’ perception of the extent to which their service/school communicates well with external services and families

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
My workplace has referral procedures in place for students/children experiencing mental health challenges	80(59, 100) [412]	92(71, 100) [153]	12(4.95, 19.05)/0.001
My workplace collaborates well with mental health services	70(50, 87) [408]	84(60, 97) [153]	14(7.96, 20.04)/<0.0001
My workplace works with other mental health services that support students/children with mental health needs	70(50, 87.5) [404]	85.5(60, 100) [156]	15(9, 21)/<0.0001
My workplace communicates effectively with families of students/children experiencing mental health challenges	76(54.5, 93) [388]	85(66, 99) [145]	9(3.34, 14.66)/0.002
Average:	71.25(69, 73.53) [421]	82.63(79.75, 87.74) [162]	11(6.1, 15.9)/<0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Table 4.29 Practitioners' perception of the extent to which their workplace has a culture that supports and promotes mental health

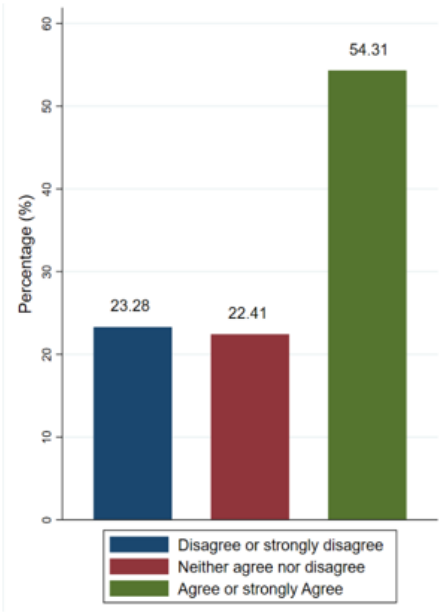
	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
My workplace has policies and procedures that support a mentally healthy workplace culture	80(60, 100) [166]	81(63, 90) [59]	1(-7.96, 9.96)/0.826
Mental health is important to our broader workplace community	100(90, 100) [149]	99(90, 100) [51]	-1(-3.53, 1.53)/0.437
Our broader workplace community supports and promotes mental health	83.5(69, 97) [146]	80(65, 91) [50]	-3(-12.31, 6.31)/0.526
My workplace has a strong community of learning around mental health	86(67, 100) [147]	84(60, 96) [51]	-2(-11.83, 7.83)/0.689
Average:	83.13(80.32, 86.78) [172]	84(74.38, 87.43) [64]	1(-5.19, 7.19)/0.751

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Table 4.30 Practitioner's perception of the extent to which their workplace communicates well with external services and families

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
My workplace has referral procedures in place for children experiencing mental health challenges	81.5(60, 100) [162]	86(65, 100) [59]	5(-6.93, 16.93)/0.410
My workplace collaborates effectively with mental health services	73.5(55, 91) [170]	79(57, 90) [61]	6(-3.23, 15.23)/0.202
My workplace works with other mental health services that support children and/or families with mental health needs	79(58, 98) [169]	76(58, 90) [61]	-3(-13.52, 7.52)/0.575
My workplace communicates effectively with families of children experiencing mental health challenges	91(77, 100) [157]	84(70, 98) [55]	-7(-13.39, -0.61)/0.032
Average:	77.88(74.89, 82.22) [174]	82(74.18, 86.9) [65]	4.5(-2.84, 11.84)/0.228

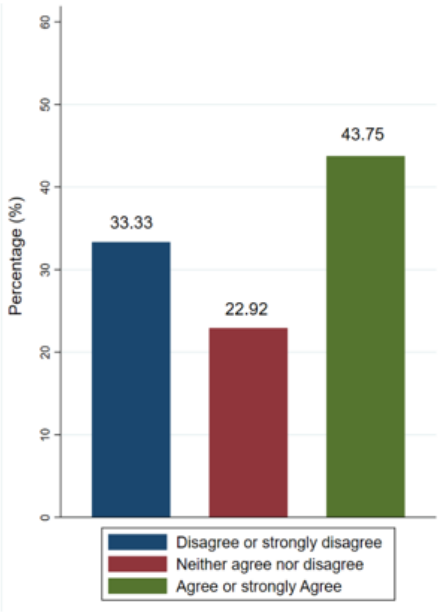
Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.



Proportion of level of perceived agreement (%)

I am encouraged by my school/service leadership to participate in the **Be You** program

Mdn = 69 (IQR: 44.5, 90) [N = 116]



Proportion of level of perceived agreement (%)

I am encouraged by my workplace leadership to participate in the **Emerging Minds** program

Mdn = 50.5(IQR: 26, 79.5) [N = 48]

Note. Responses were provided on a 100-point VAS ranging from 0 (Strongly Disagree) to 100 (Strongly Agree). Participants' responses were categorised into Disagree or Strongly disagree (0–40), Neither agree nor disagree/neutral (>40–60) and Agree or Strongly agree (>60–100).

Figure 4.6 Be You users' (left) and Emerging Minds users' (right) perceptions of whether their workplace leadership encourages them to participate in the initiative

Question 3, subquestion c, indicator 1: Degree to which users feel confident identifying children and youth at risk of experiencing mental health conditions compared to no Program.

Table 4.31 shows that Educators exposed to the Be You initiative had greater confidence and knowledge (Average Mdn = 87) in identifying children and youth at risk of experiencing mental health conditions compared to no Program (Average Mdn = 70). Table 4.32 shows that there was no significant difference in the confidence and knowledge of Practitioners exposed to the Emerging Minds initiative (Average Mdn = 88) compared to Practitioners not exposed to the Emerging Minds initiative (Average Mdn = 87). Practitioner confidence and knowledge to identify children and families at risk of mental health challenges was consistently high, regardless of exposure to the initiative.

Table 4.31 Educators' confidence in identifying children and young people at risk of experiencing mental health conditions

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
I am confident in my ability to identify students/children *experiencing* mental health challenges	77(59, 90) [399]	90(78, 100) [150]	13(8.35, 17.65)/<0.0001
I have the level of knowledge required to meet the mental health needs of students/children	62(40, 80) [391]	84.5(62.5, 95.5) [148]	22(14.57, 29.43)/<0.0001
Average:	69.5(66.5, 72.5) [400]	87(82, 90.5) [150]	17(11.43, 22.57)/<0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Table 4.32 Practitioners' confidence in identifying children and families at risk of experiencing mental health conditions

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
I am confident in my ability to identify children and/or families *experiencing* mental health challenges	91(80, 100) [163]	91(84, 100) [57]	0(-6.46, 6.46)/1.00
I have the level of knowledge required to meet the mental health needs of children and/or families	84(67, 95) [163]	86(71, 96) [57]	2(-6.11, 10.11)/0.628
Average:	86.5(83.73, 90) [163]	87.5(85.5, 91) [57]	1(-4.92, 6.92)/0.739

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Question 3, subquestion c, indicator 2: Users report an increased willingness to have conversations about mental health with children, young people and families, compared to no Program.

Willingness to have conversations with children and families about mental health was significantly higher for Educators exposed to the Be You initiative (Average Mdn = 96) compared to Educators not exposed to the Be You initiative (Average Mdn = 80; see Table 4.33). There was near universal willingness to have conversations with children and families about mental health regardless of exposure to the Emerging Minds initiative. That is, there was no significant difference between groups, and willingness was consistently high between groups (see Table 4.34).

Table 4.33 Educators' willingness to have conversations about mental health with children, young people and families

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
I am willing to have conversations with students/children about mental health	89.5(69, 100) [394]	100(83, 100) [150]	11(4.79, 17.21)/0.001
I am willing to have conversations with families about mental health	80(50, 100) [383]	96(75, 100) [145]	16(9.13, 22.87)/<0.0001
Average:	80(78, 84) [396]	96(92.74, 100) [150]	16(9.71, 22.29)/<0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Table 4.34 Practitioners' willingness to have conversations about mental health with children and families

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
I am willing to have conversations with children about mental health	100(89.5, 100) [160]	97(88, 100) [55]	-3(-5.86, -0.14)/0.040
I am willing to have conversations with families about mental health	100(88, 100) [159]	96(87, 100) [54]	-4(-7.35, -0.65)/0.019
Average:	99.75(97, 100) [160]	97(90.71, 100) [55]	-2.5(-6.01, 1.01)/0.162

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Question 3, subquestion c, indicator 3: Users report an understanding of the different mental health challenges facing children and youth, compared to no Program.

Table 4.35 shows that Be You users reported having a greater understanding of the mental health challenges facing children and young people (Average Mdn = 88) compared to Educators who had no exposure to the Be You initiative (Average Mdn = 76). Table 4.36 shows that there was no significant difference between Practitioners' understanding of the mental health challenges facing children and their families based on initiative exposure (Exposed Average Mdn = 88; Control Average Mdn = 89).

Table 4.35 Educators' understanding of the different mental health challenges facing children and young people

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
I have a good understanding of the mental health challenges facing children and young people	80(64, 92) [398]	91(80, 100) [148]	11(6.15, 15.85)/<0.0001
I know enough about the different mental health challenges facing children and young people in my work role	75(50, 88) [395]	85(70, 98) [150]	10(4.14, 15.86)/<0.0001
Average:	75.75(72.5, 79.5) [400]	88(85.5, 91.01) [151]	12.5(7.43, 17.57)/<0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Table 4.36 Practitioners' understanding of the different mental health challenges facing children and young people

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
I have a good understanding of the mental health challenges facing children and young people	91(82, 100) [161]	91.5(84.5, 100) [56]	0(-4.71, 4.71)/1.00
I know enough about the different mental health challenges facing children and young people in my work role	86(75, 100) [161]	84(75, 96) [57]	-2(-8.22, 4.22)/0.527
Average:	89(86, 91.27) [163]	87.5(84.14, 90.72) [57]	-1.5(-7.2, 4.2)/0.604

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Question 3, subquestion d, indicator 2: There is increased help-seeking by children and young people compared to no Program.

There was some evidence that students' willingness to seek help for mental health issues is associated with Educators' exposure to the initiative. Table 4.37 shows that Educators exposed to the initiative reported significantly greater agreement with the statement that students often seek help for mental health issues (Mdn = 59) compared to Educators who have not been exposed to the initiative (Mdn = 45). Table 4.37 also shows that there was consistently high agreement with the statement that Educators encourage students to make use of the help available to them, regardless of group membership (i.e. no significant difference between groups: Exposed Average Mdn = 90; Control Average Mdn = 85).

Table 4.38 shows that there was no significant difference between Practitioners' agreement that children and young people seek help for mental health issues (Exposed Average Mdn = 46; Control Average Mdn = 50). There was consistently high agreement with the statement that the Practitioners encourage clients to make use of the help available to them, regardless of group membership (i.e. no significant difference between groups: Exposed Average Mdn = 94; Control Average Mdn = 95).

Table 4.37 Educators' perceptions of help-seeking by children and young people

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
Students/children often seek help for mental health issues	45(25, 63) [369]	59(39, 76) [141]	14(7.96, 20.04)/<0.0001
I encourage students/children to make use of the help available to them	85(61, 100) [370]	90(80, 100) [146]	5(-1.68, 11.68)/0.142
Average:	62.5(60.5, 65) [378]	75(71, 77.68) [146]	12.5(7.85, 17.15)/<0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Table 4.38 Practitioners' perceptions of help-seeking by children and young people

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
Children and young people often seek help for mental health issues	50(33, 63) [154]	46(27, 58) [53]	-4(-13.19, 5.19)/0.392
I encourage clients to make use of the help available to them	95(81, 100) [153]	94(84, 100) [53]	-1(-7.45, 5.45)/0.760
Average:	70(65.66, 73.34) [154]	65.5(60, 71.2) [53]	-4.5(-10.54, 1.54)/0.143

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Question 3, subquestion f, indicator 1: Uptake of suicide postvention support compared to no Program.

To understand the potential uptake of suicide postvention support, Educators who were target Be You users were asked a series of questions about whether they had a suicide postvention plan in place, and whether they had accessed a suicide postvention plan in the past 12 months. Participants responded either "Yes", "No" or "Unsure" to these questions. For analysis, the proportion of those who responded "Yes" versus "No" and "Unsure" was compared between the control and exposed group. Table 4.39 presents the results of these comparisons.

Educators exposed to the Be You initiative are more likely to have a suicide postvention plan in place at their school (44%) compared to Educators not exposed to the initiative (20%; p <.001). Educators exposed to the Be You initiative are also more likely to have accessed suicide postvention and response resources to prepare themselves should a death by suicide occur (45% exposed; 12% not exposed; p <.001), and to guide their response to a young person at risk of suicide (39% exposed; 13% not exposed; p <.001) or guide their response to a death by suicide in their school community (30% exposed; 11% not exposed; p <.001).

Table 4.39 Proportion of participants who have a suicide postvention plan in place at their school and have accessed the postvention plan in the previous 12 months

	Control %Yes (95% CI) [N]	Exposed %Yes (95% CI) [N]	*D* (95% CI) SIG
My school has a suicide postvention plan (suicide response plan) in place	19.69(15.31, 24.07) [320]	44.06(35.82, 52.29) [143]	24.37(15.14, 33.60)/<0.0001
In the past 12 months, I have accessed suicide postvention and response resources to:			
Prepare myself or my school community to be ready should a death	12.03(8.42, 15.63)	44.60(36.24, 52.97)	32.58(23.57, 41.59)

	Control %Yes (95% CI) [N]	Exposed %Yes (95% CI) [N]	*D* (95% CI) SIG
by suicide occur	[316]	[139]	/<0.0001
Guide myself or my school community to support a young person at risk of suicide	12.97(9.25, 16.70) [316]	38.85(30.64, 47.05) [139]	25.87(16.96, 34.78) /<0.0001
Guide my response or my school's response to a death by suicide and the subsequent recovery for my school community	10.79(7.35, 14.24) [315]	30.00(22.31, 37.69) [140]	19.21(10.88, 27.53) /<0.0001

Question 3, subquestion f, indicator 3: The degree to which teachers agree that suicide postvention is part of their role.

Question 3, subquestion f, indicator 4: The extent to which teachers are confident that they can respond appropriately post-suicide and reduce risk of suicide exposure and contagion.

We asked target users of Be You about their feelings about dealing with a death by suicide that impacts their school/learning community. It was clarified that we were referring specifically to a suicide that impacts the Educators' school/learning community, which may include the suicide of a student, colleague, a student's family member, someone in the community, or even a well-known public figure. Participants were asked how much they agree or disagree with five statements. Their agreement was rated on a VAS ranging from 0 (*Strongly disagree*) to 100 (*Strongly agree*).

Table 4.40 shows that there was high agreement that Educators believed that they have a role to play in supporting the mental health and wellbeing of students after a death by suicide in the school community, and that this agreement is significantly higher for those exposed to the Be You initiative compared to those not exposed to the Be You initiative. Overall, awareness and confidence to respond appropriately post-suicide and reduce risk of suicide exposure and contagion is higher in Educators exposed to the Be You initiative (Average Mdn = 80) compared to those not exposed to the Be You initiative (Average Mdn = 60).

Table 4.40 Educators' perceptions of their role and confidence in ability to respond following a suicide in the learning community

	Control Mdn (IQR)[n]	Exposed Mdn (IQR)[n]	*D* (95% CI) SIG
As an Educator, I have a role to support the mental health and wellbeing of children and young people after a death by suicide	79(50, 100) [312]	95.5(80, 100) [140]	16(8.78, 23.22) / <0.0001
I am aware of the actions that I should take following a death by suicide	58(32, 89) [301]	84(56, 100) [134]	26(16.3, 35.7) / <0.0001
I am confident that I can respond appropriately to a death by suicide	60(35, 86) [301]	80(60, 92) [135]	20(11.05, 28.95) / <0.0001
I am confident that I can identify young people who may be most impacted or at increased risk after a death by suicide	62.5(40, 84) [304]	78(56, 93) [135]	16(7.28, 24.72) / <0.0001
I am confident that I can communicate appropriately with young people following a death by suicide to avoid increasing the likelihood of suicide contagion	55(33, 82) [297]	76(51, 90) [135]	21(13.56, 28.44) / <0.0001
Average:	60(42, 81.6) [322]	80.2(56.4, 92.4) [141]	20.2(12.24, 28.16) / <0.0001

Note. D = Median Difference; IQR = Interquartile range; Mdn = Median; N = number of respondents; 95% CI = 95% Confidence Interval; SIG = p value. Bolded text represents a statistically significant difference between the control and exposed group.

Question 5, subquestion a, indicator 2: Target users identify consequences (positive or negative) of the implementation of the Program.

An open-ended question was included in each of the surveys to elicit initiative users' perspectives of any unexpected consequences (positive or negative) that came from their use of the initiative. These data were interrogated to identify common themes, and findings are presented Table 4.41 (Be You) and Table 4.42 (Emerging Minds) below.

Table 4.41 shows that unexpected outcomes of the Be You initiative were primarily framed around the users' impressions (positive and negative) of the initiative relative to their expectations (e.g. they found the resources "useful", or that the content was more basic than expected). For several users, they stated that it was simply too early to tell if anything unexpected was to come from their interactions with the initiative. For some users, the networking opportunities that came out of their involvement with the initiative was an unexpected positive. One user commented that it was unexpected and unwelcome that the KidsMatter website was closed. There were too few responses from users of the Emerging Minds initiative to identify common themes. However, Table 4.42 shows that Emerging Minds users also framed their responses around their impressions (positive or negative) relative to their expectations. One user was surprised (positively) at the applicability of the initiative to all staff members, another user mentioned experiencing an unexpected sense of "community" during their involvement in the initiative. Like the Be You users, some users mentioned that it was too early to tell.

Table 4.41 Be You users' perspectives of unexpected consequences (positive or negative) from using the Be You initiative

Question: Did anything come out of your interactions with the Be You program that you hadn't expected (either positive or negative)?			
Positive unexpected		Negative Unexpected	
Positive feedback (12): **Ease of access/use** **Useful resources**	"I found the Be You leadership modules very time consuming but so worth it!! They improved not only my practice but also my knowledge."	Negative feedback (6): Time consuming Unable to download fact sheets Frequent follow-up emails Difficult to engage with Too much reading Difficult to find specific resources	"Some staff were turned off by the length of some of the PD."
Increased their knowledge and/or confidence in child and youth mental health (6)	"It just continues to get you to question what you are doing for the better."	Content more basic than expected (2)	"I didn't get much out of Be You itself, because I do know quite a bit to do with mental health – and working as a nurse for 6 years, you pick up a little thing or two that helps to establish and flag any issues."
Too early to tell (5)	"Still at early stages of exploring Be You - but looks fantastic so far!"	KidsMatter website closed (1)	"The content from the KidsMatter website no longer available."
Experience with consultants better than expected (2)	"I have been surprised at its consistency and the work of our coordinator in continuing to push the agenda."		
Unexpected networking opportunities (2)	"I have had several opportunities to attend Master Classes and I really enjoyed the opportunity to develop networks and increase my professional knowledge."		
Staff engagement (1)			
Staff wellbeing (1)			

Table 4.42 Emerging Minds users' perspectives of unexpected consequences (positive or negative) from using the Emerging Minds initiative

Question: Did anything come out of your interactions with the Emerging Minds program that you had not expected (either positive or negative)?			
Positive unexpected		Negative unexpected	
Initiative exceeded expectations (2)	"Fabulous to have such a resource!" "Like their practical resources."	Content more basic than expected	"I found the online training very basic and simplistic, did not provide at times a complete picture/overview of the topics (trauma and the child, infant mental health, child aware)."
Change of personal mindset and attitudes (1)	"It helped me reflect on the work I had done with families in the past and that how there are so many opportunities for all health care professionals to make a difference in children's and families' lives."	Surprised about lack of evidence/research in area	"I thought there may have been more recent statistics regarding the prevalence of parental mental health – but most research and data is quite old."
Surprised about applicability of initiative to all staff in organisation (1)	"I've now incorporated two of the online courses into all new starters onboarding plans to be completed in the first month of employment, regardless of their skills and experience as I believe they are foundational courses and ensure we are all operating from the same language/mindset."		
Unexpected feeling of "community" during upskilling (1)	"The community feeling when upskilling within the industry was unexpected and appreciated."		
Too early to tell (1)			

4.10 Discussion

The survey was designed to elicit views on understanding, acceptance, engagement, integration, support, participation and other workforce concerns during the process of change associated with the implementation of the Program. It tested the impact of the Program on existing support networks, determined perceived benefits and barriers to implementation of the Program objectives, and identified potential gaps or opportunities for building workforce capability.

4.10.1 Be You

The survey findings indicate that for Educators, the Be You initiative is associated with greater confidence to connect and use external mental health services, greater confidence in identifying and addressing mental health challenges in students, increased willingness to have conversations with students and families, more frequent application of evidence-based practice, greater uptake in suicide postvention resources, and greater confidence to respond appropriately to a suicide event in the learning community, compared to those Educators not exposed to the initiative. Educators who were exposed to the initiative more strongly agreed that their workplace had a mentally healthy school culture, and that they worked within a school that collaborated well with external mental health support agencies, than Educators not exposed to the initiative. However, there was no significant difference in perceptions between Educators in the control group and exposed group that their school had implemented whole-school policies and procedures to create a mentally healthy school culture.

Be You users' perspectives on the appropriateness of the initiative to deliver the intended outcomes were mixed. Although satisfaction ratings for the ease and convenience of accessing online resources was high, there was low agreement with the proposition that the initiative could meet all their needs to address the mental health of children and young people. As such, there was limited evidence that the initiative is operating as an end-to-end education-based program at the time of the survey for those sampled. The timing of this evaluation activity was within the early implementation stage of the initiatives and the Be You initiative continues to develop new resources and content.

The qualitative data on enablers and barriers of supporting child and youth mental health, and enablers and barriers of implementation, highlight the need to address the time and workload constraints of Educators, and prioritise addressing the structural and leadership support and mentally healthy school culture that is needed to support the effective implementation of the initiative at the school or ELS level.

4.10.2 Emerging Minds

Overall, we did not observe a robust effect of the Emerging Minds initiative on the indicators of interest in the Practitioner survey. This could be explained in part by a "ceiling effect" for Practitioners. This effect occurs when the majority of responses to an item approach the upper limit of the scale used to measure the construct, which constrains the variance and reduces the sensitivity of tests to determine whether groups differ significantly from one another. We observed that the Practitioners, regardless of exposure to the Program, reported high levels of confidence and knowledge to support mental health of children and families. High confidence and self-reported knowledge were indicators of the Program's outcomes for Educator and Practitioner capability development, and regarded as a necessary step towards competence and eventual improved outcomes for children. These data suggest that the Emerging Minds workforce target may have a high baseline of knowledge and confidence, and so we suggest that for Practitioners with higher perceived competence and confidence, it may be more appropriate to assess their competence, or to look for benefit in downstream outcomes for children. We expect that these outcomes will be examined in future evaluations, particularly regarding impact on the Program beneficiaries.

Despite our observation of a ceiling effect for our Program vs no-Program comparisons, we observed substantial variation in Emerging Minds users' perceptions of the Program. Most notably, there was low level of agreement that the Emerging Minds initiative provided the users with everything they needed to support the mental health of children. This finding may reflect the early implementation stage of the initiative and the development approach taken by Emerging Minds (see KPI interviews), whereby resources and content were developed iteratively over time. The overall level of satisfaction with the initiative across a range of indicators was strong.

The qualitative data on enablers and barriers of supporting child mental health, and enablers and barriers of initiative implementation, were mostly consistent with the themes that emerged in the Educator survey. Specifically, key enablers of support included the availability of evidence-based programs, workplace structural and leadership support, and a workplace culture that supports and promotes mental health. Users highlighted time constraints, barriers to

accessing external services, and lack of funding and resources as key barriers to supporting child and youth mental health. Enablers of implementation of the Emerging Minds initiative included workplace structural and leadership support, timing, resourcing to access initiative during work hours and support from colleagues. Barriers of implementation included time constraints, lack of relevance to work type, and lack of workplace structural and leadership support.

4.11 Limitations

There are a range of limitations with the survey data that should be acknowledged when considering the findings from this report.

4.11.1 Selection bias

It is possible that our recruitment approach, although derived in consultation with the Department and a requirement of each jurisdiction's Department of Education ethics committee, may have resulted in a selection bias. For example, it is possible that principals who prioritise fostering a school environment that values mental health may have been more likely to agree to participate than those who do not.

4.11.2 Timing of the evaluation

The Overarching Evaluation was commissioned during the advanced stage of Program implementation. As such, there was no opportunity to collect baseline (pre-Program) data. Furthermore, the widespread implementation approach of the Program meant that exposed and control groups could not be randomly assigned (as would be typical in a controlled comparison). To address the limitations associated with the commencement of the Overarching Evaluation after the implementation of the Program, we:

- reconstructed a control group by asking participants to report their exposure to the Program
- reconstructed baseline data by including a retrospective estimate of pre-intervention state for those who had and had not had access to the Program.

This approach provides a "reconstructed control group" for assessment of change due to exposure to the Program.

The limitations of reconstructing a control group in this way are that there is no way to objectively verify and control actual exposure and dose of the Program. The limitations of reconstructing baseline data are that it is susceptible to recall bias (i.e. memory fallibility) and social desirability bias (i.e. participants may wish to overestimate change after exposure to a program). Additionally, to reduce the burden on respondents and to improve the response rate, we did not include a retrospective estimate of pre-intervention stage for each item. As such, utilising a retrospective pre-post design was not possible for each survey item.

4.11.3 Timing of data collection

The survey provides an estimate of Program effects at a single point in time. As such, these data do not describe trends over varying stages of the Program's implementation. Given the timing of the Overarching Evaluation, these data provide an estimate of effects at the very early stages of implementation of the Program. As such, these data primarily address the immediate initiative- and system-level outcomes referenced in the Program Logic (see Appendix A). There have been substantial historical events that have occurred during the evaluation (e.g. major bushfires, COVID-19 global pandemic; see evaluation timeline for more detail). The survey results represent a point in time just before the impact of COVID-19 and associated public health measures were experienced by children and young people, and by the implementing organisations (i.e. Beyond Blue, Emerging Minds and their delivery partners). Data relevant to COVID-19 impacts, and medium- and long-term Program outcomes (e.g. social and emotional wellbeing of children and young people) are not captured directly in this evaluation activity.

4.11.4 Sample size

As agreed with the Department, direct recruitment efforts for the survey were limited to reduce respondent burden at the start of the COVID-19 pandemic. It was then agreed to formally cease recruitment in mid-May 2020. Opportunities for further data collection were not possible within the remaining evaluation period. The recruitment approach for these surveys also limited our ability to directly contact Educators and Practitioners to encourage participation. We undertook a broad recruitment approach to ensure we recruited Educators and Practitioners who were exposed and *not* exposed to the Program. However, because of this broad recruitment approach and early stage of implementation of the Program, we identified a relatively small number of exposed participants, particularly among respondents for the

Emerging Minds survey. These data limitations prevent the analysis of the survey data according to varying levels of "Program dose" or user characteristics. For example, the proportion of early childhood Educators for the Be You survey was low (2.4%), which means that generalisability to this cohort of Educators is limited. The smaller sample size limits our capacity to statistically identify real but small effects. However, we are confident in the differences found in our comparisons. The smaller sample size may reduce representativeness of the sample (e.g. the variation in knowledge, confidence and context of Educators and Practitioners), and hence the generalisability of the findings. Further insights into the effectiveness of the Program could be gained by understanding the impact of varying levels of engagement or exposure to the Program.

When considering the survey findings, it is important to do so within the constraints of the data limitations. Where possible, we triangulate these findings with other sources of data from the evaluation to assess the Program's overall appropriateness and effectiveness.

4.12 Conclusions

This survey allowed us to identify the state of knowledge and capabilities of workforces who interacted with children and young people across Australia during the implementation phase of the Program. This was a period marked by two major historical events: the severe bushfires and the COVID-19 pandemic. These events impacted not only the Program delivery and the Overarching Evaluation's data collection, but also impacted children and families and the services available to support them (see Timeline –Figure 1.2 in section 1.7). From these findings, evidence-informed recommendations have been derived to inform further Program development to support children and young people's mental health (see Chapter 8: Conclusions). These recommendations have the potential to advance current policies and practices surrounding the mental health of children and youth across Australia, which may help to reduce the overall, long-term burden of poor mental health to society.

5. Integrated Data Analysis

5.1 Background and purpose

The Integrated Data Analysis was one of the four core evaluation activities. The Integrated Data Analysis utilised existing data sources and available activity indicators to measure and monitor national mental health outcomes relevant to the Program's implementation. This activity was designed to support two major areas in this evaluation: assessing the appropriateness of the Program; and assessing the effectiveness of the Program against specific output and outcome indicators in the Evaluation Framework.

In this Integrated Data Analysis activity, we used data from various selected national and regional longitudinal, as well as repeated cross-sectional, datasets to determine mental health outcome indicators for children and young people relevant to the Program evaluation through integrated analysis.

Although the initiatives target change at the workforce level (i.e. Educators and Practitioners), this Integrated Data Analysis aimed to examine the impact of the Program at a population level for beneficiaries of the Program (i.e. changes in key mental health outcomes of children and youth in Australia. The Program's implementation is within the very early stages (2–3 years since the launch of the initiatives), which, according to the Program Logic, is likely to be too early to see a significant impact of the Program on intermediate and long-term outcomes.

As such, we describe the baseline trends in these mental health indicators for the period prior to the implementation of the Program, and present projected future trends of these indictors in the absence of the Program and external factors. The immediate value of understanding these trends is to inform understanding of potential priority areas and appropriate future targets for the Program. When follow up data are available (and change on these outcomes is reasonably expected to be observed according to the Program Logic), these projections can then be used to estimate the benefits associated with the Program against these child mental health indicators.

5.2 Objectives of integrated analysis

The objective of the integrated analysis was to use, where appropriate and feasible, existing data sources to develop indicators for measuring and monitoring national mental health outcomes relevant to the implementation of the Program.

Specific objectives were:

- to assess the appropriateness of the Program by estimating the match between Program implementation areas and geographic and demographic identifiers of need for mental health supports
- to assess the baseline and future trend of the planned mental health related indicators (output and outcome) in the evaluation framework, as well as the effectiveness of the Program against those indicators where possible from existing data sources.

5.3 Ethics

The Integrated Data Analysis activity used secondary data sources. Ethics approval for this research was obtained from The University of Queensland's HREC (Approval #2020000170). An additional ethics approval was needed to access the WA Health & Wellbeing Surveillance System (HWSS), which was obtained from the Department of Health WA HREC (Approval #RGS0000004249). Data access approvals were granted for the Australian Longitudinal Study on Male Health (Ten to Men; approval date 21 October 2020); Longitudinal Surveys of Australian Youth (LSAY – Y09 & Y15 cohorts only; access approved 3 June 2020); and LSAC (approved 4 June 2020). No approval process was required for the other data sources as only aggregate data were obtained.

5.4 Methods

5.4.1 Data from Program implementing partners

Program-related data were obtained from Beyond Blue and Emerging Minds for this activity. Emerging Minds launched its initiative in the last quarter of 2017, whereas Beyond Blue launched the Be You initiative in the last quarter of 2018 (see Timeline, section 1.7). Thus, we consider the period of 2018 to 2020 as the duration of Program implementation relevant to the Overarching Evaluation for the purpose of this activity. Although it was originally agreed that we would consider data up until 31 July 2020, delays in receiving the final datasets meant that we considered

data related to the Program implementation/coverage up to 30 September 2020 for Be You and 25 August 2020 for Emerging Minds.

We received Program data from Be You at different levels, such as the number of registered organisations (with geographic identifiers), registered users, module completion by the users, and the number of events organised by Be You. Beyond Blue provided a description of the features of the Be You data to facilitate interpretation and understand data limitations (see Appendix G). Similarly, we received Program data from Emerging Minds, including a list of engaged organisations/institutes (with geographic identifiers), lists of different engaged actions[2], and data on different types of social media activities such as webinars, events, webpage and Emerging Minds' Facebook page views (see Table 5.1). We did not receive all user-level data (e.g. e-learning registrations and course completions) for Emerging Minds. Emerging Minds was only able to provide us with a sub-sample of users (N ~8000) who consented to participating in their individual evaluation activities, and location data for these users was not useful for estimating full Program coverage. As such, we were unable to include these data in our geo-spatial description of Program coverage. The depiction of reach for Emerging Minds represents its engagement with organisations only, which is one of its three key strategy components.

5.5 Data sources for integrated analysis

We used two different sources of data in this integrated analysis of the Program: existing data from administrative datasets, longitudinal studies and repeated cross-sectional surveys in Australia that collect child and youth mental health related outcomes; and data from the Program implementing partners (Beyond Blue [Be You] and Emerging Minds). Data from the implementing partners were used to identify the geographic and demographic coverage, uptake and intensity of the initiatives' activities. These data sources were used to understand the level, baseline trend and geographic extent of the mental health outcomes of the Australian children and young people based on the planned evaluation indicators.

Table 5.1 Program coverage data from Be You and Emerging Minds

Data Sources	Indicators	Relationship to Program Logic	Information received
1. Be You implementation records: CRM organisation data [specifically geographical region of the services]	Extent of geographical reach of each initiative	Mapping to visualise the Program coverage	1. List of Be You registered organisations with demographic and geographic identifiers 2. List of Be You registered users with date of registration 3. Be You module completion data 4. Monthly event data
2. Emerging Minds implementation records [specifically geographical region of the services]	Extent of geographical reach of each initiative	Mapping to visualise the Program coverage	1. List of engaged organisations/institutes with geographic locations and types of organisation 2. List of engaged actions by the engaged organisation, date and types of actions, number of attendees in the engaged action 3. Monthly number of different types of events (webinar, workshop, dissemination of the information through different social media channels such as Facebook, LinkedIn, E-news)

Note. CRM = Customer Relationship Manager.

5.5.1 Existing data sources related to mental health indicators

There were nine different types of child and youth mental health indicators defined in the project's Evaluation Framework. These indicators were selected from a subset of potential indicators by the Evaluation Team (with input from the Scientific Advisory Group), in consultation with the Department of Health, following a review of existing Australian data sources. This review, which was completed for the Evaluation Framework, assessed the relevance

[2] Engagement action data refers to the activity of consultants whose role is to promote the uptake of the program directly with services, as an additional resource to the web hub (eLearning) and communications strategy.

and reliability of data sources in a number of key areas, including adequate coverage of target population, the timeliness of data availability during the evaluation period, and relevance to Evaluation Questions. Through the data audit procedures (see detail in the Evaluation Framework), 13 existing data sources were identified as containing sufficiently reliable and relevant indicators of child and youth mental health. Among these, eight data sources are nationally representative and the remaining five data sources contain regional survey data (Victoria, NSW, and WA). We were unable to include three out of 13 data sources due to access difficulties (NSW-CDS, ABS and CATS sources). A list of the indicators and associated existing data sources, timing of the surveys and target population are given in Table 5.2.

Table 5.2 Evaluation indicators and associated data sources examined in the Integrated Data Analysis

Indicators	Link to Program Logic	Planned dataset	Included in IDA	Coverage[1]	Measurement of the indicators	Target population
There is an increase in help-seeking by children and young people compared to no Program		LSAC	Yes	National: 2013–2017	Sought help from teacher, other school staff or mental health professional	Children aged 14–20
		LSIC	No[2]	--	--	--
		Ten to Men	Yes	National: 2013–2015	Children visited counsellor/psychologist or psychiatrist in past 12 months	Children aged 10–18 years
		WA-HWSS	Yes	Regional: 2012–2019	Mental health service used in last 12 months	Children aged 0–15 years
Changes in the rate of death by suicide for children and youth compared to no Program	F2	ABS (cause of death)	No[3]	--	--	--
Change in the rate of emergency department visits for i) deliberate self-harm, ii) related to mental health and addictions; and iii) change in rate of hospital admissions related to mental health and addictions	F1	MHE-NMDS	Yes[4]	National: 2014–2018	Emergency department visits related to mental health and addictions	Adolescents (12–17 years)
Changes in proportion of developmentally vulnerable children by the time they start school compared to no Program	F1	AEDC	Yes	National: 2009–2018	Emotional maturity domain: Experience a number of challenges related to emotional regulation (using Australian version of the Early Development Instrument)	Children in Australia in their first year of full-time school (~ 5 years old).
Proportion of children or young people who exceed the thresholds on the Strengths and Difficulties Questionnaire (SDQ)	F1	LSAC (added later)	Yes	National: 2011–2017	SDQ >17	Child aged 10–20
		LSIC	Yes	National: 2010–2017	SDQ >14	Children aged 4–15 years

Indicators	Link to Program Logic	Planned dataset	Included in IDA	Coverage[1]	Measurement of the indicators	Target population
		SEHQ (Victoria)	Yes	Regional: 2010–2018	SDQ >17	Children at entry to primary school
		NSW-CDS	No[5]	--	--	--
		CATS (Melbourne)	No[6]	--	--	--
Changes in proportion of parents reporting high levels of subjective poor health and wellbeing compared to no Program	F1	WA-HWSS	Yes	Regional: 2012–2019	High level (highest two "highest" and "high" out of four categories) of physiological distress based on K10 group variables	Adult sample
		SEHQ (Victoria)	Yes	Regional: 2009–2015	Parents report high levels (highest two out of five categories) of family stress in the past month	Parents of the interviewed children at entry to primary school
There is increased resilience in children and young people compared to no Program	F1	VSHAWS (Victoria)	Yes	Regional: 2014–2018	Without positive psychological development (measured by the Ryan and Deci 2001 resilience scale).	Students in Years 5, 8 and 11
Change in reported quality of family relationship compared to no Program	E3, F1	LSAC	Yes	National: 2011–2017	Poor (lowest category as "poor" out of five categories) ability of family to get along with one another	Child aged 10–20
		WA-HWSS	Yes	Regional: 2012–2019	Poor family functioning using McMaster Family Functioning Scale	Children aged 0–15 years
		Mission Australia Youth Survey	Yes	National: 2012–2020	Poor (lowest category as "poor" out of five categories) ability of family to get along with one another	Young people aged 15–19
There is improved wellbeing outcomes of children and young people compared to no Program	F1	Mission Australia Youth Survey	Yes	National: 2012–2018	Psychological distress (using Kessler 6, K6)	Young people aged 15–19
		VSHAWS(Victoria)	Yes	Regional: 2014–2018	High levels of psychological distress (depressive symptoms measured by Short	Students in Years 5, 8 and 11

Indicators	Link to Program Logic	Planned dataset	Included in IDA	Coverage[1]	Measurement of the indicators	Target population
					Version Moods and Feelings scale)	
		LSAY (Y09 cohort)	Yes	National: 2012–2018	Not completely satisfied ("0–9, not completely" out of 10 categories) are you with life these days	15–23 years

Notes. IDA = Integrated Data Analysis.

LSAC: The Longitudinal Study of Australian Children; LSIC: The Longitudinal Study of Indigenous Children; Ten to Men: Australian Longitudinal Study on Male Health; WA-HWSS: WA Health and Wellbeing Surveillance System; ABS: Australian Bureau of Statistics; MHE-NMDS: Mental Health Establishments National Minimum Data Set; AEDC: Australian Early Development Census; SEHQ: School Entrant Health Questionnaire; NSW-CDS: NSW-Child Development Study; CATS: Childhood to Adolescence Transition Study; VSHAWS: Victorian student health and wellbeing survey; LSAY: Longitudinal Surveys of Australian Youth.

[1]Survey starting year.

[2]No data on help seeking or health service utilisation related to mental health

[3]No publicly available data for children or young people

[4]Data related to i) deliberate self-harm, and iii) hospital admissions due to mental health and addictions are not publicly available

[5]Highly restricted for accessing the unit as well as aggregated data

[6]Data are restricted for public use. CATs study based on Melbourne only – SEHQ (Victoria) can complement with larger area of data coverage. Therefore, CATS data access was not requested

Brief description of the existing data sources

Through the data audit, the following data sources were identified to include potentially relevant mental health related indicators for children and young people in Australia. Table 5.3 lists the specific items from each of the data sources used within the integrated analysis.

- ***The Longitudinal Study of Australian Children (LSAC):*** This is a major nationally representative study following the development of approximately 10,000 children and family from all parts of Australia. The study began in 2003 with a representative sample of children (who are now teens and young adults) from urban and rural areas of all States and Territories in Australia. This study collects data from two cohorts every two years, including a range of information on child mental health. The first cohort of 5,000 children was aged 0–1 years in 2003–04, and the second cohort of 5,000 children was aged 4–5 years in 2003–04 (wave 1). Data up to wave 8 is currently available.
- ***The Longitudinal Study of Indigenous Children (LSIC):*** The LSIC is a study of Aboriginal and Torres Strait Islander children living in selected locations across Australia. This study represents the broad distribution of Aboriginal and Torres Strait Islander people around Australia. The study began in 2008 (Wave 1) by including two groups of Aboriginal and/or Torres Strait Islander children: cohort B (aged 6–8 months), cohort K (3.5–5 years). The survey in this study is conducted in every year and collects information about parenting, family relationships, childhood education, child and parent health including mental health, as well as questions about culture and community. Currently wave 10 (survey year 2017) data are available for public use.
- ***Australian Longitudinal Study on Male Health: Ten to Men:*** This is a longitudinal study that began in 2013 with the aim to improve the health and wellbeing of Australian men and boys by understanding the dynamics of men's health outcomes. The survey topics include a broad range of areas relating to male health, including mental health issues. In wave 1, the study collected health and lifestyle information from over 15,000 men and boys across the country via surveys and interviews. Currently wave 2 (2015) is available for public use. Wave 3 of the study (July 2020 – December 2020) has now been completed, with wave 3 data yet to be released.
- ***WA Health and Wellbeing Surveillance System (WA-HWSS):*** This system was launched in 2002 to monitor the health status of the general WA population. Each month, approximately 550 randomly selected households take part in a telephone survey. This survey collects information on health status, use of health services (mental health), smoking, physical activity, nutrition, alcohol consumption, and socio-demographic information such as age, sex and geographic location.
- ***Australian Bureau of Statistics (ABS):*** This is Australia's national statistical agency, providing trusted official statistics on a wide range of economic, social, population and environmental matters of importance to Australia. The ABS Causes of Death collection includes all deaths that occurred and were registered in Australia, including deaths of persons whose usual residence is overseas. Deaths of Australian residents that occurred outside Australia may be registered by individual Registrars but are not included in ABS deaths or causes of death statistics. Currently the ICD 10th revision is used for Australian causes of death statistics. A range of socio-demographic data also are available from the ABS Causes of Death collection. Standard classifications used in the presentation of causes of death statistics include age, sex and Aboriginal and Torres Strait Islander status. Statistical standards for social and demographic variables have been developed by the ABS. The data sources are highly restricted for public use.
- ***Mental Health Establishments National Minimum Data Set (MHE-NMDS):*** These datasets were developed to better understand mental health service delivery in Australia. There are three "patient level" national collections in this dataset that cover the mental health care provided in hospitals, residential settings and community services. Admitted Patient Mental Health Care collects information at the national level on consumers admitted to public and private psychiatric hospitals or in designated psychiatric units in general hospitals. Commenced in 1996–1997, the collection provides information on approximately 110,000 treatment episodes per year. Residential Mental Health Care reports on the care provided to consumers admitted to government-operated, 24-hour staffed residential units. This is a new collection, commencing in 2004–2005. Community Mental Health Care is designed to collect information on the services provided by public sector mental health services to consumers who are living in the community, external to hospital and residential settings. Commenced in 2000–2001, the collection gathers information on an estimated 5 million service contacts provided to approximately 300,000 consumers.
- ***Australian Early Development Census (AEDC):*** This is a nationwide data collection of early childhood development assessed at the time children commence their first year of full-time school. The AEDC is intended to highlight what is working well and what needs to be improved or developed to support children and their families by providing evidence to support health, education and community policy and planning. The AEDC is held every three years, and it started in 2009. The census involves teachers of children in their first year of full-time school completing a research tool, the Australian version of the Early Development Instrument. The Instrument collects data relating to five key areas of early childhood development referred to as "domains": Physical health and

wellbeing, Social competence, Emotional maturity, Language and cognitive skills (school-based), Communication skills and general knowledge.

- ***School Entrant Health Questionnaire (SEHQ):*** This is an annual survey that records the observations and concerns of parents about their child's health and wellbeing in Victoria. This survey has been conducted since 1997 and provides insights into health and wellbeing of children during their crucial movements into early primary schooling. In 2017, there were 63,937 responses from parents, representing 90% of all Victorian children enrolled in Prep that year. Topics covered by the survey include general health, speech and language, service use, general development, behavioural and emotional wellbeing, and family stress. Currently, data up to year 2018 are available for analyses.
- ***NSW-Child Development Study (NSW-CDS):*** This is a longitudinal study of child mental health and wellbeing in a cohort of children in NSW who were assessed using the AEDC in 2009 or the Middle Childhood Survey in 2015. The study combines record linkage with cross-sectional assessment. The survey collects information about children's thoughts, feelings, actions and experiences, as well as social skills, sleep patterns, and family and community networks, and measures children's mental health and wellbeing at population level. The wave 2 survey, which was conducted in 2016, can be considered as baseline data. The next survey (wave 3) was conducted at the end of 2019. However, the wave 3 data will not be available until mid-2021. The data sources are highly restricted, with limited availability for public use.
- ***Childhood to Adolescence Transition Study (CATS):*** This is a longitudinal study of children in Melbourne as they move into high school and through adolescence. An important focus of this study is on the health and emotional development of children in the middle years of school. In 2012, 1,200 Victorian Year 3 students from across 43 primary schools were included in this study (Wave 1). Currently, data up to 2018 (Wave 7) is available. Data from wave 8 (collected in 2019) were also available within the evaluation period. The data sources are highly restricted, with limited availability for public use.
- ***Mission Australia Youth Survey:*** This is Australia's largest online youth survey, providing a platform for young people aged 15–19 to "speak up" about the issues that really concern them. The survey has been conducted annually since 2002, with the aim to identify both the values and issues of concern to young people. It gives valuable insights into the lives of young Australians and an understanding of their aspirations, values, concerns and ambitions. This survey collects information on a range of issues including metal health and wellbeing. Data from this survey are available from 2002 up to 2020.
- ***Victorian Student Health and Wellbeing Survey (VSHAWS):*** This survey (known as the "About You Survey") collects important information about the health, development, learning, safety and wellbeing of children and young people in Victorian schools. The survey is conducted every two years with students in Years 5, 8 and 11 from a sample of Victorian schools across all school sectors. The survey covers topics relating to nutrition, health, physical activity, safety, life satisfaction and family relationships. Data for this survey is currently available for the years 2014 and 2018.
- ***Longitudinal Surveys of Australian Youth (LSAY):*** This is a nationally representative annual survey involving samples of young people from ages 15–25. The aim of this survey is to understand key transitions and pathways in the lives of young people, particularly the transitions from compulsory schooling to further education, training and employment. This survey began in 1995. It collects information on various areas relevant to youth transitions, including educational participation and achievement, labour force status, student background and social development. While the focus is on education and employment, LSAY also collects information on important factors such as wellbeing, financial security, and personal goals and aspirations. Currently data up to year 2018 are available for analyses.

Table 5.3 The specific items from each data source examined in the Integrated Data Analysis

Data source	Questions	Response
LSAC	Have you sought help for personal or emotional problems from any of these in the last 12 months	• Sought help from boyfriend or girlfriend/partner • Sought help from friend • Sought help from parent • Sought help from brother or sister • Sought help from other relative/family member • Sought help from teacher • Sought help from other school staff • Sought help from family doctor / GP • Sought help from mental health professional • Sought help from work colleague • Sought help from other adult • Sought help from phone help line • Sought help from internet • Sought help from someone else not listed above
	Ability of family to get along	• Excellent • Very good • Good • Fair • Poor
	Maternal reported SDQ	Numeric scores
LSIC	Parent reported SDQ scores	Numeric scores
Ten to Men	Son visited counsellor/psychologist (past 12 months) OR Son visited psychiatrist (past 12 months)	• Yes • No
ABS	Causes of Death, Australia (suicide)	Excluded from analysis
MHE-NMDS	Annual number of emergency department presentations in public hospitals, by SA3 and demographic characteristics of the patient, States and Territories	Annual numbers
AEDC	Vulnerable – Emotional maturity (derived variable to identify the grouping variable for the cumulative frequency of scores in the emotional maturity domain)	1 = 0 to 10th percentile 2 = 11th to 25th percentile 3 = 26th to 50th percentile 4 = 51st to 100th percentile

Data source	Questions	Response
LSAY	How happy are you with your life as a whole	0–10 rating scale: 1 = Completely unsatisfied to 10 = Completely satisfied
Mission Australia Youth Survey	How well they felt their family gets along with one another	• Excellent • Very good • Fair • Poor
	The levels of psychological distress experienced by young people, the Kessler 6 (K6)	Scoring (based on established scoring criteria, the K6 can be used to classify Youth Survey respondents into two groups – those who qualify as having psychological distress and those who do not)
WA-HWSS	Mental health service – number of times used in last 12 months	Number of times
	McMaster Family Functioning Scale of 12 questions	Children with poor family functioning
	The Kessler Psychological Distress Scale-10 (K10)	Four categories: low, moderate, high and very high psychological distress
SEHQ (Victoria)	SDQ scores	Numeric scores
	Family's level of stress over the month prior to completing questionnaire	Rating scale: "little or no stress/pressure" to "almost more than I can bear"
VSHAWS	Basic psychological needs scale	Positive psychological development
	Index of depressive symptoms based on the International Youth Development Study, short version moods and feelings scale	High levels of psychological distress
CATS	SDQ scores	Numeric scores
NSW-CDS	SDQ scores	Numeric scores

Methods related to objective 1

The first objective of the Integrated Data Analysis was to assess the appropriateness of the Program by estimating the match between Program implementation areas and geographic and demographic identifiers of need for mental health supports. In this activity, we explored whether the Program is reaching regions and areas in Australia where child and youth mental health problems are more prevalent. To do this, first we explored the Program coverage in terms of geographic distributions as well as number of organisations/institutes and participants (Educators/Practitioners) exposed to the Program from August 2017 to September 2020. Secondly, we estimated baseline (before Program started, ~ 2015–2017) prevalence of three different child and youth mental health indicators at different lowest available geographic level such as postcode, SA2 and SA3 in the data. These indicators were: children with SDQ>17 (LSAC), emotional developmental vulnerability index (AECD), and number of emergency department visits due to mental health issues (MHE-NMDS). Finally, we constructed mapping of these three indicators and matched that distribution against the areas where the Program had been implemented. The methodology for this activity is briefly described below.

Measurement of child and youth mental health and their geographic distribution

Nationally representative data from the LSAC, AEDC and MHE-NMDS were used to measure these child and youth mental health indicators. The percentage of children or young people who exceed the thresholds on the SDQ (SDQ >17) was estimated at the postcode level using maternal reported SDQ variable in wave 7 (survey year 2015) of LSAC survey data. The percentage of children with emotional developmental vulnerability were measured at the SA2 level using data on the emotional maturity domain in AEDC survey in 2015. The proportion of children (per 10,000) who visited an emergency department due to mental health and addiction were estimated at the SA3 level based on data from MHE-NMDS in 2016–2017.

These estimates were used to create three different maps of child and youth mental health indicators using ArcGIS software (ver. 2.6, Esri). These maps were developed to understand the baseline geographic distribution and magnitude of child and youth mental health problems in Australia.

Geographic extent of the Program coverage against areas of mental health needs

Based on the available geographic identifier (postcode) of the organisations engaged to Be You and Emerging Minds, we created the Program coverage map using ArcGIS software highlighting the number of organisations/users within each postcode zone. This map depicts the extent of geographic reach of the Program implementation by Be You and Emerging Minds, as well as the number of organisations/users per postcode exposed to the Program. However, there were substantial limitations with the postcode data collected for Be You and Emerging Minds, which meant that the analysis depicts a conservative representation of Program reach. These postcode limitations are discussed further in the Challenges and Limitations section below.

Finally, child and youth mental health maps were compared with the Program coverage map to understand the reach of the Program to areas of mental health need in Australia.

Methods related to objective 2

The second objective of the Integrated Data Analysis was to assess the baseline and future trend of the planned mental health related indicators (output and outcome) in the Evaluation Framework, as well as effectiveness of the Program against those indicators where possible from existing data sources.

Selection of mental health related indicators and their measurements

The Overarching Evaluation plan identified nine different indicators with potential to measure the trend in mental health outcomes for Program beneficiaries (i.e. children and young people in Australia). The indicators were used to demonstrate baseline (i.e. before the Program was initiated) and future trends, which included:

- change in help-seeking by children and young people
- change in rate of death by suicide for children and youth
- change in rate of emergency department visits/hospitalisation due to mental health and addictions
- changes in proportion of developmentally vulnerable children
- changes in children and young people with SDQ >17 (>14 for Indigenous children)

- changes in the proportion of parents reporting high levels of subjective poor health and wellbeing
- changes in resilience in children and young people
- changes in reported quality of family relationship
- changes in wellbeing outcomes of children and young people

Measurement of each of the indicators is briefly described in Table 5.2.

Design of the evaluation

The planned study design for the Integrated Data Analysis was a pre-post intervention design that controlled for exposure to the Program. However, based on the assessment of the available Program data (i.e. Be You had broad coverage based on available postcode data, and poorly defined level of engagement to explore dose-response relationships) and the availability of existing data, the study design was amended to pre-post intervention only. This amendment was made in consultation with the Department (monthly meeting, 24 September 2020) when it was identified that there were insufficient appropriate control areas (i.e. geographically determined regions without exposure to the Program), with only low-level geographic identifier data available in the Program data (see section 5.7.3, below). Using the pre-post intervention design, data collected before 2017 were considered as pre-intervention data (prior to implementation of the Program), whereas data collected from 2018 onward were considered as post-intervention data for the purpose of this analysis.

5.6 Data analysis

In the analysis related to objective 1, descriptive and spatio-temporal analyses were used to understand the Program coverage and uptake of different initiative activities over the time. For the analysis related to objective 2, we conducted a time-series analysis to investigate the baseline as well as future trends in the proportion of various child and youth mental health indictors relevant to the Overarching Evaluation.

The baseline trend of child and youth mental health related indicators was observed between 2009–2017 (before the Program was initiated) using time-series plot on annual proportion rates of the indicators. Then, using available data up to 2017, we estimated and compared the average annual rate of change (AARC) across the different child and youth mental health related indicators using the model derived by UNICEF (2007). Technically, the following model was used to quantify the average annual rate of change in proportions from earliest available survey to the year the Program initiated (~2017):

$Yti = Y*(1-b)(ti-t0)$ so that

$\ln(Yti) = \ln(Y0) + (ti-t0)*\ln(1-b\%) = \ln(Y0) + ti*(1-b\%) – t0*\ln(1-b\%) = \beta*ti + C0$

Where ti, (i=0,1,2…n) survey years, Y0 and Yi is the proportion of the indicators (e.g. proportion of children with SDQ >=17) at earliest available survey year and different subsequent survey years. $\beta=\ln(1-b\%)$ is the coefficient of ti in a regression of ln(Yi) against ti, and $C=\ln(Y0) –t0*\ln(1+b\%)$ constant (UNICEF, 2007).

Using the estimated β, we calculated AARC in both the direction such as average annual rate of reduction (AARR) as well as increment (ARRI) as: AARR = 1- EXP (β) and AARI = EXP (β) -1 respectively. In this document, we reported AARC with negative values representing an annual rate of reduction, and positive values representing an annual rate of increase.

Using the estimated AARC based on available data up to the survey year, 2017, we projected the proportion of youth mental health related indicators for the years 2018 to 2024 to estimate the future trends of the child mental health related burden in Australia. These projections assume no change associated with the Program or external factors. At the national level, both the baseline and future trends were estimated, but at the State level, only the baseline trend and its variation were observed.

Table 5.4 and Table 5.6 present the characteristics of the activities and registration data provided by Be You at the organisation and individual user level, respectively.

5.7 Results

5.7.1 Understanding Program coverage

Characteristics of the Program participants (Be You and Emerging Minds)

Table 5.4 shows that 10,595 organisations were registered to Be You as at September 2020. The majority of registered organisations were schools. The majority of the organisations were located in the two most populous Australian States of New South Wales and Victoria. Engagement status (Participating, Emerging, Embedding and Leading) refers to the level of recognition that an organisation (i.e. school or learning service) has achieved for their progression with the Be You initiative. To achieve the different levels of recognition, the organisation can make an application that is assessed against key criteria. Participating, Emerging, Embedding and Leading categories reflect increasing levels of engagement. The participating level of engagement status indicates that an organisation is currently participating as a whole setting in Be You and has an Action Team Leader and consultant. Of the Be You registered organisations, 98% were classified as “Participating”, 2% were considered “Emerging”, and 0.2% were “Embedded”. No organisations met criteria for “leading”.

Table 5.5 presents the characteristics of individual users registered to Be You between October 2018 and September 2020. This Table shows that the majority of individual users were registered with a registered organisation, but 45,568 individual users were registered from 5,530 non-registered organisations.

Table 5.4 Characteristics of Be You registered organisations (October 2018 – September 2020)

Be You registered organisations	% (n)
Total number of registered organisations	10595
Type of organisation	
– ELS	37.4 (3961)
– Education	0.2 (20)
– School	62.4 (6,614)
Registered organisations by State or Territory	
– ACT	2.6 (276)
– NSW	30.9 (3,268)
– NT	2.3 (241)
– QLD	19.3 (2045)
– SA	7.6 (805)
– TAS	3.2 (343)
– VIC	24.4 (2582)
– WA	9.8 (1033)
Having a registered user in the organisation	
– Yes	91.1 (9,642)
– No	9 (953)
– Medium (IQR) number of registered users per organisation	4 (2-8)
Engagement status	
– Embedding	0.2 (23)
– Emerging	2.3 (245)

Be You registered organisations	% (n)
– Participating	97.5 (10,327)

Table 5.5 Characteristics of Be You registered users (October 2018 – September 2020)

Be You users	Organisation; % (n)		
	Registered	Non-registered	Total
Number of registered organisations	10,595	5,530	16,125
Number of registered users (N)	73,739	45,568	119,307
Users categorised by type of users			
– ELS leader	4.9 (3,621)	5 (2,294)	5 (5,915)
– Educator	66.3 (48,901)	35.4 (16,136)	54.5 (65,037)
– Not an Educator	0.0 (1)	--	0.0 (1)
– Other	4.9 (3,620)	19.9 (9,073)	10.6 (12,693)
– Pre-service Educator	0.01 (7)	17.9 (8,160)	6.9 (8,167)
– School leader	10.5 (7,751)	4.4 (1,984)	8.2 (9,735)
– Specialist and support staff	13.3 (9,836)	14.2 (6,470)	13.7 (16,306)
– Tertiary professional	0.0 (2)	3.2 (1,451)	1.2 (1,453)
Users categorised by type of organisation*			
– ELS	27.2 (20,059)	--	--
– Education	0.04 (32)	--	--
– School	72.8 (53,648)	--	--
Users categorised by State*			
– ACT	4.9 (3,620)	--	--
– NSW	32.4 (23,922)	--	--
– NT	1.4 (1,056)	--	--
– QLD	14.5 (10,717)	--	--
– SA	8.2 (6,012)	--	--
– TAS	2.8 (2,030)	--	--
– VIC	21.6 (15,926)	--	--
– WA	14.2 (10,452)	--	--
User completed at least one module			
– Yes	35.1 (25,863)	21.5 (9,778)	29.9 (35,641)
– No	64.9 (47,876)	78.5 (35,790)	70.1 (83,666)
Medium (IQR) number of modules completed	3 (2-9)	3 (2-7)	3 (2-9)

*Information only available for registered organisation

Table 5.6 presents the characteristics of the activities of Emerging Minds. Table 5.6 shows that Emerging Minds engaged with 691 organisations between November 2017 and August 2020. These organisations were classified as non-profit/NGOs, State Government, Peak bodies or Academic and education. Approximately half of the organisations worked with both children and adults, 35% worked with adults only, and 11% worked with children only (Table 5.6).

In total, there were 1,968 engaged actions taken by Emerging Minds between November 2017 and August 2020. Engagement actions are defined as "discrete, countable promotion and implementation support activities recorded in the CRM" (Emerging Minds, Final Report, June 2017 – December 2019, p. 28). The majority of these actions were coded as being about communication. Most of the engaged actions were undertaken in South Australia. Emerging Minds categorises the stage of its engagement with an organisation into four levels: Purveyor of Information, which is a style of engagement that aims to share information about the importance of the Program; Fact Finder, which is a type of engagement that involves learning about the organisation, its needs and unique circumstances; Joint Problem Solver, which is a type of relationship between the consultant and organisation that aims to choose and develop new practices for child mental health, and make plans to monitor practice change; Process Counsellor, which is the most intensive type of consulting style, where the consultant works with the organisation for more full implementation or organisation-wide system change. Most of the action types were coded as "Purveyor of Information".

Although individual user level data (e.g. e-learning registrations and course completions) were not made available to us, we note that there were 39,233 total individual e-learning registrations as at May 2020, with 25,136 total course completions (see National Workforce Centre for Child Mental Health: Evaluation Report 2020).

Table 5.6 Characteristics of Emerging Minds engaged organisations and engaged actions (November 2017 – August 2020)

Emerging Minds engaged organisations and engaged actions	% (n)
Total number of organisations engaged (N)	691
Type of organisation	
– Aboriginal Services Organisation	1.2 (8)
– Academia and Education	7 (48)
– Collective/Network	3.2 (22)
– Community Led Group	0.7 (5)
– Corporate Organisation	1.6 (11)
– Government: Commonwealth	1.7 (12)
– Government: Local	3.9 (27)
– Government: State	22.7 (157)
– Non-profit/NGO	39.2 (271)
– Peak Body	8.8 (61)
– Private Practice	5.4 (37)
– Unknown (missing)	4.6 (32)
Engaged organisations categorised by State	
– ACT	2.9 (20)
– NSW	13.9 (96)
– NT	2.9 (20)
– QLD	21.4 (148)
– SA	28.2 (195)

Emerging Minds engaged organisations and engaged actions	% (n)
– TAS	1.7 (12)
– VIC	14.3 (99)
– WA	7.7 (53)
– Unknown (missing)	7 (48)
Engaged organisations categorised by service reach	
– Local/Regional	26.3 (182)
– National	9.4 (65)
– Outside of Australia	0.3 (2)
– State/Territory	29.7 (205)
– Unknown (missing)	34.3 (237)
Engagement organisation categorised by (mainly) work with	
– Children	11.1 (77)
– Children & Adults	51.1 (353)
– Adults	35.3 (244)
– Unknown (missing)	2.5 (17)
Engagement organisation categorised by (mainly) having aboriginal specific service	
– Yes	18.2 (126)
– No	40.2 (278)
– Unknown (missing)	41.5 (287)
Median (IQR) number of attended in the action by the organisation; N= 438	6 (2-27)
Total number of engaged actions (N)	1,968
Engaged actions categorised by type of actions	
– Communication	63.2 (1244)
– Education	20.9 (411)
– Quality Improvement	15.9 (313)
Engaged actions categorised by State	
– ACT	3.7 (73)
– NSW	13.5 (265)
– NT	1.9 (37)
– QLD	23.5 (463)
– SA	32.1 (631)
– TAS	1.6 (31)
– VIC	14.9 (294)

Emerging Minds engaged organisations and engaged actions	% (n)
– WA	4.6 (91)
– Unknown (missing)	4.2 (83)
Engaged actions categorised by engage stage	
– Convert	0.1 (2)
– Fact Finder	17.5 (345)
– Joint Problem Solver	14.5 (285)
– Paused	1.6 (32)
– Process Counsellor	7.7 (152)
– Purveyor of Information	58.5 (1152)

5.7.2 Program uptake

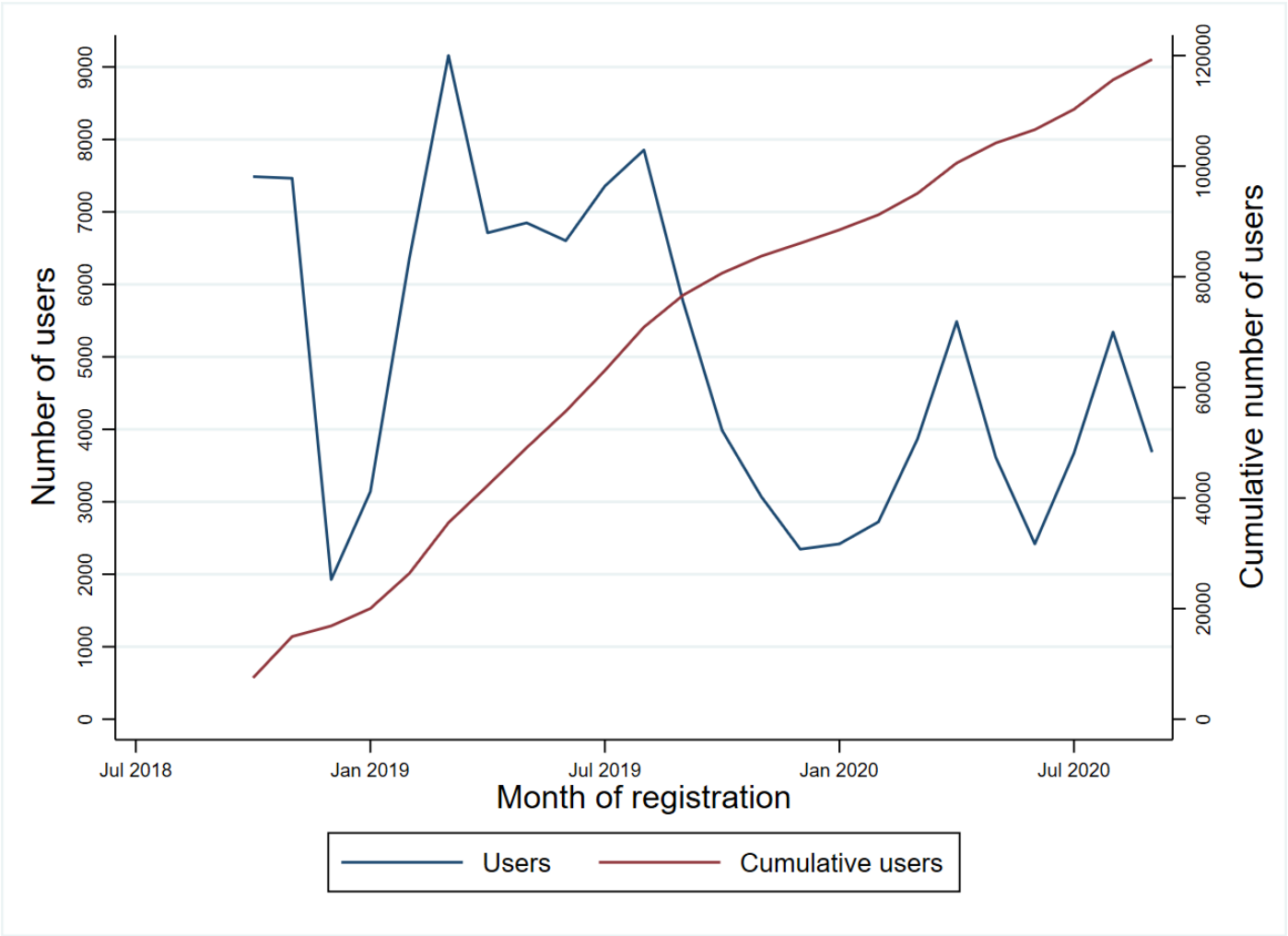
Module completion (Be You)

There were 13 different modules related to mental health available for Be You registered users to complete. The module completion rate was low during the evaluation period, October 2018 to September 2020. About 64.9% of the registered users did not complete any of the modules (78.5% and 70.1% for registered and non-registered organisations respectively). The median (IQR) number of completed modules was 3 (2–9) among the registered users who completed at least one module (overall, 35.1%) during the assessment period (see Table 5.5).

Spatio-temporal distribution of the Program activities (Be You & Emerging Minds)

The temporal distribution of the monthly number of users registering to Be You showed that there were two major peaks between October 2018 and September 2020 (Figure 5.1). The highest peak in the number of new user registrations was March to September 2019. The trend in registrations for schools and ELSs was similar. However, significant variation was observed in the trend of registered Be You users over time between different States and Territories. For example, the trend of new user registrations remained constant across 2020 in New South Wales and Victoria, whereas it declined in 2020 for Queensland, Western Australia and South Australia.

a) Overall Be You user engagement



b) Be You user organisations by State or Territory

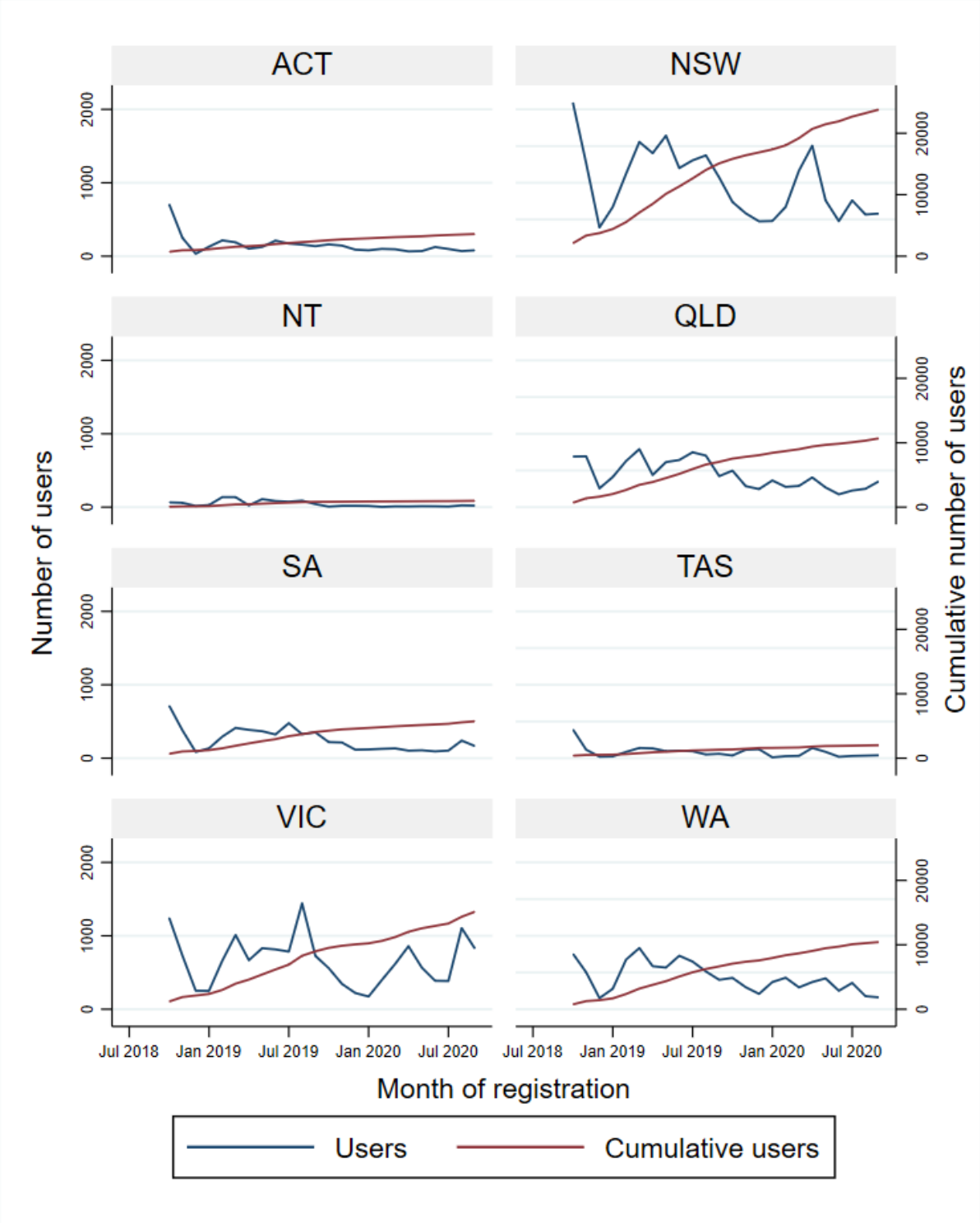
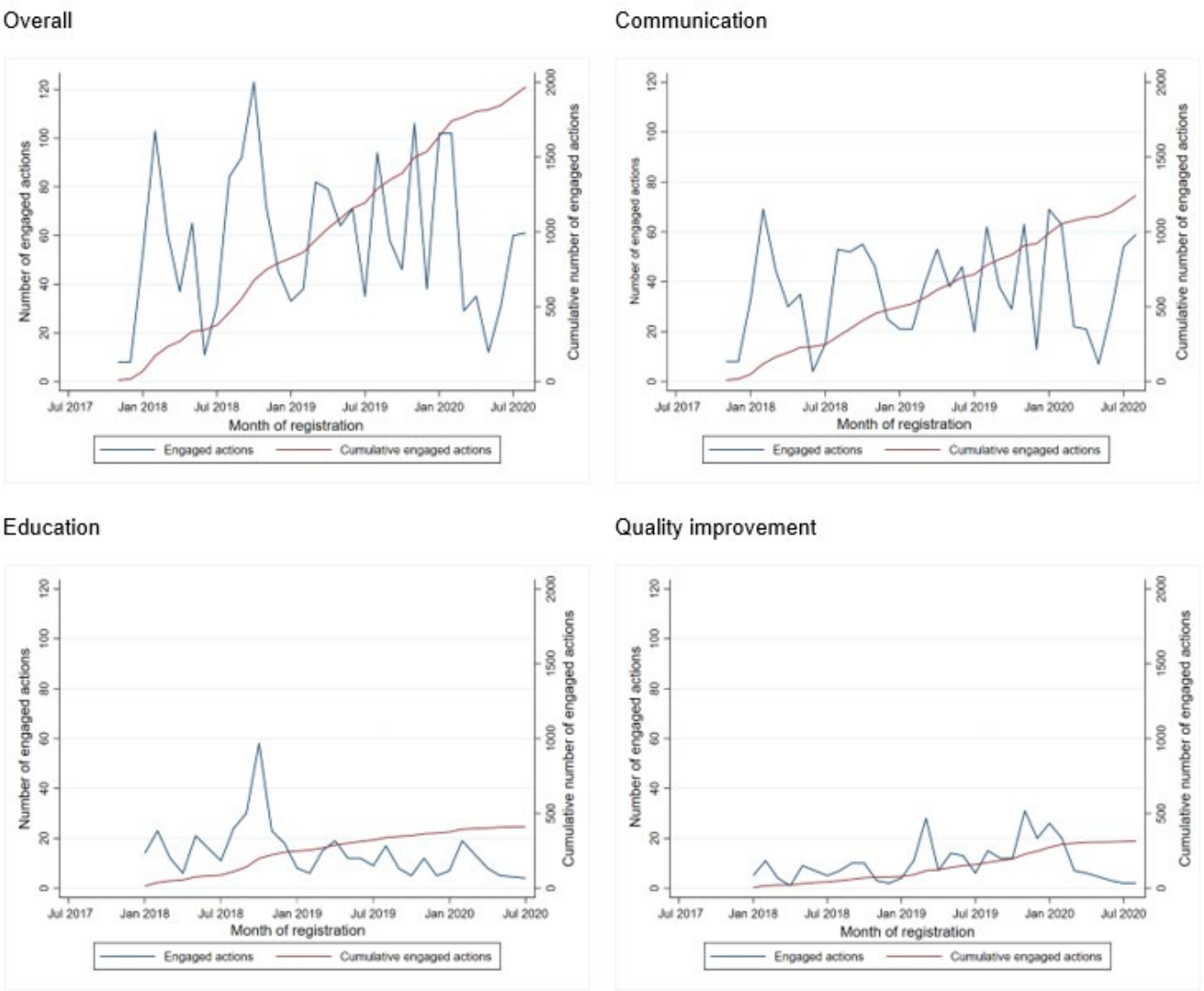


Figure 5.1 Trend of new user engagement with Be You between October 2018 and September 2020, a) overall, and b) categorised by State or Territory

For Emerging Minds, the temporal distribution of the number of monthly engaged actions showed that the overall trend was similar throughout the evaluation period, except for a fall in the number of monthly actions in early 2020. While looking at different types of actions, communication actions increased in the three months after this initial fall, but education and quality improvement actions continued to decrease (Figure 5.2 (a)).[3] As with Be You, variation between States and Territories was observed in the trend of the monthly number of Emerging Minds engaged actions. For example, the trend in the monthly number of engaged actions remained the same in South Australia throughout the Program period, whereas there was a decline in this activity at the end of 2020 in other States and Territories (Figure 5.2 (b)).[4]

a) Overall Emerging Minds engaged actions, and action categorised by action type



[3] These changes in activities coincided with the COVID-19 related public health movement and gathering restrictions. During this period, Emerging Minds' policies restricted in-person quality improvement activities. Organisations were also less likely to participate in quality improvement activities during this time.

[4] This observation may be explained by the Emerging Minds' head office, and the majority of consultants, being based in South Australia, and travel restrictions across states limited activities by these consultants in other states.

b) Emerging Minds engaged actions, categorised by State or Territory

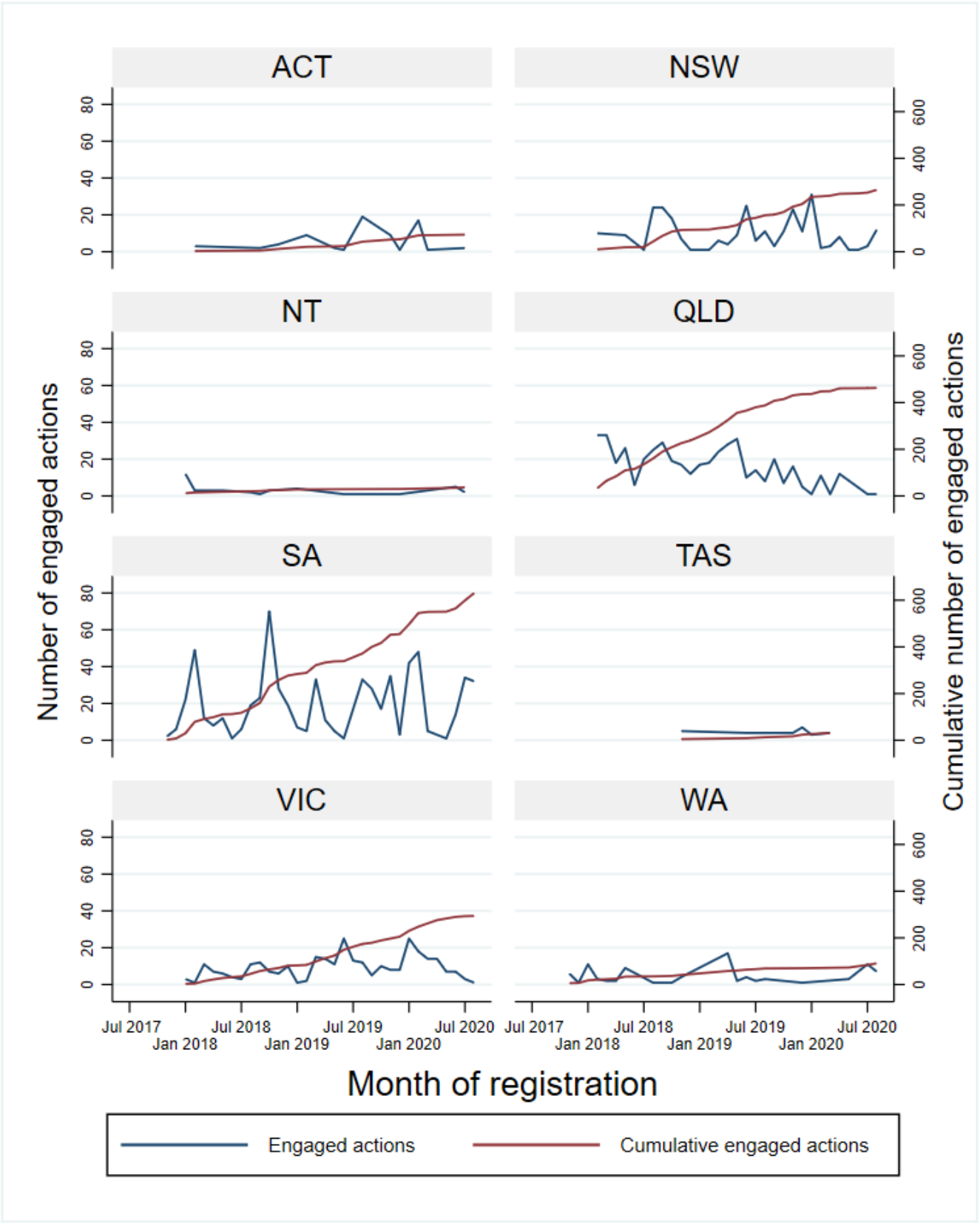


Figure 5.2 Trend of Emerging Minds engaged actions, November 2017 – August 2020, a) overall, as well as categorised by action type, and b) categorised by States

The Program's reach through different events and different digital engagements are presented in Appendix H. These engagements represent different indicators of the overall activity of the Program, and all show growth over time. The digital engagements are an indicator of digital reach that may be independent of geography.

Spatial distribution of registered organisations

The spatial distribution of registered organisations of Be You and Emerging Minds based on the available physical postcode data is presented in Figure 5.3. It is important to note that postcode data was not available for a significant number of organisations from both Be You (34.3%) and Emerging Minds (44.3%). As a result, there are a substantial number of organisations that were not included in this spatial distribution of the Program coverage. In addition, the physical postcode data for organisations engaged with by Emerging Minds consultants often relates to a head office, which may extend services beyond that one postcode and overestimate engagement in capital cities. Based on available organisation level postcode data, we observed that almost all the geographic regions (75.5% postcode, 99.4% SA2, and 99.7% SA3 in Australia) were exposed to the Program in some way (i.e. at least one registered organisation from that geographic location) between November 2017 and September 2020 (see Table 5.7). This finding is a conservative representation of Program reach due to the limitations of the postcode data.

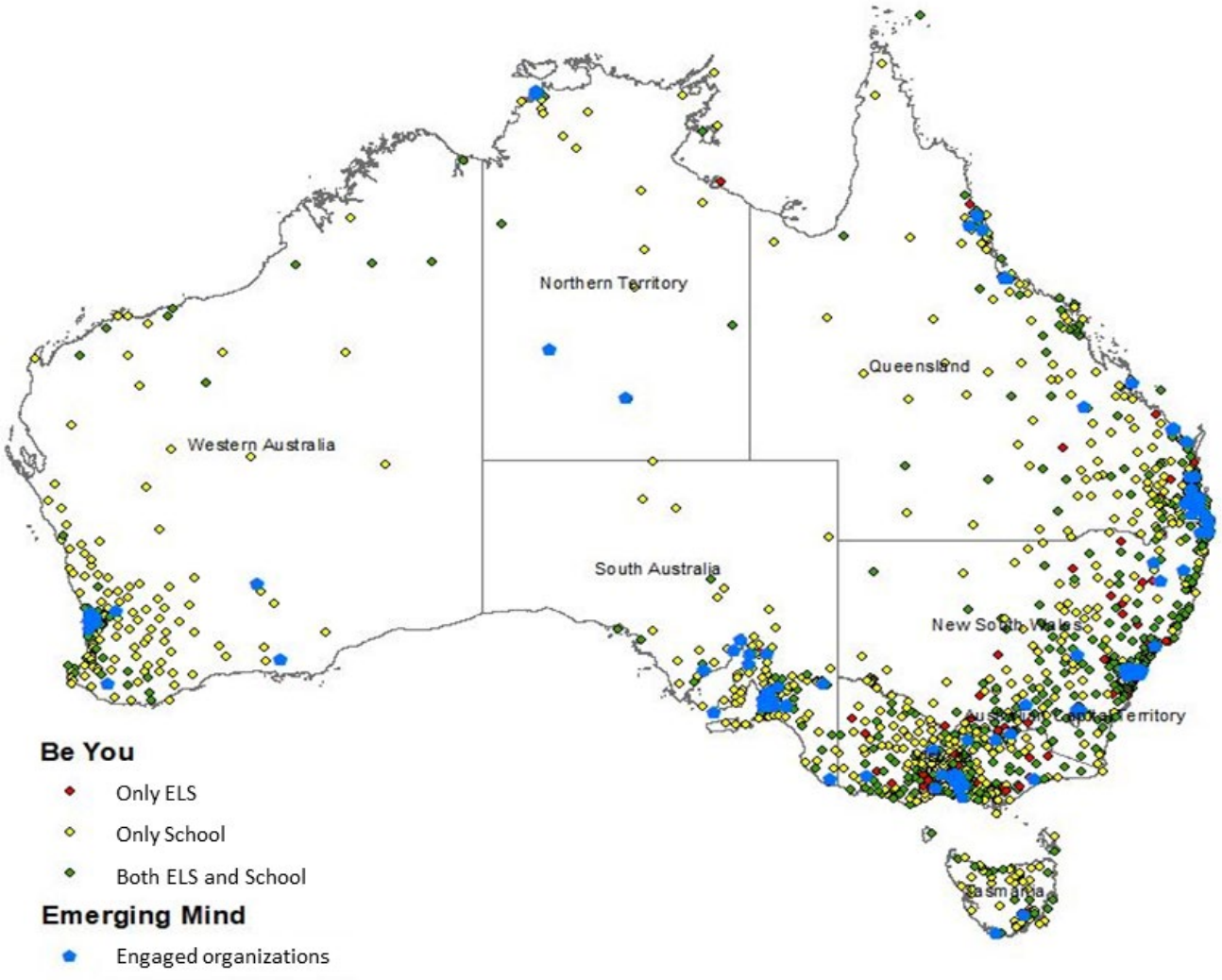


Figure 5.3 Spatial distribution of Be You and Emerging Minds engaged organisations (physical postcode of the registered/engaged organisations)

Table 5.7 Summary of combined Program coverage by Be You and Emerging Minds, November 2017 – September 2020

Geographic unit	Program reached	Unknown*	Total geographic units in ASGS file
Postcode area**	2014 (75.5%)	655 (24.5%)	2669
SA2	2,238 (99.4%)	13 (0.7%)	2,251
SA3	338 (99.7%)	01 (0.3%)	339

Notes. SA2 = Statistical Areas Level 2**.** According to the ABS, SA2s reflect functional areas that represent a community that interacts together socially and economically. SA2s generally have a population range of 3,000 to 25,000 persons (average 10,000). SA3 = Statistical Areas Level 3. According to the ABS, SA3s reflect regional areas through clustering groups of SA2s that have similar regional characteristics, administrative boundaries or labour markets. SA3s generally have a population range of 30,000 to 130,000 persons.

*Unable to label as "No-Program/Control" as we did not get the physical postcode of all Be You and Emerging Minds organisations.

**There are 3,280 valid Australian postcodes including 2,630 Delivery Areas (real geographic locations). In the concordance (postcode to SA2 or SA3) file, total number of postcode areas was 2669.

5.7.3 Amendment of the planned study design

Be You and Emerging Minds each provided data specifying the geographic locations (e.g. postcode) of registered/engaged organisations that they had been working with. Parallel location data were not available for the location of individual users. The organisation level location data were not appropriate for classifying areas as exposed or not exposed to the Program for three reasons: an individual user's workplace may not always be in the same location as the registered or engaged organisation; no location data were recorded for about 34.3% and 44.3% of the organisations that engaged with Be You and Emerging Minds respectively; and the lack of high-level geographic data for organisations meant that the Program was effectively active in the majority of lower level geographic areas (such as SA2 or SA3) in Australia (see Figure 5.3 and Table 5.7), resulting in a lack of identified control (no Program) locations for comparison. Based on these limitations, it was necessary to amend the evaluation design for this Integrated Data Analysis activity to a "pre-post intervention only" design.

Data collected before 2017 were considered as pre-intervention data, whereas data collected from 2018 onward were considered as post-intervention data. Many of the existing data sources identified as relevant for the Overarching Evaluation (see Table 5.2) have not yet provided sufficient follow-up data to be included in analyses. These data were unavailable due to delays in processing and releasing data, or because planned data collection was not yet completed. A number of these resources are expected to be available in later 2021 and 2022. Therefore, our focus was to describe the baseline trends in these mental health indicators for the period prior to the implementation of the Program, and to present projected future trends of these indictors in the absence of the Program and external factors. The immediate value of understanding these trends is to inform understanding of potential priority areas and appropriate future targets for the Program. When follow-up data are available, these projections can be used to estimate the benefits associated with the Program against these child mental health indicators.

5.7.4 Geographic distribution of child and youth mental health problems and Program coverage

The baseline spatial distribution of child and youth mental health problems (based on the three selected evaluation indicators, refer to Table 5.2) showed that the burden of child and youth mental health was relatively high in remote areas; however, the number of registered Program users or engaged actions were relatively less prevalent in these remote areas (Figure 5.4). For example, the number of child emergency department visits due to mental health issues were proportionally high in NT and WA, but the number of users/actions were comparatively lower in those States and Territories than other States and Territories in Australia (Figure 5.4).

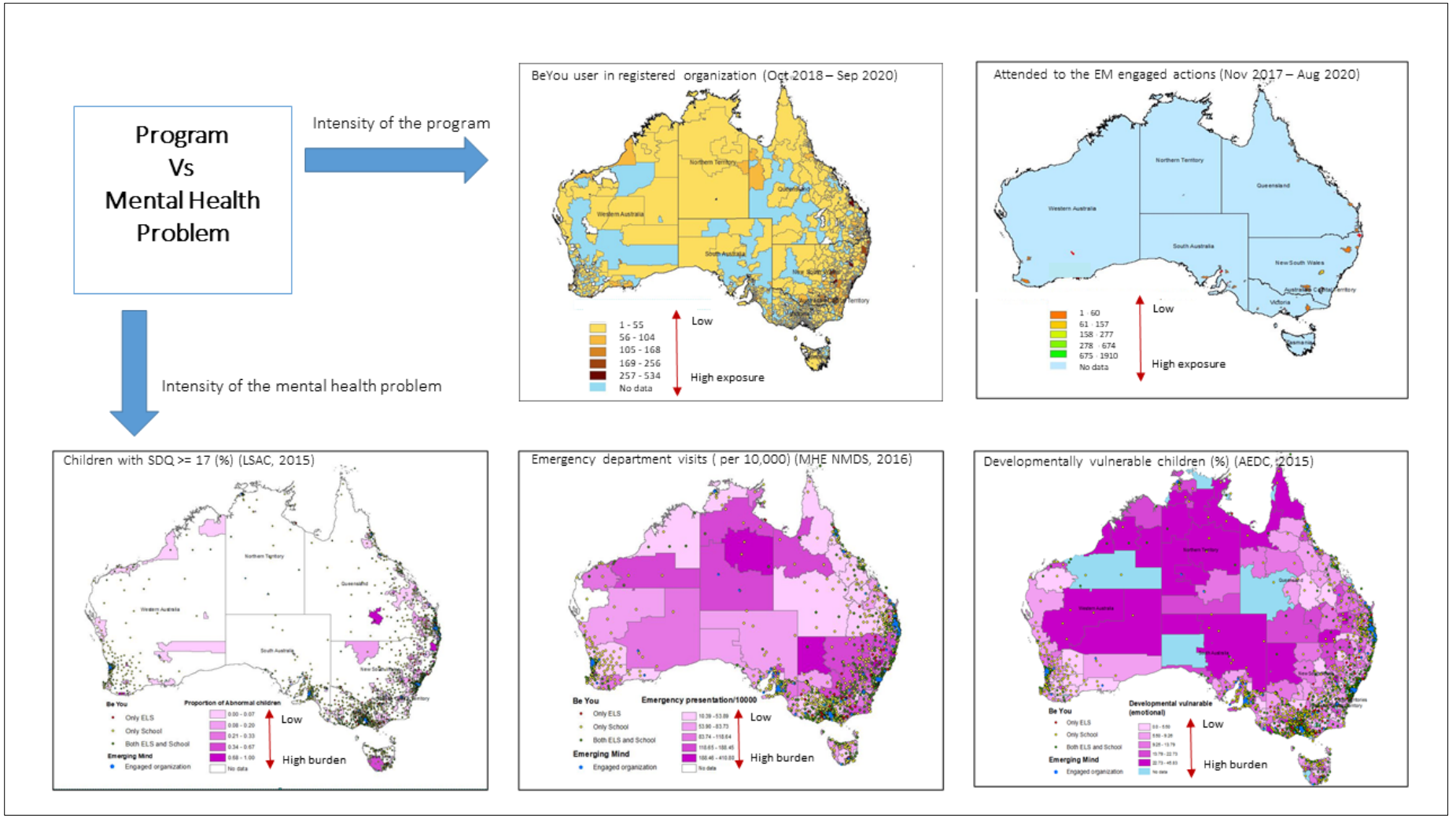


Figure 5.4 Spatial distribution of the proportion of children with SDQ >= 17 (LSAC Wave 7, 2015–2016), developmentally vulnerable children (Emotional domain; AEDC 2015), mental health related emergency visits (MHE-NMDS, 2016–2017) and physical postcode of engaged/registered Program organisations

5.7.5 Assessment of the mental health evaluation indicators

In this section, we address the second objective of the Integrated Data Analysis, which was to assess the baseline and future trend of the planned mental health related indicators (output and outcome) in the Evaluation Framework, as well as the effectiveness of the Program against those indicators where possible from existing data sources. To do this, we calculated trends (increase or decrease) in the planned child and youth mental health indicators. These indicators were developed and refined in activities for the Evaluation Framework. The Department of Health and the Evaluation Team (with input from the Scientific Advisory Group) agreed on the Overarching Evaluation Questions and developed an Indicator Framework to monitor the performance of the Program against specified criteria. The Indicator Matrix is presented in Appendix B. The Indicator Matrix defined nine different indicators with potential to measure the trend in mental health outcomes for Program beneficiaries (i.e. children and young people in Australia). The Program's implementation is within the very early stages (2–3 years since the launch of the initiatives), which according to the Program Logic is likely to be too early to see a significant impact of the Program on intermediate and long-term outcomes for Program beneficiaries. As such, we describe the baseline trends in these mental health indicators for the period prior to the implementation of the Program, and present projected future trends of these indictors in the absence of the Program and external factors. The data sources for these indicators are depicted in Table 5.2, above.

Indicator 1: Changes in help-seeking by children and young people

Changes in help-seeking by children and young people were assessed using three different existing data sources: two of national level data and the other of regional level data. Using AARC estimates attributed from the national level data, we found that that the proportion of children's mental health related help-seeking, or service utilisation, was decreasing in the 12 months prior to the Program starting (AARC = -5.2% for LSAC: LSAC, 2013–2018; and AARC= -1.3% for Ten to Men,2013–2015). However, estimates from the WA-HWSS data revealed that mental health service utilisation in the 12 months prior to 2018 by children was increasing before the Program stated (AARC = 8.3%; Figure 5.5). This variation may be due to real differences in national and regional trends, or due to other differences between data sources and demographics. For example, Ten to Men survey data included males only. Overall, we observed that visits to mental health professionals in the 12 months prior to the Program starting increased in most of the States and Territories except NSW and VIC (see Supplementary Table I.1 in Appendix I).

Indicator 2: Changes in rate of death by suicide for children and youth

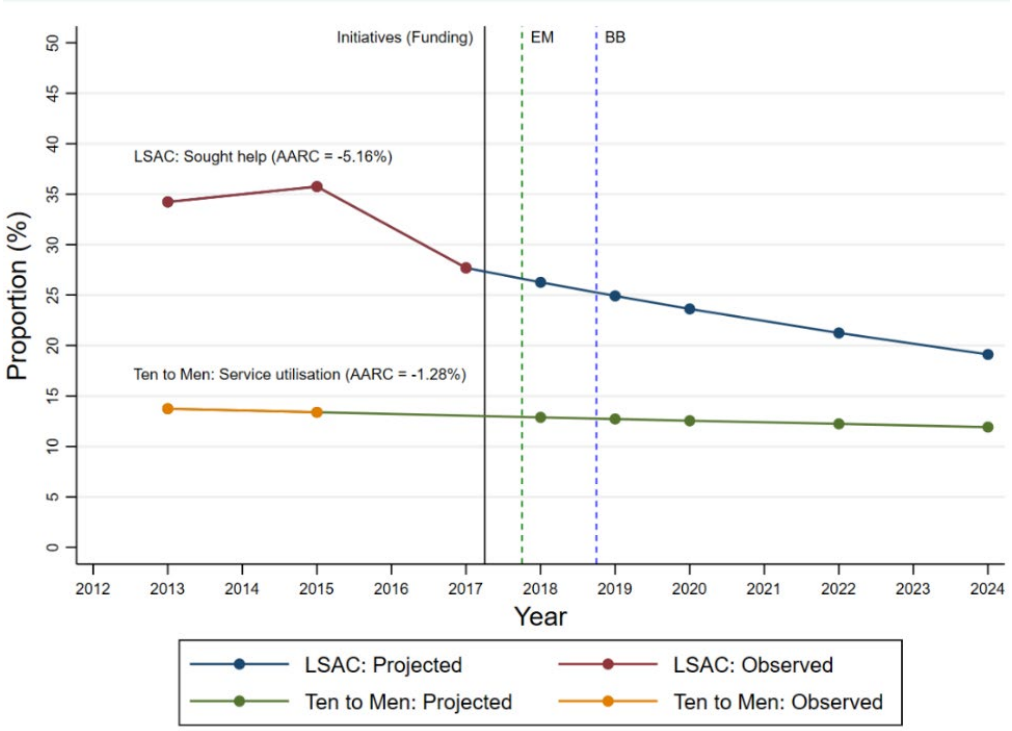
The rate of death by suicide was assessed using ABS cause of death data. This data is highly restricted to access. We used only publicly available data at the national level released by ABS. Using AARC estimates, we found that the rate of suicide (per 100,000) of children aged 5–17 had increased during 2014–2017 (AARC = 6.32%) (Figure 5.6). If the trend is unchanged, the suicide rate may increase to 3.99 per 100,000 children in Australia in 2024, from 2.60 in 2017. However, observed (actual) data showed that the proportion started to decline during the Program implementing period, and it decreased to 2.4 per 100,000 children in 2020. We do not attribute this change to the Program because outcomes for Program beneficiaries are not expected to be observed within this period. Additionally, the broader policy context makes it difficult to attribute such change to the Program alone within the limitations of the Overarching Evaluation design.

Indicator 3: Change in rate of emergency department visits for i) deliberate self-harm, ii) related to mental health and addictions; and iii) change in rate of hospital admissions related to mental health and addictions

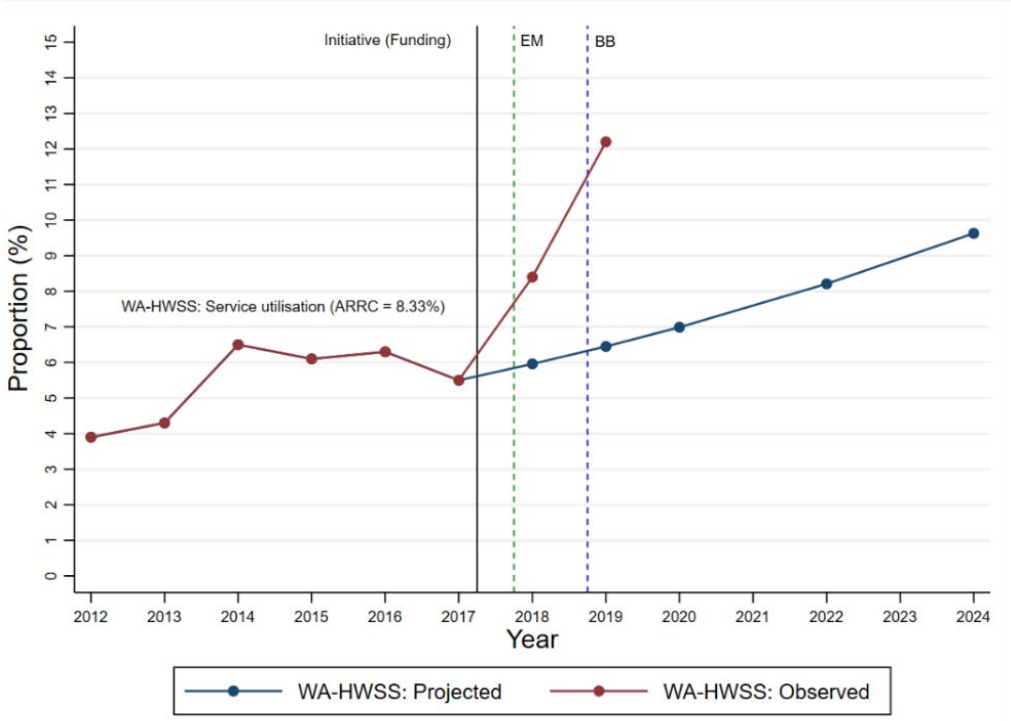
The proportion of children (per 10,000) who visited the emergency department due to mental health and addiction issues increased nationally from 72.5 per 10,000 in 2014 to 85.4 per 10,000 in 2017 (MHE-NMDS data). This increasing trend in emergency department visits at the national level was also observed in all the States and Territories except the Northern Territory.

At the national level, we found that the average rate of change in the proportion of emergency department visits was 5.46% before the Program stated (2014–2017). If this rate of increment continued, the proportion of children who visit emergency departments due to mental health and addictions issues will be 124 per 10,000 in 2024 (Figure 5.7).

National level data



Regional level data: Western Australia



LSAC: Sought help form professional staff (school teacher, other staff, or mental health professional)
Ten to Men: Boys visited mental health care providers (counsellor/psychologist or psychiatrist) in last 12 months
WA-HWSS: Mental health service used in last 12 month

Figure 5.5 Baseline and future trends in the proportion of a) children who sought help/utilised service for mental health related problems in Australia during 2012–2024. [Sources: LSAC (2013–2018), Ten to Men (2013–2015), and WA-HWSS (2012–2019)]

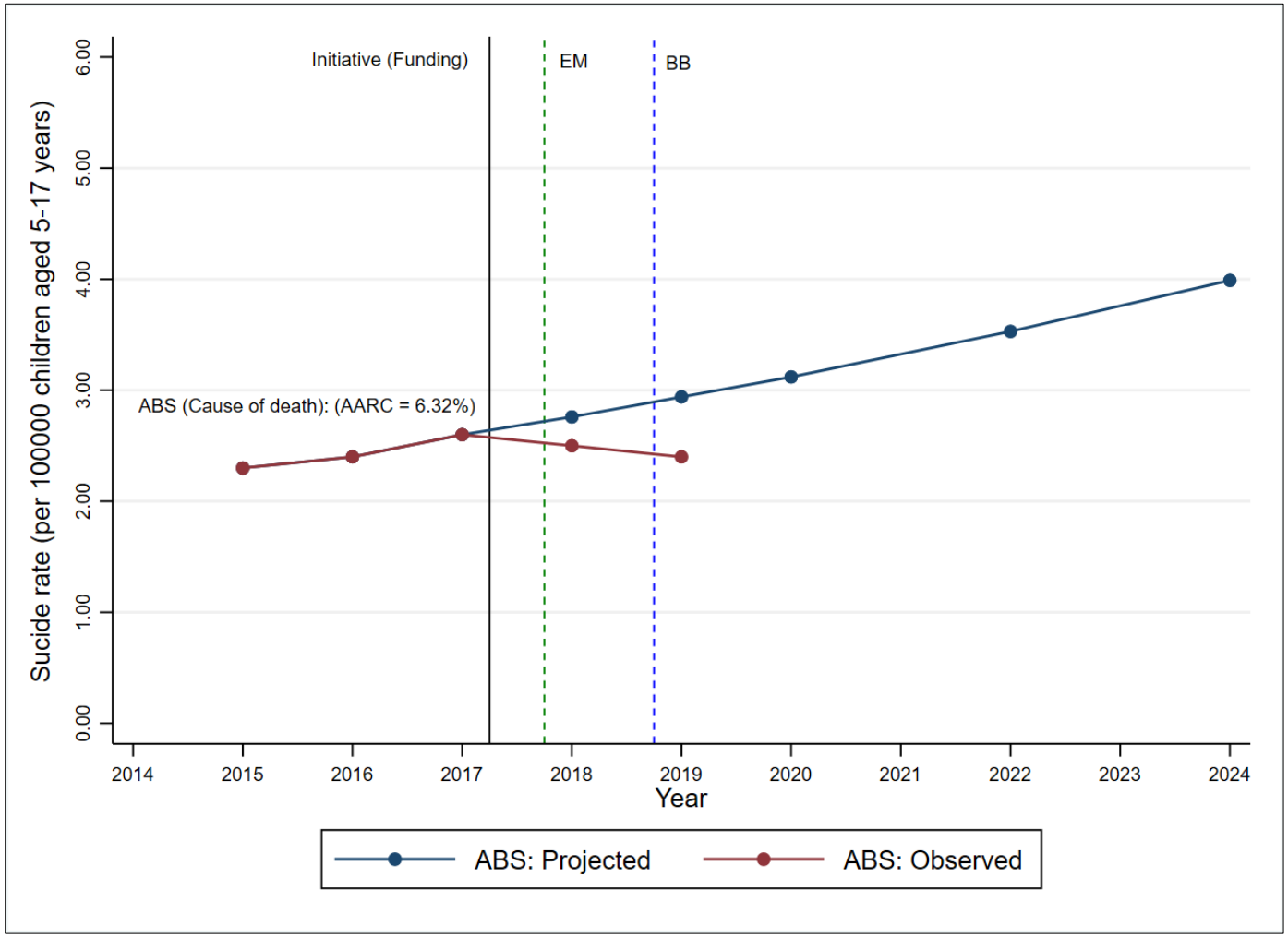
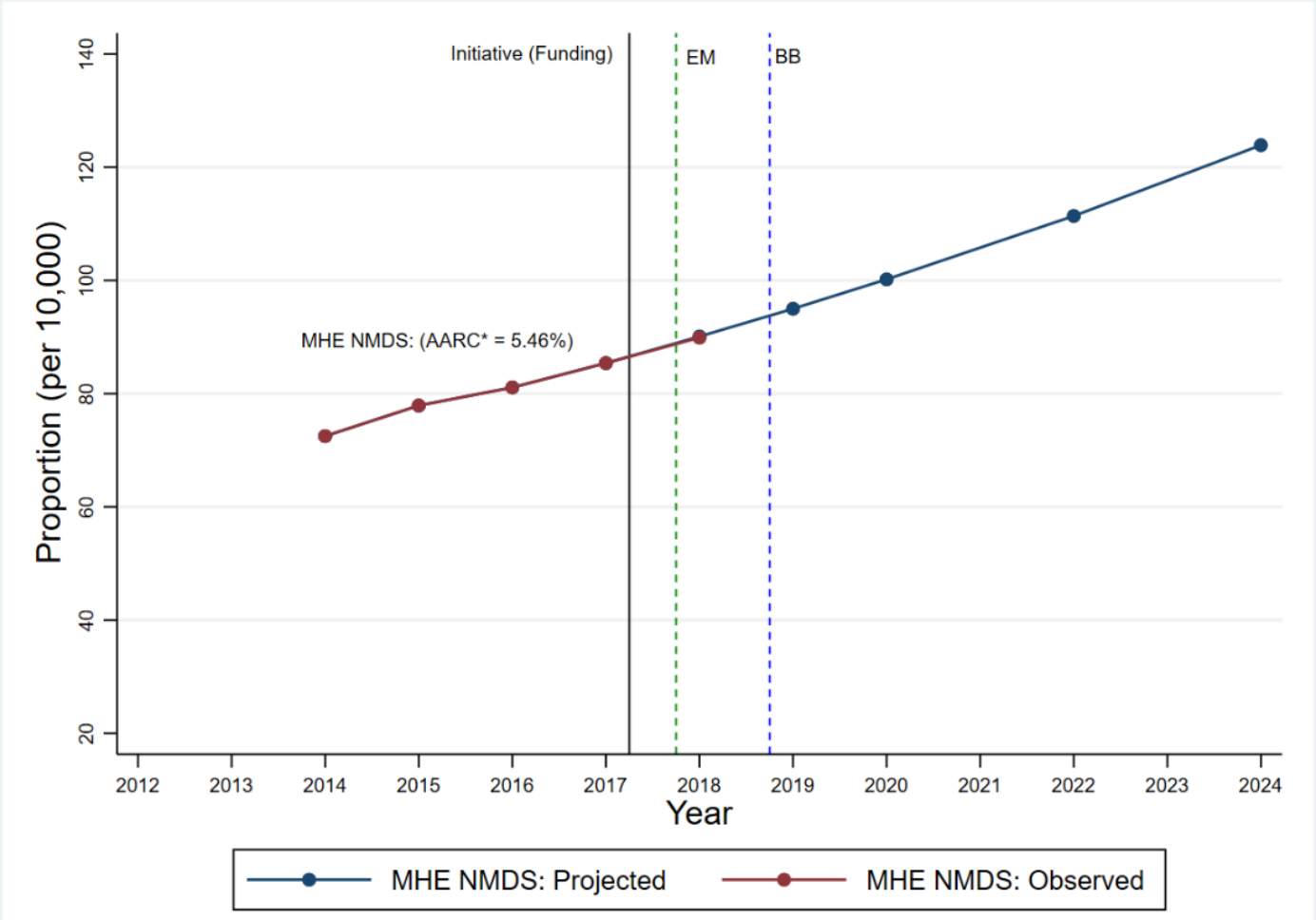


Figure 5.6 Baseline and future trends in suicide rate (per 100,000) of children aged 5–17 during 2014–2024 in Australia [Source: ABS Cause of death data]



*AARC statistically significant

Figure 5.7 Baseline and future trends in the average number and proportion (per 1000) of children per SA3 who visited the emergency department due to mental health and addictions issues during 2014–2024 in Australia [Source: MHE-NMDS data]

Indicator 4: Changes in proportion of developmentally vulnerable children by the time they start school

Data from the AEDC survey showed that the proportion of emotionally developmentally vulnerable children did not change substantially across the period prior to the Program. We found a slight reduction in the proportion of emotionally developmentally vulnerable children between 2009 and 2015 (AARC= - 0.9%); followed by a slight increase from 2015 to 2018 (Figure 5.8). A similar trend was observed across different States and Territories (see Supplementary Figure J.3 in Appendix J). If the national level baseline trend remains the same, the projected prevalence of emotionally developmental vulnerable children in Australia will be decreased to 8.7% in 2024 from 9.5% in 2015.

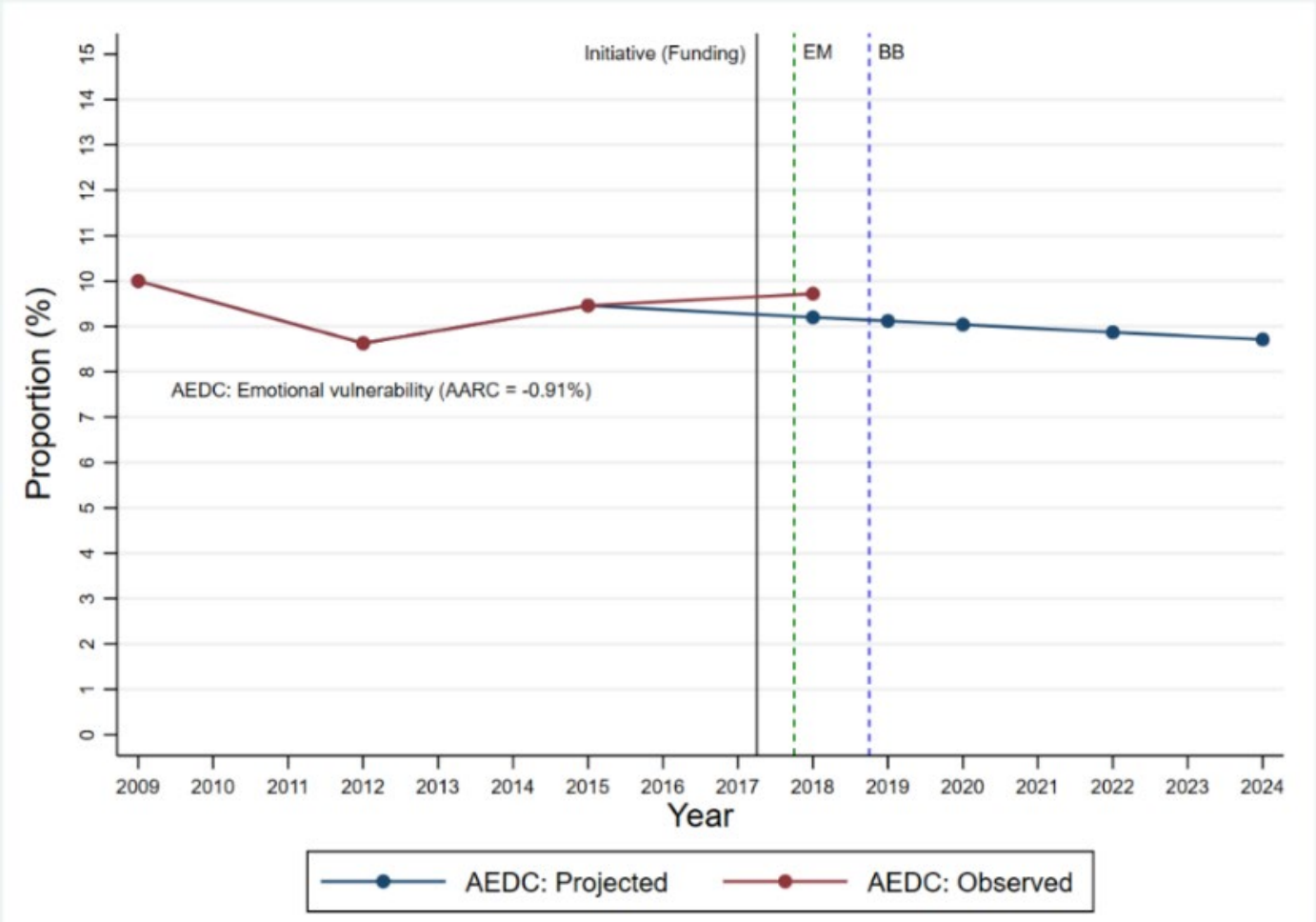
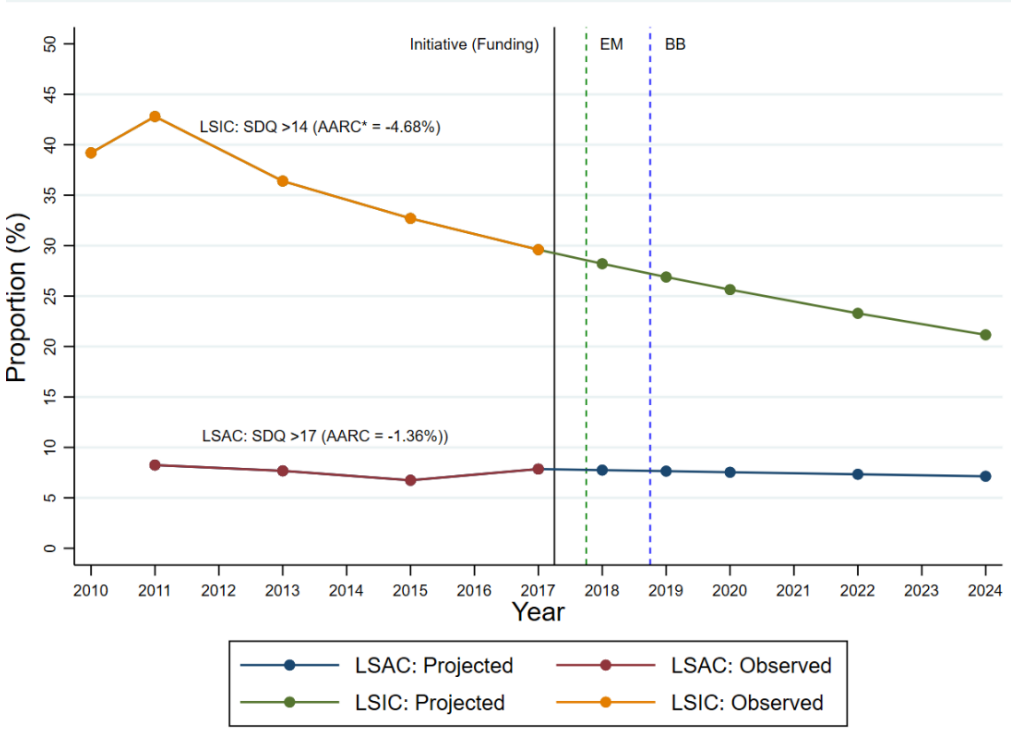
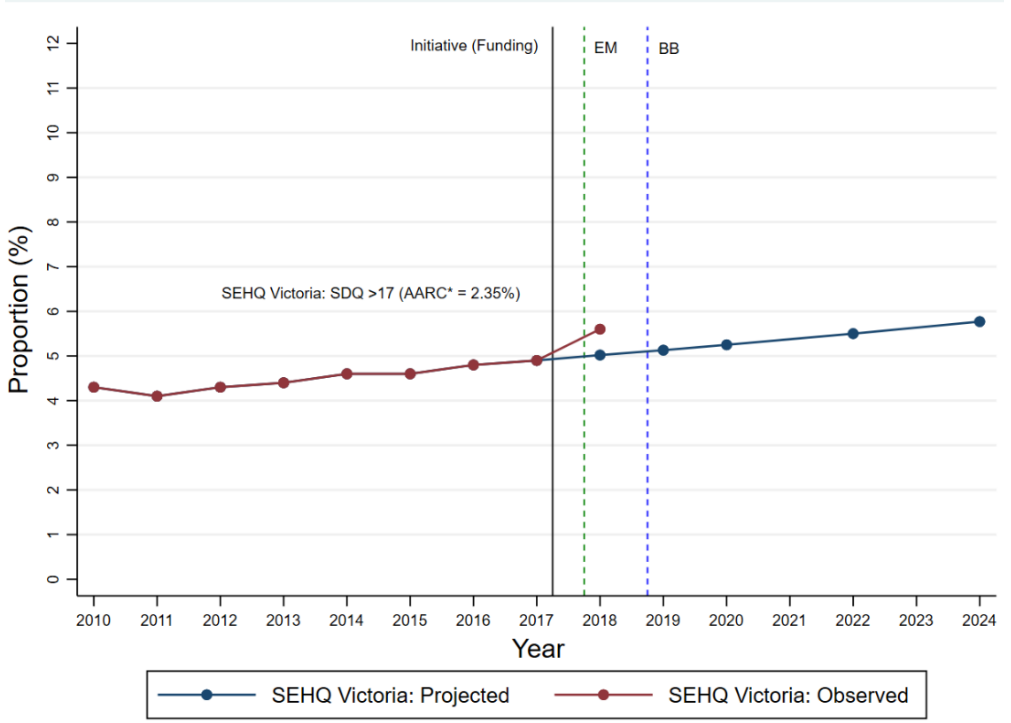


Figure 5.8 Baseline and future trends in the proportion of developmentally vulnerable children in Australian, 2009–2024 [Source: AEDC Survey Data]

National level data



Regional level data: Victoria



*AARC statistically significant

Figure 5.9 Baseline and future trends in the proportion of children with SDQ >=17 (>=14 for Aboriginal and Torres Strait Islander children) in Australia during 2010–2024 [Sources: LSAC (2011–2017), LSIC (2010–2017) and SEHQ (2010–2018)]

Indicator 5: Changes in the proportion of children or young people who exceed the thresholds on the SDQ

Children and young people's SDQ scores were assessed using three different existing datasets, two of them at national level (LSAC and LSIC) and the other at regional level (SEHQ Victoria). For Indigenous children, if the SDQ is examined in relation to child psychopathology in a research context (not clinical), where these are examined as binary variables, it is recommended that a cut-off of ≥ 14 (for surveys for children aged 4–17 years) is used (Thurber, 2019). The proportion of Indigenous children with an SDQ score >14 had sharply declined between 2010 and 2017 (AARC = -4.7% in LSIC survey data; Figure 5.9). If this rate of change persists, the proportion of Indigenous children with an SDQ score >14 will decrease to 21.2% in 2024 from 29.6% in 2017.

Using LSAC survey data, we calculated that the proportion of Australian children with an SDQ score >17 had slightly decreased over time from 2011 to 2017 (AARC = -1.4%). However, estimates from the SEHQ (Victoria) data revealed that the proportion of children with an SDQ score >17 slightly increased leading up to the Program's initiation (AARC = 2.4%; Figure 5.9). State and territory level analysis of LSAC data also showed that the proportion of children with an SDQ score > 17 increased over time in some States and Territories, for example, Victoria, Western Australia and the Australian Capital Territory (see Supplementary Figure J.4 in Appendix J).

In summary, the proportion of children exceeding thresholds on the SDQ had decreased prior to the Program's implementation for Indigenous children; however, this proportion was either unchanged or slightly increased for non-Indigenous children.

Indicator 6: Changes in the proportion of parents reporting high levels of subjective health and wellbeing

Parental mental health data were assessed using two regional level surveys: the SEHQ (Victoria) and the WA-HWSS (Western Australia). SEHQ data showed that the proportion of children with parental reported high levels of family stress remained stable over time (10.5% in 2009 and 9.9% in 2015). However, data from the WA-HWSS showed that the trend in the proportion of adults with high levels of psychological distress increased from 5.8% in 2012 to 7.2% in 2017 (AARC = 5.9%). If this upward trend is continued, the proportion of parents experiencing distress will be increased to 10.8% by 2024 in Western Australia (Figure 5.10).

Indicator 7: Changes in resilience in children and young people

This indicator was measured as the proportion of children and young people with positive psychological development using the VSHAWS in Victoria for the period between 2014 and 2018. Data were available for two time-points only before the initiation of the Program. VSHAWS data showed that the proportion of children and young people without resilience in Victoria in 2014 was 30%, which has slightly increased over time (31.2% in 2016 and 32.7%) (Figure 5.11).

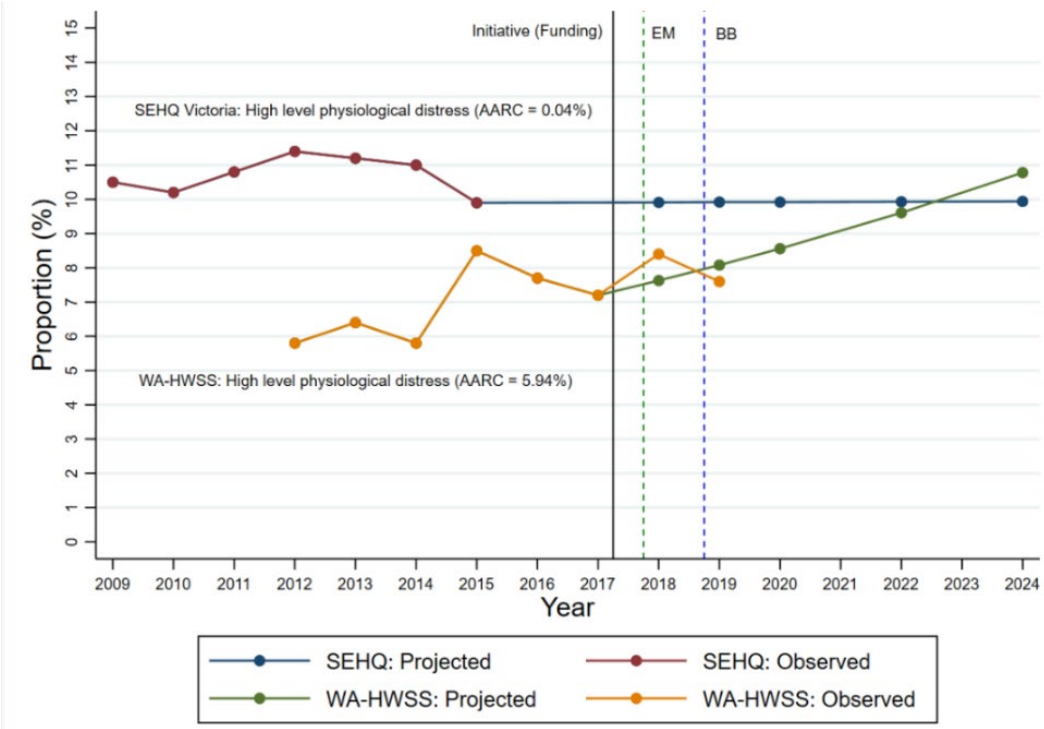


Figure 5.10 Baseline and future trends in the proportion of children at school entry whose parents report high levels of family stress in the past month (SEHQ) or in the proportion of high level of physiological distress among adults (WA-HWSS) in Australia, 2009–2024. [Sources: SEHQ (2009–2015), WA-HWSS (2012–2019)]

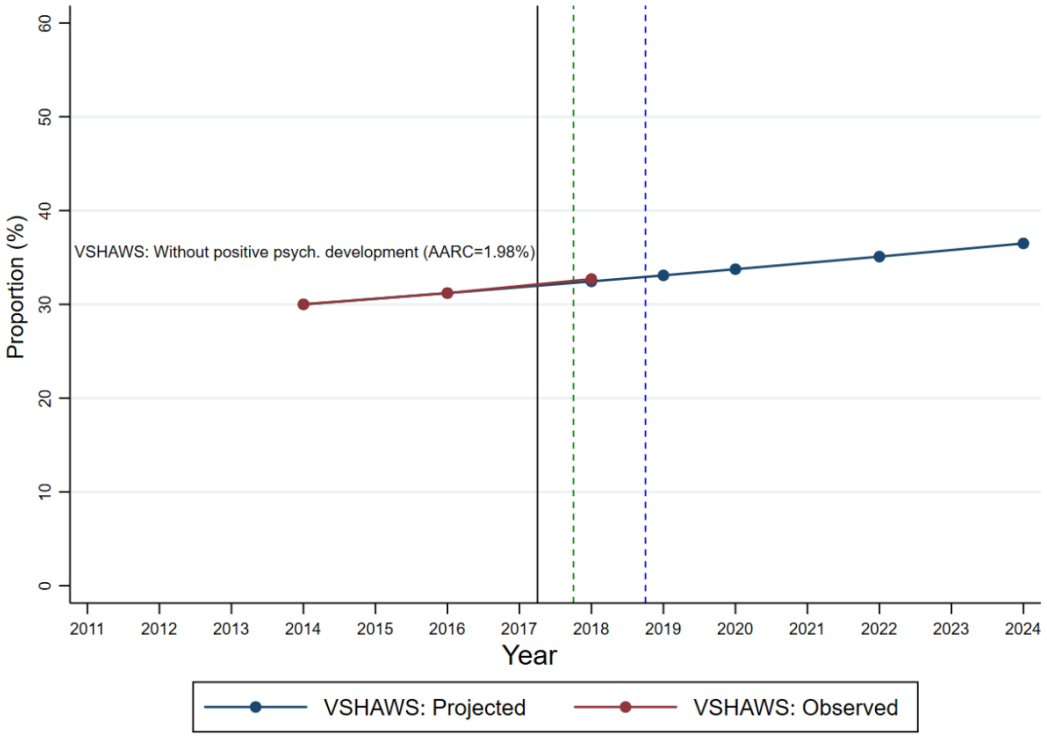


Figure 5.11 Baseline and future trends in the proportion of children and young people children without positive psychological development in Victoria, 2014–2024 [Source: VSHAWS (2014–2018), also known as “About You”)]

Indicator 8: Changes in reported quality of family relationship

The quality of family relationships was assessed using three different existing data sources, two of them at national level (Mission Australia Youth Survey and LSAC) and the other at the regional level (WA-HWSS). Using AARC estimates attributed from the Mission Australia Youth Survey data, we found that the proportion of children with poor family relationships increased from 6.2% in 2012 to 7.3% in 2017 (AARC = 1.3%; Figure 5.12, and Supplementary Table I.1 in Appendix I). If this trend persists, the proportion will increase from 7.3% in 2017 to 8% in 2024. However, we observed (actual) data that showed that the proportion started to decline after the Program's implementation period, and it decreased to 5.2% in 2020. The extent to which these positive changes can be attributed to the Program is unknown. For example, estimates from LSAC data showed a decline in the proportion of children with poor family relationship between 2011 and 2017 (Figure 5.12).

Estimates from the WA-HWSS data revealed that the trend in the proportion of children with poor family functioning has fluctuated over time, with a decrease between 2012 and 2014, and a sharp increase between 2014 and 2017 (Figure 5.12). While looking at the State and Territory level trends in both sets of national level survey data, we observed that the trend in the proportion of poor family relationships is similar to the national level trend, with the exception of a sharp decline in the Northern Territory and the Australian Capital Territory (see Supplementary Figure J.5 (a) (b) in Appendix J).

The Mission Australia Youth Survey provided the only follow-up data relevant to the evaluation period (2020). This data enables the calculation of the crude change in the evaluation indicator of poor family functioning coinciding with the implementation period of the Program by comparing the projected and observed trend. The Program commenced in 2017. Using an annual rate of changes before the Program initiated, we expected that the prevalence of poor family functioning experienced by children and young people would continue to increase. However, the observed follow-up data showed a decrease. Based on the difference between the observed data and the predicted trend, we found that the average annual reduction was 20.65% in the prevalence of poor family functioning (2012–2017 vs 2018–2020: see Table 5.8). Similar analyses of change in other evaluation indicators over the evaluation period can be done in future using other identified existing data sources when sufficient follow-up data are made available.

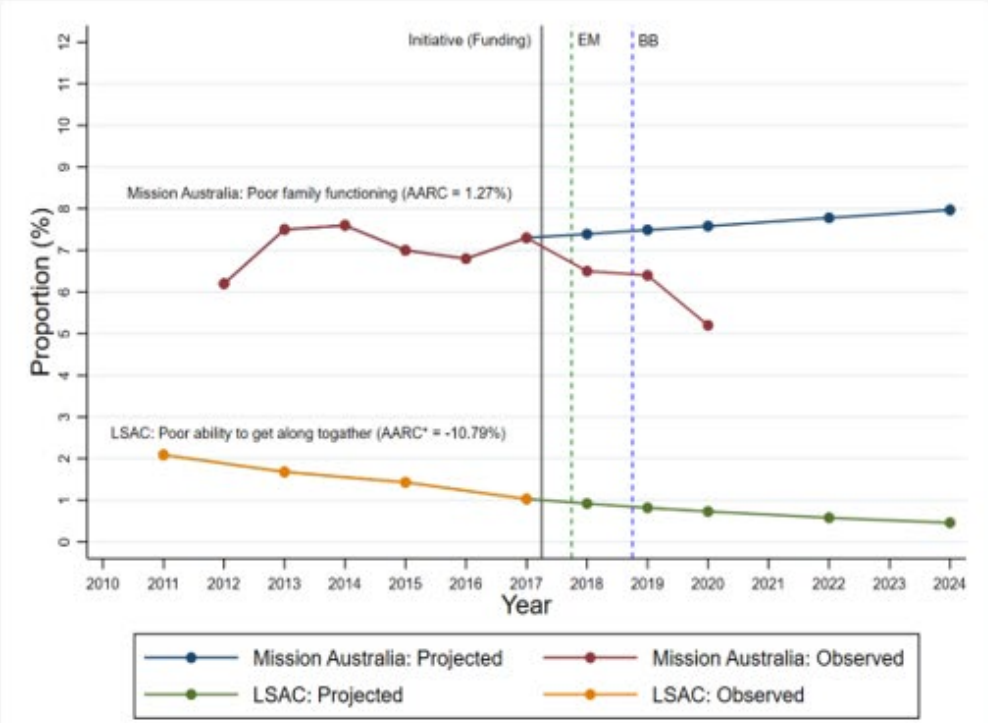
Table 5.8 Effect of the Program on the prevalence of poor family functioning in Australia, 2012-2020 (an example from Mission Australia Youth Survey)

Program initiated	Mean proportion of poor family functioning (%)		Estimated changes in the prevalence after initiating the Program in % **
	Observed	Predicted*	
Before (2012–2017)	7.07	7.07	-20.65 %
After (2018–2020)	6.03	7.49	

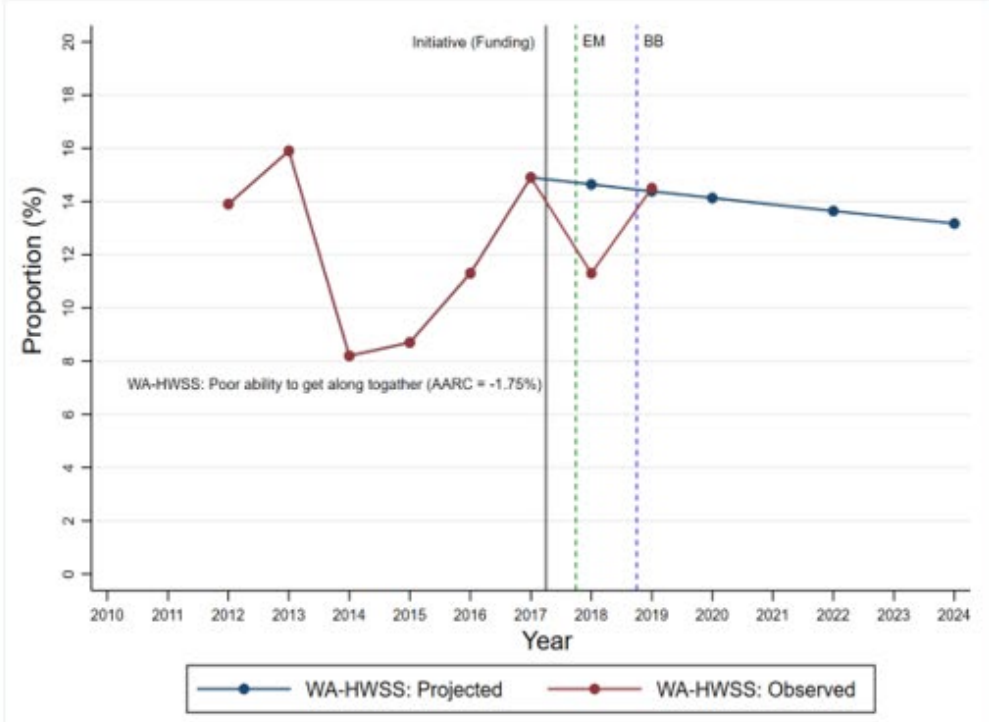
*Assuming same proportion as observed proportion at baseline.

**Crude estimated effect in the prevalence (% effect). Effect of Program (EP): (B-A) – (D-C); Where, A = mean observed prevalence before the Program initiated (2012–2017); B = mean observed prevalence after the Program initiated (2018–2020); C = mean predicted prevalence before the Program initiated (2012–2017); D = mean predicted prevalence after the Program initiated (2018–2020). Negative sign represents reduction in the prevalence whereas positive sign represents increment. Then the per cent effect by the Program is calculated as: (EP/A)x100.

National level data



Regional level data: Western Australia



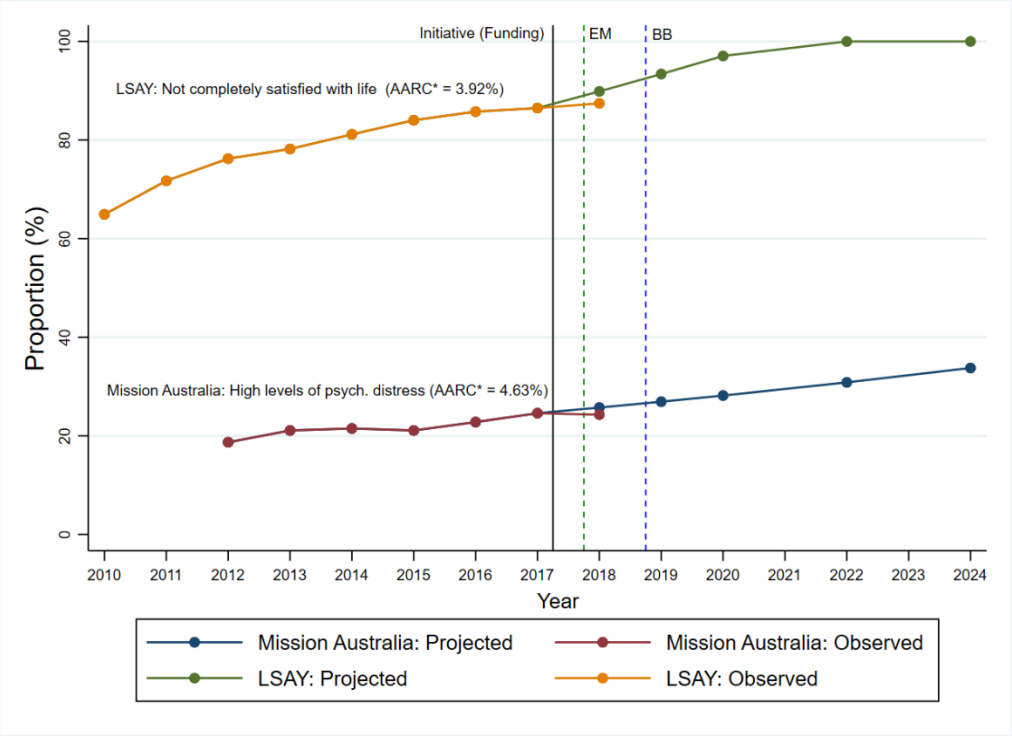
Mission Australia Youth Survey: Poor (lowest category as "poor" out of five categories) ability of family to get along with one another
LSAC: Poor (lowest category as "poor" out of five categories) ability of family to get along with one another
WA-HWSS: Poor family functioning based on McMaster Family Functioning Scale
*AARC statistically significant

Figure 5.12 Baseline and future trends in the proportion of children and young people with poor family functioning in Australia, 2011–2024 [Sources: Mission Australia Youth Survey (2012–2020), LSAC (2011–2017), WA-HWSS (2012–2019)]

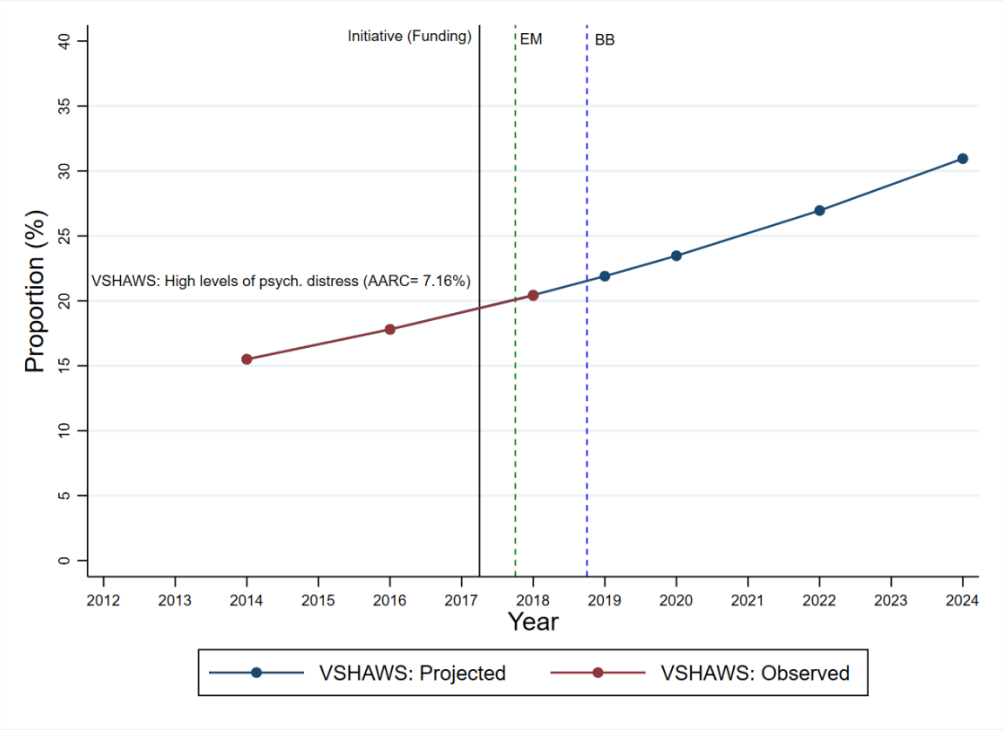
Indicator 9: Changes in wellbeing outcomes of children and young people

Children's and young people's wellbeing outcomes were assessed using three different existing datasets: Mission Australia Youth Survey and LSAY (national level), and VSHAWS (regional level-Victoria). Estimates from each of these surveys showed that child wellbeing outcome were worsening over time (Figure 5.13). In LSAY data, we observed a high rate of annual reduction (AARC = -12.7%) in the proportion of children and young people who were completely satisfied with their life in Australia during 2010–2017 (35.1% in 2010 vs 13.5% in 2017: Figure 5.13). The Mission Australian Youth Survey data also clearly showed that the proportion of young people with psychological distress had increased over time (AARC = 4.6%; 2012–2017). A similar sharp increase in the proportion of children with psychological distress was observed in the VSHAWS data (AARC = 7.2%). Consistent trends were observed in the proportion of child and youth wellbeing outcomes at the State and Territory level (see Supplementary Figure J.6 (a) and (b) in Appendix J). The baseline AARCs for all the indicators are summarised in Figure 5.14. Five out of eight evaluation indicators showed that baseline trend for child and youth mental health outcomes was decreasing (worsening) over the time.

National level data

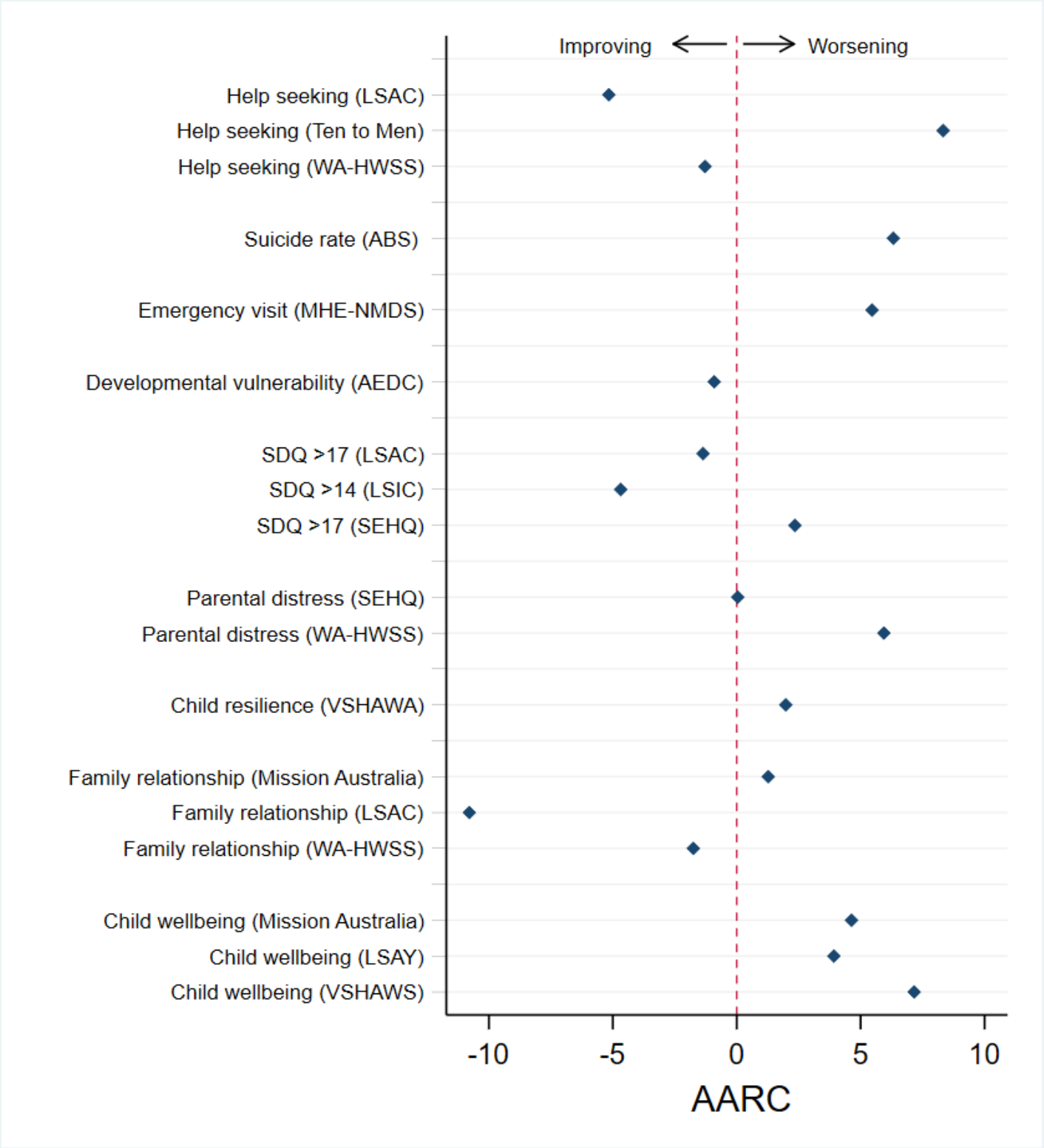


Regional level data: Victoria



Mission Australia Youth Survey: Psychological distress (using K6; higher score indicates greater distress)
LSAY (Y09 cohort): How completely satisfied ("completely" out of 10 categories) are you with life these days
VSHAWS (Victoria): High levels of psychological distress (depressive symptoms measured by Short Version Moods and Feelings scale)
*AARC statistically significant

Figure 5.13 Baseline and future trends in the proportion of psychological distress/life satisfaction among children and young people in Australia during 2010–2024 [Sources: Mission Australia Youth Survey (2012–2018), LSAY (2010–2018), VSHAWS (2014–2018)]



Negative and positive AARC represents improving and worsening in the child and youth mental indicators across the baseline period respectively.

Figure 5.14 Baseline (earliest to before Program started) AARCs for all the child and youth mental health indicators

5.7.6 Challenges and limitations of the Integrated Data Analysis

One of the key challenges of this activity was accessing suitable data to adequately answer the Overarching Evaluation Questions. Identification of appropriate location data was a particular challenge. Be You and Emerging Minds recorded some location data at the level of engaged or registered organisations, but location data were not consistently collected at the level of individual users. Postcode data were not available for a significant number of organisations from both Be You (34.3%) and Emerging Minds (44.3%). As a result, there were a substantial number of organisations that were not included in the spatial distribution of Program coverage. Additionally, the physical postcode data for organisations engaged with by Emerging Minds consultants often relates to a head office, which may extend services beyond that one postcode, and overestimates engagement in capital cities. As a result, it was not possible to accurately determine where the Program users were located. Therefore, it was not possible to conduct the planned pre-post Program–non-Program evaluation design as originally proposed. To overcome this limitation, we redesigned this Integrated Data Analysis evaluation activity as a pre-post intervention design only. This is a less robust design and limits the attribution of observed effects to the Program.

Although one of the principles of the evaluation was to leverage existing data, in a number of cases there were no available or appropriate existing data available (see Evaluation Framework) that were pertinent to the evaluation indicators.

Another limitation in this Integrated Data Analysis was a lack of sufficient follow-up data from contemporaneous data initiatives. As per our evaluation design, we determined that data collected from 2018 onward could be considered as relevant to post-Program implementation analyses. However, due to the short timeframe of the evaluation period, we were unable to access survey data that was collected after 2018. For example, the latest available data for LSAC was collected in 2017. The LSAC follow-up data was collected in 2019, but was not available for public use within the evaluation timeframe. AEDC and MHE-NMDS data were available for 2018 only (not 2019 and 2020) within the evaluation timeframe.

Due to the lack of sufficient follow-up data, we were unable to make direct comparisons between indicators collected before and after the beginning of the Program. However, we have provided estimates of historical trends in those indicators and projected those trends forward to 2024. These analyses will assist in benchmarking progress associated with the Program in future analyses or evaluations. However, these projections should be interpreted cautiously due to the broad impacts of the bushfires and the COVID-19 pandemic, with potential effects on mental health and wellbeing relevant to these projections. The existing data sources were typically designed to assess broader dimensions of mental health and wellbeing, rather than to elicit specific responses that align with the proposed evaluation indicators. As a result, the exact measurement of the mental health evaluation indicators, as well as nature of the target population, varied across different data sources. For example, indicator 1 (help-seeking) was determined from three discrete data sources: LSAC, Ten to Men and WA-HWSS. Across these data sources, the measurement approach, specific items and scales, as well as the sampling population, were heterogeneous. For example, LASC is a longitudinal study with data from children aged 14–20 years (both sexes), and Ten to Men is also a longitudinal study, but of boys aged 10–18 years only. The WA-HWSS has a repeated cross-sectional surveillance design with children aged 0–15 years (both sexes), therefore, its estimated indicators may not be directly comparable, but do suggest the direction of change.

5.8 Conclusions

Despite several limitations, the Integrated Data Analysis provides valuable information to help to understand and inform ongoing Program activities. Although the Program implementation partners (Beyond Blue and Emerging Minds) engaged a large number of organisations to their initiatives, the depth of engagement was limited. For example, while more than 100,000 users have registered with Be You in the last two years, two thirds of these users have not completed any mental health related training modules.[5]

The Integrated Data Analysis also identified that the Program was not clearly reaching the places where need was greatest. For example, the burden of child and youth mental health was high in remote areas in some States and Territories; however, the number of registered Program users or engaged actions were less prevalent in these areas of States or Territories. However, this finding needs to be interpreted with the caveat that the data provide only a conservative representation of Program reach. Additionally, it may be that there are fewer services and schools for the Program's initiatives to connect with in some of these more remote areas. This interpretation is consistent with other observations by the Overarching Evaluation Team that the Program does not directly address issues of service availability and accessibility. For an initiative like Emerging Minds, this means that its reach can only match the level of workforce present in a given area. Understanding the proportion of Educators, learning communities and workforces reached in a given area may provide more contextual information. The Integrated Data Analysis also identified the baseline temporal distribution of various child and youth mental health indicators at the national and State and Territory level, which shows that most of the child wellbeing outcomes are worsening over time. Projected estimates could help the Program to understand the future direction of the mental health related indicators. Therefore, the spatio-temporal distribution of child and youth mental health burden in the Integrated Data Analysis could help inform Program activities in future.

The Program targets change at the workforce level (Educators, or Practitioners working with children) to support the mental health of children and young people. The Integrated Data Analysis aimed to examine the impact of the intervention at a population level for beneficiaries of the Program (changes in key mental health outcomes of children and young people in Australia). The Program's implementation is within the very early stages (2–3 years since the launch of the initiatives), which according to the Program Logic is likely to be too early to see a significant impact of the Program on intermediate and long-term outcomes. As such, a longer term evaluation of these key outcomes may be required to observe the genuine change at the workforce level, as well as to demonstrate the impact of the Program at the population level of beneficiaries. Additionally, the Program is only one of many programs and initiatives the Commonwealth and State Governments are implementing to support the mental health and wellbeing of children and young people, which presents challenges in attributing change to the Program. For any future evaluation, it is important that location data are collected at high resolution and stability for all individuals and organisations using the Program, including valid data on level of engagement to understand the Program dose. Recommendations to address data gaps and limitations identified through this activity are presented in the Conclusions chapter (Chapter 8, below).

[5] Module completion data may underestimate level of engagement as some users who transitioned from KidsMatter and MindMatters may have not needed to complete modules. In addition, some learning communities may be undertaking modules as a group and not as individuals, thus underestimating completion numbers.

6. Value for Money

6.1 Be You Value for Money assessment

The Be You initiative aims to promote mental health and wellbeing for children and young people commencing in the early years through to the age of 18 by facilitating practice change for Educators. The strategy for achieving this aim is to empower Educators to take a more active role in supporting the mental health and wellbeing of children and young people, and to build capacity in the skills and knowledge needed to promote wellbeing and address mental health issues among children and young people. Be You offers Educators and learning communities evidence-based online professional learning opportunities complemented by a range of tools and resources (including consultant support) to turn learning into action. This, in turn, generates an effective model for a whole-of-community learning approach to mental health and wellbeing.

We conducted a Value for Money assessment to determine whether Be You demonstrates value for money in improving Educators' capacity by promoting the skills and knowledge necessary to support the mental health of children and young people. There is no clearly defined control group for the purposes of comparison since the Be You initiative was introduced universally across Australia. In the absence of a well-defined control group to which the costs (and benefits) of the Be You initiative can be compared, the initiative delivery costs were compared to other "next best" alternative interventions. The first step in assessing value for money using this methodology was to understand how and where Educators would otherwise have sought the skills and information needed to identify and navigate mental health issues in children and young people without the Be You initiative (i.e. what might have occurred in the absence of Be You).

By identifying these alternative scenarios, we then compared the relative costs of achieving the same outcomes (i.e. creating awareness, and developing the necessary skills and knowledge to address youth mental health issues) between the alternative scenarios and the Be You initiative. This approach was described and agreed upon in the Value for Money workplan (refer to Value for Money refined activity workplan, accepted 20 March 2020). Since the Program is in its early stages of implementation, there is no way to currently study the overarching benefits in terms child health outcomes. Additionally, there is no way to study the true outcomes of the alternative scenarios. The Value for Money approach therefore assumed that the quality of the outcomes under the alternative scenarios and Be You is similar or standardised. Given that we cannot compare benefits across options, we conducted a cost comparison, assuming the quality of outputs delivered does not significantly vary. Using survey responses, we present the benefits of the initiative in terms of time spent using the resources, ease of access and cost to users.

6.1.1 Value for Money assessment

Determining the status quo and alternative scenarios

Using responses from some of the open-ended survey questions, we devised appropriate and credible alternative scenarios for comparison with Be You. Participants in the survey were directly asked to list the activities or tools they used for their professional learning regarding their students'/children's mental health (Q109 and Q229).[6] These open-ended questions were intended to identify any alternative mental health resources that Educators and health professionals could turn to if resources through the Be You initiative did not exist or were not available for their reference.

Based on the responses to these specific questions, we extracted three general themes related to where Educators sought information or the skills needed to identify and support mental health issues in young people, including:

- **health professional staff consulting** – consulting a health professional, which included school psychologist, counsellor, wellbeing officer (or coordinator) or school nurse
- **external training and coursework** – completing a mental health first aid course, workshops with experts, information sessions and seminars

[6] Q109 and Q229 [Be You exposed]: [Other than Be You], What are the activities and/or tools (if any) you use for your professional learning regarding students/children's mental health?

- **other online programs** – such as Berry Street model resources, gatekeeper training, Black Dog Institute and Peaceful Kids program.

The main survey response provided by Educators was that when they needed support to address the mental health concerns or wellbeing of children and young people in their care, they consulted the school-based health professional (in particular, school psychologists, but also nurses, counsellors and wellbeing officers). In this situation, a health professional provides case-by-case advice, guidance and information to an Educator on how best to manage a particular concern or situation for a given student. This approach is as per the current Australian Psychological Society framework for effective delivery of school psychology services (2016), whereby the role of a psychologist extends beyond counselling and psychological assessment of students to include other indirect services, such as Educator consultations. In doing so, it is likely that the Educators can enhance their knowledge and abilities to support students in the mental health and wellbeing space. Indeed, it is important to note that, as long as Educator–psychologist consultations are an option within school environments, these are likely to occur even with the availability of Be You or any alternative scenarios outlined in this document. For this reason, we regarded Educator–psychologist consultations as the status quo in situations where Educators require support navigating the mental health matters of children and young people in their care.

Status quo: Educators consult a school psychologist (or school nurse or counsellor) about students' mental health on a case-by-case basis (i.e. an informal set-up).7

The main consideration when selecting suitable alternative scenarios for the Value for Money assessment was whether a given scenario would be a convincing alternative if the Be You initiative did not exist. Based on this consideration, and the above-mentioned themes from Educators' responses, the scenarios below are generated for the purposes of the Value for Money comparison with Be You. The Value For Money approach is to cost each of the identified alternative scenarios with a view to work out an average of these to be compared with Be You costs, assuming the quality of the outcomes are standardised.**Scenario 1:** Educators complete a mental health first aid course to gain a set standard of knowledge and skills needed to identify and support mental health issues among students (a formal certification).

Scenario 2: Schools hold regular mental health seminars and information sessions for Educators where health experts present and impart knowledge and skills for identifying and supporting mental health issues among students.

Another likely scenario that can be considered is that a school psychologist or school health-based professional runs regular workshops and information sessions for Educators so that Educators in the broader learning community are well informed on identifying and supporting students' mental health issues. This is a highly hypothetical scenario and would involve restructuring the role of the school health professional to also include preparing and delivering mental health training sessions. Further, not all schools have a devoted school-based psychologist, so this is not regarded as a reasonable alternative scenario to consider at the present time. These challenges are explained in the Productivity Commission Inquiry Report (2020, pp. 231–232), which clearly identifies a shortfall of psychologists in school settings, as well as in mental health service in general. In Western Australia and the Northern Territory, for example, the psychologist-to-student ratios are 1:885 and 1:3090 respectively, which fall short of the recommended Australian Psychological Society ratio of 1:500. The Productivity Commission Inquiry Report (2020, p. 208) also identified that Educators in early learning settings do not always have access to external mental health staff when they may need to seek advice.

Determining and calculating costs

Categorising costs into like groups is the first step in determining, calculating and, ultimately, comparing the costs of Be You and alternative scenarios.

- **Opportunity costs** – These are the costs of forgoing another activity in order to participate in Be You or an alternative scenario. An Educator must sacrifice time they would otherwise spend teaching or preparing classwork, for example, if they choose to spend that time engaged in mental health training. Even though

[7] This status quo is most relevant to Educators from the Preparatory year to Year 12 across the State and private school systems. This status quo may not be relevant to ELSs where access to internal specialised support, such as mental health professional services, may not be an option.

opportunity costs are not direct monetary expenses, they are key costs incurred by users and employers in return for their involvement in a training activity.

- **Development costs** – These costs cover the design and development of content/material required for a training activity. Intellectual resources that make the design and development processes possible are also pertinent here. When it comes to a Value for Money assessment, the cumulative total of the development costs should be apportioned over the life of a given training initiative or activity, or until the content/material in question is outdated or superseded. Development costs may increase over time if additions are made to training packages, meaning the investment of more intellectual resources and the generation of new content/material.
- **Delivery costs** – These costs relate to human resources, direct operational expenses, marketing and personnel salaries. Delivery costs are incurred on an ongoing basis over the life of a training activity and are recorded on an annual basis. By taking these costs into consideration, we are looking at the incremental or marginal cost of delivering the initiative.

Costing for the Be You initiative and the alternative scenarios will be calculated and presented by cost per user. Below we present the overall costs and explain how the cost per user is calculated.

6.1.2 Delivery and development costs

Overall costs

A summary of overall costs of the Be You initiative is outlined below (see Table 6.1), the details of which have been extracted from an indicative budget for the National Support for Child and Youth Mental Health Program – Mental Health in Education (1 April 2017 to 30 June 2019). Line items have been categorised according to the type of cost they represent (development or delivery), and this is noted under assumptions. Dollar values exclude GST and represent the total investment for each line item during the 2018–2019 financial year.

Please note that Table 6.1 summarises costs exclusive to the Be You initiative. It excludes any line items (such as administrative and corporate overheads)[8] from the National Support for Child and Youth Mental Health Program indicative budget where it is assumed that those items and associated costs would have still been incurred by Beyond Blue if Be You did not exist.

[8] Administrative costs include office rent, outgoings, equipment and supplies. Corporate overheads include office of CEO, corporate services and organisational governance.

Table 6.1 Summary of Be You delivery and development costs for the financial year ending 30 June 2019

Item and description	Dollar value	Unit(s)	Assumptions
Platform and content development **Includes agencies commissioned to develop the online platform and its content, and other formative research. Based on fixed price contracts.**	$6,345,000	N/A	Cost category: Development Dollar values are cumulative for the period 01.04.2017 to 30.06.2019 due to the volume of work involved in developing the Be You platform and content before, during and after implementation in November 2018.
Education Specialist Consultants **Commissioned consultants to assist in pre-servicing training integration. Based on fixed price contracts.**	$330,000	N/A	
Human resources **Includes remuneration, staff training and recruitment costs.**	$14,271,999	Average 60 FTE staff/year	Cost category: Delivery All staff are dedicated solely to the delivery of the Be You initiative.
Travel* **Travel expenses for staff not responding to suicide.**	$300,000	$5000/FTE staff/ year ($5000*60)	Cost category: Delivery
IT systems and maintenance **Includes online platform hosting and maintenance, software licences, telephone and internet costs, IT equipment and maintenance.**	$905,046	N/A	Cost category: Delivery
Advertising and marketing **Includes social media, resource distribution and other related costs.**	$1,514,254	N/A	Cost category: Delivery
Total	$23,666,299		
Data sources **Indicative budget tables for FY 2019 were made available by the Department of Health.**			

Notes: FTE = Full Time Equivalent. * Travel expenses for facilitation officers responsible for suicide responses have been excluded.

Delivery and development costs – per user

Delivery and development costs per user can be calculated by drawing on the information above and dividing the total overall cost of the initiative ($23,666,299 – from Table 6.1) by the number of its users at the time. Actual user numbers versus potential user numbers are a key consideration here. The potential user pool for Be You is extensive, with registrations open to all education professionals who work with children and young people up to

the age of 18 across Australia. The actual user numbers (Be You registrations) at any given time are likely to be only a proportion of eligible registrants (all education professionals in Australia).

Be You user registrations are grouped into high-level categories relevant to the education field. These categories are Educators, specialist and support staff, school leaders, ELS leaders, tertiary professionals, pre-service Educators, and others.[9] The potential user pool for Be You, however, can be established using data from the Australian Bureau of Statistics (ABS), which is categorised at the individual professional level. Table 6.2 aligns 2019 ABS details and figures on education professionals in Australia with their corresponding Be You registration categories and tallies.

Essentially, Table 6.2 shows that, as at August 2019, the total potential user pool for Be You sat at 724,138. Actual Be You registrations at that time stood at 66,925.[10] By dividing the overall costs of Be You in 2019 by the number of actual registrations, it can be determined that the cost of the initiative per user was $353.70.[11]

Table 6.2 Be You registrations in 2019 – actual numbers versus potential numbers within the education field

Be You professional categories	Australian education professions (ABS)	Employment figures by profession (ABS)[a]	Potential Be You user pool	Be You registrations as at August 2019[b]
Educators	Early childhood (pre-primary school) teachers	44,400	536,501	43,358
	Primary school teachers	168,800		
	Middle school teachers	700		
	Secondary school teachers	154,700		
	Child carers	167,900		
Specialist and support staff	Special education teachers	24,500	148,139	10,477
	Education aides	103,100		
	Education advisers and reviewers	20,500		
School leaders	School principals	24,700	24,651	8,307
ELS leaders	Childcare centre managers	14,800	14,846	4,783
Total			724,138	66,925

Data sources:
[a] A full time equivalent (FTE) of total staff, Australia as at August 2019 (6291.0.55.001 - EQ08 - Employed persons by Occupation unit group of main job (ANZSCO), Sex, State and Territory, August 1986 onwards).
[b] Be You registration data

[9] ABS data pertaining to pre-service Educators and "others" is not available and is therefore excluded from the analysis. Be You registration numbers by tertiary professionals are insignificant and therefore excluded from the analysis as well.

[10] This registration number includes Educators, specialist and support staff, school leaders and ELS leaders. As at August 2019, there were 1,116 tertiary professionals, 4,102 pre-service Educators and 8,406 registrants under the "other" category. This takes the total registrations as at August 2019 to 80,549. Professionals in these three categories were excluded from calculations. If they are included, the Be You cost per participant would reduce further than stated in the body of this report.

[11] With all Be You registration numbers of 80,549 (including all registration categories), the cost per participant is $293.81.

Opportunity costs

Educators are required to invest approximately 14 hours to complete the course modules of the Be You initiative. This means that Educators need to take time away from their "business as usual" activities in a school or ELS environment to complete the course modules and utilise Be You resources. This time away for Educators is an important non-financial cost to measure, especially since survey and focus group participants identified availability to complete professional development training as a major challenge – often the biggest obstacle – when it comes to using Be You (please refer to the enablers and barriers of user implementation; see Table 4.15 in Chapter 4). Essentially, opportunity costs equate to the time or duration that an Educator is absent from their classroom, teaching preparation or administrative duties due to Be You training commitments.

Opportunity cost is calculated by multiplying the average hourly rate by profession (sourced from the ABS Survey of Employee Earnings and Hours) by the 14 hours needed to complete the Be You modules.

Table 6.3 Average opportunity cost to complete Be You training modules

Be You professional categories	Australian education professions (ABS)	Salaries[a,b]	Opportunity cost of attending 14 hours of training	Assumptions
Educator	Early childhood (pre-primary school) teachers	Weekly = $1,516 Hourly rate = $40.97	$573.72	Salaries are median for full-time non-managerial employees paid at the adult rate, before tax and including amounts salary sacrificed, collected in May 2018 by ABS. Weekly salaries include a 1.9% wage growth introduced in 2019 for the Education and Training industry. Hourly salaries are based on a 37-hour work week. Education advisers and reviewers include curriculum advisory teachers, education officers, home-school liaison officers and preschool advisers. The exact number and break up of health-based specialist staff in school environments is not provided by the ABS so these numbers have been excluded from the specialist and support staff pool. These health-based professionals likely need to complete other training to fulfil professional development requirements in the area of mental health. University lecturers and tutors (tertiary professionals) and other category users are not considered in the analysis.
	Primary school teachers	Weekly = $1,835 Hourly rate = $49.60	$694.41	
	Middle school teachers	Weekly = $1,991 Hourly rate = $53.81	$753.40	
	Secondary school teachers	Weekly = $1,950 Hourly rate = $52.70	$737.98	
	Child carers	Weekly = $971 Hourly rate = $26.24	$367.45	
Specialist and support staff	Special education teachers	Weekly = $1,950 Hourly rate = $52.70	$737.98	
	Education aides	Weekly = $1,115 Hourly rate = $30.14	$421.81	
	Education advisers and reviewers	Weekly = $2,058 Hourly rate = $55.62	$778.85	
School leaders	School principals	Weekly = $2,601 Hourly rate = $70.30	$984.05	
ELS leaders	Childcare centre managers	Weekly = $1,296 Hourly rate = $35.03	$490.44	

Be You professional categories	Australian education professions (ABS)	Salaries[a,b]	Opportunity cost of attending 14 hours of training	Assumptions
Data sources: **a Salaries are sourced from ABS Survey of Employee Earnings and Hours, May 2018 (cat. No. 6306.0). They are taken from a customised report from the Australian Government Job Outlook Website. (https://joboutlook.gov.au/a-z/)** **b Wage growth for 2019 is taken from ABS Wage Price Index, 2019. (https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/wage-price-index-australia/dec-2019)**				

6.1.3 Alternative scenarios

Delivery and development costs – per user

To determine costs associated with the alternative scenarios, we gathered information from online resources regarding the financial aspects of each. Based on online searches, the two alternative scenarios identified are very similar in structure as well as costs. In scenario one, for example, a professional mental health instructor or expert delivers a mental health first aid course to users. This is very similar to scenario two, where a mental health expert imparts pertinent professional knowledge to education professionals through the facilitation of regular seminars and information sessions. Considering the two alternative scenarios have similar characteristics, the same costing information can be used for both and compared with the costs of the Be You initiative. Table 6.4 below summarises the main costs associated with the alternative scenarios.

Table 6.4 Summary of alternative scenario costs

Item	$ Value[a]	Unit(s)	Assumptions
A mental health expert or trainer is invited to deliver a mental health course or seminar series to education professionals	Youth Mental Health First Aid = $150–$300 per 14-hour course Fees paid by an Educator, Government department or education organisation to attend the course	Fees are per Educator/user	• Course attendance fees are paid by the Educator or the Educator's employer. • The costs of the mental health expert/trainer's preparation and own professional development are disregarded as these costs will be incurred even if they do not deliver the first aid course to Educators. • Delivery and development costs are captured in the per user fees. • The course requires a time commitment of 14 hours over a two-day period, which aligns with the time commitment required for Be You initiative completion too.
[a] Course cost per user is taken from the Mental Health First Aid Australia website. (https://mhfa.com.au/courses)			

Opportunity costs

The mental health first aid course prescribed for scenario one requires a time commitment of 14 hours over a two-day period. The same approximate time commitment would be expected for scenario two, with the 14 hours of training simply broken into smaller information sessions over the duration of a term or semester. This 14-hour time commitment aligns well with that required for Be You completion, meaning the opportunity cost of pursuing an alternative scenario in this case can be considered to be similar to the opportunity cost associated with the Be You initiative.

6.1.4 Analysis of costs

Drawing on the delivery, development and opportunity costs identified, in this section we bring together, analyse and discuss these costs and compare them across the Be You and alternative initiatives. The costs determined above are presented in a graphical form in Figure 6.1 below, where the y-axis is the cost per user and the x-axis is the initiative uptake rate. The initiative uptake rate is calculated as a percentage of the total potential user pool

of 724,138 as at August 2019 (as per available ABS data). A breakdown of incremental uptake rates is given in Appendix K (Table K.1) alongside the number of potential users each uptake rate corresponds to (column 2) and the cost per user at that uptake rate for the Be You initiative (column 3).

Figure 6.1 depicts the Be You delivery and development costs, which are shown by the curved line, conveying that these costs decrease as more eligible participants engage with the program. This trend is known as economies of scale whereby delivery and development costs start off higher for the program when participant uptake is still low, but gradually decrease as participant uptake increases. For example, when Be You uptake is only 10%, delivery and development costs per participant sit at approximately $327 (see Appendix K, Table K.1) versus a delivery and development cost of approximately $93 per participant when program uptake is at 35%. The opportunity costs illustrated in this figure have been calculated based on how much time (and therefore money) each respective Educator type is required to spend on average completing Be You course modules. The figure shows that opportunity costs are the largest costs to consider. The alternative scenario lines in the figure indicate the upper and lower cost margins to expect if looking at different available scenarios to the Be You program. As the figure shows, the constant costs of the alternative scenarios are not affected (lowered) by participant uptake as it increases.

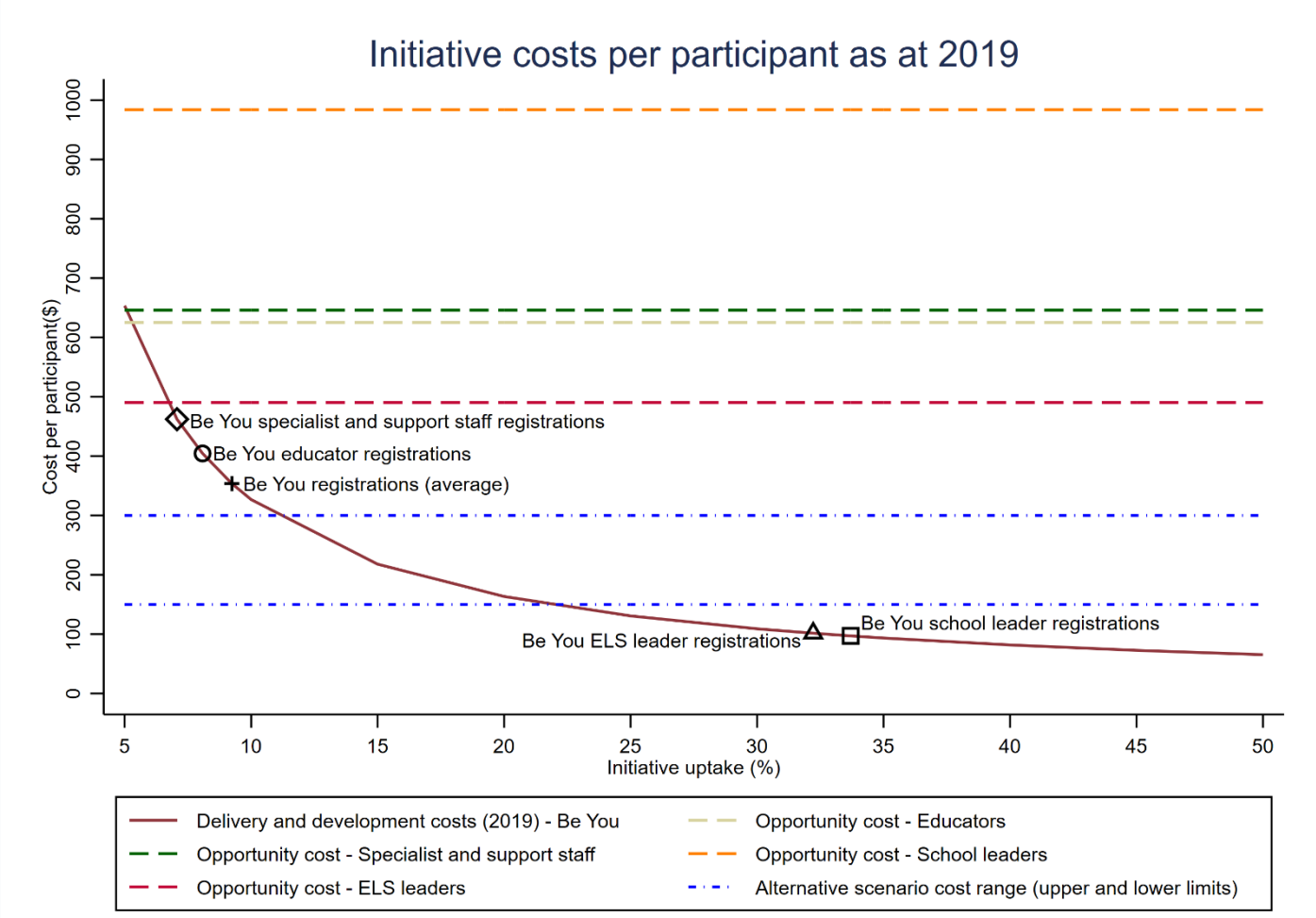


Figure 6.1 Graphical representation of Be You and alternative scenario costs based on initiative uptake

Opportunity costs of time

From Figure 6.1 (and Table 6.3), it is clear that the average opportunity costs for both the Be You and alternative initiatives are the largest cost components for all registration categories (and with future wage rate increases, we would expect these opportunity costs to increase). In saying this, a high time or non-financial cost was expected for this study, given the National Support Network Survey and Community Case Studies findings that one of the major barriers faced by Educators was their lack of available time to complete professional development activities on mental health. This point was also identified in the focus groups reported in the Be You

Implementation and Early Outcome Evaluation Report (Access Economics Deloitte). Staff in school and early learning environments are time poor, with most of their time devoted to teaching, care and activities, and class preparation. This means that it is often difficult for staff to allocate time for activities like professional development that are not curriculum related. To combat this challenge of time, it is advantageous that Be You resources are accessible online. This means that Be You users can complete modules at their own pace and, even after fulfilling their training requirements, can revisit the Be You platform as needed to refresh their knowledge or review online content relevant to their work.

Economies of scale

In relation to the delivery and development costs, the Be You initiative enjoys the benefits of economies of scale, which is indicated by the steep downward sloping cost curve (maroon line) in Figure 6.1. This means that, although we could expect a higher initial cost per user for Be You, this cost will decrease significantly as user uptake and engagement in the initiative increase (also see column 3 of Appendix K, Table K.1). Essentially, Be You will demonstrate more value for money as more users sign up and utilise the resources.

As at August 2019, approximately 9.2% of all eligible Educators had signed up for the Be You initiative (see Table 6.5 and Figure 6.1). When we examine uptake rates across the different Be You registration categories, some disparities are clear – registrations were highest among school and ELS leaders as at August 2019, with 33.7% and 32.2% respectively participating in Be You. In contrast, only 7.1% of specialist and support staff and 8.1% of Educators were registered with Be You at that time. Due to this rate of uptake, Be You costs per user were higher as at August 2019 for Educators and specialist and support staff than for other education professionals. It is important to note that August 2020 registration numbers (see Table 6.5) show an increase in Be You registrations across all professional categories. In effect, because of the increase in uptake, costs per user would have been lower in 2020 than they were in 2019, and this represents likely increasing value for money.

Table 6.5 Be You registration numbers and uptake rates over time

	August 2019			August 2020		
Be You categories	Potential pool[a]	Be You registrations[b]	Uptake as a proportion of potential pool	Potential pool[a]	Be You registrations[b]	Uptake as a proportion of potential pool
Total Educators	536,501	43,358	8.1%	485,998	69,411	14.3%
School leaders	24,651	8,307	33.7%	20,424	11,527	56.4%
Specialist and support staff	148,139	10,477	7.1%	157,736	17,900	11.4%
ELS leaders	14,846	4,783	32.2%	16,105	7,069	43.9%
Total	724,138	66,925	9.24%	680,263	105,907	15.57%

Data sources:
[a] A full time equivalent (FTE) of total staff, Australia as of August 2019 (6291.0.55.001 - EQ08 - Employed persons by Occupation unit group of main job (ANZSCO), Sex, State and Territory, August 1986 onwards).
[b] Be You registration data

In comparing Be You and alternative scenario costs – using the upper limit of alternative scenario costs as shown in Figure 6.1 – Be You starts to become a better value for money option once uptake of the initiative passes 11% of all eligible registrants. This benchmark is evident in Figure 6.1, where the Be You cost curve intersects the (upper) horizontal alternative scenario cost line. If total Be You registration figures continue to grow and uptake of the initiative passes approximately 22%, Be You becomes the better value for money option over the lower limit of alternative scenario costs too. In addition to the alternative scenarios, participants of community consultations (on 30 March 2021 – see Community Case Studies chapter) mentioned other

professional development initiatives that they have used in the past that may be considered as alternatives to Be You. These other professional development initiatives range in price from approximately $55 per person for a two-hour course module to in excess of $1,000 per person in some cases. Regardless of alternative scenario costs, the Be You initiative and its associated costs will continue to benefit from economies of scale.

If more costs associated with the development and introduction of new content and resources, or additional human resourcing (e.g. more consultants), were added over time, the curve would shift upwards to the right based on the added initial costs. However, the shape of the curve would remain the same – a downward sloping graph indicative of increasing value for money would continue to be observed as Be You registrations grow.

Costing the past five initiatives (a brief note)

The National Mental Health Commission Review of Mental Health Programmes and Services Report of 2014 identified that there were multiple initiatives promoting social and emotional health and wellbeing for children and young people across education settings – Response Ability, KidsMatter Early Childhood, KidsMatter Primary, MindMatters and headspace School Support. It was recommended that these initiatives be integrated into one single national education-based program. Each of these initiatives had been funded by the Australian Government. From 1 July 2012 to December 2017, approximately $21M[12] was spent annually on average on the five initiatives combined. In comparison, just over $23M[13] every year on average has been budgeted for the Be You initiative starting from April 2017 up until June 2020, which is broadly an equivalent total cost per year. The benefits associated with each phase (previous five initiatives versus the current Be You initiative) cannot be directly compared with available data. However, indicators of benefits drawn from the survey and focus group evaluation activities suggest ongoing benefits and efficiencies in approach and delivery, and an increasing level of contact with potential users, as evidenced by the increase in registration numbers.

6.1.5 Analysis of benefits specific to the Value for Money assessment

To study the benefits of the initiative from a Value for Money assessment perspective, we utilised the responses from the National Support Network Survey items for the following constructs:

- the time that participants would take to obtain the relevant mental health information in the absence of the Be You
- the ease of access of Be You resources compared to other resources
- the costs incurred in using the Be You resources.

To study the three domains of time, ease of access and costs, we drew upon data from the survey responses by Educators exposed to the Be You initiative. Survey participants were asked two specific questions per domain (see Table 6.6). To answer these questions, participants responded on a VAS ranging from 0 to 100. For simplicity in analysis, the VAS for each domain was organised into smaller ranges, which were then converted to categories. These modifications are outlined in the third column of Table 6.6. The distribution plots of participant responses to each question are presented in Appendix K (Figures K.1 to K.3).

[12] Dollar figures were taken from the budget section of the deeds of variation documents for each of the five initiatives. The figures were calculated as the total budget minus any underspent (returned) amount, and are GST exclusive. The KidsMatter programs have financials starting from July 2011, while the headspace program started in January 2012. The rest of the programs only started in the 2012–2013 financial year. As such, the average spend per year is calculated from July 2012 until the conclusion of the five initiatives. It seems there was also some funding provided to the five initiatives as they transitioned to the Be You initiative; this added funding has been included in the average yearly spending calculations.

[13] Total Be You budgeted costs have been taken from the Be You indicative budget spreadsheets starting from April 2017. April 2017 to December 2017 was the transition period from the five initiatives to Be You. This period has been considered in the Be You average yearly budget calculations.

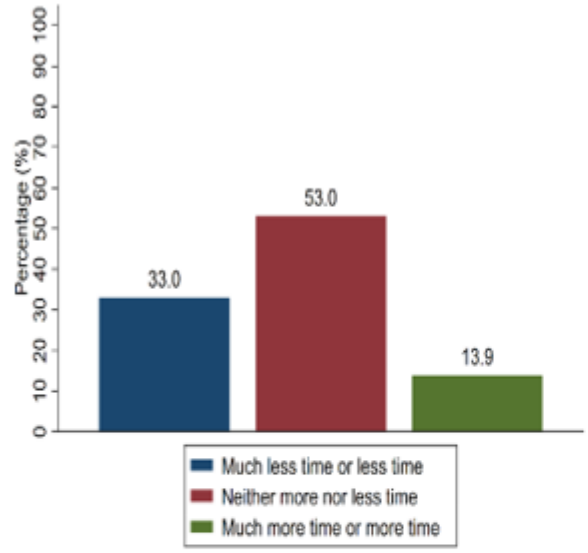
Table 6.6 Survey questions for the time, ease of access and cost domains (Be You)

Domain	Questions	Modified scale
Time	• If Be You was not available, how much time would it take to obtain the relevant information from other sources to support your students'/children's mental health? • Compared to other activities or tools you use for your professional learning, how much time does Be You take up?	1 Much less time or less time (VAS score – 0–40) 2 Neither more nor less time (VAS score – >40–60) 3 Much more time or more time (VAS score – >60–100)
Ease of access	• If Be You was not available, how much easier or harder would it be to obtain information needed to support your students'/children's mental health? • Compared to other activities or tools you use for your professional learning, how much easier or harder is Be You to use?	1 Much easier or easier (VAS score – 0–40) 2 Neither easy nor hard (VAS score – >40–60) 3 Much harder or harder (VAS score – >60–100)
Costs	• If Be You was not available, how much money would it cost to obtain information needed to support your students'/children's mental health? • Compared to other activities or tools you use for your professional learning, how costly is Be You?	1 Much less costly or costly (VAS score – 0–40) 2 Neither more nor less costly (VAS score – >40–60) 3 Much more costly or costly (VAS score – >60–100)

Time

The results in this section refer to the two questions focused on time (see Figure 6.2). The majority (53%) of participants responded that Be You takes up *neither more nor less time* than other activities or tools used for their professional learning in relation to child and youth mental health. This indicates that Be You seems to be just as time-consuming as any other mental health professional development available to them. In general, education professionals have identified time as one of the major barriers to completing any professional development activities in the mental health space. The barrier of time is a theme identified even in the Rosie's Learning Centre Spotlight Case Study and other open-ended survey questions (see Survey report).

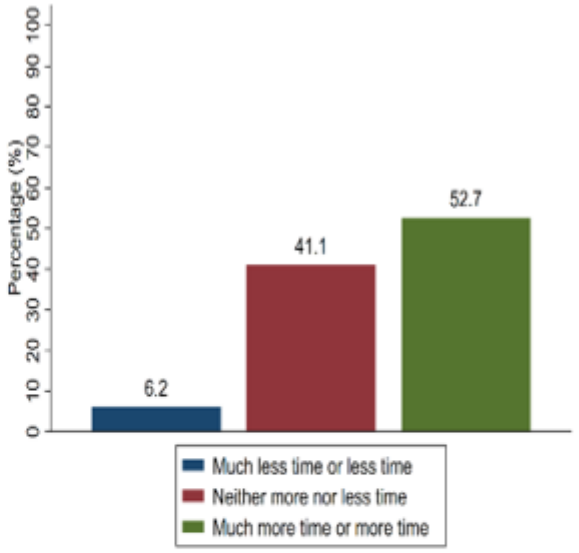
On the other hand, 52.7% of participants responded that they would have taken *more or much more time* to source the information they needed to support their students' mental health if the Be You initiative did not exist. This indicates that the Be You initiative (i.e. the online resources and Be You consultants) streamlines the learning and research process for Educators when it comes to finding information that is both beneficial and suitable for their needs.



Proportion of participant response to perceived time spent (%)

Compared to other activities or tools you use for your continuing professional learning; Be You takes up how much of your time?

Mdn = 49(IQR: 30, 50)[N = 115]



Proportion of participant response to perceived time spent (%)

If **Be You** was not available, how much time would it take to obtain the relevant information from other sources to support your students'/children's mental health?

Mdn = 65(IQR: 50, 83)[N = 129]

Figure 6.2 Survey responses for "time" domain (Be You)

Ease of access

The results in this section refer to the two questions focused on ease of access (see Figure 6.3). 49.1% of participants exposed to Be You reported that the initiative is *easier or much easier* to use for their professional learning compared to other activities or tools available for them to use. Just under 38% of survey participants returned neutral responses to the question, while a minority noted that they found Be You harder to access than alternative options.

Similarly, a majority of survey participants (56.7%) reported that, in the absence of the Be You initiative, it would be *harder or much harder* to obtain information needed to support their students' mental health. This response signals that the availability of Be You resources at the convenience of Educators is highly valued.

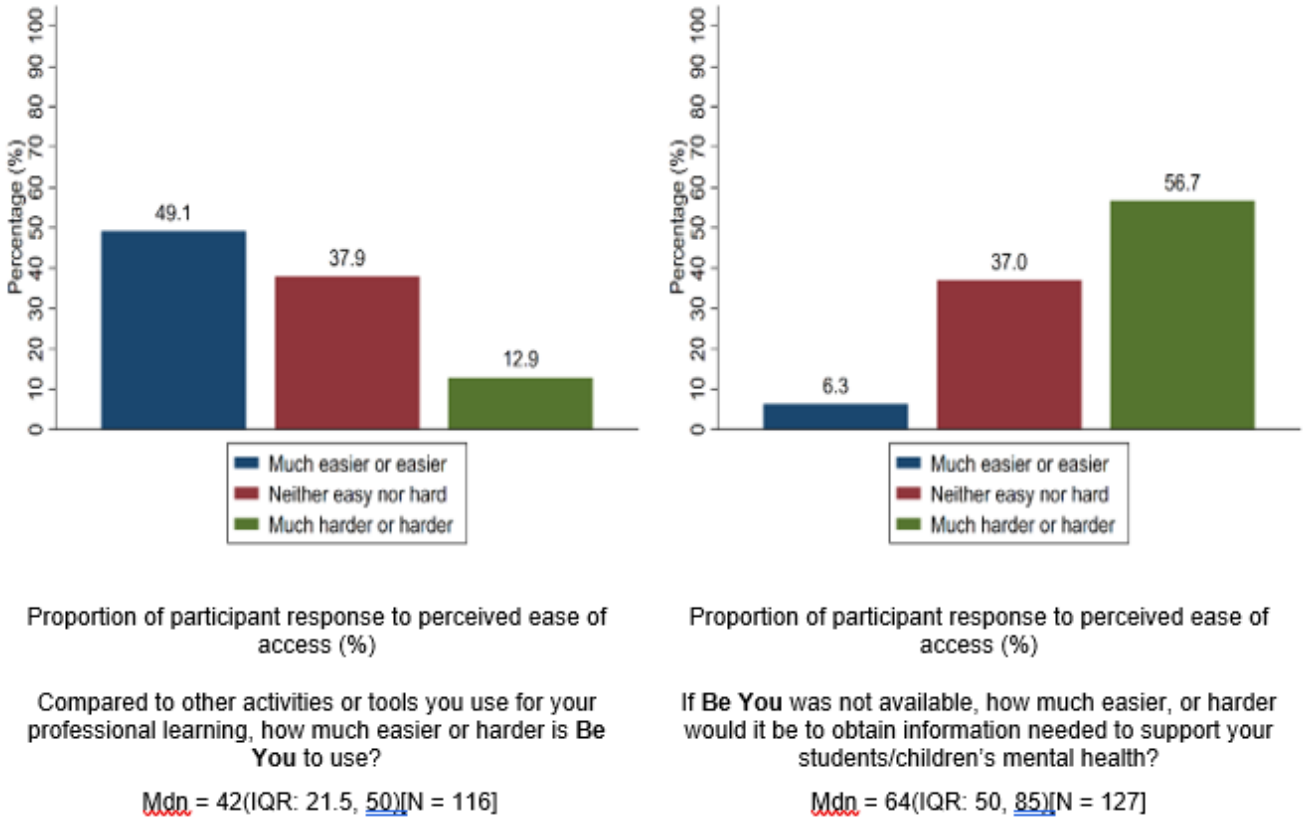
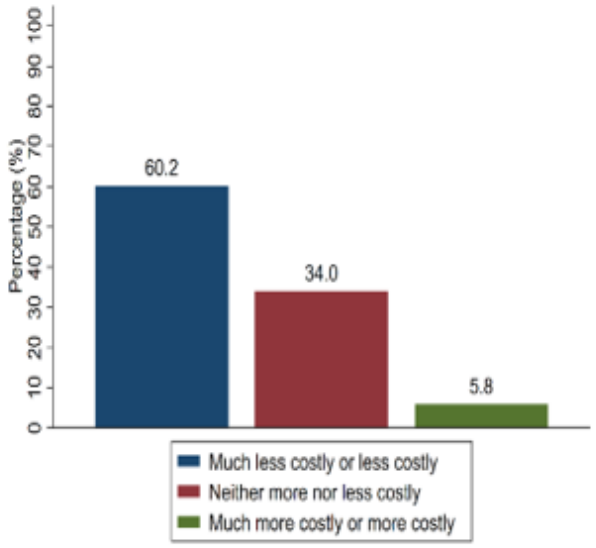


Figure 6.3 Survey responses for "ease of access" domain (Be You)

Costs

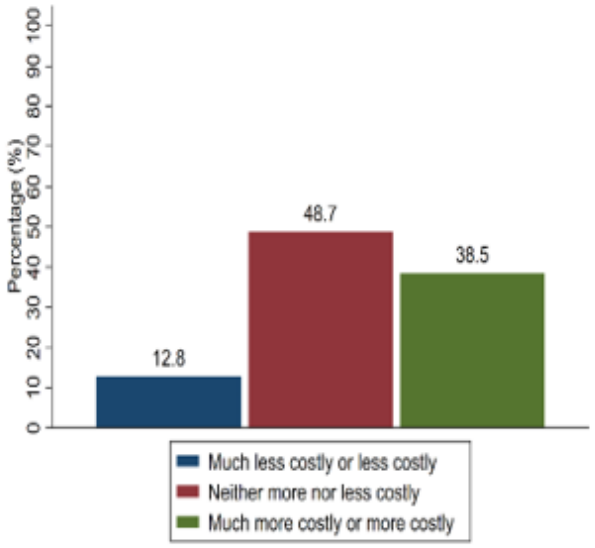
The results in this section refer to the two questions focused on costs (see Figure 6.4). 60.2% of participants exposed to Be You reported that the initiative is *less or much less* costly to use for their professional learning compared to other activities or tools available for them to use. At the same time, approximately 48.7% of participants exposed to Be You reported that, in the absence of the initiative, it would cost a similar amount to obtain information needed to support their students' mental health. Another 38.5% of participants responded that it would cost them *more or much more* if Be You was not available to them.



Proportion of participant response to perceived costs (%)

Compared to other activities or tools you use for your professional learning, how costly is Be You?

Mdn = 29(IQR: 11, 50)[N = 103]



Proportion of participant response to perceived costs (%)

If **Be You** was not available, how much money would it cost to obtain information needed to support your students'/children's mental health?

Mdn = 52(IQR: 50, 75)[N = 117]

Figure 6.4 Survey responses for 'cost' domain (Be You)

6.1.6 Limitations of the Value for Money assessment

One of the key limitations associated with conducting a Value for Money assessment for the Be You initiative is that there is no defined counterfactual or control group to which we can compare Be You costs and benefits. This is why the assessment has been conducted by first identifying alternative scenarios, then comparing the costs of the main alternative with the Be You initiative. Benefits were compared using Be You user responses from the National Support Network Survey. Ideally, the Value for Money assessment would have involved introducing the Be You initiative along with a comparison group at the same time, and collecting appropriate cost- and benefit-related data for Be You and the comparison group from inception.

The assumption that the quality of the alternative and Be You initiatives is standardised is another limitation that needs to be taken into consideration. Due to this limitation, there was no quantitative value of benefits for the purposes of comparison. Instead, the benefits component of the Value for Money assessment has been completed based on subjective information provided by Be You participants regarding their experiences of using Be You resources.

Another limitation faced with this Value for Money assessment relates to the measurement of Be You benefits on children and young people's mental health. The relatively short timeframe over which Be You has been implemented to date does not offer enough implementation time for assessing critical benefits on students' mental health outcomes. To carry out this area of analysis, a longer period of implementation is required, as well as regular student-level health data. This information can be used to measure quantifiable benefits, such as health indicators and a Quality Adjusted Life Years score.

6.1.7 Concluding remarks – Be You

Across all three benefit domains – time, ease of access and cost – the majority of Be You users surveyed provided responses that were favourable towards the initiative overall. In general, Educators identified lack of time as one of the major barriers to completing any professional development activities related to addressing and supporting the mental health of children and young people. In saying this, most participants acknowledged that they would have taken much more time to access the information they needed for their professional

development if Be You did not exist. A high proportion of Be You users acknowledged they value the ease with which they can access Be You resources. An overwhelming majority also reported that, compared to other activities or tools, Be You is less costly to use for professional learning.

Looking at the cost analysis conducted, it is evident that the Be You initiative will benefit from economies of scale (see Figure 6.1). With online resources and foundational modules already in place for Educators to use, the continued uptake of Be You will see a reduction in costs per user, which represents increasing value for money over time. From August 2019 to 2020, Be You registration numbers increased across all professional categories (see Table 6.5). We expect this trend to continue and, therefore, look forward to long-term cost advantages through economies of scale.

Addressing and supporting the mental health of children and young people is an evolving conversation. New topics, resources and information are constantly being raised, researched and developed. This means a higher initial set-up cost for Be You, preparing and adapting modules and curriculum to incorporate updates so content remains relevant and accessible for its intended audience. However, the principle of economies of scale still applies. As more Educators register for Be You, the less costly (more cost efficient) the initiative will become over time. This is a crucial point to remember when sourcing funding in future for the development of fresh Be You content and resources.

6.2 Emerging Minds Value for Money Assessment

The Emerging Minds initiative aims to equip health Practitioners and organisations who work with children, parents and families with the skills to identify, assess and support children at risk of mental health conditions. The initiative seeks to build capacity and knowledge among clinical and non-clinical Practitioners by way of an online workforce gateway where training, practice guides, webinars, tools and other resources are available. The initiative also provides consultants to support organisations to implement child-aware practice, create system change and improve awareness of children's mental health. In effect, through exposure to Emerging Minds, it is anticipated that Practitioners and organisations will be better equipped to identify children who are at risk of developing mental health difficulties, assess how best they can support those children and their families, and implement measures to support them as needed.

Emerging Minds' online education system offers a gradual learning journey through courses and resources to help Practitioners build their understanding and practice to support infant and child mental health. Each learning journey is delivered in modules (courses), which can be customised by specific Practitioners, and cover the foundations of child mental health and trauma, as well as skills development targeted to a user's specified profession. Considering this targeted approach, we suggest conducting any Value for Money assessments of the initiative on an individual professional basis. Assessing value for money in this way enabled identification of professions whose engagement to the initiative is particularly costly or where potential value for money is not yet being realised.

A Value for Money assessment typically requires a comparison to be made between the subject of the assessment – in this case, Emerging Minds – and a control group, with the view being to establish which option is more favourable in pursuing a given purpose or objective. Since Emerging Minds was introduced universally across Australia, however, no clearly defined control group (i.e. a group with no exposure to Emerging Minds) exists. In the absence of a control group to which costs associated with Emerging Minds can be compared, comparisons can instead be made between Emerging Minds and "next best" alternatives – if Practitioners had not been exposed to Emerging Minds, how and where else would they have sought the skills or information needed to identify and navigate mental health issues in children? What could or would have occurred in the absence of Emerging Minds? By identifying these alternative scenarios, we can compare the relative costs of achieving the same or similar outcomes (i.e. creating awareness, and developing the necessary skills and knowledge to address children's mental health issues) between the alternative scenarios and the Emerging Minds initiative.

This section introduces a conceptual framework for how a Value for Money assessment of Emerging Minds could be approached – with a particular focus on the online learning courses or modules. A fully informed Value for Money assessment requires a thorough cost analysis and benefits study, neither of which is feasible at present. With insufficient cost-related data available to conduct a cost analysis, this document can be used for a

future Value for Money assessment when such data are available. Additionally, since the initiative is in its early stages of implementation, there is no robust way to estimate the overarching benefits in terms of child mental health outcomes. Likewise, there is no way to study the true outcomes of the alternative scenarios. Therefore, an estimate of short-term benefits is restricted to responses to the National Support Network Survey by participants exposed to Emerging Minds initiative.

6.2.1 Determining the alternative scenarios and costs

Identifying appropriate alternative scenarios is the first step towards calculating the real or potential costs of those scenarios and comparing these costs to the costs of Emerging Minds. A comparison between Emerging Minds and alternative scenarios is conducted on the premise that all options result in the same desired outcomes; that is, awareness, skills and knowledge needed by Practitioners to care for children's mental health. Such an assumption must be made as the scope of this study does not allow for in-depth examination of the content contained in each alternative scenario, nor their outcomes. The alternative scenarios we present are derived from Practitioners' responses to a series of open-ended survey questions:

- Q90: What are the activities and/or tools (if any) you use for your professional learning regarding children's mental health?
- Q206: Other than Emerging Minds, what are the activities and/or tools (if any) you use for your professional learning regarding children's mental health?

The themes of need or areas of priority highlighted by survey participants varied depending on their background and skill set, as well as by their specific professional or occupational level and years of work experience. Participants that are likely to utilise the resources from Emerging Minds are skilled within their health field and are likely to already have existing knowledge or training in identifying and supporting children and their families with mental health issues. There is, however, a continuing need for Practitioners to keep their industry-relevant skills and knowledge up to date. Survey responses to the above open-ended questions revealed a number of avenues through which health professionals acquire their learning:

- peer-reviewed journal articles
- peer consultations
- conferences, seminars and online courses
- supervision and mentoring exercises
- professional development workshops.

All the above activities can contribute to continuing professional development (CPD). Most health Practitioners are required to participate in CPD each year in order to maintain their industry registration. Health Practitioners in general are required or encouraged to participate in CPD "to maintain, develop, update and enhance their knowledge, skills and performance to help them deliver appropriate and safe care" (Australian Health Practitioner Regulation Agency). Therefore, understanding these professional development criteria is important for establishing the alternative scenarios. Table 6.7 presents a summary of CPD requirements for common occupations of Practitioners who use Emerging Minds.

Each profession within the health sector has its own benchmarks or criteria for what constitutes a professional development activity. These criteria differ by profession, but typically incorporate some degree of training and knowledge development relevant to the given profession. Emerging Minds may be regarded as a CPD activity in this respect. For the purposes of this study, and considering the broad range of Practitioners with access to Emerging Minds, a sample of the most common users of Emerging Minds by profession has been drawn (based on current registrations) and data extrapolated accordingly.[14]

[14] It is important to note that, of the professions available for users to nominate when registering with Emerging Minds, the "other" category appears most popular. As at June 2020, 11,295 out of 40,063 registrations sat under the "other" category (see Appendix K, Table K.1). The registration data was only made available by Emerging Minds on 7 May 2021. Therefore, these data were not available for use in the Integrated Data Analysis.

Table 6.7 Continuing Professional Development (CPD) requirements by Practitioner occupation

Occupation/ profession	CPD overview	CPD requirements specific to profession	Emerging Minds as CPD	Alternative scenarios and costs
Psychologists	CPD is mandatory and is regulated by the Australian Health Practitioner Regulation Agency via the Psychology Board of Australia. Psychologists need to be registered with the Board to practise. They need to stay up-to-date with CPD obligations to maintain their registration.	CPD policy[15] as established by the Board is well-defined and includes completing 10 hours of peer consultation activities per year and 20 hours of other CPD activities involving learning modules. Learning needs and goals are mainly determined by the individual psychologist to ensure CPD relevancy to their field of practice. CPD can involve learning activities that are not specifically linked to a psychologist's practice but that will broaden their general knowledge of psychological practice.	Yes Learning activities are very much driven by psychologists' own learning goals.	Psychologists can register to become members of the Australian Psychological Society (APS). The APS provides professional development activities for their members at a cost. Some APS professional development courses specific to children's mental health can be used as alternative learning scenarios to Emerging Minds. These courses include: Children's Mental Health – Foundations – online learning[16] (cost = $300; CPD hours = 18.5) Creative Ways to Help Children Manage Emotions – one-day workshop[17] (cost = $350–$395; CPD hours = 6)
Nurses and Midwives **(Specialty mental health nurses)**	CPD is mandatory and is regulated by the Australian Health Practitioner Regulation Agency via the Nursing and Midwifery Board of Australia. Nurses and midwives need to be registered with the Board to practise. They need to stay up-	CPD guidelines[18] as established by the Board are well-defined and include completing 20 hours per year of CPD activities. CPD activities can include (but are not limited to) short courses, workshops, seminars and discussion groups through a professional group or organisation who may issue a certificate of compliance/completion. Self-directed learning and other structured learning activities can be counted as CPD.	Yes Learning activities are very much driven by nurses' and midwives' own learning goals.	Nurses and midwives can register with many associations, trade unions or organisations that offer learning tools relevant to their professional CPD requirements. Options include the Australian College of Mental Health Nurses, Australian Nursing and Midwifery Federation, New South Wales Nurses and Midwives' Association and Queensland Nurses and Midwives' Union of Employees. There are

[15] https://www.psychologyboard.gov.au/Registration/Continuing-Professional-Development.aspx

[16] https://www.psychology.org.au/Event/21861

[17] https://www.psychology.org.au/Event/21997?view=true

[18] https://www.nursingmidwiferyboard.gov.au/Registration-Standards/Continuing-professional-development.aspx

Occupation/ profession	CPD overview	CPD requirements specific to profession	Emerging Minds as CPD	Alternative scenarios and costs
	to-date with CPD obligations to maintain their registration.			upfront membership fees for these groups. Of the CPD courses they offer, some are free for members while others are available at a discounted price. Non-members can also participate at a premium price. Based on a cursory search, there are few CPD courses available for nurses and midwives focused on supporting children's mental health. Options include: Introduction to Mental Health for Nurses and Midwives (Members $90, Non-Members $190; CPD hours = 6)[19] Australian College of Nursing Mental Health – online course (self-paced; CPD hours = 4)[20]
General Practitioners (GPs)	CPD is mandatory and is regulated by the Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine. GPs must adhere to a very strict CPD points system and requirements.	The CPD requirements for GPs are extraordinarily complex. In its most basic form, Practitioners must complete a certain number of accredited learning modules per year to ensure up-to-date knowledge and skills relevant to their field of medicine.	Yes Only one relevant module is available on Emerging Minds: A GP framework for child mental health assessment (5–12 years). Completion of this module earns a GP 40 CPD points.	There do not seem to be other courses for GPs that focus on the mental health of children aged 5 to 12. It is challenging, therefore, to identify a suitable "alternative scenario" at this time for GPs' CPD to compare to Emerging Minds.

[19] https://www.nswnma.asn.au/events/introduction-to-mental-health-for-nurses-and-midwives-6/

[20] https://www.acn.edu.au/education/cpd-online/mental-health

Occupation/ profession	CPD overview	CPD requirements specific to profession	Emerging Minds as CPD	Alternative scenarios and costs
Social Workers	There are no mandatory regulated CPD requirements for social workers.	There is no regulatory body overseeing the social work profession at this point in time. Social workers can engage in learning activities for their own professional development but such endeavours are self-motivated and for social workers' own interest rather than mandated by any Board or association. Social workers do have the option of registering with the Australian Association of Social Workers (AASW) if they wish. This is a professional representative body offering support to qualified AASW members to maintain, improve and broaden their skills, knowledge and expertise, and develop professional practice qualities through CPD. The AASW has CPD or professional development activities available for members and non-members.	Yes Social workers can use Emerging Minds as a form of their own CPD.	There is a range of online courses available to AASW members that can be used as alternative scenarios.[21] Courses range from $60 to $299 for approximately 2.5 hours. Two AASW courses pertaining to children's mental health are: Empowering Excellence: An introduction to infant mental health and infant-led work with families ($199 for AASW members, $299 for non-members; 2.5 hours) Collaborative Partnerships to Support Children & Young People in the School Setting ($60 for AASW members, $80 for non-members; 3 hours)

6.2.2 Alternative scenario costs – per user

As evidenced by the information contained in Table 6.7 above, the training courses, time commitment and costs associated with CPD activities can vary across occupations/professions. It is common in the health sector for individuals to pay for their own training opportunities each year in order to fulfil their CPD obligations, especially those employed outside of the public sector. Given this variation across professions, comparisons within the Value for Money assessment were made at the level of individual professions.

The alternative scenarios presented in Table 6.7 were selected to match the key features of similar modules available via Emerging Minds. It is important to maintain this alignment for the purposes of a fair cost comparison in the Value for Money assessment. Likewise, the alternative scenarios that were selected involved a time commitment from the Practitioner equivalent to that of involvement with Emerging Minds. In this respect, time and training options (i.e. Emerging Minds vs alternatives) remain constants, while costs will be the variable to be determined and analysed.

Opportunity costs

Where CPD activities are an annual requirement of an individual's role, the training undertaken can be assumed to be *not* an opportunity cost or time lost. This is assumed because the hours spent completing that training go towards fulfilling the Practitioner's annual CPD requirements.

Annual CPD may not be mandatory (but typically always encouraged) for all Practitioners. If skills development or training is undertaken at the initiative of an individual during their usual work hours, then an opportunity cost would apply. This is because the individual is spending time on training activities that they would have otherwise spend on work duties. In this case, the opportunity cost of an individual voluntarily participating in CPD activities

[21] https://www.aasw.asn.au/professional-development/swot-social-work-online-training

can be calculated by multiplying the average hourly rate of the individual's profession (as can be sourced from the ABS Survey of Employee Earnings and Hours) by the number of hours needed to complete the training.

6.2.3 Determining costs associated with Emerging Minds

Costing by module and by individual Practitioner

Emerging Minds modules vary in anticipated completion time, ranging from one hour to more than four hours. With each module differing from the next – some for universal application and others for specific Practitioner types only – a significant research and development effort is required to deliver the module. Costs for this phase may include:

- situational/needs assessments, including consultations and evidence reviews
- recruitment costs for research consultants
- translation activities, such as publications, building modules and designing interactive content
- loading content into the online learning system
- webinars and live events
- accreditation costs (if any)
- reviews of, and updates to, content as part of quality assurance and quality improvement processes.

While costs associated with the original development of each learning module will likely remain fixed, additional costs are expected over time per module based on module-specific additions and amendments. Therefore, module costs are expected to be the marginal or incremental cost of delivering a module each year or specific time period.

- costs per professional user – for a module designed for specific Practitioner
- costs per user for a module that is specifically designed for a particular profession can be calculated by taking the total cost of that module and dividing it by the number of module registrants.

Hypothetical example for calculating the cost per user for a module specifically designed for a particular profession.

The Emerging Minds module designed specifically for GPs is titled *A GP framework for child mental health assessment (5-12 years)* and takes approximately six hours to complete. It includes reading material and videos. The module is also CPD accredited and constitutes 40 CPD points.

To cost this module by user, we can take the total cost of the module at a given period and divide it by the number of GPs enrolled in it. Inputting hypothetical figures, for example:

Total cost per GP user = Total cost of the module/Total GP uptake

Assuming Total cost = $50,000 and number of GPs participating in the module = 100, then:

Total cost per GP user = $50,000 / 100 GPs = $500 per GP

In this hypothetical example, the cost of the module per user is $500. With an increasing uptake of the module over time, however, this cost will reduce. This means that the module benefits from economies of scale.

Costs per professional user – for a module designed for all Emerging Minds users

The cost per professional user for a module designed for universal users within the health sector can be calculated in a similar way, but an additional step is required. This step involves apportioning the total cost of the module by a user's respective health profession. To calculate the apportioned component (proportion), the number of all Practitioners within the given field in Australia (e.g. the population of social workers) is divided by the number of all Practitioners in Australia overall (i.e. Emerging Minds total target population). This provides the proportion of the given profession (e.g. social workers) that are eligible to register for Emerging Minds universal modules. From there, that proportion is multiplied by the total module cost to establish the cost of making the particular module accessible for all members of the given profession. Dividing that answer by the number of actual module registrants from that professional field will determine how much the module costs per professional user.

This calculation can be repeated for each Practitioner field, ultimately resulting in a proportion for each profession out of all Emerging Minds users. Those proportions can then be used to calculate costs of an Emerging Minds module for different Practitioner groups as well as individual users within a particular profession.[22]

Hypothetical example for calculating the cost per professional user for a universal (foundational) module designed for all Practitioners

There are various universal (foundational) modules available via Emerging Minds that are designed to provide knowledge and understanding of child mental health and trauma. Many of these courses are available in the online training section of Emerging Minds website. We can conduct a cost analysis on any one of these modules using the formulas below.

Let's assume, for example, we would like to cost the module *Supporting children who have experienced trauma* for a social worker.

Costing the module by each social worker in this case would involve taking the total apportioned cost of the module at a given period and dividing it by the number of social workers enrolled in the course, inputting hypothetical figures, for example: total social workers = 2,500; total health Practitioners targeted = 10,000; total module cost = $20,000; total social worker Emerging Minds uptake = 100.

Apportioned component (0.25) = Total social workers in Australia (2,500) / Total health Practitioners targeted to complete this module (10,000) [23]

Module cost at a given period per social worker = (Total cost of the module at a given period * Apportioned component) / Total social worker uptake

Module cost per social worker = ($20,000 * 0.25) / 100 social workers = $50 per social worker

In this hypothetical example, the cost of the module per social worker is $50. With an increasing uptake of the module over time, however, this cost will reduce. This means that the module benefits from economies of scale.

As noted, data limitations mean that a Value for Money assessment is not currently possible at the level of module or individual profession. In order to carry out such an assessment, accurate estimates of the costs associated with each module are crucial, as is accurate registration data per occupation/profession. Available data only included high-level Emerging Minds budgets, and incomplete registration numbers. For example, the "other" profession category constitutes the majority of registrations identified, sitting at approximately 30% as at June 2019. The professions contained within that group are not identified. More specific data are needed for a fully informed Value for Money assessment.

Opportunity costs

Understanding costing data from users of Emerging Minds – what costs they incur while learning through the modules and online resources – is also important. For each profession, consideration needs to be given to whether professional development activities (such as those available via Emerging Minds) are an annual requirement. If they are a requirement, any relevant learning activities undertaken do not constitute an opportunity cost. On the other hand, if training and skills development is undertaken at the initiative of an

[22] The alternative approach to apportioning costs is the program-based approach. This involves calculating how many Practitioners within a given field are registered with Emerging Minds, then dividing that number by how many Practitioners are registered with Emerging Minds in total at that point in time. This can calculate the proportion of Emerging Minds users per profession but looks more towards actual or realised figures rather than predicted or potential figures like the economy-based approach. The economy-based approach is the preferred approach in this situation as the denominator of the formula is likely to remain stable over time, while the proportion of Emerging Minds registrations is likely to increase over time.

[23] This professional-level data is available by the ABS. Please see detailed table titled a full time equivalent (FTE) of total staff, Australia (6291.0.55.001 - EQ08 - Employed persons by Occupation unit group of main job (ANZSCO), Sex, State and Territory, August 1986 onwards).

individual professional, an opportunity cost is likely to apply. The opportunity cost in such a situation is calculated by multiplying the time spent completing the learning activity by the professional's average hourly rate.

6.2.4 Analysis of costs

Once individual professional costs are determined for alternative scenarios and for the equivalent Emerging Minds modules, comparisons can be made between the options. This is similar to the way in which Be You and its alternatives were compared in section 6.1. A thorough analysis of costs is not currently feasible for Emerging Minds due to the limitations of available information.

Emerging Minds comes at no direct personal monetary cost to individual professionals (i.e. Emerging Minds users). From a funding perspective, it should also be acknowledged that online modules and resources will attract a higher initial cost due to the upfront investment required to research and develop fit-for-purpose materials. With increased uptake of online modules, however, it is expected that the cost per user will decrease over time (a benefit of economies of scale), so greater value for money will be observed with greater initiative uptake.

6.2.5 Analysis of benefits specific to the Value for Money assessment

The benefits of the Emerging Minds initiative relevant to the Value for Money assessment perspective were estimated from responses to the National Support Network Survey, with a specific focus on understanding the initiative's benefits in terms of the reduced costs associated with the provision of Emerging Minds resources:

- the time that participants would take to obtain the relevant mental health information in the absence of Emerging Minds
- the ease of access of Emerging Minds resources compared to other resources
- the costs incurred in using Emerging Minds resources.

To study the three domains of time, ease of access and costs, we drew upon data from the survey responses of Practitioners exposed to Emerging Minds initiative. Survey participants were asked two specific questions per domain (see Table 6.8). To answer these questions, participants responded on a VAS ranging from 0 to 100. For simplicity in analysis, the VAS for each domain was organised into smaller ranges, which were then converted to categories. These modifications are outlined in the third column of Table 6.8. The distribution plots of participant responses to each question are presented in Appendix L, Figures L.1 to L.3.

Table 6.8 Survey questions for the time, ease of access and cost domains (Emerging Minds)

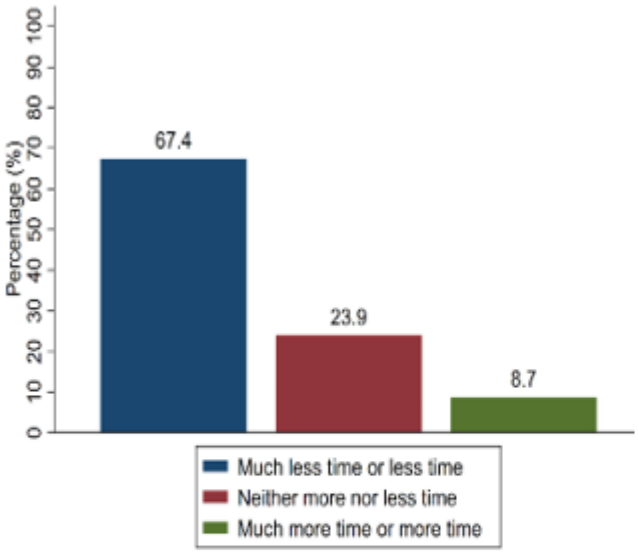
Domain	Questions	Modified scale
Time	• If Emerging Minds was not available, how much time would it take to obtain the relevant information from other sources to support children's mental health? • Compared to other activities or tools you use for your continuing professional learning, how much time does Emerging Minds take up?	1 Much less time or less time (VAS score – 0–40) 2 Neither more nor less time (VAS score – >40–60) 3 Much more time or more time (VAS score – >60–100)
Ease of access	• If Emerging Minds was not available, how much easier or harder would it be to obtain information needed to support children's mental health? • Compared to other activities or tools you use for your continuing professional learning, how much easier or harder is Emerging Minds to use?	1 Much easier or easier (VAS score – 0–40) 2 Neither easy nor hard (VAS score – >40–60) 3 Much harder or harder (VAS score – >60–100)
Costs	• Compared to other activities or tools you use for your continuingprofessional learning, how costly is Emerging Minds?	1 Much less costly or costly (VAS score – 0–40) 2 Neither more nor less costly (VAS score – >40–60)

Domain	Questions	Modified scale
	• If Emerging Minds was not available, how much money would it cost to obtain information needed to support children's mental health?	3 Much more costly or costly (VAS score – >60–100)

Time

The results in this section refer to the two questions focused on time (see Figure 6.6). The majority (67.4%) of participants responded that Emerging Minds takes up *less or much less time* than other activities or tools used for their professional learning in relation to child and youth mental health. This response indicates that making use of Emerging Minds is less time-consuming than other professional development activities presently available in the mental health space.

Participants also responded positively when asked about the time they would have taken, in the absence of Emerging Minds, to find relevant information from other sources to support children's mental health. Approximately 54.9% of respondents indicated that they would have taken *more or much more time* to source the information they needed if the Emerging Minds initiative did not exist. This indicates that the Emerging Minds initiative (comprising online Emerging Minds resources, and consultants) streamlines the learning and research process for Practitioners when it comes to finding information that is both beneficial and suitable for their needs.



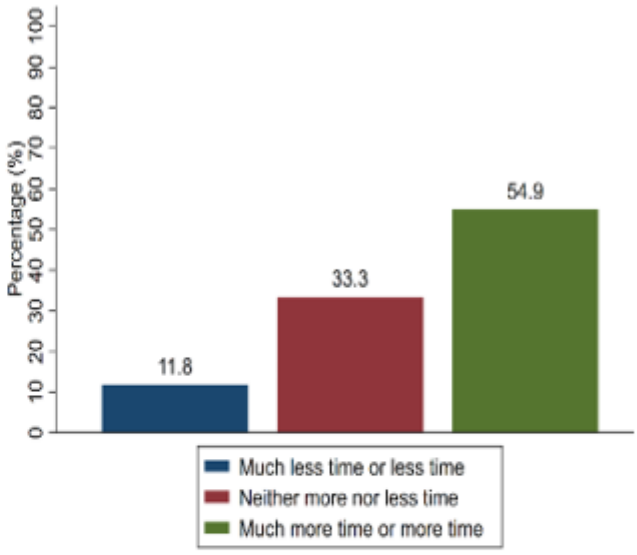


Figure 6.5 Survey responses for "time" domain (Emerging Minds)

Ease of access

The results in this section refer to the two questions focused on ease of access (see Figure 6.6). The majority (76%) of participants exposed to Emerging Minds reported that the initiative is *easier or much easier* to use for their professional learning compared to other activities or tools available for them to use. Just under 24% of survey participants returned neutral responses to the question, while no one found Emerging Minds harder to access than alternative options.

Similarly, a majority of survey participants (59%) reported that, in the absence of the Emerging Minds initiative, it would be *harder or much harder* to obtain information needed to support children's mental health. This response signals that the availability of Emerging Minds resources at the convenience of Practitioners is highly valued.

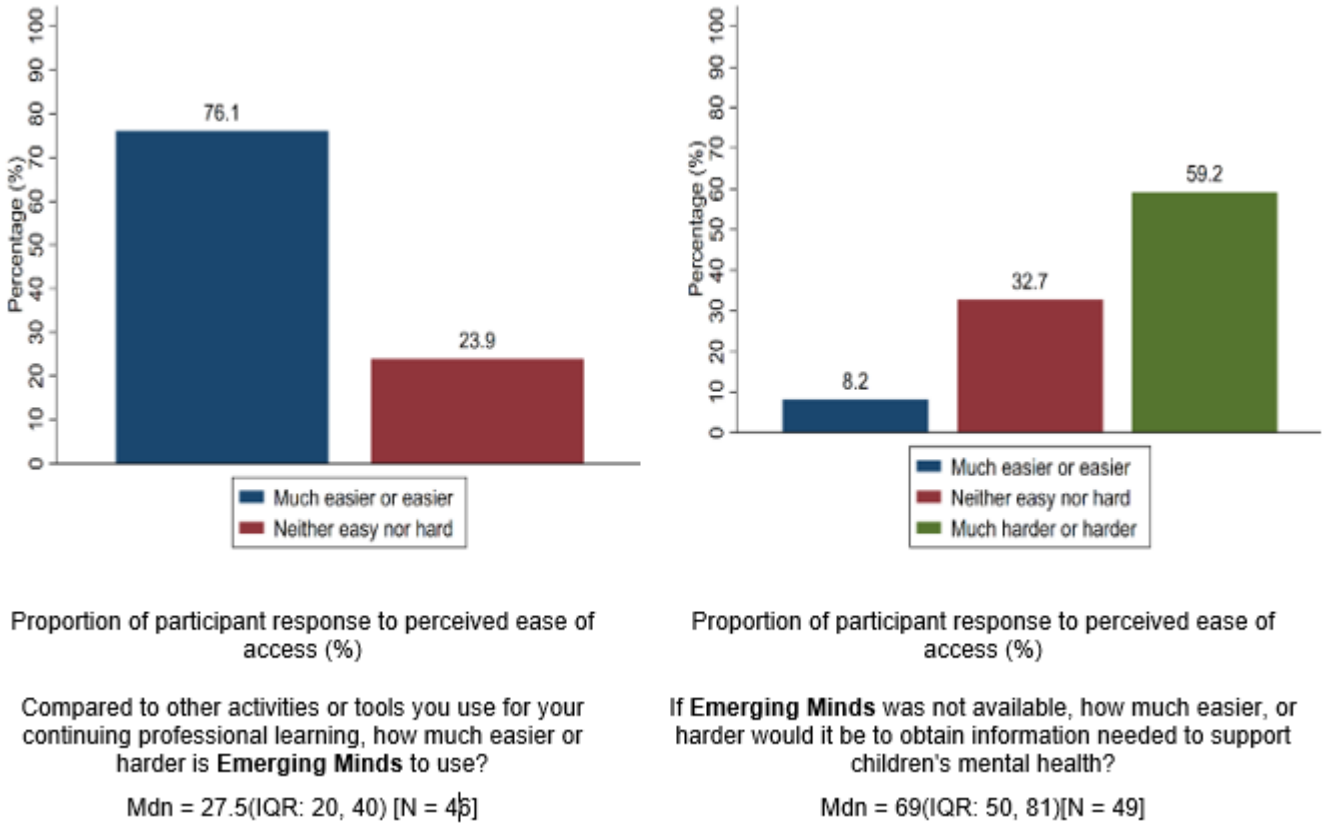


Figure 6.6 Survey responses for "ease of access" domain (Emerging Minds)

Costs

The results in this section refer to the two questions focused on costs (see Figure 6.7). A majority (80%) of participants exposed to Emerging Minds reported that the initiative is *less or much less* costly to use for their professional learning when compared to other activities or tools available for them. A minority (2%) indicated that the initiative is *more or much more* costly compared to other activities. Although approximately 47% of participants exposed to Emerging Minds reported that, in the absence of the initiative, the costs to obtain information from other sources to support children's mental health would be similar to those associated with Emerging Minds, another 45% of participants responded that it would cost them *more or much more* if Emerging Minds was not available to them. A minority (8%) responded that it would be *less* costly.

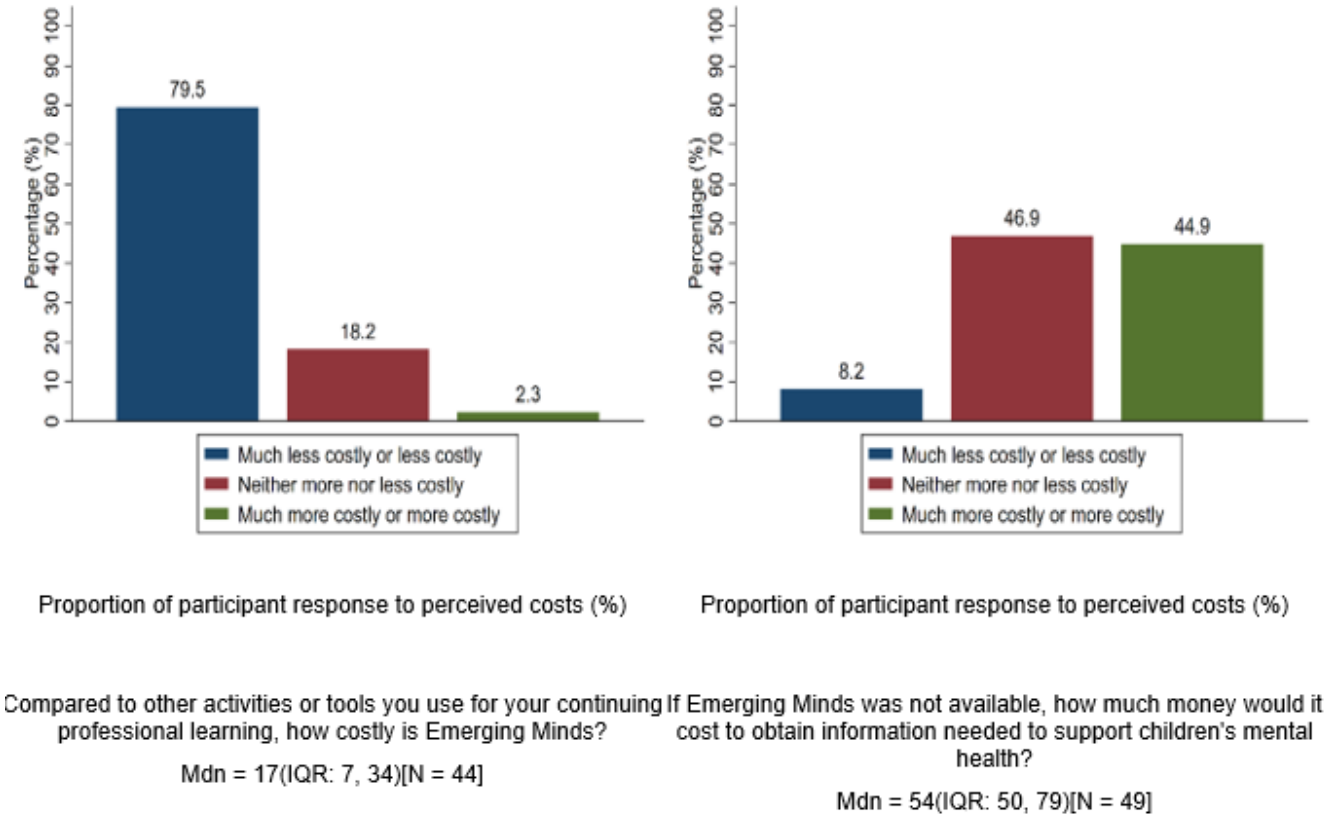


Figure 6.7 Survey responses for "cost" domain (Emerging Minds)

6.2.6 Concluding remarks – Emerging Minds

Across all three benefit domains – time, ease of access and cost – the majority of surveyed Practitioners exposed to the initiative provided responses that were favourable towards Emerging Minds and the resources it provides for health Practitioners. Regarding the time taken to obtain relevant mental health information for professional learning, most Emerging Minds Practitioners felt that the learning experience provided by the initiative was streamlined in comparison to other activities or tools. Users also consider Emerging Minds resources, tools and modules to be easier to use and access compared to other options. An overwhelming majority reported that Emerging Minds is less costly to use than the alternatives they would otherwise have to source to obtain the same level of training required to support children's mental health.

Conducting a cost analysis on Emerging Minds was not possible at this time given the lack of module-level costing data and accurate registration figures by profession. It is recommended that the Emerging Minds initiative routinely collects registration and uptake data by profession, ideally in accordance with the four-digit Australian and New Zealand Standard Classification of Occupations (ANZSCO) identifier codes. The ABS records most employment numbers and average salary figures (as used for cost comparison calculations) under the ANZSCO coding system.

It is also recommended that the Emerging Minds initiative looks to attribute costs to specific activities, and in particular to individual modules. As an online initiative providing crucial mental health information and training for a very broad spectrum of professionals across the health sector, users' needs and expectations of Emerging Minds will constantly evolve. Industry updates and new research findings will call for regular work on Emerging Minds content development, needs assessments, evidence reviews and other efforts of continuous improvement. Although costs associated with the original development of each learning module will likely remain fixed, additional costs should be expected and tracked per module based on any module-specific additions or amendments.

The online education system of Emerging Minds is constantly advancing by offering registered users a scaffolded learning pathway of modules (courses) and resources so they can gradually build their understanding and practice to support infant and child mental health. These learning journeys are customised by profession

and include foundational modules to improve general understanding of child mental health and trauma, customised modules for specific professions in need of targeted skills development, and implementation toolkits for Practitioners and organisations alike. Based on such distinctions between different Emerging Minds modules (their offerings and intended audiences), recording costs at the module level is imperative for a well-informed cost analysis in future.

7. Community Case Studies

7.1 Purpose and design

The purpose of the Community Case Studies was to explore the reach and influence of the Program within local place and context among community Practitioners, Educators and parents/carers. To this end, consultation was embedded within the unique contexts of four distinct communities (remote, regional, suburban, urban) across Queensland and Western Australia. Rather than asking directive questions about the experiences, uptake and impact of the specific initiatives, these consultations enabled a "deep dive" into the experiences of children and young people's local support networks, and the enablers and barriers they experience in seeking support around mental health. Information pertaining to available mental health training and education, and specific questions pertaining to the knowledge of, and engagement with, the Program emerged through the consultation. Consultation participants were key community stakeholders: health professionals, Educators, parents, and non-parent caregivers. Cultural inclusion was integral to the consultation approach, with specific attention given to ensuring the voice of Aboriginal and Torres Strait Islander people was heard and that issues relating to social and cultural disadvantage were raised.

Consistent with the aim to contextualise the Program within community locations, the consultative methodology afforded opportunity to examine the effectiveness of the Program against a background of community service integration, contextual risks, and local capacities to respond effectively and strategically to support child and youth mental health. Data in the form of qualitatively analysed recordings, discussion artefacts and stakeholder quotes provide rich narratives about the impact of the Program to complement direct questions about the experiences, uptake and impact of the Program provided by other components of the evaluation (e.g. the National Support Network Survey).

The Community Case Studies provided place-based information about:

- Program-related needs of diverse and at-risk groups
- Program awareness
- Program burden
- Provider and child/parent experience of interacting with different programs and services
- referral pathways
- perspectives of Program resources and coverage
- the nature of help-seeking by families and young people
- workforce capacity
- Program enablers, barriers and unintended consequences.

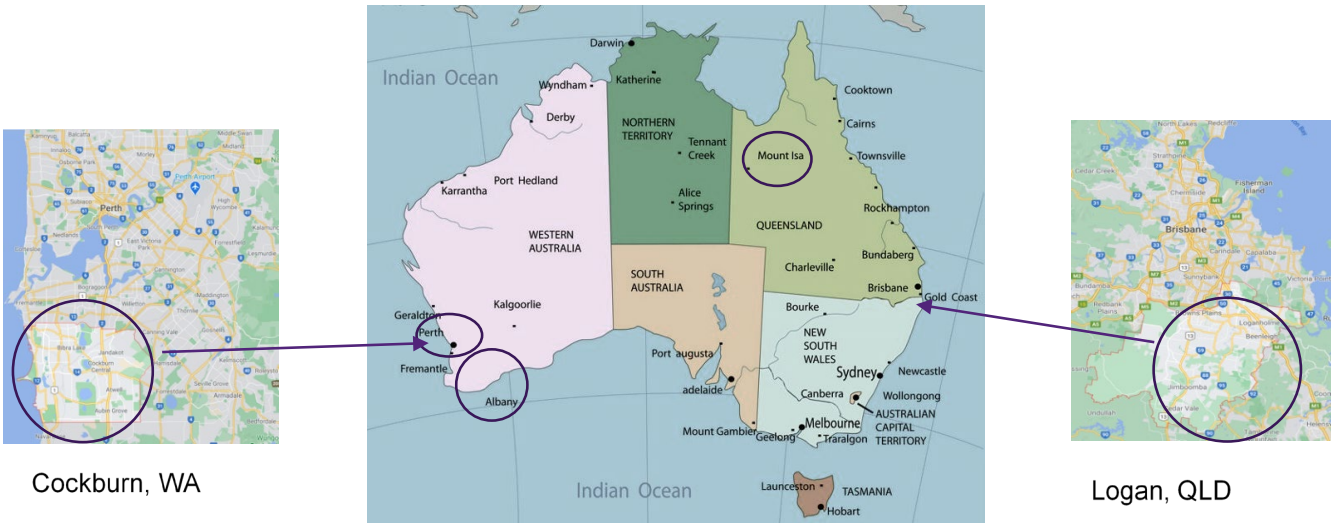
7.2 Ethics

The research was approved by The University of Queensland HREC (A, B, and LNR), Approval Number 2019001538. The study in all ways complied with the NHMRC's *Ethical guidelines for research with Aboriginal and Torres Strait Islander peoples* (2018).

7.3 Sampling

Four communities, two in Queensland and two in Western Australia, were selected to represent urban, suburban, regional and remote locations. The selection of sites for the Case Studies was made with reference to publicly available data on community demographics and mental health indicators to capture population diversity and areas where mental health concerns were prevalent. In selecting from candidate sites, those with which the research team had pre-existing relationships of trust with community were prioritised given the sensitivity of the consultation focus. Mapping of the sites is provided in Figure 7.1 and each community is described below.

Figure 7.1 Community Case Study sites



Western Australia

Two Western Australian municipalities were selected:

- **Albany:** Albany is a regional city of 38,000 people with a mean Socio-Economic Indexes for Areas (SEIFA) score of 989, which sits in the 39th percentile for disadvantage. This masks substantial geographic variance in disadvantage in the Albany area, with some neighbourhoods in the 76th percentile and others in the 8th percentile. Youth unemployment and youth disengagement are noted problems for Albany. Over 35% of households in Albany are families with children, with one in ten households having a sole parent. This catchment captures families living in the surrounding region, given Albany's role as a hub for services. Rates of developmental vulnerability of children (as rated by the Australian Early Development Census, AEDC) indicate very high rates in this surrounding rural region, with up to 52.3% of children rated vulnerable, compared to the national average of 23.5%.
- **City of Cockburn:** Cockburn is an outer southern suburb of Perth, with a 2019 population of 112,000, and constitutes primarily suburban neighbourhoods of the greater Perth metropolitan area. The SEIFA score for disadvantage for Cockburn in 2016 was 1033. The years between 2011 and 2016 saw an increasingly multicultural population, with a 64% increase in residents of Chinese ancestry, a 52% increase in residents of Indian ancestry, a 57% increase in residents of Filipino ancestry, and a 40% increase in residents with Iranian ancestry. Over 45% of households include children, with 10.2% living in households with a single parent. Rates of social housing exceed the rate for Greater Perth, with 3.5% of households in social housing.

Queensland

Two Queensland municipalities were selected:

- **Mt Isa and surrounds:** Mt Isa is a large but remote town in far north-west Queensland. Mt Isa is a mining town with a population of 18,600, and a mean SEIFA score of 988, with approximately 14% of the population within the most disadvantaged quintile. Approximately a quarter are Indigenous, and children and youth aged 0–14 years also make up a quarter of the town's population. Over 45% of households in Mt Isa are families with children. The percentage of families with children under 15 years of age and no parent employed is 14%. AEDC figures indicate that approximately 34% of children enter school with at least one developmental vulnerability.
- **Logan City:** Logan is an urban area located between Brisbane and the Gold Coast, with a population of approximately 340,000. The SEIFA score for disadvantage for Logan City is 959, with a third of the population within the most disadvantaged quintile. Nearly half of the population are families with children, with children and youth aged 0–14 years representing nearly a quarter of the overall population. It is a diverse cultural and social location with pockets of extreme poverty, and includes significant refugee

populations as well as Aboriginal, Torres Strait Islander and Pasifika groups. Data from the AEDC indicates that approximately one third of children have a developmental vulnerability at entry to school.

7.4 Recruitment

The study was promoted in the four communities through personal contacts and through flyers distributed via community and professional networks to solicit participation by: community Practitioners and Educators; parents/carers; and specifically, parents/carers of Indigenous families.

Contact within the communities and display of the flyers was achieved through:

- **Aboriginal medical services:** promoted the study by displaying the study flyer in the waiting area and directing interested participants to the research contact person
- **community organisations providing child and youth services:** these included council interagency networks, community playgroups, Mt Isa Centre for Rural and Remote Health, Young People Ahead, headspace, local General Practice clinics, family day-care centres, Indigenous Consumer Assistance Network, WA Country Health Service Great Southern, Child Health Nurses for Chid & Adolescent Health Service – Community Health, Palmerston Drug and Alcohol Service, Connecting4Kids and the Albany Youth Support Association, which promoted the study and identified potential clients who may like to participate in the research project
- **community Elders:** in Mt Isa, Indigenous co-researcher, Mrs Dixie Samardin, attended the Mt Isa meetings with Elders to provide an overview of the research, promote the research and explain potential benefits to the community from this project
- **snowball sampling:** word-of-mouth promotion to contacts of those recruited
- **online recruitment**: i.e. by posting the study flyer and study details on community Facebook pages.

7.5 Procedure

A series of focus groups were conducted in each location, grouped for parents, Educators and health Practitioners separately. Individual interviews were conducted at the request of individuals, and in the case of the Logan site, via telephone or Zoom as the COVID-19 pandemic prevented in-person contact. In this case, the interviews were semi-structured, used the same guiding questions as those in the focus group procedure. Interviews were conducted in a private space convenient to both researcher and participant, or by telephone or online Zoom meeting.

Participants were given detailed information via a Participant Information Sheet prior to agreeing to participate. Written consent was obtained and de-identified details of the organisations represented were recorded. Specific details were given on the purpose, nature and content of the focus groups, benefits/risks, data confidentiality and project contact details if the participant wished to obtain any further information beyond what was provided on the information sheet. The participants were also informed that they could refuse to take part in the research or exit/withdraw from the focus groups at any time without penalty. They were also informed that they were free to decline to answer any particular questions they did not wish to answer for any reason.

Where Indigenous people were included, community contacts and Indigenous co-researchers were present at the time of the focus group sessions to support and provide advice, to ensure informed participation and cultural safety.

Focus group and interview participants were reimbursed for their time with a $50 gift voucher at completion of the session.

The focus groups involved strategies provided in the University of Alberta Community Evaluation Toolbox and their application in prior Australian studies (e.g., Leske et al., 2015). These methods included a group-based activity that provided the impetus for discussion. The activity asked 2–3 people within a focus group to work together to generate visual representations of community assets, mental health concerns, and directions for improvement and change. Using a combination of semi-structured dialogue and visual artefacts as stimuli, respondents were then consulted about their experiences. We overlaid this knowledge with consideration of how Program activities in the community had contributed to identified strengths and barriers. The Discussion Guide for interviews and focus groups is presented in Table 7.1.

Questions for qualitative community study	Interviewer to attend to and prompt if needed
1. Who cares about child/youth mental health in this community?	Identify: Strengths Challenges Solutions
2. Who has a role in improving it?	
3. How do they do that?	
4. How do they connect with young people for this?	
5. What makes it easier to connect with mental health services/supports for young people who need them?	*Looking for:* Have you experienced Emerging Minds/Be You?
6. Are you satisfied with what's available?	
7. What resources do you tap into to help? **7a. How well are they:** • **easy to access?** • **suitable for your needs?**	*Looking for:* Are they suitable for the children/young people you support?
8. What's working now for providing mental health supports for children/young people? **8a. What more do you need?**	
9. How comfortable/skilled do you feel to interact with families about their children's mental health?	*Looking for:* Have you used Emerging Minds/Be You to upskill?
10. What helps you learn more about child/youth mental health and how to support young people?	
11. What supports do you need to keep learning?	*Looking for:* Have you used Emerging Minds/Be You to upskill?
12. How does your organisation/community support/encourage you to support young people's mental health?	*Looking for:* Policies/referral protocols/on-site professionals

7.6 Participants

In total, 17 focus groups were completed at three sites (Cockburn and Albany, WA; Mt Isa, Qld), with a further 13 individual phone/online interviews conducted with community members of the South Brisbane/Logan City area. These activities were documented in an activity plan that was approved by the Department as part of the Evaluation Framework. In total, 85 individuals participated in the Community Case Studies activity. The participant details are summarised in Table 7.2. It should be noted that participant roles should not be considered as exclusive; many identified with multiple responsibilities.

Table 7.1 Breakdown of participant roles for each case study site

Location	Focus group type/identified role	N-Focus groups	N-Participants	Comment
Western Australia				
Cockburn	Parents	1	4	
	Educators	1	10	
Albany	Parents	1	1	
	Educators	1	3	
	Health/social Practitioners	1	3	
Queensland				
Mt Isa	Parents	2	16	One focus group Indigenous only N=8
	Educators	2	6	
	Health Practitioners	2	40	
Logan	Parents/community members	0	7	COVID-19; participants identified with multiple roles
	Educators	0	7	
	Health/social Practitioners	0	3	

7.7 Analysis

Focus group discussions/interviews were recorded and transcribed verbatim. Transcriptions were analysed in two distinct ways:

- **Inductive analysis** – to understand community context and mental health concerns for children and young people within the community, a series of thematic analyses was undertaken, following a procedure outlined by Braun and Clarke (2006), guided by the key Overarching Evaluation Questions.
- **Deductive analysis** – to enhance quantitative data pertaining to the key questions specified in the Program Logic, we scanned individual and community transcripts to provide deeper understanding of:
  - community child and youth mental health problems
  - resources and supports for child and youth mental health problems
  - challenges and proposed solutions in child and youth mental health
  - the experiences and assessment of the Be You and Emerging Minds initiatives.
- **Artefact analysis –** to discern patterns of consistency and contrast between focus groups and study locations, we scanned the hard-copy artefacts from each consultation, identifying and grouping concerns and checking for variation across sites.

Themes that emerged through the three analytical processes were consolidated across sites and aligned with the Evaluation Questions.

Table 7.3 clarifies the ways in which these Case Studies fit into the Overarching Evaluation research questions.

Table 7.2 Relationship between Evaluation Questions, indicators, and Case Study focus group/interview questions

Question	Indicator	Sample	Case Study prompt questions
Question 1 subquestion d indicator 2	The degree to which Educators and Practitioners report feeling confident in their ability to connect with, utilise and, where appropriate, refer children and young people to mental health supports compared to no Program	Educators and Practitioners	What makes it easier to connect with mental health services/supports for young people who need them? Are you satisfied with what's available?
Question 1 subquestion d indicator 3	The degree to which Educators and Practitioners report changes to ways of working with, or referring on to, other mental health settings, compared to no Program	Practitioners and Educators, community members	Who cares about child/youth mental health in this community? Who has a role in improving it? How do they do that? How do they connect with young people for this? Identify: • strengths • challenges • solutions.
Question 1 subquestion e indicator 1	Reported enablers and barriers of implementation identified by users, consultants, and Beyond Blue and Emerging Minds	Practitioners and Educators	What resources do you tap into to help? How well are they: • easy to access? • suitable for my needs? What's working now for providing mental health supports for children/young people? What more do you need?
Question 3 subquestion a indicator 2	The extent to which users report being better (e.g. more frequent, more confident, more competent) users of evidence compared to no Program	Educators and Practitioners	What helps you learn more about child/youth mental health and how to support young people? What supports do you need to keep learning?
Question 3 subquestion b indicator 1	Extent to which users report that their Early Learning Service, school, or organisations have implemented policies and programs to support/reinforce a mentally healthy culture based on the contents of the Program	Educators and Practitioners	How does your organisation/community support/encourage you to support young people's mental health? Looking for: • policies • referral protocols • on-site professionals.
Question 3 subquestion c indicator 2	Users report an increased willingness to have conversations about mental health with children, young people and families, compared to no Program	Educators and Practitioners	How comfortable/skilled do you feel to interact with families about their children's mental health?

7.8 Member-checking

A brief summary report (in the form an infographic mini poster) for each community was sent to consultation participants from that community via the contacts through which they were recruited. In this way we were able to receive feedback and check that these had accurately captured each community's perspectives. While the organisational and role identities represented by participants as a group were noted, no personal identification was disclosed within the reports.

7.9 Data limitations

The participants were not a representative sample, and their views may not be indicative of the relevant populations of other community Practitioners/Educators, parents/carers, or parents/carers of Indigenous children or youth. These data were collected to provide a rich insight into sample communities on how the Program might have impacted on community capacities to support children's mental health and wellbeing. Communities were selected to represent a reasonable cross-section of Australian localities, but budgetary and operational constraints precluded inclusion of extremely remote communities. Across the four Community Case Study sites, we encountered a limited overall awareness and uptake of the Be You and Emerging Mind initiatives. Therefore, we were able to make only limited assessments on several of the Evaluation Questions and indicators. The limited access to the initiatives by the sample meant that it was not feasible to conclude changes to practice or capabilities of Educators and Practitioners.

7.10 Results

The limited uptake and awareness of the initiatives across the Community Case Study sites is reflected in the Program statistics for the four locations. From the available Customer Relationship Management data, we were unable to identify Emerging Minds registered users/attendees in Mt Isa, Cockburn or Albany. Nearly 200 were identified for Logan/South Brisbane. Be You data showed registered users and schools/ELSs in all four locations, with the highest number of registered users in Cockburn (n=279) and the lowest in Mt Isa (n=85).

Despite the low levels of awareness encountered, we were able to gather feedback from a significant number of participants who represented all of the backgrounds we sought to consult. Overall, 92 people contributed to the Community Case Studies: 79 people (71% female) took part in focus groups, and another 13 people (all female) took part in interviews due to COVID-19 restrictions. The focus group profiles are summarised below:

- Mt Isa – 9 sessions; 52 people; roles included parents, Educators, community members, Practitioners (health, mental health and youth support); 73% female
- Albany – 4 sessions; 13 people; roles included parents/carers, Educators, Practitioners; 46% female
- Cockburn – 4 sessions; 14 people; roles included parents, Practitioners; 86% female
- Logan – 13 individual interviews: roles included parents, community members, Educators and Practitioners: all were female.

Major themes and concerns emerging through the Community Case Studies are presented in summary form in the mini-posters on the following pages.

One organisation in the Logan/South Brisbane region, several of whose staff members took part in individual interviews, had significant exposure to the Program, and discussed not only individual experiences of this engagement, but also the structural whole-of organisation approach that supported implementation of the new learnings across that setting. We present findings from these consultations as a **Spotlight Case Study** to showcase the efficacy of such an approach.

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MOUNT ISA
Community Case Study

The Overarching Evaluation of the National Support for Child and Youth Mental Health Program

FOCUS GROUPS

Researchers from the University of Queensland visited Mt Isa from 28-30 October 2019 and met with community members to discuss the wellbeing and experiences of children, young people, and their support networks in the local community. 45 community members took part in focus groups.

PEOPLE CONSULTED

Indigenous and non-indigenous people, including:

- School teachers & after-school hours carers
- Parents
- Health care workers
- Community representatives and community support professionals

WHAT WE HEARD FROM THE COMMUNITY

SYSTEM ISSUES

- Mental health issues are stigmatised in the local community, delaying young people from seeking help and accessing support.
- When they access mental health services, young people prefer health professionals that they trust or have built a long term relationship with. High staff turn-over is a major issue for young people trying to access support.
- Very little support is available for children in their early years, especially under-12's, if they experience mental health issues. Early intervention is needed to prevent more serious issues developing later.
- Clinical services (e.g. hospitals, GPs, and psychologists) are often needed but hard to access because of complex referral pathways and long waiting times. Little or no support is available during waiting times. Some services only admit young people who meet strict diagnostic criteria.
- A focus on youth crime and punishment can be damaging to young people's mental health. Sending children to detention centres away from home does not solve youth crime but does exacerbate young people's mental health issues.
- Funding for mental health services and projects is insufficient and very inconsistent.
- There is a need for mental health services to share information and cooperate, rather than competing with each other to attract funding.

PROGRAM AWARENESS

- Almost no one had accessed or heard of 'Be You' and 'Emerging Minds'. Despite high demand, practitioners find it very difficult to access professional development. They strongly prefer in-person (rather than on-line) sessions and more localised content.

PROGRAM ISSUES

- School is potentially a good place to support young people's mental health. However, too much expectation is placed on teachers and educators as they are not always equipped with the right knowledge and skills, nor do they have sufficient time and resources.
- Community support services are generally well-received as they provide both basic life needs (e.g. food and shelter) and supportive environments (e.g. peer support and safe situations).
- Many parents do not have enough awareness of young people's mental health issues, nor do they have enough time as they struggle for basic livelihood. Some families cannot provide safe and nurturing environments to support young people's material or emotional needs.

INDIGENOUS CULTURAL APPROACH

- There is very little recognition and appreciation of the Indigenous understanding of mental health issues and of the Indigenous way of healing. Western approaches to mental health, especially clinical treatments and medications, do not align with Indigenous values and practices and so have limited effect in resolving young people's mental health issues.

TELETHON KIDS INSTITUTE

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BRISBANE SOUTH/LOGAN
Community Case Study

The Overarching Evaluation of the National Support for Child and Youth Mental Health Program

FOCUS GROUPS

Researchers from the University of Queensland interviewed community members from South Brisbane and Logan from 27-29 April 2020 and 11-15 May 2020 to discuss the wellbeing and experiences of children, young people, and their support networks in the local community. 14 community members took part in the interviews.

PEOPLE CONSULTED

- School teachers & after-school-hours carers
- Parents
- Health care workers
- Community representatives & community support professionals

WHAT WE HEARD FROM THE COMMUNITY

STRUCTURAL/SYSTEM ISSUES

- Clinical support for young people with mental health issues is problematic on a structural level. Some practitioners simply put children on mental health plans, which cannot address the contextual risk factors around the young person and their family.
- Young people face long waiting times to access mental health services, with no support during waiting times.
- Mental health support services tend to focus on serious or extreme cases that meet strict diagnostic criteria. This often leaves the 'struggling middles' unsupported, and worse mental health problems develop later.

HEALTH PRACTITIONER AWARENESS

- Clinical professionals often have very fragmented understanding of the mental health support system and don't know where to refer young people to.
- Clinical professionals are sometimes insensitive and lack the awareness and interpersonal skills needed for talking to young people with mental health issues.

REFERRAL PATHWAYS AND COMMUNITY AWARENESS

- Mental health support organisations need to provide support for young people's mental health AND offer help for young people and their families to navigate between different support services.
- Mental health support organisations need to make themselves visible and available to young people and their families, so that accessing these services doesn't require specialist connections.

PROGRAM AWARENESS AND UTILITY

- About half of the interviewees had heard of or accessed 'Emerging Minds' and 'Be You'. However, awareness and understanding of these organisations was mostly at name-recognition level.
- People who had accessed 'Emerging Minds' and 'Be You' websites generally regarded them as 'easy to navigate' and 'user-friendly'.

PROGRAM ISSUES

- Educators and parents often lack awareness and knowledge of young people's mental health problems and mistake them as 'bad behaviour' or 'emotional upsets' that don't need intervention. They also lack time and the right skills to support young people's mental health needs.
- Improving early-years support and early resilience skill building are needed to address the mental health needs of very young children.

CULTURALLY APPROPRIATE APPROACH

- More attention is needed for the unmet cultural requirements of CALD populations when it comes to mental health supports and resources

PROFESSIONAL DEVELOPMENT

- Practitioners and educators tend to choose resources for upskilling or professional development based on the credibility of the sources, their own current interests, their current workplace's philosophy, and the availability and accessibility of the resources.

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THE UNIVERSITY OF QUEENSLAND
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CREATE CHANGE

COCKBURN
Community Case Study

The Overarching Evaluation of the National Support for Child and Youth Mental Health Program

FOCUS GROUPS

Researchers from the Telethon Kids Institute visited Cockburn from 6-18 December 2019 and 6-7 February 2020 and met with community members to discuss the wellbeing and experiences of children, young people, and their support networks in the local community. 14 community members took part in focus groups.

PEOPLE CONSULTED

- School teachers
- Parents
- Health care workers

WHAT WE HEARD FROM THE COMMUNITY

STRUCTURAL/SYSTEM ISSUES

- It is important to provide young people with access to acute mental health support when needed, instead of having to experience long waiting times.
- Instead of providing a 'one-off' mental health service, practitioners and support services should engage in more long term support and seek to engage with children in a consistent and continuous way.
- 'Siloing' happens: some local organisations (e.g. schools) tend to work on their own to support young people's mental health instead of seeking cooperation and collaboration from other professional support services, resulting in potentially poorer support outcomes.
- Stronger connections are needed between support services for children and support for adults, so young people's mental health issues can be addressed in a holistic way that takes their family's context and mental health needs into consideration.

COMMUNITY ATTITUDES

- There is stigma around mental health issues in the local community, even among young people themselves and their peers, which hinders them from receiving mental health support.
- There is a lot of 'informal support' happening in the local community that effectively helps young people with mental health issues. There is little recognition and only minimal resourcing to support this practice.

PROGRAM AWARENESS

- Very few people had heard of or accessed 'Be You' or 'Emerging Minds'; there was only basic understandings of these organisations.

PROGRAM ISSUES

- There is not sufficient training for educators/practitioners on how to communicate with parents on the topic of young people's mental health. Family is the primary setting for engaging with young people, so this is critical.
- More early intervention, such as resilience and awareness building in early years and school curricula, is urgently needed to prevent more severe mental health issues developing in adulthood.
- More focus and early intervention for vulnerable but under-attended to young people are needed to prevent them from progressing from pre-diagnostic into 'high risk' categories and developing more serious mental health issues.

INDIGENOUS CULTURAL APPROACH

- The Indigenous community requires tailored support and more health practitioners from Indigenous backgrounds are needed to encourage Indigenous mental health support access.

ALBANY Community Case Study

The Overarching Evaluation of the National Support for Child and Youth Mental Health Program

FOCUS GROUPS

Researchers from the Telethon Kids Institute visited Albany on 30 & 31 January 2020 and met with community members to discuss the wellbeing and experiences of children, young people, and their support networks in the local community. 13 community members took part in focus groups.

PEOPLE CONSULTED

- School teachers
- Parents
- Health care workers

WHAT WE HEARD FROM THE COMMUNITY

STRUCTURAL/SYSTEM ISSUES

- The mental health support system assumes that 'the young person is the problem' and so often fails to address the underlying contextual and environmental issues around young people.

PROGRAM ISSUES

- Interviewees stressed the importance of creating safe spaces for and positive relationships with young people when supporting their mental health.
- Services provided by the local community (e.g. school chaplains, pastoral care services, family sport and music activities, local parenting groups) are highly regarded as they provide mental health support in a casual way, in which young people also have the opportunity to connect with each other.
- Often limited by their funding bodies, mental health support organisations often have strict boundaries for their target population, leaving those who don't meet the criteria unsupported. Support organisations could be more flexible in terms of who they can support.
- Organisations should go into the local community and understand their needs to improve practices, rather than being a 'franchise' that applies a universal approach across all areas.
- Parents and educators sometimes don't recognise early signs or patterns of young people's mental health issues and often mistake them as 'bad behaviour' or 'emotional upsets' that don't need active intervention.

PROGRAM AWARENESS

- None of the community members interviewed had heard of or accessed 'Emerging Minds' or 'Be You'.

COMMUNITY ATTITUDES

- Mental health issues are stigmatised in the local community. This stigma is exacerbated in regional settings by a lack of confidentiality and anonymity and the presence of traditional culture and attitudes.
- Interviewees noted some benefits of being in a small regional community:
  1. Services are physically more available for young people.
  2. The community understands what local young people need the most.
  3. Neighbours and friends can sometimes provide support for young people.
- As a regional town, only minimal mental health supports and resources are available to young people.

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7.10.1 Artefact analysis

The artefact analysis covered only the focus groups, as individual interviews did not include the initial mini-group phase that generated these artefacts. However, the ideas that emerged from the focus groups were explored during the individual interviews. Five main themes were elicited across the consultations:

- upskilling of Educators and Practitioners
- the role of schools in young people's mental health
- challenges to young people's mental health
- other community organisations with potential to support young people's mental health
- other community strengths to be leveraged for young people's mental health.

In summary, discussions indicated that both Educators and Practitioners valued ongoing opportunities to improve their knowledge and skills regarding support for young people's mental health, and noted specific concerns regarding the dearth of information or attention to the needs of younger (0–12) children. Practical skills training and ongoing mentoring to support improved practice were regarded as areas of need, as well as debriefing/counselling to help them manage the stresses of working with young people's mental health problems. They did, however, note some structural challenges to engaging with continued learning, such as learners needing facilities to access online learning (Mt Isa and Cockburn – the two more disadvantaged communities), and a need to recognise both the new learning and prior knowledge to increase the value placed on the learning by host organisations.

All communities identified schools as having a positive role in identifying and responding to young people's mental health, but noted other staff in the school community (not just Educators) may be involved and should be able to access upskilling opportunities. In addition to broadening access to the Program within school settings and formal health/social support services, the consultations suggested that a range of other community organisations are well placed to address youth mental health: PCYC, church and sporting groups, and Indigenous support agencies. Such organisations would also benefit from access to the Program, with the downstream outcome of more aspects of the community being knowledgeable about young people's mental health.

In addition to well-known challenges to youth mental health such as socio-economic pressures, mental health literacy and stigma, participants noted significant barriers to accessing support services that would affect uptake of referrals once given by Educators or Practitioners: youth-friendliness or cultural safety of services, wait times and costs (including travel), and a lack of support for the families of children in need.

One final issue that emerged was the presence of individual champions in communities and organisations, and the impact of these on the successful implementation of similar projects. Although positive, such champions present something of a risk to sustainability of effort and highlight the need for systemic support of the Program specifically and young people's mental health more broadly.

Table 7.4 below shows the distribution of these themes across the four communities.

Table 7.3 Themes across communities

General notes regarding upskilling of Educators/Practitioners:

Issue	Mt Isa	Logan	Albany	Cockburn
Organisations may not value CPD points		💬		
Mentoring would be a good dimension to add to training	✓			
Counselling support/resilience training would be good for workers to manage stress & burden	✓			
Some individuals may need a place to go to do online learning (appropriate facilities not available at workplace or residence)	✓			✓
Any sense of Recognition of Prior Learning for existing qualifications			✓	
Need to focus on under-12s – understanding their mental health needs	✓	💬		

Role of schools in young people's mental health:

Issue	Mt Isa	Logan	Albany	Cockburn
Identified as a source of support, information, referral and a mechanism to reach or connect with young people	✓	💬	✓	✓
Guidance officers, school elders and peers all sources of positive support	✓	💬	✓	✓
Positive Learning Units, Pastoral Care systems, in-school mentoring, peer support all positive *systems* items within schools	✓		✓	✓
Sporting/arts organisations (may/not be connected via school) also opportunities to connect with young people	✓	💬	✓	

Challenges to youth mental health identified:

Issue	Mt Isa	Logan	Albany	Cockburn
Isolation/lack of transport to reach supports	✓	💬	✓	✓
Limited local options	✓		✓	✓
Cost of services (e.g. gap payments)	✓		✓	✓
Wait times	✓	💬	✓	✓

Issue	Mt Isa	Logan	Albany	Cockburn
Communications/connections and referrals between services/supports	✓	💬	✓	✓
Mental health literacy/awareness	✓	💬	✓	✓
Knowledge of what is available	✓		✓	
Stigma and confidentiality	✓		✓	✓
Youth-friendliness of available supports/services		💬		
Support available for family	✓	💬		
Cultural appropriateness (language, sexuality, gender, Indigenous status) of supports	✓	💬	✓	✓
Socio-economic pressures: social pressures, food/home insecurity, gendered or otherwise externally determined roles/stereotypes, AOD issues, suicide	✓	💬	✓	✓
Services' ability to attract/retain staff	✓		✓	✓
Funding models determine services available	✓		✓	✓

Other community organisations with potential to support youth mental health identified:

Issue	Mt Isa	Logan	Albany	Cockburn
Beyond Blue and Be You & Emerging Minds (mentioned once each)	✓	💬		
Specialist youth mental health agency: headspace (ubiquitous mention)	✓	💬	✓	✓
General clinical health facilities: hospitals, Aboriginal medical services, child & adult mental health services, private psychologists	✓	💬	✓	✓
Non-health government agencies: Youth Justice, Child Safety, Police	✓	💬		✓
Indigenous support agencies (not specifically mental health): Young People Ahead, Gidgee Healing, Bush Kids, Injilinji, Ngathuarti	✓	💬	✓	
NGOs (general support): Centacare, PCYC, church groups	✓	💬	✓	✓

Issue	Mt Isa	Logan	Albany	Cockburn
Outreach models good	✓	💬	✓	✓
Support provided within funding limitations			✓	

Other community strengths:

Issue	Mt Isa	Logan	Albany	Cockburn
Individual champions of youth and family wellbeing noted – in schools and other organisations – rather than system-wide championing of young people's mental health	✓	💬	✓	

7.10.2 Summary of consultation analyses

Deductive analysis was used to analyse the focus group and interview transcriptions for data pertaining to the key Evaluation Questions and indicators. Key findings from this analysis were that the Program's reach to its intended participants was limited where internet access, technology, and facilities are not readily available. Consistent with other Evaluation activities, issues of time, resources, and competing pressures were all noted as potential barriers to uptake and implementation of learning from the Program. The results also showed that there were mixed perspectives about the online delivery of professional training programs. Those who preferred face-to-face learning modalities suggested that online training lacks interactive and skills-practice components, is hard to access without internet or appropriate technology, and may be less stimulating and engaging. In contrast, those who supported online delivery of professional training programs suggested that online programs are easy to attend, self-paced, flexible and without unnecessary social interactions.

Also consistent with findings from other Evaluation activities was widespread commentary regarding the need for inclusion of culturally appropriate materials, where cultural needs included those for Aboriginal and Torres Strait Islanders, gender/sexuality-diverse people, and people with culturally and linguistically diverse backgrounds. As such, the appropriateness of the Program design was limited for some people in rural and remote areas, those whose preferred learning style was interactive and those with specific cultural requirements.

Areas of further need identified by participants included a desire for guidance around navigating between different resources to better support youth mental health, as well as guidance regarding the evidence base for such resources, suggesting that a robust evidence base is of interest to users. Community members also provided commentary on the dearth of information/understanding about sub-clinical presentations, for example, how to identify children, especially under-12s, as having mental health needs.

Within the context of overall awareness and uptake of the Be You and Emerging Mind initiatives by participants in these communities, these findings suggest that the activities and outputs of the Be You and Emerging Minds initiatives are consistent with community expectations of the Program, but that further development in specific areas would be helpful. The full report for this analysis is presented in Appendix M.

7.10.3 Spotlight Case Study: Rosie's Early Learning, Logan City

Rosie's Early Learning is a long day-care service situated in the City of Logan, and interviews with a range of its staff were included in the Logan Community Case Study. Rosie's Early Learning is rated Exceeding under the National Quality Standard for early education and care. Families accessing the service are from a diversity of cultural and social backgrounds, and include families with an inter-generational history of trauma.

The service provides an example of Be You implementation in practice and the use of Emerging Minds resources. Rosie's Early Learning has a strong philosophy of ongoing professional learning that is enacted through selection of a focused "research area" that is undertaken collaboratively by all centre staff across a defined period of time, typically a school term. This spotlight case study illustrates how the Program can be used and implemented when accompanied by optimal organisational supports and identifies some key factors critical to this successful implementation.

A collective focus on child mental health

In 2020, the research focus selected by Rosie's staff was trauma-informed practice. The service identified its position as an early years provider as one that was important in early identification of, and intervention for, mental health problems. It also recognised the need for high-quality training:

"We are not mental health professionals so we need to learn as much from the professionals as we can to successfully work with children."

The service identified Be You and Emerging Minds as focus resources to undertake its program of learning. The leadership team identified these programs through presentations in the Logan City Council's interagency network. The leadership team felt the Be You training was well tailored to their needs:

"I wanted not to overwhelm our team and to be very precise with the training." **Member – leadership team**

"Be You is an integrated program that you bring to a team. Its modules online have a really nice sequential learning process. … Emerging Minds has a lot of resources that can be brought into the team." **Member – leadership team**

The team had engaged with other programs in mental health training. From this experience, they were clear that criteria for uptake of further training must align with their value systems and a pedagogical philosophy of engaged learning (*giving us good data to think about*) rather than didactic (*this is how you do it*):

"What's more important to me is an alignment with values, ethics and the pedagogy." **Member** – **leadership team**

The management team were also clear that costs of professional development, both monetary and staff time, meant selection of Programs was important:

"People give up time for professional development … I want (my staff) to leave thinking that was definitely worth my time."

A collective engagement with Be You

Engagement with Be You commenced with a Zoom meeting with a Be You team member who gave an overview of the modules and navigation of the website. In engaging with Be You, a whole-of-centre approach was taken in which implementation was shared and reflected upon. Groups of Educators undertook different modules, bringing their learning back to the whole team at staff meetings for discussion before moving to another group and module. In this way learning was collaborative and critically reflective:

"We are currently engaging in Be You online training So we've teamed up all of the educators into groups so each group will engage in one of the modules. So there are four groups. They're all doing a different module. They'll come together at staff meeting, put together the information they brought from it and present it to the rest of the team and then they'll swap groups."

Response to Be You and Emerging Minds

At the time of interviewing the staff at Rosie's, the team were at the beginnings of working with the Be You initiative and tapping into the Emerging Minds resources.

The response from the leadership team and the diversity of the Educators (varying from Certificate III through to degree qualified) was extremely positive:

“For the leadership team the Be You program covered content not integrated into pre-service training of educators. I don’t feel any early educator, to be quite honest, without doing some precise learning around this stuff and ongoing learning could be prepared. It is definitely not in the courses ….”

The content was seen as appropriately pitched:

“There’s some good stuff there … content is not over their skill-set.”

“(We’ve) all enjoyed working through the modules – really informative. No one has come back and said it is really boring and we’re quite open.”

“They’re simple language. There’s no jargon in it, and that’s what I think turns people off.”

“Appeal to beginning educators as well as more skilled ones.”

The response from Educators, similarly, was very positive:

“The readings that you could access were really good – it (Be You) was really good as well … It was written in a way that everybody would be able to understand.”

“It gives you awareness of things to look out for … Make you more self-aware I mean we were already on track because we were researching but it really supported that research for me.”

“Mental health is a serious issue. But … presented in a friendly manner, well for myself anyway, it makes me more inclined to sit and listen to it, rather than have a professor, probably in a suit and tie … it’s kind of off-putting.”

“It’s free and accessible to me … I can do it at home.”

The Educators clearly described a positive impact on their practice with children and families:

“Yeah. I think it is hard to understand sometimes when you have not had a trauma background … but when you learn about it and when you see it in action it all makes sense. What you’ve learnt about it, it all makes sense.”

One notable message that came through the responses from staff was that engagement with Be You had assisted the team through the disruptions of the COVID-19 pandemic. In this centre, many children “at risk” could not come into the centre. The centre responded with connection at distance:

“I’d say some of the (Be You) work we‘ve already done has influenced the way we thought about it (connection during COVID) and the importance of it”

Reaching out to community

Beyond the centre, the Rosie’s team felt the Program also reached out to the broader community. They utilised their own learning and the resources embedded within Be You and Emerging Minds to disseminate to families:

“I am explaining to (families at church) things that come through Be You but in my own words to them.”

“I often use Emerging Minds stuff for families … the podcasts through Spotify in Emerging Minds, for example, is you know really excellent to have.”

“The articles we have printed out sometimes and put in the centre for parents to take home as well.”

Key success factors

- ✓ Awareness – Logan is a well-connected community and Be You and Emerging Minds were promoted through key networks
- ✓ Advocates – champions in community and work sites
- ✓ Accessibility – materials were free, could be shared as a group and were “approachable”

- ✓ Appropriateness – materials were well tailored for purpose – in the case of an Early Childhood Centre this also meant for the diverse levels of education of staff

7.11 Discussion

The Community Case Studies were designed to explore the reach and influence of the Program within local place and context among community Practitioners, Educators and parents/carers within specific local places and contexts. This activity sought to understand the different contexts in which the Program operates, to examine the effectiveness of the Program against a background of community service integration, contextual risks, and local capacities to respond effectively and strategically to support child and youth mental health.

The inductive analysis of the Community Case Studies elicited a series of themes that emerged from each community context, and themes about the mental health concerns for children and young people within each community. These themes included structural/system issues (e.g. access to clinical services), community attitudes (e.g. stigmatisation in community), Program-related issues (e.g. community perspectives of issues of high need), and cultural/Indigenous cultural approaches (e.g. need for tailored support). The themes that emerged for each community highlight the different place-based contexts that the Program operates within and opportunities for tailoring the approach and support for some communities.

The artefact analysis further highlighted ideas of community assets, mental health concerns, and directions for improvement and change. Findings suggested that community members value ongoing upskilling of Educators and Practitioners. The analysis also showed that community members agree that schools play an important role in young people's mental health, but that there are a range of other community organisations and other community strengths that may also be well-placed to address young people's mental health. Challenges to young people's mental health included socio-economic pressures, mental health literacy and stigma, and barriers to accessing support services. These findings reflect the ideas that also emerged from the focus groups and individual interviews.

The Spotlight Case Study provided an example of Be You implementation in practice and the use of Emerging Minds resources. The Spotlight case study illustrated how well the Program can be used and implemented when accompanied by optimal organisational supports and identified some key factors critical to this successful implementation, which mirrored issues raised in other community consultations (e.g. promotion of the initiatives through key networks, individual champions in communities and organisations, accessible free resources, appropriate resources that were tailored for purpose). Overall, the case study highlighted the efficacy of a structural whole-of-organisation approach that supported implementation of the new learnings from the Program across the ELS setting.

The deductive analysis of the focus group and interview data against the Evaluation Questions and indicators highlighted some opportunities for improvement, including the need to consider equity of access for some areas where internet access, technology and facilities are not readily available. The results also revealed mixed perspectives about the mode of delivery of professional training programs, highlighting areas for consideration for those whose preferred learning style was interactive. There was low level of awareness/uptake by the participants from these communities, which was consistent with available data on Program reach from these areas. This finding likely reflects the early stage of implementation when this activity took place. The multitude of providers of professional development and wellbeing support for children and young people's mental health reported by Participants also highlights the complex environment in which the Program operates and may effectively need to compete for recognition and use by members of the community.

Strengths and limitations

The strength of this Evaluation activity was that it enabled a "deep dive" into the experiences of children and young people's local support networks, and the enablers and barriers they experience in seeking support around mental health. Cultural inclusion was integral to the consultation approach, with specific attention given to ensuring the voice of Aboriginal and Torres Strait Islander people was heard and that issues relating to social and cultural disadvantage were able to be raised. This activity built upon the qualitative research

conducted by the initiatives' individual evaluations by contributing place-based information relevant to the experiences, uptake and impact of the specific initiatives in four communities where mental health concerns were prevalent.

The findings of this Evaluation Activity need to be interpreted with respect to the stated limitations These limitations include that the findings are not generalisable due to sample size and participants not being representative of the broader population. Similarly, the communities chosen are not representative, and will not generalise to other communities. However, the intent of this activity was not to seek representative samples, but to allow specific contexts to be explored; the congruence of issues raised across these differing contexts may suggest broad applicability of the concerns raised.

Additionally, this evaluation activity took place over a short period of time during the early phase of Program implementation. The initiatives have rapidly expanded their reach over time (see Integrated Data Analysis) and have undertaken significant work and development since these data were collected. The findings from this activity present a point in time just before the impact of COVID-19 and associated public health measures began for most of the communities consulted. Participants from one community (i.e. Logan City) were interviewed one-on-one via teleconferencing or videoconferencing (rather than participating in focus groups) due to the onset of COVID-19 related public health orders that restricted movement and gatherings. These one-on-one interviews present a point in time in the very early period of these COVID-19 restrictions for these participants.

Conclusion

Despite low levels of awareness/uptake of the initiatives by the participants from these communities, the Community Case Studies provide valuable information about the context of the Program in the community, and whether community needs are being met by the Program or not. Significantly, many of the issues raised echo findings from other Evaluation activities. Importantly, consulting with these communities may inform ongoing Program activities by identifying different place-based contexts in which the Program operates, and the associated additional opportunities for tailoring the provision of support by the initiatives to communities with more prevalent mental health concerns.

8. Conclusions

A range of early indicators are consistent with the Program's intent to build capability in Educators and Practitioners to support the mental health and wellbeing of children and young people. The Program is still in a relatively early phase (2–3 years since launch dates) of implementation. Although experiencing some initial delays and timeline challenges, the Program's delivery organisations have worked to rapidly meet and exceed ambitious recruitment targets for their respective initiatives and have shown themselves to be responsive to evaluation findings. The level of change in response to the Program observed by the Overarching Evaluation is consistent with the expected stage of maturation predicted by the Program Logic. The next step for the Program is to work to embed frameworks within systems and monitor the outcomes and impacts of the Program at the child and family levels.

8.1 Summary of findings

The Program was implemented largely as expected according to the organisations leading the delivery, but the period of implementation was marked by extraordinary disruption to the way of life of children and young people, and the people and systems who support them. The intense bushfire season of 2019–2020 and the COVID-19 pandemic were major historical events that had widespread impacts, including for the operation and evaluation of the Program.

Recruitment of Educators and Practitioners to the Program initiatives has increased over time, and in alignment with targets, but with low levels of engagement and practice-change reflecting the early phase of implementation. The Program has targeted an appropriate (although not exhaustive) range of people in professional roles who interact with children and young people, with the proportion of individuals reached in these roles by the Program increasing overtime. The Overarching Evaluation findings indicate that there was breadth of coverage in geographical terms based on the registration and engagement data provided. However, the approach to implementation was at first broad and universal, with limited targeting of the initiatives to recruit users who work in higher needs areas or users who work with diverse and higher needs groups of children and young people. The extent to which the service coverage of the Program was perceived to be equitable by users was mixed, and issues of inequity were found with digital access to online environments, especially in regional and remote areas.

The initiatives' design, philosophy and content development are evidence-informed. The majority of users engaged with by the Overarching Evaluation activities indicated that they were satisfied, for the most part, with the initiatives. Users reported that the quality of the professional development of both initiatives was excellent. However, only a small proportion of users agreed that the initiatives provided them with everything they needed to support the mental health of children and young people. Although the objectives of the Program are aligned with improving integration with existing services (e.g. by improving confidence and understanding of referral pathways), the Program does not address the barriers to accessing health services or gaps in service coverage. Addressing these barriers is outside of the scope of the Program, and the extent this is addressed by Government through broader reforms was outside the scope of the Overarching Evaluation.

Evidence of capability development, consistent with the Program Logic, was found for Educators exposed to the Be You initiative, including improved mental health literacy, improved knowledge and confidence to refer children and young people as needed to external supports, improved use of evidence-based information, and improved knowledge and confidence to respond following a suicide in the learning community. Practitioners exposed to the Emerging Minds initiative reported a high baseline of knowledge and confidence to support children experiencing, or at risk of experiencing, mental health challenges, likely consistent with their professional training, work roles and settings. The impact of the Emerging Minds initiative may be better evidenced by downstream organisational, child and family level indicators.

The assessment of these downstream indicators of child, youth and family level mental health and wellbeing for the Overarching Evaluation was limited by practical constraints around the timely availability of relevant

and appropriate data. The Program's implementation is within the very early stages (2–3 years since the launch of the initiatives). This reflects an early stage in eventual translation to benefit for children, young people and their families, and longer term benefits to community and other social supports. Although it is likely to be too early to see a significant impact of the Program on these critical intermediate and long-term outcomes, there is a need to monitor these outcomes over time as the Program matures. Consideration of the complex policy environment, including the range of Commonwealth and state and territory government programs and services that have been (or will be) implemented on the continuum of early intervention and prevention for child and youth mental health support, will be important to contextualise the impact of the Program. The ways in which these other services and supports intersect with the Program present substantial challenges to attributing change.

Lack of time was consistently identified by Program users as a barrier to accessing and applying the learnings of the Program. The time costs associated with the implementation of the Program was also evident with the high opportunity costs reported in the Value for Money assessment, where the opportunity cost of time was the highest component of all other costs. Despite this, the vast majority of users reported that it takes no more or much less time to engage with the initiatives' resources than available alternatives, and that it is much less costly for users to engage with than available alternatives. The Value for Money assessment indicated that the Be You initiative demonstrates economies of scale with increasing uptake by Educators. Although there was insufficient data for a formal Value for Money assessment of Emerging Minds, it is expected that a similar pattern of results would be found based on the commonalities of initiative design.

Strong uptake of the Program's initiatives suggests that there is a strong imperative from individuals and learning and service settings to engage with resources and information to support the mental health and wellbeing of children and young people. However, findings from the Overarching Evaluation suggest that further progress is required to ensure that the Program is suitable for a broad range of needs of users and to reflect the needs of the community. To optimise the impact of the Program, an emphasis on large-scale organisational change is needed.

8.2 Summary of recommendations

This report was prepared for the Department of Health and the recommendations are intended to guide the Department in working with Be You and Emerging Minds to improve their initiatives in alignment with the objectives of the Program.

While many of the recommendations relate to the operations of the individual initiatives, there are some recommendations that relate specifically to the Department's role as funder of the Program, and the ways in which the Department can influence the achievement of the Program objectives.

The Australian Government and the Department also have a range of levers that can be employed, beyond the initiatives comprising this Program, to influence the effectiveness of the Program. These include leveraging incentives to improve the availability, accessibility and scope of mental health services to support children, young people and their families at a system level. Such improvements are beyond the scope of the Be You and Emerging Minds initiatives, but are essential to ensure that the widespread improved knowledge and practice achieved through the initiatives, once maximised, do not result in unmanageable pressures on services or delays in providing support. Working in concert with service development, the Program can then result in the improved mental health and resilience of children and young people, and the reduced risk and impact of suicide in this age group, as originally envisioned.

Recent national developments in mental health policies and strategies, including funding announcements from the recent 2021-22 Federal Budget (see section 1.5: Policy context) may interact with the ways in which the Program and its outcomes develop going forward.

The recommendations detailed in this report are grouped under the following categories:

- the structure of the Program

- evaluation and monitoring priorities
- implementation advice
- Program alignment and integration with external mental health support services
- whole-of-setting engagement
- equity of access
- blended delivery model
- the evidence base
- data issues and information gaps.

These recommendations build upon the "Considerations and Future Opportunities for Be You and Emerging Minds Brief" provided to the Department on 3 March 2020, which was provided to assist in improving the targeting and management of the Program.

The recommendations provided in this report acknowledge the challenges and opportunities for the future development of the Program and provide advice on change. With continued development, the Program has potential to make a valuable contribution to children and young people's mental health by facilitating practice change and capability development among key actors in the community who work in roles that support them. Table 8.1 below presents the full summary of the key recommendations of the Overarching Evaluation.

Table 8.1 Summary of key recommendations of the Overarching Evaluation

	Context	Recommendations for future development of the Program	Timeframe
Structure of the Program	Further collaboration between Be You and Emerging Minds should continue to identify areas of crossover and alignment, build on strengths and capitalise on efficiencies.	The Department to facilitate increased collaboration between Beyond Blue and Emerging Minds to: • better coordinate their approaches to monitoring Program outcomes • strengthen information-sharing processes • build mechanisms to foster ongoing synthesis of evidence and sharing of evidence • avoid duplication of effort and redundancy of content • explore opportunities for "collective impact" • explore opportunities to bridge connections between Educators and Practitioners.	Short term
Evaluation	As the Program matures, increased focus should be given to moving from process and activity-based reporting to outcome-based reporting. Agreed, robust, consistent outcome measures of change in Educator and Practitioner capability are needed. Additionally, agreed, robust, consistent outcome measures of social and emotional wellbeing in	The Department to: • align the requirements of the individual initiatives' evaluation imperatives to move toward an outcomes-focused approach • reduce activity reporting burden on initiatives • work with Be You and Emerging Minds to continue to support a continuous quality improvement approach • work with Emerging Minds to build its capability and capacity in data analytics. Emerging Minds may require further	Medium term

	Context	Recommendations for future development of the Program	Timeframe
	children and young people are needed to monitor the overall benefits and impacts of the Program.	funding, consultation and support to do this work. • Conduct future outcome- and impact-focused evaluations consistent with the Program's Theory of Change and with built-in continuous feedback mechanisms to ensure that initiatives remain responsive to the original scope and objectives of the Program.	
Implementation by context and need	There are opportunities to improve targeting of initiatives to better tailor information, resources, programs and servicing to Educators and Practitioners working with higher needs or diverse groups of children and young people. Although there is some evidence that the initiatives, particularly Emerging Minds, are making progress to address these issues with new learning pathways/content, further progress is required to address these unmet needs.	The Department to consider: • reducing emphasis on recruitment targets and set targets for the level of engagement within participating settings • expanding the scope for the Program to increase its reach to key community groups who interact with children and young people. The Department to work with Be You and Emerging Minds to consider the following (which may require further funding and support): • Attention should be paid to local school and community context: explore ways to leverage local knowledge and use data to inform regional level planning for consultant activities. • The Program should make progress toward making resources and services for each initiative more relevant for diverse user and beneficiary groups in the next funding period. • The Program should consider additional professional learning and resources to support users who work with higher needs or special groups of children and young people. • The Department to continue to work with the initiatives to address the structural barriers to implementation of the Program reported by users. • The Department to consider the emerging recognition of the need for appropriate mental health services for early childhood (1–5 years). • The Department to consider the role of the Program in meeting the needs of young people (+12) who have disengaged or been excluded from education.	Medium term

	Context	Recommendations for future development of the Program	Timeframe
Program alignment & integration	The success of the Program is premised on a range of assumptions, including that broader mental health systems and services have maintained or improved their capacity to address referrals and interactions from Educators and Practitioners. Improving knowledge, awareness and confidence of Educators and Practitioners to refer children and young people to appropriate supports is only one component of improving access to early intervention services for children and young people at risk of, or experiencing, mental health difficulties. Building this capacity does not directly address issues with accessing services (availability, timeliness, location, affordability) or fill service gaps. These barriers to access were frequently reported by Educators and Practitioners as preventing them from being able to support child and youth mental health. Although schools may be an effective gateway to the broader mental healthcare system, system-level accessibility issues are not addressed by the Program.	The Department to: • consider tracking external mental health service capacity and any other changes in context that might bear on the utility of the Program. Specifically, monitoring the capacity to meet increasing demand for services as Program users become more confident to refer, and monitoring the breadth of available services to ensure that the specific needs of children across a range of ages and mental health problems are met • consider the alignment between clinical capacity in current support systems and potential changes in referrals to these because of the Program • identify and remove barriers to accessing mental health services and supports • ensure targeted activities of the initiatives retain alignment with the longer term objectives of the Program	Long term
Whole-of-setting engagement	Individual Educators and Practitioners reported a range of barriers to supporting child and youth family health. School/organisational structural and leadership support of initiatives can address many of the common barriers that individual Educators and Practitioners report facing (e.g. lack of time, competing priorities, role confusion). A whole-of-school/service and organisation	The Department to • consider clarifying the policy intent of the Program to emphasise whole-of-setting changes • identify enablers and barriers to whole-school/whole-organisation uptake • leverage positive drivers of engagement, for example professional accreditation or Continuing Professional Development (CPD) recognition • collect rigorous data on school/organisation-level of engagement, accountability, activity and outcomes.	Medium term

	Context	Recommendations for future development of the Program	Timeframe
	approach empowers individual users to utilise external supports and services. Whole school/organisation "buy in" promotes a consistency of approach to child and youth mental health and wellbeing within the setting.		
Equity of access	Issues of inequity of access were found related to digital access to online environments, especially in regional and remote areas.	The Department to consider barriers to equity of access to the Program and the potential utility of supplementary face-to-face services aligned with the Program.	Long term
Blended delivery model	The predominantly online mode of delivery allows for scalability and sustainability of the Program. However, the blended model of delivery (website platform with consultant support) is appropriate to deepen engagement and address the needs of users who have needs that cannot be sufficiently met by online resources or who have alternative learning preferences. The use of consultants in some form is needed, particularly at important points of engagement with schools and organisations (e.g. early in engagement or after critical incidents). Awareness of and satisfaction with the current blended delivery model was mixed.	The Department to review funding to ensure initiatives have sufficient resources (e.g. consultant workforce) to support the blended delivery model as increasing numbers of early learning settings, schools and organisations engage with the Program. The Department to work with Beyond Blue and Emerging Minds to: • promote benefits of online access • promote role and functionality of consultants • ensure there is sufficient capacity for consultant support targeted at areas of higher need.	Short Term
Evidence base	The design of the Program's initiatives was mostly informed by the evidence, but there was limited evidence for an effectively evidenced implementation and dissemination strategy for both initiatives, or for a whole-of-Program strategy.	The Department to work with Emerging Minds and Be You to: • continue to foster "culture of evidence", including diversity of evidence types (e.g. considering clinical/Practitioner knowledge, lived experience) • continue to consider and build in "evaluability" for any new initiative developments • develop overt Program level strategy for evidence dissemination	Medium term

	Context	Recommendations for future development of the Program	Timeframe
		• follow recommendations from implementation science for further roll-out and scale-up.	
Data issues and information gaps	This Overarching Evaluation was limited by the lack of reliable and valid data about the geographical reach of the initiatives, which limited the types of analyses that could be completed, impacting the extent that we could describe the reach of the Program and attribute change to the Program.	The Department to: • explore opportunities to encourage embedded data collection on wellbeing outcomes for children and young people in all jurisdictions and learning settings, including early learning services. These data would need to be nationally consistent to inform ongoing evaluation of the Program and other wellbeing programs delivered in learning settings. This is consistent with the Productivity Commission's recommendation to "collect nationally consistent data on student wellbeing and use it to report on progress against the outcomes in the national agreement, inform policy planning and improve schools' implementation of a social and emotional wellbeing curriculum" • improve data collection by Emerging Minds, Beyond Blue and their delivery partners to support Program-level evaluation, for example, accurate demographic and geographical data, identification of Practitioner roles by ANZSCO identifier codes, and valid data on level of engagement/exposure to the Program (i.e. participation of individuals in modules, module completions, assessment of module learning) • build in evaluability for any future iterations of the Program (e.g. use of regional pilot trials with a well-defined control group) • improve alignment between evaluation types and Program activities for any future initiatives to ensure that implementation is appropriate (process evaluation) and outcomes meet the expectations of the Program (outcome or impact evaluation).	Short term

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Appendix A: Program Logic and Theory of Change

Program Logic and Theory of Change

This Program Logic model looks at the way that the National Education Initiative and the NWC initiative work in large-scale to achieve the aims of the National Support for Child and Youth Mental Health Program (the Program), in order to show how the over-arching evaluation will synthesise and add value to the individual evaluations.

Definitions, abbreviations and notes

The following terms are used to describe the components of our over-arching Program Logic:

Problem statement: describes the nature and extent of the problem that needs to be addressed by the Program

Goal: The higher order program or sector objectives that the Program is intended to achieve

Inputs: Financial human and other resources used to undertake activities which are expected to produce outputs

Output: A defined quantity of things, events and services provided by the Program

Outcomes: Changes that are expected to occur after the delivery of an output or several outputs; outcomes are broken down into early, intermediate, and long term, with timeframes defined for the Program (see below)

Impact: Change in context as a result of interventions, events or trends; often much longer term

For the purpose of this Program Logic, we use the term 'Practitioners' to include Educators, early childhood (EC) workers, clinicians and non-clinical professionals (NCP).

The term 'whole of setting' refers to a school, a professional practice or an organisation in which a group of Practitioners operates.

Other abbreviations used are as below:

EC = early childhood

EI = early intervention

DOH = Department of Health

MH = mental health

NCP = non-clinical professionals

NEI = National Education Initiative

NWC = National Workforce Centre

Developing the Program Logic

In developing this Program Logic, a Draft Program Logic (dated 1 August 2017, as provided by the Department, see Evaluation Framework Document) was reviewed, as well as the component Program Logics for the National Education Initiative and the NWC. After considering the documentation available to us regarding the overall Program, a simplified model of the Program and its Logic was drafted for the purpose of the Program Logic Workshop. To assist with this process, simplified descriptions of the components of each initiative were used. This was not to de-emphasize components of either initiative, but instead to provide utility in understanding commonalities and divergences between the approaches, and in focussing on their contributions to the overall Program.

This evaluation design workshop was attended by representatives from Beyond Blue, the NWC, the Department, and the Scientific Advisory Group. The resulting Draft Overarching Evaluation Program Logic was provided to the Department; subsequent feedback has been incorporated into this version.

The language used in this Program Logic aims to reflect a synthesis of the component individual evaluations, documents describing the Program purpose, and to align with the Evaluation Questions developed with input from the stakeholder groups.

Elements of the Program Logic

Problem statement

The mental health of young Australians is at risk. Suicide rates are high and appear to be increasing. Transition points, such as the transition from primary to secondary education, are important. There is a need to integrate the current good but disconnected programs that address this issue.

[Derived from the Contributing Lives review – National Mental Health Commission, 2014]

Elements of the **Program Logic** are described here and refer to the Figure below:

Vision/Goal

That the mental health and resilience of children and young people improve, and the risks and impacts of suicide in this age group are reduced.

Program aim

The National Support for Child and Youth Mental Health Program contributes to improving mental health outcomes for children and young people, commencing with the early years and going through to adolescence, by providing targeted grants for workforce and education activities that will build capabilities aligned to the Program objectives.

[Derived from the Draft Program Logic: National Support for Child and Youth Mental Health Program Logic 1 August 2017]

Inputs/activities

Adopting the over-arching perspective, some of the activities and outputs of the individual initiatives (e.g., the National Education Initiative and NWC and their online learning portals) and their outcomes (e.g., improved capacity of Educators/clinical and non-clinical workforce) are here considered inputs and activities respectively for the over-arching Program. As such, information regarding these should be collected as part of the individual evaluations. These elements are shaded in blue (National Education Initiative) and green (NWC) (Table A.1 below).

Where elements refer to the way in which the National Education Initiative and NWC work together as part of the Program, those elements are shaded grey.

Where elements relate to the over-arching perspective of the Program (rather than the component initiatives), those elements are shaded in purple.

Elements reflecting the activities of the evaluation process or continuous improvement stream are shaded in orange.

Outcomes (initiative level)

These are outcomes of the component initiatives and should be captured by the component sub-evaluations (marked as “sub” in the Program Logic). Information from the sub-evaluations will be used to inform assessments of these outcomes. Where mechanisms to collect this information are not apparent in the sub-evaluation plans to which we have access, the Evaluation Team will seek other mechanisms to address this outcome.

Where outcomes are reflected in the broader community, rather than among Practitioners or schools/services, those are considered under the overarching perspective (marked OA in the Logic).

Outcomes (early)

Early outcomes are those for which emerging evidence may be available within twelve months of the component initiatives being launched. These reflect changes in workforce responsiveness, evidence of implementation of best practice by individual Practitioners, evidence that whole-of-setting engagement is taking place, and that interactions with the community are taking effect.

Outcomes (intermediate)

Intermediate outcomes may show emerging evidence within the first two-three years of Program operation (i.e., within the timeframe of the evaluation); further monitoring may be required to substantiate early indicators of change.

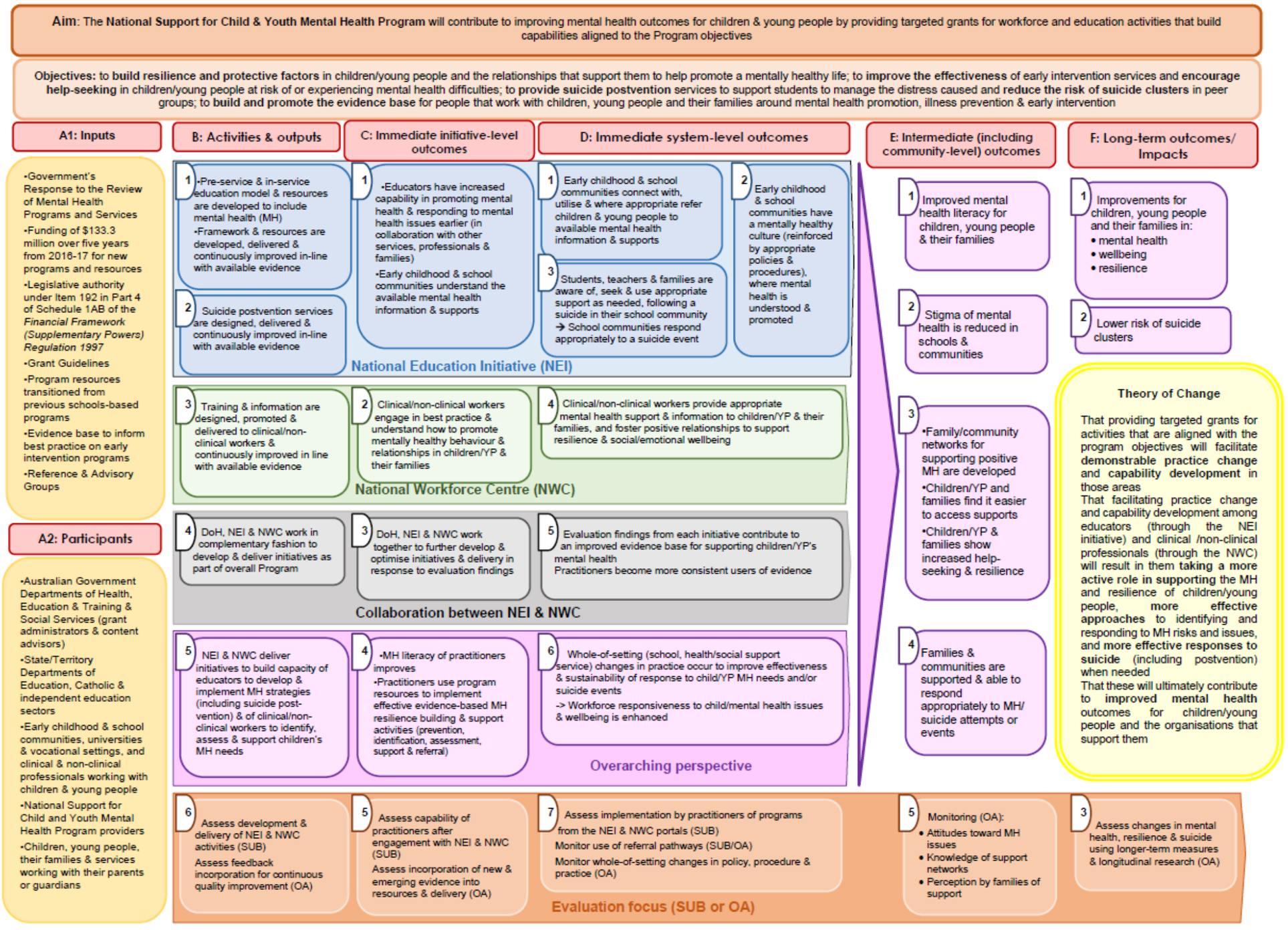
Impact (long term)

Longer-term outcomes or sector-wide impacts may not be evident within three years of Program operations, and may require longer-term monitoring (e.g., up to five years, or through longitudinal research, i.e., beyond the timeframe of the evaluation) to be assessed.

Table A.1 Colouring of Program Logic elements

	Blue boxes: relate primarily to the National Education Initiative (NEI)
	Pale green boxes: relate primarily to the National Workforce Centre (NWC) initiative
	Grey boxes: relate to collaboration and synergies between the initiatives
	Purple boxes: relate to the over-arching perspective of the Program
	Orange boxes: relate to evaluation/continuous improvement facets of the Program

Figure A.1: Program Logic for the over-arching evaluation



A Theory of Change is the empirical basis underlying any social intervention; it articulates the cause-effect relationships between the Program inputs, activities and outputs and the expected outcomes and impacts. This Overarching Program Logic (above) illustrates a Theory of Change for the Program that expects:

That **providing targeted grants** for activities aligned with Program objectives will facilitate **demonstrable capability development and practice change** among teachers, early childhood Educators, clinical and non-clinical professionals who work with children.

That the two initiatives (National Education Initiative and NWC) will work in a **complementary** manner to reach the full spectrum of Practitioners who work with children,

That the two initiatives will be **responsive to evaluation** findings and use a continuous improvement framework to optimise the Program over time, and that these findings will **enhance the evidence base for** the support of children/young people's mental health.

That facilitating capability development and practice change in **Educators** will result in them taking a **more active role** in supporting the mental health and resilience of children & young people and providing effective responses to suicide (including postvention) when needed

That facilitating practice change and capability development in **clinical and non-clinical professionals** will result in **a more effective approach** to identifying and responding to mental health risks and issues ultimately contribute to improved mental health outcomes for children, young people and the families, communities and organisations that support them.

That developing a **whole-of-setting approach** to addressing mental health issues in schools or services that work with children will support more **sustainable** change.

That encouraging schools/services to **interact with families and communities** will facilitate a community-wide approach to supporting positive mental health and support a **more mentally healthy culture**, including a reduction of the stigma attached to mental health.

That a mentally healthy culture and broader mental health literacy (for children, families, Practitioners and the community) will contribute to improved mental wellbeing and resilience of children and young people.

That **changed perceptions** of mental health, improved mental health and enhanced school/service responses will reduce the risk and impact of suicide among children and young people.

Assumptions

This Program relies on the following assumptions:

- That funded activities will align to the Program objectives and to best practice
- That Practitioners will engage with and make use of the resources and use these to build their own capacity to address mental health needs of children/young people
- That Practitioners will implement new knowledge and capacity in school/service settings
- That children/young people and their families will engage with the supports made available to them
- That communities will engage with the education/service settings in which change is being affected

External factors

The following external factors may affect the way in which the Program is implemented or the way in which its outcomes develop but are outside the sphere of influence of the Program itself. As such, these should be considered in undertaking this evaluation:

- Changes in availability of ongoing funding and/or Commonwealth support for the Program
- Changes in the capacity of education/service settings to implement better practice in mental health support for children/young people
- Other initiatives in place or implemented during the course of the Program to build capacity of Practitioners, improve young people's mental health and resilience or promote healthier community attitudes to child/youth mental health and suicide
- General other conditions which affect the quality of life of young Australians

Appendix B: Simplified Indicator Matrix

Question	Sub question	Indicators	Data Source
1. How well has the Program been implemented?	a. To what extent has the Program been implemented as expected?	1. The extent that The Program is implemented as it was prescribed (adherence to implementation plans and protocols) by a) Beyond Blue and Emerging Minds and b) consultants.	i. **NEI Implementation Evaluation indicator(s):** "67. Consultants adherence to implementation plans and protocols". [BB] ii. **Emerging Minds:** Emerging Minds performance reports (e.g., no. of resources developed, workshops delivered, downloads from website) iii. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]
		2. Extent that the initiatives collaborated with each other and with reference groups during the development and across delivery of The Program.	i. **NEI Formative Evaluation indicator(s):** "The degree to which stakeholders felt they were adequately included in the design process", "Establishment of stakeholder engagement and breadth of relevant stakeholders", "Establishment of Technical Advisory Networks with Australian experts to advise on the design process". [BB] ii. **NEI Implementation Evaluation indicator(s):** "103. Consultation and collaboration with key education and mental health stakeholders – number of key stakeholders engaged and how". [BB] iii. **EM:** Dates of meetings (e.g., program logic, evaluation subcommittee, implementation subcommittee, regular joint meetings) v. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]

Question	Sub question	Indicators	Data Source
		3. The extent to which initiatives have adopted continuous evaluation (including robust consistent outcome measurement) at the ground level and respond to generated evidence (i.e., have an implementation cycle), if prescribed.	i. **NEI Formative Evaluation indicator(s):** "Stakeholder satisfaction that their views have been reflected in the final design". [BB] ii. **NEI Implementation Evaluation indicator(s):** "93…. Number of NEI in-school surveys completed", "94…Number of NEI in-school surveys completed". [BB] iii. EM: : Internal evaluation reporting cycle, CQI sessions with national to local consultants, CQI sessions with workforce development officers, reporting cycle of resource outcome measurement and user interaction with steering group iv. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]
	b. To what extent has implementations varied across different contexts?	1. The extent to which Beyond Blue and Emerging Minds delivered their initiatives to different contexts (e.g., different population groups, geography, service types)	i. NEI Implementation Evaluation indicator(s): Indicators 43-51 [BB] ii. EM: : Participant demographics at registration and participant demographic data relevant to EM impact iii. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]
		2. The extent to which users (Educators and Practitioners) working in different contexts used the Program to change their practice*.	i. NEI Implementation Evaluation indicator(s): Indicator 110 [BB] ii. **EM Evaluation Framework outcome/measure/indicator:** Pre-post workforce Questionnaire (Practitioner survey of knowledge, attitudes skills and practice) [EM]

Question	Sub question	Indicators	Data Source
			iii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
	c. To what extent has the Program reached the intended participants	1. The proportion of disadvantaged (i.e., high risk) areas reached by the Program	i. **NEI Implementation Evaluation indicator(s):** 25. Indicators denoted with 1 by CRM organisation data" [BB] ii. EM Evaluation Framework outcome/indicator/measure: "Increase access… [key outcomes]" [EM]
		2. Extent to which users and stakeholders agree that the Service coverage/provision is designed to be equitable, needs-driven.	**i. NEI Formative Evaluation indicator(s):** "The extent to which design considers needs of end users", "Consultant satisfaction that initiative meets user needs", and "State and Commonwealth Department of Health and Education, as well as bbNEI consultant, **satisfaction that program reflects all contexts" [BB]** ii. EM: Stakeholder consultation measures. Relevant questions on e-learning, workshops and webinars. iii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		3. Extent of geographical reach of each initiative.	i. **NEI Implementation Evaluation indicator(s):** "18-20" by CRM organisation data [specifically geographical region, if known] [BB]

Question	Sub question	Indicators	Data Source
			ii. EM Evaluation Framework outcome/measure/indicator: "Increase access…[key outcomes]" [BB]
		4. Number of users and proportion (if denominator available) by role type reflects the potential pool of people who interact with children.	i. **NEI Implementation Evaluation indicator(s):** "22. Number or registered users by role type" [BB] ii. **EM Evaluation Framework measure:** "Increase access…[key outcomes]" [EM]
		5. Extent that the number of users and registrations (i.e., schools/ELS) of each initiative aligns with targets and increases over time.	i. **NEI Implementation Evaluation indicator(s):** "18. Number of ELSs and schools registered with the NEI", "19. Number and proportion (if denominator known of educators and Action leaders within each learning environment registered with the NEI", "20. The extent to which registration in the NEI in ELSs and schools has aligned with registration targets", 39. Number of registrations (pre service educators), "81. Number of new registrations over time (both individual educator and Action Team Leaders/leadership". [BB] ii. EM Evaluation Framework Outcome/Measure/Indicator: Numbers trained [EM]
	d. To what extent is the Program aligned/integrated with existing services?	1. Extent of the Program's overlap (e.g., age range, location, delivery environment) with State programs targeting child and youth mental health.	i. Environmental Scan [UQ]
		2. The degree to which Educators and Practitioners report feeling confident in their ability to connect with, utilise and, where appropriate, refer children and young people to mental health	i. **NEI Implementation Evaluation indicator(s):** "113. Educators report a change in confidence responding to mental illness in their education settings", "114. Educators report improved knowledge of how and where to refer learners and families to mental health services", "115.

Question	Sub question	Indicators	Data Source
		supports compared to no Program. *	Educators report improved understanding of their capabilities, including when to appropriately refer learners and families to mental health services". [BB] ii. **EM Evaluation Framework measures/indicators:** "Numbers in work-force who can confidently identify, assess and support/refer children at risk and promote resilience [measures]", [EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		3. The degree to which Educators and Practitioners report changes to ways of working with, or referring on to, other mental health settings, compared to no Program*	i. **NEI Implementation Evaluation Indicator(s):** "113. Educators report a change in confidence responding to mental illness in their education setting", "85. Reported ELS and school features that support practice change". [BB] ii. **EM Evaluation Framework outcomes/measures/indicators:** "- have there been less or more tertiary referrals such as to CAMHS or CP, or a reduction of inappropriate referrals? [EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
	e. What are the implementation lessons?	1. Reported enablers and barriers of implementation identified by	i. **NEI Implementation Evaluation indicator(s):** "42. Reported barriers and enablers to

Question	Sub question	Indicators	Data Source
		users, consultants, and Beyond Blue and Emerging Minds.	engagement [ELSs and school users]", "49. Reported system-level differences across contexts that have enabled NEI implementation", "52. Identification of barriers", 53. Identification of enablers", "54. Identification of features useful for implementation:", "90. Reported enablers and barriers [pre-service]", "72. The reported impost on educators and schools to implement and engage with the NEI", "73. The reported impost on pre-service educators to engage with the NEI", "85. Reported ELS and school features that support practice change". [BB] ii. **EM Evaluation Framework outcomes/measures/indicators:** "Identified barriers and enablers to practice development at the level of the practitioner, organisation, and system of care" [EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] iv. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ] v. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]
2. How appropriate is the Program design to deliver the intended outcomes?	a. To what extent does the design of the Program address the needs in the community?	1. The degree to which users agree that the range of resources (e.g., modules, programs, webinars, factsheets, etc.) meets their needs to address child and youth mental health needs.	i. **NEI Implementation Evaluation indicator(s):** "108. Reported degree to which NEI meets the needs of ELSs and schools….." [BB] ii. **EM Evaluation Framework outcomes/measures/indicators:** "Qualitative interviews to understand usefulness of resources, willingness/readiness to utilize the resources and practice challenges", "Qualitative interview to

Question	Sub question	Indicators	Data Source
			understand use of resources, how they are improve and refine practice" [EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] iv. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		2. The degree to which users agree that the primary mode of Program access (i.e., online portal) meets their needs to address child and youth mental health needs.	i. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] ii. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		3. The degree to which users agree that the activities of the consultants meets their needs to address child and youth mental health needs.	i. **NEI Implementation Evaluation indicator(s):** "28. Reported degree of satisfaction with, and value derived from, engagement between consultants and Action Team Leaders" [BB] ii. **EM:** Relevant questions from workshops, e-learning webinars, and the CRM data and EQUIP tool data reporting on implementation consultations [EM]. iii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] iv. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		4. The degree to which users prefer self-directed/online learning used in the Program versus alternative	i. **EM Process and Outcomes Evaluation:** "7.2 e-learning experiences and insights. P.40" [EM]

Question	Sub question	Indicators	Data Source
		learning modalities not utilised in the Program.	ii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] iii. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		5. The above indicators disaggregated by users working with diverse and at-risk groups.	i. Above data sources disaggregated by users working with diverse and at-risk groups
	b. To what extent is the Program evidence based?	1. The extent to which the design of each of the initiatives is informed by the evidence base.	i. **NEI Formative Evaluation indicator(s):** "Appropriateness of inputs to inform program design" [BB] ii. **NEI Implementation Evaluation indicator(s):** "48. Documentation of evidence to inform selected adaption across different contexts [BB] iii. **EM:** Evidence of procedures for resource development from a data driven population health approach iv. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]
		2. Initiatives have policy document/statements consistent with or supporting an evidence base philosophy.	i. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]
			i. **EM:** Documentation of evidence base philosophy
		3. The extent to which initiatives consider evidence when selecting information and programs/interventions and	i. **NEI Formative Evaluation indicator(s):** "The degree to which interventions and activities suggested in the program content can be mapped to a proven evidence base" [BB]

Question	Sub question	Indicators	Data Source
		activities (e.g., initiatives have clear decision rules about use of evidence).	ii. **EM:** Resource development protocols iii. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]
	c. How well is the Program viewed by participants?	1. Reported degree of user satisfaction with access to sufficient resources and services to meet their needs within The Program (i.e., users don't need to go elsewhere to access information) compared to no Program*	i. **NEI Implementation Evaluation indicator(s):** "107. Level of satisfaction reported by educations" [BB] ii. **EM Evaluation Framework outcomes/measures/indicators: "**pre-and post on user satisfaction and knowledge acquisition".[EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
3. How well has the Program achieved its outcome	a. To what extent has the Program established an evidence base for mental health promotion, prevention and early intervention?	1. There is evidence of a dissemination strategy for evidence generated by the initiatives.	i. OA Evaluation Activity: Semi-Structured Interviews with key Program informants [UQ]
		2. The extent to which users report being better (e.g., more frequent, more confident, more competent) users of evidence compared to no Program*.	i. **NEI Implementation Evaluation indicator(s):** indicators 91-93, and "96. Frequency and nature of NEI content being used in the classroom" [BB] ii. **EM Evaluation Framework outcomes/measures/indicators:** "did you use these skills and knowledge in practice [indicators]", "willingness/confidence? To use skills or knowledge learned or accessed? [indicators]. [EM]

Question	Sub question	Indicators	Data Source
			iii. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
	b. To what extent has the evidence base informed mental health policy and programs in schools/support organisations?	1. Extent to which users report that their Early Learning Service, school, or organisations have implemented policies and programs to support/reinforce a mentally health culture based on the contents of the Program.	i. **NEI Implementation Evaluation indicator(s):"**97. Action team leader/leader use of NEI content to initiate whole-of-school practices". [BB] ii. **EM Evaluation Framework outcomes/measures/indicators:** "Consultants have supported or enhanced the development of networks, organisational policy and procedures, and training and practice support for identification, assessment, support and referral for child mental health [measures]", "has this information been integrated into service or practice-related policies or systems? [indicators]" [EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
	c. To what extent has the Program improved mental health literacy?	1. Degree to which users feel confident identifying children and youth at-risk of experiencing mental health conditions compared to no Program*	i. **NEI Implementation Evaluation Indicator(s):** "102. Educators/leaders confidence in identifying and responding to mental health concerns among children and young people" [BB] ii. **EM Evaluation Framework outcomes/measures/indicators:** "Practice improvements in identification, assessment support and referral related to child mental

Question	Sub question	Indicators	Data Source
			health" [outcome]"; Improvement in mental health literacy. [EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		2. Users report an increased willingness to have conversations about mental health with children, young people, and families, compared to no Program. *	i. **NEI Implementation Evaluation Indicator(s):** "100. Educators reporting, they feel confident talking about mental health to children, young people and families" [BB] ii. EM: Workforce Questionnaire; Child Mental Health Awareness Survey iii. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		3. Users report an understanding of the different mental health challenges facing children and youth compared to no Program. *	i. [Relevant data from BB - TBA] ii. **EM Evaluation Framework outcome/measure/indicators: "**Increased understanding of strengths and vulnerabilities (incorporating risk and protective factors) important for child mental health in local workforce" [EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ]

Question	Sub question	Indicators	Data Source
			v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		4. Users report an improved understanding of when it is *appropriate* to refer children and young people for specialist support compared to no Program. *	i. **NEI Implementation Evaluation Indicator(s):** "113. Educators report a change in confidence responding to mental illness in their education setting", "115. Educators report improved understanding of their capabilities including when to appropriately refer learners and families to mental health services". [BB] ii. **EM Evaluation Framework outcome/measure/indicators:** "have there been less or more tertiary referrals such as to CAMHS or CP, or a reduction of inappropriate referrals?" [indicator], "Practice improvements in identification, assessment support and referral related to child mental health" [outcome]" [EM] iii. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
	d. To what extent has the Program improved access by (target group) children and young people to mental health services?	1. The extent that users report an improved understanding, awareness and availability of appropriate service referral pathways compared to no Program. *	i. **NEI Implementation Evaluation Indicator(s):** "114." Educators report improved knowledge of how and where to refer learners and families to mental health services. [BB] ii. **EM Evaluation Framework outcome/measure/indicators:** "Practice improvements in identification, assessment support and referral related to child mental health." [EM]

Question	Sub question	Indicators	Data Source
			iii. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ] iv. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]
		2. There is increased help-seeking by children and young people compared to no Program.	i. **OA Evaluation Activity: Existing Data:** The Longitudinal Study of Australian Children (LSAC): Growing up in Australia [The National Centre for Longitudinal Studies] [UQ to access] ii. **OA Evaluation Activity: Existing Data:** The Longitudinal Study of Indigenous Children (LSIC): Footprints in Time [UQ to access] iii. **OA Evaluation Activity: Existing Data:** Australian Longitudinal Study on Male Health: Ten to Men [UQ to access] iv. **OA Evaluation Activity: Existing Data:** WA Health and Wellbeing Surveillance System [UQ to access] v. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ] vi. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ] vii. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
	e. To what extent has the Program improved mental health and wellbeing for	1. Change in rate of death by suicide for children and youth compared to no Program.	i. OA Evaluation Activity: Existing Data: Causes of Death [Australian Bureau of Statistics, ABS] [UQ to access]

Question	Sub question	Indicators	Data Source
	children, young people and their families?	2. Change in rate of emergency department visits for deliberate self-harm in children and youth compared to no Program.	i. OA Evaluation Activity: Existing Data: Mental Health Establishments National Minimum Data Set (MHE-NMDS) [UQ to access]
		3. Change in rate of emergency department visits related to mental health and addictions for children and youth compared to no Program.	i. OA Evaluation Activity: Existing Data: Mental Health Establishments National Minimum Data Set (MHE-NMDS) [UQ to access]
		4. Change in rate of hospital admissions related to mental health and addictions for children and youth compared to no Program.	i. OA Evaluation Activity: Existing Data: Mental Health Establishments National Minimum Data Set (MHE-NMDS) [UQ to access]
		5. Change in proportion of developmentally vulnerable children by the time they start school compared to no Program.	i. OA Evaluation Activity: Existing Data: Australian Early Development Census (AEDC) [Australian Government Department of Education and Training] [UQ to access] ii. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
		6. Proportion of children or young people who exceed the thresholds on the Strengths and Difficulties Questionnaire.	i. OA Evaluation Activity: Existing Data: School Entrant Health Questionnaire (Victoria) [UQ to access] ii. OA Evaluation Activity: Existing Data: The Longitudinal Study of Indigenous Children (LSIC): Footprints in Time [UQ to access] iii. OA Evaluation Activity: Existing Data: New South Wales Child Health Survey [UQ to access] v. OA Evaluation Activity: Existing Data: Childhood to Adolescence Transition Study [UQ to access]

Question	Sub question	Indicators	Data Source
			v. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
		7. Change in proportion of parents reporting high levels of subjective health and wellbeing compared to no Program.	i. OA Evaluation Activity: Existing Data: School Entrant Health Questionnaire (Victoria) [UQ to access] ii. OA Evaluation Activity: Existing Data: WA Health and Wellbeing Surveillance System [UQ to access] iii. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
		8. Change in reported quality of family relationships compared to no Program	i. OA Evaluation Activity: Existing Data: Mission Australia Youth Survey [UQ to access] ii. OA Evaluation Activity: Existing Data: WA Health and Wellbeing Surveillance System [UQ to access] iii. OA Evaluation Activity: Existing Data: The Longitudinal Study of Australian Children (LSAC): Growing up in Australia [The National Centre for Longitudinal Studies]: [UQ to access] v. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
		9. There is increased resilience in children and young people compared to no Program.	i. OA Evaluation Activity: Existing Data: The Longitudinal Study of Australian Children (LSAC): Growing up in Australia [The National Centre for Longitudinal Studies]: [UQ to access]

Question	Sub question	Indicators	Data Source
			ii. OA Evaluation Activity: Existing Data: Victorian student health and wellbeing survey [UQ to access] iii. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
		10. There is improved wellbeing outcomes of children and young people compared to no Program	i. OA Evaluation Activity: Existing Data: Mission Australia Youth Survey [UQ to access] ii. OA Evaluation Activity: Existing Data: Victorian student health and wellbeing survey [UQ to access] iii. OA Evaluation Activity: Existing Data: Longitudinal Surveys of Australian Youth [UQ to access] iv. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
	f. To what extent has the Program reduced the risk of suicide clusters?	1. Uptake of suicide postvention support compared to no Program	i. **NEI Implementation Evaluation Indicator(s):** Indicator 22 “downloaded a suicide response kit”, indicator 105 “Availability of suicide postvention support to respond to, and assist, secondary schools in the event of a suicide of a student” [BB] ii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ]
		2. Number of registrations via suicide postvention as a proportion of school-aged suicides	i. **NEI Implementation Evaluation Indicator(s):** Indicator 23 “Number of schools registering via suicide postvention” [BB]

Question	Sub question	Indicators	Data Source
			ii. OA Evaluation Activity: Existing Data: Causes of Death [Australian Bureau of Statistics, ABS] [UQ to access]
		3. The degree to which teachers agree that suicide postvention is part of their role	i. **OA Evaluation Activity: National Support Survey**: Purpose developed or existing standardised item/s to address indicator [UQ]
		4. The extent to which teachers are confident that they can respond appropriately post suicide and reduce risk of suicide exposure and contagion	i. **OA Evaluation Activity: National Support Survey:** Purpose developed or existing standardised item/s to address indicator [UQ]
		5. Student psychological distress scores post suicide within the school community is reduced	i. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
		6. Rate of suicide clusters for children and youth	i. **Longitudinal Research Study:** The identification or development of an appropriate measure will be considered in the longitudinal research study plan [UQ]
4. How cost-effective is the Program?	a. How efficiently have Program resources been used?	1. The extent that the Program is implemented efficiently with respect to time, costs, and resources used	i. Program costing information and pre-program 'typical spend' costing information on capability development in supporting child and youth mental health [DOH] i. Breakdown of initiative costing information by set up, resource development, and ongoing operation costs [BB] i. Breakdown of initiative costing information by set up, resource development, and ongoing operation costs [EM] v. Initiative Registration data [BB & EM]

Question	Sub question	Indicators	Data Source
			v. Data relevant to user knowledge and confidence indicators (outcomes denoted with an asterisk above)
		2. The extent the Program efficiency varies across different contexts	i. As above for question 4a indicator 1
		3. The extent that Program efficiencies are achieved over time (i.e., set up costs reduce over time, operational costs associated with outcome attainment do not increase over time)	i. As above for question 4a indicator 1
	b. What are the (additional) costs associated with the Program?	1. Users, Emerging Minds, and Beyond Blue report additional costs are identified as being associated with the Program	i. **NEI Implementation Evaluation indicator(s): "71.** Extent to which educators report having sufficient time to access the NEI", "72. The reported impost on educators and schools to implement and engage with the NEI", "73. The reported impost on pre-service educators to engage with the NEI" [BB] ii. **EM:** Focus group data that discusses the need for time allocation to do the training iii. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] iv. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ] v. OA Evaluation Activity: Semi-Structured Interviews with key Program informants: Purpose developed question/prompt to address indicator [UQ]

Question	Sub question	Indicators	Data Source
	c. How do user costs compare to no Program?	1. Users report changes to costs associated with capability development in supporting child and youth mental health	i. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ]
5. Were there any unintended outcomes or consequences associated with the Program?	a. What were the unintended outcomes/consequences?	1. User knowledge and confidence (outcomes denoted with an asterisk above) indicators do not improve compared to no Program	i. As described for relevant indicators
		2. Target users identify consequences (positive or negative) of the implementation of the Program.	ii. **NEI Implementation Evaluation indicator(s):** "86. Identification of consequences", "101. Educators reporting unintended consequences relating to mental health beyond the ELS/school". [BB] iii. EM: Negative impacts of EM reported in focus groups or surveys e.g., increased waiting lists for services [EM] v. **OA Evaluation Activity: National Support Survey:** Purpose developed item/s to address indicator [UQ] v. **OA Evaluation Activity: Community Case Studies:** Purpose developed question/prompt to address indicator [UQ]

Notes:

Data sources identified from the individual evaluations have been taken from the DAE BB NEI Formative Evaluation Framework, DAE BB NEI Implementation Evaluation Framework, and the Emerging Minds Evaluation Frameworks. The data required for the Overarching Evaluation will likely be the data used for the relevant individual evaluation indicators. These indicators are either noted in full or referred to as they are numbered in the indicator matrices of the aforementioned documentation.

ABS = Australian Bureau of Statistics; BB = Beyond Blue; bbNEI = Beyond Blue National Education Initiative; CAMHS = Child and Adolescent Mental Health Service; CRM = Customer Relationship Manager; DAE = Deloitte Access Economics; ELS = Early Learning Service; EM = Emerging Minds; LSAC = The Longitudinal Study of Australian Children; NEI= National Education Initiative; OA = Overarching; PRC = Parenting Research Centre; SDQ = Strengths and Difficulties Questionnaire; SSI = Semi-structured interview; TBA = To be advised; TBD = To be determined; UQ = The University of Queensland;

* User knowledge and confidence indicators

Appendix C: Summary Findings: Semi-structured Interviews with Key Program Informants

Summary of key points against the relevant indicators:

Overarching Evaluation Question 1: How well has the Program been implemented?

Sub question 1a: To what extent has the Program been implemented as expected?

Indicator 1: The extent that the Program is implemented as it was prescribed (adherence to implementation and protocols) by a) Beyond Blue, b) Emerging Minds, and c) Initiative consultants

Findings from Be You

- Perception that implementation has occurred predominantly as originally conceptualised, with some exceptions.
- Belief that overall Be You stayed true to big picture 'vision' from tender.
- Implementation challenge from recruitment perspective: The expectation that ~4500 KidsMatter and MindMatters schools would transition to Be You did not occur (the reality was ~1800 schools). As a result, during early implementation, Be You experienced a more intense recruitment phase than expected.

Summary: It appears that the original vision for the National Education Initiative has mostly 'stood up', with some exceptions. The recruitment phase was unexpectedly intense early on.

Findings from Emerging Minds

- Perception that the implementation was 'fairly close' to original idea. The key strategies planned at tender submission iteratively evolved and changed as anticipated.
- Major difference from original design was the timeframes that it took to happen, particularly around internal capacity development to make sure that practice translation was at the centre of the work.
- Perception that Emerging Minds has been able to deliver on building capacity to deliver on practice translation, but they underestimated the time it would take to do so.

Summary: It appears that Emerging Minds has been implemented as originally conceptualised, however, the major departure from original implementation plans occurred due to longer than expected timelines for internal capacity development and practice translation.

Sub question 1a: To what extent has the Program been implemented as expected?

Indicator 2: Extent that the initiatives collaborated with each other and with reference groups during the development and across the delivery of The Program

Findings from Be You

Collaboration with Emerging Minds

- Perception that collaboration with Emerging Minds was of strong importance early on, for example, through setting up the National Reference Group, and other groups. However, the importance of these groups decreased as the initiatives focussed on deep implementation.
- Tim recognised the importance of collaboration between Be You and Emerging Minds because of shared learnings with similar challenges faced.
- There was an inconsistency of collaboration with Emerging Minds over time: "it probably ebbs and flows, based on different priorities around how we're working".

2020 saw increased collaboration with Emerging Minds again "we've done a lot of work particularly over the last … year particularly, around bringing that back together" … so we're starting to … focus again now on bringing

them much more closely aligned". These more recent collaborations are conducted in a structured way with an established working group with representatives from both organisations.

- Emerging Minds are key partners of Be You's Bushfire Response Program as well.
- Tim commented that Be You had also had discussions with Emerging Minds around evaluation.
- Pending board approval, Emerging Minds will be invited as a participant on the National Advisory Group/Council.

Summary: Evidence of some collaboration, but lack of ongoing, planned coordination, especially in delivery, and during our evaluation period.

Other Reference Group collaboration

- Involvement of Reference Groups also now "ebbs and flows". Tim reflected on how Be You streamlined some of the reference groups in response to an evaluation learning that the extent of collaboration with these groups had impacts on Beyond Blue's ability to 'turn things around' in the development phase.
- More recently, National Advisory Group/Council used for strategic advice (currently going through a membership refresh).
- Be You also seeks input from Project Steering Committee and Education Voices. Education Voices are valuable for ongoing feedback.

Summary: Extent of collaboration has changed over time, which reflects different stage of the initiative, as well as learnings from earlier evaluation that 'too many voices' was having a negative impact on decision making.

Findings from Emerging Minds

- Perception that collaboration has been important, but a regret that there was not more collaboration earlier on.
- Lack of earlier collaboration a reflection of different approaches to delivery

"I think both models probably did what they had to do [at launch], but we sort of went with the light version of ourselves, which would grow. And I think they went with a deeper version, which enabled them to do a bit more preparatory work for release."

- Collaboration in the early stage also impacted by different stages of delivery (e.g., Beyond Blue had transitional arrangements to address).
- Challenges collaborating due to no engagement with each other during grant application process and need to prioritise internal structures and processes.

"So to actually communicate around potential collaboration and what that might look like has been quite hard because we've been refining our models".

- The bushfire response was an example of where the initiatives were able to collaborate well at a regional level and test out the concept of what a 'double dose' could potentially look like.
- Increased collaboration in 2020 on issues such as COVID-19 impact, and where there might be joint priorities.
- Expressed readiness now to move to joint projects and increased collaboration or different ways of working by bringing together the education system with health and social services at a regional place-based level, for example.

Summary: Collaboration was limited due to different approaches. Opportunities for collaboration were not fully realised.

Other reference groups

- Nature of relationship with other reference groups has changed a lot over time.
- Emerging Minds experienced challenges in collaborating with reference groups because of number of sectors targeted.

- Collaboration approach has been to segment collaboration to separate sectors initially because of challenges with collaborating across multiple systems.
- Reference Groups now operating to support content level co-design through consultation. Much of this process happens at micro level, with a workforce development officer working with advisory structure for that sector.
- Governance structures significantly changed over last 12-18 months. Originally these groups (e.g., RACGP) tried to assist in strategic element, but Emerging Minds already had a board and experience to shape strategic goals. Now more recent engagement has provided clarity around responsibility for delivery (e.g., Aboriginal networks and healing foundations).

Summary: Evidence of collaboration with other groups and willingness to adapt ways of working to improve delivery.

Overall summary for collaboration between initiatives: Evidence of some collaboration with each other, but lack of ongoing, planned coordination, especially in delivery, and during our evaluation period. The lack of collaboration was influenced by the different approaches to development taken by the initiatives. As such, opportunities for collaboration were not fully realised.

Sub question 1a: To what extent has the Program been implemented as expected?

Indicator 3: The extent to which initiatives have adopted continuous evaluation (including robust consistent outcome measurement) at the ground level and responded to generated evidence (i.e., have an implementation cycle), if prescribed.

Findings from Be You

Perception that evaluations have been critical in terms of continuous improvement, noting the following areas:

- Content development: focus on user centric model, appropriateness for diverse populations, how to include an ‘education voice’.
- Enhancing platform and digital capabilities.
- Delivery model: for example, working with delivery partners: “Evaluation again has fed into a lot of the way that we continue to enha-, um evolve our relationship (relationship of headspace and ECA and Beyond Blue) and ways of working as well”.
- Governance and advisory: impacts of ‘many voices’ and how to streamline this aspect.

Summary: Evaluation has influenced continuous quality improvement. Some evidence of continuous evaluation, but with limitations to the robustness of consistent outcome measurement.

Findings from Emerging Minds

- Internal evaluation used to collect data to continually change initiative delivery if needed. Brad acknowledged that it has taken a long time to get data at a quantity for that process to be effective.
- Process of using evaluation data has changed over time: early on, they drew on past experience, then a reliance on engagement data and internal staff feedback.
- Their first evaluation provided evidence for what they thought was happening. From this evaluation, they redesigned the learning management system to be more segmented.
- Data and feedback from focus groups resulted in a shift from Emerging Minds’ first courses, which were generic/’foundational’ with workforce consultants doing some contextualising, to having additional targeted sector-specific pathways (i.e., automated contextualisation).

Summary: Implementation cycle evidenced by change in approach from workforce consultants contextualising information, to having additional targeted sector-specific pathways (i.e., automated contextualisation). Evidence of continuous evaluation, but with limitations to the robustness of data collected (although this has improved overtime).

Sub question 1b): To what extent has implementations varied across different contexts?

Indicator 1: The extent to which Beyond Blue and Emerging Minds delivered their initiatives to different contexts (e.g., different population groups, geography, service types)

Findings from Be You

- To address challenges around delivery in different contexts, Be You considers the imperative to "continually develop our workforce". Tim reflected that Be You is starting to build an understanding of how the workforce needs to work with communities based on what their needs are. He acknowledged that there is still work to do to improve on this area.
- The Be You Workforce is used to understand local context and help or guide the user: "We're never gonna be in a position where we can provide unique content, content and resources to every specific um challenge that a school or a service might have, or a different diverse settings or populations. But we need our consultants to be able to be the ones that interpret and give them meaning to well what does it mean from my context and how do I go about using that."
- The place-based approaches of the Pilbara and Kimberley Project and Bushfire Response Program focus on context and community needs, but it is not a model suitable for Be You generally. The learnings from these projects can be embedded in Program design to work with other communities.
- There was a perception that it was of real benefit that the partner organisations of headspace and ECA had strong embedded ways of working with and supporting the needs of Aboriginal and/or Torres Strait Islander Groups and cultures.
- Working within the COVID context provided opportunities. Tim expressed a hope that the focus on wellbeing by Educators, which was reflected by an increased uptake of resources, would remain.

Summary: Be You representative highlighted the difficulties of addressing every context in materials, therefore Be You places responsibility of adapting for context on consultants to contextualise existing materials to different contexts. Kimberley/Pilbara and Bushfire Response Programs provides evidence of delivering the initiative to different contexts, but these programs are outside of the Overarching Evaluation scope. Evidence of flexibility to address demand demonstrated throughout the COVID-19 lockdown period and beyond.

Findings from Emerging Minds

- First courses were generic, but now moving towards targeted sector specific pathways
- First evaluation indicated user preference for specialisation of content for different sectors
- See discussion on COVID-19 below for an example on adapting to different or unexpected contexts.

Summary: There has been a shift away from the development of generic materials approach to sector-specific pathways and content in the learning management system, which was informed by Emerging Minds' first evaluation. Evidence of flexibility to address demand demonstrated throughout the COVID-19 lockdown period and beyond.

Sub question 1e): What are the implementation lessons?

Indicator 1: Reported enablers and barriers of implementation identified by users, consultants, and Beyond Blue and Emerging Minds.

Findings from Be You

Enablers:

- Flexibility of the Be You approach
- Readiness of schools: "the schools and services that have dedicated resources or have resources they can contribute to do this initiative as sorta part of their job, are the ones that are doing exceptionally well".

Challenges:

- Rapid transition from 5 existing initiatives to Beyond Blue's control

- Short timeframe to develop workforce
- Supporting KidsMatters and MindMatters initiatives while also designing, developing, and preparing to implement Be You
- Recruitment of schools and services into KidsMatters and MindMatters while explaining that these would soon transition to Be You, without being able to disclose what Be You would look like or be known as.
- Bringing three organisations together, each with different cultures/ways of doing things despite an aligned purpose.
- In the early phase there was a strong need for a "sales force" to facilitate recruitment, whereas the workforce employed had skills, training, and experience that weren't necessarily suited to these tasks. Workforce expectations of the work was that they would be working with schools and services on content, products, and delivery, rather than such a heavy focus on recruitment.
- Biggest barrier is the time of the Educators: Trying to help them to understand that it [Be You] is a "solid investment in time because it's actually going to improve the way that they work within the classroom.. and it's going to save time in the future"

Findings from Emerging Minds

Enablers:

- Being *"in the business"* and already delivering to an existing group of interested users.
- Enablers initially were engagement work by consultants, communication strategies, and content (e.g., webinars).
- Having led the National Children of Parents with a Mental Illness initiative (COMPI), Emerging Minds had existing relationships with peer advisors and children and young people to advice.
- The focus of the work that was about accepting complexity connected with the reality of lived experience, which increased acceptability across sectors.

Challenges:

- Building capacity of internal team in tight timeframe: There were challenges in helping Emerging Minds' multidisciplinary team translate their knowledge and skills to outward-facing work with multi-sector work force clients.
- The number of sectors that Emerging Minds has had to target and how segmented and specialized that work was/is.
- Structural barriers are ongoing: Practitioners must work within systems/circumstances as they are, even when they're not optimal. It's not possible to wait for the ideal system to evolve: *"…for professionals um we're expecting them to change their behaviour in the context of systems that might not necessarily support them, in the practices that we desire and they may even desire as well".*
- Even when systems authorize working in new ways, there's sometimes not a willingness to do it on the ground.
- Specialist workforce shortage – challenge of how to be able to work in the more specialist end of the spectrum. There is an increased need for skilled Practitioners with a broad lens. Overcoming churn due to burnout.

Overarching Evaluation Question 2: How appropriate is the Program design to deliver the intended outcomes?

Sub question 2b): To what extent is the Program evidence-based?

Indicator 1: The extent to which the design of each of the initiatives is informed by the evidence base.

Findings from Be You

- Perception that Be You has done a lot of work around how the use research and evidence coming through their feedback, evaluation, and website analytics, advisory groups, and expert channels.
- Be You has a major focus on working with subject matter experts.
- Currently redefining the way they engage with subject matter experts (including cultural consultants) to make sure that they are embedded within the process when developing content. Process is increasingly more structured (and sometimes procured).

Summary: There is a heavy reliance on subject matter experts external to Beyond Blue to assess evidence.

Findings from Emerging Minds

- Perception that evidence is very important. Brad reflected that a lot of effort was expended in this area during grant writing process, although they did not document it (e.g., reviewed international and national evidence on child and adolescent mental health strategies, workforce development, implementation sites etc.).
- They also drew on families with lived experience through Emerging Minds already strong network.
- Brad draws on informal and formal processes to share evidence with international networks, as well as drawing on literature (e.g., implementation science literature).
- Brad identified evidence gaps of how to get people to translate the knowledge into practice, and how to scale things up to a national initiative level.
- Brad acknowledged that because they were dealing with complex practices that there were limited examples of evidence that could inform a roll out at a national initiative to improve children's mental health, but they drew on bits and pieces where they could.
- The organization anticipated iterative change in response to new or generated evidence.

Summary: There is evidence that Emerging Minds drew on the available research evidence using a systematic and thorough process, but that evidence was limited. Non-traditional evidence has also informed the initiative, including lived experience of families and Practitioner expertise. Evidence appears to be at the core of the Emerging Minds initiative, with the initiative anticipating iterative change in response to new or generated evidence.

Sub question 2b): To what extent is the Program evidence-based?

Indicator 2: Initiatives have policy document/statements consistent with or supporting an evidence base philosophy.

Findings from Be You

- No relevant information obtained.

Findings from Emerging Minds

- No relevant information obtained.

Sub question 2b): To what extent is the Program evidence-based?

Indicator 3: The extent to which initiatives consider evidence when selecting information and programs/interventions and activities (e.g., initiatives have clear decision rules about use of evidence)

Findings from Be You

- As above (Sub question 2b, Indicator 1).

Findings from Emerging Minds

- As above (Sub question 2b, Indicator 1).

Overarching Evaluation Question 3: How well has the Program achieved its outcome?

Sub question 3a): To what extent has the Program established an evidence base for mental health promotion, prevention and early intervention?

Indicator 1: There is evidence of a dissemination strategy for evidence generated by the initiatives*

Findings from Be You

- Learnings are used in continuous quality improvement of products, which in turn are made available for Educators. Webinars and communications are also used to share learnings with Educators.
- Be You does work to feedback learnings to their workforce, key stakeholders (e.g., Department of Education at State and territory level), and to their National Advisory Council through regular meetings.
- Cited intention to do keynote addresses and presentations at conferences (although did not cite evidence that this type of dissemination had already been completed).
- Indicated plans to develop a knowledge translation strategy within the next 6 months.
- Acknowledged room for improvement with making best use of the large amount of data collected.

Summary: Be You predominantly disseminates evidence generated by the initiatives internally, but also more widely to stakeholders and at conferences. They have a stated intention to develop a knowledge translation strategy but acknowledge that there is room for improvement with the extent that they disseminate their generated evidence.

Findings from Emerging Minds

- Evidence dissemination occurs directly through policy submissions, engaging with policy officers, and taking advantage of opportunities relating to contributing to policy.
- Contribute through formal structures (e.g., senate inquiries)
- Disseminate through informal networking (e.g., workforce consultant builds relationship with leadership of CAMHS to provide input into a Family Focused Recovery Strategy).

Summary: Emerging Minds has a focus on policy influence when disseminating knowledge.

Overarching Evaluation Question 4: How cost-effective is the Program?

Sub question 4b): What are the (additional) costs associated with the Program?

Indicator 1: Users, Emerging Minds, and Beyond Blue report additional costs are identified as being associated with the Program

Findings from Be You

- Able to deliver initiative within budget (with an underspend)
- Areas of investment: Beyond Blue workforce (increasing size and capacity at different stages) and website and digital platforms/infrastructure (will need to invest over time to help sustainability and scalability): *"that's [digital platforms/infrastructure] probably going to be an area that we will continue to need to invest over the time, because again, that's going to be the – we're, we're gonna have a limited workforce in terms of how we, how many people that we can have. But we – but if we can provide um better functionality through our digital platforms and our infrastructure, then hopefully that will help with the sustainability and scalability as well".*

Findings from Emerging Minds

- No significant additional expense at current scale, but Emerging Minds were able to take advantage of prior development work and existing audience and contacts.
- Emerging Minds have identified ways to expand scope (e.g., with Aboriginal & Torres Strait Islander organisations) that cannot be resourced within current initiative.
- Efficiency has increased over time, which is why content development is prolific.
- Perception that this type of initiative would ideally need an ongoing investment over years: "there's so many opportunities that could be expanded to go deeper and harder".

COVID & Bushfires

Findings from Be You

- COVID provided an opportunity for Be You with Educators embracing modality.
- Perception that COVID encouraged schools and Educators to think about doing development in this area online, rather than needing someone to visit the school or do face-to-face development: *"there's now the consideration of sitting here going okay, well you don't need to be sitting here face to face in the same room. You can actually do things, um online".*
- Opportunities for national stakeholder engagement, without need to travel.
- Demand for trauma-informed and recovery support with bushfires compared to COVID. The focus was on supporting community. Be You played a coordination role as well, to help schools navigate influx of offers of support.
- Expressed intention to embed learnings from Bushfire Response Program into the core Be You (including suicide postvention work) so that schools and services are better equipped to respond to future disasters, whatever they may be.

Findings from Emerging Minds

- COVID did not impact operations and may have assisted growth of engagement due to readiness of digital platform (they had a preparedness) for the demand, which has sustained since.
- Bushfire's work helped with preparedness for COVID shutdown due to the networks and co-/development of work.
- Brad has the perception that through bushfires and COVID, that children had a lot of visibility. He believes that there are increased conversations around trauma and mental health.
- During COVID, there was anecdotal evidence that there was a multisector concern for children because the support of school was no longer there. Some data supported need for concern (e.g., child protection).
- Brad views concerns as a long-term issue, which COVID-19 may have uncovered or exacerbated, but the work needs to continue.

Questions: Semi-structured Interview with Key Program Informant

Note: the following questions will be used to guide discussions but will allow flexibility to pursue arising issues.

How well has Be You/Emerging Minds been implemented?

Q1. To what extent were you able to implement Be You/Emerging Minds as it was originally prescribed? What challenges did you have implementing Be You/Emerging Minds as it was originally prescribed?

Q2. A) How important was it to work with Emerging Minds/Be You to achieve the aims of the Program (i.e., the National Support for Child and Youth Mental Health Program)? What were the benefits? What were the challenges?

B) How important was it to work with reference groups to achieve the aims of the Program? What were the benefits? What were the challenges?

Q3. How have you used the evaluations to improve Be You/Emerging Minds?

To what extent has implementations varied across different contexts?

Q.4 Was Be You/Emerging Minds able to adapt its delivery to different or unexpected contexts easily? What challenges did you face delivering the initiative in different or unexpected contexts?

What are the implementation lessons?

Q5 A) What were the enablers of implementation?

B) What were the barriers of implementation?

To what extent is Be You/Emerging Minds evidence based?

Q6. How important was using evidence to inform the design of the initiative to Beyond Blue/Emerging Minds? What do you do to factor in new or emerging evidence into Be You/Emerging Minds? How do you determine the validity of evidence used in Be You/Emerging Minds?

To what extent has Be You/Emerging Minds established an evidence base for mental health promotion, prevention and early intervention?

Q7. How is Be You/Emerging Minds disseminating knowledge and evidence generated by the initiative?

What are the (additional) costs associated with the initiative?

Q8. What additional costs have you identified as being associated with the initiative? From a financial perspective? Resourcing perspective? Others?

Other questions

Q9. How did COVID-19 impact the delivery of Be You/Emerging Minds?

Q10. How did the bushfires impact the delivery of Be You/Emerging Minds

Appendix D: Jurisdictional Approval Processes and Impacts

Jurisdictional approval process and impacts on recruitment.

Some jurisdictions accepted the National Application Form (NAF), while others required their own application form, supporting documentation and process. Jurisdictional approvals from State and Catholic sectors took far longer than anticipated. While some applications were approved within 4 weeks, some took over 16 weeks for approval. The last State jurisdictional approvals for Western Australia and Queensland were received in December 2019 – 17 weeks or nearly 4 months after initial submission. Some jurisdictions either did not respond to application requests, refused permission, or later rescinded or suspended their approval. This is described in 'Notes' of Table D.1. For example, approval was refused by one Catholic Education Diocese, another Diocese granted permission, but then later withdrew this permission. Approvals were not received from three Catholic Education jurisdictions (despite several attempts to follow-up).

Table D.1 Jurisdictional Approvals (by State)

Jurisdiction	Application Submitted	Approval Received	Notes
New South Wales			
State			
NSW Department of Education	16/08/2019	23/09/2019	
Catholic			

Jurisdiction	Application Submitted	Approval Received	Notes
Armidale	5/09/2019		*Refused*: 2/10/2019
Broken Bay	23/08/2019	16/09/2019	
Bathurst	23/08/2019	4/09/2019	*Rescinded*: 12/09/2019
Sydney	22/08/2019	25/09/2019	
Lismore			Not accepting applications
Parramatta	23/08/2019	25/092019	
Maitland/Newcastle	30/08/2019	4/09/2019	
Wilcannia-Forbes	3/09/2019		No Response
Wollongong	30/08/2019	30/09/2019	
Wagga Wagga	3/09/2019	25/09/2019	
Victoria			
State			
Department of Education	20/08/2019	17/10/2019	*Suspended*: 17/07/2020
Catholic			
Ballarat	22/08/2019	11/09/2019	
Melbourne	20/08/2019	30/08/2019	
Sale	30/08/2019	20/11/2019	
Sandhurst	30/08/2019	9/09/2019	*Suspended*: 17/04/2020
Queensland			
State			
Education Queensland	20/08/2019	4/12/2020	*Suspended*: 1/04/2020
Catholic			
Brisbane	20/08/2019	6/09/2019	*Suspended*: 24/03/2020
Cairns	24/09/2019		No response
Rockhampton	22/08/2019	11/09/2019	

Jurisdiction	Application Submitted	Approval Received	Notes
Toowoomba	21/08/2019	9/09/2019	
Townsville	30/08/2019	9/09/2019	
South Australia			
State			
Department of Education	20/08/2019	3/10/2019	
Catholic			
Adelaide & Port Pirie	20/08/2019	3/10/2019	
Western Australia			
State			
Department of Education			Delay in receiving jurisdictional clearance
Catholic			
Catholic Ed WA	20/08/2019	17/12/2019	Secondary schools only
Tasmania			
State			
Department of Education	20/08/2019	20/09/2019	
Catholic			
Catholic Education Tas	23/08/2019	18/12/2019	
Northern Territory			
State			
Department of Education	20/08/2019	26/09/2019	
Catholic			
Catholic Education NT	20/08/2019		No response
ACT			
State			
ACT Education	4/09/2019	24/09/2019	

Jurisdiction	Application Submitted	Approval Received	Notes
Catholic			
Canberra & Goulburn	4/09/2019	9/10/2019	

Other impacts on recruitment

With the onset of the COVID-19 pandemic in March and April 2020, three school jurisdictions (State and a Catholic jurisdiction in Queensland and a Catholic jurisdiction in NSW) suspended their approvals. All requests to suspend were to avoid additional demands on the schools within these jurisdictions during this time.

The 2019/2020 Bushfires and the COVID-19 pandemic also impacted on our ability to reach clinicians and Practitioners as the focus of their work shifted due to demands for clinical assistance and the move to the provision of Telehealth platforms for the delivery of their services.

Recruitment context

Recruitment of participants for the Education initiative survey (i.e., early learning service Educators, primary and secondary school Educators) and Workforce initiative survey (i.e., clinicians and non-clinicians) involved some differences in recruitment strategies. The survey designed to evaluate the Be You and Emerging Minds programs required the following broad inclusion criteria.

Prior to receipt of approvals from educational jurisdictions to approach schools, contact was made with independent schools and Early Learning Centres, as well as with clinicians and Practitioners for the Emerging Minds survey (more information about recruitment in this sector is described in the next section). This contact was maintained throughout the rest of 2019.

As jurisdictional approvals were received, contact was made by an initial ‘approach’ email to Principals at schools within that jurisdiction. This email gave information about the evaluation and provided Principals with exemplars of the surveys and copies of ethical clearances and approvals from their jurisdiction. Following best practice guidelines from some jurisdictions to improve likely uptake of the research, phone calls to Principals were scheduled five days after the initial email. This allowed time for Principals to read the information provided and to make an informed decision when providing their staff the opportunity to take part. Follow up emails were sent approximately two weeks after initial contact. If they (or other staff) agreed, the survey link was sent by email. This process worked well during Term 3 of the 2019 school year. However, the overall response rate was not high, with many Principals citing that staff were too busy at that time of the year or had already been overburdened by research requests during the year.

School holidays across September and October 2019 saw recruitment shift to recruitment of clinicians and Practitioners for the Emerging Minds survey.

The lag over the school holidays, coupled with schools’ end of year activities (including exams and other activities), during the last months of 2019, meant that fewer Principals agreed to distribute the survey to their staff. Some Principals indicated an interest in the New Year, but very few of these subsequently agreed to participate.

The two last State jurisdictions to be approved at the end of 2019 (QLD & WA) were approached at the beginning of the school year (end of January 2020). To streamline recruitment, the initial email contact with Principals included the survey link directly rather than waiting for an expression of interest. This produced a mixed response rate, with many schools again citing the ‘busy-ness’ of the start of a new school year. The bushfires at the beginning of the school year also hampered contact with some jurisdictions.

The impacts from COVID-19 prompted the end of active recruitment in schools on March 25, 2020, to not overburden school communities as they worked to move teaching to online platforms. For some jurisdictions, this meant that there was only a one-month window in which it was possible to recruit schools and Educators.

Approach via organisation

Organisations that employ workers in roles who work with either or both children and adults, in either public or private settings, in the Australian health and human services sectors, such as children's hospitals and Primary Health Networks, were first approached for participation. If the contact person agreed to distribute the survey to their workforce, this was done via online staff newsletters and other online portals such as websites for their network members. This approach was necessary for engagement with the organisations but meant that direct contact and interaction with clinicians and other workers directly was not possible.

Smaller organisations such as the various State Child and Youth Mental Health services were also contacted directly to distribute the survey to their workforce.

Approach via Professional Associations

We contacted a range of professional associations and groups for assistance in distributing the survey link to network members.

The use of professional associations was a potential way to reach many clinicians, but it relied on individual clinicians accessing and reading the study material and opting to complete the survey. That is, there was no direct control of 'reach' using this method.

Some professional associations provided a database of members which included contact details for individual clinicians. We were able to reach individual clinicians using contact information from a range of organisational websites, including those of the Australian Psychological Society, Australian Association of Social Workers, Australian Counselling Association, Australian College of Mental Health Nurses, and others. This approach was the most effective way of reaching clinicians as we were able to contact them directly and invite them to participate.

Online Search

Finally, we searched for clinics or practices for practitioner groups online and emailed the survey link to the practice manager. This included workforce groups like GPs, youth workers, psychologists, and allied health. GP Super clinics were a good way of contacting multidisciplinary groups of clinicians. As per other approaches, this first required interest and approval from practice managers to distribute the survey link, and then the individual clinician's choice to participate (or not).

Appendix E: Logic Used to Allocate Participants to the Control and Exposed Groups

Emerging Minds – Logic for Control and Exposed Group Allocation

Question for participants using the Emerging Minds program	Question about Emerging Minds program	Question on the Emerging Minds resources / information tools	Question on the Emerging Minds eLearning course	Group allocation
Q14 Have you heard about or participated in any of the following programs before?	**Q16** Have you heard about Emerging Minds?	**Q17** Have you, browsed, read or downloaded any resources (e.g., articles, podcasts webinars, research papers, toolkits) on the Emerging Mind website?	**Q18** Have you registered online for Emerging Minds eLearning courses?	Condition Group
If Emerging Minds selected: Skipped to Q17 & Q18	X		See logic below	Either Exposed Or Control Group
If Emerging Minds NOT selected: Q16 asked	If **Yes** is selected: Q17 & Q18 asked		See logic below	Either Exposed Or Control Group
	If **No** is selected: Skipped directly into Control condition	X	X	Control Group

Re-directed Logic: participant will be re-directed to **'Control'** Survey based on responses provided to questions Q17 and Q18 in screening questions at beginning of 'Exposed' survey

'Exposed' survey responses resulting in re-direction to 'Control' Survey	Combination responses and resulting allocation					
Q17 Have you, browsed, read or downloaded any resources (e.g., articles, podcasts webinars, research papers, toolkits) on the Emerging Mind website?	Yes	Yes	No	No	Unsure	Unsure
Q18 Have you registered online for Emerging Minds eLearning courses?	Yes	No	Yes	No	Yes	No
	Exposed	Exposed	Exposed	Control	Exposed	Control

Be You – Logic for Control and Exposed group allocation

Question for participants using the Emerging Minds program	Question about Emerging Minds program	Question on the Emerging Minds resources / information tools	Question on the Emerging Minds eLearning course	Group allocation
Q25 Have you heard about or participated in any of the following programs before?	**Q27** Have you heard about Be You?	**Q28** Have you, browsed, read or downloaded any resources (e.g., articles, podcasts webinars, research papers, toolkits) on the Be You website?	**Q29** Have you registered online for Be You eLearning courses?	Condition Group
If Be You selected: Skipped to Q28 & Q29	**X**		See logic below	Either Exposed Or Control Group

Question for participants using the Emerging Minds program	Question about Emerging Minds program	Question on the Emerging Minds resources / information tools	Question on the Emerging Minds eLearning course	Group allocation
If Be You NOT selected: Q27 asked	If **Yes** is selected: Q28 & Q29 asked		See logic below	Either Exposed Or Control Group
	If **No** is selected: Skipped directly into Control condition	**X**	X	Control Group

Re-directed Logic: participant will be re-directed to **'Control'** Survey based on responses provided to questions Q28 and Q29 in screening questions at beginning of '**Exposed**' survey

Questions	Response 1	Response 2	Response 3	Response 4	Response 5	Response 6
Q28 Have you, browsed, read or downloaded any resources (e.g., fact sheets, tools) on the Be You website?	Yes	Yes	No	No	Unsure	Unsure
Q29 Have you registered online as an individual educator or staff member for Be You?	Yes	No	Yes	No	Yes	No
	Exposed	Exposed	Exposed	Control	Exposed	Control

Appendix F: Difference-in-Difference Analysis: National Support Network Survey

The data presented in this section show the results of the difference-in-difference (DID) analysis, which was used for selected constructs in the Educator and Practitioner surveys. The purpose of this type of analysis was to examine whether self-reported change over time (i.e., pre-to-post) is associated with exposure to the intervention. This type of analysis is useful when randomisation into control and intervention groups is not possible.

Participants were asked to rate their extent of agreement on a series of items that measured different aspects of a construct (e.g., knowledge of referral pathways), reflecting on their experiences 'at this time'. At the end of each survey section[24], participants were asked to reflect on the past and rate the extent that they agreed with a statement as they would have '12 months ago' (control group) or 'before the Be You/Emerging Minds program' (exposed group). That is, respondents reported their current status (i.e., post-test status) and their retrospectively recalled perceived status prior to the initiative (i.e., pre-test). Collecting this 'pre-test' data at the postintervention time frame was needed because there was no available baseline data. To obtain this 'pre-test' data we asked: "Now thinking 12 months ago (or 'before Be You/Emerging Minds' [exposed group], do you agree or disagree with the statement... I understood the range of external mental health services available and how to appropriately refer children and/or families for mental health support"[25]. These 'past reflection' and 'at this time' items that comprise each of the constructs examined are presented in Table F.1. The outcome indicators were assessed in two different scales in the efficacy analysis: i) numeric score that ranged from 0-100, and ii) nominal scale with binary category (score >=80 vs <80). We used binary categories because of an observed clustering of scores around the mid-point (i.e., 50) of the response scale, which may have indicated a non-response or neutral rating.

For Be You, the analyses based on the numeric score are presented in Table F2 and Figure F1. The analyses based on the binary categories for Be You are presented in Table F3 and Figure F2.

For Emerging Minds, the analyses based on the numeric score are presented in Table F4 and Figure F3. The analyses based on the binary categories for Emerging Minds are presented in Table F5 and Figure F4.

A positive difference-in-difference (>0) means that the proportion of agreement on the items improved among exposed participants compared to the control participants.

[24] Note: there were a total of 8 sections relevant to both control and exposed participants for the surveys, with an additional section on suicide postvention for the Be You survey

[25] Due to survey length constraints, summary 'past reflection' items were used (i.e., one item for each construct), rather than including a 'past reflection' item for each item. As such, for the purpose of analysis, the 'at this time' items that were most relevant to the 'past reflection' item (either a single item, or an aggregate of the most relevant items) were used for the pre-to-post comparison.

Table F.1Items that comprise constructs examined for the Difference in Difference analysis.

Construct	Now thinking 12 months ago/before the Program….	At this time:
Knowledge of referral pathways to external mental health services to support children and families	.... I understood the range of external metal health services available and how to appropriately refer children and/or families for mental health support.	I understand the range of external services available to support student/child mental health.
Confidence in working with external mental health services to support children and families	…. How confident were you with connecting and using external mental health services to support students/children with mental health needs	I know how to connect children and/or families with mental health services external to my workplace setting when needed.
Confidence and knowledge to identify and address the different mental health challenges facing children and young people	…. I was confident in my abilities to address the different mental health challenges facing students/children? -	I am confident in my ability to identify students/children experiencing mental health challenges.
Confidence and willingness to have conversations with children and families about mental health	.... I was confident in having conversations with children and/or families about mental health issues	I am willing to have conversations with students/children about mental health. I am willing to have conversations with families about mental health.
Perceived self-efficacy for promoting mental health	How confident were you in helping students/children learn about their mental health and about the resources available to them?	I can help my students/children to be more aware of their mental health. I can improve students/children's general knowledge about mental health. I can improve students/children's knowledge of resources available to support their mental health.
Extent that workplace culture supports and promotes the mental health of children and young people	…our school/learning community valued, supported and promoted the mental health of students/children learn about their mental health.	Mental health is important to our broader school/learning community. Our school/learning community feels safe and connected. Our broader school/learning community supports and promotes mental health. My school has a strong community of learning around

Construct	Now thinking 12 months ago/before the Program….	At this time:
		mental health.
Extent that workplace culture supports and promotes Educator/Practitioner mental health	My workplace valued and supported my mental health	My workplace understands the importance of mental health for staff. My school/learning community supports my mental health. It is important to look after my own mental health.
Extent of the application of evidence-based practice regarding mental health	would learn and critically apply new evidence about mental health to my work practise in relation to student/childcare.	Do you critically appraise any literature/information or intervention programs you have discovered? Do you integrate the evidence you have found with your expertise?
Knowledge and confidence to appropriately respond to a suicide in the learning community	I knew of my role and was confident that I could respond appropriately post suicide in such a way that reduced the chance of another suicide	Supporting the mental health and wellbeing of students/children after a death by suicide is part of my work role. I am aware of the actions that I should take following a death by suicide that impacts my school/learning community. I am confident that I can respond appropriately to a death by suicide that impacts my school/learning community. I am confident that I can identify young people who may be most impacted or at increased risk after a death by suicide that impacts my school/learning community. I am confident that I can communicate with young people after a death by suicide that impacts my school/learning community in a way that reduces the chance of another suicide.

Table F.2Difference in Median Score Between Exposed and Control Participants With Respect to Their Median score at 12 Months Ago (Be You)

Indicators	Participant	Median score		D* (95% CI) [P-value] in Past	D* (95% CI) [P-value] in Recent	DID**(95% CI) [P-value]
		Past	Recent			
Knowledge of referral pathways	Control	60.68	55.5	20.7(11.4, 29.99) [<0.0001]	28.15(21.48, 34.82) [<0.0001]	7.45(-4.44, 19.35) [0.219]
	Exposed	81.38	83.65			
Confidence in connecting with external mental health services	Control	50	54.03	29.15(21.33, 36.96) [<0.0001]	31.53(24.47, 38.58) [<0.0001]	2.38(-7.42, 12.18) [0.633]
	Exposed	79.15	85.55			
Confidence in abilities to identify and address student/child mental health challenges	Control	59.97	69.35	24.01(16.12, 31.9) [<0.0001]	17.08(11.42, 22.74) [<0.0001]	-6.93(-16.93, 3.07) [0.174]
	Exposed	83.98	86.43			
Confidence and willingness to have conversations with children and families about mental health	Control	72	80	14.86(6.56, 23.15) [<0.0001]	15.05(8.75, 21.35) [<0.0001]	0.19(-9.98, 10.37) [0.97]
	Exposed	86.85	95.05			
Confidence in helping promote student/child mental health awareness	Control	64.43	76.05	20.12(12.66, 27.59) [<0.0001]	13.78(8.69, 18.87) [<0.0001]	-6.34(-15.29, 2.61) [0.164]
	Exposed	84.55	89.83			
Extent that workplace supports and promotes mental health	Control	66.99	76.18	12.64(4.44, 20.85) [0.003]	8.07(3.11, 13.04) [0.002]	-4.57(-14.23, 5.09) [0.352]
	Exposed	79.64	84.25			
Extent that workplace supports and promotes Educator/Practitioner mental health	Control	67.28	75.31	16.15(7.02, 25.28) [0.001]	11.26(4.67, 17.84) [0.001]	-4.89(-16, 6.23) [0.388]
	Exposed	83.43	86.57			
Extent of application of evidence base practice regarding mental health	Control	63.01	64.35	17.93(9.45, 26.41) [<0.0001]	17.9(11.12, 24.68) [<0.0001]	-0.03(-10.89, 10.82) [0.995]
	Exposed	80.94	82.25			

Indicators	Participant	Median score		D* (95% CI) [P-value] in Past	D* (95% CI) [P-value] in Recent	DID**(95% CI) [P-value]
		Past	Recent			
Knowledge and confidence to appropriately respond to a suicide in the learning community	Control	52.62	64.7	19.73(11.74, 27.71) [<0.0001]	18.89(11.86, 25.91) [<0.0001]	-0.84(-11.33, 9.65) [0.875]
	Exposed	72.34	83.59			

Note. 95% CI = 95% Confidence Interval; DID = Difference in difference statistic.
*Difference between exposed and control at recent time
** Differences in difference between exposed-control and past-recent time

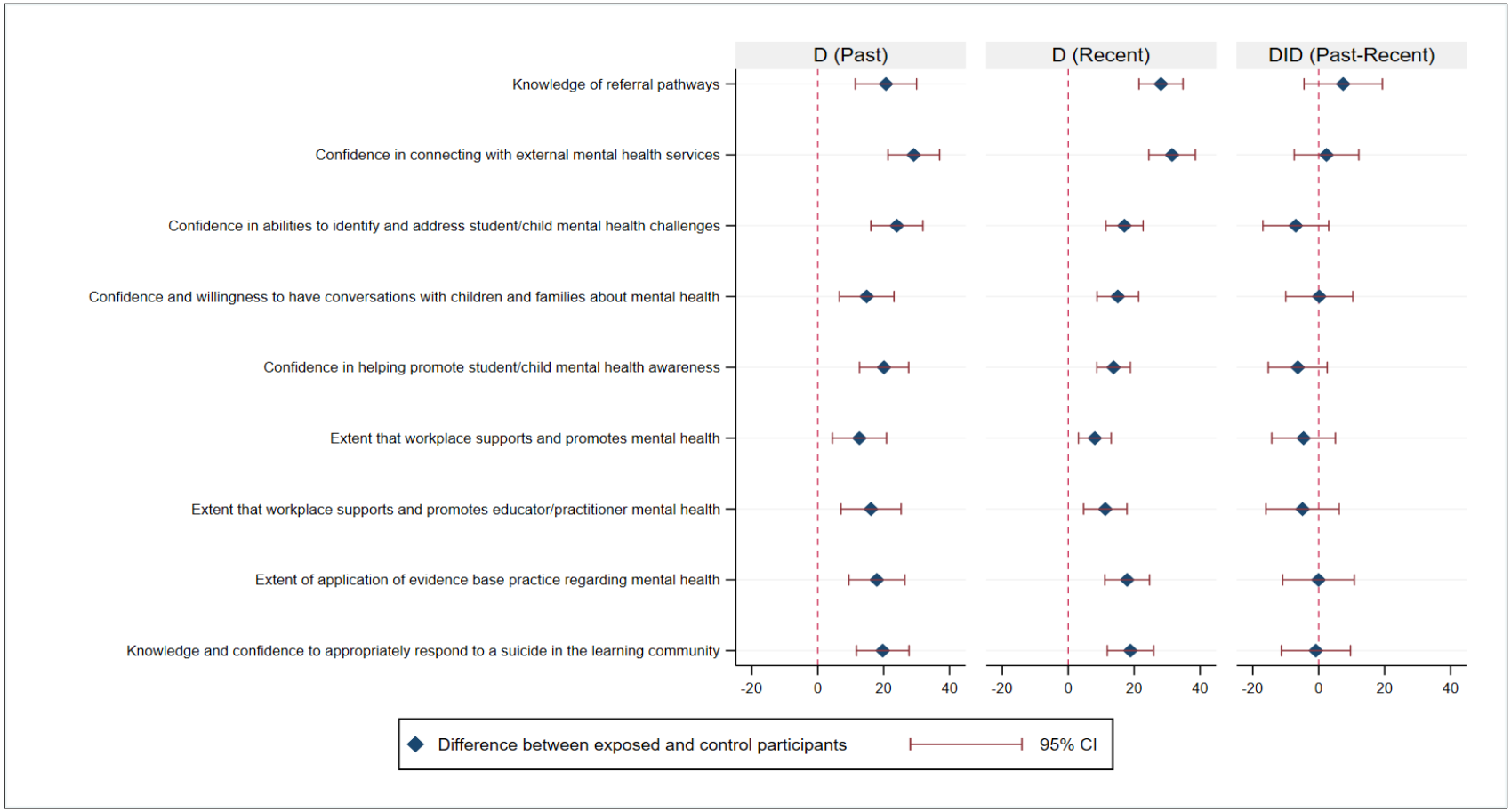


Figure F.1 Difference in median score between exposed and control participants with respect to their median score at 12 months ago (Be You)

Table F.3Difference in Proportion (Score>=80) Between Exposed and Control Participants With Respect to the Proportion at 12 months ago (Be You)

Indicators	Participant	Proportion (%) of score>=80		D * % (95% CI) [P-value] in Past	D* % (95% CI) [P-value] in Recent	DID** % (95% CI) [P-value]
		Past	Recent			
Knowledge of referral pathways	Control	31.52	22.73	20.9(11.76, 30.04)	35.66(26.99, 44.34)	14.76(2.21, 27.31)

Indicators	Participant	Proportion (%) of score>=80		D * % (95% CI) [P-value] in Past	D* % (95% CI) [P-value] in Recent	DID** % (95% CI) [P-value]
		Past	Recent			
	Exposed	52.42	58.39	[<0.0001]	[<0.0001]	[0.021]
Confidence in connecting with external mental health services	Control	23.03	27.1	28(18.8, 37.2)	31.38(22.56, 40.21)	3.38(-9.36, 16.12)
	Exposed	51.03	58.48	[<0.0001]	[<0.0001]	[0.603]
Confidence in abilities to identify and address student/child mental health challenges	Control	29.39	35.1	27.03(17.6, 36.46)	28.6(19.57, 37.63)	1.57(-11.54, 14.69)
	Exposed	56.42	63.7	[<0.0001]	[<0.0001]	[0.814]
Confidence and willingness to have conversations with children and families about mental health	Control	41.05	52.1	19.47(9.88, 29.06)	20.66(12.05, 29.26)	1.19(-11.76, 14.13)
	Exposed	60.52	72.76	[<0.0001]	[<0.0001]	[0.857]
Confidence in helping promote student/child mental health awareness	Control	34.57	44.99	25.61(15.52, 35.7)	26.92(18.01, 35.83)	1.31(-12.65, 15.27)
	Exposed	60.18	71.91	[<0.0001]	[<0.0001]	[0.853]
Extent that workplace supports and promotes mental health	Control	34.29	43.69	17.17(7.62, 26.71)	19.79(10.68, 28.9)	2.62(-10.49, 15.74)
	Exposed	51.45	63.48	[<0.0001]	[<0.0001]	[0.695]
Extent that workplace supports and promotes Educator/Practitioner mental health	Control	37.9	44.7	17.95(8.05, 27.85)	15.48(6.18, 24.78)	-2.47(-16.23, 11.28)
	Exposed	55.85	60.18	[<0.0001]	[0.001]	[0.724]
Extent of application of evidence base practice regarding mental health	Control	30.52	29.35	23.96(14.32, 33.6)	24.99(15.3, 34.67)	1.02(-12.6, 14.65)
	Exposed	54.48	54.33	[<0.0001]	[<0.0001]	[0.883]
	Control	27.22	31.94	17.05(7.07, 27.03)	28.25(18.97, 37.52)	11.19(-2.07, 24.46)

Indicators	Participant	Proportion (%) of score>=80		D * % (95% CI) [P-value] in Past	D* % (95% CI) [P-value] in Recent	DID** % (95% CI) [P-value]
		Past	Recent			
Knowledge and confidence to appropriately respond to a suicide in the learning community	Exposed	44.27	60.18	[0.001]	[<0.0001]	[0.098]

Note. 95% CI = 95% Confidence Interval; DID = Difference in difference statistic.
*Difference between exposed and control at recent time
** Differences in difference between exposed-control and past-recent time

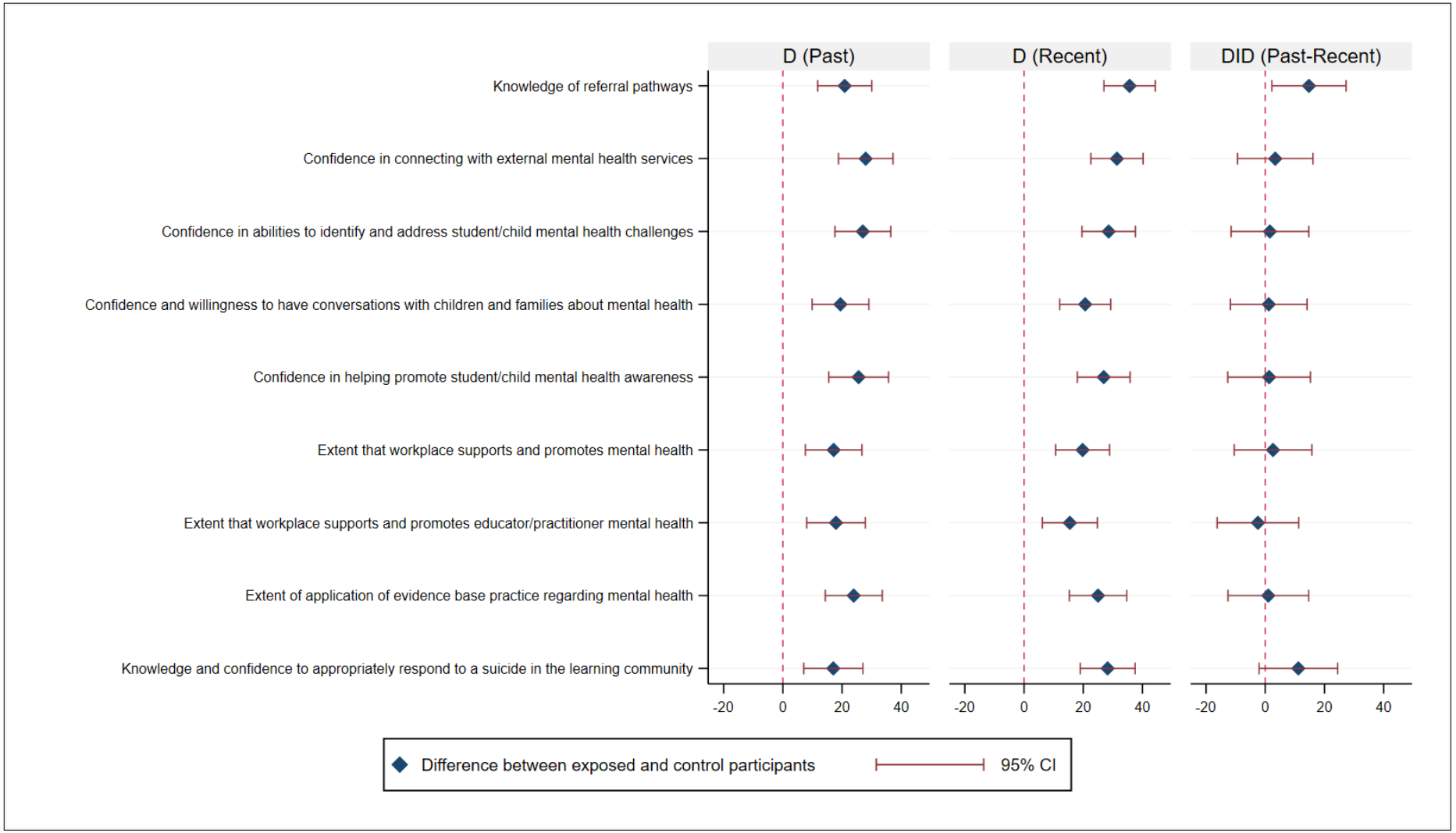


Figure F.2 Difference in proportion (score>=80) between exposed and control participants with respect to the proportion at 12 months ago (Be You)

Table F.4Difference in Median Score Between Exposed and Control Participants with Respect to Their Median Score at 12 Months Ago (Emerging Minds)

Indicators	Participant	Median score		D * % (95% CI) [P-value] in Past	D* % (95% CI) [P-value] in Recent	DID** % (95% CI) [P-value]
		Past	Recent			
Knowledge of referral pathways	Control	73.35	73.85	7.09(-2.65, 16.82) [0.153]	8.89(0.02, 17.75) [0.049]	1.8(-12.5, 16.1) [0.805]
	Exposed	80.44	82.74			
Confidence in connecting with external mental health services	Control	71.11	82.95	15.05(3.53, 26.56) [0.011]	4.28(-2.39, 10.96) [0.207]	-10.77(-24.08, 2.55) [0.113]
	Exposed	86.15	87.24			
Confidence in abilities to identify and address student/child mental health challenges	Control	79.45	86.39	0.31(-8.75, 9.36) [0.946]	1.36(-4.33, 7.06) [0.638]	1.05(-9.51, 11.62) [0.845]
	Exposed	79.76	87.75			
Confidence and willingness to have conversations with children and families about mental health	Control	89.94	98.14	0.2(-8.02, 8.42) [0.962]	-2.86(-6.9, 1.18) [0.164]	-3.06(-12.18, 6.06) [0.51]
	Exposed	90.14	95.28			
Confidence in helping promote student/child mental health awareness	Control	80.24	89.65	2.72(-6.71, 12.16) [0.569]	0.06(-5.76, 5.88) [0.983]	-2.66(-13.62, 8.29) [0.633]
	Exposed	82.96	89.72			
Extent that workplace supports and promotes mental health	Control	80.97	84.31	5.03(-4.2, 14.26) [0.282]	1.92(-3.76, 7.6) [0.506]	-3.12(-13.73, 7.5) [0.564]
	Exposed	86	86.23			
Extent that workplace supports and promotes Educator/Practitioner mental health	Control	80.45	85.44	2.8(-8.13, 13.73) [0.614]	-0.94(-9, 7.12) [0.818]	-3.74(-17.62, 10.15) [0.597]
	Exposed	83.25	84.5			
Extent of application of evidence base practice regarding mental health	Control	85.16	87.31	-0.82(-8.8, 7.15) [0.838]	-3.38(-10.65, 3.89) [0.358]	-2.56(-13.75, 8.64) [0.653]
	Exposed	84.33	83.93			

Note. 95% CI = 95% Confidence Interval; DID = Difference in difference statistic.
*Difference between exposed and control at recent time
** Differences in difference between exposed-control and past-recent time

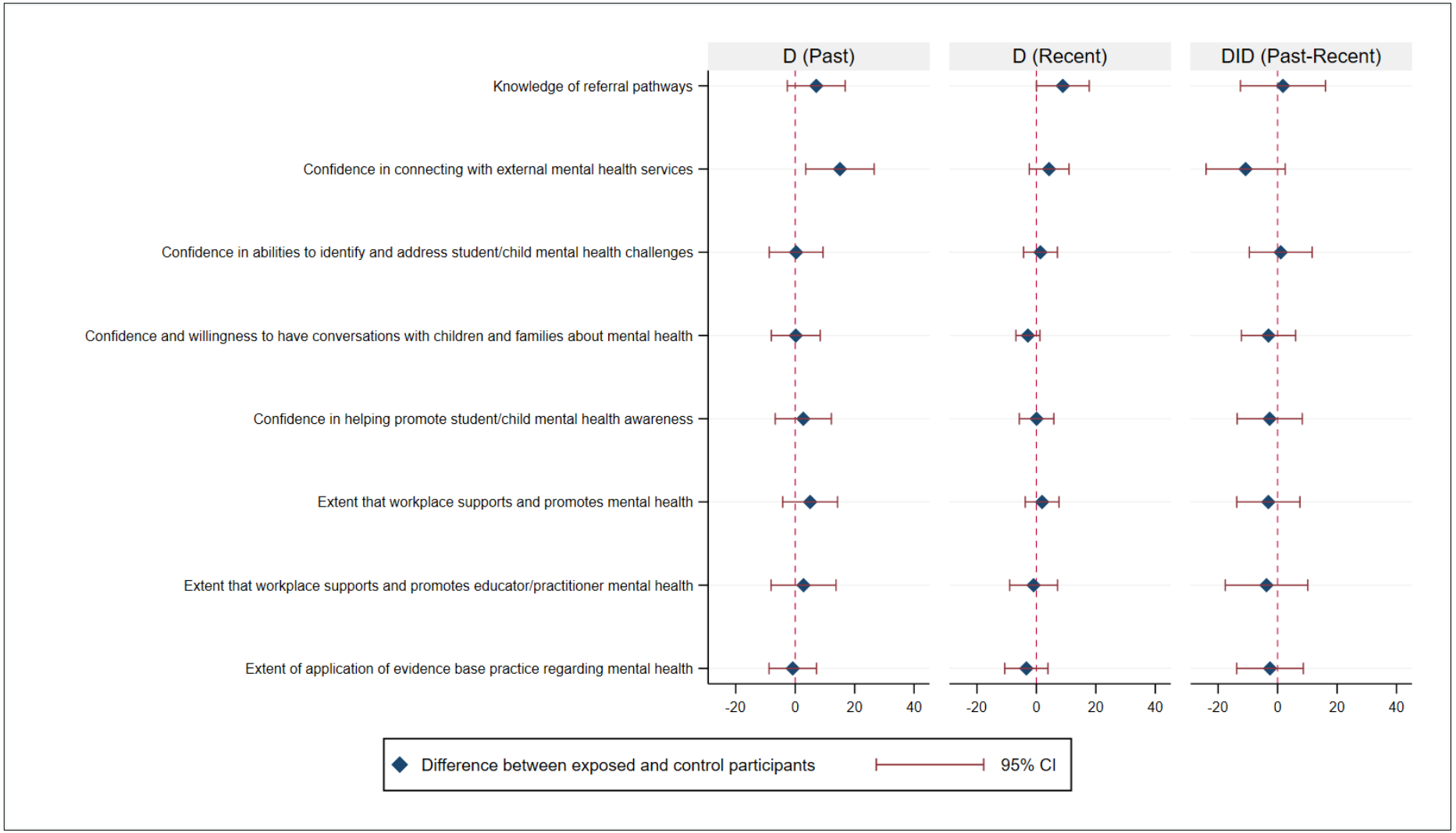


Figure F.3 Difference in median score between exposed and control participants with respect to their median score at 12 months ago (Emerging Minds)

Table F.5Difference in Proportion (score>=80) Between Exposed and Control Participants With Respect to the Proportion at 12 Months Ago (Emerging Minds)

Indicators	Participant	Median score		D * % (95% CI) [P-value] in Past	D* % (95% CI) [P-value] in Recent	DID** % (95% CI) [P-value]
		Past	Recent			
Knowledge of referral pathways	Control	38.03	40.6	16.28(1.39, 31.16) [0.032]	16.32(1.95, 30.7) [0.026]	0.04(-20.63, 20.72) [0.997]
	Exposed	54.31	56.92			
Confidence in connecting with external mental health services	Control	40.83	55.74	20.25(5.21, 35.29) [0.008]	17.26(3.79, 30.72) [0.012]	-2.99(-23.15, 17.17) [0.771]
	Exposed	61.08	73			
Confidence in abilities to identify and address student/child mental health challenges	Control	50.4	66.09	2.29(-13.05, 17.63) [0.769]	5.53(-8.2, 19.26) [0.43]	3.24(-17.34, 23.81) [0.758]
	Exposed	52.69	71.62			
Confidence and willingness to have conversations with children and families about mental health	Control	65.03	82.23	5.13(-9.43, 19.68) [0.49]	3(-8.51, 14.51) [0.609]	-2.12(-20.99, 16.75) [0.825]
	Exposed	70.15	85.23			
Confidence in helping promote student/child mental health awareness	Control	55.6	70.03	5.17(-9.75, 20.09) [0.497]	7.74(-6.1, 21.58) [0.272]	2.57(-17.24, 22.38) [0.799]
	Exposed	60.77	77.77			
Extent that workplace supports and promotes mental health	Control	56.51	64.2	4.95(-10.41, 20.31) [0.527]	-0.74(-15.68, 14.2) [0.923]	-5.69(-27.19, 15.82) [0.604]
	Exposed	61.46	63.46			
Extent that workplace supports and promotes Educator/Practitioner mental health	Control	54.4	60.31	5.75(-9.51, 21.02) [0.46]	4.92(-10.02, 19.85) [0.518]	-0.84(-22.58, 20.91) [0.94]
	Exposed	60.15	65.23			
Extent of application of evidence base practice regarding mental health	Control	65.14	66.63	-1.68(-16.93, 13.56) [0.829]	-5.63(-20.85, 9.59) [0.468]	-3.95(-25.64, 17.74) [0.721]
	Exposed	63.46	61			

Note. 95% CI = 95% Confidence Interval; DID = Difference in difference statistic.
*Difference between exposed and control at recent time
** Differences in difference between exposed-control and past-recent time

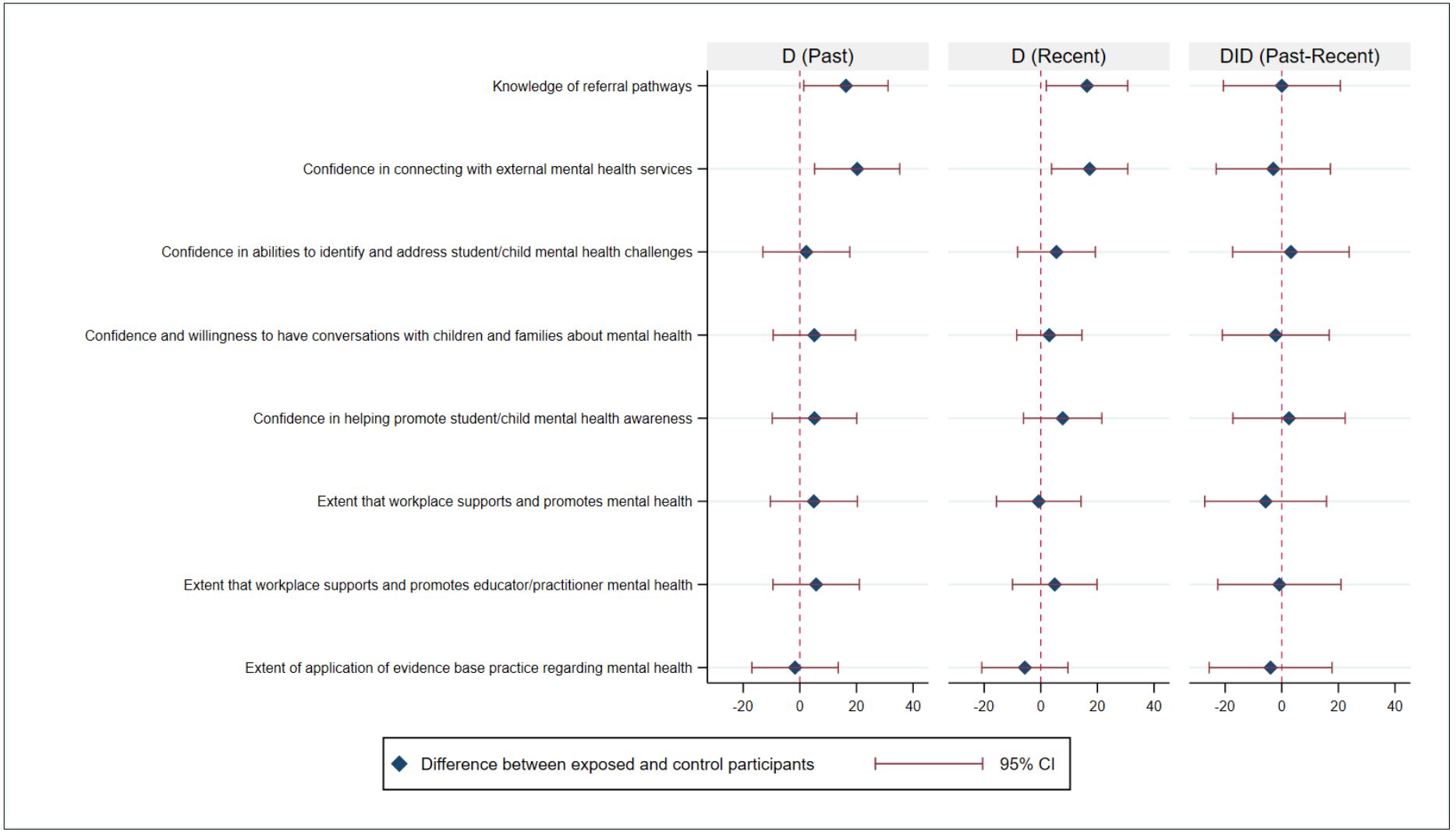


Figure F.4 Difference in proportion (score>=80) between exposed and control participants with respect to the proportion at 12 months ago (Emerging Minds)

Appendix G: Be You bLink Data Extract Features

Note: the following information was provided by Be You initiative

Background

The Be You Performance and Evaluation team provided University of Queensland (UQ) evaluators a data extract containing information extracted from the bLink system as at 30 September 2020. This document provides a list of features of the data extract that should enable a better understanding of the analysis that is able to be performed using the data.

bLink

bLink is the name of the Beyond Blue Customer Relationship Management (CRM) system. It allows Be You to keep user details up to date and track interactions.

As of 30 September 2020, bLink collected the following broad groups of information relating to Be You:

- Information about Educators that have registered to be part of Be You (users)
- Information about Be You professional development module completion amongst registered users
- Information about Learning Communities (Early Learning Services and schools) that have registered to be part of Be You (organisations)
- Information about Be You consultants from our service delivery partners Early Childhood Australia (ECA) and headspace.
- Information about the interactions that consultants have with organisations and users.

More detail about these data groups (relating to the extract) are provided below.

It is important to note that the bLink system is not static. It has had a number of changes in the type and definition of data collected as the initiative has matured. More changes are planned or have already been implemented since this data was extracted for the evaluation.

Any analysis of the data provided for the evaluation will not necessarily represent the data that is currently collected at the time of the report publication date.

It is important to note that this excludes information about the headspace suicide postvention service, the Be You Bushfire response, the Be You Pilbara Kimberley project and the pre-service pilot.

Be You journey

The interaction with Be You starts with an Educator signing up as a registered user on the Be You website. We collect a small amount of information about the user at this point, including their email address. Upcoming website changes will change the amount of demographic data that is collected about users at this point.

Users can then choose to link themselves to a Learning Community. If the user is part of a registered Be You organisation, they link themselves to that organisation. Other options would be for example a pre-service Educator such as a university student who is studying education. Their university would not be part of Be You (because it's for Early Learning and schools only), so they would attach themselves to a non-Be You organisation. We also have individual users that we call household members. At the time of the data extract we are not collecting information about organisations that are not registered with Be You, nor are we collecting information about individual households.

Characteristics of Be You data

Be You data features one group of information that relates to users i.e. module completions, and another group of information that relates to Be You learning communities i.e. demographic profile of the school/service. Because we don't know information about organisations that have not registered with Be

You, we don't have information about their demographic composition. Similarly, because we do not collect mandatory information about Be You users we do not have information about their demographic characteristics. As mentioned above these features are changing but no changes as of the 20 September extract.

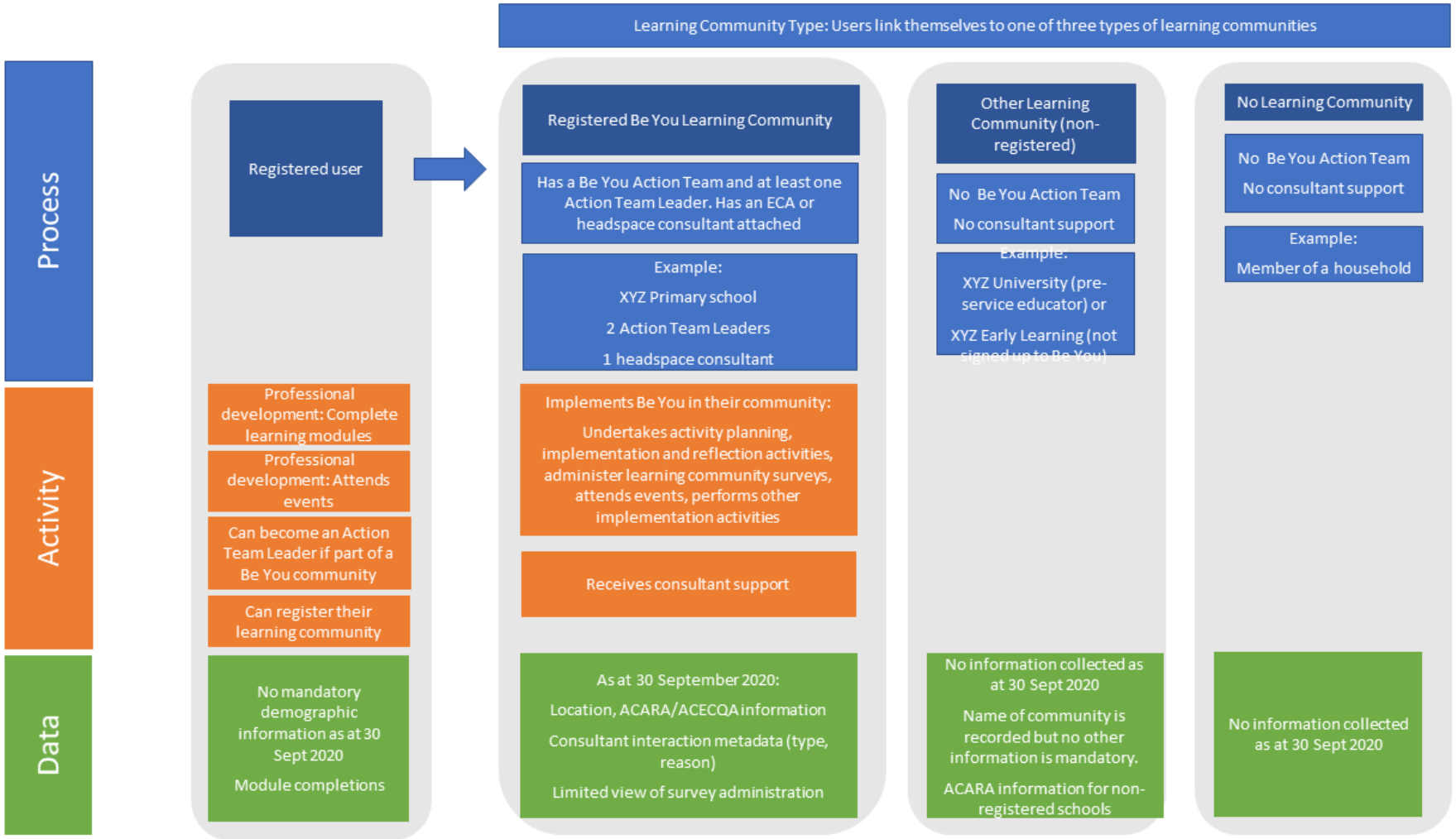
Data extract description

The following table provides a description of the files provided to UQ. All data relates to the period of time between Be You launch and 30 September 2020 inclusive. These reports were custom generated for the evaluation work that is being undertaken by both the UQ evaluators and for the internal evaluation of Be You conducted by the Australian Council for Education Research (ACER) and Social Ventures Australia (SVA).

Data	Description	Notes
All Be You users	A list of all Educators registered on the Be You website until 30 September 2020	Can be linked to org data via the Org ID. Will only link to Org ID if user is part of a Be You registered org
Be You module completion data	A list of all professional development modules completed by Be You users until 30 September 2020	Can be linked to user data via the user ID
Be You registered Organisations	A list of all organisations that have registered to participate as a Be You learning community	Can be linked to users using the Org ID. Only includes organisations that are registered as participating in Be You.

The diagram below provides an overview of the signup process, the activities undertaken, and the data collected for each major element of Be You.

It is important to note that this excludes information about the headspace suicide postvention service, the Be You Bushfire response, the Be You Pilbara Kimberley project and the pre-service pilot.


Learning Community Type: Users link themselves to one of three types of learning communities
Process
Activity
Data
Registered user
Professional development: Complete learning modules
Professional development: Attends events
Can become an Action Team Leader if part of a Be You community
Can register their learning community
No mandatory demographic information as at 30 Sept 2020
Module completions
Registered Be You Learning Community
Has a Be You Action Team and at least one Action Team Leader. Has an ECA or headspace consultant attached
Example:
XYZ Primary school
2 Action Team Leaders
1 headspace consultant
Implements Be You in their community:
Undertakes activity planning, implementation and reflection activities, administer learning community surveys, attends events, performs other implementation activities
Receives consultant support
As at 30 September 2020:
Location, ACARA/ACECQA information
Consultant interaction metadata (type, reason)
Limited view of survey administration
Other Learning Community (non-registered)
No Be You Action Team
No consultant support
Example:
XYZ University (pre-service educator) or
XYZ Early Learning (not signed up to Be You)
No information collected as at 30 Sept 2020
Name of community is recorded but no other information is mandatory.
ACARA information for non-registered schools
No Learning Community
No Be You Action Team
No consultant support
Example:
Member of a household
No information collected as at 30 Sept 2020

Appendix H: The Program's reach through different events

The number of monthly events conducted by Be You and Emerging Minds are presented in Figure H.1 and Figure H.2, respectively. It was observed that Emerging Minds reached many people in every month through the different platforms of social media communications. The highest reach was achieved through Facebook posts and Emerging Minds webpage visits.

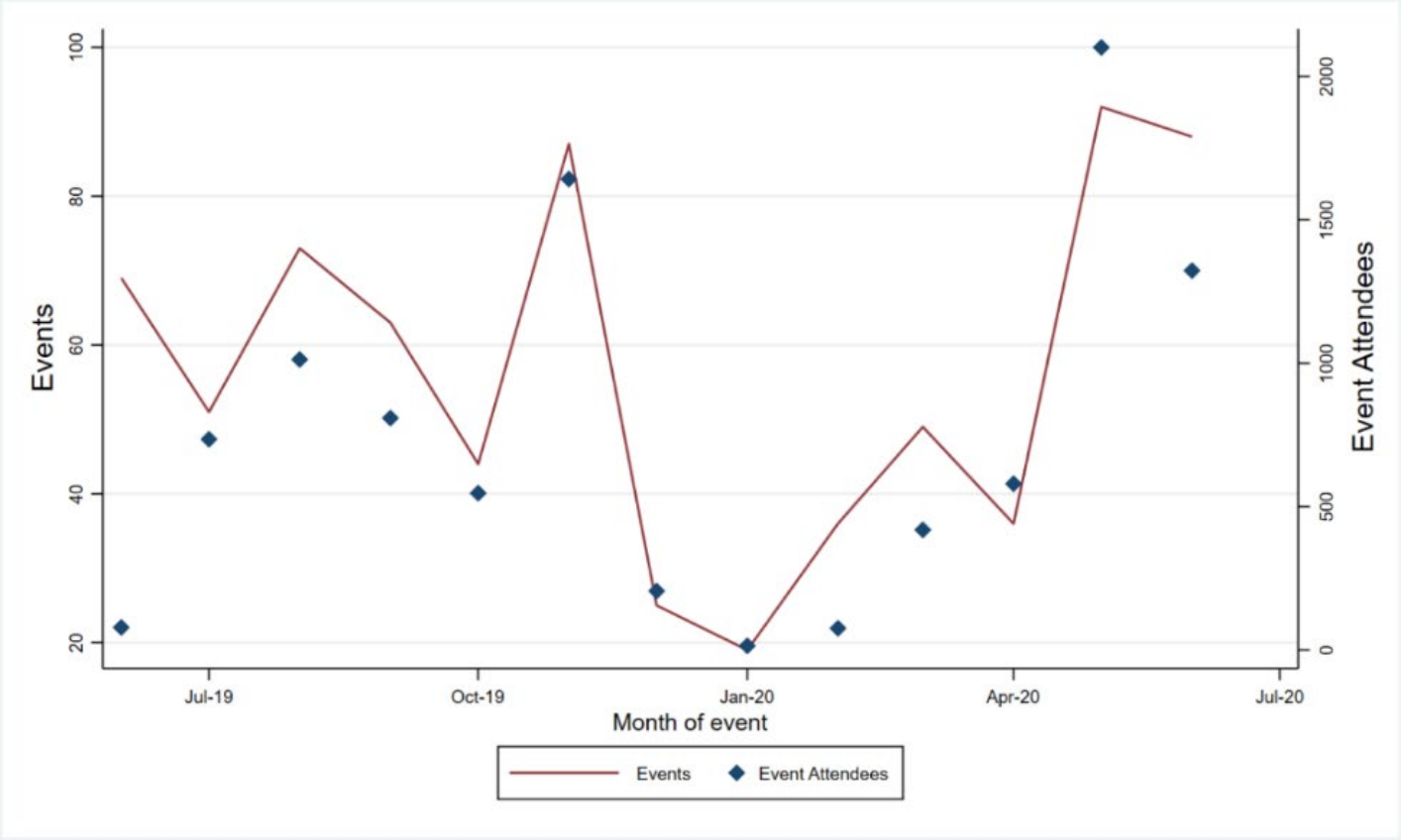
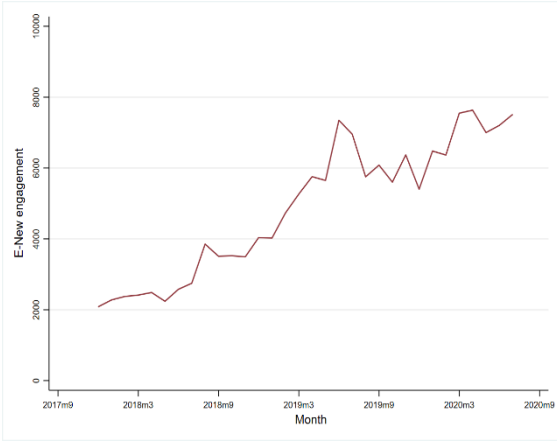
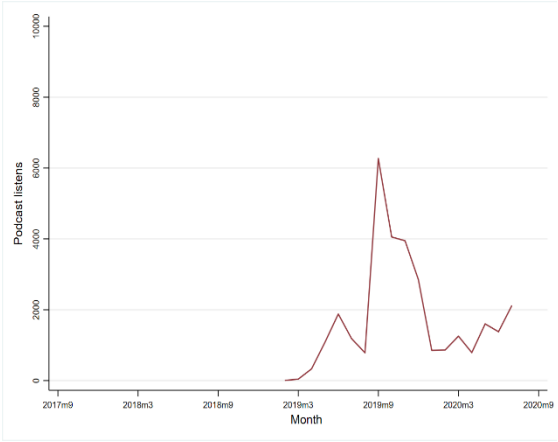


Figure H.1 Number of events and event attendees organised by Be You by months, June 2019 – June 2020

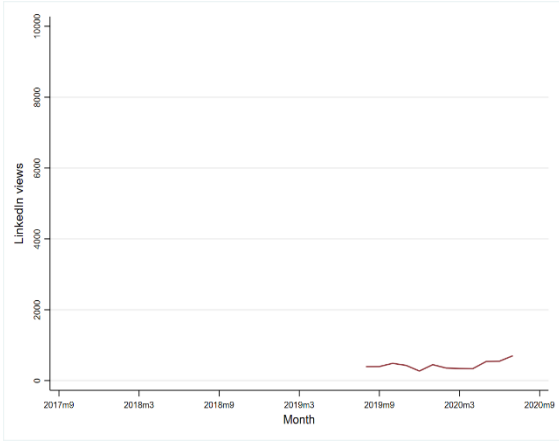
E-News Engagement



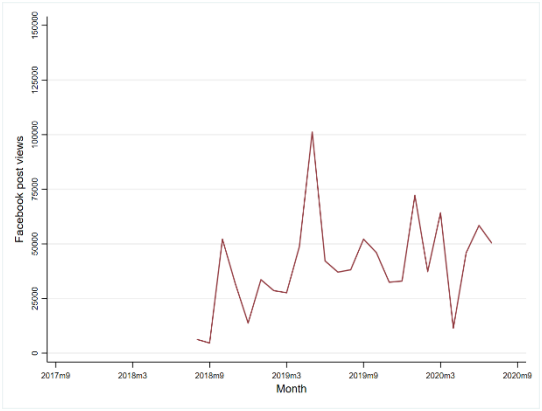
Podcast Listens



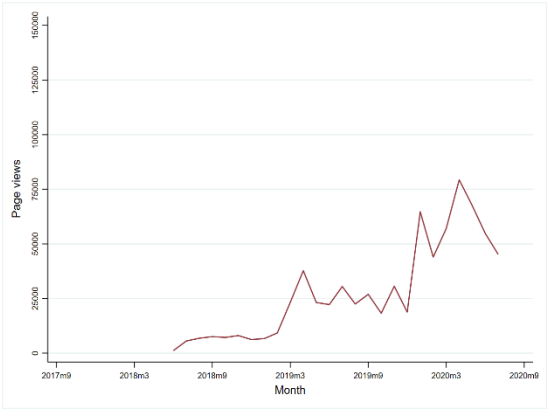
LinkedIn Views



Facebook Post Views



Emerging Minds Page Views



Total Reach

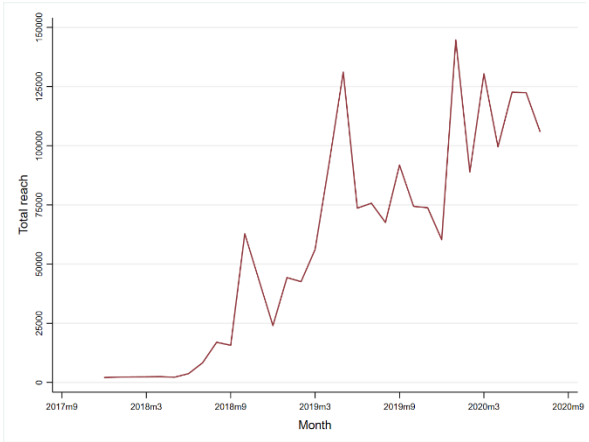


Figure H.2 Trends in digital reach through Emerging Minds social media activities, November 2017 – August 2020

Appendix I: Observed and predicted estimates of the child and youth mental health related indicators

Supplementary Table I.1: Observed and predicted estimates of the child and youth mental health related indicators.

INDICATORS	OBSERVED				PROJECTED			
	Year	LSAC	WA-HWSS	Ten to Men	Year	LSAC	WA-HWSS	Ten to Men
Indicator 1: There is an increase in help-seeking by children and young people compared to no Program[a]	2012		3.9		2018	26.27	5.96	12.88
	2013	34.24	4.3	13.74	2019	24.92	6.45	12.72
	2014		6.5		2020	23.63	6.99	12.55
	2015	35.76	6.1	13.39	2022	21.25	8.21	12.24
	2016		6.3		2024	19.12	9.63	11.92
	2017	27.7	5.5					
	2018		8.4					
	2019		12.2					

INDICATORS	OBSERVED				PROJECTED			
Indicator 2: Changes in the rate of death by suicide for children and youth compared to no Program[b]	Year	ABS			Year	ABS		
	2015	2.3			2018	2.76		
	2016	2.4			2019	2.94		
	2017	2.6			2020	3.12		
	2018	2.5			2022	3.53		
	2019	2.4			2024	3.99		
Indicator3: Change in the rate of emergency department visits related to mental health and addictions[c]	Year	MHE-NMDS			Year	MHE-NMDS		
	2014	72.5			2018	90		
	2015	77.9			2019	95		
	2016	81.1			2020	100		

INDICATORS	OBSERVED				PROJECTED			
	2017	85.4			2022	111		
	2018	89.9			2024	124		
Indicator 4: Changes in proportion of developmentally vulnerable children by the time they start school compared to no Program[d]	Year	AEDC			Year	AEDC		
	2009	10			2018	9.2		
	2012	8.63			2019	9.12		
	2015	9.46			2020	9.04		
	2018	9.72			2022	8.87		
					2024	8.71		
Indicator 5: Proportion of children or young people who exceed the thresholds on the Strengths and Difficulties Questionnaire (SDQ)[e]	Year	LSAC	LSIC	SEHQ	Year	LSAC	LSIC	SEHQ
	2010		39.2	4.3	2018	7.75	28.21	5.02

INDICATORS	OBSERVED				PROJECTED			
	2011	8.25	42.8	4.1	2019	7.65	26.89	5.13
	2012			4.3	2020	7.54	25.64	5.25
	2013	7.68	36.4	4.4	2022	7.34	23.29	5.5
	2014			4.6	2024	7.14	21.16	5.77
	2015	6.75	32.7	4.6				
	2016			4.8				
	2017	7.86	29.6	4.9				
	2018			5.6				
Indicator 6: Changes in proportion of parents reporting high levels of subjective poor health and wellbeing compared to no Program[f]	Year	SEHQ	WA-HWSS		Year	SEHQ	WA-HWSS	
	2009	10.5			2018	9.91	7.63	

INDICATORS	OBSERVED				PROJECTED			
	2010	10.2			2019	9.92	8.08	
	2011	10.8			2020	9.92	8.56	
	2012	11.4	5.8		2022	9.93	9.61	
	2013	11.2	6.4		2024	9.94	10.78	
	2014	11	5.8					
	2015	9.9	8.5					
	2016		7.7					
	2017		7.2					
	2018		8.4					
	2019		7.6					

INDICATORS	OBSERVED				PROJECTED			
Indicator 7: There is increase resilience in children and young people compared to no Program[g]	Year	VSHAWS			Year	VSHAWS		
	2014	30			2018	32.45		
	2016	31.2			2019	33.09		
	2018	32.7			2020	33.75		
					2022	35.09		
					2024	36.5		
Indicator 8: Change in reported quality of family relationship compared to no Program[h]	Year	Mission Australia	LSAC	WA-HWSS	Year	Mission Australia	LSAC	WA-HWSS
	2011		2.09		2018	7.39	0.92	14.64
	2012	6.2		13.9	2019	7.49	0.82	14.38
	2013	7.5	1.68	15.9	2020	7.58	0.73	14.13

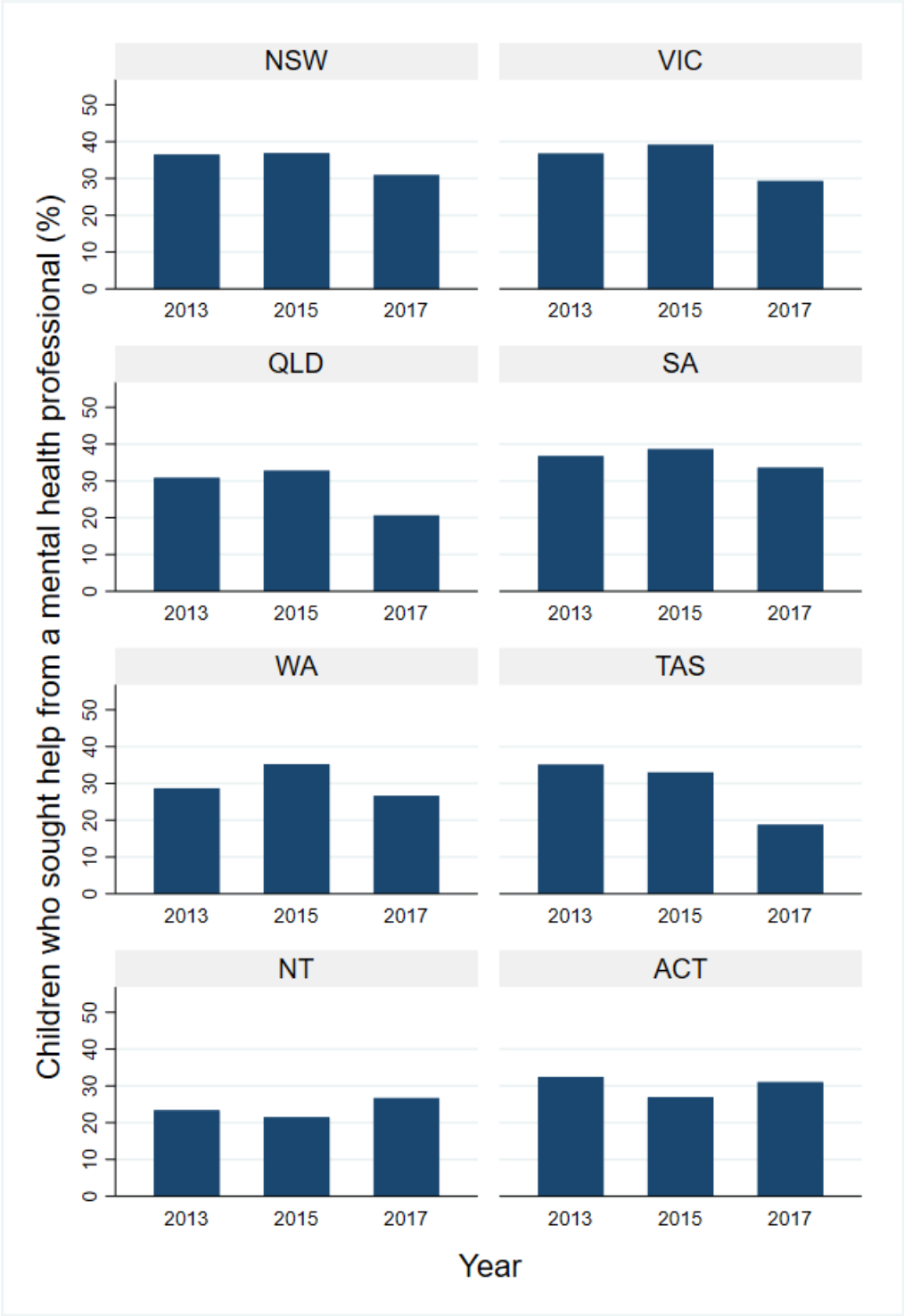
INDICATORS	OBSERVED				PROJECTED			
	2014	7.6		8.2	2022	7.78	0.58	13.64
	2015	7	1.43	8.7	2024	7.97	0.46	13.17
	2016	6.8		11.3				
	2017	7.3	1.03	14.9				
	2018	6.5		11.3				
	2019	6.4		14.5				
	2020	5.2						
Indicator 9: There is improved wellbeing outcomes of children and young people compared to no Program[i]	Year	Mission Australia	LSAY	VSHAWS	Year	Mission Australia	LSAY	VSHAWS
	2010		64.93		2018	25.74	89.87	20.44
	2011		71.73		2019	26.93	93.39	21.9

INDICATORS	OBSERVED				PROJECTED			
	2012	18.7	76.23		2020	28.18	97.05	23.47
	2013	21.1	78.19		2022	30.85	100	26.95
	2014	21.5	81.15	15.5	2024	33.77	100	30.95
	2015	21.1	84.02					
	2016	22.8	85.76	17.8				
	2017	24.6	86.48					
	2018	24.3	87.44	20.4				

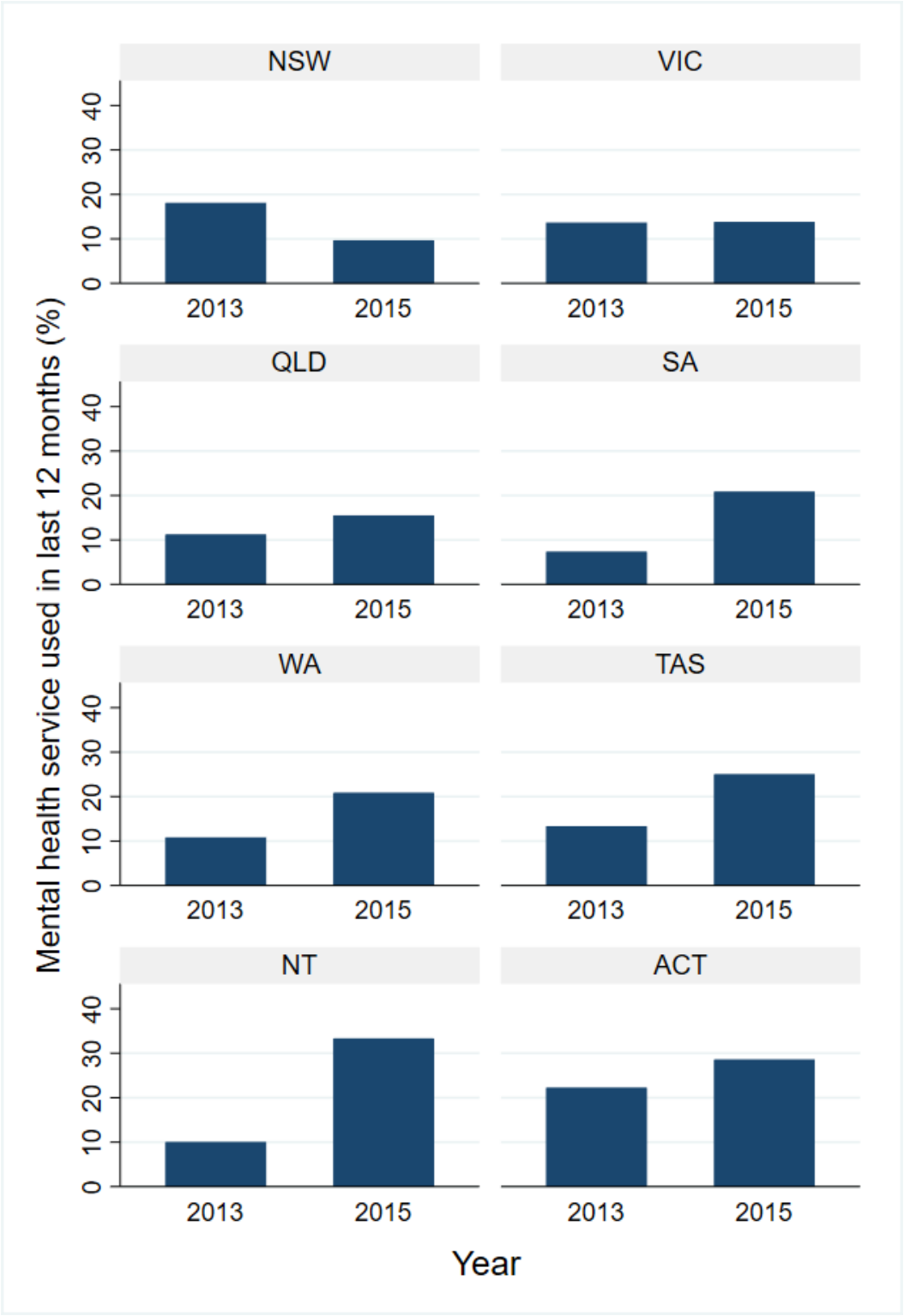
Notes. a = Unit values are proportion in %; b = Unit values are rate per 100000; c = Unit values are rate per 10000; d = Unit values are Proportion in %; e = Unit values are proportion of SDQ>17 for LSAC and SEHQ and SDQ>14 for LSIC in %; f = Unit values are proportion in %; g = Unit values are proportion in %; h = proportion as %; i = proportion in %.

Appendix J: State level variation in the recent trend in various child and youth mental health indicators

Evaluation Indicator 1: Help-seeking by children and young people

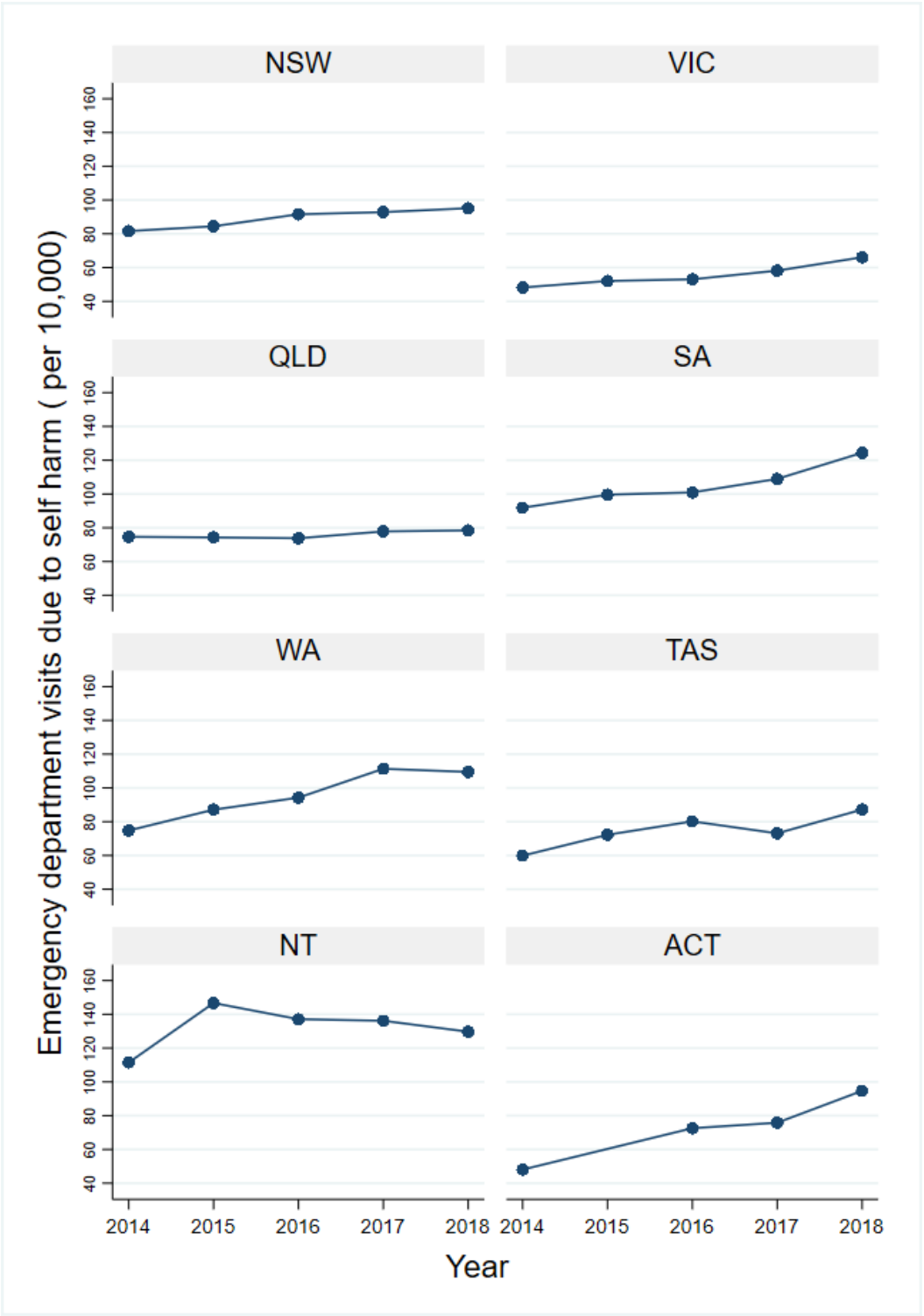


Supplementary Figure J.1 (a): Trends in the proportion of children seeking help for mental health related problem with professionals (school teacher, other staffs, or mental health professional) in Australia, 2013-2018 (LSAC data, Wave 6-8); categorised by State or Territory



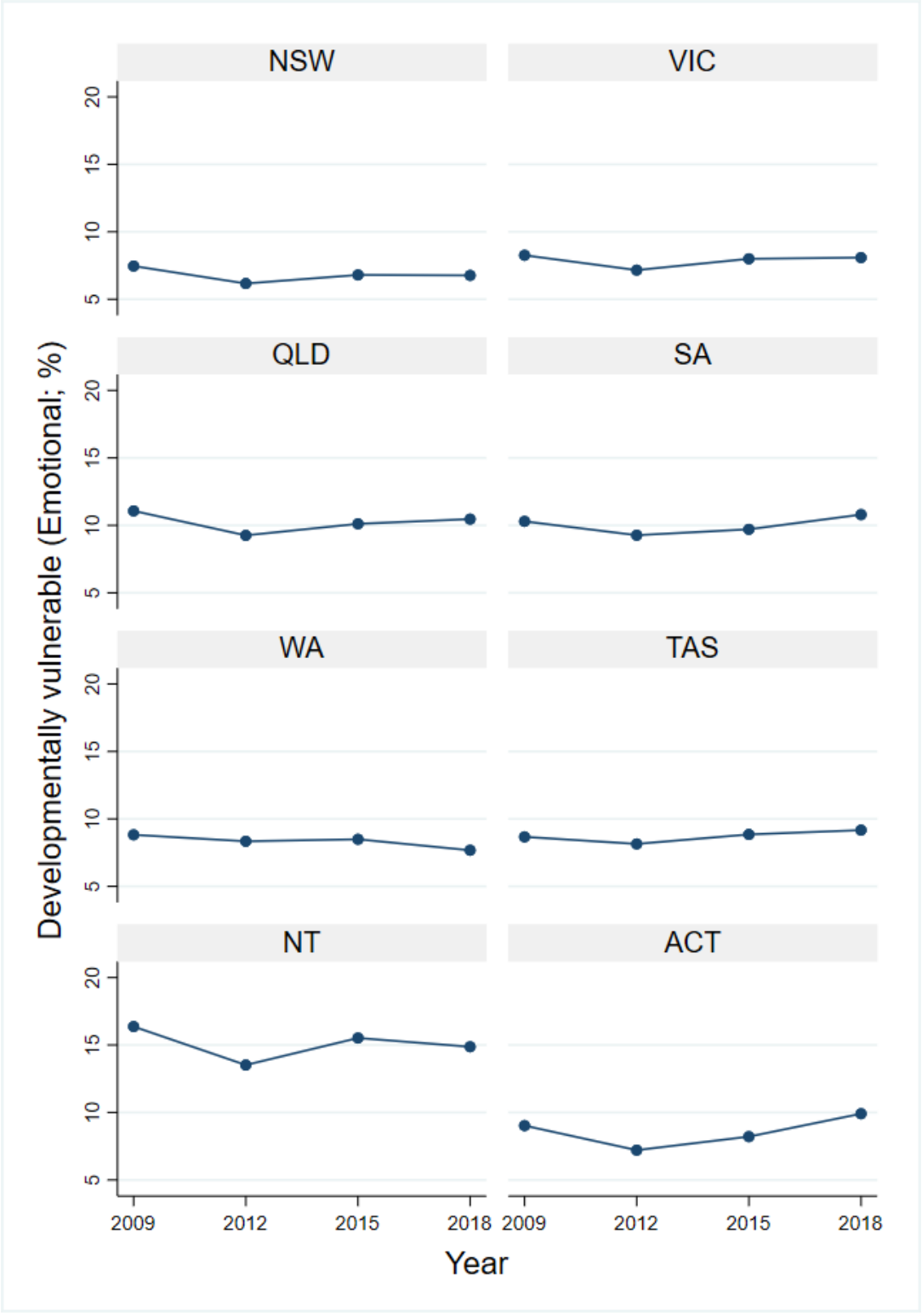
Supplementary Figure J.1 (b): Trends in the proportion of boys who visited mental health care providers in last 12 months in Australia, 2013-2015 (Ten to Men survey data, Wave 1-2), categorised by State or Territory

Indicator 3: Change in rate of emergency department visits for i) deliberate self-harm [No demographic data- unable to extract child and youth age group data], ii) related to mental health and addictions; and iii) change in rate of hospital admissions related to mental health and addictions



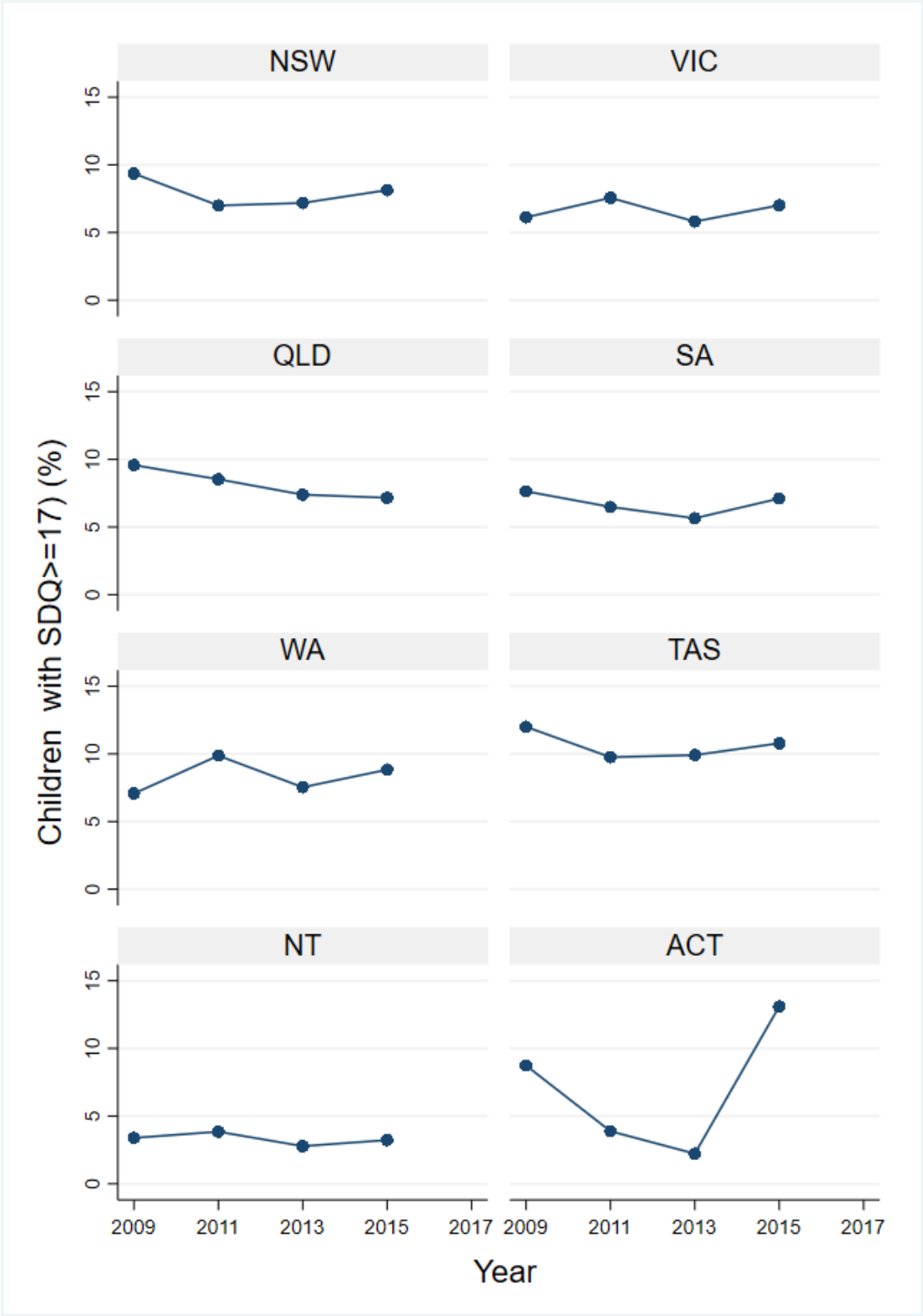
Supplementary Figure J.2: Trends in the average number and proportion (per 10000) of children per SA3 who visited the emergency department due to mental health and addiction issues during 2014-2018 in Australia; categorised by State or Territory.

Indicator 4: Changes in proportion of developmentally vulnerable children by the time they start school compared to no Program



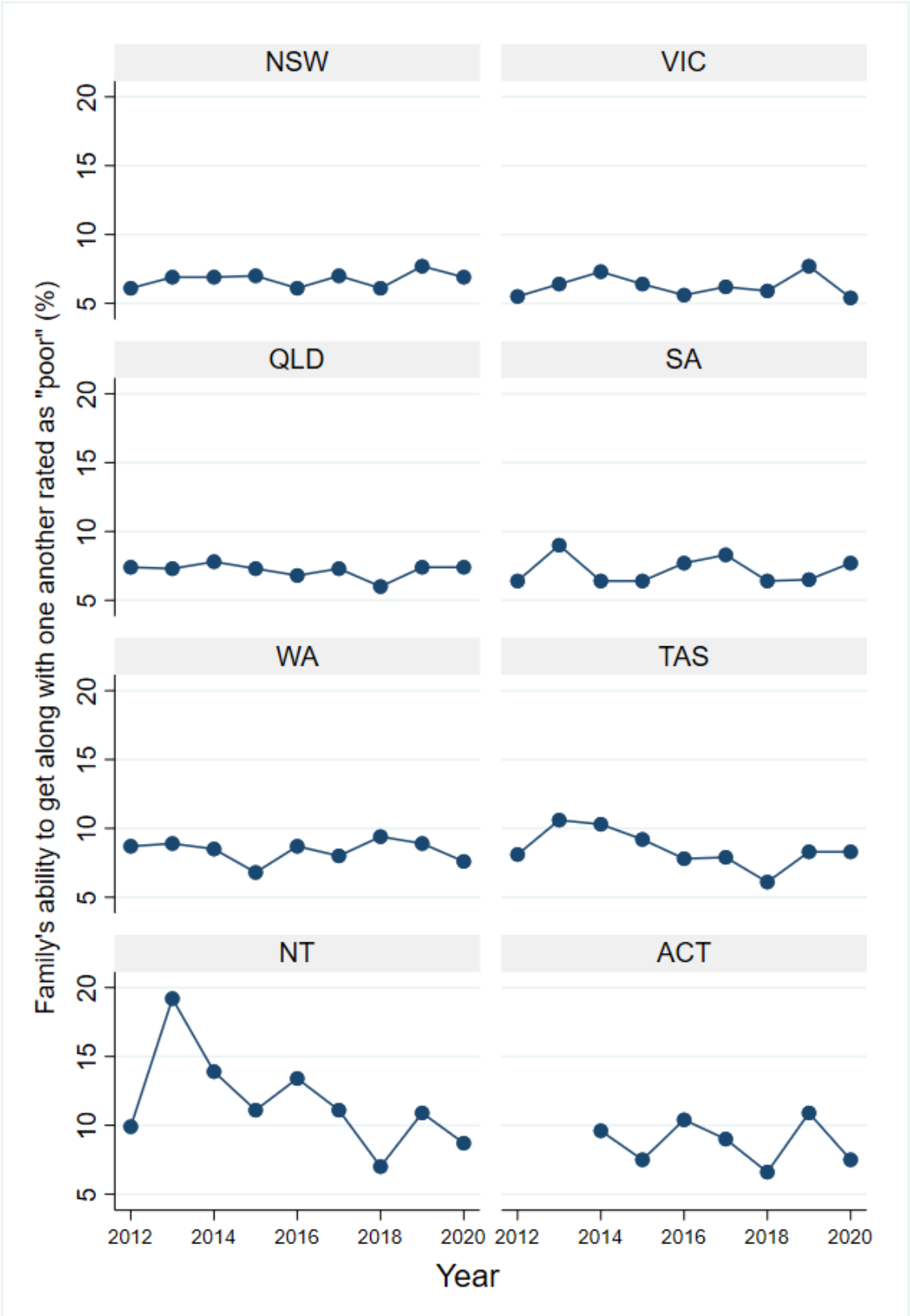
Supplementary Figure J.3: Trends in the proportion of developmentally vulnerable children in Australia, 2009-2018 (AEDC Survey Data), categorised by State or Territory

Indicator 5: Proportion of children or young people who exceed the thresholds on the Strengths and Difficulties Questionnaire (SDQ)

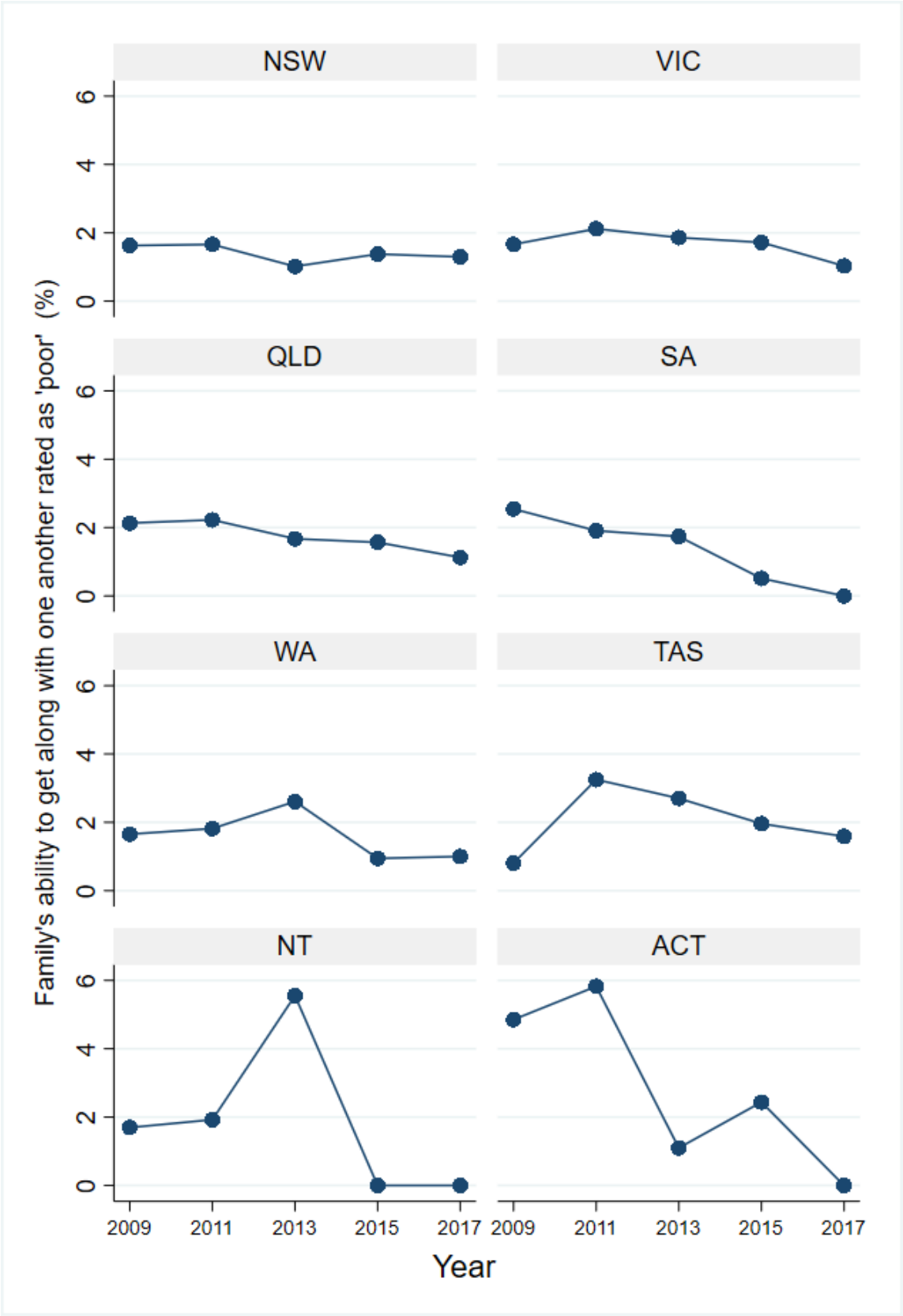


Supplementary Figure J.4: Trends in the proportion of children with SDQ score >=17 in Australia between 2009-2018, categorised by State or Territory (LSAC survey data)

Indicator 8: Change in reported quality of family relationship compared to no Program

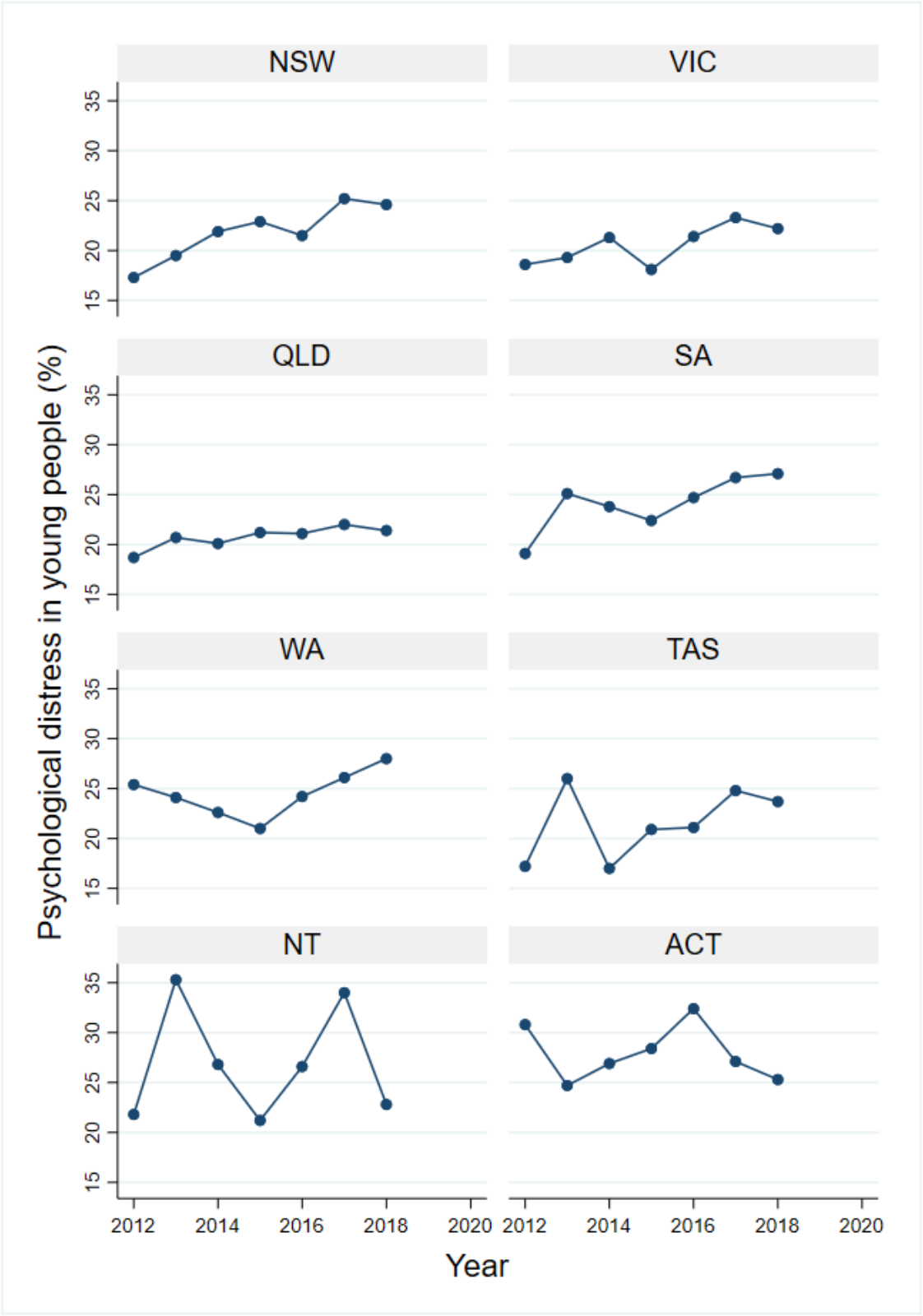


Supplementary Figure J.5 (a): Trends in the proportion of young people who rated their family's ability to get along with one another as 'poor' in Australia, 2012-20 (Mission Australia Youth Survey) categorised by State or Territory

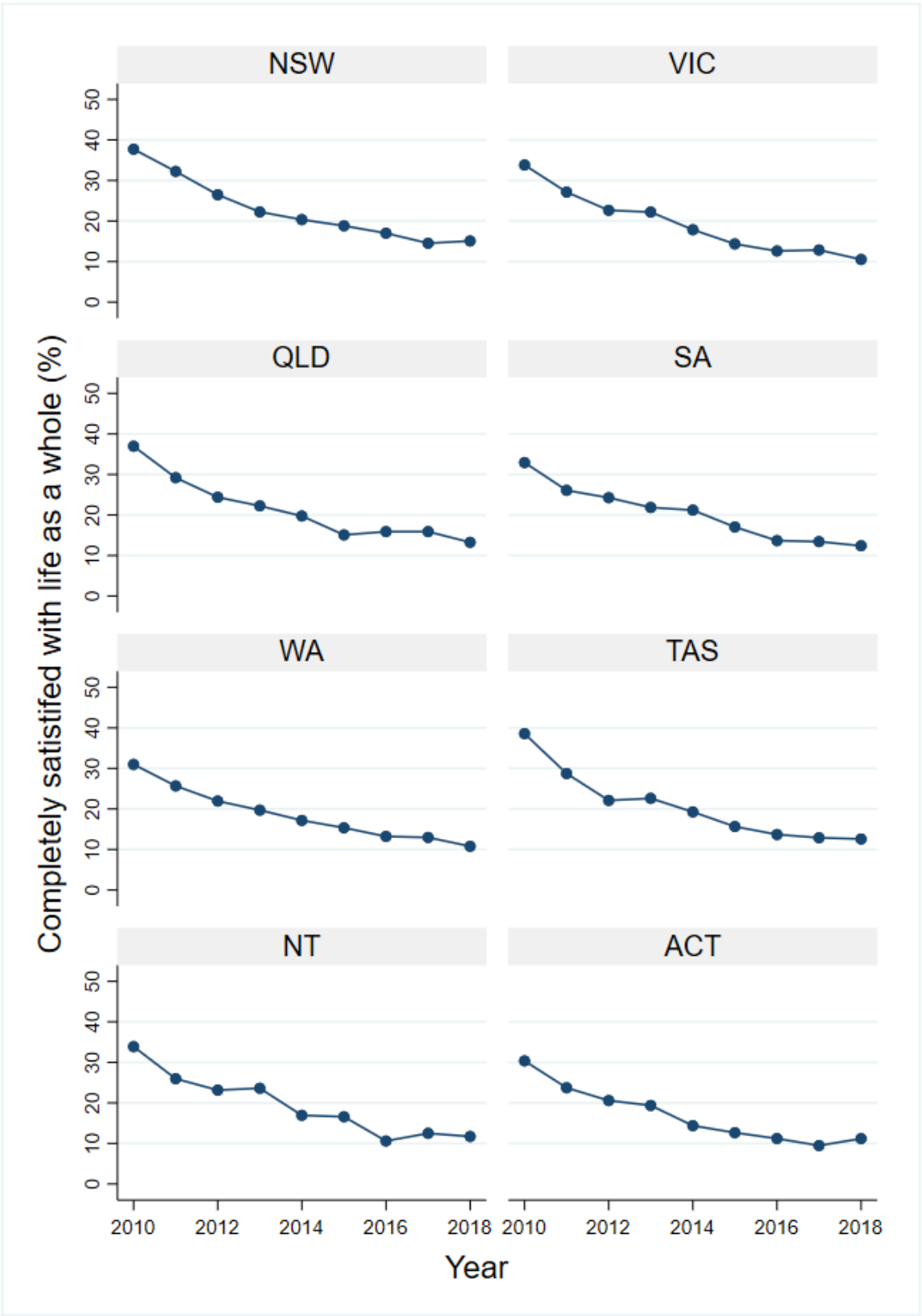


Supplementary Figure J.5 (b): Trends in the proportion of young people who rated their family's ability to get along with one another as 'poor' in Australia, 2012-20 (LSAC survey data) categorised by State or Territory

Indicator 9: There is improved wellbeing outcomes of children and young people compared to no Program



Supplementary Figure J.6 (a): Trends in the proportion of psychological distress in young people (15-19 years), 2012-18 in Australia (Mission Australia Youth Survey), categorised by State or Territory



Supplementary Figure J.6 (b): Trends in the proportion of life satisfaction among children and young people in Australia during 2011-2018 (LSAY) categorised by State or Territory

Appendix K: Value For Money - Be You

Table K.1: Potential users and costs by proportion

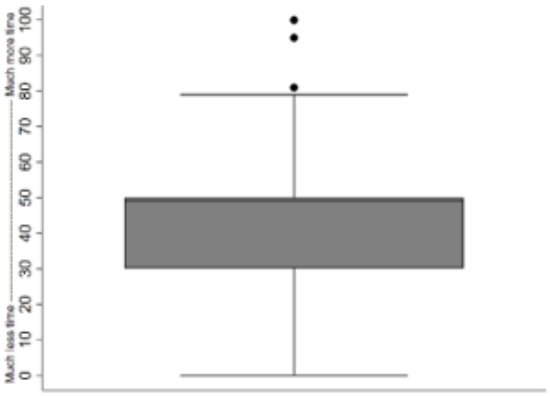
Proportion	Potential users	Be You potential cost per user[a]
5.00%	36,207	$653.64
10.00%	72,414	$326.82
15.00%	108,621	$217.88
20.00%	144,828	$163.41
25.00%	181,034	$130.73
30.00%	217,241	$108.94
35.00%	253,448	$93.38
40.00%	289,655	$81.71
45.00%	325,862	$72.63
50.00%	362,069	$65.36
100.00%	724,138	$32.68

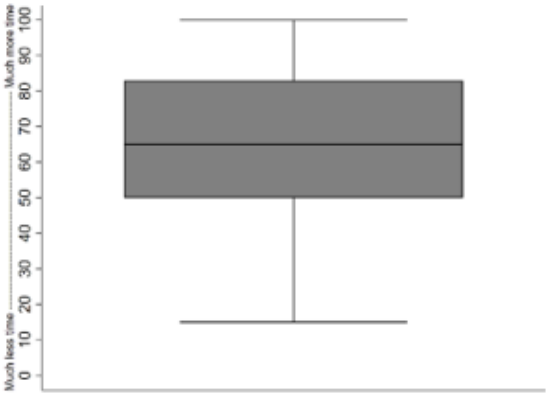
[a] Be You potential cost per user = Total delivery and development cost - 2019 ($23,666,299) / potential users

Table K.2: Be You registration numbers and uptake rates over time (All categories)

Be You Categories	August 2019			August 2020		
	Total pool[a]	Be You registration[b]	Proportion	Total pool[a]	Be You registration[b]	Proportion
Total Educators	536,501	43,358	8.08%	485,998	69,411	14.28%
School leaders	24,651	8,307	33.70%	20,424	11,527	56.44%
Specialist and support staff	148,139	10,477	7.07%	157,736	17,900	11.35%
Early learning service leaders	14,846	4,783	32.22%	16,105	7,069	43.89%
Tertiary professionals	95,649	1,116	1.17%	115,503	1,556	1.35%
Pre-service Educator	No data	4,102		No data	7,960	
Other		8,406			13,175	

Data source:
[a] A full time equivalent (FTE) of total staff, Australia as of August 2019 (6291.0.55.001 - EQ08 - Employed persons by Occupation unit group of main job (ANZSCO), Sex, State and Territory, August 1986 onwards).
[b] Be You registration data





Participant response to perceived time spent (%)

Compared to other activities or tools you use for your continuing professional learning; Be You takes up how much of your time?

Mdn = 49(IQR: 30, 50) [N = 115]

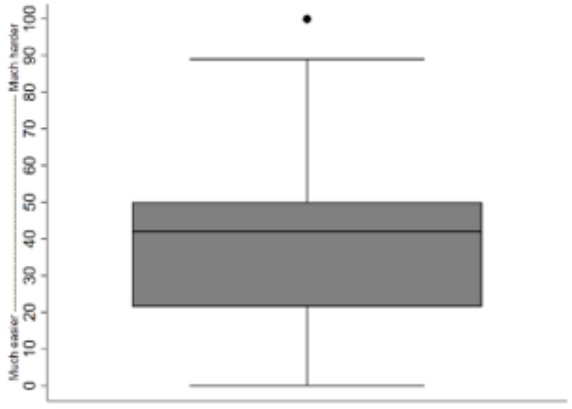
Participant response to perceived time spent (%)

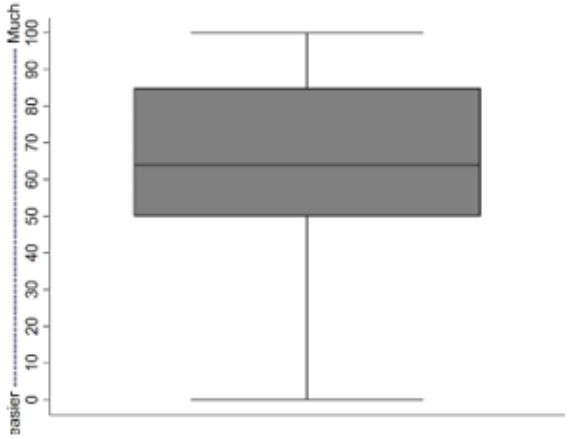
If Be You was not available, how much time would it take to obtain the relevant information from other sources to support your students'/children's mental health?

Mdn = 65(IQR: 50, 83) [N = 129]

Note. Responses were provided on a 100-point Visual Analogue Scale ranging from 0 (Much less time) to 100 (Much more time).

Figure K.1: Survey responses: Time domain





Participant response to perceived ease of access (%)

Compared to other activities or tools you use for your professional learning, how much easier or harder is Be You to use?

Mdn = 42(IQR: 21.5, 50) [N = 116]

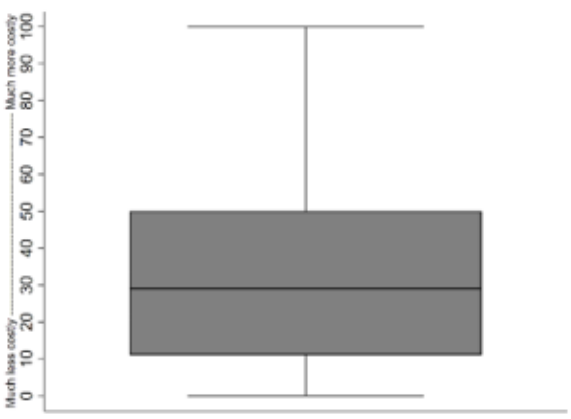
Participant response to perceived ease of access (%)

If Be You was not available, how much easier, or harder would it be to obtain information needed to support your students/children's mental health?

Mdn = 64(IQR: 50, 85) [N = 127]

Note. Responses were provided on a 100-point Visual Analogue Scale ranging from 0 (Much easier) to 100 (Much harder)

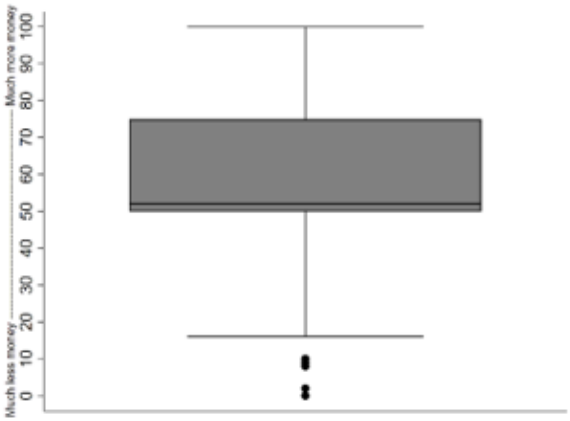
Figure K.2: Survey responses: Ease of access domain



Participant response to perceived costs (%)

Compared to other activities or tools you use for your professional learning, how costly is Be You?

Mdn = 29(IQR: 11, 50) [N = 103]



Participant response to perceived costs (%)

If Be You was not available, how much money would it cost to obtain information needed to support your students/children's mental health?

Mdn = 52(IQR: 50, 75) [N = 117]

Note. Responses were provided on a 100-point Visual Analogue Scale ranging from 0 (Much less costly) to 100 (Much more costly)

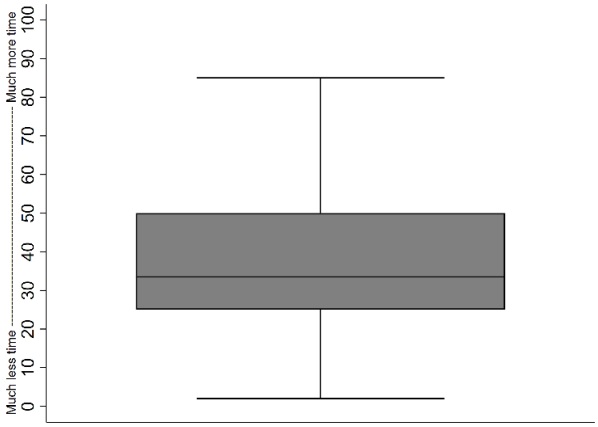
Figure K.3: Survey responses: cost domain

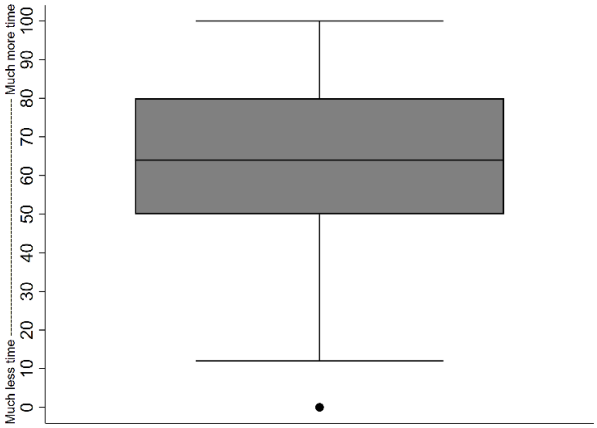
Appendix L: Value For Money - Emerging Minds

Table L.1: Registration numbers by profession

Occupation	June 2019 (proportion)	June 2020 (proportion)	Increase over time
Aboriginal and Torres Strait Islander health worker	1 (0.003%)	33 (0.082%)	32
Aboriginal and Torres Strait Islander SEWB (social and emotional wellbeing) worker	0	70 (0.175%)	70
Academic researcher	2 (0.007%)	82 (0.205%)	80
Alcohol and drug worker	269 (0.928%)	405 (1.011%)	136
Child and family Practitioner	6 (0.021%)	355 (0.886%)	349
Child protection Practitioner	3 (0.010%)	120 (0.300%)	117
Consumer or carer consultant	241 (0.831%)	297 (0.741%)	56
Counsellor	1345 (4.639%)	1868 (4.663%)	523
Disability worker	0	247 (0.617%)	247
Early childhood worker	1071 (3.694%)	2422 (6.045%)	1351
General Practitioner	942 (3.249%)	1123 (2.803%)	181
Health promotion or community development officer	141 (0.486%)	219 (0.547%)	78

Occupation	June 2019 (proportion)	June 2020 (proportion)	Increase over time
Lawyer/legal services worker	0	11 (0.027%)	11
Maternal and child health nurse	5 (0.017%)	115 (0.287%)	110
Mental health nurse	2084 (7.187%)	2320 (5.791%)	236
Midwife	3 (0.010%)	28 (0.070%)	25
Non-specialist trainee	0	14 (0.035%)	14
Occupational therapist	1315 (4.535%)	1614 (4.029%)	299
Other	8787 (30.304%)	11295 (28.193%)	2508
Other medical specialist	0	5 (0.012%)	5
Other nurse	4 (0.014%)	100 (0.250%)	96
Paediatrician	0	10 (0.025%)	10
Physio/osteo/chiropractor	0	9 (0.022%)	9
Police or fire services officer/paramedic	0	3 (0.007%)	3
Psychiatrist	179 (0.617%)	196 (0.489%)	17
Psychologist	2503 (8.632%)	3120 (7.788%)	617
Social worker	5818 (20.065%)	7365 (18.384%)	1547
Speech pathologist	157 (0.541%)	264 (0.659%)	107
Teacher	1418 (4.890%)	2525 (6.303%)	1107
Tertiary student	1883 (6.494%)	2455 (6.128%)	572
Youth worker	819 (2.825%)	1373 (3.427%)	554
Total	28996	40063	11067





Proportion of participant response to perceived time spent (%)

Proportion of participant response to perceived time spent (%)

Compared to other activities or tools you use for your continuing professional learning, how much time does Emerging Minds take up?

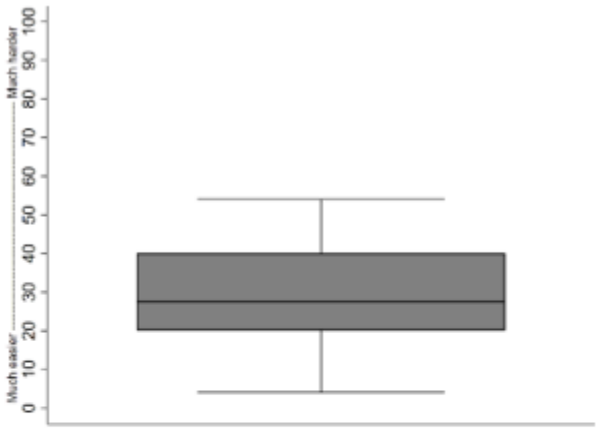
Mdn = 33.5(IQR: 25, 50)[N = 46]

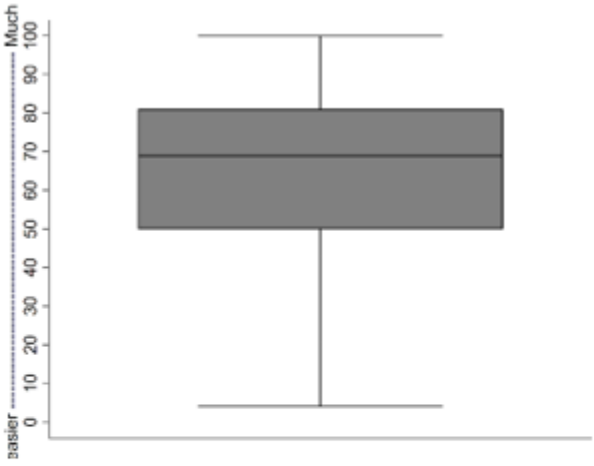
If Emerging Minds was not available, how much time would it take to obtain the relevant information from other sources to support children's mental health?

Mdn = 64(IQR: 50, 80)[N = 51]

Note. Responses were provided on a 100-point Visual Analogue Scale ranging from 0 (Much less time) to 100 (Much more time).

Figure L.1: Survey responses: Time domain





Proportion of participant response to perceived ease of access (%)

Proportion of participant response to perceived ease of access (%)

Compared to other activities or tools you use for your continuing professional learning, how much easier or harder is Emerging Minds to use?

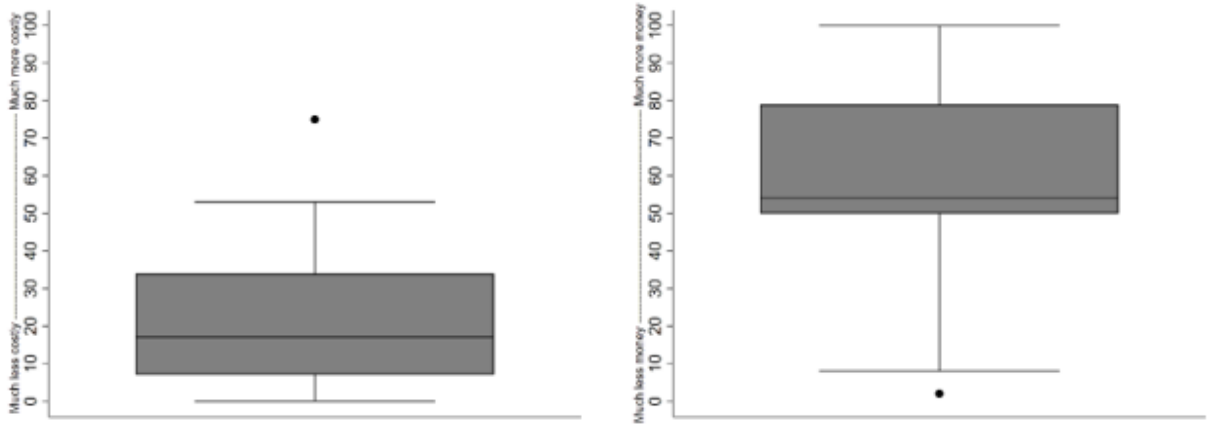
Mdn = 27.5(IQR: 20, 40) [N = 46]

If Emerging Minds was not available, how much easier, or harder would it be to obtain information needed to support children's mental health?

Mdn = 69(IQR: 50, 81) [N = 49]

Note. Responses were provided on a 100-point Visual Analogue Scale ranging from 0 (Much easier) to 100 (Much harder)

Figure L.2: Survey responses: Ease of access domain



Proportion of participant response to perceived costs (%)	Proportion of participant response to perceived costs (%)
Compared to other activities or tools you use for your continuing professional learning, how costly is Emerging Minds?	If Emerging Minds was not available, how much money would it cost to obtain information needed to support children's mental health?
Mdn = 17(IQR: 7, 34) [N = 44]	Mdn = 54(IQR: 50, 79) [N = 49]

Note. Responses were provided on a 100-point Visual Analogue Scale ranging from 0 (Much less costly) to 100 (Much more costly).

Figure L.3: Survey responses: cost domain

Appendix M: Summary of Consultation Analyses

Overarching Evaluation Question 1: How well has the Program been implemented?

Sub question b: To what extent has implementation varied across contexts?

Indicator 2: The extent to which users (Educators and Practitioners) working in different contexts used the Program to change their practice.

PROGRAM LOGIC C1

Educators have increased capability in promoting mental health & responding to mental health issues earlier (in collaboration with other services, professionals & families)

Findings: Educators reported having have some capability in promoting and responding to children and young people's mental health issues in the early years setting (e.g., Logan). However, this is more likely to be due to existing networks and workplace practices than new knowledge via Be You/Emerging Minds. Some Educators reported engaging in timely communications with mental health professionals and families/carers with the aim of promoting the importance of youth mental health as well as destigmatising it. For example, the following Educator describes their well-established connection with other local organisations and personnel to support young people's mental health:

"There's been a few things we've done. So we've either written things for the family to take to the mental health professionals, it might be a physio[therapist]…we've got some good relationships with some behavioural specialists. And they've come [to the centre] and we've all sat down together, the family, us the professional and just, you know, had a chat at the centre." **Educator, Logan ELS**

Participants also mentioned other community stakeholders whose roles in young people's mental health suggest they may benefit from connection to BeYou and Emerging Minds. These included sporting and arts organisations, church organisations, pastoral care providers, Councils, and non-government social service providers.

PROGRAM LOGIC C2

Clinical/non-clinical workers engage in best practice & understand how to promote mentally healthy behaviour & relationships in children/young people and their families

Findings: Clinical/non-clinical mental health workers' contributions to youth mental health were recognised by community members/parents as valuable. However, focus group participants suggested that some practices in promoting youth mental health may need improvement, as well as relationships with the young people and their families. There have been criticisms of their a) strong deficit-oriented clinical focus on mental health, b) inconsistent and short-term engagement with children and young people, c) lack of essential interpersonal skills when communicating sensitive topics with young people from different backgrounds and d) lack of engagement with families.

It is worth noting that interviewees recognised that some of the aforementioned problems were due to structural issues in the healthcare system.

"…Say you've got a suicidal teenager and you want to get them on a mental health plan and immediately start addressing what might be, you know, creating this state of mind and things like that… However, after the intake, it could take three to six months for the psychiatrist or psychologist to get back to you." **Logan**

Program Logic D1

Early childhood & school communities connect with, utilise & where appropriate refer children & young people to available mental health information & supports

Findings: Despite some structural barriers hindering access (e.g., cost, transport to reach services, referral processes, wait times), early childhood and school communities reported working closely with available local mental health supports and promoting youth mental health collaboratively. Although they may face obstacles

in the long and complex referral process, some schools have developed their own mental health support system for the students, often involving non-teaching staff (counsellors, chaplains/pastoral care workers, learning support staff). Such staff may also benefit from learning opportunities via Be You/Emerging Minds:

"In the school there's school chaplains who are provided by YouthCARE and they have played a very vital role locally to help the kids through. But specifically, there's a [school] and they take kids with all sorts of learning difficulties or social difficulties…and the teachers are fantastic and the whole school is about relationship." **Parent, Albany**

Some noted it difficult to connect with parents to provide mental health support:

"It's hard to get the parents of at-risk families to actually come to anything that we hold…half the time we're preaching to the converted." **Teacher, Cockburn**

PROGRAM LOGIC D4

Clinical/non-clinical workers provide appropriate mental health support & information to children/young people & their families, and foster positive relationships to support resilience & social/emotional wellbeing

Findings: Few interviewees agreed that clinical/non-clinical workers' practices support young people's mental health appropriately. Almost all believed that the relationships between young people and mental health Practitioners are often one-off and inconsistent. As a result, there are significant numbers of young people who are reluctant or do not access mental health supports at all. Practitioners report that resilience and social emotional wellbeing training were almost non-existent in the clinical settings.

System-level barriers include the time allowed for consultations being inadequate to develop appropriate rapport to address mental health needs:

"[When visiting GP now], you are in and out…it's 15 minutes and you are purely based on solving what you came in and presented with, which will very rarely be your underlying problems, or concerns." **Cockburn**

Another significant issue reported by participants was the timeliness of access to supports, where waiting lists become a barrier, and the lack of connection between services means repetition can re-traumatise young people:

"So - because a teenager, three months is a long time. Three to six months…I've had a child, my eldest, who I tried to get into headspace and she just lost interest… teenagers don't want to explain themselves to the doctors. After they've already gone through as much as they can with their parents and then go to a service with a counsellor or an intake administrator and talk about that. And then wait another few months before they have to explain the whole thing again to a psychologist or a psychiatrist." **Parent/Educator, Logan**

It was also noted by several parents/community members that some clinical professionals may lack the right interpersonal or professional skills to support youth mental health: An interviewee who self-identified as bisexual described a traumatising experience visiting a psychiatrist, indicating that more training is needed for professionals to develop this sensitivity and awareness.

"…a psychiatrist …and so he said, well you cannot be bisexual, you're either gay or straight. And he said, you're the reason your parents are having marital issues… I don't think you need interpersonal skills training to know that you really shouldn't say that to a vulnerable 14-year-old who's having suicidal thoughts." **Young community member, Logan**

A need has also been noted for front desk staff at support organisations to be included in training opportunities.

"Reception people need upskilling too – they end up as 'incidental counsellors." **Parent, Logan/South Brisbane**

PROGRAM LOGIC D6

Whole-of-setting (school, health/social support service) changes in practice occur to improve effectiveness & sustainability of response to child/young people's mental health needs and/or suicide events -> Workforce responsiveness to child/mental health issues & wellbeing is enhanced

Findings: There was limited consistent evidence across the four communities to provide assessment of progress towards this stage in the Program Logic. However, one Early Learning Service in the Logan/South Brisbane area (QLD) provided information for a case study to illustrate how this may be achieved (**refer Spotlight Case Study**).

Conclusion: The above section described Educators' and Practitioners' capacity in supporting youth mental health issues. Given the initiatives have seen limited access or use in this sample, it is not feasible to conclude that the initiatives have changed these practices and capabilities across the board. In general, interviewees suggest that Educators have better capacity and more appropriate skills than clinical professionals when it comes to addressing youth mental health issues from a holistic family view.

Sub-question c: To what extent has the Program reached the intended participants?

Indicator 2: Extent to which users and stakeholders agree that the Service coverage/provision is designed to be equitable, needs-driven

PROGRAM LOGIC C1

Educators have increased capability in promoting mental health & responding to mental health issues earlier (in collaboration with other services, professionals & families)

PROGRAM LOGIC C2

Clinical/non-clinical workers engage in best practice & understand how to promote mentally healthy behaviour & relationships in children/young people & their families

Findings: Given its online-based nature, access to this Program was perceived by some participants as not equitable, especially in rural and remote areas where internet connection is often unstable or non-existent. Access to computers and/or somewhere to work online was also an issue in some communities/among lower socioeconomic status workers.

"…Quite often, having an internet connection is a privilege and not an everyday occurrence in rural remote [areas]. Even if someone's got a phone, it doesn't mean they've got the data, it doesn't mean they've got the bandwidth to be doing anything online…"

Interviewees also suggested a limited need for developing another online platform, suggesting that numerous platforms offering collated general mental health information are already available. The range of sources noted by participants included some with a significant evidence base but others less well credentialled. Interviewees suggested that a platform that provides guidance around navigating between different resources to better support youth mental health might be more useful. Guidance regarding the evidence base for such resources may also be helpful.

Conclusion: The Program's reach to its intended participants is limited where internet access, technology and facilities are not readily available. This means that service coverage/provision is not equitable for those who live in rural and remote areas and already have less access to learning/professional development opportunities.

Sub-question d: To what extent is the Program aligned/integrated with existing services?

Indicator 2: The degree to which Educators and Practitioners report feeling confident in their ability to connect with, utilise, and, where appropriate, refer children and young people to mental health supports compared to no Program

PROGRAM LOGIC C1

Educators have increased capability in promoting mental health & responding to mental health issues earlier (in collaboration with other services, professionals & families)

PROGRAM LOGIC C2

Clinical/non-clinical workers engage in best practice & understand how to promote mentally healthy behaviour & relationships in children/young people and their families

Findings: Educators generally reported lower levels of confidence in supporting youth mental health than some of the health Practitioners. This content was not typically available in their previous trainings and they noted a scarcity of professional development opportunities targeting youth mental health. Some Practitioners noted that the opportunity to build networks with other people/services was missing from online learning opportunities.

"For me it's about face to face… I learn better but it's also about building relationships and connections with the other people in the room… strengthen your own network and hopefully add value to other people's networks…" **Practitioner, Cockburn**

"…You don't just attend the {[training], you're grabbing people for coffee [to connect about services] and pulling [organisations] together…" **Practitioner, Albany**

Given the low uptake rate of the initiatives among participants, there is not enough evidence to comment on the impact of the Program compared to no Program.

Sub-question d: To what extent is the Program aligned/integrated with existing services?

Indicator 3: The degree to which Educators and Practitioners report changes to ways of working with, or referring on to, other mental health settings compared to no Program.

PROGRAM LOGIC D1

Early childhood and school communities connect with, utilise and where appropriate refer children and young people to available mental health information and supports

Findings: Educators and Practitioners generally reported low levels of confidence in linking children and young people to mental health supports. A number suggested that instead of platforms that provide mental health information/training, they would prefer services/platforms that helps them better identify and navigate between available services in the local area:

"But if there was maybe something like that you could actually put in some key words and it would tell you what [mental health services] are locally available…that might be quite useful". **Educator, Mt Isa**

This lack of awareness did not always reflect the level of services available in the local community:

"We've got …22 pages of different services that can help you…but they are too busy to realise what help they need, or crisis mode all the time…." **Council member, Cockburn**

Given the low uptake rate of the initiatives among participants, there is not enough evidence to comment on the impact of the Program compared to no Program.

PROGRAM LOGIC D3

Students, teachers, and families are aware of, seek and utilise appropriate support as needed, following a suicide in their school community -> school communities respond appropriately to a suicide event

PROGRAM LOGIC D4

Clinical/non-clinical workers provide appropriate mental health support and information to children/ young people and their families, and foster positive relationships to support resilience and social/emotional wellbeing

Findings: There was not enough evidence to provide assessment of this indicator (i.e. comparison with no Program).

Conclusion: The Program offered limited assistance for Educators and Practitioners to connect with existing mental health services since most users have only accessed the initiatives as sources of mental health information. Links to localised service directories may be a helpful addition to the platforms.

Sub-question e: What are the implementation lessons?

Indicator 1: Reported enablers and barriers of implementation identified by users, consultants, and Beyond Blue and Emerging Minds

PROGRAM LOGIC D1

Early childhood and school communities connect with, utilise and where appropriate refer children and young people to available mental health information and supports

PROGRAM LOGIC D2

Early childhood & school communities have a mentally healthy culture (reinforced by appropriate policies & procedures), where mental health is understood & promoted

PROGRAM LOGIC D4

Clinical/non-clinical workers provide appropriate mental health support and information to children/ young people and their families, and foster positive relationships to support resilience and social/emotional wellbeing

Findings: Participants noted a number of barriers that were more related to the structure of the mental/health system, rather than the Program. These included costs, transport issues, waiting times, complex referral pathways, youth-friendliness or cultural appropriateness of available supports, discontinuity of service availability due to funding arrangements, stigma, and lack of integrated family support.

Participants identified a number of local champions of youth and family wellbeing – in schools and other organisations, but these tended to be individuals rather than system-wide championing of young people's mental health.

Issues of time, resources and competing pressures were all noted as potential barriers to uptake and implementation of learning from the Program.

"Child health nurses…have got more and more things they have to do… domestic violence screening…whatever the age and state requirements … a whole different tick list of things to do… there's less chance of actually finding [mental health problems]." **Practitioner, Cockburn**

There was limited evidence across the communities to provide overall assessment of this indicator, but the Spotlight Case Study (below) provides information on how this may be achieved.

Conclusion: There was not enough evidence to provide assessment of this sub-question.

Overarching Evaluation Question 2: How appropriate is the Program design to deliver the intended outcomes

Sub-question a: To what extent does the design of the Program address the needs in the community

Indicator 1: The degree to which users agree that the range of resources (e.g., modules, programs, webinars, factsheets, etc.) meet their needs to address child and youth mental health needs.

Findings: Few interviewees reported having utilised Be You and Emerging Minds resources; of those who did, most reported accessing webinars. The spotlight case study organisation reported use of modules from Be You and videos and articles from Emerging Minds. Those who have used resources have found the information from the seminars generally useful and the learning modules well-designed. However, they have not found these resources unique.

"I found them very, very helpful. I think they would really appeal to beginning Educators as well as more skilled ones. They feel very, relatable. They're very simple language. There's not a lot of jargon in it, and I think that's what does turn people off. If you go in to do a module online, and if it's full of jargon and you may not understand what the word means, and you're - you're having to go out to - to actually clarify what it is they're talking about. It really puts you off. But I found that they were all really well-written and there's questions and answers. You know, a recap on your learning, and then you get your level certificate. But yeah, I think they're really good. And, you know, you can share those sorts of learnings with your families in time." **Educator** (early childhood); **community engagement** role, **South Brisbane Logan**

"Had a little look at the Be You website as to the different fact sheets and different things you can access as well. I can do it at home, I can do it here. Because it's free and it's accessible. It's [Be You resources] very accessible for everyone that can access it, which is great… I'm not very tech-savvy and I seemed to navigate

it okay. I'm a very visual person, so I liked how it had the videos and the different ways of learning." **Educator** (early childhood); also involved with church group, **South Brisbane Logan**

"…the work we're doing with Be You is more of that integrated kind of program that you can bring into your team. It's that modules online that that have got kind of this really nice sequential kind of learning process that happens." **Educator** (early childhood) – **centre director, South Brisbane Logan**

"I would say we use obviously Be You a lot for the modules. I find Emerging Minds really helpful for short videos, articles, you know if we just need to find some quick information on a particular thing that might have popped up. I find that it's got a lot on it, Emerging Minds. So, I would go to that one [Emerging Minds], probably first. And then Be You for the more formula - formalised modules." **Educator** (early childhood) **– leader, South Brisbane Logan**

Sub-question a: To what extent does the design of the Program address the needs in the community

Indicator 2: The degree to which users agree that the primary mode of Program access (i.e. online portal meets their needs to address child and youth mental health needs.

Findings: Although there were few discussions around the Program, interviewees offered views on online delivery of programs which were split. Those who supported online delivery of professional training programs suggested that online programs are easy to attend, self-paced, flexible, and without unnecessary social interactions. Those who preferred face-to-face learning modalities suggested that online training lacks interactive and skills-practice components, is hard to access without internet or appropriate technology, and may be less stimulating and engaging.

"It's very easy. I found it very easy to navigate, and I'm not technically - I don't have much patience with the computers. If you can't find it within one or two clicks, I tend to get frustrated. But I found it really easy." **Educator** (early childhood); **community engagement** role, **South Brisbane Logan**

"I think that, the end product of with an engaging program or anything like that, the only way something's going to be taken up really and work successfully is through relationships. So, if you don't get a relationship through an online program, and you don't get those support and connections. So, if somebody comes out to do some training with you, you've straightaway got a link with that person." **Teacher, Mt Isa**

"So, definitely I agree their [Be You] resources, and the structures they provide, especially, like, suicide post-vention and stuff like that is, all really great stuff. But the actual training, the upskilling of people and the things that they need needs, to be done differently." **Teacher, Mt Isa**

Sub-question a: To what extent does the design of the Program address the needs in the community

Indicator 3: The degree to which users agree that the activities of the consultants meet their needs to address child and youth mental health needs.

Findings: There was limited evidence to provide assessment of this indicator. A number who reported having 'found' Be You 'by accident' rather than as part of structured learning approach were not aware of the consultant role. Those who had engaged with consultants (refer Case Study) reported finding them helpful and effective.

"We've found it quite easily, actually. We did a Zoom meeting at the very start, where the team member at Be You went through with us the modules and how to do them and how to navigate them. It's quite straightforward, really." **Educator** (early childhood) **– leader, South Brisbane Logan**

"We had an online session with the Be You facilitator and she showed us lots of stuff and talked through some of the modules… it was good and helpful. She [Be You consultant] had good knowledge based and about what the sort of underpinning messages are for each of the modules… this was the key for us, as we didn't know where to start or how to roll that out to get maximum kind of learning." **Educator** (early childhood) – **centre director, South Brisbane Logan**

Sub-question a: To what extent does the design of the Program address the needs in the community

Indicator 4: The degree to which users prefer self-directed/online learning used in the Program versus alternative learning modalities not utilised in the Program.

Findings: Many interviewees, especially those residing in rural and remote areas, found it difficult to learn online because of their limited access to reliable internet. Others noted a lack of time or learning space after hours to engage with self-directed learning. Some others also preferred face-to-face delivery of training as they found youth mental health training better with in-person mentoring and practicing.

“I found out about Be You, and I talked to the representative in here, and we signed the school up. But it’s hard to say, do this in your free time, to teachers.” **Teacher, Mt Isa**

“The Be You program has really helped me because I can do it on my own time. I can go back again and read it and watch the video or some of that session, so you know it's really given me some ideas and just refresh my mind about things that I've been doing that I have forgotten actually to do.” **Educator** (early childhood); **nursing** background; works with **church** group, **South Brisbane Logan**

“….it's time, you know, because it's something that I'm gonna have to do in my own time. So, it's all very well having an agency offering more training, but if the clinicians who are on the ground can't implement it because of other constraints, that doesn't really resolve the problem very much.” **Practitioner, Cockburn**

Sub-question a: To what extent does the design of the Program address the needs in the community

Indicator 5: The above indicators disaggregated by users working with diverse and at-risk groups.

Findings: There is not enough evidence to provide overall assessment of this indicator. Commentary was noted regarding the lack of culturally specific resources or modules, e.g. for Indigenous and Pasifika groups, or for people from culturally and linguistically diverse (CALD) backgrounds.

Conclusion: The Program design was not considered entirely appropriate, especially not for people in rural and remote areas, or those whose preferred learning style was interactive.

Sub-question c: How well is the Program viewed by participants?

Indicator 1: Reported degree of user satisfaction with access to sufficient resources and services to meet their needs within The Program (i.e. Users do not need to go elsewhere to access information) compared to no Program.

Findings: A handful of users reported the initiatives as useful in terms of providing knowledge and information, and generally rated the Be You platform as being easy to navigate and user-friendly However, it does not provide opportunities or specific information for its users to connect with other professional services (referral points). Focus group participants reported using a broad range of alternative information and training sources to improve their capabilities regarding youth mental health.

“But I do think the point for me, in this sort of counterfactual world, is that I know that that’s [Be You website] is a reliable source of information.” **Teacher, Albany**

Conclusion: There is limited evidence to provide further assessment of this sub-question.

Overarching Evaluation Question 3: How well has the Program achieved its outcome?

Sub question a: To what extent has the Program established an evidence base for mental health promotion, prevention, and early intervention?

Indicator 2: The extent to which users report being better (e.g., more frequent, more confident, more competent users of evidence compared to no Program

Findings: There is not enough evidence from data to provide assessment of this indicator.

Conclusion: There is not enough evidence from data to provide assessment of this sub-question.

Sub question b: To what extent has the evidence base informed mental health policy and programs in schools/support organisations?

Indicator 1: Extent to which users report that their Early Learning Service, school, or organisations have implemented policies and programs to support/reinforce a mentally healthy culture based on the contents of the Program.

Findings: There is not enough evidence to provide assessment of this indicator.

Conclusion: There is not enough evidence to provide assessment of this indicator.

Sub question c: To what extent has the Program improved mental health literacy?

Indicator 1: Degree to which users feel confident identifying children and youth at-risk of experiencing mental health conditions compared to no Program?

Findings:

"I think it [Be You] gives you an awareness of what you - of what things to look out for and, you know, it makes you more self-aware. I mean, we were already on the track because of what we were researching, but it really supported that research for me." **Educator** (ELS), **South Brisbane Logan**

There is not enough broad evidence to provide assessment of this indicator but the Spotlight Case Study offers some support for positive effect.

Sub question c: To what extent has the Program improved mental health literacy?

Indicator 2: Users report an increased willingness to have conversations about mental health with children, young people, and families, compared to no Program.

Findings: Some participants from Logan ELS interviews indicated that staff felt more confident to discuss mental health issues with families, with support from senior staff, as result of their engagement with the Be You training, but would appreciate resources produced for families that would help facilitate this.

"We are not mental health professionals, but we feel equipped with the information that we've got from some of the sites like the Be You and Emerging Minds. So, it provides us with a platform to give the information that we can give to assist the families to find the support they can get." **Educator** (ELS) – **leader, South Brisbane Logan**

There is not enough evidence to provide assessment of this indicator, but the Spotlight Case Study offers some support for positive effect.

Sub question c: To what extent has the Program improved mental health literacy?

Indicator 3: Users report an understanding of the different mental health challenges facing children and youth compared to no Program?

Findings: There is not enough evidence to provide assessment of this indicator. However, community members provided commentary on the dearth of information/understanding about sub-clinical presentations, e.g. how to identify children, especially under-12s, as having mental health needs rather than "being naughty" or "a bit introverted".

"Anyone under five, there's no understanding …GPs have very limited understanding that children are affected at all. I just repeatedly see children with significant mental distress that it's been completely ignored or just no awareness at all." **Child Nurse Practitioner, Cockburn**

Sub question c: To what extent has the Program improved mental health literacy?

Indicator 4: Users report an improved understanding of when it is appropriate to refer children and young people for specialist support compared to no Program.

Findings: There is not enough evidence to provide assessment of this indicator.

Conclusion: There is not enough evidence to provide assessment of this sub-question.

Sub-question d: To what extent has the Program improved access by (target group) children and young people to mental health services?

Indicator 1: The extent that users report an improved understanding, awareness and availability of appropriate service referral pathways compared to no Program.

Findings: There is not enough evidence to provide assessment of this indicator.

Conclusion: There is not enough evidence to provide assessment of this sub-question.

Overarching Evaluation Question 4: How cost-effective is the Program?

Sub-question b: What are the (additional) costs associated with the Program

Indicator 1. Users, Emerging Minds, and Beyond Blue report additional costs are identified as being associated with the Program.

Findings: Participants reported different mental health services available for young people and professional development opportunities available for mental health professionals in each of the Case Study areas. Some professional development opportunities are provided free of charge, others require quite substantial investment. Not all espouse a strong evidence base. This suggests recognition of an ongoing need for a free-to-access, evidence-based learning resource, even in the absence of broad experience of the Program in these communities.

Overarching Evaluation Question 5: Were there any unintended outcomes or consequences associated with the Program?

Sub-question a: What were the unintended outcomes/consequences?

Indicator 2. Target users identify consequences (positive or negative) of the implementation of the Program

Conclusion: There is not enough evidence from data to provide assessment of this Sub-question.